

A New Public-Private Partnership:

Catastrophic Public and Front-End Private LTC Insurance

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Executive Summary

Current U.S. policy toward the financing of long-term services and supports (LTSS) underserves people who need care, overburdens families who care for them, and strains state budgets supporting Medicaid services when personal resources fall short. The fundamental LTSS financing problem is the absence of an effective insurance mechanism to protect people against the costs of extensive LTSS they may require over the course of their lives. Building on the direction of recent bipartisan recommendations, we developed and analyzed a proposal to combine public catastrophic insurance (protection after a waiting period) with gap-filling private LTSS insurance to promote comprehensive insurance protection, focused on middle-income people.

We use the Urban Institute’s dynamic micro simulation model (DYNASIM) to project how public catastrophic protection with either an income-related or a flat waiting period would alter the scope of services, individual or family out-of-pocket costs, and Medicaid obligations for people ages 65 and over, relative to the current LTSS financing system. The Urban Institute’s researchers also estimate the tax costs of financing such proposals.

Regardless of waiting period configuration (i.e., income-related versus flat), a public catastrophic program injects significant new dollars into the LTSS system by enhancing benefits for people with impairments of long duration, reducing unmet LTSS needs and mitigating burdens facing family caregivers. In fact, we project a public catastrophic program for older Americans would enhance LTSS spending by 14 percent, reduce out-of-pocket spending by 15 percent, and reduce Medicaid spending by 23 percent, compared to projected spending under

current law. A program with shorter waiting periods for low- and modest-income people reaches greater numbers of – and devotes more of its spending to – people with low and modest incomes than would a similar benefit with a flat waiting period and could be financed with a 1.0 percentage point addition to the payroll tax beginning at age 40.

Introduction

Finding a way to better finance long-term services and supports (LTSS) is high on the list of the nation's health policy and political challenges, even though it is not high on today's political agenda. Current policy underserves people who need care, overburdens families who care for them, and strains state budgets supporting Medicaid services when personal resources fall short. These already significant shortcomings will only increase as the population ages and more people need care.

The fundamental LTSS financing problem is the absence of an effective accessible insurance mechanism to protect people against the costs of extensive LTSS they may require over the course of their lives, which often far exceed most people's ability to pay. LTSS presents exactly the kind of unpredictable, potentially catastrophic risk and expense, with a high degree of variability, that insurance is designed to address. Most people now turning age 65 cannot know in advance whether they will be among the roughly half of their age cohort who are expected to die without suffering significant levels of impairment – that is, having two or more limitations in Activities of Daily Living (ADLs) or having severe cognitive impairment – or be among the 12 percent expected to need more than five years of substantial care.¹ When LTSS needs last for at least two years, average LTSS spending is about five times higher than for older people whose LTSS needs do not last that long. Most of the nation's LTSS costs are incurred by people with long-lasting needs.²

Although private insurance for LTSS has existed since the early 1980s, it has never grown to meet early expectations.³ Between seven and eight million people have private Long-Term Care (LTC) insurance policies that cover LTSS – less than 10 percent of all people

estimated as able to afford and qualify for a policy.⁴ While some have argued that the Medicaid program, which represents the largest public payer of LTSS, “crowds out” or suppresses demand for private insurance, evidence suggests that the impact is likely modest in light of other issues affecting demand and that such effects are operant at the lower end of the income scale;⁵ even proponents of the theoretical argument for “crowd-out” point to problems with the private products as an empirical explanation of the market’s failure to thrive.^{6,7,8,9,10,11,12}

Recent financial experience has led many major LTC companies to exit the market. The number of insurers willing to sell policies to insure catastrophic or “tail” risk has declined significantly and the proportion of policy sales covering that risk have dropped from about a third in 1995 to less than 10 percent today.¹³ Insurers have also increased their premiums substantially – by 145 percent between 1995 and 2010 for new policies sold to individuals age 55-64 and by 134 percent for new policies sold to people over age 65 – largely in an effort to “true up” unsupportable earlier pricing assumptions. In 2010, only about a third (36 percent) of purchasers were middle-income people.¹⁴

At the same time, public “insurance” – through Medicaid – supports services only after people pay what might be called an “infinite deductible” – that is, only after they expend most, if not all, of their personal liquid financial resources. In many places, Medicaid also limits access to services at home or in the community and there are often waiting lists to receive such services. The fiscal burden on states of a growing elderly population raises questions about the future of even limited Medicaid protections in the coming decades.¹⁵ Recent Congressional efforts included provisions that, if put into effect, would have significantly reduced Medicaid funding of LTSS and other services to the states.¹⁶

Absent private or public insurance, the vast majority of people living in the community who need LTSS rely on families to provide that care. On average, people with significant LTSS need who rely exclusively on their families for help report receiving 173 hours of care over the course of a month – about the equivalent of a full-time job.¹⁷ Although surveys reveal that a majority of caregivers helping with LTSS needs derive personal benefits from their efforts, these benefits come at considerable personal and family costs – including loss of employment opportunities, income, and retirement benefits, especially for caregivers helping people who need a great deal of hands-on care over a long period of time.¹⁸

Finally, not everyone can rely on family caregiving and even many of those who do may not be receiving adequate care. According to the most recent surveys, almost three in four people with the most severe impairments – limitations in three or more basic tasks – report soiling themselves, going without bathing or eating, having to stay in bed or indoors or experiencing other hardships because a task is too difficult for them or because no one is available to help them. Even at lower levels of need, a high proportion of individuals report unmet needs.¹⁹

The lack of an effective LTSS insurance mechanism has not escaped policymakers' attention, but agreement on a policy solution has long been stymied by a fundamental philosophical conflict between those who would limit public policy to the promotion of private insurance and those who regard public insurance as essential to the assurance of adequate, affordable protection. This was evident in the inability of the 2013 Commission on Long-Term Care to come to consensus regarding the proper approach to financing care.^{20,21} This commission was established in part as a result of the failure of the Community Living Assistance

Services and Supports Act (or CLASS Act) – the last national attempt at LTSS financing reform. The CLASS program was part of the Affordable Care Act and would have created a voluntary and public long-term care insurance option for employees, but was repealed January of 2013 as unworkable.

In 2016, however, a number of LTSS financing experts spanning the political spectrum coalesced around a strategy that emphasizes a combined public and private approach to promoting comprehensive insurance protection. The Bipartisan Policy Center endorsed exploration of a public program to cover the catastrophic costs of LTSS, provided that its benefits would be fully financed and that incentives for the purchase of private insurance be put in place.²² Going a significant step further, the Long-Term Care Financing Collaborative explicitly called for adoption of a public catastrophic program to protect against LTSS costs along with strategies to reinvigorate the private insurance market.²³ Finally, LeadingAge, a major trade association representing the non-profit providers of care and services for older adults also put forward proposals supportive of a public catastrophic insurance approach.²⁴ In essence, these groups have argued for the establishment of a public program to cover catastrophic or “back-end” LTSS costs alongside steps to encourage private insurance take-up rates to protect against “up-front” risks.

Changes in the political landscape have replaced efforts to reform federal LTSS financing, and instead are increasingly focused on limiting public LTSS spending. But financing challenges will continue to grow with the aging of the population. Research undertaken now on the design and challenges of specific proposals for LTSS financing reform will provide the

necessary intellectual infrastructure and foundation for effective action when policymakers are inevitably forced to address the issue in the years ahead.

Purpose

The purpose of this research is to consider the costs and distributional impact of a specific design for public catastrophic LTSS protection. The Urban Institute’s dynamic microsimulation model (DYNASIM) is used to project the proposal’s impacts on people, programs, and overall public spending for people ages 65 and over.²⁵ That model has already demonstrated its effectiveness in comparing public LTSS financing options including generalized or stylized front-end, comprehensive, and back-end public insurance approaches. Earlier work also focuses on these more generalized models.^{26,27,28} The model is not only well grounded in thorough analysis of empirical evidence but has also been extensively reviewed by public and private actuaries and LTSS financing experts.^{29,30} Here we extend previous modeling work by focusing on a detailed configuration of catastrophic protection and estimating a broader set of its impacts.

The specific proposal analyzed would provide public protection after waiting periods that would vary with people’s economic circumstances – longer for higher income people, shorter for people with lower incomes. The intent with this design is twofold: first, to target publicly-financed benefits to expenses that exceed amounts that middle-income (along with higher-income) people can reasonably be expected to manage – either with private insurance or personal resources; and second, to enhance the attractiveness and purchase of the limited-coverage private insurance products that insurers prefer by positioning them as gap fillers that, in combination with public insurance, facilitate relatively comprehensive protection against LTSS

costs. To assess the effectiveness of the approach, the analysis compares the impact of an income-related waiting period to an alternative policy that would establish a single or flat waiting period without regard to income. The advantages of a flat waiting period include administrative simplicity and relatively simple communication of the gap people would be expected to fill with private insurance or their own resources.

The analysis aims to answer four questions:

- Who benefits from the new program?
- How does the program alter the availability of services, out-of-pocket spending, and Medicaid obligations relative to projections under current law?
- How does the program distribute benefits across the beneficiary population, by income?
- What are the costs of the program?

Policy Design Features of the Public Catastrophic Insurance Program

Table 1 summarizes the key design features of the income-related program analyzed using the Urban Institute model.

Eligibility

The public insurance benefit would provide benefits to people whose impairments satisfy a functional or cognitive threshold (i.e. benefit trigger) after they experience a waiting period that would vary with income. A time-based rather than an expense-based waiting period is employed in order to recognize and encourage family-caregiving. Eligibility for public benefits is contingent on an individual's having worked for 40 quarters once the program has gone into effect and, as in Medicare, would extend to nonworking spouses. (Program cost estimates assign

nonworking spouses the maximum waiting period, in order not to create inequities between working and nonworking spouses.)

Table 1: Policy Design Features of Catastrophic Public Long-Term Care Insurance Program

<p>Description:</p> <ul style="list-style-type: none"> • A public catastrophic insurance program for LTSS costs that takes effect after an income-related waiting period has been met. • A package of actions designed to spur development of affordable products and significant growth in the private long-term care insurance market.
<p>Eligibility (Phased-In) and Benefit Trigger:</p> <ul style="list-style-type: none"> • Eligibility would be phased in over ten years, with people eligible for benefits once they work 40 quarters after the law’s enactment (assumed as January 1, 2015 for modeling purposes. Current elderly and people with disabilities would not be eligible). • Benefits would become available once people incur impairments in 2+ ADLs and/or severe cognitive impairment – that is, the HIPAA benefit “trigger” for federally qualified private long-term care insurance.
<p>Coverage/Benefits:</p> <ul style="list-style-type: none"> • Up to \$110/day cash benefit (2014 dollars) • Paid out either daily or weekly • Unlimited benefit once an income-related waiting period is met • Waiting period of 1 year for people with lifetime incomes in the lowest two quintiles of the distribution and 2, 3, and 4 years for people with incomes in the third, fourth and highest quintiles, respectively. • Annual benefits increase at the rate that hourly costs increase for home health aide workers
<p>Financing:</p> <ul style="list-style-type: none"> • Premium surcharge on Medicare tax • Medicaid savings due to substitution of new public benefit plus potential impacts of higher private insurance take-up

The benefit would continue as long as an individual satisfied the impairment thresholds. To allow sufficient time to accumulate public funding, to invest in public education, and to implement policies to re-invigorate the private insurance market, the full benefit would be phased in over time. For analysis purposes, the policy is modeled as enacted as if effective in

2015 and would therefore become fully available to individuals who complete the necessary quarters of work on or after January 1, 2025. (Our projections assume that individuals' age 65 or older by that date and already impaired would then face the waiting period appropriate to their incomes.)

Benefit Trigger

Individuals assessed as meeting the current Health Insurance Portability and Accountability Act (HIPAA) impairment thresholds – two or more limitations in activities of daily living (ADLs) or severe cognitive impairment expected to last more than 90 days – would qualify for benefits once they satisfy the waiting period. This is the same standard used today for private LTC insurance policies. The benefit eligibility triggers and the standards used to assess them must be similar across private and public insurance benefits so that there is certainty and continuity of coverage. Independent third-party assessment conducted by trusted and highly respected organizations would therefore necessarily be an important feature of this approach, as employed in both public and private programs today.

Waiting Period for Public Coverage

The length of the waiting period is a function of lifetime income at age 65. Although subsequent projections of program impact reflect only wage-based income, lifetime income could also be defined as total wage and non-wage income, consistent with the application of the Medicare tax under current law. Table 2 shows the relationship between income and the waiting period for the proposal modeled here.

Table 2: Waiting Periods for Public Coverage, by Income Quintile

Waiting Period	Lowest Quintile	Second quintile	Third quintile	Fourth quintile	Fifth Quintile
Family Income Limit for each quintile ³¹	\$28,894	\$50,520	\$78,000	\$121,059	>\$121,059
Average income	\$16,109	\$39,514	\$63,916	\$97,207	\$169,000
Waiting Periods	1 year	1 year	2 years	3 years	4 years

As shown, the choice of waiting periods – which range from one to four years and increase as income rises – is informed by two factors: (1) current premium costs for private insurance policies of different durations relative to incomes and (2) evidence related to people’s willingness to pay for private insurance premiums. We base our measure of “willingness to pay” on both the share of income people are actually spending on private insurance policies and the share of income non-purchasers indicate they would be willing to spend. (We use modeling results from unpublished premium estimates for long-term care insurance, by the actuarial firm Milliman to present average individual insurance premiums by age for alternative policy durations. Since these premiums reflect today’s marketplace, they may be overestimates of premium costs, as the presence of a public program and other actions that we are recommending may generate a much larger market and lead to lower costs over time.)

In 2010, middle-income individuals purchasing private LTC insurance spent an average of 3.6 percent of their income on policies; lower-income purchasers spent 7.5 percent.³² These may be upper-bound estimates of willingness to pay since these individuals likely perceive their risk of need to be higher than that of other individuals. Surveys of middle-income individuals

who were offered policies and chose not to purchase indicate they would be willing to spend 2.2 percent of their income on insurance premiums.³³

Table 3: Relationship between Income Quintiles and Potential Affordability of Private Insurance Premiums³⁴

Waiting Periods:	1 Year Policy	2 Year Policy	3 Year Policy	4 Year Policy
Adjusted 2010 LTC Insurance Premiums				
Age 45	\$488	\$975	\$1,251	\$1,484
Age 50	\$541	\$1,082	\$1,392	\$1,646
Age 55	\$628	\$1,255	\$1,620	\$1,908
Age 60	\$757	\$1,514	\$1,961	\$2,297
Age 65	\$1,012	\$2,023	\$2,625	\$3,053
Range of Percent of Income that would need to be spent on premiums by families (age 50) ³⁵				
Lowest Quintile	3% - >10%	6% - 15%	8% - 19%	10% - 21%
Second Quintile	2% - 3%	4% - 6%	5% - 8%	6% - 10%
Third Quintile	1% - 2%	2% - 4%	3% - 5%	4% - 6%
Fourth Quintile	1%	2%	2% - 3%	2% - 4%
Highest Quintile	<1%	1%	1% - 2%	2%

Given the average cost of policies in the individual market, waiting periods of one to four years, rising with income, would make premiums for gap-filling policies available at about two to four percent of income for all income groups except the lowest quintile – putting them in the range of what people appear willing to spend for such policies. Newer forms of long-term care insurance like family policies – products that combine long-term care with life and annuity coverage – would likely play an increasingly important role in filling the gap between up-front need and back-end coverage, and potentially at more affordable prices.

Facilitating Planning for the Self-Funding Period

To encourage people to plan for future needs, the program would inform individuals beginning at age 40 about the waiting period or gap they would likely need to fill at age 65. The information would be based on projections of their current incomes. Individuals are accustomed to receiving projections from Social Security regarding their likely benefits during retirement and receiving a waiting period projection is in line with this practice. Given the vicissitudes of income over a lifetime and the uncertainties of projections, individuals may end up with waiting periods that are longer or shorter than they had expected. People whose incomes at age 65 are significantly higher than expected would have the opportunity to enhance their private insurance benefits (if needed) to fill the larger-than-anticipated waiting period. They might, however, face stricter underwriting guidelines and higher premiums by purchasing an upgrade at this age. Such individuals would, by definition, be among those with more means. Alternatively, if someone had expected a longer waiting period and, because of lower-than-anticipated income faced a shorter one at retirement, they could “buy-down” private insurance benefits and pay lower premiums.

Benefit Payments: Level and Form

The level of benefit payments modeled is linked to direct service costs, excluding room and board.³⁶ Further, for administrative simplicity and to assure some level of continuity between front-end private insurance and public coverage, modeled is a single daily benefit level, equal to the average hourly cost of a home health aide (which in 2016 averaged about \$22) for five hours a day, producing a total benefit of \$110 per day in 2016.³⁷ The daily amount could be adjusted for geographic variation and changes in costs over time. Historical estimates suggest

that the inflation adjustment based on actual costs would be roughly three percent per year, in line with changes in hourly earnings of home health aides and homemaker services over the past decade.³⁸ While the benefit is keyed off of home care costs, it could be applied to nursing home stays.

Consistent with the trend supporting consumer autonomy and flexibility, modeled is a cash benefit payment rather than an expense reimbursement approach. Cash benefits have raised some concerns. First, there is a concern that they facilitate the substitution of public benefits for family spending, rather than supporting additional services. Second, private insurers typically avoid cash benefits, due to fears that the appeal of cash will lead to overuse of benefits. However, the use and cost concerns for the public catastrophic benefit would be mitigated by the waiting period, with benefits only applicable for some time after the onset of significant care needs.

An alternative approach for those who have purchased private insurance could be to have the private insurance company administer the public benefit after the waiting period has been met, either as a service or cash benefit. If someone chooses the reimbursement model, rather than cash, then they would receive a higher level of payment – say 25 percent higher – under the public catastrophic benefit. Thus, for example, if the cash payment was \$110 per day, when taken on a reimbursement basis, the benefit may be up to \$135 per day. This approach helps to assure managerial and administrative continuity between the two programs and encourages individuals to purchase insurance to cover front-end liabilities.

Program Financing

The program would be financed in large part by increasing the Medicare tax split between employees and employers that would begin at age 40. The premium would be set to assure that the program is self-supporting and actuarially sound for a 75-year period, with defined periodic review periods to assure that if premium adjustments are required, they can be made to meet the sustainability objective. The Medicare payroll tax, unlike the Social Security payroll tax, applies to all wages (is not capped), and, for higher income earners, imposes both a higher tax rate on wages and a tax on unearned income.³⁹ Linking the tax to Medicare is administratively simple and may broaden the program's appeal. Additional financing for the program would come from Medicaid savings that would accrue from the substitution of new public insurance benefits for benefits that Medicaid currently pays.

Private Market Reforms to Promote Gap-Filling Protection

Alongside the public catastrophic program, actions are required to revitalize the private long-term care insurance market to effectively protect people against shorter-term or front-end LTSS needs. As explained in previous work, key steps needed to overcome historic underperformance and enhance market penetration include: (1) reducing the marketing costs of the product, (2) reducing product complexity, (3) changing product pricing strategies, (4) reforming elements of insurance regulation, and (5) repurposing current tax subsidies to assure that benefits are targeted to reach potential middle- and lower-income purchasers.^{40,41} As well, support for new products (e.g. long-term care with life or annuity products) may make insurance accessible to those who would not otherwise pass the underwriting screens for more conventional insurance. These approaches are designed to lower the cost of insurance, change

people’s “tastes” for insurance, and encourage more companies to enter the market to provide new products to cover front-end risk.

While the current knowledge base does not allow an accurate modeling of the magnitude of the impact of these approaches (in the context of a public catastrophic insurance program) on take-up rates, in other countries such as France and Israel, both of which offer limited public insurance coverage, private insurance take-up is significant.^{42,43}

The Impact of Public Catastrophic Long-Term Care Insurance

Using DYNASIM, we now consider how public catastrophic protection with either an income-related or a flat waiting period design could alter the scope of services, individual or family out-of-pocket costs, and Medicaid obligations relative to the current LTSS financing system. In order to assess a fully-implemented program, the projections assume that the program begins in 2015 and results are focused exclusively on the 1976-1980 birth cohorts. These are people who would begin turning age 40 and start contributing at that point. People in that cohort who became impaired would qualify for benefits after the applicable waiting period, once they turned age 65.

Everyone in the cohort who worked and contributed the required 40 quarters could qualify for coverage. The projections indicate that 92 percent of the cohort (94 percent of men, 92 percent of women) would qualify for coverage. The coverage gap reflects limited work experience, most notably among people who receive disability insurance benefits prior to age 49, most of whom are projected never to satisfy the work requirements. Although 35 percent of 65-year-olds in the lowest quintile of the income distribution would not qualify, the gap declines

rapidly to 13 percent of individuals in the third-lowest decile and to less than 10 percent in higher deciles of the income distribution.

Table 4 shows the proportion of covered individuals by specific characteristics who are projected to receive benefits under both an income-related waiting period (defined by income group to be between one and four years) and a flat waiting period (modeled at 2.2 years – the average value of the waiting periods in the income-related approach).

Table 4: Proportion of Eligible Survivors to age 65 receiving Catastrophic Insurance Benefits

Characteristic	Income-Related Waiting Period	Fixed Waiting Period at 2.2 Years
Total	32%	33%
Gender		
Men	30%	30%
Women	34	36
Years of Impairment after age 65+		
Less than 1 year	0%	1%
1-2 years	20	0
2-3 years	39	60
3-4 years	65	92
4-5 years	89	95
5 or more years	96	96
Income Decile at age 65		
Lowest	41%	34%
Second	45	36
Third	43	33
Fourth	43	34
Fifth	34	34
Sixth	35	34
Seventh	33	38
Eighth	28	32
Ninth	22	32
Highest	21	29
Percent of Baseline Costs Covered by the Program	31%	31%

Regardless of approach, roughly one-third of all covered individuals are projected to receive benefits from the program, which is roughly equivalent to the proportion of individuals projected to require care for more than two years. Under both approaches, covered are just under a third (31 percent) of projected LTSS expenses under current law for the overall eligible population –ranging from slightly over a third for people with incomes in the lowest income deciles to about a quarter for people in the highest deciles. Although not shown in Table 4, projected differences across the two waiting period approaches are small. Under the income-related approach, the projected share of expenses covered is two to three percentage points higher for people with the lowest income groups and two points lower in the highest income groups. Under both approaches, the longer the duration of impairment, the more likely people are projected to receive benefits – consistent with the focus on “catastrophic” protection.

The difference in impact between the two waiting period designs is revealed in the varying proportions of people projected to receive benefits by income and by duration of impairment. With an income-related waiting period, the proportion of people projected to receive benefits declines significantly as income rises. That program is projected to reach more than 40 percent of the population in each of the lowest four deciles of the income distribution – seven to ten percentage points higher than the percentage reached by a program with a flat waiting period. This difference between the two approaches disappears in the middle-income ranges, but at high incomes, the proportion of people projected to receive benefits is eight to ten percentage points higher with a flat compared to an income-related waiting period.

Because the flat waiting period approach applies a shorter waiting period for people with higher incomes, a far larger proportion of people with two to four years of impairment would be

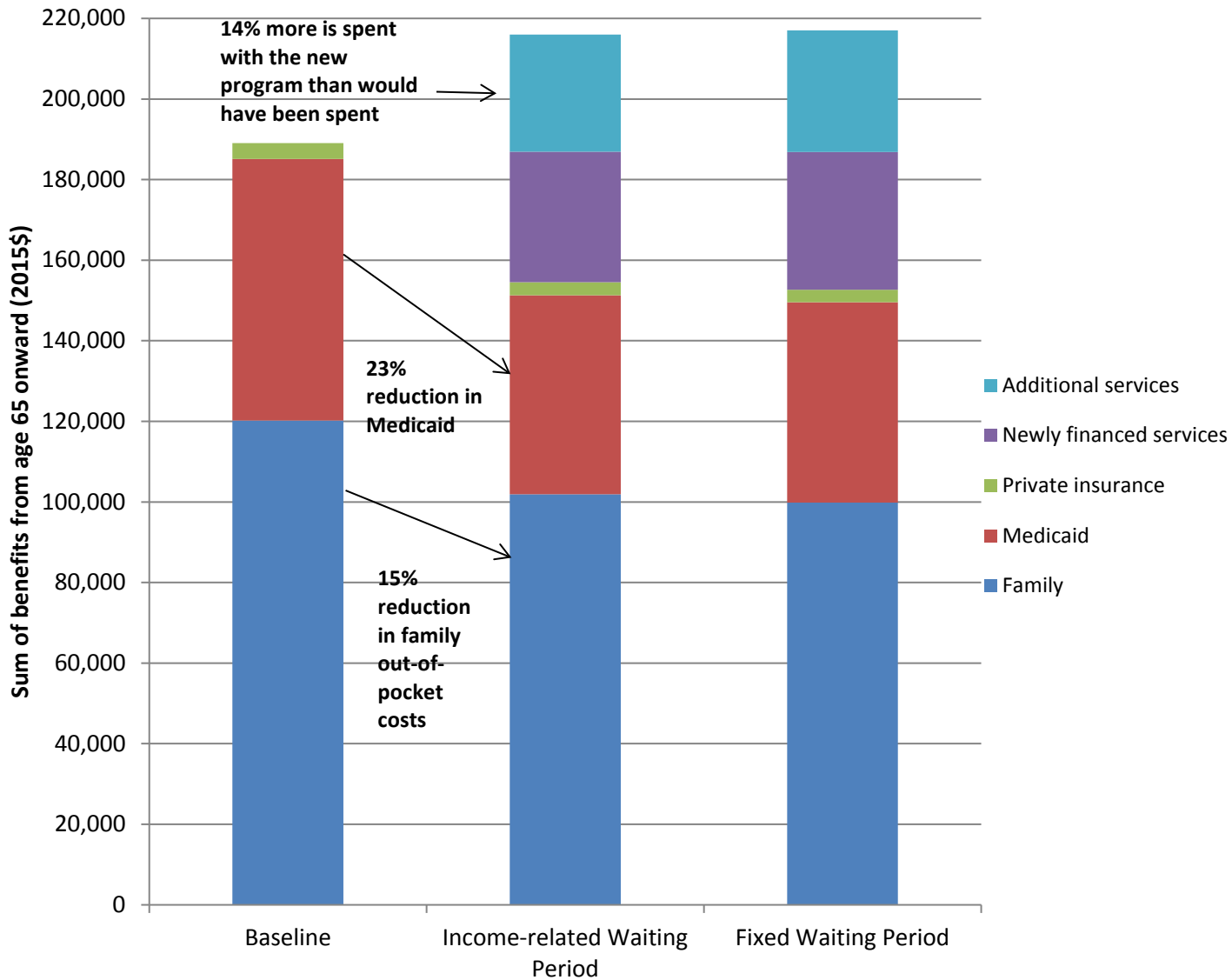
projected to be covered than would be covered with an income-related waiting period (60 percent versus 39 percent for impairment durations of two to three years; 92 percent versus 65 percent for durations of three to four years). The average waiting period for individuals under the flat waiting period scenario is 2.8 years, in contrast to 3.2 years for the income-related design. After four years of a disability spell, both approaches are projected to reach a similar proportion of individuals.

Compared to projections under the current financing system (Figure 1), the two programs have virtually identical aggregate impacts on overall service spending, out-of-pocket spending and Medicaid spending. The new program is projected to increase overall spending by 14 percent (“new services”) and to offset current spending (“newly financed services”) by a roughly equivalent amount. It is also projected to reduce Medicaid spending by 23 percent and out-of-pocket spending by 15 percent, relative to current financing.

Family caregivers and direct beneficiaries would benefit from more paid services, reductions in unmet need, and reductions in the burdens associated with family-provided hands-on caregiving. Previous research shows that even in the presence of significant insurance-financed benefits, families continue to contribute significant effort to caregiving but shift their focus to companionship and assistance with instrumental activities of daily living (IADLs).⁴⁴ This suggests that family care is not a perfect substitute for paid care and that in the presence of insurance-financed benefits, the disabled individual receiving care will experience a net welfare gain, likely at the same time that the caregivers will experience a reduction in the costs associated with workforce accommodations. In fact, the amount of unpaid assistance provided to

people with private LTSS insurance is only 6 to 15 percent lower than provided to people without insurance.⁴⁵

Figure 1: Sum of LTSS (2015 dollars) spending from age 65 onward by payers under baseline and alternative waiting period options fully-phased in cohorts (born 1976-1980)



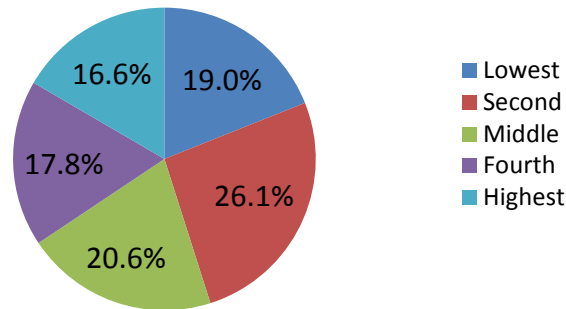
Source: Author's tabulations from DYNASIM3.

Notes: Sample excludes unauthorized and late arriving immigrants. Assumes no administrative costs and a retrospective program start to 2015.

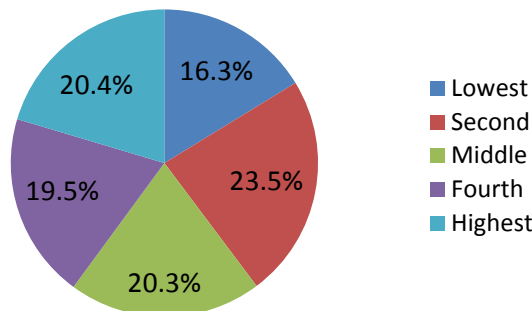
Figure 2 shows the projected distribution of total spending by option across income quintiles of the population. People in the two lowest income quintiles receive about a five percentage point larger share of total benefits with an income-related than with a flat waiting period (45 percent versus 40 percent), while people in the two highest income quintiles receive a six percentage point smaller share (34 percent versus 40 percent).

Figure 2: Share of new spending under back-end LTSS programs to people ages 65 and older by lifetime family earnings quintile, fully phased in cohorts (born 1976-1980)

Income-Related Waiting Period



Fixed Waiting Period



Source: Author's tabulations from DYNASIM3.

Notes: Sample excludes unauthorized and late arriving immigrants. Quintiles are defined at age 65, based on survivors to that age.

Variation between the two approaches becomes more apparent when the projected distribution of benefits is compared across income deciles (Figures 3 and 4). The figures present the mean value of total benefits under the program by income decile – distinguishing new services, out-of-pocket savings and Medicaid reductions by income decile.

Figure 3: Distribution of mean LTSS Spending Changes: Income-Related Waiting Period (2015 Dollars)

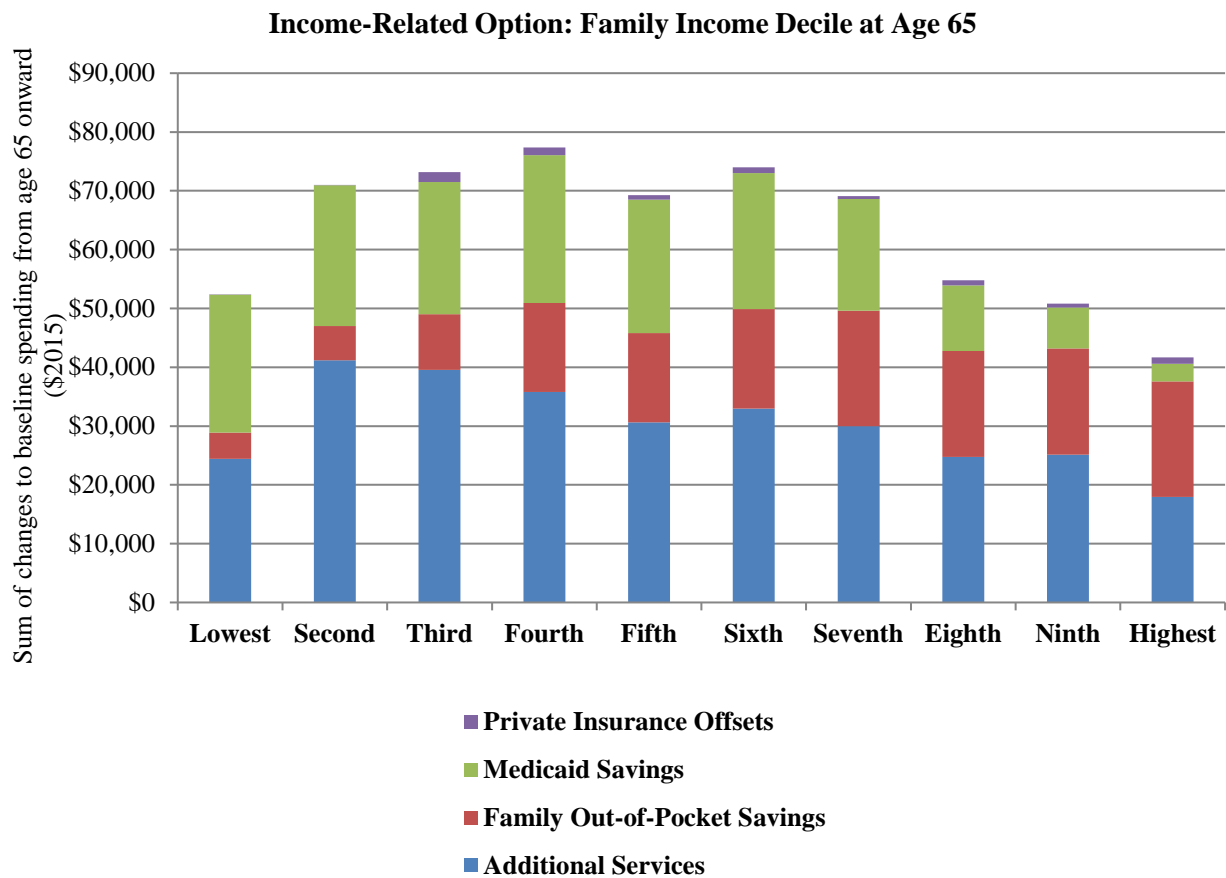
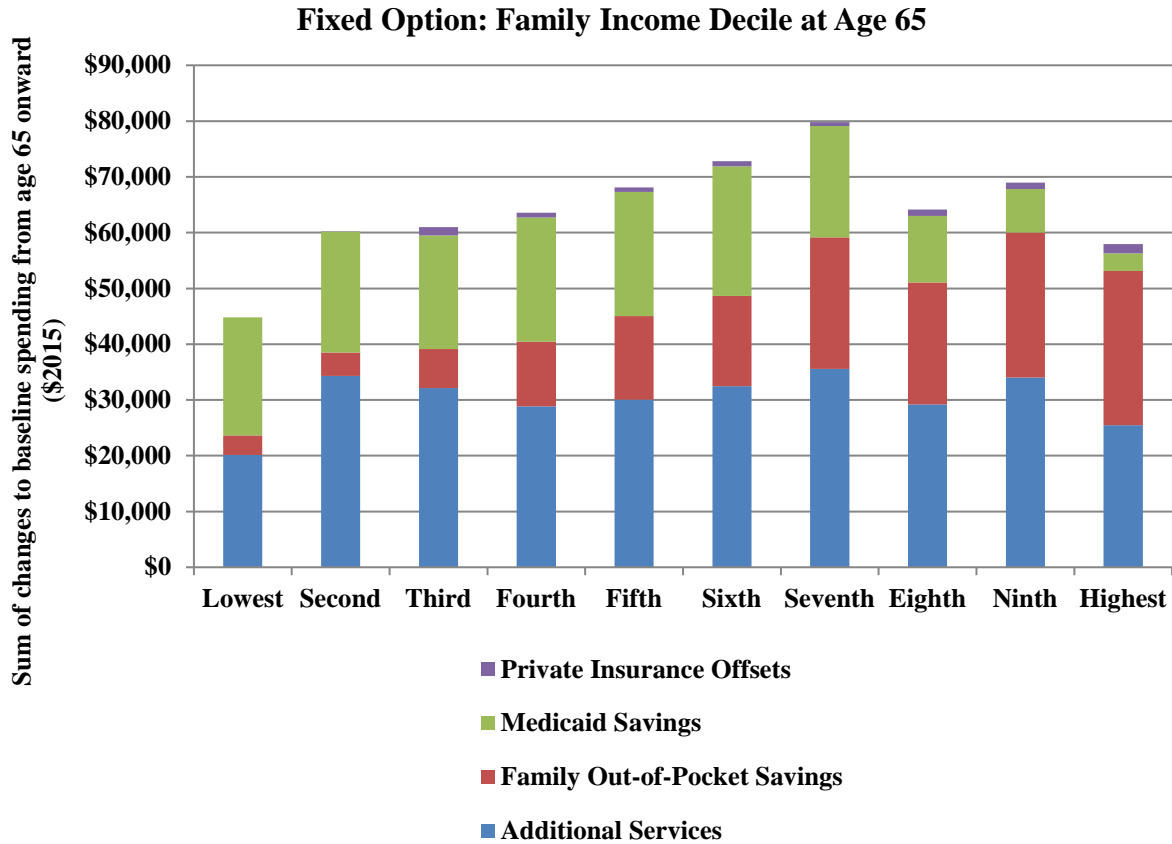


Figure 4: Distribution of Mean LTSS Spending Changes for Fixed Waiting Period (2015 Dollars)



The key difference is that when targeting is based on an income-related approach rather than a flat-waiting period, higher levels of new services are projected for lower-income deciles (i.e. the second, third and fourth income deciles) and there are lower projected reductions in out-of-pocket costs at the higher-income deciles (i.e. in the seventh decile and above). More specifically, these lower-income individuals are projected to receive about \$39,000 in higher new benefits and the out-of-pocket savings for these higher-income individuals are reduced by an average of \$19,000. Projected Medicaid savings are roughly similar across the two groups.

As explained at the outset, benefits would be financed through an increase in the Medicare tax. It is designed to assure fiscal sustainability over a 75-year period and paid by people age 40 and over. The current Medicare tax is 1.45 percent of all earnings for most workers and 2.35 percent of earnings for workers whose incomes exceed a threshold. (The thresholds are \$250,000 for married taxpayers who file jointly and \$125,000 for married taxpayers who file separately and \$200,000 for single and all other taxpayers.)

For individuals who exceed that threshold, there is an additional 3.8 percent tax on unearned income. For ease of estimating, we focused only on the earned income tax base and estimated that an *additional tax* of about 1.0 percent of earned Medicare-covered income would be sufficient to finance the proposed program over the required period assuming that the surplus revenue from early years were invested in a secure Trust Fund. (This is higher than a comparable estimate from Actuarial Research Corporation, which estimated an additional Medicare payroll tax of 0.85 percent.) This represents a higher rate than would be necessary if the surcharge would be applied to unearned income, as well. The dollar amount that corresponds to these tax rates for a worker earning the average covered wage in 2016 (\$48,642) is \$486 per year or roughly \$41 per month – an amount roughly equivalent to the monthly cost of internet access. If the tax surcharge is split evenly between employees and employers, then the direct cost to employees is about \$20 per month.

Summary and Discussion

The goal of this analysis was to present and assess a specific approach to combining public catastrophic LTSS insurance with a reinvigorated private LTSS insurance market in order to promote relatively comprehensive insurance protection, especially for middle-income people.

The analysis shows that regardless of waiting period configuration (i.e. income-related versus flat), a public catastrophic program injects significant new dollars into the LTSS system—enhancing benefits for people with impairments of long duration, reducing unmet LTSS needs and mitigating burdens facing family caregivers. The analysis also shows that a new catastrophic insurance program of this scope would reduce the financial burden of LTSS felt by millions of families by an estimated 15 percent, and would reduce Medicaid’s fiscal burdens on states by almost a quarter. The latter reflects the substitution of contributory public insurance financing – a dedicated premium/tax – for services currently financed out of general revenues at the state and federal levels.

The projections indicate that differences in waiting period design make a difference to the distribution of benefits across people at different income levels. A program that applies shorter waiting periods for low- and modest-income people and longer waiting periods for higher-income people will reach more of, and devote more of its spending to, people with low and modest incomes than would a benefit with a flat waiting period equivalent to the average waiting period under the income-related approach.

These projections of impact do not take into account the potential effects of the insurance reforms designed to enhance the capacity of private insurance to fill in up-front gaps in a public catastrophic program. A roughly comparable example of the potential for a private market “wrap-around” of a public insurance program is the Medigap insurance market, where there is significant market growth with projections of more than 19 million older adults having policies in the next few years and more than 285 carriers currently in the market.⁴⁶ A vibrant market with multiple policy configurations is critically important to enabling middle-income people to

plan for our proposal’s significant level of uncovered up-front obligations. The fact that the public sector would be covering the “tail risk” – something that private insurers are unwilling to do – should encourage new carriers to enter the market in the context of well-defined public and private responsibilities, enhancing the value of the product in the eyes of consumers.

The analysis raises a number of questions. The most fundamental is whether the targeting of benefits to middle-income people accomplished with an income-related waiting period is sufficiently effective to warrant the administrative complexity this approach would necessarily entail. Although the income-related waiting period reaches more modest income people with greater benefits, the difference in actual dollars is relatively small. However, a flat waiting period of roughly two years would make private insurance coverage unaffordable for more modest income families. Adequate insurance protection for middle-income people would therefore require other mechanisms – whether reforms in Medicaid eligibility or income-related subsidies to encourage the purchase of gap-filling private LTSS insurance.

Clearly a program that has both an income-related benefits approach and a highly progressive financing mechanism will face significant political hurdles, and not only in the current political environment. Thus, as an alternative to a mandatory tax-financed approach, one might consider treating the Medicare surcharge more as a premium than a tax by allowing people the opportunity to opt out of the program. To limit adverse selection, people could be given the opportunity to opt out twice, for example, between the ages of 40 and 55, and their obligation to pay the tax throughout their working years is triggered only if at age 55 they explicitly chose to participate. To encourage early participation, the surcharge might be higher for people nearing retirement – increasing beginning at age 60. Though potentially feasible and a lighter political

lift, previous analysis suggests that the scope of coverage would likely be much more limited with this approach.⁴⁷ Major changes in attitudes and knowledge would have to occur in order to encourage very high participation rates, which would mitigate adverse selection.

Nearly 40 percent of individuals receiving LTSS services are under age 65, and the program modeled here does not address this population.⁴⁸ The current program could be extended to younger people with disabilities by adjusting work requirements, as Social Security does, with important cost implications. Certainly, how best to fully address meaningful LTSS insurance protection for younger as well as older people requires full and thoughtful treatment, and was beyond the scope of the current analysis.

The analysis also reveals the significant transitional issues associated with a pre-funded public catastrophic program. The analysis focused on the impact on people who will have had the opportunity both to work and to make necessary tax contributions from age 40 onward. Reliance on self-funding necessarily means excluding baby boomers too old or otherwise unable to work and contribute for 40 quarters, once the program has begun. And it clearly excludes people already in need of LTSS. Unless general revenues support a transition plan that does not require full contributions from older workers and that supports better, if not full, protection for people already impaired when the program begins, the current strains on individuals, families and state governments will persist for at least another 20 to 30 years. The implication is that Medicaid will remain a vital part of the nation's overall LTSS system – whether for people currently impaired or for people for whom our proposal is insufficient to provide meaningful insurance protection against substantial LTSS risk.

Underlying the analysis is the fundamental premise that insurance is the most appropriate and effective way to finance the unpredictable catastrophic risk of LTSS – the only reasonable way to enable people to plan or take responsibility for potential LTSS needs. The proposal offers a path to achieving that goal, through a combination of public catastrophic and limited private insurance protection. The intention is that it contributes to the analytic foundation essential to shifting from an LTSS system dependent on impoverishment and last-resort public financing to a financially sound insurance system that can provide meaningful protection for people with LTSS needs.

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