

CHAPTER 3

THE RISE AND FALL OF THE CLASS ACT: WHAT LESSONS CAN WE LEARN?

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The Patient Protection and Affordable Care Act (ACA) of 2010 (HR 3590/ PL 111-148)¹ included the Community Living Assistance Service and Supports (CLASS) Act, a voluntary national long-term care insurance program. The CLASS Act had the potential to begin to shift long-term care financing in the U.S. from a structure that relies heavily on the means-tested Medicaid program to a more financially sustainable and consumer-oriented insurance-based system. However, as designed, CLASS attempted to accomplish two disparate goals: It was both a benefit program for working people who already have a disability and voluntary insurance for those seeking to hedge against the cost of future disability. As a result, in a phenomenon known as adverse selection, large numbers of high-risk buyers could drive up premiums and threaten the program's viability. Because of these and other problems the Obama Administration concluded the program was not viable and abandoned it in October, 2011.

What were the flaws in CLASS, how can it be improved, and what are possible next steps to build on this controversial idea?

Background

In contrast to acute medical care, long-term care helps those with chronic illnesses manage their daily lives in relative comfort and security. Such care is provided to both the frail elderly and younger people with disabilities, and may include assistance such as eating, bathing or toileting, cooking, or eating. It may be provided at home, in a nursing facility, or in other settings such as assisted living facilities or group homes.

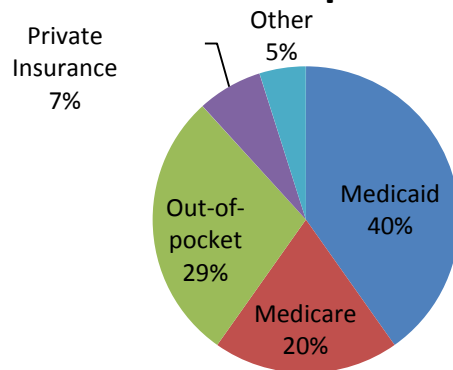
About two-thirds of those who turned 65 in 2005 will need some long-term services in their lives. They will require assistance for an average of three years over their remaining lifetimes (Kemper, Komisar, and Alexih 2005).² Currently 10 million Americans need some form of long-term care. Sixty percent are 65 or older.

Long-term care can be extremely expensive. The "private pay" rate for a single room in a nursing home averages \$75,000 per year. Home health aides cost an average of \$20 per hour (Metlife 2009). A person would have to put away nearly \$50,000 at age 65 to cover the average lifetime cost of long-term care (Kemper, Komisar and Alexih 2005).³ Overall the U.S. spent about \$230 billion in 2008 on long-term services.

In the United States, 40 percent of paid long-term care is funded by Medicaid, the joint federal-state health program for the poor.⁴ Less than 10 percent is financed by private long-term care insurance. Much of the remainder is paid out-of-pocket by those receiving care or by their families (Komisar and Thompson 2007). However, it is important to note that well over half of all long-term care is informal unpaid assistance provided by friends or relatives, usually spouses or daughters (Johnson, Toohey, and Weiner 2007). AARP calculates the economic value of this care was \$375 billion in 2007 (Houser, Fox-Grage and Gibson 2009).

Figure 1: Long-Term Care Spending in the U.S.

Share of Total Spending 2008



Source: SCAN Foundation/Avalere Health (2010)

While the existing Medicaid-based system offers relatively comprehensive coverage for the poor, it is problematic for the middle class. To become eligible, people face severe income and asset limitations and must effectively impoverish themselves. In most states, an unmarried individual must “spend down” financial assets to \$2,000 to qualify.

Although the United States makes limited consumer-directed care available through Medicaid, most payments are still made directly to highly-regulated and licensed providers, such as nursing homes or home care agencies. In addition, Medicaid provides a federal entitlement for institutional services only. As a result many frail elderly and younger adults with disabilities receive benefits only if they reside in a nursing facility, despite consumers’ preferences to remain at home as long as possible. In recent years, Medicaid has taken steps to rebalance its benefits through multiple state waiver programs. However, in 2007, nearly three-quarters of the program’s long-

term care benefits for adults with disabilities and the frail elderly were paid to nursing facilities (AARP 2009).

At the same time, growth in long-term care costs for both the elderly and disabled is driving substantial increases in government health expenditures, especially for Medicaid, which spent more than \$100 billion—or one-third of its budget—on such assistance in 2007 (Burwell, Sredl, and Eiken 2008). This cost growth may become especially problematic as 77 million Baby Boomers reach old age over the next three decades. By 2050, total Medicaid spending could exceed 6.5 percent of Gross Domestic Product (Kronick and Rousseau 2007), the equivalent of \$900 billion today.

Consumers seeking to hedge against their risk of needing costly long-term services may purchase private insurance (Stevenson, Cohen, Burwell, and Tell, this volume). However, to date the demand for such insurance has been modest due to the price and complexity of policies and the reluctance of consumers to confront the costs of potential disability in old age. In addition, in a process known as medical underwriting, private insurers may deny coverage or charge higher premiums to applicants with pre-existing conditions.

The existence of Medicaid may be a further disincentive to the purchase of private insurance (Brown and Finkelstein 2004). There are roughly 7 million policies in force, covering only about 10 percent of adults.⁵

History of the Class Act

Its supporters intended the CLASS Act to be the most significant reform in the financing of long-term care since the creation of Medicaid in 1965. However, CLASS may be seen as only one step—albeit a noteworthy one—in a decades-long process aimed at addressing structural flaws in the initial Medicaid design.

The Pepper Commission

In 1990, the U.S. Bipartisan Commission on Comprehensive Health Care [chaired by Representative Claude Pepper (D-FL) and commonly known as the Pepper Commission] identified the flaws in Medicaid long-term care. It noted the development of private long-term care insurance—at the time a relatively new product. But the panel questioned whether such a product could provide comprehensive coverage to sufficient numbers of elderly and disabled (U.S. Bipartisan Commission on Comprehensive Health Care 1990).

The commission explicitly rejected a “two-tier” system of Medicaid for the poor and private insurance for the well-off. It also chose only limited public insurance. It gave two reasons. First, echoing concerns first raised in the 1965 Medicaid debate, the

panel concluded that costs for nursing home care would “require substantial public resources.” Second, it feared social insurance would allow the wealthy to preserve assets without having to buy private insurance.

Under the Commission’s design, government would provide benefits for all those with severe disabilities, regardless of age. It would pay for most home care, but individuals would be responsible for a modest co-payment. The program would also pay for the first three months of nursing home care for all, regardless of income. Longer-stay nursing home residents would also be eligible for benefits, but only after they had “spent-down” to the program’s new asset limits. However, protected assets would be significantly higher than in Medicaid. The Commission would have allowed individuals to preserve up to \$30,000 (\$60,000 for couples) in financial assets. Even today, Medicaid only permits individuals to retain no more than \$2,000. The Commission also recognized that some consumers would want to buy long-term care insurance to supplement the new government benefit. As a result, it recommended these purchasers receive the same tax benefits as buyers of health insurance.

The Pepper Commission recognized this new program would be expensive—it estimated \$70 billion annually in 1990 dollars. It did not recommend a specific new tax to fund the benefit, but urged that any financing mechanism be progressive, sufficient to keep up with benefit growth, and imposed on people of all ages.

While none of the major Pepper Commission recommendations were adopted, many of its concepts were embraced three years later by the Clinton Administration as part of The Health Security Act--its ambitious, but ultimately ill-fated, health reform plan.

Long-Term Care Reform in the Clinton Health Bill

The Health Security Act would have created a new state-administered, but nearly entirely federally financed, Home and Community-Based Services (HCBS) program for severely physically, developmentally, mentally, and cognitively impaired individuals, regardless of age (Office of Disability, Aging and Long-Term Care Policy 1994). And, in a key change from Medicaid, all medically-eligible individuals could receive home care benefits, regardless of income. However, institutional care, as well as assistance for those with less severe disabilities, would remain in the welfare-based Medicaid program. In addition, users would pay co-insurance tied to their income levels.

While these long-term care provisions eventually died with the rest of Clinton health bill, other reforms surfaced during Congressional debate. One, especially, would play a key role in future reform efforts. In June, 1994, the health reform bill approved by the Senate Labor and Human Resources Committee included The Life Care Act,

introduced by Senator Edward Kennedy (D-MA).⁶ That proposal would have created a voluntary, fully-funded public insurance program to cover extended nursing home stays (Weiner et al. 2001).

Other Reform Efforts

For more than a decade after the demise of the Clinton health bill, much of the focus on long-term care shifted to improving the delivery mechanisms under Medicaid. The federal government and the states took modest steps to shift Medicaid from a nursing home benefit to one that also assists those receiving care at home. This was done principally through the use of limited demonstration projects, as well as the more widespread use of state waivers. These exceptions allowed states to offer home care benefits under certain federal strictures.

This shift has occurred steadily, but slowly. Today nursing home residents continue to be the only enrollees entitled to Medicaid long-term care benefits. State home care programs remain optional, vary widely in scope and quality, and are often underfunded. As a result recipients continue to face either limited benefits or long waiting lists.

While some modest changes were being made in Medicaid, long-term care financing reform in the U.S. largely languished in the policy wilderness. Congress adopted only two significant initiatives—both aimed at enhancing consumer demand for private long-term care insurance. In the Health Insurance Portability and Accountability Act of 1996, Congress approved modest tax incentives to encourage the purchase of private policies. These were scaled-back versions of ideas developed in the Health Security Act. At the same time, more than 30 states enacted tax incentives to encourage purchase of private policies, although there is little evidence these subsidies significantly increased participation rates (Stevenson, Frank, and Tau 2009).

In 1988, the Robert Wood Johnson Foundation funded an experiment known as the Long-Term Care Partnership Program. Originally adopted by four states, the Partnership allowed consumers who purchased long-term care policies to qualify for Medicaid without first having to impoverish themselves. Initially, it produced only modest increases in purchases of long-term care insurance. Congress expanded the Partnership program significantly in 2005, and, as of May, 2010, 37 states were participating. To date, about 120,000 new policies have been sold under the expanded program.⁷ There is not yet evidence of the effects of this expansion on state Medicaid costs.

Even as the U.S. moved to enhance the use of private long-term care insurance to partially substitute for Medicaid, other major developed nations were moving in a

very different direction.⁸ In the 1990s, they too had recognized their means-tested long-term care financing systems were placing severe financial strains on government finances even as the care they funded was less than satisfactory. However, their solution was the one explicitly rejected in the U.S.—universal government long-term care insurance (Gleckman 2010).

Table 1: International Models for Long-Term Care Financing

	Financing	Benefit	Eligibility	Coverage by Private Insurance
U.S. (Medicaid)	General Revenue	Service/ Limited cash	Means-tested	<10%
France	General Revenue	Cash only	Universal for 60+ /Steep income-related coinsurance	25% of those 60+
Germany	Payroll Tax	Cash or Service	Universal	<10%, Optional for high-earners
Japan	Payroll Tax/ General Revenue/ Income-related Premium	Service only	Universal for 65+	None
CLASS	Voluntary premium	Cash	Universal	<10%

In 1995, Germany created a system that provides either a cash or service benefit to adults of any age with limited functional ability. The German system is funded by a payroll tax—currently about 2 percent—and aims to finance about 50 percent of the cost of home care. Institutional benefits are also provided, but for nursing care only. Room and board are excluded. In Germany, some buyers may purchase private insurance in lieu of government policies, though fewer than 10 percent do so.

In 2000, Japan designed a system of national insurance that aimed to pay 90 percent of the cost of home care for those 65 and older or those 40-64 with age-related disabilities. Japan provides a service benefit only. Much like Medicare, the Japanese system is funded by a mix of payroll taxes, general revenues, and income-related premiums.

In 2002, France created a long-term insurance benefit as part of its national pension system. French insurance is funded through general tax revenues. Benefits are

available to those who are age 60+, and are paid in cash only. All those who meet a functional test are eligible for assistance. However, benefits are steeply means-tested. As a result, middle- and upper-middle class people have begun to purchase private long-term care insurance to supplement their government coverage. Private insurance, which was unknown in France prior to creation of the national benefit, now covers about 25 percent of those age 65 or older, and pays about 30 percent of all long-term care costs.

The CLASS Act

In 2003, with little fanfare, Senator Edward M. Kennedy (D-MA) began to develop a long-term care insurance model that was dramatically different from both the proposals of the Pepper Commission and the Clinton Administration on one hand, and the social insurance model adopted by much of the developed world on the other.⁹ The initial focus of this new initiative was working adults with disabilities as well as the frail elderly. Unlike the Life Care Act, it was aimed at people receiving care at home, rather than in nursing facilities.

Since the 1970's, Senator Kennedy had been deeply involved in expanding opportunities for people with disabilities. In 1999, for example, he cosponsored the Ticket to Work and Work Incentives Improvement Act. This legislation made it possible for adults with disabilities to retain Medicaid benefits while employed. But by 2003, Kennedy was looking to break the link between personal care needs and means-tested Medicaid program. His intent was to provide a maximally flexible benefit outside of Medicaid that could help a working person with disabilities with activities of daily living. His solution was insurance.

From the first drafts in 2003, Kennedy insisted on several elements aimed at assisting the working disabled. Benefits would be in cash. They would be available for life or as long as care was required. In addition, no one could be denied coverage due to pre-existing health conditions, so even those who already had functional limitations could become eligible for benefits.

However, Kennedy also recognized the need to keep premium costs relatively low. The 2005 version of the bill proposed an average monthly premium of just \$30. His 2009 version estimated premiums would average \$65. To keep premiums low, the daily benefit would be relatively modest—\$50 for someone who required assistance with two activities of daily living or \$100 for a person who needed help with four ADLs. Kennedy also included two provisions intended to substitute for traditional underwriting: People would have to be actively working to participate in the program, and they would have to be enrolled in CLASS for five years before claiming benefits.

Kennedy made one other critical decision. While the insurance industry and many independent analysts urged him to make the program mandatory, he never seriously considered this option, either for individuals or employers. While Kennedy recognized the potential economic benefits of a mandatory program, he felt such a system would not be approved by Congress. However, while CLASS was not mandatory, workers would be automatically enrolled in the program by those employers that chose to participate. Employees could reject coverage, but to do so they would have to make an affirmative choice to opt-out of the program.

All of these elements were included in Kennedy's first CLASS bill, introduced as S. 1951 on November 2, 2005. Kennedy's cosponsor on that version was a conservative Republican, Senator Michael DeWine of Ohio. Later versions, including the 2009 measure that became the basis for the legislation included in the ACA, were remarkably similar to the 2005 proposal. However, several key changes were made before the final bill was passed. While earlier versions included both premium and daily benefit amounts, the final bill gave the Secretary of the Health and Human Services substantial discretion to design CLASS insurance policies. The projected premium costs were dropped, and the two-tier benefit structure was replaced with a design that allows for between two and six benefit levels. In addition, while some early versions allowed unemployed spouses of eligible workers to enroll, this provision also was dropped in the final measure.

In sum, CLASS became a hybrid aimed at achieving several goals at once. It took on some characteristics of national government insurance, but was voluntary. It represented the first steps away from means-tested Medicaid long-term care benefits, but also maintained Medicaid as a key component of long-term care financing. It was both insurance for those who seek to protect themselves should they age into disability, and effectively a guaranteed benefit program for those with pre-existing disabilities who work.

Because CLASS enrollment was explicitly tied to work, current retirees were not eligible. While relatively young seniors could continue—or resume—work to take advantage of the program, CLASS was principally aimed at creating an insurance program for younger people.

It should be noted that social insurance is not necessarily mandatory. For instance, participation in Medicare parts B, C and D is optional. However, successful social insurance programs must approach universal participation, whether through mandates or incentives for participation sufficiently strong to make enrollment nearly universal (Van de Water 2008). For instance, 95 percent of seniors are enrolled in either Medicare Part B or C. Although participation is optional, the combination of public

subsidies and late enrollment penalties, as well as the immediate need for services, has generated extremely high take-up.

How Did CLASS Pass?

Until the summer of 2009, few expected CLASS would be added to the health bill. Advocates were divided over whether to try to include long-term care in a broader health measure and CLASS itself had little political support. Kennedy's cosponsor, Senator DeWine, was defeated for reelection in 2006 and no other Republican stepped forward to support the bill. Kennedy himself fell ill in May 2008 and was limited in his ability to advocate for either broad health reform or the CLASS Act. Senate Finance Committee Chair Max Baucus (D-MT), who was a key player in the health reform effort, did not support CLASS. While Barack Obama had co-sponsored CLASS as a senator, he said little about long-term care during his presidential campaign and did not publicly endorse the bill until late in the health reform debate.

The long-term care insurance industry was divided on the bill, although major carriers were strongly opposed since they feared it would discourage consumers from purchasing private coverage.

Despite these problems, CLASS had important support. Though ill, Kennedy remained enormously influential in the health debate and was deeply committed to CLASS. In the House, the bill was introduced by senior Democrats John Dingell (D-MI) and Frank Pallone (D-N.J.). At the grassroots level, Kennedy succeeded in building a broad coalition of advocates from both the disability and the aging communities, as well as some long-term-care providers—groups that rarely worked together. In addition, while CLASS had few congressional supporters, it also attracted relatively little criticism since most opponents were devoting their energies to other provisions of the broader health bill.

However, CLASS probably passed in large part due to the Congressional Budget Office, the official scorekeeper of the cost of legislation. In June and July of 2009, CBO estimated that CLASS would generate \$58 billion in revenues from 2010-2019 (Elmendorf 2009a). Due to the bill's five-year vesting period, it would produce premium income during its early years but pay no claims. This windfall, the congressional Democratic leadership claimed, would help reduce the budget deficit, blunting Republican objections that the ACA would increase fiscal shortfalls (Gleckman 2009). While the initial Democratic interpretation raised serious questions about the insurance nature of the bill and its ability to build up reserves, CBO's budget accounting turned CLASS from something of a sideshow into an integral part of the Affordable Care Act.

The final version of CLASS included provisions intended to protect the integrity of both premiums and reserve fund investment earnings. However, due to CBO conventions, CLASS still was scored as reducing the deficit by \$70.2 billion over 10 years (Elmendorf 2009b).

It should be noted that while some critics of CLASS claimed five-year vesting was included expressly to help finance health reform, this argument is implausible. The waiting period was included in CLASS as early as 2005, four years before the health reform debate. In addition, CLASS would likely have produced a similar temporary build-up of revenues had it relied upon traditional underwriting since very few policyholder would go to claim within five years of purchase.

A Brief Description of CLASS

The CLASS Act was designed as a national voluntary long-term care insurance program. Coverage was to be provided by the federal government although CLASS was to be fully funded by premiums without additional taxpayer support.

There was no underwriting, thus coverage was guaranteed and premiums could not be adjusted to reflect pre-existing conditions. Those 18 and older who worked, even part-time, were eligible to participate. Very low-income workers and students would pay a monthly premium of \$5. For others, premiums were age-rated and level. Thus, a participant would pay an initial premium based upon age at enrollment that would not increase over the enrollee's life. However, premiums could be raised for all to maintain solvency for a 75-year period.

Participation was voluntary. In an effort to increase take-up, some workers would be automatically enrolled in CLASS insurance, though they would have the option to opt-out. However, this auto-enrollment feature applied only to employees at firms that chose to participate in the program. The law included neither requirements nor incentives for such employer participation. Other workers could voluntary enroll through an undefined mechanism.

Participants were eligible for benefits after a five-year vesting period. Daily benefits were to be paid in cash, average a minimum of \$50 and increase with an enrollee's need for personal assistance, and would be paid for life. The cash benefit could be used for a wide range of purposes, including paying family members for assistance, hiring home health aides or nurses, adult day care, assisted living, or skilled nursing facilities. Benefits could also be used to make a home accessible to someone with disabilities. Expenses for marketing, counseling, and other administrative costs would be limited to 3 percent of premium revenues.

This overall design would have resulted in extremely high premiums. HHS staff concluded that monthly premiums for basic CLASS insurance as defined in the statute would have averaged as much as \$391. At such a level, few healthy people would buy, and participation rates would have been only 2 percent.

Many details of CLASS insurance design were left to the discretion of the Secretary of Health and Human Services (HHS). The Secretary had until October, 2012 to develop a specific insurance design. However, on October 14, 2011, the Secretary declared that CLASS insurance was unsustainable and ordered her department to cease implementation of the program.

Well-Intentioned But Poorly Designed: Why CLASS Failed

CLASS had the potential to become a critical bridge from the current means-tested Medicaid system to a more sustainable insurance-based design. Such a reform promised benefits for both government and recipients of long-term care and their families. It would make it possible for both federal and state governments, which face a long period of deep financial stress, to transfer some risk of long-term care to households. This would allow them to target increasingly scarce Medicaid resources to those who need them most.

Middle-class families would insure themselves against part of the risk of long-term care (Medicaid would remain a safety net). While individuals who chose to enroll would be responsible for pre-funding a share of their future long-term care costs, these buyers would benefit since CLASS would provide both an additional financial resource and broad flexibility to tailor care to their individual needs. In addition, it may have somewhat reduced the caregiving burden now borne by family members.

The steady and predictable revenue source provided by CLASS would likely have driven changes in the provider market as well. For instance, it may have created new incentives for innovation in delivery designs, such as new forms of community-based assisted living.

However, after her staff spent nineteen months analyzing the law, HHS Secretary Kathleen Sebelius concluded that it would be impossible for her department to design a sustainable insurance program. What went wrong? Why did she abandon the program and what could be done to improve it?

CLASS was killed long before policies were ever offered for three reasons: political, legal, and financial. In 2010 and 2011, the Obama Administration faced strong opposition to many elements of the ACA. While many objections to the overall health law were partisan in nature, criticism of CLASS was bipartisan, with many key

Democrats, as well as Republicans, expressing strong reservations (Gleckman, 2011). Much of this concern was focused on the fear that the program would be unable to sustain itself and eventually require significant taxpayer support to remain solvent. In addition, because CLASS addressed long-term care, it was easily separated from the rest of the ACA, which was principally focused on health care. In such a political environment, it was not surprising that the Administration chose to avoid yet one more draining battle over health reform.

The legal concerns were more ambiguous. Even before the ACA was passed, the White House recognized flaws in CLASS and attempted to amend the law to repair some major problems. Immediately after passage, it once again considered offering a package of amendments but never did so. Even had the Administration proposed changes, there was no chance a deeply-divided Congress would have passed them.

As a result, the Administration was left on uncertain legal ground. It could have attempted to change the CLASS design administratively. But its legal authority to do so was unclear and would have relied on vague and sometimes contradictory language in the statute. HHS attorneys were themselves uncertain about the degree of the Secretary's legal authority to revise the program, arguing that some changes may have stood up in court while others probably would not (U.S. Department of Health and Human Services, 2011).

Ultimately, however, CLASS failed as a result of its substantive flaws. Despite its good intentions, independent and government analysis concluded that CLASS's imperfect design would generate premiums that would have been prohibitive for most buyers. As a result, participation rates would likely have remained below 5 percent. This would have created serious adverse selection problems, and risked throwing the program into a classic insurance death spiral.

CLASS suffered from three major design flaws: it was voluntary; it required no underwriting; and it attempted to serve two incompatible purposes by creating both a new benefit program for working people with disabilities and an insurance system for those looking to hedge against the risk of long-term care in old age.

Combined, these three elements doomed the program. The voluntary nature of CLASS and lack of underwriting increased the likelihood that those who chose to enroll would eventually go to claim. This was especially true given CLASS's explicit attempt to provide new, non-Medicaid benefits for working people with disabilities.

Delinking this population from Medicaid (which has strict income eligibility rules) would make it possible for more people with disabilities to work—an outcome many feel is beneficial. However, as with any insurance, if participants are more likely than

average to receive benefits (known as adverse selection), premiums must rise to support those additional claims costs. As premiums increase, healthy consumers are less likely to buy, increasing the share of those in the risk pool who will eventually claim benefits. This phenomenon is known as a death spiral.

CLASS attempted to increase participation by young, healthy workers through its negative opt-out design. However, this would have applied only where employers chose to offer CLASS coverage, and employer participation was fully voluntary. Thus, it was unlikely the opt-out design would have materially improved CLASS's anti-selection problems.

However, making CLASS broadly available to working people with disabilities meant that large numbers of people who were certain to go to claim would enroll. In effect, this would create a new national benefit program for millions of working people with disabilities. However, instead of this new program being funded through tax revenues or another broad-based funding source, only those seeking to purchase insurance for care in old age would finance the program. This would inevitably drive premium costs to unaffordable levels.

What Next?

Given the design flaws of CLASS, policymakers have several options. They are: maintain the basic design of CLASS but attempt to repair its flaws; create a structure that includes private insurance and strong positive and negative incentives for enrollment; or adopt a universal, mandatory long-term care insurance system

Repair CLASS

The most obvious option is to build on CLASS and try to create a revised voluntary public program. Doing so would require addressing CLASS's strong anti-selection bias. Ideally such changes would reduce average monthly premiums to \$100 or less. At this level, the program might enjoy sufficiently broad participation to become a policy alternative to Medicaid for all but the poorest workers. However, these reforms would require changes in eligibility, enrollment, benefits, and premium structure.

The HHS staff itself proposed several significant changes to the CLASS design (U.S. Department of Health and Human Services, 2011). However, while these proposals were quite creative, they were constrained by the limitations of the law itself. In this brief section, I will suggest ways to improve a voluntary, government program in ways that go well beyond the CLASS statute. Thus, these changes would require new legislation.

Eligibility. The first reform addresses eligibility. This may require two solutions to two separate problems: financing care for working people with disabilities and providing insurance for healthy people seeking to protect against the uncertain risk of needing long-term care in the future, especially in old age.

Providing care for working people with disabilities is a major challenge but beyond the scope of this chapter. In 2010 about five million working people had some disability (Bureau of Labor Statistics 2010). In 2007, about half, including 700,000 of those with a “self-care” disability, worked full-time (Rehabilitation Research and Training Center 2009). The rest worked part-time or were self-employed and may satisfy the minimal work requirement needed to enroll in CLASS (Schur 2004). Other research suggests about one million people, or one-quarter of working adults who need help with at least one activity of daily living or one instrumental activity of daily living¹⁰ would have been eligible to enroll in CLASS.¹¹

Unfortunately, coverage of this population was a major reason why CLASS insurance would have been unaffordable. Thus, voluntary public insurance for those seeking to hedge against a future risk would almost certainly exclude this group.

Private insurance addresses the selection issues created by this population by denying them coverage through underwriting. While underwriting is inappropriate for public insurance, premiums can be controlled through the use of an at-work requirement. For instance, working age people might be eligible to enroll in a public insurance program if they work a minimum of 20 or 25 hours per week.

Enrollment. A second concern relates to the auto-enrollment mechanism of CLASS. Behavioral economics suggests that properly designed, such a mechanism could significantly increase enrollment. For instance, evidence of auto-enrollment/opt-out with 401(k) plans suggests that participation nearly doubles, especially for young workers (Madrian and Shea 2001).

The incentive effects of an auto-enrollment model for long-term care insurance are unknown. However, insurance industry actuaries suggest it may have some positive effect on participation rates, though far more modest than the 401(k) experience (Schmitz 2009).

A successful negative opt-out requires broad employer participation. Currently, few employers offer long-term care insurance and participation rates are quite low, even where underwriting is limited.¹² An employer mandate, similar to the requirements of the medical insurance provisions of the ACA, would increase enrollment. Short of a mandate, modest incentives, such as support for administrative costs, may increase

participation somewhat. Similarly, including long-term care insurance in a pre-tax employee benefit package may also increase take-up, though only modestly.

The most critical element of any voluntary system may be the proper set of incentives to encourage enrollment at a relatively young age. Absent either positive or negative incentives, a voluntary long-term care insurance program is likely to fail due to adverse selection issues discussed above.

Medicare Part B is an example of how properly designed incentives can drive participation. Thanks to a mix of subsidies, severe late enrollment penalties, and the recognition that it is difficult, if not impossible, for those 65+ to purchase insurance in the private market at an affordable price, more than 95 percent of those eligible are enrolled in either Medicare Part B or Medicare Advantage. By contrast, private long-term care insurance, where there are few incentives to participation and significant disincentives (including price and the availability of Medicaid) is an example of a market failure.

What incentives could drive the purchase of optional public insurance? Inflation-adjusted premiums would reduce costs for young enrollees (see discussion below). Negative incentives could include penalties for delayed enrollment beyond normal age-rating; a temporary exclusion of benefits for pre-existing conditions at the time of enrollment; or inclusion of home equity when calculating Medicaid eligibility for those who do not purchase insurance.

Benefits. The third concern is the benefit structure. Benefit design must address three issues: daily benefit, duration of benefit, and payment mechanism. The CLASS design was significantly different from private insurance in all three. Its daily benefit was relatively low—an average minimum of \$50. Its duration was quite long—for life. And its payment mechanism was quite generous—cash. By contrast, the private market has evolved away from this model. In contrast to the “long and skinny” design of CLASS, most private insurance policies are “short and fat.” In other words, they provide a more generous daily benefit for a shorter duration—typically \$125 for 3-5 years.

Lifetime benefits were once popular with private insurers but have been largely abandoned in new policies due to the “tail” risk of infrequent but very costly multi-year claims. These long claim periods are often driven by dementia, which represents about half of long-term care insurance claims. Lifetime benefits generally add 40 percent to the cost of an otherwise identical five-year policy.¹³

At the same time, with only a few exceptions private insurance pays on a reimbursement model, rather than cash. While cash benefits offer a significant

potential advantage to consumers, this design is rarely sold by private carriers without limitations such as lower payments or higher disability thresholds. Premiums for private policies that offer cash benefits can be as much as twice the cost of reimbursement policies.

Government insurance could address this set of challenges by offering a limited package of optional products. For example, buyers could choose between a CLASS-like policy, a typical private insurance policy of \$125-a-day for 3-years, or a high-end policy of, say, \$200-a-day for 5 years. Segmenting buyers in this way does create its own selection issues, but it may also create a more attractive product, which is critical in a voluntary market.

Premiums. The key to a successful insurance program is affordable premium. This challenge continues to vex the private market, where the average monthly premium now exceeds \$200 (LIMRA, 2011). One study concluded that after purchasing life and health insurance and assuring for adequate retirement savings, only about one-third of couples age 35-59 could afford mid-price long-term care insurance (Merlis 2003).

Table 2: CLASS Act versus Private Insurance Benefits

	CLASS	Private Insurance ^a
Underwriting	None; work requirement/vesting	Yes
Benefit	Cash	Reimbursement/ rarely cash
Benefit Amount	Minimum \$50 (inflation-adjusted)	\$125 (inflation- adjusted)
Benefit period	Lifetime	3-5 Years
Time before receiving benefit	5 Years after enrollment	90 days after meeting functional limitation test

^aPrivate insurance design is based on a typical policy. Private carriers offer a wide range of benefits.

In addition, potential buyers appear to be very sensitive to price. One industry-funded survey finds that only 20 percent of consumers would opt-out of a CLASS like program with a \$35 monthly premium, while 83 percent would opt out of coverage with a \$110 premium (Greenwald 2009). As private insurers have found, keeping premiums low often requires scaling back benefits. For instance, many private carriers have been reducing inflation protection in newly-issued policies—a poor choice for many buyers.

Low premiums are likely to be a key to participation among young workers. One way to reduce their monthly costs may be to shift from a level-premium design to an inflation-adjusted premium. This idea, which was considered by the Administration, would keep monthly costs very low for young workers and gradually rise with age (and wages). However, when offered by private carriers this design has been criticized by state regulators who suggest it could lead to inadequate coverage or high lapse rates.

Long-Term Financial Stability. In any public system, policymakers should create a separate quasi-government insurance fund that would have the flexibility to invest premiums in a diversified portfolio. This would allow CLASS to collect and invest reserves just as a private carrier might. Such a design may both allow for a more prudent investment portfolio than Treasuries-only and reduce public skepticism about the program's solvency.

The Role of Private Insurance in a Public Program

A critical issue is whether private insurers would write coverage that supplements a public program or whether they would attempt to compete with government insurance. Private insurers that have the ability to underwrite could “cherry pick” low-risk customers, leaving government with the highest-risk, most costly pool, exacerbating its already challenging adverse selection problems.

Another challenge to building a successful partnership with private carriers is determining which coverage is “first-payer.” This has been the subject of much disagreement among private insurers, although the most likely solution would designate this role to private insurance, leaving government with the uncertain “tail risk” of catastrophic insurance. This issue is especially important when considering the budgetary effects for Medicaid. If it remains primary payer, Medicaid would likely save relatively little. By contrast, savings may be quite substantial if Medicaid becomes the secondary payer to private insurance. However, the amount of savings would still vary significantly, depending on the benefit design.

A Full Public/Private Insurance Partnership

Policymakers may want to consider going beyond a fully public model and instead adopting a full partnership with private insurance. Such a model could be built on the Medicare Part D drug benefit or in the health insurance design of the ACA. In this model, insurance is sold by private carriers (with or without a “public option”) through an insurance exchange that is operated by government. Insurers are uniformly regulated, and prices and benefits are fully transparent and easily compared.

In this model, insurance could be mandatory or voluntary. A mandatory system would be based upon guaranteed issue so no buyer could be rejected for coverage. Voluntary insurance would still have to address all of the anti-selection issues of pure government insurance. In this design, underwriting could be based upon a moderately strict at-work requirement (20 or 25 hours per week) or could include short-form underwriting that is similar to private group insurance today.

Buyers above a certain income would purchase at market rates. Low-income buyers would receive a subsidy scaled to their income. Public insurance, such as Medicaid, would continue to be available for those who are unable to work or otherwise uninsurable.

Because long-term care insurance, unlike health insurance, requires the long-term viability of private carriers, government would be required to guarantee policies, perhaps through a system of reinsurance.

Genetic Testing

Any voluntary long-term care insurance—whether government or private—must take into account the likelihood that accurate genetic testing for diseases such as dementia will become widely available. If private insurers have access to those results, they will inevitably deny coverage to those who test positive. If carriers are barred by law from seeing the results (or, in a government model, do not underwrite) they will adjust premium prices upward to reflect the likelihood that many buyers (who would have access to this information) carry genetic markers for these diseases. Either way, such tests will drive major changes in the design of private insurance where underwriting is permitted and have profound negative effects on guaranteed, but voluntary, public coverage.

A Universal Public Program

Economists and actuaries generally agree that the ideal long-term care insurance system would be mandatory. This change would address all of the adverse selection issues that plague voluntary insurance (both public and private). It would also make

coverage available for an extremely modest premium. An insurance model created by the SCAN Foundation and the consulting firm Avalere Health finds consumers could purchase mandatory CLASS-like coverage for less than half the premium price of the voluntary version (SCAN Foundation/Avalere Health, 2010).¹⁴

However, a universal system must overcome two substantial hurdles: political resistance and financing. The political obstacles were apparent in the debate over the ACA, where a Democratic Congress was unwilling to accept even a “public option” to private health insurance. While universal long-term care insurance has been adopted by most major developed nations, the likelihood that the U.S. will embrace such a model in the current political environment is vanishingly small. The second key to designing such a plan is financing, particularly given public resistance to higher taxes. Leonard Burman (this volume) describes a model of expanded Medicare funded by higher taxes. In another model, Yung-Ping Chen has proposed embedding long-term care insurance into Social Security. In effect, retirees would forego a small piece of the annuity portion of their Social Security benefit in exchange for long-term care insurance. Such a design could also add long-term care insurance to existing benefits (funded with an additional payroll tax). Either way, private insurance would supplement basic long-term care coverage (Chen, 2007).

Conclusion

The CLASS Act had the potential to fundamentally redesign the way long-term care is financed in the U.S. Its cash benefit and the possibility that it would have encouraged some to shift from reliance on Medicaid to self-funded insurance were powerful reforms. However, the design of CLASS undermined its many potential benefits.

Policymakers now have two options. They can try to redesign a voluntary system that avoids the pitfalls of CLASS. This would require building a model that boasts both affordable premiums and a sufficiently attractive benefit structure. Such a design has, so far, eluded carriers of private insurance. It is possible, however, that the right mix of policy carrots and sticks might encourage enough young, healthy consumers to enroll that the program could become self-sustaining. Under this option, insurance could be provided by government, private carriers, or some combination of both. Their second option is to attempt to build a mandatory program. This is the choice already made by most of the developed world. However, in the current political environment there seems little interest in such a design in the U.S.

The most likely course, however, is that Congress will do nothing. After its experience with CLASS, and given the policy and political challenges of reopening

the issue of long-term care financing, it is unlikely that lawmakers will soon attempt to address this serious national problem.

Notes

- ¹ The ACA [[H.R. 3590](#)] is available at online; the CLASS provisions are Title VIII, beginning on page 710
- ² Of those who need care, 17 percent will receive assistance for a year or less while one of five will require assistance for five years or longer.
- ³ This estimate is in 2005 dollars, and represents present discounted value of average lifetime out-of-pocket costs. This is in addition to costs covered by Medicaid or private insurance.
- ⁴ There is little agreement among analysts on the share of long-term care funded by Medicare. This program is explicitly designed to provide health care, and not long-term care. However, while Medicare by law provides only limited post-acute personal and nursing care, it is likely that it also funds some long-term care. In new estimates of long-term care financing in 2008, Carol O'Shaughnessy includes no Medicare funding, but calculates the Medicaid share at 62 percent (see National Health Policy Forum, [National Spending for Long-Term Services and Supports](#), 2012).
- ⁵ Data on long-term care policies are uncertain. However, LIMRA International estimates that 4.8 million individual policies were in force at the end of 2008 and about 2.1 million lives were covered under group policies through 2007. LifePlans Inc. estimates between 6.75 and 7.75 million policies are in force in 2009.
- ⁶ S. 1757; the bill was reintroduced by Kennedy in 1995 as part of [S. 168](#).
- ⁷ Partnership data are available on Thomson-Reuter's [Long-Term Care Partnership Program Website](#).
- ⁸ For more information on the experience in Scotland, see David Bell and Alison Bowles (this volume). For more on the Scandinavian experience, see Svein Olav Daatland (this volume).
- ⁹ This brief history of the CLASS Act is based on author interviews with several participants in the legislative process including Constance Garner of the Senate Health, Education, Labor, and Pensions Committee who was Sen. Kennedy's chief aide on disability issues, and others who asked to not be identified.
- ¹⁰ The law defines ADLs as eating, toileting, transferring, bathing, dressing, and continence. IADLs are activities such as shopping, cooking, traveling, or managing finances. Requiring assistance with IADLs does not qualify a CLASS enrollee for benefits.
- ¹¹ Unpublished tabulations prepared by Melissa Favreault of the Urban Institute, based on 2001 and 2004 Survey of Income and Program Participation (SIPP) data.

- ¹² Large employers often offer insurance with limited underwriting sometimes referred to as “short-form” underwriting. Participation rates, however, remain low, only about 6 percent. The federal government has offered long-term care insurance to its employees for several years. Enrollment in the government plan, even with limited underwriting, is also about 6 percent.
- ¹³ See the [U.S. Office of Personnel Management LTC insurance calculator](#). The monthly premium for a typical lifetime policy for a 60-year old is \$251 while an otherwise identical five year policy costs \$183.
- ¹⁴ This projection was based on the HELP Committee’s version of CLASS which was amended in some respects in the final law.

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