

CHAPTER 4

THE CLASS PROMISE IN THE CONTEXT OF AMERICAN LONG-TERM CARE POLICY

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Long-term care (LTC) has long been a stepchild in the social policy family in the United States. Even in the broader context where America has been seen—as a “laggard” (Orloff 1988), as “exceptional” (Lipset and Marks 2001), and as “reluctant” (Wilensky and Lebeaux 1958), long-term care has occupied an especially residual place. Against this backdrop, enactment of the CLASS Act as part of the Affordable Care Act (ACA) in 2010 was seen as a remarkable achievement on at least three counts. Politically, enactment of the CLASS Act as a part of a far-reaching health care reform package, itself historic, was doubly unexpected. Programmatically, the inclusion of the CLASS Act and other provisions pertaining to chronic illness and disability gave a new prominence to long-term care concerns within the much more highly institutionalized world of health and medical care. And conceptually, having CLASS predicated on the principles of social insurance added a third leg—however shaky it proved to be—to the firmly institutionalized income and health care protections for the old and people with disabilities represented by Old Age Survivors and Disability Insurance and by Medicare.

In light of these historical breakthroughs in the long-term care policy arena, the CLASS Act’s being “suspended” in 2011 (Sibeliuss 2011) or “abandoned” (Gleckman this volume) represents a major setback to the LTC community. The provision of non-means-tested cash benefits for disability and chronic illness would have opened a new social policy front for the United States, joining—however haltingly—several other nations which have added public LTC benefits to their social policy offerings in recent years. In particular, the great hope and guarded expectation of advocates and policymakers who brought the CLASS Act to fruition was that it could propel long-term care from the “residual” to the “institutional” policy arena. The purpose of this chapter is to suggest what that transformation looked like at the time and how important it could be seen to be in both conceptual and programmatic terms.

The Residual Place of Long-Term Care: The Populations and the Problem

The distinction between residual and institutional problems and policies is useful for putting the evolving world of long-term care in perspective. As a problem statement, residual refers to that which is only marginally acknowledged and addressed, whereas the institutional refers to problems which have attained a higher level of legitimacy

and which are deserving of a more mainstream response. As an approach to policy, in Wilensky and Lebeaux's classic phrasing, "[The residual] holds that social welfare institutions should come into play only when the normal structures of supply, the family and the market, break down. [The institutional], in contrast, sees the welfare services as normal, 'first line' functions of modern industrial society" (1958: 138). Until passage of the CLASS Act long-term care had been a residual arena on at least three counts: the populations addressed; the social and political construction of the problem; and the policy response.

The Residual Populations of Long-Term Care

First, the populations that stand to benefit from CLASS have been historically vulnerable, barely visible, and politically weak. As old age and its decrements came to be understood as an illness (Haber 1983) and the disabled were slotted into a "sickness" role (Erkulwater 2006) for which there was essentially no cure, there was minimal interest in providing aid, either through institutional or community-based charity care. As for mental impairments among the old, "public officials saw no obvious solution to the dilemmas presented by aged senile persons. Some proposed that counties or family assume fiscal responsibility; others urged the construction of separate building at mental hospitals, and yet others insisted that sons and daughters be forced by law to meet their responsibilities toward parents" (Grob 1986: 40). In Rosenberg's (1986) reckoning, it was the combination of illness and dependence of these individuals, which left them under-attended: "Almshouses and their historical successors, municipal hospitals, often contained 'old folks' wards, demonstrating in practice their administrators' inability to distinguish categorically between sickness and dependence" (p. 236).

The passage of time brought little added enlightenment. Within the older population, individuals in need of long-term care services were understood, by definition, to be some combination of frail, ill, poor, and isolated. Beset by a mix of chronic and acute health care conditions, their ability to function independently was clearly compromised. Often widowed, divorced, or never married, not only were their family and social networks highly circumscribed, but their economic means were wholly inadequate. Periodic and episodic health-related needs could make any given locus of care inappropriate at any point in time. In the event of cognitive deficits, their sense of place and presence may be highly compromised. Their labor force presence was marginal at best, rendering the notion of "retirement income" remote at best.

For their part, historically, people with disabilities had in many ways a tougher row to hoe. Whereas in Haber's (1983) words, "the aged were consciously omitted from 'the redeemable,' i.e., those who should be expected to earn their own support," the

disabled have long been a more suspect group. As framed by Stone (1984), the social welfare question is one of distributive justice, specifically weighing the work-based system against the needs-based system. Not only were children and the old given something of a pass in gaining entrance to the needs-based system, as a matter of *administration*, their entry was straightforward, aka, evidence of a birth date “if not simply visual observation” (p. 23); proof of widowhood was nearly as straightforwardly ascertained. However, as Stone goes on to observe: “Disability however, has always been more problematic, both because no single condition of ‘disability’ is universally recognized, and because physical disability and mental incapacity are conditions that can be feigned for secondary gain” (p. 23). Erkuwalter (2006) echos this sentiment in noting that “[p]eople in wheelchairs are regarded as the deserving disabled by most Americans, but mental disabilities... and chronic pain are poorly understood impairments that elicit as much skepticism as they do empathy” (p. 16).

The Residual Problem of Long-Term Care

The second residual feature that the CLASS Act potentially addresses is the problem of long-term care itself or, more precisely, where to locate it. At what point do long-term disabling conditions move beyond being a trying situation for individuals and families and attain the status of a social problem warranting a formal and bureaucratized response? Beyond that juncture lies determining the balance between private and public sector actors for that formal response. Finally, should these responses remain localized and “closer to the problem” or be organized centrally and subject to more universal standards of intervention and assessment? These distinctions for locating problems and tailoring responses—informal and formal, private, and public, and local and national—are useful here in positioning the long-term care issue in the broader context of American social policy. More specifically, they illuminate the conceptual breakthrough that the CLASS Act represented in comparison to virtually all earlier efforts to locate both the long-term care problem and the responsibility for addressing it.

Over the course of a century or more, what we label today the long-term care problem has moved both slowly and unevenly along each of these dimensions, from what can be seen as the residual constellation of the informal, private, and local toward the more institutionalized one of the formal, public, and national. Once largely the province of families, communities, and local officials charged with care of the poor and helpless, the problem of long-term care came to be seen as something that required a broader and more sustained response. Importantly, what that “something”

was and to whom that response fell became subject to unending conflict and avoidance.

Focused on the old, the problem could be seen as one inadequate income, poor health, physical frailty, mental impairments, or lack of shelter. Yet for the old, the problems of inadequate income and acute health care needs were addressed— first during New Deal and later during the Kennedy/Johnson years. Indeed, centering policy initiatives on the income and acute health care needs of the aged became an overt strategy used by reformers to establish the larger policy principle that could be later extended to additional populations (Hudson 1978). Old Age Assistance and Old Age Insurance stood as Titles I and II of the original Social Security Act, Franklin Roosevelt stating that “poverty in old age should not be regarded either as a disgrace or necessarily as a lack of thrift or energy . . . it is a mere byproduct of modern industrial life” (quoted in Rimlinger 1971: 212). In the case of Medicare, Marmor (1970) quotes Wilber Cohen that “the subsequent massing of data to prove the aged were sicker, poorer, and less insured than other adult groups was like using a steamroller to crush an ant of opposition” (p. 17).

However, “locating” the problem of chronic illness was not nearly so straightforward as was the long-established need for adequate income or hospital and physician care. Because chronic illness involved myriad vulnerabilities and different attitudes about its origins and severity, it was central to none of the sectors that might respond. For the elderly, sustenance and shelter centered initially on “indoor relief,” later replaced by modest cash grants, and later yet by a range of services. The world of health was dominated by physicians and hospitals, neither of which had great interest in long-lasting conditions not lending themselves to fairly immediate remedy. The frail old, in need of a combination of income, health, and social supports, was left ill-attended. As summarized by Benjamin (1993):

Care of the chronically ill [aged] had become a problem: for physicians, who could do little to treat heart disease and cancer; for voluntary hospitals, which found that their beds were occupied by the incurable chronically ill despite determined efforts to screen out patients who ostensibly undermined hospital capacity to provide beds for the potentially curable; for local and state governments, whose public hospitals bore the brunt of chronic care demands; and of course for increasing numbers of the chronically ill themselves (p. 132).

For the disabled, the need for medically-based, diagnostic certainty was ever-present as a means of both eligibility determination and fraud prevention. Until roughly the 1960s, the individual condition of disability had to be established and, once done, the

individual had to assume “the sick role,” a role to which they might be confined for a lifetime. Moreover, “because the ‘problems’ posed by disability were understood as inherent within the individual, there was no attempt at social reform” (Erkuwalter 2006: 29). Yet, having once been seen as the near-embodiment of moral hazard itself, people with disabilities in the 1970s began pressing for social inclusion, asserting that disability was more a socially constructed category than an individual condition. This recasting of the issue led to insistence for integration, accommodation, and recognition rather than care and rehabilitation.

Cross-cutting these formal problem clusters was the looming issue of private or public responsibility for fashioning and supporting some set of appropriate responses. Not put too fine a point on it, Farrow, et al. (1981) contend: “the most important policy problem [in long-term care] is a lack of consensus about the nature and extent of public responsibility for meeting long-term care needs” (p. 7). Denial, limiting, or shifting public sector responsibility has long been a central barrier to effectively addressing long-term care needs. For the old, few public sector figures wished to assume responsibility; for the disabled, many wondered if they should assume responsibility at all. Initially, towns, counties, and states tried to offload responsibility for these populations onto each other. Later, and to this day, the states and federal government have pressed each other to take the lead fashioning and paying for long-term care interventions. Employing so-called “Medicaid maximization strategies,” states frequently “reconfigured state-funded programs to be compatible with Medicaid rules and to earn federal matching funds” (Coughlin et al. 1994: 87). People with disabilities, having recast the issue as a problem with society rather than with themselves, demanded public intervention through legislative and judicial means, both centered on policy demands based on rights and transferrable into cash (Erkuwalter 2006).

Since its emergence, long-term care has constituted a set of interrelated problems and highly vulnerable populations neither of which had the standing, positioning, or resources to attract a coherent and concentrated response from policymakers. This lack of policy ownership has long meant that “the long-term care individual is *marginal* to the service providers upon which he/she depends” (Callahan 1981: 156). In more recent years, of course, initiatives involving ever-increasing amounts of public dollars have been directed toward financing and coordinating long-term care service delivery for the chronically ill elderly, though still primarily through the means-tested Medicaid program. People with disabilities were more able to find their own political voice and reconstruct both the issue and the response to it (Stone 1984). Through these two wide lenses, the conceptual contribution of the CLASS Act was to

lift age-oriented long term care out of the world of public assistance and to further extend community-based cash assistance to people with disabilities.

The Residual-Institutional Social Policy Distinction

The residual place of long-term care as a social problem and the marginal status those of need in of such services long occupied centrally shaped what occurred in the public policy arena as well. The policy application of the residual-institutional distinction is largely realized in the origins and workings of public assistance and social insurance programs. For its part, long-term care policy has long been centered exclusively in the world of public assistance, and—until the passage of the CLASS Act—efforts to extend social insurance coverage to it had long been resisted. At least in conceptual terms, the CLASS Act having extended social insurance cash-benefits to long-term care—however incompletely—represented an unprecedented development.

The critical differences between the two program types can be seen in comparing them along key program dimensions: eligibility, benefits, administration, and financing. Public assistance programs, being based on notions of adequacy, are targeted on those who are demonstrably poor or otherwise in need, and this selectivity is operationalized through the mechanism of formal means-testing. In contrast, social insurance programs are inclusive, impose no means test, have dedicated funding streams tied closely to earnings, and have benefits that are based principally on the value of equity.

The U.S. has chosen to extend *eligibility* for social insurance coverage to a selective set of risks: loss of income due to old age, unemployment, long-term disability, and to meeting acute health care needs among the old and people with disabilities (but not the costs associated with child-rearing, a benefit found in most other developed democracies). These are considered classic risks involving ordinary and expected life problems and are directed to populations whose attachment to the labor force has earned them the right to coverage. In covering only the demonstrably needy, public assistance is instead animated by notions of charity (and, in its behaviorist manifestation, control).

The principal distinction in the *benefits* offered through public programs is between cash and benefits in lieu of cash. The former, being universally accepted “currency,” offers maximum choice and control to beneficiaries. In-kind benefits, consisting of either delivered services or vouchers, constrain such choice (Gilbert and Terrell 2002). While public assistance and social insurance programs each contain a mix of benefits, cash benefits are disproportionately found among the social insurance programs and in-kind benefits among public assistance ones. Old Age, Survivors, and Disability

Insurance continue to outweigh Medicare's health services benefits, whereas Food Stamps, Section 8 housing, and Medicaid constitute a greater portion of public assistance benefits than do the Supplemental Security Income and Earned Income Tax Credit programs. With the passage and evolution of the Temporary Assistance to Needy Families program, benefits for low-income single parents have become weighted much more heavily toward service benefits than was the case under the predecessor Aid to Families with Dependent Children program.

The *administrative* dimension of policy has both vertical and horizontal components. The principal vertical tension centers on federal-state relations in the design and delivery of program benefits. For most of the half-century following the New Deal period, the pendulum swung toward Washington, whose approach to federalism rang of what Derthick refers to as a "distinct moralism." She goes on to cite the comment by long-time Department of Health, Education, and Welfare social worker Jane Hoey who, in 1969, wondered which were the "good states," only to learn that "there were no good states. There were states that had some good things about them, but there were no *good* states" (Derthick 1975: 21). With a barrage of criticism in the wake of the Great Society programs (Lowi 1969; Davies 1996), the move to Washington stalled and was partially reversed during the Nixon and Reagan years. There has long been a pronounced division of federal-state responsibility between social insurance and public assistance programs. The former have largely been centered in Washington, with essentially no role for state governments, save involvement of state-level disability officials and employment agencies in eligibility determination under the Disability and Unemployment Insurance programs. In recent years, however, a number of income-related public assistance programs—SSI, Food Stamps, and the Earned Income Tax Credit—have been nationally administered.

The horizontal administrative issue centers on program coordination and integration at respective levels of government. The loosening of federal restrictions in the post-Great Society period was engineered by governors and state budget officials who felt hamstrung by inconsistent regulations associated with numerous federal categorical grants, resulting a condition labeled by Wright (1972) as "picket fence federalism" and by Seidman (1971) as "vertical functional autocracies." More recently, easing this top-down posture has been yet more fundamentally undone with the emergence of policies which are consumer- or client-centered (DeJong et al.1992). In concept, and to a growing degree in practice, the earlier top-down model is being supplanted by a bottoms-up one, a development that represents a true paradigm shift in the public administration of in-kind benefit programs. These dynamics are becoming central to public assistance programs because their reliance on services benefits introduces an

administrative element absent from the major cash benefit programs associated with social insurance.

Financing mechanisms are the fourth core distinction between social insurance and public assistance programs. What lends a mixture of insurance aura and reality to the former programs is their separate funds supported through dedicated contributions (Thompson 1994). The FICA tax supporting OASDI programs, Part A of Medicare, and a portion of Part D of Medicare are the principal examples; employer payments are the principal source of funds for the Unemployment Insurance program.

In stark contrast, public assistance programs are supported through general tax revenues, at both the federal and state levels (and in some states, counties as well). That being the case means there is no budgetary fire wall to protect program funding, leaving public assistance interests to compete with others that may be more popular in federal, and especially, state budgetary battles. Again, because the social insurance programs are both federally and trust-fund supported, most of social policy debate and expenditures at the state-level involve public assistance programs. This situation is especially problematic in the case of Medicaid, which constitutes the second largest program in most states general fund budgets, following primary and secondary education (Kaiser Family Foundation 2010).

The Residual Standing of Long-Term Care Policy

Until passage of the CLASS Act, long-term care policy in the U.S. found itself lodged almost entirely in the world of public assistance. Historically, long-term care was the province of the family, yielding in part over time to the world or private sector charity, including community hospitals. Nascent public sector involvement centered on the almshouse or “indoor relief,” where the impoverished and frail old and people with disabilities increasingly found themselves, while those suffering from mental illness were treated separately, often in asylums (Rothman 1971). Thus, the residual nature of care was clear from the beginning, with families, charities, lodges, and fraternal orders providing what care they could and local governments providing onerous institutional care where no other alternatives existed.

By the time of the New Deal, population growth, urbanization, and dire economic need had pushed long-term care needs to a less tenuous place in the social policy world. The principal development during these years was both an ideological and budgetary desire to move long-term care populations out of institutional settings and ease them somehow into local communities. Most notable in this regard was Social Security’s Old Age Assistance program, which “forbade payments to any inmate of a public institution (Vladeck 1980: 36). In broad scope, it is important to note that cash

benefits were at the heart of most of the titles of the 1935 Social Security Act—including both public assistance and social insurance programs. Yet, not surprisingly, cash proved not enough for those impoverished individuals suffering from chronic and disabling conditions. “Pensions, it turned out, were *not* a substitute for indoor relief, at least not for the elderly who were infirm as well as poor” (Vladeck 1980: 37). This led to an expansion of “mom and pop” boarding homes, where proprietors—also suffering from the ravages of the Depression—took in boarders and their Old Age Assistance checks and also to a nascent proprietary nursing home industry that would grow enormously over the ensuing half-century.

Those in need of long-term care services continued without a clear policy or residential home up to and including passage of Medicaid and Medicare in 1965. Medically-oriented welfare amendments to the OAA in 1950 acknowledged the partial place of these individuals somewhere in the health care system, but the lack of clarity concerning their relative need for money, housing, or health care left them falling between a host of cracks. The continued unwillingness to “own” the long-term care problem was highlighted by the simultaneous passage of Medicare and Medicaid. Health care reformers—whose struggles and disappointments extended from the Roosevelt through the Truman years—were determined to see Medicare’s passage. Among other provisions omitted during that process was virtually anything that smacked of long-term care, seen as a costly and secondary element and one certainly not needed to secure passage of a major social insurance program dedicated to acute health care needs (Marmor 1970).

As something of an afterthought, the Medicaid public assistance program was enacted, expanding the earlier Kerr-Mills program directed to the impoverished aged, and providing federal matching grants to the states for the categorical public assistance populations and others deemed “medically indigent” (at state option). Provisions included medical and skilled nursing services for the poor elderly and disabled, but continued to tie them to a welfare system run largely by the states. In the watershed year of 1965, “the nursing home issue was not confronted directly. Medicaid, hastily created and enacted, was only a sideshow in the health insurance circus” (Vladeck 1980: 51).

In the ensuing years, Medicaid has dominated public financing of long-term care services. The acute care-oriented Medicare program also pays for what can be labeled long-term care services, but these are nursing home or home health stays resulting from an acute care episode, which requires some extended rehabilitative care. As for the chronically ill and disabled populations, the financing story remains largely “Medicaid and you,” with the program paying 48 percent of all monetized long-term

care costs, with an additional 18 percent paid out-of-pocket by care recipients or their families (Gonyea 2010). On a more positive note, the locus of care funded by Medicaid dollars has been gradually shifting from institutional to home and community based care (HCBC) since enactment of Medicaid waiver programs, beginning in the early 1980s. HCBC accounted for only 10 percent Medicaid long-term care spending in 1988, with that proportion having risen to 40 percent in 2007 (Burwell et al. 2007).

A last major legislative episode sheds additional light on several elements of the preceding discussion. In the wake of Richard Nixon and Daniel Patrick Moynihan's failed attempt to revolutionize AFDC through a proposed Family Assistance Program, the Supplemental Security Income program emerged, bestowing benefits on the public assistance "adult categories" of 1935; the poor old and the poor blind (the low-income totally and permanently disabled were included in 1951, constituting the third of the adult groupings). SSI remained a public assistance program, but created a nationally guaranteed minimum benefit and, unlike the predecessor programs and AFDC, was to be administered (reluctantly and, initially, poorly) by the U.S. Social Security Administration (Derthick 1990). While it involved three categories of low income individuals, Congress presumed—quite correctly in 1973—that it was mainly about the impoverished old (Burke and Burke 1974). Little mention was made of people with disabilities, but SSI proved to be a major source of cash benefits for disabled individuals in the community. Whereas most aged SSI recipients were already receiving Social Security benefits, fewer than one in five people who had been receiving benefits under the predecessor Aid to the Totally and Permanently Disabled program were also Social Security recipients (Erkulwater 2006: 78). Over time, the balance of beneficiaries and payments shifted away from the aged and toward the disabled because OASI benefits continued to succeed in "withering away" the OAA/SSI program whereas SSI's disability benefit, in conjunction with a growing advocacy movement within the disability community, served to lend both monetary support and legitimacy to the disability rights movement.

In the period immediately prior to the passage of ACA and the CLASS Act, long-term care continued to be a social problem firmly lodged in a residual policy world. For the aged, the principal connection was to Medicaid and only modestly to SSI. And even though formal care provision has increased and complemented family care, informal care provision remains dominant, with 66 percent of older adults living in the community relying on informal supports alone and an additional 26 percent rely on a combination of formal and informal supports (Gonyea 2010). Moreover, a substantial majority of those informal caregivers are women (Stone et al. 1987; Harrington-

Meyer 2000). In absolute terms, the public sector's role has grown, largely through the Medicaid program, but as a state-administered and partially state-funded public assistance program, it remains firmly in policy's residual world. For people with disabilities, the residual legacy lay primarily in state-level institutional care and a problem definition based on their individual inabilities and to a somewhat greater degree on SSI cash benefits. For both populations, the CLASS Act brings a cash benefit and eligibility based on insurance rather than poverty to long-term care.

The CLASS Contribution

The CLASS Act and selected other provisions found in ACA represented a major turning point in public long-term care policy for the chronically ill old and people with disabilities. It was not a complete transformation—indeed, some observers felt that it was not transformative enough—but it was nonetheless unprecedented in concept and might have proven to be in operation. In the context of the present discussion, the CLASS Act departed from the world of public assistance and clearly if incompletely entered the world of social insurance. In so doing, it went further than any preceding legislation in moving long-term care away from its historical residual standing.

In brief, CLASS was a voluntary, consumer-financed, publicly-administered, cash benefit insurance plan (Manard 2010). By itself and in conjunction with other provisions found in ACA and allied legislation, it brought long-term care policy into a more normative and universal policy world than it had ever before occupied. These putative gains can be seen along each of the program dimensions discussed above.

The key advance around program eligibility was, of course, the introduction of social insurance principles to long-term care. As do Old Age, Survivors, Disability Insurance and Medicare, the CLASS Act defined long-term care needs as insurable events that should be addressed through public auspice. Thus long-term care was understood as a risk that might befall anyone and, in anticipation of the possibility of that risk occurring, a risk for which resources should be pooled and safeguarded. This was a major advance over the historical understanding that long-term care needs were a condition that one must either endure alone, or perhaps in the company of family, charitable, or public assistance.

The conceptual advance noted, the CLASS Act did not meet the complete test of social insurance. Voluntary enrollment would have very much limited the universal feature associated with social insurance. As had been widely noted, and was a principal factor in the legislation's downfall, the program ran severe adverse selection risks in that those most likely to enroll were those who had or had reason to think they

might develop chronic or disabling conditions. In what might be termed actuarial understatement, Tumlinson, Ng, and Hammelman (2010: 28) observed, “The CLASS Act has generated a great deal of interest because it does not exclude individuals from enrollment based on health status, and yet it does not mandate that individuals participate.” Depending on the eventual participation rate, premiums under the program could have varied from \$62 per month (at a 30 percent participation rate) to \$124 per month (at a 5 percent participation rate) (Tumlinson, Ng, and Hammelman 2010). The CMS actuary posited the possibility of a \$240 monthly premium if the program generated only a 2 percent participation rate (Foster 2010). Firmly believing that insisting on mandatory coverage would have earlier doomed the CLASS proposal, advocates made this concession and openly conceded the difficulties it presented (Manard 2010).

Nonetheless, inclusion of the CLASS Act in health care reform was an historic breakthrough in long-term care policy. Instead of being based on demonstrated poverty and current functional impairments, program eligibility was based on an insured status that neither required that one be poor or to become impoverished. In this regard, the CLASS Act joined two other recent insurance initiatives directed toward long-term care: private long-term care insurance and state-based public/private long-term care partnerships. Private long-term care insurance policies have been available for several years, though they continue to account for less than 10 percent of formal long-term care expenditures, are relatively expensive, and are often denied to those with a range of pre-existing conditions. More intriguing have been so-called Medicaid/private long-term care insurance partnerships, which allow individuals to preserve assets equivalent to the private long-term care insurance coverage they have purchased at such time as they must resort to services through Medicaid (Pasaba and Barnes 1996). In speaking of these insurance variants, Doty (2010) observes: “what public, private, and public/private long-term care insurance approaches all have in common is that policyholders become eligible for benefits based on meeting a threshold of disability severity, not based on whether they qualify for an institutional level of care and whether or not third-party payers would prefer them to receive less expensive services in other settings” (p. 8).

Beyond introducing the social insurance paradigm to long-term care, the CLASS also introduced cash benefits. While this was not a novel notion within the disability community—where the line between income and care support has become increasingly narrow—a cash benefit for chronically ill elders was a significant development. Cash benefits have often been circumscribed in public assistance programs because of the belief and/or the reality that recipients either could not or

should not be able to spend freely. The poor could not be trusted, and those in need of health, mental health, or personal care services could not be expected to make informed decisions. The cash benefit under the CLASS Act moved the beneficiary from services client to services consumer, with the question of choice central to the distinction (Simon-Rusinowitz et al. 2010).

In particular, the cash benefit concretized the overwhelming preference people have for community-based rather than institutional care. CLASS benefits would have unquestionably accelerated the shift long underway in Medicaid programming toward home and community-based care. Moreover, within the world of community-based care, CLASS would have helped sustain so-called “cash and counseling” initiatives, which give long-term care consumers a wide degree of choice in arranging for their own care (Doty, Mahoney, and Sciegaj 2010). Control—whether onerous or beneficent—has long been a hallmark of residual programs; choice is associated with the autonomy, acceptance, and legitimacy that accompany social insurance. The CLASS Act extended such consumer choice to long-term care.

The pooled insurance cash benefit as part of the CLASS Act also partially augmented long-term care policy’s remedial approach to need by adding at least an ounce of prevention. The preventative idea in social insurance is seen most distinctly in the case of Social Security, where benefits both prevent precipitous drop in income and economic need not having to be demonstrated. Long-term care policy differs in necessitating some measure of functional impairment before benefits are forthcoming, but under CLASS these payments would have come independent of economic need and could have been used by consumers—and especially by a consumer’s family caregivers—as an income as well as a care support.

The CLASS Act’s having been about cash and, in turn, about choice would have contributed to the paradigm shift in long-term care service delivery noted earlier. Leery of being caught up in the unappealing policy world of long-term care, federal officials long kept the states on a short leash when it came to expenditure of federal matching funds. Even with the introduction of Medicaid waiver programs, they usually required that community-care residents have the same level of impairments as those individuals in skilled nursing facilities and for a period insisted that community-care provision be accompanied by a corresponding reduction in nursing home beds (Doty 2010). These strictures were loosened somewhat grudgingly over time, as a growing popular and professional consensus emerged that there was more value to community-placement than presumed budgetary savings.

As a result of liberalization of Medicaid programming and in the presence of other community-based entities, there is now in place an extended world of long-term care

service planners and providers. Yet, there is a well-documented lack of coordination and considerable degree of competition among many of these entities. What cash-carrying CLASS Act beneficiaries would have encountered upon entering this thicket of agencies remains a great unknown. They would not only have been feeling their way through the new world of “consumer preference versus professional judgment,” but they would have also potentially been dealing with multiple agencies whose interventions were colored by organizational concerns as well professional judgment. Where a client or consumer enters the so-called system, what services are available, who runs them, and how they are paid for would have likely continued to be a source of endless frustration. By itself, CLASS would have done little to remedy this state of events; indeed, in the absence of other initiatives, CLASS-generated benefits could have sown further confusion by introducing significant new unchanneled resources to this unwieldy enterprise.

Of course, policymakers and analysts have been keenly aware of these difficulties on the ground and have designed a host of interventions to overcome them. This noted, the sheer number of such initiatives itself has been cause for possible concern. The following items, as part of ACA and allied legislation and administrative actions in recent years, are in place or in various stages of development: State Balancing and Incentive Payments program; Community First Choice Option; Removal of Barriers to Providing Home and Community-Based Services; Money Follows the Person demonstration; the National Pilot Program on Payment Bundling and Related Provisions; Choices for Independence Initiative, including Aging and Disability Resource Centers, the Nursing Home Diversion program, and Evidence-Based Disease Prevention programs (O’Shaughnessy 2008; Wiener 2010). If it proves difficult for program administrators to keep these all straight, one can only imagine how consumers may struggle with this new alphabet soup. As Shugarman (2010) observes, in the absence of service delivery improvements emanating from some combination of these initiatives, CLASS would have represented something of a pyrrhic victory, with participants being “enriched with new purchasing power for needed long-term care service but would still have the same broken system to navigate.”

Yet, acknowledging problems that may arise from this administrative “noise,” the longer range view cannot lose sight of the advances CLASS would have represented and which community-based care continues to represent. Until the 1970s, long-term care was largely about institutional care, administered in a highly regulated, largely inflexible, not infrequently corrupt manner on behalf of the most vulnerable members of society. To make community alternatives available to a wider range of beneficiaries

able to participate in their own care decisions was clearly a step forward. But it also brought its own set of challenges.

The financing of CLASS, while a notable break with Medicaid's reluctant claim on general revenues, emerged nonetheless as "social insurance light." Its voluntary nature clearly limited both the volume and make-up of the risk pool. Its having been consumer-financed, even though publicly administered, rendered it closer to private long-term care insurance than the progressive funding associated with social insurance schemes. The monthly premium for low-income enrollees and students would have been only \$5, and premiums would have been age-graded, but there was no added progressivity, such as that associated with the major social insurance programs which "are designed to address such social purposes as alleviating poverty, providing added protection of families versus single workers, and providing a larger degree of earnings replacement for low-paid versus high-paid workers" (Committee on Ways and Means 1998: 5). The provision that "no federal taxpayer funds shall be used for payment of benefits" (Manard 2010: 2) also served to underscore that the CLASS Act was not an entitlement program, that is, one where the federal government is obligated to support all eligible program participants independent of fixed appropriations.

Finally, cash benefits derived from the CLASS Act being tightly tied to work in the case of younger people with disabilities and accumulated premiums in the case of older people with chronic illnesses underscored the last salient feature of the law, that of promoting personal responsibility. While enactment of CLASS meant that we would no longer target benefits only on those deemed unable to help themselves, it did not mean that the government would provide benefits—beyond those based on dedicated premium payments—to those who could and should have addressed their current needs or planned for their future needs. The government would have been in the position of encouraging and facilitating the creation of a long-term care insurance pool, but it would not have assumed added responsibility for guaranteeing or augmenting benefits generated by that pool. In what Marmor, Mashaw, and Harvery (1990) refer to as "America's Opportunity/Insurance State," CLASS represented a hybrid in which the government would have provided the opportunity to insure oneself against the costs of disability and long-term care. Unlike Medicaid, CLASS recognized chronic illness and disability as risks rather than conditions, but it limited its own exposure to costs associated with those risks more than in any other social insurance program.

Yet, despite these strictures, a combination of political resistance and operational concerns has suspended, and one must presume ended, the addition of long-term

illness and disability to the list of risks against which American government insures its citizens.

References

- Benjamin, A.E. 1993. "An Historical Perspective on Home Care Policy." *Milbank Quarterly* 71(1): 129-66.
- Burke, V. and V. Burke. 1974. *Nixon's Good Deed*. New York: Columbia University Press.
- Burwell, B., K. Sredl and S. Eiken. 2007. "[Medicaid Long-Term Care Expenditures, FY 2007](#)" (online). Thomson Reuters.
- Committee on Ways and Means, U.S. House of Representatives. 1998. *Green Book*. Washington, D.C.: Government Printing Office.
- Callahan, J. Jr. 1981. "Delivery of Services to Persons with Long-Term Care Needs." In J. Meltzer, F. Farrow, and H. Richman (eds.), *Policy Options in Long-Term Care*. Chicago: University of Chicago Press.
- Coughlin, T.A., L. Ku, and J. Holahan. 1994. *Medicaid Since 1980: Costs, Coverage, and the Shifting Alliance between the Federal Government and the States*. Washington, D.C.: Urban Institute.
- Davies, G. 1996. *From Opportunity to Entitlement: The Transformation and Decline of Great Society Liberalism*. Lawrence: University of Kansas Press.
- DeJong, G., A.I. Batavia, and L.B. McKnew. 1992. "The Independent Living Model of Personal Assistance in National Long-Term Care Policy." *Generations* 16: 89-95.
- Derthick, M. 1975. *Uncontrollable Spending for Social Services Grants*. Washington D.C.: The Brookings Institution.
- Derthick, M. 1990. *Agency Under Stress: The Social Security Administration in American Government*. Washington, D.C.: The Brookings Institution.
- Doty, P. 2010. "The Evolving Balance of Formal and Informal, Institutional and Non-Institutional Long-Term Care for Older Americans: A Thirty-Year Perspective." *Public Policy & Aging Report* 20 (1): 3-9.
- Doty, P., K.J. Mahoney, and M. Sciegaj. 2010. "New State Strategies to Meet Long-Term Care Needs." *Health Affairs* 29 (1): 49-56.
- Erkulwater. J.L. 2006. *Disability Rights and the American Social Safety Net*. Ithaca, N.Y.: Cornell University Press.
- Farrow, F., T. Joe, J. Meltzer, and H. Richman. 1981. *Policy Options in Long-Term Care*. Chicago: University of Chicago Press.

- Foster, R. 2010. "Estimated Financial Effects of the PPACA as Passed by the Senate on Dec. 24, 2009." Washington, D.C.: Centers for Medicare and Medicaid Services.
- Gilbert, N., and P. Terrell. 2002. *Dimensions of Social Policy*. New York: Boston: Allyn and Bacon.
- Gonyea, J.G. 2010. "The Oldest-Old and a Long-Lived Society." In R.B. Hudson (ed.), *The New Politics of Old Age Policy* (2nd ed.). Baltimore: Johns Hopkins University Press.
- Grob, G.N. 1986. "Explaining Old Age History: The Need for Empiricism." In D. Van Tassel and P.N. Stearns (eds.), *Old Age in a Bureaucratic Society*. Westport, Connecticut: Greenwood Publishing.
- Haber, C. 1983. *Beyond 65: The Dilemma of Old Age in America's Past*. Cambridge, UK: Cambridge University Press.
- Harrington-Meyer, M. (ed.). 2000. *Care Work: Gender, Class and the Welfare State*. New York: Routledge.
- Hudson, R.B. 1978. "The 'Graying' of the Federal Budget and its Consequences for Old Age Policy." *The Gerontologist* 18(5): 429-40.
- Kaiser Family Foundation. 2010. *State Fiscal Conditions and Medicaid*. Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.
- Lipset, S.M. and G. Marks. 2001. *It Didn't Happen Here: Why Socialism Failed in America*. New York: W.W. Norton.
- Lowi, T.J. 1969. *The End of Liberalism*. New York: Norton.
- Manard, B. 2010. "Dueling Talking Points: Technical Issues in Constructing and Passing the CLASS Act." *Public Policy & Aging Report* 20(2): 21-27.
- Marmor, T.R. 1970. *The Politics of Medicare*. Chicago: Aldine.
- Marmor, T.R., J. Mashaw and P. Harvey. 1990. *America's Misunderstood Welfare State*. New York: Basic Books.
- Orloff, A.S. 1988. "The Political Origins of America's Belated Welfare State." In M. Weir, A.S. Orloff, and T. Skocpol (eds.), *Social Policy in the United States*. Princeton, N.J.: Princeton University Press.
- O'Shaughnessy, C.V. 2008. "The Aging Services Network: Broad Mandate and Increasing Responsibilities." *Public Policy & Aging Report* 18 (3): 1-18.
- Pasaba, J.C. and A. Barnes. 1996. "Public-private partnerships and long-term care: Time for a re-examination?" *Stetson Law Review* 26 (2):529-559.
- Rimlinger, G. 1971. *Welfare Policy and Industrialization in Europe, America, and Russia*. New York: John Wiley.

- Rosenberg, C.E. 1986. "The Aged in a Structured Social Context: Medicine as a Case Study." In D. Van Tassel and P.N. Stearns (eds.), *Old Age in a Bureaucratic Society: The Elderly, the Experts, and the State in American Society*. New York: Greenwood.
- Rothman, D. 1971. *The Discovery of the Asylum*. Boston: Little Brown.
- Seidman, H. 1971. *Politics, Position, and Power*. New York: Oxford University Press.
- Shugarman, L.R. 2010. "Health Care Reform and Long-Term Care: The Whole is Greater than the Sum of its Parts." *Public Policy & Aging Report* 20 (2): 3-7.
- Sibelius, K.G. 2011. "[Secretary Sebelius' Letter to Congress about CLASS.](#)" (online document).
- Simon-Rusinowitz, L., D.M. Loughlin, K. Ruben, G. Martinez Garcia, and K.J. Mahoney. 2010. "The Benefits of Consumer-Directed Services for Elders and Their Caregivers in the Cash and Counseling Demonstration and Evaluation." *Public Policy & Aging Report* 20 (1): 27-31.
- Stone, D.A. 1984. *The Disabled State*. Philadelphia, PA: Temple University Press.
- Stone, R., G.L. Cafferata, and J. Sangl. 1987. "Caregivers of the Frail Elderly: National Profile." *The Gerontologist* 27 (5): 616-626.
- Thompson, L. 1994. "The Roles of Social Insurance, Tax Expenditures, Mandates, and Means-Testing." In R.B. Friedland, L.M. Etheredge, and B.C. Vladeck (eds.), *Social Welfare Policy at the Crossroads*. Washington, D.C.: National Academy of Social Insurance. Pp. 9-30.
- Tumlinson, A., W. Ng, and E. Hammelman. 2010. "The Circular Relationship between Enrollment and Premiums: Effects of the CLASS Program Act." *Public Policy & Aging Report* 20 (2): 28-30.
- Vladeck, B. 1980. *Unloving Care: The Nursing Home Tragedy*. New York: Basic Books.
- Wiener, J. 2010. "What Does Health Reform Mean for Long-Term Care?" *Public Policy & Aging Report* 20:8-15.
- Wilensky, H. L. and C.N. Lebeaux. 1958. *Industrial Society and Social Welfare*. New York: Free Press.
- Wright, D.S. 1972. "The States and Intergovernmental Relations." *Publius* 1: 21-37.