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The CLASS Act and Its Aftermath

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BACKGROUND

The Community Living Assistance Services and Supports (CLASS) Act is a part of the Patient Protection and Affordable Care Act legislation relating to a voluntary federal insurance program for long-term care (LTC[1]).This program was subsequently repealed due to serious actuarial issues in implementation. This article discusses the lessons learned from the CLASS program and the prospect for future social LTC financing.

LTC is comprised of a broad range of chronic care services for the elderly and younger individuals with disabilities. Such services include care in nursing facilities, therapeutic services, adult day care, home care services, homemaker services, etc. LTC services are generally not covered by private medical insurance. Medicare covers very limited LTC services for retirees.[2] Medicaid provides LTC only for individuals with minimal income or assets. However, since the costs of LTC can rapidly deplete an individual's assets, a sizable portion of low- to middle-income individuals can qualify for Medicaid after they start paying for LTC services. Thus, Medicaid serves as an LTC safety net for many more individuals besides the indigent.

Approximately 1 out of 2 persons over age 65 will need some form of formal LTC services over his or her lifetime.[3] The current average annual cost of nursing home services per person is $77,000; the corresponding cost for home health care services per person is approximately $20,000.[4] An average LTC episode is about 30 months.[5] Thus LTC expense poses a significant financial risk for seniors.

Because of the aging population, it is also a social financial risk for all Americans as well. In 2015, there are 6.3 persons of working ages 18 to 64 for every elderly person age 70 and over. By 2040, there will be only 3.5 workers to support every such elderly person.[6] Unless the current "pay-as-you-go" funding mechanism for Medicare and Medicaid is changed, LTC will put an increasingly heavy financial burden on future generations of workers.

Private LTC insurance has generally been proven to be ineffective for financial protection against LTC risk for the society as a whole. Because premiums are relatively expensive and unstable, sales have been anemic with less than 6 percent of the adult population covered.[7] More importantly, there is hardly any penetration on the low-income population that is most at risk to become future Medicaid beneficiaries.

CLASS ACT

The CLASS Act legislation was forged under this stark context by the late Senator Edward Kennedy in 2010. It was intended to be a voluntary insurance program funded only through participants' contributions. The statute required the program to be self-sustaining and to accept participation with no underwriting. In lieu of underwriting, the act enforced a five-year waiting period from the enrollment date before a participant can claim benefits. The daily benefit varied from $50 to $75, which was adequate for home and community care but insufficient to pay for typical nursing facility care. Students and low-income individuals would only pay a token premium. Other challenges for program implementation included payment of benefits in cash, payments to family members, restricted administrative expenses and the lack of marketing allowance. Besides these obstacles, the major requirements of voluntary participation and guaranteed issue made the program design actuarially unsound.

Because the final version of the statute was drafted almost overnight, there was no legislative history for interpretative guidance. Nevertheless, the Secretary of the U.S. Department of Health and Human Services had sufficient latitude under the act to implement a viable program, subject to potential legal challenges. The Administration was on the defensive at the very start. The program was under constant attack by Republicans particularly in regard to the advertised promise

of federal savings over the first 10 years due to the waiting period provision. Another obstacle to implementation was the mandatory launch of no later than 2013. This precluded the possibility of testing various designs that might maximize participation and thereby minimize adverse selection.

After nearly a year of deliberation, the Secretary declared that the CLASS Act was unworkable. It was repealed under the 2012 American Taxpayer Relief Act. In its place, an LTC Commission was formed to study various LTC issues and make recommendations. The commission concluded its findings in 2013 but failed to recommend specific financing solutions.

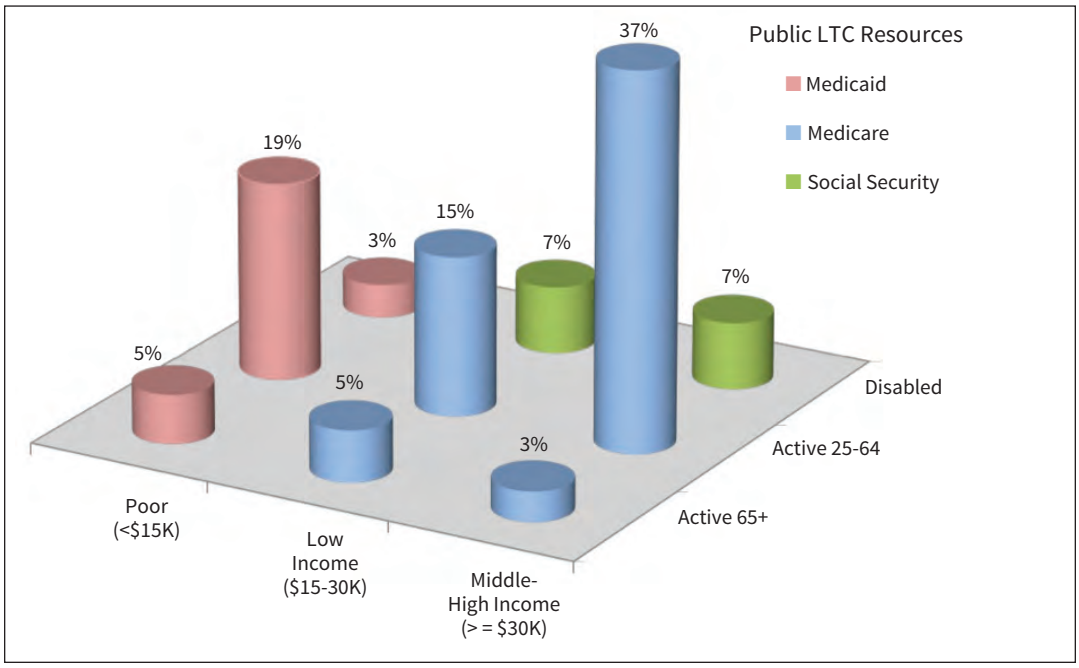
FINANCING CHALLENGE

A fundamental question on LTC financing is the role of the government. Is it solely an individual's responsibility or is the government obligated to assist in the growing demand for LTC? Should LTC be considered as a basic need that warrants social support such as police and fire protection and other critical public assistance?

Perhaps a related but more practical question is whether doing nothing is an option. The need for LTC is growing as the population ages. As an indication, total LTC expenditures were 1.3 percent of the gross domestic product during 2010.[8] This number is projected to reach 2.6 percent in 2040. In the past, workers have been paying for benefits of the old in public programs. In the future, there will be fewer workers to support a higher proportion of seniors. The current de facto public programs for LTC will be burdensome for future workers.

Currently, there are 217 million U.S. adults age 25 and over.[9] In order to appreciate the challenges in LTC financing, it is useful to segment this population by age and income,[10] as well as by current or earmarked coverage from the public programs. (See Figure 1.)

Figure 1



An LTC social financing program should address the specific needs of the 5 groups of constituents: the poor, the low-income workers, middle-to-high-income workers, the retirees and the disabled. A 'one size fits all' method will probably not work. The poor and the disabled are currently covered by public programs. Medicaid pays for LTC services for the poor and Social Security typically pays income and medical benefits for the disabled. An overhaul of the current systems to accommodate LTC would need to account for these two groups. If a new LTC financing program leaves the current support systems intact, then it can focus on the remaining groups: the two income classes of workers and the retirees.

LEARNING FROM THE PAST

The most straightforward financing solution would be an expansion of the current public programs. In this era of large government deficits, there is little political appetite for this approach. Moreover, any expansion would exacerbate the increasing burden of current programs for current and future workers. Accordingly, most discussions have centered on financing mechanisms that involve minimal or no monetary government support. The prevailing view, evidenced from public surveys,[11] is that LTC is largely an individual's responsibility and not a basic social right.

This perspective was the fundamental premise for the CLASS Act. The act emphasized long-term actuarial soundness with only incidental government support. The soundness requirement underscored the attention to careful premium development and proper program risk management. Despite its major failing, it had a number of salient features that a future financing program should emulate. It provided for only a basic level of benefits that struck a proper balance between minimally adequate benefits and

CONTINUED ON PAGE 60

affordable premiums for most participants. This feature allowed for the purchase of additional coverage through private insurance. From a marketing perspective, it relied on the employers to promote employee participation in the workplace.

One of the major pitfalls of the CLASS Act is that it attempted to cover the low-income workers and disabled individuals through subsidization. The stipulated low premium for the near-poor and low-income merely shifted the costs to other workers and subsequently made the contributions less affordable to the rest of the participants. Under a voluntary program, this creates adverse selection risk and adds to the instability of the contribution structure.

FINANCING OPTIONS

Perhaps the real downfall of CLASS is that the drafters had limited information through research and analysis for prudent program design. They underestimated the need for incentives in order to achieve the participation level that is necessary in a guaranteed issue, voluntary program. Two critical ingredients for success—namely, incentive and insurance principle—must work in unison for all constituents in the program. What follows is a discussion of a number of financing options that may enhance the chance for success in a future financing program.

As adopted in the CLASS Act, the logical direction to LTC financing is a pre-funding approach. Since not everyone will need LTC services, an insurance program with a pre-funding feature is most efficient in this respect. However, this approach is problematic for retirees. The likelihood of needing LTC services is much greater at advanced ages and the relatively short funding period would cause the contribution level to be unaffordable to most retirees. Many of the proposals focusing on the retirees involve the trade-off concept. Retirees can trade a portion of their Social Security benefits for coverage in an insurance program. Retirees can trade equity in their homes or death benefit in their life insurance for LTC benefits. None of these proposals can curtail the rising Medicaid LTC expenditures since they do not prevent low-income retirees from becoming Medicaid beneficiaries. The lack of effective immediate coverage for retirees is a harsh reality of LTC financing. This means that any viable financing solution would have little near-term savings in government programs.

For the working population, the CLASS Act has shown that a voluntary program with no underwriting is actuarially unworkable given the anticipated low level of participation. There is also a current stigma against mandatory individual contributions to public programs. Attention is therefore being directed toward proposals to provide incentives for working adults to participate.

One incentive is to make the access to the insurance program simple. The workplace is ideal where workers can participate through the normal benefit enrollment and payroll deduction procedures. Under the CLASS Act, companies can offer eligible employees the opportunity to participate. Employees would be automatically enrolled unless they opt out. This approach should be adopted under a new LTC social insurance program. In order to have greater participation, the offer should be made mandatory by the employers. A number of large employers are already offering LTC insurance to their employees. Like other health benefits, LTC insurance coverage should be made ubiquitous.

The use of 401(k) or individual retirement account (IRA) funds for LTC is an attractive option for middle- to-high-income workers. As shown in Figure 1, this is the largest segment (37 percent) of the current adult population age 25 and over. Approximately 40 percent of all workers have a retirement savings account and the average balance is slightly over $50,000.[12] A proposal is to allow tax-free and penalty-free withdrawals from these accounts to pay LTC service costs when they are incurred or to pay LTC insurance premiums. An example of such an insurance design is to set up an LTC subaccount in the 401(k) account where account value is allocated for LTC insurance purposes. From this subaccount, the insuring entity would annually deduct a cost of insurance for the LTC insurance coverage for that year. For most workers, this amount would only be a few hundred dollars. This cost of insurance would go up each year as the risk of LTC grows by age. The insuring entity would periodically advise the workers of the balance in the subaccount that is necessary to fund future insurance costs. The subaccount operates in a similar fashion to a universal life insurance policy but does so inside the 401(k) account.

Unless the current "pay-as-you-go" funding mechanism for Medicare and Medicaid is changed, LTC will put an increasingly heavy financial burden on future generations of workers.

Conceptually, LTC financial security is a part of retirement security. Out-of-pocket LTC expenses are detrimental to retirement savings. The use of funds in the account to protect the account itself serves the workers' best interest. The attraction to the workers is that the LTC premiums become practically painless since there is practically no deduction from their paychecks. This would reduce the number of opt-outs significantly and increase the level of participation in the LTC insurance program.

The potential downside of allowing such withdrawals is the loss of federal tax revenues.

There are three sources of loss. First, there is the withdrawal from the account to pay for incurred LTC expenses. This tax revenue loss is relatively minor since LTC events are rare during the working years. Second, there is the loss when costs of insurance are deducted on a tax-free and penalty-free basis. However, there is no real current loss. The tax loss would be far in the future when funds used to pay for premiums would have been distributed then. Finally, this incentive might encourage workers without a tax-deferred savings account to initiate one. Since they are likely to be workers with low income, potential tax revenue loss would be partially offset by Medicaid savings. Overall, the option of allowing the use of 401(k) funds should have minimal impact on the federal budget.

The low-income workers, at an estimated 15 percent of the current adult population, have little or no discretionary income. Incentives are not that helpful to them. They would need subsidies in order to participate. Unfortunately, there is no readily available source of subsidies unless it is from the federal or state government. An alternative is to require new workers entering the workforce to participate. Employers would be given incentives in order to subsidize their employees' premiums on a temporary or a permanent basis. This is plausible since premiums for beginning workers would be quite low. As this alternative would likely leave a sizable segment of the current low-income workers out of the program, it would take longer for the positive effect of the insurance program on government programs to take place.

It is intuitive that a well-designed program can result in future Medicare and Medicaid savings. With proper modeling tools and techniques, such savings perhaps can be quantified in a fairly precise fashion. If this can be done, then future savings can be set aside to pay for current subsidies for the low-income working class. Since benefit claim rates are low for workers, the majority portion of the premiums in their working years would have been reserved for future claims anyway. The insurance program would be actuarially sound during the beginning years if the promise of future funds can be relied on. In order for this funding option to work, there must be proper accounting of the future savings and legislative discipline to protect such funds from other uses. As with the option of requiring new workers to participate, this option would lengthen the time period for positive impacts on government programs.

LOOKING FORWARD

Even though the LTC Commission punted on the financing issues, the momentum to search for solutions has been building. There is a recent groundswell of activities sponsored by interested groups such as the SCAN Foundation and the Bipartisan Policy Center, as well as the Office of the Assistant Secretary of Policy and Evaluation (ASPE) in the Department of Health and Human Services. Their goal is to develop estimates of future LTC expenditures and model the impact of various potential solutions.

The significance of their efforts extends beyond the technical analysis toward viable solutions. The deliberation of the results of the analysis will continue the public discourse toward greater clarity and common understanding of the financing dilemmas. Hopefully, a number of reasonable proposals will surface. These proposals can potentially be tested in a few states.

Perhaps most importantly, a consensus may be formed with broad support from various interested groups. A consensus is crucial because LTC financing is an important public issue but not urgent. A sensible solution will necessarily be a compromise and may be in direct conflict with certain noble certainties. To push any such proposal through legislation would require the dedication of a fearless champion who will need as wide a support base as possible.

Out of respect and appreciation for our seniors, protecting them from LTC financing risk is fittingly an important element of the society's attention on retirement security. The ultimate goal is overall successful aging for seniors. To this end, governmental and private stakeholders will be continuously seeking innovative ways to deliver high-quality, individualized LTC support in conjunction with formulating financing solutions. ■

ENDNOTES

1. Another acronym is LTSS, which stands for Long-Term Services and Supports.
2. Medicare pays for the first 20 days of a skilling nursing facility stay after at least three days of hospital stay and pays for amounts in excess of $157 per day (in 2015) for the next 80 days. It also pays for limited home health care services due to injury or illness.
3. *Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?* Peter Kemper, Harriet L. Komisar and Lisa Alecxih, Table 2, Inquiry, Volume 42, Winter 2005/2006.
4. Genworth 2014 Cost of Care Survey. Home care cost assumed 20 hours a week.
5. *2014 Sourcebook*, American Association for Long-Term Care Insurance.
6. These dependency ratios were derived from population projections based on the 2010 Census—U.S. Census Bureau.
7. There are approximately 10 million LTC insurance policies in force—*Long-Term Care Insurance: A Product and Industry in Transition*, Marc A. Cohen, Ph.D., LifePlans, Incorporated, November 2012.
8. *Rising Demand for Long Term Services and Support for Elderly People*, Congressional Budget Office, June 2013—Exhibit 23.
9. U.S. Census Bureau.
10. *Personal Income 2010 and Americans with Disability 2010*—U.S. Census Bureau.
11. See, for example, 2014 *Survey of Long-Term Care Awareness and Planning*, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
12. Private Pension Bulletin—Table E20: *http://www.dol.gov/ebsa/pdf/historicaltables.pdf.*

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