

# The CLASS Act and the Future of Long-Term Care Financing

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## **Abstract**

The Community Living Assistance Services and Supports (CLASS) Act's designers and promoters envision the program as a noble plan to relieve the financial strain on Medicaid long-term care and enable disabled and elderly Americans to purchase more home care and suffer less nursing home institutionalization. Unfortunately, CLASS treats only symptoms without addressing the causes of America's long-term care financing problems. This paper explains why CLASS, like private long-term care insurance, is doomed to failure unless and until the crowd-out effect of easy access to Medicaid LTC benefits is addressed. Either by policy or by default, however, Medicaid is nearly finished as the dominant payer for LTC in the United States and therein lies the probable future of long-term care financing.

## Introduction

The Community Living Assistance Services and Supports (CLASS) Act is the federal government's latest attempt to fix long-term care service delivery and financing.<sup>1</sup>

A long-term care trade association instrumental in its design<sup>2</sup> described the CLASS Act as a “new voluntary nationwide long-term services and supports insurance program for persons with disabilities and seniors with chronic illness.”

If we unpack that succinct definition, we find several key issues CLASS is supposed to address. For example:

- CLASS is voluntary in that anyone may opt out anytime, but enrollment is automatic to encourage participation.
- CLASS covers long-term services and supports to help people stay at home, not long-term care, which many associate with nursing homes.
- CLASS is insurance, not a means-tested public assistance program, or welfare, like Medicaid.
- CLASS covers people with disabilities as well as seniors with chronic illness, a boon for the working disabled who are largely unhelped by Medicaid.
- CLASS is nationwide in that it will be the same everywhere in the United States, unlike Medicaid, the primary long-term care payer today, which varies in every state.

In other words, CLASS is the non-Medicaid program. It reverses Medicaid's institutional bias by putting hard cash in beneficiaries' hands so they can purchase the care they prefer in their homes and communities. CLASS uses a social insurance model so it has no welfare stigma. CLASS relies on participants' premiums so it does not drain public coffers and may reduce Medicaid expenditures. Every aspect of CLASS is aimed at correcting some shortfall in Medicaid's long-term care program.

So, is CLASS the future of long-term care? Will it solve the problems associated with Medicaid, such as exploding costs, nursing home bias, access and quality problems, discrimination, impoverishment and dependency? Does CLASS meet the challenge of long-term care financing and fill a gap in the current system or could it actually exacerbate current problems?

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<sup>1</sup> This paper assumes the reader has a working familiarity with the CLASS Act including its implementation timeline, enrollment procedures, and likely premiums, benefits and triggers. For extensive coverage of the CLASS Act including descriptions, analysis and criticism, see the appendix.

<sup>2</sup> The American Association of Homes and Services for the Aging, <http://www.aahsa.org>.

## Understanding the LTC Status Quo

To answer those questions, we need to know why long-term care is the way it is in the United States today. To pose a solution like CLASS without identifying the source of the problem it is supposed to solve runs the risk of making matters worse instead of better by potentially repeating the same mistakes.

How did America—the wealthiest country in the world—come to have a welfare-financed, institution-based long-term care system when no one wants to go to a nursing home but most of the public remains in denial about the risk and cost of long-term care?

When we have the answer to that question, we will be able to ask and answer whether CLASS will improve or worsen the status quo. The answer is a long, complicated story, but in a nutshell:

Medicaid made nursing home care free or radically subsidized beginning in 1965. At first, there were not even restrictions on transferring assets to qualify. So virtually everyone who needed long-term care was eligible.

Families saw that placing their frail or infirm elder in a nursing home was free or very inexpensive while caring for the loved one at home was expensive and uncompensated by government.

As a result, there was little private financing to build and sustain a home- and community-based services infrastructure. Long-term care became equated with nursing home care in the public's mind. Few alternatives existed.

The nursing home industry accepted the new bonanza of Medicaid funding four decades ago and built new skilled nursing facilities throughout the country. Early on, Medicaid's LTC reimbursements were lucrative and highly profitable.

But as Medicaid LTC costs exploded, government officials took dramatic measures to control nursing home expenditures.

First, they capped the supply of nursing home beds with Certificate of Need (CON) programs. But restricting supply predictably increased prices. Nursing homes responded by charging state Medicaid programs more.

So, Medicaid capped reimbursement rates. That was the origin of the differential between high private-pay rates and low Medicaid rates. Throughout the United States, to this day, Medicaid reimbursement is only 76 percent of the private pay rate on average.<sup>3</sup>

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<sup>3</sup> Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," 8th ed. (Washington, D.C.: AARP, 2009), [http://assets.aarp.org/rgcenter/il/d19105\\_2008\\_atc.pdf](http://assets.aarp.org/rgcenter/il/d19105_2008_atc.pdf).

As the public came to realize that paying privately for long-term care was expensive and unnecessary, given Medicaid's generous and elastic LTC eligibility rules (explained below), more and more people converted from private pay to Medicaid.

As profitable private-pay revenue plummeted from half of nursing homes' receipts in the beginning to only about 10 percent today, nursing homes were forced to economize to remain financially viable.

They had only two ways to reduce expenses and neither method was well-received by government and consumers:

1. If they cut costs for staff or services, nursing homes were accused of providing poor quality care.
2. If they tried instead to attract higher-paying private residents, they were accused of discriminating against Medicaid recipients.

In time, low Medicaid reimbursements and reduced private-pay revenue created a serious quality-of-care problem in nursing homes.

In the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the federal government insisted on higher staffing, more training and better care in Medicaid- and Medicare-financed nursing homes.

But higher public reimbursements to finance the desired improvements were not forthcoming. Despite valiant efforts by nursing home providers to ensure quality care, low Medicaid reimbursements continue to be a severe handicap.

The main way nursing homes have managed through these last four decades of changes is that while their residents were mostly Medicaid and reimbursed therefore at minimal levels, they at least were the dominant venue of care so they had a mix of low-acuity, higher-profit residents to balance the cost of caring for their higher-acuity, less profitable residents.

By changing the rules recently so that nursing homes must treat increasing numbers of more demanding, less profitable, higher-acuity residents while they lose more of their less demanding, more profitable, lower-acuity residents, state Medicaid programs have run the risk of further crippling nursing homes' ability to provide quality care.

To make matters even worse, another key public funding source for nursing homes is also highly vulnerable. Nursing homes nationally receive 18 percent of their revenue from Medicare. Unlike Medicaid, Medicare pays very generously. Nursing homes make a profit on their limited Medicare business. They need that profit to counterbalance their losses on Medicaid residents.

But Medicare nursing home financing is highly vulnerable in the future. The program has an \$89 trillion infinite-horizon unfunded liability.<sup>4</sup> The Medicare Payment Advisory Commission (MedPAC) advises Congress annually to curtail nursing home reimbursements. So far, Congress has refused but the jaws of a fiscal vise are closing on Medicare inexorably. It may not sustain nursing homes much longer in the absence of higher Medicaid or private pay revenues.

Social Security, another fiscally vulnerable federal entitlement program, itself with a \$17 trillion unfunded liability,<sup>5</sup> has also been critical to Medicaid's ability to fund nursing home care. People on Medicaid must contribute most of their income to offset the cost of their care to Medicaid. This source of financing covers roughly 13 percent of nursing home revenues, fully half the amount of out-of-pocket expenditures reported by CMS.<sup>6</sup> If Social Security needs to cut back some day, as its trustees predict, it would devastate Medicaid's ability to pay for long-term care.

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<sup>4</sup> Social Security and Medicare Trustees 2009 reports as cited in The Concord Coalition, *Facing Facts Quarterly*, 5, no. 3: 3, [http://www.concordcoalition.org/files/uploaded-pdfs/FF\\_Newsletter\\_V-3\\_09-1206\\_1.pdf](http://www.concordcoalition.org/files/uploaded-pdfs/FF_Newsletter_V-3_09-1206_1.pdf).

<sup>5</sup> *Ibid.*

<sup>6</sup> See Stephen A. Moses, "LTC Bullet: So What if the Government Pays for Most Long-Term Care? 2008 Data Update," (Seattle, Wash.: Center for Long-Term Care Reform, January 13, 2010), <http://www.centerlrc.com/bullets/latest/855.htm>.

## Can Medicaid Rebalance Its Way to Solvency?

As explained so far, Medicaid became the dominant payer of long-term care and paid mostly for nursing home care, which became the prevailing venue of care. But the program's exploding costs and the public's dissatisfaction with nursing home care led academics, legislators and Medicaid officials to attempt to save money and provide more desirable services by focusing on home care instead of nursing home care.

But that policy created a new problem. Saving money by rebalancing from institutional care, with its economy of scale, to home- and community-based care, with its fragmented, labor-intensive services, is dubious. Most research has shown for decades that home care delays but does not replace nursing home care.<sup>7</sup>

While individual lower-acuity patients may be cheaper to care for in the community than in a nursing home initially, across lifetimes and across populations, long-term savings are highly doubtful.<sup>8</sup>

In fact, no state Medicaid program has yet reduced combined institutional and noninstitutional LTC expenses over time.<sup>9</sup> Nursing home expenditures flatten or even decline but home care costs skyrocket.<sup>10</sup>

This is true already even though the long-anticipated baby boom Age Wave in America has barely begun and will soon explode. Our population age 85 plus, the age group most likely to need LTC, is projected to increase by 74 percent, from 5.4 million of the oldest old or 1.8 percent of the total population to 9.5 million or 2.6 percent between 2007 and 2030.<sup>11</sup>

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<sup>7</sup> "When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care." General Accounting Office, "The Elderly Should Benefit from Expanded Home Health Care but Increasing Those Services Will Not Insure Cost Reductions," (Dec. 7, 1982): 43, <http://archive.gao.gov/f0102/120074.pdf>.

<sup>8</sup> "An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations." John F. Holahan and Joel W. Cohen, *Medicaid: The Trade off Between Cost Containment and Access to Care* (Washington, D.C.: The Urban Institute Press, 1986), 106.

"Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective." Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly* 69, no. 2 (1991): 322.

<sup>9</sup> Some recent research makes the case that maybe some day funding more home- and community-based care through Medicaid will save money: "Medicaid spending on home- and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings." H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" *Health Affairs* 28, no. 1 (2009): 262, <http://content.healthaffairs.org/cgi/reprint/28/1/262>.

<sup>10</sup> "While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007." Kaiser Commission on Medicaid and the Uninsured, "Medicaid Home- and Community-Based Service Programs: Data Update," (November 2009): 1, <http://www.kff.org/medicaid/upload/7720-03.pdf>.

<sup>11</sup> Ari Houser, Wendy Fox-Grage, and Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," 8th ed. (Washington, D.C.: AARP, 2009), [http://assets.aarp.org/rgcenter/il/d19105\\_2008\\_at.pdf](http://assets.aarp.org/rgcenter/il/d19105_2008_at.pdf).

The final straw that breaks the back of any plan to save money by rebalancing Medicaid is that funding for the disabled and for home- and community-based care is the first thing states cut when the economy declines. National Association of State Medicaid Directors executive director Ann Kohler was quoted Aug. 6, 2010, in *USA Today*: “I think every state wants to provide more community-based care, but they just can’t afford it.”<sup>12</sup>

Nevertheless, making more home- and community-based long-term care available to more people is unquestionably desirable. So, whether it costs less or not, we should focus on how to pay for it, either publicly, privately or both.<sup>13</sup> But how to pay for home- and community-based care deserves far more attention than it has received so far.

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<sup>12</sup> Marisol Bello, “Recession-battered States Cut Funding for the Disabled,” *USA Today* (August 6, 2010), [http://www.usatoday.com/news/washington/2010-08-06-ada06\\_ST\\_N.htm?csp=34news](http://www.usatoday.com/news/washington/2010-08-06-ada06_ST_N.htm?csp=34news).

<sup>13</sup> “Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. ... We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services.” Diane Dion Hallfors, “State Policy Issues in Long-Term Care for Frail Elders,” (Brandeis University: Center for Vulnerable Populations, Institute for Health Policy, March 30, 1993), 8.

## The Woodwork Effect

The practical problems of providing long-term care in the home and community are perhaps not the biggest risk of potential cost over-runs.

Public officials should also consider the possibility that offering services that people want more than nursing home care may increase demand. This is the familiar problem of the “woodwork” effect.

For every person in a nursing home, two or three are managing at home with equal or greater disability—half of whom are bedbound, incontinent or both—because of heroic efforts made by their loved ones, mostly women—wives, daughters and daughters-in-law—to keep them out of nursing homes.<sup>14</sup>

State Medicaid programs across the country are not only making more desirable Medicaid-financed services available, they are often changing the clinical and financial eligibility rules to make home care services easier and nursing home care more difficult to obtain.

It is also important to remember that Medicaid eligibility often includes coverage of medical services seniors need that Medicare does not cover. It is not unusual for Medicaid benefits to exceed the range of coverage in private health insurance plans.

In combination and over time as the public becomes aware of them, these benefits and initiatives are likely to increase the demand for Medicaid-financed long-term care, enhance the market for Medicaid planning (artificial impoverishment) to qualify for Medicaid, and reduce the public’s sense of urgency about responsible LTC planning through savings, investment or insurance.<sup>15</sup>

Are these extra loads on already scarce public resources an added responsibility state and federal Medicaid officials are prepared to assume?<sup>16</sup>

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<sup>14</sup> “...75% of LTC is given by family members, and ... one-half of the patients so helped are bedbound or incontinent or both.” William E. Oriol, *The Complex Cube of Long-Term Care*, (Washington, D.C.: American Health Planning Association, 1985), 210.

Little has changed since 1985: “*The community-based disabled population is sizable* [italics in the original]. In 2002, about 8.7 million people age 65 and older living at home, or 26.5 percent of the population, reported some type of disability that limited their ability to perform basic personal activities or live independently. About 6.1 percent, or 2.0 million people, were severely disabled. By comparison, about 1.4 million older people lived in nursing homes in 2002.” Richard W. Johnson and Joshua M. Wiener, “A Profile of Frail Older Americans and Their Caregivers,” Occasional Paper no. 8, (Washington, D.C., February 2006), vii, [http://www.urban.org/UploadedPDF/311284\\_older\\_americans.pdf](http://www.urban.org/UploadedPDF/311284_older_americans.pdf).

<sup>15</sup> The fact that offering more home- and community-based care induces greater Medicaid dependency is nothing new as this quote from leading LTC scholars attests: “Given a choice between nursing home care and nothing, many elderly will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use.” Joshua M. Wiener and Katherine M. Harris, “Myths & Realities: Why Most of What Everybody Knows about Long-Term Care is Wrong,” *The Brookings Review* (Fall 1990), 32.

<sup>16</sup> “The deepening financial crisis is expected to impact the ability of many states to provide both acute and long-term care Medicaid services to the growing number of individuals eligible for Medicaid.” Terence Ng, Charlene Harrington, and Molly O’Malley, “Medicaid Home- and Community-Based Service Programs: Data Update,” (Kaiser Family Foundation, December 2008), 1, [http://www.kff.org/medicaid/upload/7720\\_02.pdf](http://www.kff.org/medicaid/upload/7720_02.pdf).

Is that wise during a recession, with state deficits rising, and under a program in which federal matching funds are more and more likely to be curtailed?

What if the recent massive infusion of supplemental federal Medicaid matching funds that has brought \$87 billion into states' coffers from the American Recovery and Reinvestment Act of 2009 is cut off on Dec. 31, 2010, or July 1, 2011 depending on what Congress and the president feel they can afford?

## **How to Avoid the Pitfalls of Rebalancing**

All of these problems are manageable if and only if Medicaid reconfigures LTC financial eligibility to target the program's limited resources to people most in need.

It must also incentivize others, who remain young, healthy and affluent enough, to plan early for long-term care and save, invest or insure privately so they do not become a burden on the public program.

Currently, few Americans purchase private long-term care insurance. Probably less than 10 percent of eligible consumers have the coverage. The Long-Term Care Partnership Program, intended to encourage private coverage by forgiving some Medicaid spend down, remains slow to develop and only marginally successful.

Agents often attribute the lagging LTC insurance market to consumer denial, ease of access to Medicaid-financed LTC, widely available Medicaid planning advice and a shortage of insurance producers able to make a living while specializing in the product.

Even fewer Americans use reverse mortgages to fund their own home- and community-based care before they turn to public assistance. Why do so when Medicaid exempts the home and home equity is easy to divert from estate recovery liability?

Although federal law has mandated that state Medicaid programs recover the cost of their care from the estates of deceased recipients, most states have very limited estate recovery programs and recover only a small fraction of the non-tax revenue they could receive with more robust efforts.

So, that, in briefest summary, is how Medicaid-financed nursing home care came to dominate long-term care financing in the United States and why retrofitting a home- and community-based services system on it after the fact is so difficult. But it still doesn't explain why Medicaid pays for most long-term care.

## Why Does Medicaid Pay for Most Long-Term Care?

If long-term care is such a high risk of catastrophic financial loss as often asserted, why is it that most people who need LTC end up on Medicaid, a means-tested public welfare program, but statistics show little evidence the public has to spend down savings before qualifying for government assistance?<sup>17</sup>

Americans face a 69 percent probability of needing some long-term care and a 20 percent probability of needing five years or more.<sup>18</sup>

LTC in the United States is very expensive whether provided in the home (home health aide, \$21 per hour; homemaker/companion, \$19 per hour) or in adult day care (\$67 per day), assisted living (\$3,131 per month) or a nursing home (\$198 semi-private room per day, \$219 private room per day).<sup>19</sup>

Yet the vast majority of expensive long-term care throughout the United States is funded by third parties such as Medicaid, Medicare and private insurance, or by spend-through of Social Security income or other private income by people already on Medicaid.<sup>20</sup>

One can account for 85 to 90 percent of the entire cost of expensive long-term care in the United States without touching any of anyone's personal savings.<sup>21</sup>

The conventional wisdom that people all across the country are being forced into impoverishment by the high cost of long-term care is demonstrably false and has been so for decades.<sup>22</sup>

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<sup>17</sup> America spent \$138.4 billion on nursing home care in 2008. Of that, Medicaid paid 40.6 percent; Medicare, 18.6 percent; other public funds, 3.0 percent; private health insurance, 7.4 percent; and other private funds, 3.7 percent. Only 26.7 percent of nursing home funding was paid out of pocket and half of that was spend-through of Social Security income of people already on Medicaid. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Health Expenditures Data, (January 8, 2010), Table 9, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>. The situation with home health care financing is very similar to nursing home financing. America spent \$64.7 billion on home health care in 2008. Medicare (41.1 percent) and Medicaid (34.6 percent) paid 75.7 percent of this total and private insurance paid 9.0 percent. Only 10.2 percent of home health care costs were paid out of pocket. The remainder came from several small public and private financing sources. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Health Expenditures Data, (January 8, 2010), tables 4 and 11, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

<sup>18</sup> "While an estimated 31 percent of people currently turning 65 will not need any LTC before they die, 20 percent will need care for more than five years." Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry* 42 (Winter 2005/2006): 342.

<sup>19</sup> Figures cited are average private-pay rates for the United States as reported in MetLife Mature Market Institute, "The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," (October 2009), <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf>.

<sup>20</sup> See Micah Hartman, et al., "Health Spending Growth at a Historic Low in 2008," *Health Affairs* 29, no. 1: 147-55, <http://content.healthaffairs.org/cgi/content/full/29/1/147>, and Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care," Policy Analysis no. 549, (Washington, D.C.: Cato Institute, September 1, 2005), <http://www.cato.org/pubs/pas/pa549.pdf>.

<sup>21</sup> See Stephen A. Moses, "LTC Bullet: So What if the Government Pays for Most Long-Term Care? 2008 Data Update," (Seattle, Wash.: Center for Long-Term Care Reform, January 13, 2010), <http://www.centerltc.com/bullets/latest/855.htm>.

<sup>22</sup> Stephen A. Moses, "The Fallacy of Impoverishment," *The Gerontologist* 30, no. 1, (February 1990), 21-25.

But, what if it's true that most people can ignore the risk of long-term care, avoid the responsibility to save, invest or insure for that risk, wait to see if they ever need expensive LTC and, if they do, get someone else to pay?

If that is true, wouldn't it make sense that most Americans don't worry about long-term care until it's too late to prepare responsibly and therefore end up on the public program that pays for most long-term care?

But how can it be true that people qualify for public funding of their expensive long-term care without first spending themselves into financial ruin?

That is in fact how Medicaid long-term care financial eligibility actually works despite the common view that getting government to pay for LTC requires spending down into impoverishment.

## How Medicaid LTC Eligibility Actually Works

Most of what one reads in the media, trade journals or even in peer-reviewed research articles, says that Medicaid long-term care eligibility requires poverty-level income and asset spend down into penury.

The whole truth is more complicated. On the income side, most states have medically needy income eligibility systems. That means the state deducts the cost of private nursing home care and other insurance and medical expenses from a Medicaid applicant's income before asking if any remaining income meets the poverty-level standard.

Even in so-called income-cap states, people with incomes much higher than the cap can qualify for Medicaid by setting up a Miller income diversion trust.

Consequently, successful applicants for Medicaid long-term care do not have to be low income. They only need to have a cash flow problem after they have paid their LTC and medical expenses.

In a recent study, Rhode Island's Medicaid eligibility policy chief stated he had only seen eligibility denied to two applicants based on excess income during his decades of experience with the program.<sup>23</sup>

But what about assets? Don't Medicaid applicants have to spend down their personal savings privately for their own care until they get down to a draconian limit of about \$2,000?

No again or not exactly.

Federal Medicaid rules do not require that assets be spent down specifically *for long-term care*.

Take a world cruise or throw a big party, some experts advise. As long as you don't give assets away for less than fair market value to qualify for Medicaid, no transfer-of-assets eligibility penalty applies. Applicants and recipients may purchase any amount of exempt assets to reduce their resources to the Medicaid eligibility limits.

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<sup>23</sup> Stephen A. Moses, "Doing LTC RIght," (Providence, R.I.: Ocean State Policy Research Institute, January 2010), [http://www.centerltc.com/pubs/Doing\\_LTC\\_RIght.pdf](http://www.centerltc.com/pubs/Doing_LTC_RIght.pdf).

Furthermore, allowable exempt assets are virtually unlimited. In addition to the small amount of cash that recipients are allowed to retain, they may also keep the following without affecting their Medicaid eligibility<sup>24</sup>:

- A home and all contiguous property up to \$500,000 in equity;<sup>25</sup>
- One business including the capital and cash flow of unlimited value;<sup>26</sup>
- Retirement funds such as individual retirement accounts (IRAs), at least in Rhode Island;<sup>27</sup>
- One automobile of unlimited value if used for the benefit of the Medicaid recipient, which is assumed;<sup>28</sup>
- Unlimited prepaid burial plans for the Medicaid recipient and immediate family members;<sup>29</sup> and
- Unlimited term life insurance.<sup>30</sup>

Medicaid exempts many other assets but those are the major ones, except for household goods discussed below. Again, these exemptions are mandatory under federal law and regulations.

Do these federal rules cause Medicaid to expend more state and federal resources for long-term care than would otherwise be true? Undoubtedly. Consider, for example, the home equity, prepaid burials and household goods exemptions.

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<sup>24</sup> Citations to Federal regulations for the following asset exemptions and others may also be found in Stephen A. Moses, “Aging America’s Achilles’ Heel: Medicaid Long-Term Care,” Policy Analysis no. 549, (Washington, D.C.: Cato Institute, September 1, 2005), <http://www.cato.org/pubs/pas/pa549.pdf>.

<sup>25</sup> Federal Medicaid LTC eligibility rules exempted unlimited home equity, including the value of all property contiguous to the home, until the Deficit Reduction Act of 2005, signed into law by President George W. Bush February 8, 2006, capped the home equity exemption at \$500,000 or \$750,000 depending on state legislative option. Most states opted for the lower cap. New York, California, Connecticut, Massachusetts and Idaho opted for the higher cap.

<sup>26</sup> “Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990.” Social Security Administration, *Program Operations Manual System (POMS)*, <http://policy.ssa.gov/poms.nsf/lnx/0501130501>.

<sup>27</sup> “A recipient could have \$500,000 in an IRA and it’s not counted.” Interview with Deborah Castellano, chief case work supervisor, Rhode Island Department of Human Services, on October 28, 2009.

Mandatory periodic payments from retirement accounts are counted as income but rarely cause ineligibility. Social Security Administration, “SI 01120.210: Retirement Funds,” *Program Operations Manual System (POMS)*, <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120210!opendocument>.

<sup>28</sup> “One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual’s/couple’s household. ASSUMPTION: [emphasis in original] Assume the automobile is used for transportation, absent evidence to the contrary.” Social Security Administration, “SI 01130.200: Automobiles and Other Vehicles Used for Transportation,” *Program Operations Manual System (POMS)*, <http://policy.ssa.gov/poms.nsf/lnx/0501130200>.

<sup>29</sup> “A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.” Social Security Administration, “SI 01130.400: Burial Spaces,” *Program Operations Manual System (POMS)*, <http://policy.ssa.gov/poms.nsf/lnx/0501130400>.

<sup>30</sup> “[T]he FV [face value] of the following are not taken into account: burial insurance policies; and term insurance policies that do not generate a CSV [cash surrender value].” Social Security Administration, “SI 01130.300: Life Insurance,” *Program Operations Manual System (POMS)*, <http://policy.ssa.gov/poms.nsf/lnx/0501130300>. Why would a 90-year-old buy a \$1 million term life policy when the premium would almost equal the benefit? Instantaneous self-improvement and the term insurance benefit passes to the beneficiary at death, thus avoiding Medicaid’s “mandatory” estate recovery requirement.

## Home Equity

More than 80 percent of seniors own their homes and more than 70 percent of these own their homes free and clear.<sup>31</sup> By the time they rely on Medicaid to fund their long-term care, only about 14 percent of recipients still own their homes.<sup>32</sup> Thus, most of the elderly's home equity disappears before they start receiving Medicaid LTC benefits.

How much equity is lost and what happens to it? Some possibilities include transfers outside the five-year transfer-of-assets penalty window,<sup>33</sup> sale of the home with re-purchase of an interest in an adult child's home<sup>34</sup> and life estates with reserved special powers.<sup>35</sup>

It behooves state Medicaid programs to find out what's happening to home equity that could otherwise relieve the financial pressure on Medicaid to fund long-term care.

Even after most of the equity has disappeared, Medicaid still exempts billions of dollars of home equity for LTC recipients.<sup>36</sup>

But isn't that money recaptured later by Medicaid estate recovery? Much of it could be but little of it is recovered because few states recover from estates aggressively.

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<sup>31</sup> "The vast majority of Americans age 65 and older in 2004 (82 percent) are homeowners (Callis and Cavanaugh 2004). Over half the net worth of seniors is currently illiquid in their homes and other real estate (Orzechowski and Sepielli 2003)." p. 1.

<sup>32</sup> "Based on the Health and Retirement Study, in 2000 there were 27.5 million elder households with at least one resident age 62 or older. A high proportion (21.1 million) of these households (78 percent) were homeowners (Figure 3.2). About 74 percent owned their homes free and clear of any mortgages. In aggregate, elder households have accumulated over \$2 trillion in home equity." p. 26. Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, (January 2005), <http://www.reversemortgagetimes.org/guides/reverselongterm.pdf>.

<sup>33</sup> General Accounting Office, "Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs," *GAO/HRD-89-56*, (March 1989), 4, <http://archive.gao.gov/d15t6/138099.pdf>.

<sup>34</sup> Assets transferred for less than fair market value for the purpose of qualifying for Medicaid within five years of applying for Medicaid create an eligibility penalty in months equal to the amount of assets so transferred divided by the average cost of a nursing home in the state. Assets transferred earlier than five years incur no penalty no matter how great the amount.

<sup>35</sup> The Medicaid applicant sells a home, uses the proceeds to purchase an interest in someone else's home (usually an adult child's residence) and then claims that property interest as exempt because of an intent to return to a home. Medicaid exempts homes to which recipients "intend to return."

<sup>36</sup> The elderly Medicaid applicant transfers the remainder interest in a home to an heir (usually an adult child) while retaining a life estate, i.e. the right to live in the home until death, including the right to mortgage, sell or convey an interest in the property, i.e. "special powers." State staff in Rhode Island insisted this should be a transfer of assets but that the Centers for Medicare and Medicaid Services (CMS) have allowed it.

<sup>36</sup> The median net worth of elderly households in the United States is \$130,500 of which \$109,950 is home equity. Alfred O. Gottschalck, "Net Worth and the Assets of Households: 2002 Household Economic Studies," *Current Population Reports*, (U.S. Census Bureau, April 2008), 70-115, table 4; U.S. Census Bureau, "Median Net Worth and Median Net Worth Excluding Home Equity of Households by Age of Householder and Monthly Household Income Quintile: 2000 and 2002," (December 9, 2009), 10, <http://www.census.gov/prod/2008pubs/p70-115.pdf>. According to the American Housing Survey for 2007 (<http://www.census.gov/prod/2008pubs/h150-07.pdf>), the median value of an elderly owner-occupied home in the United States was \$168,654.

## Prepaid Burials

Prepaid burials are another huge exemption that diverts public funds from purchasing long-term care services to financing the funeral industry.

State eligibility workers interviewed for several studies over the years have estimated that 65 to 85 percent of all elderly Medicaid LTC recipients purchase prepaid burials averaging \$5,000 to \$10,000 in value.<sup>37</sup>

For example: “In a study the Center for Long-Term Care Financing conducted on behalf of the Nebraska State Legislature in 2003, state eligibility workers estimated that more than 80 percent of the state’s 9,800 Medicaid LTC recipients had exempted a total of \$51 million for prepaid burials, for an average of \$6,505 per recipient. If this were true for the country as a whole, it would mean nearly \$7 billion is diverted from LTC funding at any given time to prefund burials.”<sup>38</sup>

When new Medicaid applicants have not already purchased prepaid burials, eligibility workers in many states routinely encourage them to do so.<sup>39</sup> This advice qualifies the applicant for public assistance faster, increases Medicaid’s costs and reduces private-pay revenue to long-term care providers.

It is controversial, but still a valid public policy question to ask whether state and federal Medicaid funds are more appropriately expended to provide quality LTC services to needy seniors or to indemnify heirs for their parents’ final costs by subsidizing expensive funerals.

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<sup>37</sup> For example, see Stephen A. Moses, “Long-Term Care in Montana: A Blueprint for Cost-Effective Reform,” (Kirkland, Wash.: LTC Inc., September 23, 1993), 17, <http://www.centerltc.com/pubs/MONTANA-Report.pdf>; Stephen A. Moses, “The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care,” for the Florida State Legislature (Seattle, Wash.: LTC Inc., April 21, 1994), 30, <http://www.centerltc.com/pubs/FLORIDAREP.pdf>; Stephen A. Moses, “The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois,” (Seattle, Wash.: LTC Inc., February 1, 1995), 25, [http://www.centerltc.com/pubs/MAGIC\\_Bullet.pdf](http://www.centerltc.com/pubs/MAGIC_Bullet.pdf); Stephen A. Moses, “The Heartland Model for Long-Term Care Reform: A Case Study in Nebraska,” for the Nebraska State Legislature, (Seattle, Wash.: Center for Long-Term Care Financing, December 1, 2003), 19, <http://www.centerltc.com/pubs/Nebraska.pdf>; Stephen A. Moses, “Doing LTC Right,” (Providence, R.I.: Ocean State Policy Research Institute, January 2010), 10, [http://www.centerltc.com/pubs/Doing\\_LTC\\_Right.pdf](http://www.centerltc.com/pubs/Doing_LTC_Right.pdf).

<sup>38</sup> Stephen A. Moses, “Aging America’s Achilles’ Heel: Medicaid Long-Term Care,” Policy Analysis no. 549, (Washington, D.C.: Cato Institute, September 1, 2005), <http://www.cato.org/pubs/pas/pa549.pdf>.

<sup>39</sup> For many examples, see the LTC financing studies cited in the previous two footnotes.

## Personal Property

Household goods are officially excluded under federal regulations from Medicaid's asset eligibility limits regardless of value. Many state Medicaid programs do not routinely inquire about personal property even though it is a "countable resource" if held for "its value or as an investment."<sup>40</sup>

Medicaid LTC eligibility workers in a recent study said there was no limit on home furnishings nor do they have personnel to see what applicants and recipients have. They have "no clue" what is in the homes.<sup>41</sup>

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<sup>40</sup> Social Security Administration, "SI 01130.430: Household Goods, Personal Effects and Other Personal Property," *Program Operations Manual System (POMS)*, <http://policy.ssa.gov/poms.nsf/lnx/0501130430>.

<sup>41</sup> Interview with seven Medicaid social workers and supervisors, with an average of 13 years each in the job, provided these estimates to reviewers in a meeting on October 28, 2009. Cited in Stephen A. Moses, "Doing LTC RIght," (Providence, R.I.: Ocean State Policy Research Institute, January 2010), 11, [http://www.centerlrc.com/pubs/Doing\\_LTC\\_RIght.pdf](http://www.centerlrc.com/pubs/Doing_LTC_RIght.pdf).

## Medicaid Planning

Beyond the already very generous eligibility rules imposed by federal law and regulations on all state Medicaid programs, many attorneys specialize in highly technical methods to impoverish more prosperous elders artificially for the purpose of qualifying them to receive Medicaid-financed long-term care.

An Internet search for “Medicaid planning” yielded 122,000 hits on Aug. 6, 2010. Examples of recent Internet ads for Medicaid planning include:

“Typically we can preserve somewhere between 40% to 100% of the assets and assist in obtaining Medicaid much faster.”<sup>42</sup>

“There are many options to protecting your assets from nursing home costs.

- Irrevocable trusts
- Gifting
- Converting non-exempt assets into exempt assets
- Legal spend downs
- Purchasing annuities and long-term care insurance

“We welcome you to contact the Medicaid Planning Law Center to learn more about the options we have available for protecting your assets and planning for Medicaid.”<sup>43</sup>

The National Academy of Elder Law Attorneys (NAELA), the Medicaid planners’ professional association, lists over 4,300 members nationwide on its website at <http://www.naela.org/MemberDirectory/default.aspx>.<sup>44</sup>

Medicaid planners use techniques such as Medicaid friendly annuities,<sup>45</sup> promissory notes,<sup>46</sup> reverse half-a-loaf strategies,<sup>47</sup> irrevocable income-only trusts,<sup>48</sup> purchase of exempt

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<sup>42</sup> Source: Zachariah & Brown Elder Law Attorneys, 4500 Walnut Street, McKeesport PA, 15132, information extracted July 26, 2010, <http://www.pittsburghelderlaw.com/medicaidplanning.html>.

<sup>43</sup> Medicaid Planning Law Center, 201 Penn Center Blvd., Suite 400, Pittsburgh, PA 15235, information extracted July 26, 2010, <http://www.medicaidplanninglawctr.com/MedicaidPlanningandAssetProtection.shtml>.

<sup>44</sup> Cited August 6, 2010.

<sup>45</sup> A typical case of this kind involves putting a couple’s excess assets into an annuity for the community spouse. It’s not a penalizable transfer because fair market value is received in the form of a cash stream. Rhode Island Medicaid LTC eligibility workers we interviewed on October 28, 2009, estimated 5 percent of elderly LTC cases use annuities averaging \$100,000 to \$150,000 to qualify. One spousal annuity case involved \$750,000 resulting in immediate Medicaid nursing home eligibility in which Medicaid pays only \$200 per month because of the high income stream from the annuity. The nursing home gets the low Medicaid reimbursement even though the client could easily have paid the full private-pay rate indefinitely. Tom Conlon, administrator of long-term care and adult services for the Rhode Island Department of Human Services, reviews all cases involving annuities including 83 such cases received between January 1, 2009, and October 27, 2009.

<sup>46</sup> The Medicaid applicant loans a sum of money to someone else, usually an heir, in exchange for a promise to repay the loan within a set length of time based on the actuarial life expectancy of the elder. The state uses standard life tables without medical underwriting, which underestimates life expectancies, enabling relatively low monthly payments. Tom Conlon, administrator of long-term care and adult services for the Rhode Island Department of Human Services, told us on July 7, 2009, that promissory notes are used in about 5 percent of the cases. Conlon reviews all cases involving promissory notes including 41 such cases received between January 1, 2009, and October 27, 2009. The average duration of these notes is about a year and the average amount around \$80,000, according to Deborah Castellano, Rhode Island Department of Human Services chief case work supervisor, in an interview on October 28, 2009.

assets,<sup>49</sup> life estates with special powers and purchase of an interest in an adult child's home to hasten eligibility for relatively affluent clients.<sup>50</sup>

From tens to hundreds of thousands of dollars or more may be involved in each of these Medicaid planning gambits. A rule of thumb for the cost of Medicaid planning is that attorneys' fees to qualify for Medicaid will be roughly equal to the cost of one month in a nursing home at the private pay rate, or around \$6,000 to \$8,000, depending on the state and locality.

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<sup>47</sup> The reverse half-a-loaf strategy replaced the notorious half-a-loaf strategy when the Deficit Reduction Act of 2005 (DRA '05) changed transfer of assets rules so that the eligibility penalty begins when the applicant applies for Medicaid instead of when the assets were transferred. In a reverse half-a-loaf, Medicaid applicants, nearly always with the advice and counsel of a Medicaid planning attorney, divest half their otherwise nonexempt assets and loan the remainder, taking a promissory note. During the penalty period thus created by the asset transfer, the Medicaid applicant uses the proceeds from the promissory note to pay privately for care. The net effect is that the applicant becomes eligible for Medicaid in half the time with only half the penalty as otherwise and legally transfers half the assets to a selected beneficiary, usually an adult-child heir. In an interview on October 28, 2009, Rhode Island Medicaid eligibility workers estimated that 5 to 10 percent of Medicaid LTC cases use the reverse half-a-loaf technique averaging between \$40,000 and \$150,000.

<sup>48</sup> Assets held in an irrevocable, income-only trust are excluded from the Medicaid LTC eligibility determination process. Tom Conlon, administrator of long-term care and adult services for the Rhode Island Department of Human Services, told us on July 7, 2009, that he sees "lots and lots" of these, that they are "used to beat us" by "people with giant money" who transfer their assets into the trust five years before applying for Medicaid to avoid the transfer of assets penalty. He reviews all such cases and has received 111 covering the period from January 1, 2009, to October 27, 2009. Deborah Castellano, Rhode Island Department of Human Services chief case work supervisor, told us in an interview on October 28, 2009, that trusts are used to qualify for Medicaid LTC in "maybe 5 or 10 percent of cases."

<sup>49</sup> One easy way to eliminate otherwise countable assets is to purchase exempt resources. This may involve home improvements or renovations worth tens of thousands of dollars. The Medicaid applicant may be advised to purchase home furnishings or a new car even if they will not live in the home nor drive the car personally. Medicaid planning attorneys maintain long check lists of exempt resources to help clients divert assets away from the Medicaid resource limit.

<sup>50</sup> For a full explanation of all these Medicaid planning techniques, see Stephen A. Moses, "Doing LTC RIght," (Providence, R.I.: Ocean State Policy Research Institute, January 2010), [http://www.centerlrc.com/pubs/Doing\\_LTC\\_RIght.pdf](http://www.centerlrc.com/pubs/Doing_LTC_RIght.pdf).

## Summary and Relevance of the CLASS Act

To understand how CLASS fits into the future of long-term care financing, we set out to answer this question first: How did America—the wealthiest country in the world—come to have a welfare-financed, institution-based long-term care system when no one wants to go to a nursing home but most of the public remains in denial about the risk and cost of long-term care?

We have the answer now: Medicaid made government-financed long-term care readily available, which obviated the need for private long-term care insurance. By paying mostly for nursing home care, Medicaid crowded out a private-pay market for home- and community-based care. As costs exploded over time, the government tried many ways to control expenditures, but all were unsuccessful. Sheltered from the high cost of long-term care, the public remains in denial about its risk and cost.

Now let's inquire whether CLASS will help or hinder progress toward better long-term care service delivery and financing. These are the basic characteristics of CLASS that we identified in the beginning. What do they mean in the context of the LTC financing problem as we have described it?

- CLASS is voluntary in that anyone may opt out anytime, but enrollment is automatic to encourage participation.

Now we know why the public is in denial about long-term care. The government has always paid for most of it. Therefore, consumers are no more likely to opt into CLASS than they were to purchase private long-term care insurance, which is less expensive and better coverage. That's why the chief actuary of the Centers for Medicare and Medicaid Services predicts only 2 percent will participate.<sup>51</sup>

- CLASS covers long-term services and supports to help people stay at home, not long-term care, which many associate with nursing homes.

Private long-term care insurance pays predominantly for home care and assisted living (roughly two-thirds), just the opposite of Medicaid (two-thirds nursing home). Simply paying for home- and community-based care will not make CLASS more attractive than private LTC insurance, which most consumers do not buy.

- CLASS is insurance, not a means-tested public assistance program, or welfare, like Medicaid.

The public has come to think of Medicaid as an entitlement. Welfare stigma has almost disappeared. Most people do not think about long-term care until they need it. Then insurance is

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<sup>51</sup> “We estimate that about 2.8 million persons would participate in the (CLASS) program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers.” Richard S. Foster, Centers for Medicare and Medicaid Services chief actuary, memorandum, (November 13, 2009), 11, [http://camp.house.gov/UploadedFiles/OACT\\_Memorandum\\_on\\_Financial\\_Impact\\_of\\_H\\_R\\_\\_3962\\_\\_11-13-09\\_.pdf](http://camp.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3962__11-13-09_.pdf).

not an option. You cannot buy LTC insurance after you have Alzheimer's disease any more than you can buy fire insurance when your house is in flames. As long as Medicaid remains an option after the insurable event has occurred, consumers will not opt in to CLASS in the future any more than they purchase private insurance today.

- CLASS covers persons with disabilities as well as seniors with chronic illness, a boon for the working disabled who are largely unhelped by Medicaid.

The working disabled dislike Medicaid because of its bias toward nursing home care, which they naturally prefer to avoid. They do not qualify for private LTC insurance because of its medical underwriting. So CLASS, with its absence of medical underwriting, sounds great. The problem is that without underwriting, high-risk people will opt into CLASS and low-risk consumers will opt out. That's called adverse selection. It leads to the classic insurance death spiral, and it means CLASS is doomed to insolvency from the start.<sup>52</sup>

- CLASS is nationwide in that it will be the same everywhere in the United States, unlike Medicaid, the primary long-term care payer today, which varies in every state.

Wouldn't it be nice to have an insurance product that is the same everywhere? Yes, but it already exists. Private long-term care insurance has only minor variations based on state regulatory requirements. One of the nice things about private LTC insurance products is that they are adaptable to the special needs and preferences of individual policyholders. CLASS, on the other hand, is the same for everyone as well as everywhere. It is a one-size-fits-all program unadaptable to particular needs.

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<sup>52</sup> "In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. ... This effect has been termed the 'classic assessment spiral' or 'insurance death spiral.'" Richard S. Foster, Centers for Medicare and Medicaid Services chief actuary, memorandum, (November 13, 2009), 15, [http://camp.house.gov/UploadedFiles/OACT\\_Memorandum\\_on\\_Financial\\_Impact\\_of\\_H\\_R\\_\\_3962\\_\\_11-13-09\\_.pdf](http://camp.house.gov/UploadedFiles/OACT_Memorandum_on_Financial_Impact_of_H_R__3962__11-13-09_.pdf).

## **Conclusion**

The CLASS Act attempts to solve problems in America's long-term care financing system without first accounting for why that system has failed. CLASS addresses the symptoms (problems of access, quality, reimbursement and institutional bias) without fixing the problem (easy access to Medicaid-funded LTC).

Do we have a problem of access? Yes. Why? Because Medicaid co-opted private financing of long-term care, leaving the country without a strong privately financed home- and community-based services infrastructure. Neither private insurance nor CLASS can retrofit a good HCBS delivery system unless and until Medicaid stops crowding out private demand.

Do we have a problem with quality of care and reimbursement? Yes. Why? Because Medicaid is the dominant payer for LTC services but pays providers too little to ensure quality care. Private LTC insurance enables policyholders to pay full market rates and to command red-carpet access to top-quality care at the most appropriate level of care. The CLASS Act's likely low benefits will not suffice in that regard, but the availability of CLASS without underwriting further desensitizes the public to the need for LTC planning. Even more people will end up dependent on Medicaid.

Do we have a problem with institutional bias? Yes. Why? Because Medicaid made nursing home care virtually free and easy to obtain. CLASS will not solve that problem by paying for home- and community-based care any more than private LTC insurance, which already pays mostly for HCBS, did. No insurance-based system, whether public or private, will eliminate institutional bias unless consumers take it up. Consumers will not take up insurance as long as Medicaid remains an option after the insurable event occurs.

## The Future of Long-Term Care Financing

Unfortunately, the future of long-term care financing will remain very much like its past until one of two things happen. Policy makers must address the cause of the problems instead of the symptoms or the existing service delivery and financing system will collapse forcing market-based adaptations.

Given the aging demographic challenges this country faces, it is probably too late already for policy makers to fix what needs to be fixed. They insist on making the problems worse. They keep Medicaid LTC eligibility easy so even the affluent can qualify. They don't enforce estate recoveries, which turns Medicaid into free inheritance insurance for boomer heirs. They make Medicaid eligibility ever more attractive by covering more home care people want and less nursing home care they'd rather avoid. They push programs like CLASS that create false hope but delay confronting hard fiscal reality.

So that leaves us with the most likely scenario in the short term. Medicaid will continue to crowd out most privately financed long-term care. Neither home equity conversion (because of Medicaid's home equity exemption) nor private long-term care insurance (because of easy Medicaid access after the insurable event occurs) will gain LTC financing market share. CLASS will flounder from low participation and rapid insolvency if it is not repealed outright. Most Americans will go on for a few more years anesthetized to the risk and cost of long-term care.

But longer term, say over the next 10 to 15 years, long-term care financing and services are likely to change dramatically. Medicaid's problems of access, quality, reimbursement and institutional bias will continue to worsen. Public financing sources that have helped Medicaid in the past, such as Social Security (Medicaid recipients must contribute most of their income to offset the program's costs) and Medicare (which pays generously for home care and nursing home care now but can't much longer) are languishing with over \$107 trillion in unfunded liabilities.<sup>53</sup> A perfect storm of demographic, fiscal and long-term care challenges is brewing.

The most likely outcome now is that Medicaid will have no choice but to cut back radically. Traditionally generous income and asset eligibility rules will be tightened. The home equity exemption of at least \$500,000 will drop to something closer to the limit in the United Kingdom of roughly \$35,400.<sup>54</sup> Unlimited exemptions for a business, auto, term life insurance and prepaid burials will disappear or be severely cut back. Sophisticated Medicaid planning techniques—such as special trusts, transfers, annuities, life care contracts and reverse half-a-loaf strategies—that enable people with hundreds of thousands of dollars above the already generous Medicaid limits to qualify will finally be prohibited.

Bottom line, as Social Security, Medicare and Medicaid face their inevitable underfunded future, economic reality will force Medicaid to become what it was always intended to be but has never been: exclusively a long-term care safety net for the truly needy. That transition will be socially and politically tumultuous. Many baby boomers will be hurt, especially the middle class,

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<sup>53</sup> The Concord Coalition, *Facing Facts Quarterly* 5, no. 3: 3, [http://www.concordcoalition.org/files/uploaded-pdfs/FF\\_Newsletter\\_V-3\\_09-1206\\_1.pdf](http://www.concordcoalition.org/files/uploaded-pdfs/FF_Newsletter_V-3_09-1206_1.pdf).

<sup>54</sup> Actually 23,500 British pounds.

and fewer heirs will reap what the Health and Human Services inspector general once called the “windfall of Medicaid subsidies.” But in the end, long-term care services and financing will improve.

Without having to cover the middle class and affluent, in addition to the poor, state Medicaid long-term care programs will be able to pay adequately for a full range of high-quality care in recipients’ homes, assisted living facilities or nursing homes as their medical needs, not inadequate program finances, require.

With Medicaid less available to relatively prosperous people, they’ll finally bear the full weight of LTC risk and cost. Only one-third of boomers have saved enough to cover their retirement income security, much less their like health and LTC expenses. So the boomers will likely spend down their savings rapidly and turn first to home equity conversion to fund their LTC. Once home equity is at risk, private long-term care insurance will finally break out of its niche market and become a mainstream financial product everyone medically and financially eligible knows they must have.

With more Americans paying privately for long-term care, financial oxygen will surge into the service delivery system, improving access and quality for all, including people who remain dependent on Medicaid but will now have the use of a more fully funded, mostly privately financed home- and community-based services infrastructure.

As it becomes obvious that long-term care is a personal and family responsibility and not a risk that can be ignored safely, the public will no longer blithely ignore the need for long-term care planning. Instead of “greedy heirs” taking early inheritances with the help of “Medicaid planners” and fighting among themselves for the spoils of “artificial impoverishment,” we’ll see adult siblings pulling together to help get Mom and Dad the LTC coverage they need and the quality care they deserve.

Ironically to some, but logically to others, the less government is able to finance long-term care for the many, the more and better care it will be able to provide to the truly needy poor. Under those circumstances, even CLASS, or some more sensible program to help the working disabled, might work.

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U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. National Health Expenditures Data, tables 4, 9 and 11. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>

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## **Appendix: Community Living Assistance Services and Supports (CLASS) Act**

### **CLASS is Title VIII of the Patient Protection and Affordable Care Act of 2010**

Patient Protection and Affordable Care Act (enrolled as agreed to or passed by both House and Senate) [[PDF](#)], aka “Health Reform,” aka “ObamaCare,” signed by President Obama on March 23, 2010.

Health Care and Education Reconciliation Act of 2010 (enrolled as agreed to or passed by both House and Senate) [[PDF](#)], aka the “Fixer Bill,” signed by President Obama on March 30, 2010.

### **Quick reference to Steve Moses’ publications on CLASS:**

*LTC Bullets on CLASS:*

[LTC Bullet: Heritage on CLASS, Monday, July 23, 2010](#)

[LTC Bullet: CLASS vs. LTCI: What’s Best for LTC Providers? Tuesday, July 20, 2010](#)

[LTC Bullet: Draft Legislation to Fix CLASS, Wednesday, June 23, 2010](#)

[LTC Bullet: New LTCI Report: Research or Propaganda? Tuesday, June 8, 2010](#)

[LTC Bullet: More CLASS, Tuesday, May 25, 2010](#)

[LTC Bullet: The CLASS Act: Implementation and Impact on Consumers, Thursday, April 29, 2010](#)

[LTC Bullet: CLASS and the Senior Care Investor, Wednesday, April 21, 2010](#)

[LTC Bullet: CLASS Caveats, Wednesday, April 7, 2010](#)

[LTC Bullet: “CLASS Dismissed” for Broker World, Thursday, February 11, 2010](#)

[LTC Bullet: DéCLASSé, Wednesday, December 9, 2009](#)

[LTC Bullet: CLASS Consciousness, Wednesday, October 21, 2009](#)

[LTC Bullet: CLASSified, Monday, October 19, 2009](#)

*LTC E-Alerts on CLASS:* You’ll need your Center for Long-Term Care Reform user name and password to access the following publications in “The Zone.” If you have any trouble getting into The Zone, just call (206) 283-7036 or email Steve (smoses@centerltc.com) or Damon (damon@centerltc.com).

[LTC E-Alert #10-091: No CLASS](#)

[LTC E-Alert #10-089: Dear Colleague Letter on CLASS](#)

[LTC E-Alert #10-088: Boustany Bill Bucks CLASS](#)

[LTC E-Alert #10-086: CLASS Doyenne Cops Out, Cashes In](#)

[LTC E-Alert #10-076: New CLASS Fix Draft](#)

[LTC E-Alert #10-066: CLASS Commission](#)

[LTC E-Alert #10-065: Latest CLASS Act Coverage](#)

[LTC E-Alert #10-062: Does CLASS Give Seniors a LTC Savings Account](#)

[LTC E-Alert #10-053: CLASS Angst](#)

[LTC E-Alert #10-052: CLASS Confusion](#)

[LTC E-Alert #10-048: SOA/AAA CLASS Webinar 4/27](#)

[LTC E-Alert #10-047: LTC Insurance vs. the CLASS Act](#)

[LTC E-Alert #10-040: The Bernie Madoff Side-by-Side](#)

[LTC E-Alert #10-038: CLASS Act May Be Hazardous to Your \(Financial\) Health](#)

[LTC E-Alert #10-037: CLASS Q&A from AALTCI](#)  
[LTC E-Alert #10-036: New CLASS Act Webinar: Immediate Access](#)  
[LTC E-Alert #10-035: Inside Dope on CLASS](#)  
[LTC E-Alert #10-033: CLASS Begins](#)  
[LTC E-Alert #10-032: SSA and LTC in NYT, OMG! \(Translation Follows\)](#)  
[LTC E-Alert #9-123: CLASS Dismissed](#)  
[LTC E-Alert #9-104: Will CLASS Pass?](#)  
[LTC E-Alert #9-076: A CLASS Half Full](#)

**Other sources about CLASS:**

[“No CLASS: How Congress Saddled Taxpayers with Another Costly Entitlement,”](#) Heritage Foundation, July 29, 2010.

**Quote:** “The Community Living Assistance Services and Support (CLASS) program is an actuarially unsound and fiscally irresponsible misadventure by Congress. Congress should never have enacted this new government-run long-term care insurance program. It places CLASS participants at risk of benefit cuts and American taxpayers at great risk of being forced to bail out this poorly designed program. Congress should promptly repeal the CLASS program and then make a serious effort to address the problem of financing the long-term care of the nation’s population in the context of an overall reform of federal entitlements.”

[The CLASS Act: Repeal Now, or Face Permanent Taxpayer Bailout Later,](#) Heritage Foundation, July 23, 2010.

**Quote:** “Healthy individuals rationally intend to bypass CLASS because it is a bad deal for them, especially compared to insurance policies they could purchase on the open market.”

[CLASS Act: Madoff Would Be Proud,](#) report of the Senate Joint Economic Committee Republicans, May 18, 2010.

**Quote:** “Obamacare includes a new long-term care entitlement called CLASS that masks health care reform’s full costs. CLASS will add to federal deficits within 15-20 years. It is financially unsustainable due to poor design. Fixing it will require premium hikes, benefit cuts, and/or mandatory participation.”

[“The CLASS Act: Are you prepared?”](#) by Larry Rubin, Jinn-Feng Lin, Victor Shi, and Alison Yao, PriceWaterhouseCoopers, 2010.

**Quote:** “This article attempts to compare the CLASS program with private sector coverage based on information available at the time of writing.”

**Categories of comparison:** Enrollment process; Participation rate; Underwriting and vesting period; Premium; Benefits amounts; Non-forfeiture benefit; Benefit payout; Administrative expense; Tax treatment; Dependent coverage; and Fund management.

[CLASS Act advances LTC awareness, April 26, 2010](#)

**Quote:** “Right now, [CLASS is] flying under the radar screen, but as more people become aware of what essentially is a public option for long-term care, I think employers are going to need to explain whether they offer the CLASS Act plan and if they don’t, what do they offer. It’s going to create an impetus to revisit their strategy as it relates to long-term care and explain why they

do what they do,” [Mike Thompson, principal and head of the NY-metro health care practice in the PriceWaterhouseCoopers Human Resource Services practice] says.”

[CMS Chief Actuary Richard S. Foster’s April 22, 2010 memorandum](#) warning anew about problems with Patient Protection and Affordable Care Act and CLASS. For comments on PPACA financing, see entries under Health Reform Implementation, Financing below for April 26, 2010.

**Quote:** “In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. ... This effect has been termed the ‘classic assessment spiral’ or ‘insurance death spiral.’” (p. 15)

[John Hancock Summary of CLASS, April 10, 2010:](#) Good with exception of reference to 7.5 percent AGI in FAQ #36 re: tax deductibility. I pointed out this is going to 10.0 percent under PPACA and JH says they will correct.

[Al Schmitz \(Milliman\) article](#) on “Adverse Selection in the CLASS Act,” December, 2009.

**Quote:** “While the eventual effects of complex financial programs are difficult to forecast, the CLASS Act as currently structured is conspicuous because it introduces guaranteed-issue LTC benefits without installing the kinds of protections necessary to minimize adverse selection risk.” (p. 1)

[The Other New Health Entitlement](#), excellent article on CLASS in *Facing Facts Quarterly: A Report About Entitlements & the Budget* from The Concord Coalition, Volume V, Number 3, New Series, December 2009.

**Quote:** “As it stands, the CLASS Act embodies the worst sort of budgetary and actuarial chicanery. It pretends that premiums can be double-counted both as a near-term budget offset and as long-term savings. And it violates the most basic principles of sound insurance design by failing to provide for either underwriting or a mandate and by underfunding the oversight needed to detect fraud.” (p. 2)

[CMS Chief Actuary Richard S. Foster’s November 13, 2009 memorandum](#) warning about problems with CLASS. Estimates 2 percent take up rate.

**Quote:** “We estimate that about 2.8 million persons would participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers.” (p. 11)

[American Academy of Actuaries, “Critical Issues in Health Reform: Community Living Assistance Services and Supports Act, November 2009](#) “concluded that an actuarially sound program may not be possible to achieve unless the issues explored in the study are addressed.”

**Quote:** “In our view, the opt-out and guaranteed issue provisions of the plan will attract a disproportionate share of higher-risk individuals such that, in a relatively short time period, future increases in premiums and/or reductions in benefits may be required to make the program sustainable.” (pps. 2-3)

[“CLASS Act Support Drops Sharply When Americans Learn Its Details,”](#) ACLI Press Release, October 28, 2009.

**Quote:** “[T]he survey found 73 percent of respondents favorable to the program before learning of its potential cost. However, as respondents heard the potential out-of-pocket costs for the program, likelihood of participation drops dramatically. At \$85 per month, 91 percent said they would likely not participate. At just \$110 per month, 95 percent said they would likely opt-out of the program.”

Lori Montgomery, [“Proposed long-term insurance program raises questions: Opponents warn plan could require vast infusions of cash,”](#) *Washington Post*, October 27, 2009. **Quote:** “Sen. Kent Conrad (D-N.D.) [chairman of Senate Budget Committee] called the CLASS Act ‘a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of,’ and he vowed to block its inclusion in the Senate bill.”

[American Academy of Actuaries July 22, 2009 letter](#) to U.S. Senate Committee on Health, Education, Labor and Pensions, Re: Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program.”

**Quote:** “Our actuarial analysis indicates that the proposed structure and funding approaches in the CLASS Act, as introduced on June 9th, will not only be unsustainable within the foreseeable future, but are unlikely to cover more than a very small proportion of the intended population.” (p. 1)

**Electronic sources on CLASS:**I don’t have Internet addresses for these documents but they are available in Word or .pdf formats.

*July 2009 Congressional Budget Office letter to Kay R. Hagan, United States Senate, warning, Re: CLASS actuarial insolvency.*

**Quote:** “Overall, CBO estimates, if the Secretary did not modify the program to ensure its actuarial soundness, the program would add to future federal budget deficits in a large and growing fashion beginning a few years beyond the 10-year budget window. If the Secretary did act to ensure the program’s solvency, the program and its effects on Medicaid spending and revenues might-or might not-add to future budget deficits, depending on the specific actions that were taken.” (p. 3)

March 2010 AHIP summary of CLASS provisions--Excellent

*November 2009 Congressional Budget Office letter to Chairman George Miller, Committee on Education and Labor, U.S. House of Representatives, warning, Re: CLASS actuarial insolvency.*

**Quote:** “The CLASS program would add to budget deficits in future decades even though the proposals require the Secretary of HHS to set premiums to ensure the program’s solvency for 75 years.” (p. 5)

“CLASS Provisions of the New Health Care Reform Bill: Top 10 Questions - April 2010,” Source: Genworth.

## **Published Materials on CLASS:**

[“Health Reform’s Long-Term Care Option,”](#) *SmartMoney*, June 11, 2010: For details, see [LTC E-Alert #10-065: Latest CLASS Act Coverage](#).

Brainspark training presentation on CLASS [here](#). Source: John Hancock Long-Term Care Insurance *Newslink*, June 4, 2010. For details, see [LTC E-Alert #10-065: Latest CLASS Act Coverage](#).

Biff Jones and Joe Barnett. “The New Long-Term Care Entitlement,” National Center for Policy Analysis, Brief Analysis No. 707, June 3, 2010, <http://www.ncpa.org/pdfs/ba707.pdf>. For details, see [LTC E-Alert #10-065: Latest CLASS Act Coverage](#).

10-minute podcast interview with Univita Health’s Peter Goldstein: [“A close look at the CLASS Act.”](#) For details, see [LTC E-Alert #10-065: Latest CLASS Act Coverage](#).

[CLASS Act could spur LTC reckoning, May 3, 2010:](#) “Organizations that decide to offer the CLASS Act option through payroll deduction as a stand-alone benefit or alongside a voluntary plan will need to explain not only how the government-run program works, but also how it differs from group LTC insurance so that there’s no confusion.”

[“Long-term care insurance enters the mix,” April 1, 2010:](#) This is how wrong rumors get started: “When annual employee benefit time rolls around in 2011, you may have a new option: government-sponsored long-term care insurance.” CLASS won’t be implemented until October 2012 at the earliest.

[“Healthcare reform: What’s in it for our seniors?” April 1, 2010:](#) Breathless editorial extolling CLASS and Medicaid home care expansions while downplaying Medicare cuts by SCAN Foundation CEO Dr. Bruce Chernof.

[“Long-Term Care Program Debuts In New Health Law,” April 2, 2010:](#) Listen to or read this fawning NPR story that claims CLASS sprung like Athena from the forehead of Zeus unbeknownst to practically anyone.

[“The Devil’s In The Details of CLASS,” April 2, 2010:](#) Critical evaluation of CLASS by a long-term care insurance broker.

[“What Is The CLASS Long-Term Care Insurance Program? How Does It Impact You? \(If You Have LTC Insurance ... If You Don’t\),” April 5, 2010 :](#) Jesse Slome of AALTCI weighs in on CLASS.

[“Analysts and Some Proponents Say Tab Is Likely to Top Forecasts for Benefits for Home-Bound,” April 5, 2010 :](#) *Wall Street Journal* article with key quotes: “The Congressional Budget Office warned last year that . . . ‘The Class program would inevitably add to future deficits...by more than it reduces deficits in the near term’ . . .” and “‘It’s a classic Ponzi scheme,’ said Sen. Judd Gregg of New Hampshire, the ranking Republican on the budget committee.”

[“Federal LTC program raising questions,” April 12, 2010](#): Lots of advice from benefits specialists adding up to “wait and see.”

[Will Private Long-Term Care Insurance Supplement the CLASS Act, April 22, 2010](#): Urban Institute’s Howard Gleckman urges cooperation of and supplementation by private insurance with CLASS. For balance, see my [LTC E-Alert #10-040: The Bernie Madoff Side-by-Side](#).

[Details on the Class Act, NYT, April 29, 2010](#): The *New York Times* “New Old Age Blog” looks at CLASS. Presents the groundless benefits but at least mentions the potential downsides.

[CLASS Act update, Pete Gelbwaks, May 10, 2010](#)