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Beyond the CLASS Act: The Future of Long-Term Care Financing Reform

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The story of the rise, passage, and repeal of the Community Living Assistance Services and Supports (CLASS) Act has, to a large extent, neglected political context. Most accounts have focused on perceived flaws in the design of the program, such as its voluntary nature or absence of underwriting. While these analyses have resurfaced old debates, spawned numerous inside-the-beltway workgroups, and contributed to some thoughtful new ideas, the political environment contributed to passage and repeal, and will continue to influence the range of available long-term care (LTC) financing options and affect future progress.

Political Analysis of the CLASS Act

Prior to work on the CLASS Act, the need for LTC financing reform had long been established and debated. History is littered with numerous failed attempts (see Table 1). However, prior to CLASS, most approaches were opposed for ideological or cost reasons—proposals for private LTC insurance tax breaks on the one side and caregiver tax credits or comprehensive social insurance programs on the other. The CLASS Act was an attempt to find a budget-neutral middle ground that had a reasonable chance to move forward.

Bipartisan Approach

The CLASS Act emerged within a conservative political environment. Initial work by Senator Ted Kennedy's (D-MA) office began around 2003 (Manard, 2010). During the 108th and 109th Congresses (2003–2007), Republicans controlled both chambers of Congress and the White House. The first version of the CLASS Act (S. 1951) was introduced as a bipartisan bill by Senators Kennedy and Mike DeWine (R-OH) on November 2, 2005. It was an attempt to design a national LTC insurance program within relatively limited parameters. The program was based on values of personal responsibility, supporting families, and independence. It was designed to be entirely self-financed and produce Medicaid savings for the federal government and the states. While many advocates would have preferred a mandatory program, or at least an opt-out approach, a more modest voluntary route was pursued given the realities of the political environment at the time. Federal bureaucracy was minimized and individual choice maximized through the use of a flexible cash benefit with safeguards to prevent fraud and abuse. An important supplemental role for private insurance was envisioned, on top of the modest foundation of benefits provided for care at home. However, the industry was not ready to embrace a public–private approach, which would have had it taking a supplemental Medigap-type role; it appears that some in the industry are today more open to such a public–private approach. In fact, others did argue that the CLASS Act would have likely jumpstarted the struggling, flat private LTC insurance market.

Politics of the Affordable Care Act

While the Affordable Care Act (ACA) provided a vehicle for the CLASS Act, its inclusion contributed to a number of political challenges that lingered well beyond passage. The larger politics of the ACA precluded overt Republican

Table 1. A Failed History of Major LTC Financing Legislative Proposals

Representative Claude Pepper Medicare Home Care Bill (1987)—Cost of $7.6 billion in 1992. Defeated on the House floor due to opposition from Democratic leaders, who provided assurances that the issue would be addressed at a later date.
Representatives Pete Stark/Henry Waxman/Senator George Mitchell Medicare Long-Term Care Bills (1988–1992)—Despite leadership from these chairmen, these comprehensive financing bills never got out of committee, largely because they were too expensive.
Pepper Commission Long-Term Care Recommendation (Report issued September 1990)—Despite receiving bipartisan support from Commissioners in an 11–4 vote, no action taken. Social insurance for home care, and first three months of nursing home care, regardless of age or income. 1990 cost of $43 billion fully implemented.
President Clinton Health Care Reform Bill (1994)—Included a new universal home care program with an enhanced Medicaid match, which was included in both the House and Senate bills. Cost estimated at $56.7 billion from 1996–2000 ($18.7 billion in 2000).
Senator Russ Feingold Long-Term Care Reform and Deficit Reduction Act (1995–1997)—Similar to the Clinton proposal. No action taken.
Citizens for Long-Term Care Proposal (2001)—Chaired by former Senator David Durenberger (R-MN), the coalition of over 60 diverse national organizations proposed that a government-sponsored LTC insurance program should provide the foundation for support, consistent with the CLASS program. No action taken.
Representative JD Hayworth Improving Access to Long-Term Care Act (2002)—Private LTC insurance tax proposal passed by the House. CBO estimated cost at $5.5 billion from 2003–2012.
Senator Tom Harkin Community Choice Act (1998–2010)—Removed the institutional bias in Medicaid and provide equal choice of community-based services. Bipartisan support but no action taken on original mandatory program. Included in the ACA as a Medicaid state plan option.
Senators Kennedy-DeWine CLASS Act (2005–2010)—Established a voluntary national LTC insurance program. Included in the ACA, enacted into law in March, 2010. Repealed January, 2013.

support for the CLASS Act, yet some offices remained supportive of the concept and offered tangible improvements during the Senate HELP Committee markup, where the bill was approved without opposition. A favorable cost estimate from the Congressional Budget Office (CBO) solidified support for the CLASS Act, with it reducing the deficit by about $80 billion over 10 years, including $3.5 billion in Medicaid savings.

However, as health reform politics heated up, so did opposition to the bill, including among some Senate Democrats, led by Budget Committee Chairman Kent Conrad (D-ND). Questions were raised about long-term budget implications and using the projected savings for other spending items. Opponents claimed that the program would increase federal spending beyond the 10-year budget window. There was some misunderstanding of the need to build initial reserves to pay for future benefits and the fact that CBO projected that it would take over 30 years for the program to dip into earned interest. This projection would have left more than enough time to make modest corrective adjustments. However, politics also played a role. After ACA passage, and amid early signs that the new law was vulnerable, the CLASS Act was seen as an easy target for Republicans determined to repeal all or part of the ACA.

Inability to Make Improvements

The political dynamics of the ACA also prevented opportunities to make any adjustments or improvements to CLASS. Our understanding is that prior to final passage, about a dozen amendments were negotiated among Democratic leaders and stakeholders, designed to strengthen sustainability, and improve the risk pool and participation rates. Some of these improvements would have provided more flexibility to the Secretary to design the CLASS program, such as tightening the work requirement and, therefore, limiting the risk pool. These changes could have been inserted into a Senate–House conference, but no such conference ever occurred due to Democrats losing CLASS's strongest advocate (Senator Kennedy) and their Senate supermajority with the special election of Senator Scott Brown (R-MA) to fill the unexpired term. A reconciliation process was necessary to overcome procedural hurdles to final passage of ACA, but only amendments that had a budgetary impact could be offered.

Ongoing partisan divisions over the ACA stood in the way of making improvements during the implementation phase. Advocates nonetheless urged: "Mend it, don't end it." CLASS did not dictate specific design parameters—such as benefit triggers, benefit levels, and premiums. Instead, it provided a general outline for an insurance program and set up a process by which the Secretary would consult with appropriate actuaries and other experts, and develop at least three actuarially sound benefit plans. A number of models and conflicting actuarial estimates were forthcoming from several sources, from both within and outside of the federal government.

In April 2010, shortly after passage and prior to formation of the CLASS Office, the CMS actuary issued a memo on the estimated financial impact of the ACA, which

disagreed with official CBO projections. Regarding the CLASS program, he asserted that after the fiscal year 2025:

> The new Community Living Assistance Services and Supports (CLASS) insurance program would produce an estimated total net savings of $38 billion through fiscal year 2019. This effect, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a very serious risk that the program would become unsustainable as a result of adverse selection by participants.

In our view, projections over 15 years are highly speculative, and the legislation provided that adjustments could be made over time to avoid any increases in federal spending.

The Department of Health and Human Services (HHS) undertook extensive work and modeling for over a year that culminated in an actuarial report released by the CLASS Office (Yee & Kissel, 2011). The report outlined over a dozen design alternatives and six proposed plan options. The HHS publically indicated that it planned to increase the work requirement, index premiums to inflation, and offer a range of CLASS policies for individuals to choose from, including different benefit amounts and less-than-lifetime benefits. According to the report, actuaries involved in the process concluded that certain of the plans designed to mitigate adverse selection could be "actuarially sound and attractive to consumers." The *National Journal* wrote: "Bob Yee, a former HHS actuary for the CLASS Act, believes the program can be saved and that Secretary Kathleen Sebelius has wide administrative authority to balance premiums, benefits, and eligibility" (Garrett, 2011). At a Kaiser Family Foundation conference, Harvard economist Richard Frank, who was Deputy Assistant Secretary for Planning and Evaluation (ASPE) within HHS, stated: "We in the Department have modeled this extensively, perhaps more extensively than anybody would want to hear about. We are entirely persuaded that reasonable premiums, solid participation rates, and financial solvency over the 75-year period can be maintained" (Pollack, 2009).

In October 2011, Secretary Sebelius announced that HHS would not move forward with CLASS at this time, citing one analysis that concluded that

> the premium for the Basic CLASS Benefit Plan. . . produces a benefit costing between $235 and $391 a month, and may cost as much as $3,000 a month, if adverse selection is particularly serious. . . . If healthy purchasers are not attracted to the CLASS benefit package. . . (t)his imbalance in the beneficiary pool would cause the program to quickly collapse. (Department of Health and Human Services, 2011; Greenlee, 2011)

Whether the decision not to move forward was based on actuarial concerns and uncertainties or because of a lack of political will was debated among those in favor of and opposed to CLASS's implementation. In our view, from an actuarial perspective, paths were available to move ahead.

Withdrawal of the White House Support While the Obama administration supported the CLASS Act and then-Senator Obama cosponsored Senator Kennedy's bill, high-level officials in the White House were focused on other aspects of ACA and never fully embraced the program as a core feature of health reform. Indeed, the initial architecture for health reform did not include LTC. Rather, inclusion of CLASS and other LTC reforms was the result of concerted pressure generated by a coalition of aging, disability, and faith-based organizations, working with long-standing Congressional social insurance advocates, notably, Senators Kennedy and Christopher Dodd (D-CT), and Representatives John Dingell (D-MI) and Frank Pallone (D-NJ).

Further, the timetable for CLASS implementation was ambitious and in competition with other critical, complex features of the ACA. As well, the larger political context surrounding ACA was problematic, including nearly unanimous Republican opposition to funding for ACA implementation, criticism for not meeting early milestone deadlines, and the specter of high-profile court challenges to the individual mandate and to expansion of Medicaid.

Shortly before the HHS announcement of the decision to postpone work on CLASS, a political trade-off was made to strip $120 million in appropriations designated for CLASS implementation and divert staff, resources, and attention to implementing what was viewed as the core features of the ACA (McKnight's, 2011). Following the October 14, 2011, announcement by HHS, the *National Journal* wrote of CLASS:

> "This isn't even a hood ornament," a senior administration official with deep experience in the health care debate told me. "It's like the windshield wiper on the back window of a car—but maybe not even that. The CLASS Act is not central in any way to the health care reform act." (Garrett, 2011)

In the wake of these political roadblocks, revised legal opinions from the HHS Office of the General Counsel, and a ruling from CBO that CLASS repeal would no longer have federal budget ramifications, CLASS was effectively doomed. The new CBO ruling negated the earlier interpretation that repeal would have added to the deficit and most likely required off-setting savings. These actions enabled

further Republican criticism of CLASS as an illustration of broader "Obamacare failure" as well as emboldening calls for full ACA repeal.

Loss of Champions As efforts to repeal CLASS intensified, many of its strongest champions were no longer there to protect it, particularly Senators Kennedy and Dodd, who had retired. Champions in the House spoke out strongly in defense of CLASS, but were unable to prevent House repeal on February 2, 2012. In the Senate, Senator Jay Rockefeller (D-WV), for decades an advocate for comprehensive LTC coverage, led the fight against repeal. In anticipation of a potential scenario where a vote could come up on a bill to repeal CLASS, as a bargaining chip, an alternative amendment was crafted. The original version of the amendment would have put in place a commission tied to specific deliverables and triggers before CLASS could be repealed. However, following an all-night session on December 31, 2012, aging and disability advocates were given a painful New Year's surprise. White House and Congressional negotiators, led by Vice President Biden and Senate Minority Leader Mitch McConnell (R-KY), had reached a deal to avert the so-called fiscal cliff and reduce the budget deficit. As part of this high-level negotiated agreement, CLASS was repealed—ironically, in the eyes of some, since the program was scored as producing Medicaid savings and reducing the deficit.

Lessons for the Future

It is unclear what paths LTC financing reform will take in the future. In the aftermath of repeal, many ideas have come forth—some old, some new. Numerous workgroups have sprung up to craft solutions. While the Federal Commission on Long-Term Care (the Commission) was unable to reach agreement on financing recommendations, it suggested some viable directions. However, any path forward will have to grapple with politics as much as substance. Based on the experience of the CLASS Act, we provide the following reflections and thoughts.

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Range of Options Going Forward

There is no single solution for LTC financing. While it is easy to call for a mixed private and public approach, finding the right balance and keeping the cost down are the key political challenges. We see two potentially viable pathways to move the discussion forward; neither one is easy. One path is to establish a voluntary, national LTC insurance program, similar to a CLASS approach but with improvements (Wiener, 2012, 2013) that would address adverse selection issues and reduce premiums. Changes attempted during passage, marketing, and actuarial work by the CLASS Office and other creative ideas that have come forward could provide a fruitful starting point. For example, some have proposed requiring a mandatory offer of qualified LTC insurance by large group employers (Frank, Cohen, & Mahoney, 2013; Pincus, Wallace-Hodel, & Brown, 2013). Another option is to require automatic enrollment with an opt-out, perhaps tied to proof of equivalent private coverage or meeting certain income and asset tests. Targeted subsidies could be considered to maximize Medicaid savings. Significant investment in outreach and marketing about the need for LTC insurance would also enhance enrollment and promote supplemental private insurance options. An obvious political barrier to this approach, however, is comparison to CLASS and its connection to the ACA.

Another potential path is movement towards a mandatory social insurance program along the lines of options presented by the Commission (Commission on Long-Term Care, 2013; Butler, Claypool, Feder, Ruttledge, & Stein, 2013). One option is a limited, catastrophic benefit (within Medicare) or a new public program. A catastrophic "back-end" benefit is something the private insurance industry has been more open to, and could therefore garner their support. It would limit risk to the front end, which would provide a more defined, affordable, and predictable role for the private sector. It would open up a market for supplemental plans marketed to individuals with resources who would be subject to the waiting period. Another key advantage in a mandatory approach is the ability to maximize Medicaid savings. One analysis, modeling a mandatory program offering a 5-year, $50 per-day benefit, found that Medicaid savings could be in the range of $49 billion over the first 15 years (Tumlinson, Hammelman, Stair, & Wiener, 2013). However, it is unclear if the political environment has shifted enough in openness to a mandatory social insurance approach. Inability of the Commission to reach agreement, along with strong opposition to the mandate for health coverage in the ACA, would suggest not. Given federal budget constraints, much will depend on CBO cost estimates and whether Medicaid savings can be achieved.

In addition to these overarching paths, some have suggested establishing simplified marketplaces for consumers to purchase insurance. For example, one promising proposal would build upon the model of the Federal LTC

Insurance Program to establish a national program that is federally regulated, with a single administrator, but multiple participating private plans (Forte, 2014). A simplified marketplace approach could be implemented in combination with the approaches above to offer both public and private insurance options. This approach could help boost the private industry, enhance consumer protections and standards on underwriting, simplify choices for consumers, and increase enrollment and coverage.

Broad-Based Support is Essential

A valuable lesson learned from the CLASS experience is that the aging and disability communities are a powerful force for change when united. Since CLASS, the collaboration between aging and disability organizations has grown even stronger with the formation of the Administration on Community Living and efforts such as the Friday Morning Collaborative, a coalition of 38 national aging and disability organizations. Meaningful LTC reform will only come from the aging and disability communities working together. While there are some differences, common interests and passions are much stronger. The two major national aging and disability organizations have agreed upon joint principles for LTC reform: the Leadership Council of Aging Organizations, representing 69 national aging organizations, and the Consortium for Citizens with Disabilities, representing over 100 national disability organizations. These LCAO/CCD (2013) principles provide a useful guide for the future.

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More needs to be done to forge collaboration with the private sector. The LTC insurance industry is at a different place than it was during passage of CLASS. Insurers that have stayed in the market now appear to be more willing to consider innovative public/private approaches. Many actuaries and others in the private sector have recently expressed more openness to including social insurance models (Society of Actuaries, 2014). However, thorny issues remain about the roles of the public and private sectors in meeting the needs of individuals unable to purchase insurance due to costs or preexisting conditions. States and the business sector also have interests in reform, and much more can and should be done to get them engaged and active. On the whole, there is plenty of room to find common ground and shared goals among a broad range of interests.

Bipartisan Champions Needed

For the foreseeable future, any significant LTC financing reform must be bipartisan to have any shot at success. We have already lost champions and are losing more with retirements, such as Senators Rockefeller and Harkin, and Representatives Dingell and Waxman. The good news is that there are many new potential champions on both sides of the aisle, as illustrated in a recent Senate Special Aging Committee hearing. We are confident that bipartisan champions will rise. The issues have not gone away. They have only intensified. They impact the economic well-being of our country and struggling middle-class families, who continue to spend down their life savings paying for care and face job loss trying to keep relatives out of institutions. On a daily basis, these issues personally touch the lives of tens of millions of individuals with disabilities, seniors, family caregivers, and direct care workers—a too often invisible, but politically powerful, majority.

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