



Will the "CLASS" Program Succeed? Is It Sustainable?

By Mark J. Warshawsky

Both the House and Senate health care reform bills currently being debated¹ would establish a new voluntary long-term care insurance program. Called CLASS,² the new program would be offered to all workers through the Department of Health and Human Services (DHHS). CLASS is significant for at least three reasons:

1. It represents a substantial source of near-term funding for the entire health care reform proposal. If participation failed to meet projections or the revenue score declined, other sources of financing would be necessary to achieve the deficit reduction goal of health reform.
2. Participating employers would enroll workers automatically, although with an opt-out option, and premiums would be paid through payroll deductions. So employers — even those that already offer their employees group long-term care insurance — would need to decide whether to participate in CLASS.
3. If the program succeeded, it would provide partial coverage of a major category of financial risk, generally not currently covered, to more of the working population and, eventually, retirees. If the program is not sustainable, the federal government might need to finance a bailout.

This article describes the motivations leading to the proposal, how the program would work, its official scoring by the Congressional Budget Office (CBO), the views of actuarial professional groups and the Centers for Medicare & Medicaid Services (CMS) actuary, and implications for employers.

Motivations for CLASS

Long-term care is currently financed primarily by Medicaid, usually for elderly individuals and couples who are low-income or have spent down their assets, and must depend on this state/federal program for nursing home and other long-term care expenses. Medicare pays for some long-term care, usually for discrete treatments of nursing, rehabilitation and home health care following hospitalization for an acute event. Some people buy long-term care insurance, either through their employer or, more commonly, on the commercial insurance market. Many more simply hope they will not need long-term care, and, in the event they lose their gamble, finance it through their retirement and other asset accumulations, value of housing, or family support and assistance.

This state of affairs has left many experts and advocates frustrated because both federal and state Medicaid costs are high and growing rapidly. Moreover, the Medicaid program is inflexible, having an institutional bias toward nursing home care rather than assistance for living in the community, and is a last resort for households after most assets are depleted. Long-term care is an insurable risk and would ordinarily create demand by consumers and workers for commercial or employer insurance coverage. But the availability of even a sub-optimal Medicaid program crowds out the purchase of long-term care insurance, particularly for individuals in the lower half to two-thirds of the income distribution.³ Additionally, commercial insurance is not available to many older workers and retirees who cannot pass underwriting. There is also concern that some policyholders, particularly older widows, let long-standing coverage lapse before qualifying for benefits. A few insurance companies have also raised their premium rates on entire classes of policyholders because of initially inadequate pricing, and the insurance industry has been criticized for this practice.⁴

Hence, for several years, many have sought the enactment of policies supporting long-term care insurance, either in the private or public sector. On the conservative and business sides of the political spectrum, these efforts have taken the form of lobbying for tax breaks for private long-term care premiums and tightening eligibility for Medicaid. On the liberal and disabled and elderly community sides of the political spectrum, advocates have lobbied for a mandatory federal social insurance program, funded by a payroll tax, or a voluntary program, with premiums subsidized by taxpayers. The latter groups have largely won the fight, although they have made political compromises along the way. Taxpayers would not explicitly subsidize the CLASS insurance program, and participation would be voluntary. There would be no underwriting, but there would be significant claw-backs by Medicaid of the cash benefit payments from the CLASS insurance program to covered beneficiaries.

Program design

All workers age 18 and older, regardless of health status, could purchase insurance from the CLASS program and receive cash benefits if they cannot perform activities of daily living or are cognitively impaired, as long as premiums were paid for at least 60 months. Under the program, the first three calendar years of premium payments must occur when the individual has some minimal attachment to the workforce, and, if the premium payment lapses for more than three months, the participant must pay 24 continuous months of premiums to be eligible for coverage. Under the House bill, the workers spouse can also get insurance coverage even if he or she is not working. People could let their policies lapse for up to five years without penalty, and still remain eligible for benefits as long as the basic conditions mentioned above were satisfied. Workers who re-enrolled after a lapse of more than five years, however, would have to pay a penalty in addition to the new premiums.

For example, a 55-year-old individual could be partially retired and modestly disabled, pay premiums consecutively for 24 months, stop paying premiums for a couple of years, have worsened disabilities, pay 12 months of premiums on and off for a couple of years, become severely disabled, retire completely, pay for two more years, and then make a claim for full benefits.

Premiums would be fixed for the lifetime of the insured, but would increase with the age at initial enrollment or reinstatement after lapsing. But premiums could not reflect health conditions, gender or any other circumstances, except that the very poor and full-time student workers would get a subsidized rate of \$5 monthly. It should be noted that considerable empirical evidence has shown that women are more likely to claim on long-term care insurance policies for longer periods of disability, so the program is likely to attract more women than men, which would necessitate higher premiums.

The legislation says that the cash benefit payment must be at least \$50 daily (indexed to the consumer price index), on average across beneficiaries. It could be used for any purpose, even to pay family members for care, for the lifetime of the beneficiary. The CLASS insurance plan must be designed to pay out higher benefits for greater levels of disability. Even so, this general design and level would only partially cover the relevant risks — home health care often costs \$20 an hour or more, and nursing home care exceeds \$250 a day in many parts of the country. Benefits are triggered by the individuals being unable to perform two (or three) activities of daily living without considerable assistance, or if there is a substantial cognitive impairment. An adjudication process would determine eligibility, but benefits would be automatic if the individual were discharged from a hospital (for long-term care), nursing facility or an institution for mental diseases. For Medicaid-eligible individuals who resided in a nursing home, 95 percent of the payment would go to Medicaid. If the individual still lived in the community, Medicaid would receive only 50 percent. Benefit payments would not be considered as income in determining an enrollees eligibility for federal assistance programs.

The bills do not entirely specify the benefit plan design. Rather, it is left to DHHS to devise the benefit plan, including premiums and benefit amounts, with advice from a council composed of representatives from the disabled community, older workers, family caregivers, providers, unions, and actuarial and insurance experts. The program must rely entirely on premium payments from enrollees, which would be held in a trust fund, and interest earnings on the fund. Moreover, the benefit plan must be designed so that the fund is projected to remain solvent over a 75-year horizon, with reserves expected to grow for the first 20 years. The program could spend no more than 3 percent of premiums collected for administration and marketing.

A board of trustees would oversee the fund, identical in structure to the Social Security and Medicare trust funds. The trustees would have to produce an annual report, including an actuarial assessment of the programs financial health by the CMS actuary. If the programs financial status is not healthy, the trustees would have to recommend an improvement plan, which could include premium increases and, perhaps, benefit cuts (but not below \$50 daily). Retirees older than 65 who had paid premiums for at least 20 years would be exempt from premium increases.

Workers could be enrolled in the program via one of two methods. Participating employers would automatically enroll their workers, through payroll deduction, with workers having the right to opt out, as in many 401(k) plans. Self-employed workers and those whose employers do not participate in the program could join through an individual enrollment mechanism to be established by the federal government. Workers could enroll only during open periods held no more frequently than biennially. The IRS would treat workers enrolled in CLASS the same way it treats premium payers for qualified long-term care insurance; that is, premiums would be tax-deductible only if medical expenses exceeded 7.5 percent (10 percent in the Senate bill) of adjusted gross income, and benefit payments would not be considered taxable income.

As mentioned above, premiums would relate to the participants age at enrollment. For the House bill, the professional actuarial societies estimate an average monthly premium of \$160, assuming an average daily (indexed) benefit of \$75.⁵ They calculate an entry-age monthly premium of \$136 for workers ages 18-39, \$144 for ages 40-49, \$152 for ages 50-59, \$231 for ages 60-69 and \$277 for ages 70-79. They anticipate that older workers will be much more likely to enroll than younger workers and that lapses occur at a rate of 1.5 percent per year.

The CBO score

Health care reform is projected to cost roughly \$1 trillion over 10 years. There are many and varied proposed sources of financing in the House and Senate bills, but both would get about 10 percent of their funding from the CLASS program.⁶ According to the CBO — the official scorer of legislation — the House version would bring in \$102 billion over 10 years, with an average monthly premium of \$146 in 2011 (premiums for new enrollees would increase with inflation in later years). The Senate version is projected to bring in \$72 billion, with an average monthly premium of \$123.⁷ The initial positive cash flows come, of course, from the five-year period before participants vest, when premiums are paid but benefits are not. Tens of billions are foreseen to flow into the trust fund during those five years. In later decades, however, the flows would turn negative and increase the federal deficit. The House version has larger cash flows than the Senate version, because of the House programs eligibility for nonworking spouses. The CBO assumes those spouses are both more likely to have impaired health and more likely to enroll than are workers; their inclusion increases the actuarially required premiums. Both versions are estimated to save the federal government about \$2 billion in Medicaid costs over the first 10 years.

Although the CBO has not revealed all the details of its projection calculations, it says that about 4 percent of the adult population (3.5 percent for the Senate version) would be enrolled by 2019 — about 6 percent of the working population. Apparently, CBO bases this assumption on the experience of some large employers with workers enrolled in group long-term care insurance, including the federal government and the state of California. These workers, however, are generally higher paid, better educated, more risk-averse, and offered more comprehensive and superior insurance programs than the general U.S. population being offered CLASS.

Actuarial views of the proposed program

Without underwriting, the central risk for any voluntary insurance program, private or public, is adverse selection — the tendency of those more likely to claim benefits, such as people with chronic conditions or disabilities, to purchase the insurance. It raises the cost of insurance and may impair its comprehensiveness. In severe cases, adverse selection triggers an insurance death cycle — lower-risk individuals do not enroll, premiums must be raised, medium-risk participants drop out, premiums are raised again, large numbers and amounts of claims are made, and the program collapses or must be bailed out.

In group long-term insurance with guaranteed issuance, adverse selection is controlled by requiring enrollees to be full-time employees, which implies at least fair to good health.⁸ Coverage for spouses is generally underwritten, and the insurer screens claims carefully. Under the CLASS program, however, the work requirement is much weaker, there is an allowance for penalty-free re-enrollment after a lapse of up to five years, and, with presumptive eligibility, claims will be made and paid easily. Actuaries do not expect the overall five-year vesting period and 24-month consecutive payment period to sufficiently counter the tendency for adverse selection. The professional actuarial societies have suggested several cogent design improvements to control adverse selection and encourage participation, including spending more on marketing, imposing a tighter at-work requirement and shorter periods for re-enrollment, and eliminating presumptive eligibility.

The CMS actuary has said that the program faces a substantial risk of being unsustainable and, moreover, will not bring in as much revenue as the CBO projects.⁹ In his view, participation will be low — 2 percent of potential participants — and the average premium high \$240 a month initially. Over 10 years, net cash flow would be only \$38 billion (\$39 billion for the House version). The actuary also believes a sizable number of individuals who already meet the functional limitation requirements for benefits would enroll immediately.

The CMS actuary expects participation to be low for a couple of reasons, including CLASS long-term care insurance being a new and unfamiliar benefit, and the availability to many of lower-priced private insurance. In addition, the Medicaid offset design will discourage low- and moderate-income workers from enrolling in the CLASS program without a subsidy.

Implications for employers

If health care reform passes, the CLASS program will be established by 2011-12. Employers would need to assess whether to offer this program to their workers on an automatic basis.¹⁰ Those organizations currently offering group long-term care insurance would also have to decide whether to drop such offerings or amend them to wrap-around the new federal program. They should compare benefits and premiums for the CLASS plan with those in group long-term insurance offered in the marketplace or even individual policies available to their workers. In that regard, employers should consider the lack of comprehensive coverage in the CLASS plan for long-term care risks.

Employers should also evaluate the possibility — according to the CMS actuary, the likelihood — of premium increases, benefit cuts or other curtailments in the future. Finally, employers would need to judge whether there is room in their employees paychecks for \$150-\$200 or even higher monthly premiums for a controversial and complex voluntary insurance program designed, explained and administered by DHHS, the states and private social service agencies. Employers would likely find themselves having to make these decisions at the same time other consequential changes were occurring in their health and other benefit programs under the larger health care reform plan.

Even if the CLASS program is as successful and sustainable as its advocates and the CBO optimistically project, the need will remain for innovations and supportive policies to make insurance coverage for long-term care more comprehensive and more widespread. Employers should be involved in that process of discovery.

¹ As of December 14, 2009.

² CLASS is an acronym for community living assistance services and supports.

³ See Jeffrey R. Brown and Amy Finkelstein, The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market, *American Economic Review*, 2008, 98(3), pp. 1083-1102.

⁴ The life care annuity, a combination of the life annuity and long-term care insurance, solves the underwriting, lapsing and premium increase problems of current practice. See Christopher Murtaugh, Brenda Spillman and Mark Warshawsky, In Sickness and in Health: An Annuity Approach to Financing Long-Term Care and Retirement Income, *Journal of Risk and Insurance*, 68(2), June 2001, pp. 225-254.

⁵ July 22, 2009, letter to the Senate Committee on Health, Education, Labor and Pensions from P.J. Eric Stallard for the American Academy of Actuaries and Steven Schoonveld for the Society of Actuaries re: Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program.

⁶ In a recent nonbinding vote, the Senate unanimously indicated its sense that positive CLASS trust fund cash flows should be reserved for that program and not used elsewhere. It is unclear how and indeed it is unlikely this sentiment will change the way deficits and financing for health care reform are measured and scored. Some opponents of the CLASS plan have called it a Ponzi scheme, and indeed if a licensed insurance company used its reserves from insurance policies to finance other spending, it would be illegal and its executives could go to prison. The Senate voted 51 to 47 to strike the program from the health care reform bill, but 60 votes against it were needed to remove the program.

⁷ Nov. 25, 2009, letter to Senator Tom Harkin (D-Iowa) from CBO Director Douglas Elmendorf on the CLASS program. The CBO staff contacts listed are Bruce Vavrichek and Stuart Hagen.

⁸ In the federal employee program, short-form underwriting is performed for active employees and their spouses during the infrequent open enrollment seasons or for newly hired employees. Otherwise, more extensive underwriting is given to applicants for the insurance.

⁹ Dec. 10, 2009, memo from Richard S. Foster, Chief CMS Actuary, on Estimated Financial Effects of the Patient Protection and Affordable Care Act of 2009, as proposed by Senate Majority Leader Harry Reid (D-Nev.) on Nov. 18, 2009.

¹⁰ Employer organizations, such as the American Benefits Council, have opposed the CLASS provisions as still needing more thorough examination before inclusion in legislation.

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