The CLASS Act: What Does It Mean for Private Long-Term Care Insurance?

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Abstract: *Recently enacted health care reform legislation establishes the Community Living Assistance Services and Supports (CLASS) program, an initiative to permit workers aged 18 years or older to purchase insurance coverage from the federal government that is similar in a number of respects to private long-term care insurance. Executive agencies will be issuing regulations over the next two years with the expectation that the CLASS program will be up and running by 2013. There is little detail at present regarding many aspects of the CLASS program, but the key features as prescribed by the new law raise questions about its sustainability (without taxpayer subsidy), its relationship to the private market for long-term care insurance, and the effect that it will have on the financial planning process. This article examines the structure of the CLASS program as specified in the law and considers some of the many open questions about how it will be implemented and the implications for private long-term care insurance.*

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Introduction

The Community Living Assistance Services and Supports Act (the CLASS Act) was signed into law by President Obama on March 23, 2010, as part of the Patient Protection and Affordable Care Act (PPACA)[1] and provides for the establishment of a national voluntary insurance program (the CLASS program) that pays benefits upon a covered individual's functional incapacity or cognitive impairment. The CLASS Act is part of the legacy of U.S. Sen. Ted Kennedy (D-MA), who previously had sponsored an earlier version of the CLASS Act as stand-alone proposed legislation.[2]

A stated purpose of the CLASS Act is to "provide individuals with functional limitations with tools that will allow them to maintain their personal and functional independence and live in the community through a new financing strategy for community living assistance services and supports."[3] This purpose coincides with a key goal that purchasers of private long-term care (LTC) insurance often have—a desire to be able to receive home care so that they can continue living in their homes as long as possible, or other noninstitutionalized care.

There is no question that America has a serious and growing LTC financing gap. The Department of Health and Human Services estimates that about 70% of people over age 65 will require some type of LTC services during their lives, with 40% requiring nursing home care for at least some period.[4] That care will be expensive. Today, the current national median rate for an individual in an assisted-living residence is over $38,000 a year, and the median annual cost of a semiprivate room in a nursing home is in excess of $67,000.[5] And, contrary to what

many people believe, Medicare and major medical health insurance policies do not pay for the majority of LTC services that most people need.

This article explores the extent to which the new national insurance program contemplated under the CLASS Act can be expected to aid Americans in meeting their LTC needs and what the CLASS Act will mean for private LTC insurance. As we explore the features of the CLASS Act, however, fundamental questions to keep in mind are:

- Who is the CLASS Act likely to protect?
- Is the CLASS program a substitute for private LTC insurance policies and how will the CLASS program affect the need for private LTC insurance?

With respect to the first question, is the CLASS Act designed to protect working individuals who have no signs of functional or cognitive impairment (and thus generally are insurable) and who want coverage to protect against the possible need for LTC in their last stages of life? Or is the CLASS Act designed to protect individuals who, at the time of their enrollment, are working (even if only a little) but have a functional or cognitive impairment, or the early signs of impairment, and thus are expected to need LTC in the near future? Because the CLASS Act guarantees enrollment regardless of the individual's current health status, the Act actually covers both populations of individuals. That fact presents one of the program's greatest challenges: how to provide appropriate and desirable coverage for both of these populations under a voluntary insurance program with benefits funded solely by participant premiums, i.e. with no federal subsidy.

It might ultimately prove true that the overall population of enrollees in the CLASS program will largely resemble the population of insureds under guaranteed issue (or limited underwriting) group LTC insurance policies. Under such policies, only a small percentage of enrollees may be uninsurable or otherwise involve a high risk of imminent need of LTC, in large part because the population of potential insureds under employer-sponsored arrangements generally consists of working individuals. Thus, the remaining enrollees typically can bear the increased costs associated with the noninsurable or high-risk enrollees because those costs are spread over many lives. Also, economies of scale associated with covering a large group of individuals helps to lower per enrollee administrative costs.

On the other hand, the CLASS Act's restriction on underwriting (and certain other rigid program design features) make substantial antiselection a real possibility (and perhaps an inevitability), which could threaten the viability of the CLASS program as an insurance program that is intended to be self-sustaining. If substantial antiselection ensues, it may become necessary to reexamine the fundamental purpose of the CLASS Act—whether it is viable as a stand-alone self-sustaining insurance program covering both of the above-described populations, or whether the needs of those with current functional or cognitive impairment are better served by a government-subsidized program, perhaps modeled on the CLASS Act in terms of benefits (once those are specified), but not financing.

With respect to the second question above, because the conditions for receipt of benefits under the CLASS program, i.e. its "benefit triggers," closely mirror those found in LTC insurance policies offered by insurance companies, the CLASS program provides insurance coverage of some of the same risks that commonly are covered by LTC insurance policies. Thus, the CLASS program will likely compete, at least to some degree, with private LTC insurance policies. Despite this, the ultimate consequences of such competition are unclear. As noted above, the CLASS program may benefit from economies of scale (similar to what occurs under large group LTC insurance policies), and this factor may lower the average cost of coverage somewhat. As also noted, however, a serious concern for the CLASS program relates to the fact that no underwriting is required for enrollment. In particular, because of this feature, premiums paid by enrollees who are healthy at the time of enrollment will (as a group) subsidize the early claims costs of those enrollees who already have functional or cognitive impairments at the time of enrollment. This subsidization has the potential of substantially increasing the average cost of coverage under the CLASS program. That, in turn, could discourage participation by healthy individuals, with some finding private LTC insurance rates and benefits more attractive.[6] Also, the fact that CLASS Act benefit payments may be inadequate to cover escalating assisted-living or nursing home costs,

for example, could further drive healthier individuals toward serious consideration of private LTC insurance. In that regard, the rollout of the CLASS Act insurance program may actually shed additional (and needed) light on the huge LTC financing risk baby boomers face as they plan for the future. This also could work to the advantage of private LTC insurance.

To understand more fully these interactions, however, it is necessary to begin with an appreciation of the features of the CLASS Act and CLASS program.

Procedures for Implementation of the CLASS program

The CLASS Act specifies key elements that must be part of the CLASS program, but many of the details have been left to the Secretary of the Department of Health and Human Services (HHS) to implement. As a first step toward implementation, the CLASS Act provides that the Secretary of HHS, "in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independence Benefit Plan…."[7] The CLASS Act then specifies required features for each of these alternative plans (as discussed below).

After the three or more alternative benefit plans are developed by the Secretary of HHS, the CLASS Independence Advisory Council[8] must then evaluate those plans and recommend a plan to the Secretary of HHS that "best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program."[9] The Secretary of HHS, however, has final discretion with respect to the designation of the CLASS program. In this regard, the CLASS Act provides that, by October 1, 2012, the Secretary of HHS must "publish such designation, along with details of the plan and the reasons for the selection by the Secretary [of HHS], in a final rule that allows for a period of public comment."[10]

Required Elements of Alternative Benefit Plans

The CLASS Act specifies four key elements that must be included under each of the three (or more) alternative benefit plans developed by the Secretary of HHS for consideration as the CLASS program. These four requirements pertain to (1) premiums, (2) vesting period, (3) benefit triggers, and (4) providing cash benefits that satisfy the requirements of PHSA Sec. 3205.[11] Also, as discussed later in this article, the CLASS Act specifies other required features for the CLASS program—for example, requirements regarding eligibility for enrollment, details regarding benefits, and restrictions on underwriting. We begin, however, with the four key elements.

Premiums

Beginning with the first year of the CLASS program and each year thereafter, the Secretary of HHS will establish the premiums that must be paid by new enrollees "based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period."[12] Although the details regarding premiums required under the CLASS program will not be known until the program is adopted, it seems likely that premiums will vary depending on the age of the enrollee at the time of enrollment. Also, the monthly premium determined for an enrollee generally will remain level for as long as he or she is an active enrollee in the CLASS program.[13] (Later, we'll discuss circumstances where premiums may be adjusted after enrollment.)[14]

The CLASS Act does not precisely describe how solvency should be measured for this purpose. However, given that each of the alternative benefit plans must be "actuarially sound,"[15] it seems clear that such determination must be made consistently with generally accepted actuarial practices. Also, the 75-year window is a rolling window, meaning that an initial 75-year window begins in the first year of the CLASS program that is used in determining premiums for such year, then a second 75-year window begins in the following year that must be used in determining premiums for such year, and so on.[16]

Special rules limit the premiums that can be charged to the poor or students. In particular, for individuals whose income does not exceed the poverty line[17] and actively employed full-time students[18] who have not attained age 22, the monthly premium cannot exceed $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for years after 2009.[19] As discussed later, premiums are

recalculated once an individual no longer satisfies the full-time student criteria for a nominal premium.[20] There does not appear, however, to be any recalculation mechanism for individuals with a nominal premium based on poverty, apart from certain generally applicable circumstances where premiums may be recalculated.[21]

Finally, as is perhaps obvious from the discussion above, the CLASS Act does not identify any particular premiums to be charged. The necessary premiums of course will vary based on the structure of CLASS program benefits and other features of the CLASS program.[22] We note, however, that the chief actuary of the Centers for Medicare & Medicaid Services stated that an estimated $240 per month average premium would be required to adequately fund CLASS program costs.[23] The CLASS Act also does not specify whether premiums will be waived for those receiving benefits. (In private LTC insurance, waiver of premium typically applies, although it might not under the CLASS program.)

Vesting Period, Eligible Beneficiaries, and Restrictions on the Use of Underwriting in Connection with Enrollment

The second key element that is required for the three (or more) alternative benefit plans is that each must provide a five-year vesting period before an enrollee is eligible for benefits.[24] This relates to the CLASS Act's definition of an "eligible beneficiary," which provides that such an individual must have paid premiums for at least 60 months in order to be treated as an eligible beneficiary under the CLASS program.[25] To be an eligible beneficiary, it is also necessary that an individual must be an "active enrollee."[26] Further, as of the date that the benefit triggers are met, the individual must have earned, with respect to at least three calendar years that occur during the first 60 months for which premiums are paid, wages and self-employment income in an amount sufficient for crediting a quarter of coverage under Sec. 213(d) of the Social Security Act for the year.[27] For 2010, such required earnings are $1,120.[28] Also, the Secretary of HHS must promulgate regulations specifying exceptions to this minimum earnings requirement "for certain populations."[29] An additional requirement is that the individual must have paid premiums for at least 24 consecutive months if a lapse in premium payments of more than three months has occurred.[30]

As noted, an individual must be an active enrollee in order to be considered an eligible beneficiary. An active enrollee is an individual who has enrolled in the CLASS program in accordance with PHSA Sec. 3204 and who has paid any premiums due to maintain such enrollment.[31] In this regard, under PHSA Sec. 3204(c) an individual generally may enroll in the CLASS program if he or she (1) has attained the age of 18, (2) has received wages or income that is subject to Social Security or self employment taxes under Secs. 3101(a), 3201(a), or 1401(a) of the Internal Revenue Code of 1986, as amended (the Code), and (3) is actively employed.[32] For this purpose, an individual generally is considered actively employed if he or she is reporting for work at a usual place of employment or at another location to which the individual is required to travel by reason of such employment (or in the case of an individual who is a member of the uniformed services, is on active duty, and is physically able to perform the duties of the individual's position) and is able to perform all the usual and customary duties of the individual's employment on the individual's regular work schedule.[33] If an individual satisfies all of the eligibility requirements when he or she first enrolls, however, eligibility to continue enrollment will not be denied just because an individual fails to continue receiving wages or income subject to these taxes.[34]

In general, underwriting may not be used to prevent an individual from enrolling in the CLASS program.[35] However, to enroll in the CLASS program, it is necessary that an individual not be either (1) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid,[36] or (2) confined in prison.[37] Also, the 60-month vesting period has the effect of underwriting in some instances, since the life expectancy of an individual who may be chronically ill (or close to it) at the time of enrollment often is substantially curtailed. In this regard, a study by the Society of Actuaries found that the mortality rate of insureds on claim under private LTC insurance was approximately 30 times on average that of insureds not on claim.[38] Also, for insureds aged 40-69 on claim, the

mortality rates were over 50 times higher on average than that of insureds not on claim. Reflecting this, for insureds in their 50s, the mortality rate was 13% per year, and for insureds in their 60s, the mortality rate was 22% per year. At these annual mortality rates, a substantial percentage of individuals would not survive the 60-month vesting period, and thus they would receive no benefits even though they had a functional or cognitive impairment at the time of enrollment.[39]

Benefit Triggers and Eligibility Assessments

The third key element that is required for the three (or more) alternative benefit plans is that each must pay CLASS program benefits only in circumstances where certain benefit trigger requirements are met. In particular, such benefits must be payable only where an individual has a functional limitation, as certified by a licensed health care practitioner,[40] that (1) is expected to last for a continuous period of more than 90 days, and (2) is described by any of the following:

1. The individual is determined to be unable to perform at least the minimum number (which may be two or three, as required by the plan) of activities of daily living (ADLs) without substantial assistance from another individual.
2. The individual requires substantial supervision to protect the individual from threats to health and safety due to substantial cognitive impairment
3. The individual has a level of functional limitation similar (as determined under regulations prescribed by the Secretary of HHS) to the level of functional limitation described under either of the prior two triggers.[41]

For purposes of the first of these benefit triggers, ADLs are defined by cross-reference to the ADLs that are specified in Code Sec. 7702B.[42] These are eating, toileting, transferring, bathing, dressing, and continence. Also, the reference to two or three ADLs permits the Secretary of HHS to develop alternative benefit plans that use either number. The CLASS Act's permissible benefit triggers otherwise are similar to those that apply for qualified LTC insurance under Code Sec. 7702B.[43] This is not surprising, since the CLASS program is treated as qualified LTC insurance for tax purposes (as discussed in more detail later).[44] However, while the CLASS Act benefit triggers are similar to those used in the tax law, they are not identical, and there is no direct link between them.

Some differences relate to the language used in defining the benefit triggers. For example, the CLASS Act refers to "substantial cognitive impairment" whereas the tax law refers to "severe cognitive impairment."[45] Also, the CLASS Act provides that the term "substantial assistance" will be as defined by the Secretary of HHS,[46] whereas the interpretation of Code Sec. 7702B is within the purview of the Secretary of the Treasury.[47] Yet another difference relates to the expectation that an insured will be impaired for at least 90 days. Under the CLASS Act, this 90-day requirement applies to both the ADL-based benefit trigger and the cognitive impairment-based benefit trigger.[48] In contrast, under the tax law, the 90-day requirement applies only to the ADL-based trigger.[49]

The CLASS Act and the tax law also are different with respect to recertifications of benefit triggers. Under the CLASS Act, an eligible beneficiary must "periodically, as determined by the [Secretary of HHS]…recertify by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits [and] submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year."[50] The tax law, in contrast, requires that an individual will not be considered to be a chronically ill individual unless he or she has been certified as such within the prior 12 months.[51]

Further differences relate to the possibility that a third benefit trigger may be prescribed. Under the CLASS Act, the Secretary of HHS is authorized to specify a third benefit trigger,[52] whereas such authority under the tax law is granted to the Secretary of the Treasury who must consult with the Secretary of HHS in the establishment of any such trigger.[53] In addition, any third benefit trigger under the CLASS Act must be similar to either the ADL-based benefit trigger or the cognitive impairment trigger,[54] whereas any third trigger under the tax law must be similar to the ADL-based trigger.[55]

In connection with benefit trigger assessments, the CLASS Act provides for the creation of an "eligibility assessment system" to facilitate the operation of the CLASS program.[56] This system must be established by January 1, 2012, and will provide for eligibility assessments of active enrollees who apply for receipt of benefits. In this regard,

the Secretary of HHS must promulgate regulations to develop an "expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner…."[57] These procedures would include determining whether an active enrollee is eligible for a cash benefit under the CLASS program and, if so, the amount of the cash benefit (under the sliding scale of benefits discussed below).[58] The Secretary of HHS also must establish procedures under which an applicant for CLASS program benefits has a right to appeal an adverse determination.[59]

The CLASS Act treats active enrollees as presumptively eligible for benefits if the enrollee (1) has applied for the maximum cash benefit available under the sliding scale established by the CLASS program, (2) is a patient in a hospital (where hospitalization was for LTC), nursing facility, intermediate care facility for the mentally retarded, or institution for mental diseases, and (3) is in the process of, or about to begin the process of, planning to discharge from such hospital, facility or institution, or is within 60 days from the date of such discharge.[60]

Cash Benefit

The fourth key element that is required for the three (or more) alternative benefit plans is that each must provide for payment of a cash benefit to eligible beneficiaries when one of the benefit triggers is satisfied and the other eligibility criteria are met. The cash benefit must be "not less than an average of $50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels)."[61] This $50 per day average amount applies for the first year that beneficiaries receive benefits under the CLASS program (which likely will be 60 months after implementation of the program), and in later years this amount is increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the prior year.[62] The cash benefit must be paid on a daily or weekly basis,[63] and such benefit is not subject to any lifetime or aggregate limit.[64]

Each alternative benefit plan that is developed also must provide for benefit amounts that vary (*i.e.,* under a sliding scale) depending on the degree of an eligible beneficiary's functional ability (with at least two, and no more than six, benefit levels).[65] While average benefits for all beneficiaries must be at least $50 per day, it appears that an alternative benefit plan could be structured with one or more scaled benefits that are less than $50 per day and with one or more other scaled benefits that exceed $50 per day. The $50 per day average benefit requirement is, however, a minimum requirement of the CLASS Act; the Secretary of HHS may develop an alternative benefit plan that provides for a higher average level of benefits.

Later in this article, we'll explore the cash benefit provided under the CLASS program in more detail, including the use of "Life Independence Accounts" to provide benefits.

Operation of the CLASS Program

Enrollment

The CLASS Act provides two mechanisms under which eligible individuals may enroll in the CLASS program. First, the Secretary of HHS will establish procedures under which eligible individuals[66] may be automatically enrolled by the individual's employer "in the same manner as an employer may elect to automatically enroll employees in a plan under [Code sections 401(k), 403(b), or 457]."[67] As is evident from this statutory language, employers have discretion whether or not they will automatically enroll employees under the CLASS program. If an employer elects to automatically enroll employees, an employee must affirmatively opt out in order not to be covered under the CLASS program.[68]

The second mechanism that may be used to enroll in the CLASS program is through an alternative enrollment process. In particular, the Secretary of HHS will establish procedures to allow for enrollment of (1) individuals who are self-employed, (2) individuals who have more than one employer, and (3) individuals whose employer does not elect to participate in the automatic enrollment process.[69]

In addition to these procedures for enrollment, the CLASS Act requires the Secretary of HHS to establish procedures for payment of premiums under the CLASS program. Such procedures include payroll deductions by employers who elect to deduct and withhold wages on behalf of enrolled employees.[70] It appears that an employer may elect to payroll deduct even if it otherwise

has not elected to auto enroll employees, since the CLASS Act in no way ties an employer's election with respect to auto enrollment to the election to payroll deduct. Of course, an employer could decide to do neither. Such procedures also include an alternative payment mechanism that individuals can use in circumstances where their employer does not elect to deduct and withhold premiums or where an individual does not earn wages or derive self-employment income.[71]

The Secretary of HHS also will establish procedures under which individuals may enroll in the CLASS program only when they are first eligible to enroll or during certain open enrollment periods, which cannot occur more frequently than biennially.[72] Further, individuals may disenroll in the CLASS program (other than for nonpayment of premium) only during an annual disenrollment period.[73]

More on the Cash Benefit: Life Independence Accounts

As discussed above, the CLASS program will provide for payment of two to six scaled cash benefits that are not less than an average of $50 per day (indexed). The Secretary of HHS has broad authority to establish procedures under which active enrollees may apply for CLASS program benefits[74] and for administering the provision of such benefits, "including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary."[75] The CLASS Act also prescribes a number of rules regarding the cash benefit and Life Independence Accounts, including the following:

- *Use of Life Independence Accounts for "nonmedical services and supports."* First, the cash benefit paid into Life Independence Accounts must be used "to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting of his or her choice in the community, including (but not limited to) home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support."[76]
- *Use of debit cards.* Second, the Secretary of HHS is directed to establish procedures for crediting an eligible beneficiary's cash benefit to an account, allowing the beneficiary to access such account through debit cards, and accounting for withdrawals by the eligible beneficiary from the account.[77]
- *Primary payor rules.* Third, if the eligible beneficiary is enrolled in Medicaid, certain primary payor rules apply that direct a portion of CLASS program benefits to the facility's or the state's cost of providing care, and thus only a reduced amount is provided as a cash benefit to the eligible beneficiary. In particular, if the eligible beneficiary is enrolled in Medicaid and is a patient in a hospital, nursing home, intermediate care facility for the mentally retarded, or institution for mental diseases, the eligible beneficiary retains 5% of CLASS program benefits, and the remainder is applied toward the facility's cost of providing the beneficiary's care (with Medicaid providing secondary coverage for such care).[78] Also, if the eligible beneficiary is receiving assistance under Medicaid for home- and community-based services, the beneficiary retains 50% of CLASS program benefits, and the remainder is applied toward the cost to the state of providing such assistance (again with Medicaid providing secondary coverage for such care).[79] Apart from these special rules for Medicaid recipients, the CLASS Act states that benefits received by an eligible beneficiary "shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other federally funded program that provides health care benefits or assistance."[80]
- *Rules for deferral of receipt of benefits.* Fourth, the CLASS Act provides that an eligible beneficiary may elect to (A) defer payment of his or her benefit and rollover any such deferred benefits from month to month "but not from year to year," and (B) receive a lump-sum payment of deferred benefits.[81]
- *Recoupment of unused benefits.* Fifth, the CLASS Act provides that the Secretary of HHS shall recoup any accrued benefits in the event of the death of a beneficiary or the failure of a beneficiary to elect under PHSA Sec. 3205(c)(4)(B) to receive a lump-sum benefit before the end of the 12-month period in which

such benefits accrue.[82] Under this rule, it appears that amounts paid into the Life Independence Account would be taken back by the government in this circumstance if not taken by the eligible beneficiary.

- *Recertifications of benefit eligibility.* Sixth, the recertification of benefit eligibility rules under the CLASS Act provide that an eligible beneficiary must periodically, as determined by the Secretary of HHS, recertify "by submission of medical evidence the beneficiary's continued eligibility for receipt of benefits" and "submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year."[83]
- *Family caregivers.* Seventh, the CLASS Act provides that nothing in such Act should be construed as prohibiting use of CLASS program benefits to compensate a family caregiver for providing community living assistance services and supports to an eligible beneficiary.[84]

Because the CLASS Act provides only a framework for the CLASS program, many of the details necessarily will remain unclear until the Secretary of HHS designates (by October 1, 2012) one of the alternative benefit plans as the CLASS program. Some important points to be resolved include the following:

- *What is the scope of nonmedical services and supports?* As discussed above, the cash benefit provided under the CLASS program is available for nonmedical services and supports, and certain examples are given of such services and supports. The scope of such services and supports is unclear, however, and may only be clarified once the CLASS program is adopted. From the primary payor rules, it seems clear that the CLASS program is intended to cover care provided in an institutional setting, such as nursing home care needed due to an eligible beneficiary's need for assistance with ADLs or cognitive impairment. This being said, the services provided in an institutional care setting seem inconsistent with nonmedical services and supports as described in PHSA Sec. 3205(c)(1)(B). Of course, in an institutional setting, *some* portion of care received would be nonmedical services and supports.[85]
- W*hat is the relationship between the nonmedical services and supports requirement and the fact that the CLASS program provides a "cash benefit" that can be taken in a lump sum?* As discussed above, the CLASS program provides a cash benefit that can be taken in a lump sum, but then provides that life independence accounts can be used only for nonmedical services and supports.[86] What mechanisms, if any, will be established so that the cash benefit is used only for nonmedical services and supports? Note that in the case of qualified LTC insurance providing per diem or other periodic benefits, policies can pay benefits only if the insured is a chronically ill individual [within the meaning of Code Sec. 7702B(c)(2)], but there generally is no mechanism in place to track or limit benefit payments to actual LTC costs incurred.

Similarly, what is the function of the requirement to submit records of expenditures at year end? Is it only to help verify proof of functional or cognitive impairment and of the appropriateness of the scaled benefit being provided (including whether a change in scale is appropriate)? Or does this requirement more directly limit benefits to incurred costs? Also, what constraints will be placed on the use of debit cards issued to eligible beneficiaries? Will they be usable only for nonmedical services and supports? Also, will the lump-sum option be provided through such debit cards or will it be provided through some other means?

- *What is the role of the forfeiture rule?* If the "cash benefit" contemplated is intended to mirror the per diem and other periodic benefits often provided under qualified LTC insurance, what is the purpose of (1) the requirement that a lump sum be elected (i.e., why not just pay the benefit immediately?), and (2) the provision that forfeits an available lump sum if the beneficiary does not request it before year-end?[87] Stated differently, given the use-it-or-lose-it aspect of these rules, in what circumstances would an eligible beneficiary choose not to receive benefits, unless the amount available is limited to actual expenses incurred for nonmedical services and supports? Is the restriction on interyear carryovers intended to prevent the Life Independence Account from being used as a savings vehicle? Dis-

allowing a carryover of an annual maximum benefit would be understandable under a reimbursement-of-expense design, because an enrollee may have incurred expenses less than the maximum amount reimbursable during the year. However, if benefits are tied solely to functional or cognitive impairment and are not limited to reimbursement of incurred costs, the forfeiture of the unrequested benefit would penalize those eligible beneficiaries who for whatever reason do not make a timely request for benefits.

Advocacy Services and Advice and Counseling Services

The CLASS Act also provides advocacy and counseling services, e.g., information on access to LTC services and supports, eligibility for benefits, development of a service and support plan, and assistance with the appeals and recertification processes.[88] Generally, the costs of these services are administrative costs that may be used by the Secretary of HHS for purposes of determining premiums.[89]

Recalculation of Premiums

In general, the monthly premium determined for an individual at the time of enrollment will remain the same for as long as the individual is an active enrollee in the CLASS program.[90] However, premiums may be recalculated (1) if needed to ensure solvency of the CLASS program, (2) when the enrollee ceases to meet the nominal premium that applies to full-time actively employed students, and (3) if an enrollee has lapsed in paying premiums.

With respect to solvency, if the Secretary of HHS determines that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with such year, premiums must be adjusted as necessary to ensure solvency over this timeframe.[91] The nominal premiums provided for the poor and full-time actively employed students (as described above) must, however, be maintained.[92] Also, any increase in premiums to ensure solvency similarly does not apply to an active enrollee who has attained age 65, has paid premiums for at least 20 years, and is not actively employed at the time such adjustment otherwise would apply.[93]

Once a full-time, actively employed student ceases to satisfy the requirements for a nominal premium (as described above), the monthly premium is adjusted to be "the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year)."[94]

In situations where an individual fails to pay required premiums and coverage lapses, the amount of recalculated premiums depends on the length of lapse. If an individual reenrolls in the CLASS program after a 90-day period during which the individual failed to pay the required monthly premium, such reenrollment is treated as an initial enrollment for purposes of determining the age-adjusted premium.[95] If the individual reenrolls within five years of the first missed premium, however, he or she will be credited with any months of paid premiums that accrued prior to lapse.[96] Also, notwithstanding the total amount of any such credited months, such individual still must satisfy the earnings requirement described above, *i.e.* he or she must have wages or earnings sufficient to earn a quarter of coverage under Social Security for at least three calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the CLASS program.[97]

If an individual reenrolls more than five years after first missing a required premium, a penalty applies for purposes of determining the recalculated premium. In particular, in this circumstance the monthly premium is the age-adjusted premium that would apply to an initially enrolling individual (who is the same age as the reenrolling individual), increased by the greater of (1) an amount that the Secretary of HHS determines is actuarially sound to account for months when premiums were not paid, or (2) 1% of the applicable age-adjusted premium for each month of such period.[98]

Other Aspects of the CLASS Act

Restriction on Taxpayer Funding

The CLASS Act states that "[n]o taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan."[99] For this purpose, the term "taxpayer funds" means any federal funds from a source

other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings.[100] Various mechanisms are incorporated into the CLASS Act to help ensure the self-sufficiency of the CLASS program.[101]

Regulatory Authority

The Secretary of HHS has broad authority to promulgate regulations as are necessary to carry out the CLASS program, including regulations to prevent fraud and abuse under the program.[102]

Tax Treatment

PHSA Sec. 3210 states that the CLASS program "shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services." As a result, CLASS program premiums generally should be deductible to the same extent that premiums for qualified LTC insurance are deductible.[103] Also, employer-paid CLASS program premiums generally should be excludable from income.[104] Finally, and perhaps most importantly, CLASS program benefits (whether or not premiums were employer paid) generally should be excludable from income.[105] If the cash benefit is structured so that it constitutes a "periodic payment" within the meaning of Code Sec. 7702B(d)(6), the exclusion from income would be limited to the so-called per diem limitation set forth in Code Sec. 7702B(d). (This limitation applies to the aggregate of all per diem benefits received that are described in Code Secs. 101(g) and 7702B. Also, the limitation is indexed for inflation. For 2010, it permits $290 per day, or the equivalent amount in the case of payments on another periodic basis, to be paid as a tax-free accident or health insurance benefit.[106])

Personal Care Attendant Workforce

The CLASS Act includes a number of provisions designed to ensure the adequacy of the personal care attendant workforce.[107] Such efforts include the establishment of a Personal Care Attendants Workforce Advisory Panel for purposes of advising the Secretary of HHS on workforce issues related to personal care attendant workers, including with respect to the adequacy of the number of such workers, salaries, wages, and benefits of such workers, and access to the services provided by such workers.[108]

National Clearinghouse for LTC Information

The CLASS Act requires that information regarding the CLASS program be included in the National Clearinghouse for Long-Term Care Information.[109] This informational resource is provided at www.longtermcare.gov and provides information (including information on private LTC insurance) to assist individuals in planning for the future possible need of LTC.

Effective Date

The amendments made by the CLASS Act generally are effective on January 1, 2011.[110] As noted above, however, the Secretary of HHS is required to designate the CLASS program through a final rule by October 1, 2012, and thus the CLASS program may not exist until such time.[111]

Summary

Table 1 summarizes various aspects of the CLASS program relative to private LTC insurance.

Commentary

The Secretary of HHS has not yet developed the three (or more) alternative benefit plans, and as noted above the Secretary has until October 1, 2012 to designate the final plan. Thus, we do not presently know what level of benefits or premiums (and other details, such as with respect to benefit triggers) will be prescribed for the CLASS program. If the average daily benefit provided ultimately is the $50 minimum prescribed by the CLASS Act or a similar low amount, this could substantially affect consumer perceptions with respect to the adequacy of the CLASS program to protect against future LTC needs. In this regard, the benefits under private LTC insurance policies are typically much higher, reflecting the fact that LTC costs typically incurred by a chronically ill individual are substantially higher.[112] Of course, the attractiveness of the CLASS program also will depend on the premium charged relative to the ben-

TABLE 1

Comparison of Key Features: Private LTC Insurance and the CLASS Program

	Private LTC Insurance	CLASS Program
Availability	Currently available from many insurers (both private and group LTC insurance). LTC coverage can be offered in combination with life insurance and annuity contracts. Policies may be eligible for beneficial treatment under Medicaid in states with Medicaid partnerships.	CLASS program must be adopted by Oct. 12, 2012. It is not currently operational. At present, it is unclear whether the CLASS program will be eligible for beneficial treatment under Medicaid partnerships.
Eligibility	Underwriting generally is required and sometimes preexisting condition limitations apply.	No underwriting or preexisting condition limitations. To enroll, an individual must be at least 18 years old and actively employed.
Vesting	Typically there is no vesting period. Often there is an elimination period, e.g., 90 days.	An individual must satisfy a five-year vesting period and satisfy certain income requirements in order to be eligible for benefits.
Benefit Levels	Benefit levels are specified in policies. Policies typically cover the cost of qualified LTC services received in a nursing home, assisted-living facility, and at home. Other benefits, such as hospice care, often are covered. Some insurers provide policies with so-called per diem benefits.	To be determined, but will be a scaled "cash" benefit (with the amount of the benefit depending in part upon the degree of functional incapacity) and will, on average, be at least $50 per day. Available for nonmedical services and supports.
Benefit Triggers	Benefits generally are payable if the insured (1) is expected to require substantial assistance with two or more of six ADLs (eating, toileting, transferring, bathing, dressing, and continence) for at least 90 days, or (2) needs substantial assistance to protect the insured from threats to health and safety due to severe cognitive impairment.	Similar to private LTC insurance triggers, but there are a number of differences and details will not be known until the CLASS program is adopted.
Premiums	Guaranteed renewable premiums specified in the policy that depend on age at issue and can change only on a class basis.	To be determined. Premiums may depend on age at issue. Premiums can change in certain circumstances, e.g., due to risk of CLASS program insolvency. A nominal premium will apply to individuals with incomes below the poverty line and to certain students.
Tax Status	Policies that are tax qualified under Code Sec. 7702B are available from many insurers. Reimbursement benefits under such policies are tax free. Per diem benefits under such policies are tax free to the extent of the per diem limitation (generally $105,850 per year for 2010).	Treated as tax qualified under Code Sec. 7702B, so that benefits generally are tax free, subject to the per diem limitation.

efits provided, and should take into account the risk that premiums may need to increase because of adverse selection in the CLASS program.

In particular, in light of the restriction on underwriting and certain other features of the CLASS Act described above (including the nominal premium for certain populations), it is unclear at this time whether the CLASS program is actuarially sustainable. A key question will be the degree to which antiselection will affect the program. Stated differently, what percentage of enrollees will already have health conditions upon enrollment that can be expected to qualify them for CLASS program benefits as soon as the five-year vesting period is completed? Another unknown is the point at which antiselection would become so significant that CLASS program benefits could not be provided with payment of a reasonable premium in a manner that is actuarially sustainable (assuming no taxpayer funding of benefits).

The concern about antiselection is shared by others, including Richard Foster, the chief actuary of the Centers for Medicare and Medicaid Services, who, in his April 22, 2010 report on the financial effects of PPACA, stated that "[i]n 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" and that "there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable."[113] The risk of antiselection and of CLASS program insolvency is fundamentally an actuarial question and will depend on the details of the CLASS program. This being said, the nature of this risk can perhaps be better understood by examining different populations of individuals that may consider enrollment in the CLASS program.

Individuals 18–65 Years Old Who at the Time of Enrollment Meet (or Soon Will Meet) the CLASS Act's Benefit Triggers[114]

This population of individuals (referred to herein as uninsurable individuals), especially those with substantial life expectancies, may find the CLASS program to be very attractive. The restriction on underwriting means that the health condition of these individuals will not bar entry into the program and there will be a substantial financial incentive for them to enroll. For example, if an individual age 30 is disabled, meets the CLASS program's benefit triggers, and has a substantial life expectancy, he or she may have to pay premiums of $240 per month ($2,880 per year) (or lower premiums, since premiums may be age based), but then would become eligible to receive CLASS program benefit (e.g., perhaps the average benefit of $18,250 per year) once the 60-month vesting period is completed.[115] For such individuals with substantial life expectancies, the absence of any lifetime benefit limit makes the CLASS program especially attractive. And the financial incentive is materially greater for full-time working students and those with incomes below the poverty line who qualify for the nominal $5 per month ($60 per year) premium.

On the other hand, while no direct underwriting can be used to bar enrollment into the CLASS program, some of the other requirements of the program could have the indirect effect of underwriting. For example, as discussed above, an individual must be actively employed to enroll in the CLASS program.[116] Also, in order to qualify as an eligible beneficiary, an individual must have earned during at least three years of the 60-month vesting period wages or self-employment income sufficient to earn a quarter of coverage under Sec. 213(d) of the Social Security Act (for 2010, this amount is $1,120).[117] In this regard, the CMS PPACA Actuarial Report stated that the CLASS Act "includes modest work requirements in lieu of underwriting."[118] An important question, however, is whether this requirement will significantly bar entry to individuals in this population who otherwise are eligible to participate in the CLASS program. To what degree, for example, will uninsurable individuals who are not currently working (because of the severity of their functional or cognitive impairment) be able to obtain some limited employment solely in order to become eligible for CLASS program benefits? Given the very low level of earnings required and the very loose definition of "actively employed," it seems that those requirements will reduce the adverse selection problem only marginally, unless the Secretary of HHS devises stringent and enforceable rules that are not detailed in the statute.

A perhaps more significant CLASS program restric-

tion that performs an underwriting role is the 60-month vesting period, which makes the CLASS program unattractive for those with very limited life expectancies. Also, if the prospective enrollee anticipates being Medicaid eligible, the CLASS program will be less attractive due to the primary payor rules, which generally require 95% of CLASS program benefits of an institutionalized individual to be paid to the facility (to replace Medicaid benefits that otherwise would cover such costs) and 50% of CLASS program benefits for an individual receiving home care to be provided to the state (to offset its Medicaid costs).[119] Of course, these primary payor restrictions are only relevant if the eligible beneficiary is receiving Medicaid assistance. For uninsurable individuals who are not receiving such assistance and have substantial life expectancies, however, the CLASS program may offer a very material benefit in return for a modest premium investment, as described above.

Individuals Ages 18–65 with No Current Signs of Functional or Cognitive Impairment (Who Also Represent a Large Part of the Target Market for Private LTC Insurance)

Individuals in this population (referred to herein as insurable individuals) may have interest in the CLASS program for the same reasons that such individuals have interest in private LTC insurance—to protect against the financial burdens that would arise should the individuals ever need LTC. While some of these individuals may become chronically ill (and thus benefit eligible) by the end of (or soon after) the 60-month vesting period due to unanticipated declines in health or other events, the considerable majority of such individuals likely will not need LTC for many years. Thus, the insurance cost per insured to the CLASS program associated with covering insurable individuals (as a group) is small compared with the population of uninsurable individuals discussed immediately above.

Because of the modest insurance cost to the CLASS program of covering insurable individuals, it seems critical to the solvency of the CLASS program that a large number of such individuals enroll relative to the population of enrolling uninsurable individuals. That way, the high cost of covering the uninsurable individuals can be borne by a large number of enrollees, so that the per-enrollee cost of covering uninsurable individuals is relatively small. In the context of group LTC insurance, for example, where all employees of an employer may have access to LTC coverage with limited or no underwriting, the fact that the employees are working (in a meaningful way) can effectively limit the number of uninsurable individuals in the population to be covered, so that premiums do not spiral significantly upward due to adverse selection.

It is unclear, however, how many insurable individuals will find the CLASS program attractive. Because of the limited actively employed and earnings requirements, a much larger population of uninsurable individuals may have access to the CLASS program, at least when compared with private group LTC insurance, and those uninsurable individuals may have a strong financial incentive to participate as described above. Also, as discussed above, other features of the CLASS program substantially favor certain populations over others, e.g., the nominal premiums that may apply and the absence of any lifetime benefit maximum (which may favor younger individuals with impairments over insurable individuals who may become impaired only once they reach a late age when life expectancy is limited). These factors may strongly discourage insurable individuals from participating, since they (if they are well informed) will know that a material portion of their premium dollars are subsidizing the actuarial cost of insurance for coverage of uninsurable CLASS program enrollees.

The degree to which employers actively participate in the CLASS program is yet another factor that has a bearing on how many insurable individuals will enroll, due to the fact that employees must affirmatively opt out of enrollment if their employer chooses to participate in the automatic-enrollment option. As discussed above, whether an employer participates is purely at the discretion of the employer, and one can expect that many employers will be concerned about burdening their employees and themselves with the affirmative opt-out requirement. While the extent of employer interest in the CLASS program is at present unclear, it seems unlikely that substantial private-sector employer participation will occur. In circumstances where employees are bearing

the full premium cost, many employers particularly might find the affirmative opt-out requirement to be unattractive. Also, even for employers that believe some of their employees would have interest in the CLASS program, they might handle this by making information available to employees regarding the CLASS program's alternative payment mechanism.

To begin with, implementation of a CLASS Act automatic-enrollment regime is likely to result in significant administrative burdens on an employer's human resources functions, with little or no appreciable benefit to the employer or employees. Taking amounts from employees' paychecks without explicit authorization has the potential to upset employees and can even be in violation of state antigarnishment laws. And any employees who do not pay sufficient attention to the CLASS program opt-out process are likely to contact their employer and demand their money back.

Any CLASS automatic-enrollment program is not likely to be analogous to the successful automatic-enrollment programs many employers have implemented in 401(k) plans. Implementing the CLASS program could also be significantly more complex than an automatically enrolled 401(k) program. The employer may not be able to determine the appropriate level of CLASS program premiums to be collected from any particular employee because premiums will vary for each employee based on a number of variables. And every time the incorrect premium is collected, the employer would be faced with a potentially expensive process of correcting the error, would face potential liability for the error under federal and state law, and would undoubtedly have to deal with an unhappy employee.

Moreover, there likely will be significantly less interest among the employee population in CLASS program participation than in 401(k) plans. To begin with, a substantial majority of workers generally will participate in a typical 401(k) plan, even without automatic enrollment. They recognize the need for and the tax advantages of saving for retirement. Often, there is also an employer-matching contribution made to the 401(k) plan. Those factors generally will not be present with the CLASS program. With only a very few employees likely to want to participate in the CLASS program, employer interest in establishing an automatic-enrollment process will be minimal, especially when those employers are being asked to consider starting the CLASS program process at the same time they are dealing with all the other burdens of implementation associated with PPACA. As noted above, the more likely result is that those employers who believe some of their employees would have interest in the CLASS program will handle this by making information available to employees regarding the CLASS program's alternative payment mechanism.

Of course, this still may leave a substantial number of insurable individuals with interest in the CLASS program, and a further question is how individuals will perceive the CLASS program in comparison with private LTC insurance. At present, it is difficult to evaluate this factor, since benefit levels and premiums have not yet been specified for the CLASS program. Given that the premiums of insurable individuals subsidize benefits of uninsurable individuals (perhaps in a manner materially more extensive than is typically the case under guaranteed issue or limited underwriting private group LTC insurance), private LTC insurance may be able to offer currently healthy individuals lower premiums (or better benefits) than the CLASS program for otherwise comparable benefits. At the same time, other factors may favor the CLASS program, such as economies of scale efficiencies that could result from significant participation in the CLASS program. It's also unclear how prospective enrollees will evaluate private insurance and the CLASS program from a qualitative perspective. For example, to what degree will individuals view government-provided coverage as a plus, and to what extent will individuals view (or be aware of) the solvency and sustainability concerns that have been raised about the CLASS program? Similarly, how will individuals view the risk of recalculated premiums under the CLASS program compared with private LTC insurance?

Individuals over Age 65

Unless CLASS program premiums are set in a manner that subsidizes coverage for older age cohorts, individuals who have retired and do not yet have any signs of functional or cognitive impairment may have little incentive to once again begin working for wages or self-

employment income that would entitle them to participate in the CLASS program. They have retired, and CLASS program coverage is unlikely to lead them to reenter the workforce if relatively comparable (or cheaper) private LTC insurance is available. On the other hand, retired individuals who have (or are showing signs of) potential functional incapacity or cognitive impairment may search for ways to return to work temporarily in order to obtain access to CLASS program benefits in the future. However, those with limited life expectancy (or those with severe impairments) may find even the loose CLASS program active-at-work requirement and the 60-month vesting requirement to be substantial disincentives to enrollment.[120] Thus, on balance, few elderly retired individuals are likely to newly enroll in the CLASS program and those who do are more likely to already be showing signs of impairment.

Conclusion

The nation's disabled clearly have substantial needs, and making it easier for such individuals to live in the community and avoid institutional care has strong merit as a policy goal. The difficulty, however, is how to finance such assistance, especially in a legislative atmosphere where the budgetary effects of any new entitlement program would receive strong scrutiny. The CLASS Act has attempted to navigate these goals and concerns through the creation of a voluntary, guaranteed issue, insurance program that has features both of LTC insurance and disability insurance. However, a prerequisite for sustainability of the CLASS program is material participation in the program by insurable individuals that allows for premiums to be set at reasonable levels relative to the value of coverage provided.[121] At present, it is not at all clear how this prerequisite will be realized for the CLASS program.

From the perspective of the financial advisor with clients who are planning for the possibility of future LTC needs, we would first observe that many critical details of the CLASS program (e.g., benefit levels and premiums) have not been finalized and may not be until the October 1, 2012 deadline for finalization of the CLASS program. Thus, it is speculative to predict the attractiveness of CLASS program coverage relative to private LTC insurance coverage. At a minimum, this means that those individuals with existing LTC insurance should stay the course. We do know that the CLASS program's coverage of potentially substantial numbers of uninsurable individuals will drive up the cost of coverage for those who decide to participate in the program. As a result, it may well be that, for comparable benefit levels, private LTC insurance will be more attractive for insurable (healthy) individuals seeking protection. Also, the scope of CLASS program benefits (which are required to average $50 per day) may not be sufficient to cover the LTC costs that individuals may incur. This means that those who want to protect themselves from the risk of catastrophic LTC expenses will still want to seriously consider private LTC insurance and could be well served by purchasing that insurance while they are still healthy.

Finally, we observe that the CLASS program may bring greater attention to the need to plan for future LTC needs. A consequence may be that greater numbers of individuals will examine the alternatives available for addressing such needs—including both the CLASS program and private LTC insurance. Ultimately, what's most important is that individuals focus on the need to plan for the serious challenges and costs associated with the need for LTC. At present, however, it's unclear what role the CLASS program will play in helping Americans prepare to meet their LTC needs. ■

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(1) Pub. L. No. 111-148. The CLASS Act is set forth as Title VIII of PPACA and was added as Title XXXII to the Public Health Service Act (PHSA) (42 U.S.C. 201 et seq.). The Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, which was signed into law on March 30, 2010, as part of health care reform, made no amendments to the CLASS Act.

(2) *See* S. 697, 111th Cong. (2009), which was introduced by U.S. Sen. Kennedy on March 25, 2009, and cosponsored by U.S. Sens. Dodd, Harkin, Brown, Casey, and Whitehouse. A version of the CLASS Act introduced in the previous Congress (S. 1758, 110th Cong. (2007)) was cosponsored by then-Sen. Obama.

(3) PHSA § 3201(1). Other stated purposes of the CLASS Act are to establish an infrastructure that will help address the nation's community-living-assistance services and supports needs, alleviate burdens on family caregivers, and address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community. PHSA § 3201(2)-(4).

(4) Department of Health and Human Services National Clearinghouse for Long Term Care Information, July 14, 2010, www.longtermcare.gov/LTC/Main_Site/Understanding_Long_Term_Care/Basics/Basics.aspx.

(5) "Genworth 2010 Cost of Care Survey, Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes" (April 2010).

(6) While the benefit triggers under the CLASS program and private qualified LTC insurance are similar in many (but not all) respects, other features may differ materially, e.g., with respect to inflation protection, nonforfeiture benefits, waiver of premium, joint coverage with a spouse, and access to coverage in combination with other insurance products. Consumers can be expected to take into account all of the various features of private coverage and the CLASS program when deciding upon which is best for their needs.

(7) PHSA § 3203(a)(1). The CLASS program is also referred to as the "CLASS Independence Benefit Plan." *See* PHSA § 3202(4) [defining the CLASS program as "the program established under (Title XXXII of the PHSA)]" and PHSA § 3202(9) [defining the CLASS Independence Benefit Plan as "the benefit plan developed and designated by the Secretary (of HHS) in accordance with (PHSA § 3203)"].

(8) The CLASS Independence Advisory Council, as established by PHSA § 3207, consists of not more than 15 individuals who are appointed by the President and a majority of whom are representatives of individuals who participate or are likely to participate in the CLASS program. PHSA § 3207(b)(1). Such members must include representatives of older and younger workers, individuals with disabilities, family caregivers, individuals with expertise in LTC or disability insurance, actuarial science, economics, and other relevant disciplines, as determined by the Secretary of HHS. PHSA § 3207(b)(1)(B). The CLASS Independence Advisory Council is tasked with advising the Secretary of HHS on matters of general policy in the administration of the CLASS program and in the formulation of regulations, including with respect to (1) the development of the CLASS program, (2) the determination of monthly premiums, and (3) the financial solvency of the CLASS program. PHSA § 3207(c).

(9) PHSA § 3203(a)(2).

(10) PHSA § 3203(a)(3). Because such designation must be made by a final rule and a period of public comment must be allowed, seemingly the Secretary of HHS will first issue a proposed rule allowing for a period of public comment that will subsequently, taking into account comments received, be published as a final rule by October 1, 2012. *See also* 5 U.S.C. 553(c) (regarding the opportunity to comment on proposed rules under the Administrative Procedures Act).

(11) PHSA § 3203(a)(1)(A)-(D).

(12) PHSA § 3203(a)(1)(A). In determining the monthly premiums for the CLASS program, the Secretary of HHS may factor in costs for administering the program, not to exceed for any year an amount equal to 3% of all premiums paid during the year. PHSA § 3203(b)(2).

(13) PHSA § 3203(b)(1).

(14) CLASS program premiums are paid into the CLASS Independence Fund, which is a trust fund maintained by the U.S. Treasury. PHSA § 3206(a). The CLASS Independence Fund is similar in structure to the Social Security trust fund. In terms of expected revenues (net of benefits), the Congressional Budget Office estimated that the CLASS Act would raise $70.2 billion during fiscal years 2010–2019. Letter from Douglas W. Elmendorf, Director of the Congressional Budget Office, to the Honorable Nancy Pelosi, at 10 (March 18, 2010). It is interesting to note that an estimated $5.4 billion would be raised during fiscal year 2012 (*i.e.* October 1, 2011 to September 30, 2012), even though under PHSA § 3203(a)(3) the CLASS program need not be established until October 1, 2012. *Compare* Richard S. Foster, Chief Actuary of the Centers for Medicare & Medicaid Services, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended,* pp. 2 and 14 (April 22, 2010) (the "CMS PPACA Actuarial Report"), which assumed lower participation rates and estimated that the CLASS Act would raise approximately $38 billion during fiscal years 2011 to 2019.

(15) PHSA § 3203(a)(1).
(16) PHSA § 3203(a)(1)(A)(i). Once the CLASS program has been in operation for 10 years, the Secretary of HHS must establish "all premiums to be paid by enrollees for the year based on an actuarial analysis that accumulated reserves in the CLASS Independence Fund would not decrease in that year" and "[a]t such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected yearly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of the CLASS Independence Fund reserves." PHSA § 3203(a)(1)(A)(iii).
(17) Under PHSA § 3202(12), the definition of "poverty line" that applies for this purpose has the meaning given that term in § 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)), which in turn cross-references the definition of "poverty line" in § 673(2) of the Community Services Block Grant Act (42 U.S.C. § 9902(2)). During 2009 (and through March 1, 2010), the poverty line under this standard for a single individual was $10,830 and for a family of four was $22,050. See 75 Fed. Reg. 3734 (January 22, 2010).
(18) The definition of a full-time student is to be determined by the Secretary of HHS. See PHSA § 3203(a)(1)(A)(ii)(I)(bb).
(19) PHSA § 3203(a)(1)(A)(ii)(II). The CLASS Act also requires the Secretary of HHS to establish procedures under which individuals may self-attest that their income does not exceed the poverty line or that they are full-time, actively employed students. See PHSA § 3203(c).
(20) See PHSA § 3203(b)(1)(D).
(21) See PHSA § 3203(b)(1)(B), (C) and (E).
(22) PHSA § 3203(b)(3)(A). Regarding the details of the CLASS program, the CLASS Act does not indicate, for example, whether premiums will be waived once an individual is eligible for benefits.
(23) "CMS PPACA Actuarial Report" at pp. 14-15. *Compare* Letter of P.J. Eric Stallard and Steven Schoonveld, on behalf of the American Academy of Actuaries and the Society of Actuaries, to the U.S. Senate Committee on Health, Education, Labor and Pensions ("HELP Committee"), at p. 2 (July 22, 2009) (the "AAA-SOA Analysis"), which analyzed a predecessor version of the CLASS Act (that was similar but not identical to the CLASS Act as enacted) that was reported by the HELP Committee as part of proposed health care reform legislation on July 15, 2009. The AAA-SOA Analysis estimated that a $160 average monthly premium would be needed for a $75 average daily benefit and a $110 average monthly premium would be needed for a $50 average daily benefit. The AAA-SOA Analysis noted, at p. 2, however, that the "premium estimates…are optimistic as they assume only a modest level of adverse selection." The AAA-SOA Analysis is available at http://www.actuary.org/pdf/health/class_july09.pdf.
(24) PHSA § 3203(a)(1)(B).
(25) PHSA § 3202(6)(A)(i).
(26) PHSA § 3202(6)(A).
(27) PHSA § 3202(6)(A)(ii) and (B).
(28) 74 Fed. Reg. 55615 (Oct. 28, 2009).
(29) PHSA § 3202(6)(C).
(30) PHSA § 3202(6)(A)(iii) and (B).
(31) PHSA § 3202(1).
(32) PHSA § 3204(c)(1)-(3).
(33) PHSA § 3202(2).
(34) PHSA § 3204(d). This rule of construction for purposes of enrollment does not obviate the need to earn wages or self-employment income in order to be credited with a quarter of coverage under Social Security, as described above.
(35) PHSA § 3203(b)(3)(B).
(36) PHSA § 3204(c)(4)(A).
(37) PHSA § 3204(c)(4)(B).
(38) *See* Society of Actuaries, Long Term Care Experience Committee Intercompany Study 1984-2004 (November 2007): pp. 84-85 (the "SOA Study").
(39) We also note that the mortality rate associated with the need of LTC is materially higher than the mortality rate of individuals with a disability. The SOA Study includes a comparison of the mortality rates of insureds under private LTC insurance with the mortality rates contained in the SOA's Table 95, which is a disabled life mortality table based on a disability income insurance definition of "disability." For individuals aged 55-69, the mortality rate of individuals on claim under private LTC insurance was over 300% the mortality rate of SOA Table 95. *See* SOA Study, at 84 (Figure 20).
(40) The term "licensed health care practitioner" is not defined by the CLASS Act. For purposes of the definition of a qualified LTC insurance contract, Code Sec. 7702B(c)(4) provides that this term means "any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary [of the Treasury]."
(41) PHSA § 3203(a)(1)(C).
(42) PHSA § 3202(3). The Code is set forth in Title 26 of the U.S. Code.
(43) *See* Code § 7702B(c)(2) (defining the term "chronically ill individual" for purposes of the definition of a qualified LTC insurance contract). Historically, there was debate regarding whether LTC insurance should receive accident and health (A&H) insurance tax treatment (where benefits are excludable from taxable income and premiums may be deductible in calculating taxable income) or whether such insurance should be treated less favorably due to the personal, nonmedical care features of such insurance (e.g., the covering of room and board expenses). This debate was resolved by the enactment of the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), with respect to qualified LTC insurance, which prescribed A&H insurance tax treatment for such insurance. See HIPAA § 321. The benefit triggers used under Code § 7702B(c)(2) are designed to protect the federal fisc, i.e. a contract will fail to be qualified LTC insurance if it permits any insurance benefits to be paid in circumstances where the insured is not chronically ill.
(44) *See* PHSA § 3210 (regarding tax treatment of the CLASS program).
(45) The Internal Revenue Service has specified safe-harbor definitions for the terms "severe cognitive impairment," "substantial supervision," and

"substantial assistance" as those terms are used in the definition of a qualified LTC insurance contract. *See* IRS Notice 97-31, 1997-1 C.B. 417.
(46) PHSA § 3203(a)(1)(C)(i).
(47) Code § 7805. *See also* Code § 7702B(g)(2)(B)(iii) (stating that the interpretation of certain consumer protection requirements imposed by cross-reference to certain provisions of the January, 1993 Long-Term Care Insurance Model Act and Model Regulation, as promulgated by the National Association of Insurance Commissioners, shall be made by the Secretary of the Treasury).
(48) PHSA § 3203(a)(1)(C).
(49) Code § 7702B(c)(2)(A)(i).
(50) PHSA § 3205(c)(6).
(51) Code § 7702B(c)(2)(A).
(52) PHSA § 3203(a)(1)(C)(iii).
(53) Code § 7702B(c)(2)(A)(ii).
(54) PHSA § 3203(a)(1)(C)(iii).
(55) Code § 7702B(c)(2)(A)(ii).
(56) PHSA § 3205(a)(2)(A)(i).
(57) PHSA § 3205(a)(2)(B).
(58) *Id.*
(59) PHSA § 3205(a)(2)(D).
(60) PHSA § 3205(a)(2)(C).
(61) PHSA § 3203(a)(1)(D)(i).
(62) PHSA § 3205(b)(1). The CPI-based increases in the $50 average benefit level are similar to CPI-based inflation protection under private LTC insurance. Unlike private coverage where typically a purchaser has the choice whether to include inflation protection, the CLASS program's inflation protection is mandatory.
(63) PHSA § 3203(a)(1)(D)(iii).
(64) PHSA § 3203(a)(1)(D)(iv).
(65) PHSA § 3203(a)(1)(D)(ii).
(66) *See, supra,* notes 32, 36, and 37 and the accompanying text regarding individuals who are eligible to enroll in the CLASS program under PHSA section 3204(c).
(67) PHSA § 3204(a)(1).
(68) PHSA § 3204(b). An individual may elect to opt out of the CLASS program at any time in such form and manner as the Secretary of HHS and the Secretary of the Treasury may prescribe. *Id.*
(69) PHSA § 3204(a)(2). Such procedures also shall ensure that an individual is not automatically enrolled in the CLASS program by more than one employer. *See* PHSA § 3204(a)(3)(A). In addition, the Secretary of HHS otherwise has authority to prescribe regulations regarding enrollment in order to ensure ease of administration. PHSA § 3204(a)(3)(B).
(70) PHSA § 3204(e)(1).
(71) PHSA § 3204(e)(2).
(72) PHSA § 3204(g)(1).
(73) PHSA § 3204(g)(2).
(74) PHSA § 3205(a)(1).
(75) PHSA § 3205(c)(1)(A). The Secretary of HHS will establish procedures to allow access to a beneficiary's cash benefit by an authorized representative of the eligible beneficiary. PHSA § 3205(c)(2). Also, the cash benefit is paid beginning with the first month in which an application for such benefits is approved. PHSA § 3205(c)(3).
(76) PHSA § 3205(c)(1)(B). The applicable period for determining the annual benefit is the 12-month period that commences with the first month in which the beneficiary began receiving such benefits and each 12-month period thereafter. PHSA § 3205(c)(5)(A). Also, the Secretary of HHS will establish procedures to address circumstances where an eligible beneficiary's functional status changes before the end of the 12-month period. PHSA § 3205(c)(5)(B).
(77) PHSA § 3205(c)(1)(C). In authorizing these debit card-accessible accounts, the statute refers to an "account" rather than to the life independence accounts, and thus there is some question whether they are one and the same and, if not, how they relate to one another.
(78) PHSA § 3205(c)(1)(D)(i).
(79) PHSA § 3205(c)(1)(D)(ii)(I). Similar rules apply to individuals receiving benefits under Medicaid for PACE (Programs of All-Inclusive Care for the Elderly) program services that are governed by § 1934 of the Social Security Act. See PHSA § 3205(c)(1)(D)(iii).
(80) PHSA § 3205(c)(7). Similarly, PHSA § 3205(f) provides that CLASS program benefits shall be disregarded for purposes of determining or continuing a beneficiary's eligibility for receipt of benefits under any other federal, state, or locally funded assistance program.
(81) PHSA § 3205(c)(4).
(82) PHSA § 3205(c)(5)(C).
(83) PHSA § 3205(c)(6).
(84) PHSA § 3205(g).
(85) With respect to the scope and intended purpose of the CLASS Act, PPACA § 8002(f) states that nothing in the CLASS Act, or the amendments made by the CLASS Act, is intended to replace or displace public or private disability insurance benefits, including such benefits that are for income replacement.
(86) PHSA § 3205(c)(1)(B) and 3205(c)(4).
(87) PHSA §§ 3205(c)(4) and 3205(c)(5)(C).
(88) PHSA § 3205(d) and (e).
(89) PHSA §§ 3205(b)(4) and 3203(b)(2). *See, supra,* note 12.
(90) PHSA § 3203(b)(1)(A).
(91) PHSA § 3203(b)(1)(B)(i). It is not clear how the 20-year solvency requirement relates to the 75-year solvency requirement for premium adequacy.
(92) *Id.*
(93) PHSA § 3203(b)(1)(B)(ii).
(94) PHSA § 3203(b)(1)(D).
(95) PHSA § 3203(b)(1)(C)(i).
(96) PHSA § 3203(b)(1)(C)(ii)(I).
(97) PHSA §§ 3202(6)(A)(ii) and 3203(b)(1)(C)(ii)(II).
(98) PHSA § 3203(b)(1)(E).
(99) PHSA § 3208(b).
(100) *Id.*
(101) As discussed above, premiums are determined based on a 75-year solvency projection (see PHSA § 3203(a)(1)(A)(i)), and if necessary premiums are recalculated based on a 20-year solvency projection (see

PHSA § 3203(b)(1)(B)(i)). Also, the board of trustees of the CLASS Independence Fund must annually report to Congress on the actuarial status of the CLASS Independence Fund, and such report must include an actuarial opinion by the chief actuary of the Centers for Medicare & Medicaid Services certifying the appropriateness of the techniques, methodologies, and assumptions used. PHSA § 3206(c)(2)(B)(i)(III) and (IV). *See also* PHSA §§ 3206(c)(2)(A)(iii) and 3206(c)(2)(C) (imposing additional solvency-related requirements on the board of trustees); PHSA § 3208(a) (requiring the Secretary of HHS to consult regularly with the board of trustees and the CLASS Independence Advisory Council to ensure that premiums are adequate to maintain the financial solvency over the 20- and 75-year periods); and PHSA § 3208(d) (requiring the Secretary of HHS to provide annual reports to Congress beginning in 2014 that address, *inter alia,* solvency). Note that PHSA § 3208(a) appears to have a typographical error, in that it refers to PHSA §§ 3202(a)(1)(A)(i) and 3202(b)(1)(B)(i) (which do not exist) but should refer to PHSA §§ 3203(a)(1)(A)(i) and 3203(b)(1)(B)(i).

(102) PHSA § 3208(c).

(103) For most individuals, CLASS program premiums will be deductible under Code § 213 only if they itemize deductions, and then only to the extent eligible LTC premiums (as defined in Code § 213(d)(10)) together with other medical care expenses exceed 10% of the individual's adjusted gross income (7.5% through 2016 for certain individuals over the age of 64). *See* Code § 213(a), as amended by PPACA § 9013 (effective for taxable years beginning after December 31, 2012) and Code § 7702B(a). Also, self-employed individuals generally may deduct eligible LTC premiums under Code § 162(l), but not in an amount in excess of such individual's earned income. For these purposes, CLASS program premiums generally should be considered as eligible LTC premiums to the extent they do not exceed the age-based limits set forth in Code § 213(d)(10).

(104) Code §§ 106(a) and 7702B(a).

(105) Code §§ 104(a)(3), 105(b), and 7702B(a).

(106) Rev. Proc. 2009-50, 2009-45 I.R.B. 617, 624. Presumably, the Secretary of HHS will provide Form 1099-LTC statements to beneficiaries reporting any per diem benefits.

(107) PPACA § 8002(b).

(108) PPACA § 8002(c). On June 16, 2010, the Secretary of HHS recently solicited nominations for this panel through a notice published in the *Federal Register;* such nominations were required to be received by June 18, 2010. 75 *Fed. Reg.* 34140 (June 16, 2010).

(109) PPACA § 8002(d).

(110) PPACA § 8002(e).

(111) PHSA § 3203(a)(3).

(112) *See,* e.g., AAA-SOA Analysis, at 6 (citing a July 2009 *Broker World* survey authored by Claude Thau and Robert Darnell, which indicated that the average daily benefit under private LTC insurance is approximately $165 per day). *See also* "Critical Issues in Health Reform: Community Living Assistance Services and Supports Act," American Academy of Actuaries (Nov. 2009), available at www.actuary.org/pdf/health/class_ nov09.pdf (the "Nov. 2009 AAA Analysis"), which describes average costs for LTC.

(113) CMS PPACA Actuarial Report, at p. 15. Similarly, the AAA-SOA Analysis, at pp. 1-2, stated: "There is considerable risk of adverse selection, which could necessitate future increases in premiums or reductions in benefits to maintain a sustainable program. As these changes are introduced there is a significant potential for increased adverse selection, necessitating further changes, which may make the program unsustainable." *See also* the Nov. 2009 AAA Analysis.

(114) While we've identified three groups of individuals with differing ages and other characteristics, our subdivisions are necessarily somewhat arbitrary. In individual circumstances, the perspective of a 62-year-old, for example, may align more with our discussion of individuals over age 65.

(115) As noted above, the CMS PPACA Actuarial Report, at pp. 14-15, stated that an estimated $240 per month average premium would be required to adequately fund CLASS program costs. The ultimate premium imposed will of course depend on the details of the CLASS program as adopted.

(116) PHSA § 3203(c)(3).

(117) PHSA § 3202(6)(A)(ii).

(118) CMS PPACA Actuarial Report, at p. 15.

(119) Note that certain institutionalized individuals currently on Medicaid generally are not permitted to enroll in the CLASS program. *See, supra,* note 36 and the accompanying text.

(120) *See, supra,* notes 38 and 39 and the accompanying text (discussing the SOA Study's findings regarding a substantially increased rate of mortality for chronically ill individuals).

(121) If premiums were set too high, this would create an even greater incentive for insurable individuals to forgo participation in the CLASS program. This, in turn, would mean that even higher premiums would be needed to appropriately fund CLASS program benefits (since the average enrollee would be less healthy), which again in turn would increase the incentive of insurable individuals to forgo participation, and so on and so on. This premium spiral is a known consequence of substantial adverse selection.