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Bringing CLASS to Long-Term Care
Through the Affordable Care Act



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Bringing CLASS to Long-Term Care

Robert B. Hudson, Editor

In an enormously important yet widely unrecognized development, passage of President Obama's health care reform legislation included major provisions centered on long-term care, including the Community Living Assistance Services and Supports program (the CLASS Act). To a world dominated by Medicaid payments to institutional providers, the CLASS Act introduces a publicly administered social insurance program for long-term care. Individuals enrolled in the program no longer will have to be demonstrably poor or spend themselves into penury to receive long-term care protection. They also will be free to elect the community-based care that the vast majority of long-term care recipients prefer. In theory, and hopefully in practice, the CLASS Act will provide meaningful protection against chronic and disabling conditions for middle-class Americans. There are significant limits to the program that may be seen as rendering the CLASS Act "social insurance light," but to see public long-term care insurance come into existence against all odds is a stunning occurrence in its own right.

With the generous support of The SCAN Foundation, *Public Policy & Aging Report* is pleased to publish the first detailed accounts of the CLASS Act and other long-term care initiatives that emerged from the Affordable Care Act (ACA). The following articles by Lisa Shugarman (from The SCAN Foundation), Joshua Wiener (RTI International), Walter Dawson (Oxford University), Barbara Manard (American Association of Homes and Services for the Aging), Anne Tumlinson and colleagues (Avalere Health), Rhonda Richards (AARP), and Kathryn Roberts (Ecumen) recount the laborious process that led to realization of the long-term care provisions found in ACA, analyze the key provisions of the legislation, and explore hurdles that are certain to be encountered during program implementation.

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Disclaimer: Statements of fact and opinion in these articles are those of the respective authors and contributors and not of the National Academy on an Aging Society or The Gerontological Society of America.

Health Care Reform and Long-Term Care: The Whole is Greater than the Sum of its Parts

Lisa R. Shugarman

Health care reform is about so much more than covering the uninsured. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) lays the groundwork for wide-ranging continuum-of-care reform and establishes a framework for care coordination and a future where care is integrated across providers and settings. Currently, the continuum of care, composed of the entire realm of primary, acute, and rehabilitative medical services along with supportive long-term care services, is fragmented and unsustainable. The new health reform law presents many opportunities to improve long-term care, concurrently creating and strengthening linkages between medical care and supportive services.

This article will describe some of the key features in the ACA that will facilitate an improved continuum of care and bolster one element of the continuum, long-term care, that has been absent from previous legislative efforts. This new era of long-term care reform begins with the Community Living Assistance Services and Supports (CLASS) program, which, for the first time, provides the middle class with the opportunity to access supportive services in the settings of their choice without impoverishing themselves to Medicaid eligibility. CLASS fundamentally reframes the concept of long-term care from one of poverty, sickness, and loneliness to one of choice, community, and personal responsibility in the face of functional impairment.

Other critical reforms discussed here include: the establishment of the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office (informally known as the “Office of the Duals”), both within the Centers for Medicare and Medicaid Services (CMS). These provisions create the space to test out ideas that can lead to improvements in care coordination, including mechanisms to break through regulatory barriers and integrate funding sources, a major contributor to the fragmentation of the current system. Efforts to transform payment and delivery system models of care such as accountable care organizations, medical/health homes, and pilots to bundle payment for acute and post-acute care services also offer the promise to expand beyond a narrow medicalized scope of practice toward connecting older adults in need of long-term care to supportive services in their communities. Finally, the ACA provides funding to expand both the provider base needed to deliver long-term care services through direct care workforce investments and resources needed to help people with

disabilities navigate the long-term care system through Aging and Disability Resource Centers (ADRCs), as well as offering states incentives to expand Medicaid-funded home and community-based services (HCBS).

A Fragmented System in Need of Repair

A major challenge facing older people and adults with disabilities in the current health and long-term care systems is the fragmentation of financing, administration, and oversight of the myriad services available (Stone, 2000). The result of this division is significant. Consumers are challenged constantly to navigate the disparate medical and social care worlds, managing the different payors and providers with little or no help. The risk of poor outcomes from the quality-of-care and quality-of-life perspectives is high, with system inefficiencies leading to increased costs for the most vulnerable in our society.

Ultimately, the goal of the long-term care system is to enhance the well-being and quality of life of individuals who experience functional or cognitive limitations because of chronic illnesses, accidents, or other causes of disability. The vision of an integrated system across the continuum of care is one that is person-centered, efficient, high quality, and accessible. The ACA offers several opportunities to move toward integration across the continuum of care; the CLASS Act presents the first opportunity for the middle class to have reasonable access to long-term care services. This new offering and the other elements described below begin to move us toward the vision presented here of a well-integrated system.

CLASS – A Middle Class Opportunity

One of the major long-term care system

challenges is access to a range of services for the near poor and middle class, as eligibility for most programs is restricted to those with the lowest income levels. There are few good choices for the non-poor who need services and few tools other than private long-term care insurance to help prepare them for long-term care needs. Currently, private long-term care insurance accounts for approximately seven percent of all long-term care expenditures (Avalere Health, LLC, 2008). Given the absence of comprehensive long-term care financing, low uptake of often costly, private long-term care insurance and low savings rates among those nearing retirement, many middle-class aging boomers likely will be unable to pay for their long-term care. The few middle class protections that exist currently are only available for those in nursing homes and not for those receiving services in the community, where individuals overwhelmingly prefer to remain as they age.

A common misperception is that Medicare will pay for long-term care costs, even though the government-funded health care program for seniors only covers short-term rehabilitative care. The only way to qualify for government assistance for nursing home care or community-based services for an extended period of time is to impoverish oneself by spending down one's personal assets to Medicaid eligibility levels. Currently, about 42 percent of people in the United States age 45 and over have saved less than \$25,000 for retirement (Helman, Copeland, & VanDerhei, 2010). Middle-class Americans generally are not capable of paying \$6,000 per month for nursing home care or \$1,700 per month for part-time in-home help (Administration on Aging, 2010a). With so little saved, the middle class is particularly vulnerable, yet the startling reality is that 70 percent of Americans over 65 will need long-term care support at some point in their lives (Administration on Aging, 2010a). Such a profound level of destitution can affect spouses along with family members who might otherwise have been able to provide a helping hand. To illustrate this point further, a March poll of California voters, commissioned by The SCAN Foundation and the UCLA Center for Health Policy Research, found that, regardless of party affiliation, people are worried about long-term care costs and are unprepared to pay for these services (Lake Research Partners & AmericanViewpoint, 2010).

The CLASS program represents the beginning of

a public long-term care safety net based on a risk pool concept. It is a voluntary public insurance program for employed individuals with no exclusion for pre-existing conditions and offers a lifetime benefit for people with significant difficulty performing daily living tasks. Premiums will be age-rated, with younger people paying considerably less and older adults more. A vesting period requires enrollees to pay premiums for at least five years prior to receiving benefits. Benefits will be cash payments averaging \$50 a day and can be used to purchase a variety of supports and services, including home care, adult day programs, assisted living, or institutional care.

Some may argue that a benefit of \$50 a day does not go very far. This benefit, however, equals approximately \$1,500 a month and perhaps \$18,000 or more additional income over a year's time, which can supplement other resources to purchase services and ease the burden that caregivers often bear when working and caring for a loved one at the same time. Daily premiums provided by CLASS will offer a stable source of funding, leading to the availability of more reliable HCBS that strengthen the continuum of care.

Care Coordination in the ACA

An important part of the foundation created by the ACA for improving the continuum of care is the continued pursuit of alternate models for paying for services and organizing care through pilot testing. CMS has a rich history of testing different methods for arranging and paying for services through Medicare and Medicaid through demonstration programs. The new law builds on this approach through the Center for Medicare and Medicaid Innovation (CMI), which creates a more rapid-cycle testing environment to develop, test, and expand innovative payment and delivery models that improve quality while controlling costs. When considering in which demonstration projects to engage, the CMI will give greater weight to those projects that address the key elements of person-centered care coordination. This may include individualized assessment focusing on the needs and preferences of beneficiaries, engagement with the appropriate medical and community-based providers using a team-based approach, and centering beneficiaries and their families in the middle of the care team.

The ACA also requires the Secretary of Health and Human Services, Kathleen Sebelius, to establish

the Federal Coordinated Health Care Office. This department will bring together CMS officials to integrate more effectively Medicare and Medicaid policy structures in an effort to improve coordination between the federal and state governments for those who are dually eligible. The primary aims of this “Office of the Duals” will be to improve care continuity and support state efforts to coordinate and align acute and long-term care services for dual eligibles.

Three innovative payment models included in the ACA incentivize providers and provider organizations to improve service arrangements for vulnerable populations: Accountable Care Organizations (ACOs), Medical Homes, and post-acute payment bundling. ACOs are collaborations of providers (physician groups, hospitals, nurse practitioners, and other providers). Those that meet both quality of care targets and reduce patient care costs through better service coordination will be eligible to share in the savings accrued to the Medicare program. This shared savings approach challenges the inpatient and outpatient providers to work together instead of engaging in “cost-shifting” behavior. The ACA also establishes a medical home program for Medicare beneficiaries with chronic conditions and offers states the option to enroll Medicaid beneficiaries in health homes. Medical/health homes are models that include a “whole-person orientation” for coordination and responsibility of an individual’s full array of health care services using a team-based approach. In its most enlightened iteration, the medical/health home also includes direct connections to supportive services recognizing that even the most chronically ill individuals live in their homes and communities, not in their doctors’ offices. Finally, payment bundling across acute and post-acute care services will be implemented as a national, voluntary pilot program. The bundled payment approach pays a single payment to hospitals and post-acute care providers for care provided during a specified episode for selected conditions (in the ACA, there are 10 conditions that have been identified to be used in determining which episodes will be eligible for the bundled payment). This model obliges acute and post-acute care providers to work together and coordinate across care settings to improve patient outcomes (i.e., reducing preventable hospitalizations) and to control overall costs of care.

Rounding out care coordination efforts in the ACA are the Community-Based Care Transitions

and Independence at Home demonstrations. The Community-Based Care Transitions program provides grants to communities seeking to improve Medicare beneficiaries’ experiences of returning home following a hospital or rehabilitative stay. Successful applications for these grant dollars must include a consortium of community-based service providers working in collaboration with hospitals and/or nursing facilities to implement an evidence-based care transitions intervention. As gerontologists know all too well, social and environmental challenges at home following an acute care stay can lead to re-hospitalization just as easily as through poor medication reconciliation (Coleman, Smith, Raha, & Min, 2005; Fu, Liu, & Christensen, 2004). For individuals who are home bound and have great difficulty visiting their doctors’ offices, the Independence at Home demonstration will support physician-led interdisciplinary team care in the home environment.

Expansion of HCBS

The ACA contains several provisions allowing states to expand HCBS offerings under Medicaid by offering new benefits under their Medicaid State Plans and creating financial incentives through increased Medicaid federal matching rates for these services.

Community First Choice. The ACA establishes a new Medicaid state plan option for states to offer community-based attendant services and supports to those beneficiaries meeting the state’s criteria for nursing facility eligibility. States that choose this option will receive a six percentage point increase in their Federal Medicaid Assistance Payments (FMAP – the federal government’s share of the Medicaid program). Not only will the Community First Choice option cover the costs of personal attendant services and supports, but it will allow states to use funds to cover the costs of community transition supports (e.g., rent/utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies) for institutionalized individuals who meet the eligibility criteria and wish to return to the community.

Medicaid Home and Community-Based Services State Plan Option. The Deficit Reduction Act of 2005 allowed states to amend their Medicaid state plans to add HCBS as an optional benefit (authorized as section 1915(i)). Since its inception, few states have opted for the 1915(i) state plan option because of several programmatic limitations. Unlike the eligibility criteria

afforded 1915(c) waiver programs that allow states to enroll individuals with incomes up to 300 percent of SSI, the 1915(i) had more stringent income eligibility criteria and thus states could not expand this program in ways that were meaningful to their residents. The ACA revises the 1915(i) option by allowing states to enroll Medicaid beneficiaries into HCBS with incomes up to 300 percent of SSI and permits states to extend the full range of Medicaid benefits to those receiving services through the state plan option. Additionally, the law now requires “statewideness” of services under this state option, meaning all who are eligible for services must have access as well.

Money Follows the Person (MFP). Also established in the Deficit Reduction Act of 2005, the Money Follows the Person demonstration provided opportunities for Medicaid beneficiaries residing in nursing facilities for at least six months to return to the community if they so wished. For the year of the transition back into the community, the state’s FMAP increases to provide necessary services to the beneficiary. The ACA extends the MFP demonstration through September 2016, and shortens the requirement for residency in a nursing facility from six months to 90 days.

State Balancing Incentive Payments Program. The ACA offers new financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into HCBS. Eligible states will be those that spend less than 50 percent of their total long-term care expenditures on HCBS. Qualifying states will receive an enhanced FMAP; those that spend less than 25 percent of their total long-term care budgets on HCBS will receive a five percentage point increase in their FMAPs for related services, and those that spend 25 percent to less than 50 percent of their total long-term care budgets on HCBS will receive a two percentage point FMAP increase. States are permitted to increase the income eligibility standards for those seeking HCBS. States choosing to participate in the Balancing Program will be required to establish a “single entry point – no wrong door” system to make it easier for beneficiaries to access services. These states also must have case management services for the eligible beneficiaries and their caregivers particularly to be used when developing care plans for those transitioning out of nursing facilities back into the community.

Other Related Provisions. Currently, states offer *spousal impoverishment protections* to the

spouses of individuals residing in nursing facilities so that the community-residing spouse does not him/herself become impoverished to meet Medicaid eligibility requirements. The ACA now extends this same protection to the spouses of those residing in the community and receiving Medicaid-funded HCBS. *Aging and Disability Resource Centers (ADRCs)* serve as a single point of entry into the array of services available in the long-term care system. The Administration on Aging (AoA) and CMS have funded one or more ADRCs in almost every state to support consumers’ efforts to navigate through the variety of long-term care services available (Administration on Aging, 2010b). The ACA appropriates additional funds and extends the ADRC program through 2014, which will enable the program to expand and be accessible to more people and help in improving care coordination for seniors and younger people with disabilities.

Support for the Direct Care Workforce

An integrated system cannot exist without a workforce to care for the population in need. In particular, there is a clear demand for a labor force that is trained appropriately to address the concerns of older adults. Building on recommendations from the Institute of Medicine’s report *Retooling for an Aging America* (Institute of Medicine, 2008), ACA allows for grants to encourage a career path for the existing direct care workforce and calls for the establishment of improved training for the next generation of direct care workers. The grants will offer tuition support for individuals already working in long-term care settings (e.g., nursing homes, assisted living, and home and community-based settings) and will require as a condition of receipt of funds that participating individuals agree to work in geriatrics, disability services, long-term services and supports, or chronic care management for at least two years following completion of advanced training.

The ACA also requires Secretary Sebelius to establish demonstration programs in up to six states for the purposes of developing core competencies, pilot training curricula, and certification programs for personal and home care aides. The core competencies prescribed by the ACA that must be included in these demonstration programs include training to be sensitive to the needs of different populations—seniors, younger disabled populations, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs.

Bringing it Back to CLASS

So what do all of these other health care reform components have to do with CLASS? These components represent the building blocks of a continuum of care that are necessary for those individuals who become eligible to draw down benefits under the CLASS program. Otherwise, disabled adults would be enriched with purchase power for needed long-term care services but would still have the same broken system to navigate. It is quite possible that the services they need and prefer would not be available without these accompanying elements that will help transform our current system into one that is better coordinated and integrated for tomorrow.

Through the implementation of the initiatives to improve care coordination, the support for efforts to grow the needed direct care workforce, and the expansion of home and community-based services under Medicaid, a new system can be created that is truly greater than the sum of its parts. It is a system that will better be able to absorb the new and likely substantial demand for long-term care services created by a population that will grow exponentially in the next 20 years as a result of the aging of the boomer population. Although it is far from perfect, the new health care reform law is an opportunity to transform care, and supports a vision that is person-centered, accessible, affordable to all, and offered in the most appropriate and preferred settings.

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What Does Health Reform Mean for Long-Term Care?

Joshua M. Wiener

The enactment of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) and the Health Care and Education Reconciliation Act (HCERA, P.L. 111-152) marks an historic moment in the reform of the American health care system. Although the two pieces of legislation focus on providing medical insurance to the uninsured and controlling acute care costs, PPACA addresses several major issues in long-term and post-acute care, including lack of health insurance among direct care workers, the inadequacy of the financing system, the lack of home and community-based services, the absence of care coordination, and poor-quality care. The inclusion of the Community Living Assistance Services and Supports (CLASS) Act in PPACA is especially notable, given the intractability of financing reform in long-term care.

Health Insurance for Direct Care Workers and Low-Income People with Disabilities

The most overlooked impact of health reform on long-term care are provisions that will provide health insurance to direct care workers, such as certified nursing assistants, home health aides, and personal care attendants, and to low-income people with disabilities. In 2008, approximately 800,000 direct care workers did not have health coverage, including approximately one-fifth of certified nursing assistants and one-third of personal and home care aides (PHI, 2010). Only about half of direct care workers have employer-based coverage. About 12 percent of people with disabilities are uninsured.

Although the new health reform law does not include an employer mandate per se, employers with more than 50 workers will have to pay a penalty if any employee receives a premium tax credit; the fee is higher if the employer does not offer health insurance. No penalty is imposed on employers for employees who enroll in Medicaid; nor is a fee imposed for failure to offer health insurance to part-time employees. In 2008, 53 percent of personal and home care aides worked part time or full time for only part of the year.

With the exception of people for whom health insurance is too expensive relative to their income, individuals not receiving health insurance through their employers are required to obtain health coverage through Medicaid or the newly formed health insurance exchanges. Currently, although there is some variation by state, Medicaid generally excludes nondisabled adults with no children, people with income above the federal poverty line, and those with more than \$2,000 in financial assets. Under health reform, all people below age 65 with income below 133 percent of the federal

poverty level will be eligible for Medicaid. Even under current rules, almost one-quarter of certified nursing assistants working in nursing homes are enrolled in Medicaid (Squillace, Remsburg, Harris-Kojetin, Bercovitz, Rosenoff, & Han, 2009). Some low-income people with disabilities who continue to work or do not qualify for Supplemental Security Income also will become eligible for Medicaid through this new pathway. Older people are excluded from the new provisions because they are eligible for Medicare.

Workers not obtaining health insurance through their employer, Medicaid, or the health insurance exchanges must pay a penalty. To make policies affordable, tax credits will be available to people with incomes between 133 and 400 percent of the federal poverty level. In addition, cost-sharing subsidies will protect people below 400 percent of the federal poverty level from high out-of-pocket costs for deductibles and coinsurance.

CLASS Act

Championed by Senator Ted Kennedy, the CLASS Act is a voluntary public insurance program for long-term care that was incorporated into PPACA. Medicare does not cover long-term care and Medicaid requires people to be poor or become poor paying for health and long-term care before it provides assistance. Only about 10 percent of the older population and less than one percent of the nonelderly adult population have private long-term care insurance. Although the CLASS Act has the potential to change radically long-term care financing over time, it received little attention during the health reform debate and few people outside of a handful of experts know about it.

The CLASS Act draws heavily on the German

and Japanese long-term care insurance programs. Unlike most private long-term care insurance policies, it does not require medical underwriting. In addition, benefits are provided on a lifetime basis rather than for a fixed number of years or expenditure level; this feature will be attractive to younger persons with disabilities who could receive benefits for decades. Only working people are eligible to enroll. After paying premiums for at least five years, enrollees who meet the disability benefit criteria will receive a regular cash payment to help meet their long-term care needs. The exact level of disability needed to obtain benefits is left to be determined by the Secretary of Health and Human Services. In order to receive benefits, however, the Secretary must set a standard that includes: (1) limitation in at least two or three activities of daily living (ADLs), (2) substantial cognitive impairment, or (3) an impairment equivalent to these two disability levels.

The initial average benefit will be no less than \$50 a day, but will vary by level of disability, with people with more severe disabilities receiving a higher payment and people with less severe disabilities receiving a lower payment. Although this payment level has been criticized as inadequate, it is about twice what Medicaid spends per year on beneficiaries in home and community-based services waivers. In addition, it provides an opportunity for private insurers to offer supplemental coverage for nursing home care. The legislation requires that there be between two and six benefit levels, but does not specify exactly how many nor what the cash benefits will be for each level. Germany established three basic benefit levels for its public long-term care insurance program and Japan has seven levels. Implementation of the CLASS Act also may draw on the experience of Medicaid programs, which routinely link disability levels to specific expenditure levels as part of the care planning process.

Unlike public insurance programs in countries such as Japan, Germany, and The Netherlands, CLASS does not require that everybody participate. Thus, the program is subject to adverse selection that could drive up the cost of premiums and potentially create an insurance death spiral. Without medical underwriting to exclude them, people with disabilities who need long-term care may enroll disproportionately in the program. To the extent that people who are not disabled do not enroll, the program's ability to spread

the costs of people using benefits across a broad population will be limited and premiums will rise, potentially causing nondisabled people to disenroll.

The CLASS Act attempts to lessen adverse selection through the following strategies:

- Enrollment is limited to people who work; retirees and people with disabilities who are not working cannot enroll. Using a definition of disability much broader than used to qualify for benefits in the CLASS program, only 19 percent of people with disabilities were working in April 2010 (U.S. Bureau of Labor Statistics, 2010). Thus, most people with disabilities are excluded from receiving benefits from the program.
- For employers who agree to administer payroll deductions, all workers will be enrolled automatically. Individuals who do not want to enroll may opt out, but they must decide actively to do so. This approach draws on behavioral economics research on participation in 401(k) retirement plans that found that enrollment rates were much higher when employees were required to opt out rather than opt in.
- To discourage people from waiting until they are disabled to enroll, enrollees must pay premiums for five years before they are eligible to receive benefits. In addition, premiums must continue to be paid after the five-year period. Thus, the requirement is more akin to a waiting period than a vesting period for a 401(k) plan.

Financing for the CLASS Act is entirely from premiums paid by enrollees, which may vary by age, as determined by the Secretary. There are subsidies to encourage enrollment for working full-time students and working people with incomes below the federal poverty level who initially will pay only \$5 per month. These subsidies are financed by other enrollees, not by federal general revenues. This subsidy by people who are enrolled in the insurance plan may raise substantially the premium for people who are not low-income or students.

Setting the premiums is a classic “chicken-and-egg” problem. If actuaries assume that large numbers of people, including substantial numbers of people without disabilities, will enroll (or not disenroll), then premiums will be relatively low and large numbers of people, including those without disabilities, are likely to enroll. Advocates for the CLASS Act point to the near universal enrollment in Medicare Part B (largely physician services) and Part D (prescription drugs) as evidence that enrollment levels will be high for the CLASS Act. Conversely, if actuaries assume that relatively few nondisabled people will enroll and that most people with disabilities will enroll, then premiums will be high and few people, especially those without disabilities, will enroll. Premium estimators who argue this position note that voluntary enrollment in private long-term care insurance policies in employment settings is low, with generally only about five to seven percent of workers enrolling.

Premium estimates developed during the health reform debate assumed low levels of enrollment, resulting in high average premiums ranging from \$123 to \$240 per month (American Academy of Actuaries, 2009; Foster, 2009; U.S. Congressional Budget Office, 2009). The SCAN Foundation and Avalere Health’s (2010) premium simulator estimates average premiums for a voluntary long-term care social insurance program with some characteristics similar to the to the CLASS Act to be three times which the premiums would be for a mandatory program in which everyone participated. Active marketing of the CLASS insurance program will be critical to the program’s success, as will convincing actuaries that a high proportion of eligible workers will enroll. The initial premium might create a self-fulfilling prophecy that could determine the program’s success or failure.

The combination of the five-year minimum enrollment and the limitation of enrollment to the working population mean that the program will start off collecting far more in revenue than it pays out. As a result, the U.S. Congressional Budget Office scored the CLASS Act as reducing the deficit by \$70.2 billion over the period 2010 to 2019 (U.S. Congressional Budget Office, 2010a), including a modest level of Medicaid savings. CLASS would begin to add slightly to the deficit after 2029 because the benefit payments made in those years would exceed the premiums collected in those years. The law requires the program to be fully self-financing over 75 years.

Promoting Medicaid Home and Community-Based Services

The most common critique of the long-term care delivery system is its institutional bias. Despite the strong preference of people to remain in their homes as they age, current spending for long-term care for older people and younger adults with physical disabilities is mostly for nursing home care. Only 32 percent of Medicaid long-term care expenditures for this population were for noninstitutional services in 2008 (Thomson Reuters, 2009).

States rely largely on Medicaid home and community-based services (HCBS) waivers to finance their expansion of noninstitutional services. These waivers allow Medicaid to cover a very broad range of services and to include people with slightly higher (although still low) income levels than are normally allowed. The waivers also give states strong fiscal control over expenditures by requiring that eligibility be limited to people who need nursing home care, mandating that average expenditures do not exceed the cost of nursing home care, and allowing states to limit the number of beneficiaries who receive services, a practice not permitted in the regular Medicaid program. The federal government exercises higher levels of administrative oversight on waivers than on regular Medicaid services, which some states view as burdensome.

The health reform law includes several additional options to cover Medicaid home and community-based services and, in some cases, provides states with a financial incentive to do so:

- *State Balancing Incentive Payments Program:* States planning to increase their percentage of long-term care expenditures for HCBS may apply to receive a time-limited (2011-2015) increase in their federal Medicaid match. The higher match is limited to states that spend less than 50 percent of their Medicaid long-term care expenditures on home and community-based services. In addition to specifying how they will increase their proportion of spending for HCBS, states must establish (1) a single point of entry to long-term care services, (2) “conflict-free” case management, and (3) standardized assessment instruments for determining

eligibility for HCBS. The legislation does not specify penalties for failure to meet the HCBS expenditure targets.

- *Community First Choice Option—Medicaid State Plan Option for Attendant Services and Supports:* This new state plan provision for attendant services and supports is an optional, less expensive version of the long proposed, but not enacted Medicaid Community Attendant Services Act. It covers a broad range of services, including those often needed to transition from the nursing home to the community (e.g., one month's rent deposit). Like Medicaid home and community-based waivers, eligibility is limited to people who need an institutional level of care with incomes up to 300 percent of the Supplemental Security Income payment level. Unlike Medicaid HCBS waivers, states are not required to limit average per person expenditures to less than or equal to what Medicaid spends on institutional care. Also unlike Medicaid HCBS waivers, states cannot set ceilings on the number of persons who can receive services nor can they limit benefits to subareas of the state. Services provided through this option receive a six percentage point increase in the federal Medicaid match.
- *Removal of Barriers to Providing Home and Community-Based Services:* The Deficit Reduction Act of 2005 established a new Medicaid state plan option for home and community-based services (Section 1915(i) of the Social Security Act). As enacted, the provision allows states to cover more than just personal care, but the range of services is less expansive than permitted under HCBS waivers. Unlike waivers, Section 1915(i) allows states to cover people needing less than institutional care. But, because this breaks the linkage to institutional care, states are not allowed to cover people up to 300 percent of the Supplemental Security Income payment level, the institutional financial eligibility

level in many states. The Deficit Reduction Act provision also does not allow waiver of “comparability,” thus requiring states to offer the same benefit package to all eligibles. Like Medicaid home and community-based services waivers, states can limit the number of people served. While four states adopted this option, the rest did not, presumably because they did not believe that it offered enough advantages over the regular Medicaid personal care benefit or HCBS waivers to implement it. PPACA modifies Section 1915(i) to address some of the state and consumer concerns by broadening the scope of covered services, allowing states to reach the same groups financially and functionally as HCBS waivers do, and waiving comparability. PPACA reduces fiscal controls, however, by eliminating the ability to establish enrollment caps, and it also requires statewide coverage.

- PPACA also extends Medicaid institutional spousal impoverishment protections to community-based spouses of people receiving HCBS (for the period 2014 to 2019). In addition, it authorizes additional funds for Aging and Disability Resource Centers, which provide single points of entry to long-term care services. Finally, it authorizes additional funds for and slightly modifies the Money Follows the Person demonstration, which is experimenting with transitioning people from institutions to the community.

These provisions illustrate several issues related to creating a more balanced delivery system. First, although the most direct way to expand Medicaid HCBS would be simply to mandate coverage, PPACA relies instead on providing voluntary options for the states, some with financial sweeteners. This policy of offering options rather than mandates reflects overall Medicaid policy of the past 20 years. Second, the State Balancing Incentive Payments program and the Community First Choice option (and the Money Follows the Person demonstration) provide states with financial incentives, but only if they comply with

certain requirements. From the federal perspective, the goal is to obtain behavioral change in exchange for the additional spending. Thus, the higher Medicaid match is provided only to states that commit to do more than they are doing now.

Third, the Community First Choice option and the modifications to the Section 1915(i) option showcase the tensions that exist between consumers and states on expanding home and community-based services. Consumers want statewide coverage of the widest possible range of services provided to the highest possible income group without the constraint of limiting average expenditures to nursing home levels and, especially, without the barrier of limitations on the number of beneficiaries and waiting lists. In contrast, states, while desirous of expanding home and community-based services, worry about runaway spending. In particular, given that less than a quarter of people with disabilities receive paid help (Kaye, Harrington, & LaPlante, 2010), states are concerned about large increases in use if they broadly offer services. States believe that they need the fiscal controls that consumers oppose and may not adopt options that do not provide them.

Chronic Care Coordination

People with chronic conditions and disabilities receive care in a fragmented and uncoordinated financing and service delivery system, both within and between the health and long-term care systems. Financing for acute care is largely the responsibility of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. This division creates incentives for cost-shifting and disincentives for cooperation across programs. The high rate of unplanned rehospitalizations often is offered as evidence of the failure to coordinate care (Jencks, Williams, & Coleman, 2009). Coordinated care may improve outcomes and reduce costs.

Because relatively little is known about the effectiveness of care coordination, most PPACA provisions address this issue through administrative changes within the Centers for Medicare & Medicaid Services (CMS) or Medicare/Medicaid demonstration projects. These include the following:

- *The Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation within CMS:* To

focus attention on this high-need, high-cost population, the Federal Coordinated Health Care Office is charged with improving coordination between the Medicare and Medicaid programs for beneficiaries dually eligible for both programs. The Center for Medicare & Medicaid Innovation, although charged with more than care coordination, will test innovative payment and delivery arrangements. Importantly, successful models can be implemented nationally without additional legislation.

- *Medicare Special Needs Plans (SNPs):* A continuing frustration with standard managed care organizations is that they lack expertise on people with chronic conditions or disabilities. SNPs are Medicare Advantage plans that target enrollment of beneficiaries who are dual eligibles, nursing home residents, or have chronically disabling conditions. Some SNPs provide both acute and long-term care services. PPACA reauthorizes SNPs, requires them to have contracts with both Medicaid and Medicare, authorizes a new risk adjustment payment for fully integrated plans, and requires accreditation by the National Committee for Quality Assurance.
- *Medical Home and Related Demonstrations:* Medical homes are initiatives to reinvent primary care as the main mechanism for care coordination, especially among Medicare and Medicaid beneficiaries with chronic conditions and disabilities. One provision creates a state grant program to establish community health teams charged with developing patient-centered medical homes. The law also establishes medical homes services as an option in the Medicaid program. Another provision, the Medicare Independence at Home Demonstration Program, will test the use of medical practices consisting of primary care teams of physicians, nurse practitioners, and others to coordinate care and to deliver care to chronically ill

and disabled populations in their homes. Closely allied with the medical homes, the Community Care Transitions Program demonstration will provide transition services to Medicare beneficiaries at high risk of rehospitalization or poor transitions from hospital to post-acute care.

- *National Pilot Program on Payment Bundling and Related Provisions:* PPACA establishes a pilot program to change the way that care is reimbursed for 10 specific chronic conditions. Instead of each provider being paid separately, payments for acute hospital care, physician services, hospital outpatient services, and post-acute care will be combined (“bundled”) into a unified payment paid to a single provider, who will be responsible for managing all care for that episode. This all-inclusive payment will encourage the development of formal or informal integrated health systems, but it raises questions of whether hospitals (the most likely recipient of the bundled payment) will increase or decrease the use of post-acute and long-term care. If successful, the pilot may be expanded nationwide without additional legislation. In a related provision, PPACA also imposes financial penalties on hospitals with high rates of preventable rehospitalizations, a provision that may increase pressure on hospitals to find ways to work with long-term and post-acute care providers to reduce rehospitalizations.
- *Medicare Hospice Concurrent Care Demonstration:* Under existing law, Medicare or Medicaid beneficiaries who elect hospice care must forgo curative care for their terminal illness. This requirement is believed to deter people from enrolling in hospice care. PPACA establishes a three-year demonstration that will allow patients who are eligible for hospice care to receive all Medicare-covered services.

Post-Acute Care Reimbursement

The health reform legislation finances expansion

of health insurance for the uninsured through new taxes mainly on higher-income people and through reductions in the Medicare payment rates. Post-acute care providers, including inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, and hospices, are among the providers affected. In part, post-acute care providers are targets because of their high Medicare profit margins. For example, the Medicare Payment Advisory Commission estimated that the Medicare margin for skilled nursing facilities will be 10.3 percent in 2010 and, for home health agencies, was 17.4 percent in 2008 (Medicare Payment Advisory Commission, 2010). Skilled nursing facilities have argued that they need higher Medicare payments to offset the losses they incur on Medicaid residents. For post-acute care providers, the savings from the health reform legislation are achieved primarily by reducing the annual update for inflation. Through 2019, the estimated Medicare savings for skilled nursing facilities, home health agencies, and hospice total \$61.1 billion, accounting for about 13 percent of provider reimbursement cuts (U.S. Congressional Budget Office, 2010a, U.S. Congressional Budget Office, 2010b).

In addition to the payment reductions specified in the legislation, PPACA establishes an Independent Medicare Advisory Board to address the long-range solvency of Medicare. If the increase in Medicare per capita growth rate exceeds certain targets, the new board is charged with making recommendations to reduce expenditures, and these will be implemented unless Congress enacts alternative proposals that achieve the same level of savings.

Nursing Home Quality Reforms

Despite improvements over time, poor-quality care in nursing facilities remains a continuing issue. In 2008, quality surveyors found that almost 26 percent of facilities had one or more deficiencies that caused harm or immediate jeopardy to residents (Harrington, Carrillo, & Blank, 2009).

The health reform legislation seeks to improve quality of care in nursing homes through the nursing home transparency and improvement, workforce, and pay-for-performance provisions. The nursing home transparency and improvement provisions, the first significant change to nursing home quality assurance system since the Omnibus Budget Reconciliation Act of 1987, are based on the notion that providing more information to consumers and regulators will

motivate providers to improve quality. These new provisions require that nursing homes disclose detailed information about ownership, staffing, and expenditures and implement compliance and ethics programs. In addition, the legislation mandates that CMS develop a standardized complaint form and improve the Nursing Home Compare Web site, which provides quality-of-care information about individual nursing homes.

Workforce problems, including high turnover, low levels of training, and poor organizational culture, are believed to be a major cause of poor quality care in nursing homes. To address workforce issues to improve quality of care, PPACA includes provisions for a national demonstration on culture change and use of information technology in nursing homes; permits the Secretary to require nursing homes to conduct dementia management and abuse prevention training, although it does not increase the number of required hours of training; and establishes a national program of criminal and background checks on direct care workers. The health reform legislation also establishes a grant program to address elder abuse, neglect, and exploitation.

Finally, PPACA includes many provisions that promote pay-for-performance reimbursement or value-based purchasing. This strategy provides higher reimbursement to providers that improve quality or supply high quality care. Although the pay-for-performance demonstration for Medicare skilled nursing facilities is ongoing, the legislation requires the Secretary to submit an implementation plan for this approach despite questions about the adequacy of the quality measures and whether the link to Medicare savings is appropriate.

Conclusion

While not as far reaching in long-term care as it is in medical care, the health reform legislation includes major provisions that will affect the financing and delivery of services for people with disabilities of all ages. First, the law aims to provide basic health insurance to all Americans, including direct care workers and persons with disabilities who are uninsured currently. For these populations, Medicaid expansions will play a critical role.

Second, although few observers initially thought it would survive to enactment, the CLASS Act has the potential to change long-term care financing from a welfare-based to an insurance-based system. In order

to do that, it will have to overcome the substantial risk of adverse selection. The program will have its biggest impact if large numbers of people enroll, which is likely to occur only if premiums are low. How the actuaries price the initial premiums will be critical for the initial and long-run success of the program.

Third, the legislation provides several new Medicaid options for the states to expand home and community-based services, but does not mandate that they do so. Given the financial troubles of the states and the availability of other Medicaid options, it is uncertain whether states will adopt these new options.

Fourth, the legislation includes a plethora of initiatives to improve care coordination for people with disabilities. While the focus is mostly on medical rather than long-term care, attention to people with chronic conditions inevitably leads to consideration of people with disabilities of all ages. In particular, the National Pilot Program on Payment Bundling and the Medicare Hospice Concurrent Care Demonstrations have the potential to fundamentally alter how the Medicare home health, skilled nursing facility, and hospice benefits operate.

Fifth, post-acute care providers will have their Medicare reimbursement trimmed substantially, which will provide savings to be used to finance expansion of health care for the uninsured. The Medicare business likely will remain profitable, but margins will be reduced.

Sixth and finally, the nursing home quality reforms will provide additional information that will be useful for regulators and consumers in monitoring and assessing providers, but will not change substantially the current system of quality assurance.

Looking to the future, additional changes, both big and small, are inevitable in the new framework established by this year's legislation. A new world of health and long-term care policy is just beginning.

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The CLASS Act and Long-Term Care Policy Reform: A Perspective

Walter D. Dawson

In the American public policy arena, long-term care generally is considered to be subsumed within health policy. While the need for health care reform has received considerable attention over the years, long-term care (LTC) has generated less interest in the public realm. Even when LTC reform was discussed,¹ any substantial change either was lost in the political fray or resulted in incremental change only. This disparity in public attention remained constant even as Congress debated and eventually passed comprehensive health reform earlier this year.

The provision of LTC is increasingly a public policy issue in all advanced industrialized countries of the world, driven by demographic changes as well as several societal transformations. The United States is no exception as it struggles with the challenges posed by an increased need for long-term services and supports (LTSS). Long-term care is defined as the services and supports needed when the ability to care for oneself has been reduced by chronic illness, disability, or aging (Miller, Ranji, Hisey, & Salganicoff, 2007). LTC includes services such as feeding, bathing, dressing and help with other activities of daily living (ADLs) or instrumental activities of daily living (IADLs) such as housekeeping that are difficult or impossible to carry out due to illness or disability.²

Long-term care is a particularly relevant topic given the aging of the baby boom generation. In 2009, it was estimated that there were 38.8 million Americans over the age of 65 in the United States (Kinsella & He 2009). The U.S. Census Bureau projects that by the year 2030, nearly one in every five Americans will be age 65 or older. This age group is projected to increase to 89 million people by 2050 (U.S. Census Bureau, 2009). The projected demographic changes will add further strain to an already overburdened system, particularly related to its ability to provide and finance care.

Large numbers of Americans currently require LTC and the costs associated with the provision of LTC services are exceedingly high. Recent estimates show that approximately 10 million Americans require LTC (Kaye, Harrington, & LaPlante, 2010). Sixty-nine percent of Americans over age 65 will need some form of long-term care before they die and almost one-third of the entire U.S. population will spend some time in a nursing home during their lifetime (Weiner,

2009). Yet not all people who rely on these services and supports to help carry out their ADLs are elderly. Elder Americans account for approximately 58 percent of those in need of LTC while those under 65 make up the other 42 percent (Feder, Komisar, & Friedland, 2007). While the need for LTC becomes more likely as a person ages, this need transcends age to include people born with disabilities or who become disabled at any age due to accident or illness.

Approximately 70 percent of Americans 65 years or older who rely on long-term care receive services in a home- or community-based setting, compared to 30 percent who receive care through an institutional setting (Colello, 2007). The use of home and community-based services (HCBS) has grown in popularity in recent years. A survey sponsored by The SCAN Foundation showed that approximately 92 percent of Americans would prefer to receive care in their own homes rather than in institutional settings (Lake Research Partners, 2009). At the moment, HCBS often are not a financially viable option for people who need LTC.

The LTC financing system in the United States is both fractured and highly inequitable. LTC is financed through a patchwork system that includes the government programs of Medicaid and Medicare, but also considerable out-of-pocket expenditures and private insurance. Approximately 50 percent of all LTC spending takes place through Medicaid, while Medicare accounts for about 20 percent (U.S. Department of Health and Human Services, 2010). Out-of-pocket expenditures make up another 18 percent, while seven percent comes from private insurance and five percent from other sources. The national median cost of a private room in a nursing home in 2010 was \$206 a day or \$75,190 annually, while a bedroom in an assisted living facility cost

\$3,131 a month or \$37,572 annually, and the average hourly cost of in-home care provided by a home health aide averaged \$19 an hour or \$43,472 annually (Genworth Financial, 2010). As a nation, the United States spent \$206.6 billion on LTC in 2005 (U.S. Department of Health and Human Services, 2010). The real costs of LTC, however, are difficult to estimate precisely as many services are provided informally (and unpaid) by family or friends. Estimates of the costs of informal, unpaid care range as high as \$375 billion (Houser & Gibson, 2008). The cost of LTC is projected to more than double over the next 40 years as the U.S. population ages (Allen, 2005). Given the high cost of care and the projected demographic changes ahead, the current LTC financing system is unsustainable. Yet despite the obvious need for a comprehensive LTC policy that more adequately meets the needs of all Americans, reform has remained elusive until now.

The Community Living Assistance Services and Support Act (CLASS Act) that passed Congress earlier this year as a part of comprehensive health reform is a way to address some of the systemic issues mentioned here. CLASS is also a way to provide LTC consumers greater choice and control over their care. The CLASS Act amends the existing Public Health Service Act (PHSA) to establish a national voluntary disability insurance program for the purchasing of community living assistance services and supports. While CLASS is not a comprehensive fix for all the problems of the LTC financing system, it is the first major change to LTC policy financing in over four decades. As such a groundbreaking piece of legislation in the field of LTC policy, it is interesting to look at how this piece of legislation became law.

The Development of CLASS

In his campaign for President, Barack Obama made comprehensive health reform a top domestic policy priority. President Obama's election and a return of large Democratic majorities in both chambers of Congress ensured that comprehensive health reform would be at the top of the domestic policy agenda. But addressing health reform did not necessarily mean that LTC reform would be included. The general consensus was that health reform and LTC reform would be addressed separately, with health reform taking precedence due to the sheer numbers of the uninsured and the ballooning costs of care. The fact that LTC

reform and the CLASS Act were a part of the health reform legislation that passed Congress this year is highly significant since very little or no changes to LTC policy have taken place since the 1960s.

Disability issues were a concern of Senator Edward M. Kennedy's for many years. He first introduced the CLASS Act in the U.S. Senate in 2005 (S.B. 1759). Representative Frank Pallone of New Jersey then introduced a companion bill to CLASS in the U.S. House of Representatives. Both pieces of legislation, however, failed to gain enough support to reach a vote in that session or the subsequent session of Congress. But, when health reform moved to the top of President Obama's domestic agenda in 2009, CLASS was included in both the Senate and the House of Representative's plans for health care reform. How CLASS went from a standalone piece of legislation to part of comprehensive health reform and finally to law is a fascinating process.

On March 25, 2009, Senator Kennedy reintroduced the CLASS Act (S. 697) as bill in the Senate. At the time, Senator Kennedy chaired the Health, Education, Labor and Pensions (HELP) Committee, one of the committees tasked with drafting health reform legislation. As chairman of the HELP Committee, Kennedy merged the CLASS Act with the committee's health care reform legislation, "The Affordable Health Choices Act" (S. 1679). Sadly, Kennedy's illness meant that he had to relinquish his chairmanship of HELP. In his absence, Senator Christopher Dodd oversaw the committee's work on health legislation until Senator Harkin took over as the new Chair. The bill passed out of the HELP committee but never reached a floor vote. Meanwhile, the U.S. House of Representatives passed "The Affordable Health Care for America Act" (H.R. 3962) through the Energy and Commerce Committee, which included a placeholder for the HELP Committee's version of CLASS. The House went on to pass H.R. 3962 on November 7, 2009, but the Senate never voted on that bill.

The Senate always took the lead on CLASS due to Senator Kennedy and the work of his staff, particularly Connie Garner, the HELP Committee policy director for disability and special populations. Since 2005, Garner worked to build a broad coalition in support of CLASS that included groups from both the disability and aging communities as well as LTC providers. This was one of the first instances where the

aging and disability communities were able to unite in support of a single piece of legislation. The coalition group met for almost five years. Their support took the form of grassroots outreach, visits to Capitol Hill, and ads in several key Washington publications like *Roll Call*. Throughout the process, the coalition provided support to legislators and coalition members to keep up the fight for CLASS.

The peak of uncertainty over the fate of CLASS—at least publically—may have been December 4, 2009, when South Dakota Senator John Thune proposed an amendment to remove the CLASS Act from the Senate’s version of health reform, “The Patient Protection and Affordable Care Act” (H.R. 3950). The Thune amendment received a majority of votes (51), but failed to pass due to Senate rules that require 60 votes to strip language from a bill once it is on the Senate floor. The failure of Senator Thune’s amendment effectively meant that CLASS likely would become law as long as health reform passed. The Senate went on to pass H.R. 3950 on Christmas Eve, but the final vote on health reform did not take place for almost three months. After much uncertainty over how to merge the two separate bills (the House and Senate versions) and whether there were enough votes to pass it again in either chamber, the House finally passed the Senate’s bill (H.R. 3950) on March 23, 2010. The bill returned to the Senate where it was re-passed and then signed into law by President Obama on March 30, 2010.

Significant Variables

Several key people were essential to the passage of CLASS, most notably Senator Kennedy and his aide, Connie Garner. As the sponsor of CLASS and the Chairman of the Senate HELP Committee, Senator Kennedy’s impact on the legislation is significant. His long-standing interest in disability issues, but also his own illness and untimely passing played their roles. Senator Kennedy saw firsthand what people in need of LTC go through on a daily basis. After he passed away, CLASS could easily have been lost in the political fray, but his aide Connie Garner who had worked on CLASS from the beginning, as well as Senators Dodd and Harkin, picked up the torch and saw CLASS through to the end. Much credit must also go to Senate Majority Leader Harry Reid and House Speaker Nancy Pelosi who kept CLASS in health reform in the

face of much criticism. Without the support of these individuals, CLASS may never have come about.

A broad coalition of advocacy groups from both the disability and aging communities as well as providers united in support of CLASS. This is one of the few instances in U.S. history where the disability and aging communities joined together behind a single piece of legislation. The aging and disability advocacy communities often compete for the same resources and attention in the political arena given the similar needs of their constituencies. This coalition, however, divided the work load between the advocacy groups making their jobs more manageable and calling greater attention to their cause. This showed members of Congress the advocacy community’s commitment to CLASS. Their joint efforts were highly significant in ensuring that CLASS remained in health reform until the final vote.

The large budgetary surplus, originally projected at \$58 billion but eventually raised to \$70 billion by the Congressional Budget Office (CBO), also played a role in the success of CLASS.³ In a political environment where new programs must be self-sustaining or create a net cost savings for the federal government, CLASS’ projected surplus meant that it would be relatively safe from attacks as an unfunded entitlement. Critics of CLASS instead often pointed to the surplus as some sort of scheme to ensure its passage under the radar. But that is highly doubtful in terms of intent and political significance. Its five-year vesting period was a part of the CLASS legislation long before comprehensive health reform was even a possibility. Moreover, it was not the positive CBO score that was so important in the passage of CLASS, but rather the absence of a negative score.

The CLASS Program

The significance of the process through which CLASS ultimately became law does not overshadow the innovative nature of the program or its potential to help people of all ages who need long-term services and supports. The CLASS Act amends the American Public Health Service Act to establish a national voluntary disability insurance program for the purchasing of community living assistance services and support (H.R. 3950). CLASS will be open to all actively working adults, regardless of

any pre-existing conditions. In place of some form of underwriting, CLASS enrollees must be working actively and must pay premiums for at least five years to be eligible to receive benefits. Participants in need of assistance to perform their ADLs will receive a cash benefit to pay for those supportive services in a home or community setting. The benefit, however, also can be applied to traditional nursing home services, although it usually will cover only a portion of institutional costs.

Unlike Social Security or Medicare, enrollment in CLASS is voluntary. Employees will automatically be enrolled in CLASS only if their employer chooses to participate, employees may opt out of CLASS at any time. The Secretary of Health and Human Services (HHS) will establish a system of enrollment into the CLASS program for people who are self-employed or whose employer does not participate. It is hoped that the voluntary approach will ensure participation levels high enough to create a large enough risk pool for financial solvency.

The premiums for CLASS will be paid through monthly payroll deductions. The amount of the monthly premiums will vary based on a person's age at enrollment, but will be set by the HHS Secretary at a level that ensures financial solvency over 75 years. Full-time students under the age of 22 and people with incomes at or below the federal poverty level will pay monthly premiums of only \$5 (adjusted for inflation). Estimates for the average monthly premiums for everyone else vary widely from CBO's assessment of \$123 to CMS' of \$240 (Elmendorf, 2010; Foster, 2010). These contrasting premium estimates reflect different levels of projected participation in CLASS. actual premium rate, however, will not be known until the HHS Secretary determinations it next year.

CLASS will provide a cash benefit of no less than \$50 a day to purchase nonmedical services and supports that the beneficiary needs in order to carry out their ADLs (with no lifetime limit on the years or amount of benefits that can be collected). Enrollees with conditions limiting their basic life activities for more than 90 days will be eligible to receive benefits. CLASS benefits will be paid into special accounts—Independence Accounts—that enrollees will access by debit card. Additional benefits provided by the CLASS program include advocacy services as well as advice and counseling on how to coordinate their LTC.

According to the CBO, CLASS will generate a \$70 billion net surplus during the first 10 years of its operation (Elmendorf, 2010). The surplus largely will be generated by a vesting period during the first five years of the program, where no benefits will be paid out to enrollees. As the cash benefit can be used to pay for nursing home costs as well as in-home care, the CLASS Act theoretically should act as a cost saving mechanism for the Medicaid program. The CBO also projects that federal expenditures on Medicaid will drop by \$2 billion over the first 10 years because the program's cash benefit will help people avoid heavy out-of-pocket expenditures on care, postponing the spend down to qualify for Medicaid.

Conclusions

The CLASS Act represents both incremental change as well as a major departure from previous LTC policy in the United States. On the one hand, the CLASS program is small in terms of its overall costs, especially when compared to Medicare or Medicaid. Moreover, while CLASS on average will cover a majority of HCBS costs, it only will cover a small portion of institutional costs. The remaining costs will continue to be financed by the patchwork mix of out-of-pocket expenditures, private LTC insurance, and the Medicare and Medicaid programs. Nonetheless, the CLASS Act constitutes the most significant change to LTC financing arrangements since the creation of Medicaid in the 1960s. CLASS is the first national, non-means tested financing program focused solely on long-term care. It is an implicit recognition by the U.S. federal government that LTC financing is a major policy concern. The CLASS program also provides a platform from which to launch future LTC policy initiatives. In other words, CLASS opens the door to universal LTC coverage in America. The policy community should take note, as it can help indicate for future reformers what works—and what does not—in terms of the legislative process.

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Endnotes

1. For example, see the Pepper Commission Report and the Health Security Act of 1994.
2. Activities of daily living (ADLs) include bathing, dressing, eating, toileting, and transferring. Instrumental Activities of Daily Living (IADLs) include food preparation, medicine management, shopping, and housekeeping.
3. An actuarial assessment of the costs of health reform completed by the Centers for Medicare and Medicaid (CMS) on April 22, 2010, lowered CLASS's projected surplus to \$38 billion.

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Dueling Talking Points: Technical Issues in Constructing and Passing the CLASS Act

Babara Manard

Passage of the CLASS Act as part of health reform astonished many, including experts in the field, current supporters, and those who opposed it. As late as January 2009, it was seemingly true to most that “we have not seen the sustained media coverage that is necessary to create a sense of urgency about either the unmet needs or the hardships that are created by a means-tested approach to LTSS [long term services and supports]. There are few if any interest groups or foundations for which reform of LTSS financing is a top priority” (Goldberg, 2009, pp. 6-7). Even today, stories about the CLASS Act frequently begin with the phrase “a little known part of health reform,” as if it had come as an afterthought.

Getting to CLASS

The genesis of the CLASS Act with Senator Ted Kennedy and Connie Garner, initially working largely with the disability community, is described elsewhere in this issue. Specialists in aging and long-term care (LTC) may know better the long debate between those who favored an all-inclusive, tax-supported social insurance plan and those who favored relying more or totally on private long-term care insurance. In 2003, at a conference where many excellent thinkers debated the matter, economist Bill Scanlon said “after 20-some years of no progress in the area of financing it would really be good to think creatively.” He noted that “much of our discussion about long-term care has always been in the context of another health service, that the only problem with long-term care financing today is that it wasn’t put on the list of services covered by one of our insurance programs and I think that the reality is that is a sort of narrow view that isn’t going to help,” and called for new options that better took into account how LTC differs from acute care: “long-term care ... while it is about maintaining life in the face of a disability it’s also about how you maintain your life, what is the sort of situation that you live in, what’s the degree of comfort that you have, what is the burden that’s imposed upon your family that’s living with you” (Scanlon, 2003).

The CLASS Act—a voluntary, consumer-financed, publicly administered, cash-benefit insurance plan—turned out to be the creative approach that worked. In 2003, work on an early version of the CLASS Act was well underway; this version was initially unknown to us at the American Association of Homes and Services for the Aging (AAHSA), which advocates for “the future of aging services in a place

called home” and represents non-profit services across the continuum. AAHSA leadership, also thinking it was time for new approaches, convened a task force in 2004 to analyze options and propose solutions. In 2005, as the analytical work and development of recommendations neared completion, we recognized them as closely compatible with principles embodied in the 2005 CLASS Act legislation that was circulating before its introduction in November. AAHSA formally adopted its proposed approach in 2006 (AAHSA Board of Directors, 2006). By 2007, I was presenting at many conferences about a topic we hoped to make true: “Financing LTC: An Emerging Consensus” (Manard, 2007).

As AAHSA and other groups from the aging side of things joined with those from the disability side of things, a powerful advocacy coalition was formed. While it might have seemed in January 2009 that not much was going on to suggest LTSS might really be included in health reform, by February 2009 an energized CLASS Act coalition was actively at work and even had a website: <http://www.passtheclassact.org/about-this-site>, onto which talking points and documents related to CLASS continue to be added in 2010.

The four critical keys to passing CLASS were congressional champions (e.g., members such as Kennedy and Dodd and the indefatigable staffer Connie Garner), presidential backing, an effective grassroots coalition, and the newly developed approach—a voluntary, consumer-financed, publicly administered, cash-benefit insurance plan. Below I outline some technical issues in that development. I am telling just one part of this story, as I saw it, from the perspective of a long-ago academic, privileged

to voyage with the political specialists, grassroots advocates, and leaders who secured the historic achievement of passing the CLASS Act.

It's Not an Entitlement

Two strands of policy analysis over the years combine in CLASS, creating the approach that passed. First, cash benefits long have been the preferred approach in disability (income support) insurance, but rare in long-term care insurance (Driscoll & Lynch, 2009). Over a decade ago, however, Robyn Stone, argued for using cash benefits in a public approach to long-term care insurance, helping to implement then later reporting on the early days of the “Cash and Counseling” experiment (Stone, 1996). That experiment, which ultimately proved the idea worked extremely well in Medicaid programs, became a favorite inspiration for financing reform ideas at key conservative think tanks (Froegue, 2003). CLASS’ cash benefit, selected originally by the law’s early supporters from the disability community, appealed across party lines.

Second, the use of premium-financed insurance—with help for low income people—became the general approach to national health insurance reform, following the model implemented in Massachusetts. It resonated with those who supported Medicare Part D—the voluntary prescription drug plan for Medicare beneficiaries—while it distressed others who favored a different approach such as a national public insurance plan, financed by progressive income taxes, spreading the financing cost more equitably from that perspective. In this regard, CLASS is a unique hybrid: a national, voluntary, publicly administered insurance plan, but one in which the law stipulates “no [federal] taxpayer funds shall be used for payment of benefits.”

Premiums pay for less than half of Medicare benefits, including the voluntary Part D; the rest comes from taxes. But by law, the CLASS Act is consumer financed, or “internally financed,” to use the more technical term. Even the subsidies for low income people—people below 100 percent of the poverty line and working students pay \$5 per month—are internally financed, and thus limited in order not to increase too much the premiums for those with higher incomes who also pay for the subsidies. The self-financing aspect of CLASS was one key to its passage. It meant that CLASS wasn’t kicked out, begging for a

share of scarce “pay-for” dollars.

The scarcity of those “pay for” dollars also meant it was virtually impossible to make CLASS mandatory, even if that might otherwise have been desirable or politically plausible. A mandatory program would require finding substantial dollars external to CLASS to subsidize more low income people, possibly up to the 400 percent of poverty settled on for “regular” health insurance reform. At that point, CLASS would have actually become the “new government entitlement” ill-informed critics labeled the voluntary, self-financing plan. Instead, congressional CLASS designers and advocates stuck with the newer concept, fully aware of the risks of adverse selection in a voluntary plan forbidding exclusion (among those otherwise eligible) of those who would more certainly use the benefits, and the need for exceptionally effective implementation. It was certainly not true in November 2009, as one blogger who favors a mandatory plan suggested, that “CLASS backers face a tough choice: pass a second-best program that runs the risk of failure, or come back again in a couple of years with a better plan” (Gleckman, 2009). The greatest risk was not taking a risk in the present time. The choices adopted in crafting the legislation in the HELP Committee and beyond were geared to designing a “first-best” program, to the best of participants’ abilities, which meant (as would have been the case at any time) efforts to balance many kinds of risks: political, administrative and actuarial.

Addressing a Key Puzzle in April-June, 2009

One goal of those drafting the CLASS Act portion of the HELP Committee’s health reform bill was to keep as close as possible to previous versions of the stand-alone CLASS Act, which had already been widely circulated and had garnered many co-sponsors and advocates. One part that needed change was the \$30 per month premiums appearing in the earlier versions. That specific dollar amount had been based on limited analyses available at the earliest point, with long-standing plans for congressional drafters to seek a more refined estimate of actuarially sound premiums from the Congressional Budget Office (CBO) or the Congressional Research Service (CRS) as the drafting progressed. But by spring 2009, some external analyses made clear that the \$30 per month premiums were too low for a sustainable

program—long a key goal of the CLASS developers. Neither the Moran Company study, an analysis commissioned by AAHSA, nor another detailed actuarial study made available to committee staff and CBO perfectly matched the CLASS Act details emerging from policy discussion in early 2009. The Moran study presented a range of premium prices that resulted from modeling a mandatory program and varying the benefit length and segments of the population mandated to participate (The Moran Company, 2007). The other study presented a range of premium prices garnered from modeling both a mandatory program and a voluntary one using various estimates of participation, biased/adverse selection, and disability rate changes, but including certain features of CLASS that already had been changed from earlier versions. The two reports, despite wide differences in many respects, reported closely similar sustainable premiums for a mandatory plan for working age (or actually employed) people in the range of \$60 to \$70 per month, using a benefit trigger of 2+ limitations of activities of daily living (ADLs) and a daily cash benefit of \$75; details of the options considered in each report facilitated drafting the legislation prior to further analysis by CBO.

The challenge for drafters updating the CLASS Act legislation was crafting a bill that (1) met program goals to be a voluntary, self-financing plan and to provide cash sufficient for a foundational level of supports and services pegged to disability level (the early version called for a daily cash benefit of \$50 for 2 to 3 ADLs and \$100 for 4+ ADLs); (2) had sufficient detail to be modeled by CBO, which was charged with producing estimates of the legislation's effect on the federal budget; and (3) provided an appropriate balance between assuring basic congressional intent sufficiently expressed in the law with allowing sufficient administrative flexibility to assure on-going program financial integrity.

In modeling a plan like CLASS, after specifying the broad outline of the population eligible for enrollment (in this case, those age 18+ and working), one needs to specify two of the following three variables and have a complex computer model to solve for the third: the amount of the daily cash benefit, the minimum benefit trigger level (e.g., 2+ ADLs or a more stringent 3+ ADLs), and the average premium price. Differences among modelers in solving those equations result from differences in the underlying

data sets used and different assumptions about inflation rates, disability incidence and continuance, participation, and adverse selection. Those choices about data and assumptions would be CBO's to make independently. The legislation, however, needed to deal with the three variables identified above.

The solution for drafting the CLASS Act that was introduced for debate by the HELP Committee was this: the legislation directed the Secretary of Health and Human Services "in consultation with appropriate actuaries and other experts" to develop "an actuarially sound" plan. Among the many possible combinations of benefit levels, triggers, and premiums for a plan, the legislation put one critical stake in the ground, saying the benefit, on average, could not be less than \$50 per day, increased annually by inflation. The Secretary was given the flexibility to select the benefit trigger from two specified options: either 2+ ADLs or a more stringent 3+ADLs (the more stringent trigger would lower premiums if all else remained constant). Finally, the legislation specified a target average maximum premium price ("for all reasonably anticipated new and continuing enrollees") of \$65 per month in 2009 dollars. But that stipulation was followed by a clause many missed that gave the Secretary the authority to adjust the \$65 per month "as necessary to ensure payment of the minimum cash benefit" in the *actuarially sound* plan to be developed. The procedure for determining plan details specified in the version debated by the HELP Committee, and still in the version now law, called for a presidentially appointed advisory council to review a set of actuarially sound options developed by the Secretary and recommend one for adoption 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." The Advisory Council in CLASS drew its inspiration from the successful Health Insurance Benefits Advisory Council which developed program details after the Medicare law was passed (Feder, 1977).

Endorsed by the President and Actuarially Sound for 75 Years

On the morning of July 7, 2009, advocates, reporters, and C-SPAN cameras jammed a senate hearing room to watch the HELP Committee debate and consider changes to the CLASS Act provisions of

the Committee's health reform bill. The day before, a crucial letter to Chairman Kennedy had arrived from Secretary Sebelius, saying the President "believes it is appropriate to include the CLASS Act as part of health reform because enactment of this important legislation would expand resources available to individuals and families to purchase long-term services and supports and enable them to remain in their own homes in the community. The CLASS Act is an innovative voluntary program that will provide important benefits to people who need them" (Sebelius, 2009).

Senator Chris Dodd (D-CT) chaired in the absence of ailing Senator Kennedy. Thick notebooks prepared by staffers containing talking points and summaries of the more than 300 amendments previously filed (35 or so on CLASS) were piled on the tables. One summary referred to an amendment championed by Senator Gregg (R-NH) that sought "to change the conditions under which the Secretary *must* adjust premiums for solvency: the legislation currently specifies that if the Secretary determines that funds are insufficient for the next *20 years*, the Secretary *shall adjust* them. The amendment proposes changing that to *75 years*." Talking points on the Democratic side listed reasons for opposing the amendment, informed by caution that "the future is more uncertain than commonly acknowledged" (Friedland & Summer, 1999).

But Senators were focused not so much on the exact language of the bill, as on the CBO analysis of costs—one of many instances when the model became assumed to be the law. CBO's model had the plan chosen by the Secretary starting out for the first decade with people paying \$65 per month for a \$75-per-day benefit. In the second decade, as modeled, the Secretary seemingly realized that this approach would not work for the long-term and therefore changed the program so that all participants (new entrants and old) got only \$50 per day benefits, and new participants paid premiums of \$85 per month. Republicans mocked this as "bait and switch" and "a loss leader approach better kept in the grocery story." One added, "Look, even if the premiums are \$100 per month, it's still a really good deal and could be a good program." Senator Dodd, wisely ignoring the talking points, advised committee members that he thought they should accept the Gregg amendment and called for a vote and the 75-year solvency amendment was adopted unanimously. Remaining amendments

were withdrawn. Thus, CLASS was included with bi-partisan support in the HELP bill. Senator Gregg quickly issued a press statement, saying "our nation needs to address the growing problem of providing health care services for older individuals who have trouble with activities and tasks of daily life.... My amendment ensures that instead of promising more than we can deliver, the [CLASS] program will be fiscally solvent, and we won't be handing the bill to future generations" (Gregg, 2009).

Reports from the CMS Actuary

As the CLASS Act moved beyond the HELP Committee, CBO estimates of CLASS Act premiums reflected the Gregg amendment as well as key differences that emerged between the House bill, which was passed November 7, 2009, and the Senate version, which was passed by the Senate on December 24, 2009 and subsequently passed by the House, becoming law when signed by the President March 23, 2010. While the CBO is the official scorekeeper for legislation, the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) also weighed in with its own analyses of CLASS. Although the CMS Actuary—Richard Foster—is technically part of the administration, his analyses of health reform legislation, including CLASS, were published with this disclaimer: "The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress.... The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration" (Foster, 2010, p. 1).

Foster wrote skeptically of CLASS' possibility of success, itemizing a litany of risks: low participation, costly premiums, and adverse selection potentially leading to a classic "insurance death spiral" (e.g., too many people with existing disabilities signing up, too few who would never use the benefit) (Foster, 2010). The CBO also described potential risks, but additionally suggested some counter-considerations including that "by keeping administrative costs to a minimum, the CLASS program might attract relatively healthy enrollees because the resulting premiums could be lower than the premiums that would be charged for many private policies that have substantially higher

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administrative costs and devote a share of their premiums to profit” (Elmendorf, 2009).

What is unclear about the CMS Actuary reports is how the Office of the Actuary calculated the reported financial results. Foster issued four reports on health reform bills that included nearly identical paragraphs about CLASS (Foster, 2010), key information from which is shown in Table 1, which compares Foster’s numbers with those of other analysts.

There were two key differences between the Senate and House versions of CLASS. First, in the Senate bill, only active workers were eligible to enroll. In the House bill, both active workers and their non-working spouses were eligible to enroll. CBO anticipated “that the average non-working spouse

who would enroll in the program would have more functional limitations than the average enrolled worker, which would make non-working spouses more likely to qualify in the future for the program’s benefits” and concluded that monthly premiums for a sustainable CLASS program would be 20 percent *higher* in the House version (\$147) than in the Senate version (\$123). Foster judged the reverse, concluding that premiums would be 25 percent *lower* in the House version (\$180) than in the Senate version (\$240), and mentions nothing about non-working spouses, so it is unclear whether that difference was taken into account.

A second difference is that the Senate (but not the House) bill specified that working students and those with incomes below 100 percent of poverty

Table 1 Estimates of Monthly Premiums for a Sustainable CLASS Plan

Analyst	Average Daily Benefit	Assumed Participation Rate [Estimated number of adult pop. Enrolled]	Non Working Spouses May Enroll	Average Monthly Premiums	Net Deficit Reduction 2010-2019
CMS Actuary (11/13/2009) “House Bill as passed”	Not stated	2% [about 2.8 million by 2013]	Not stated, but should be “Yes”	\$180	\$38.7Billion
CMS Actuary (1/8/2010) “Senate Bill as passed”	Not stated	2% [about 2.8M by 2013]	Not stated, but should be “No”	\$240	\$37.8Billion
CBO (11/19/2009) House bill	\$75/day	5-6% [slightly>10M, about 4% of adults by 2019]	Yes	\$147	\$101.6B
CBO (10/29/2009) Senate bill	\$75/day	5-6% [slightly<10M, about 3.5% of adults by 2019]	No	\$123	\$72.5B
AAA/SOA (7/22/2009)	\$76/day	6%	Yes	\$160	Not estimated

Sources: CMS estimates available at https://www.cms.gov/ActuarialStudies/05_HealthCareReform.asp#TopOfPage; CBO estimates available in Memorandum to Senator Harkin, dated November 25, 2009, at http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf. AAA/SOA letter found at http://www.actuary.org/pdf/health/class_july09.pdf.

Notes: (1) benefits increase annually with inflation; premiums for each cohort are constant from point of enrollment, each successive cohort starts with premiums higher (by inflation) than the cohort joining the previous year. (2) CBO uses 2.5 ADLs as a benefit trigger; AAA/SOA uses 2 ADLs; CMS does not say what it used.

would pay \$5 per month premiums. Foster's text regarding the different bills is identical except for one phrase found in the report on the Senate bill, but not in that on the House bill; he lists in text regarding the Senate bill "the effect of subsidizing participants paying the \$5 premium" among other reasons for low participation. But if the internal subsidies have such an effect on premiums, accounting for a 25 percent difference, then why does the Actuary estimate that participation will be identically low in reports on both versions of the bill?

Even more inexplicable are Foster's estimates of 10-year federal deficit reduction. Those numbers, as can be seen in the CBO estimates, largely reflect accumulating premiums with totals driven by the number of people paying premiums and the average premiums paid monthly. Thus CBO, with higher premiums in the House version (\$147) estimated higher (\$101.6 billion) deficit reduction for that bill; contrasting with the Senate bill's lower premiums (\$123) and resulting lower (\$72.5 billion) deficit reduction. In contrast, Foster's substantially lower premiums in the House version (\$180) than in the Senate version (\$240), with identical numbers participating in each, result in nearly identical deficit reduction: \$38.7 billion (House) and \$37.8 billion (Senate).

What the CMS Actuary says makes a difference beyond CLASS. (Witness the on-going debate over his analyses of health reform financing in general at <http://blog.kaiserhealthnews.org/index.php/2010/04/28/arguments-persist-over-cms-actuary-report/>.) In his reports on CLASS, Foster reveals so little about his methods that he appears more careless than iconoclastic.

Future Talking Points

We are beginning to hear some say that CLASS passed because the CBO scored it as a \$70B+ net deficit reducer over the 10-year period critical to accounting for the costs of health care reform. Nearly all of that deficit reduction reflects premiums collected and accounted for by the standard rules that CBO is required to follow. About \$2 billion is for savings to Medicaid (federal share). As accumulated surpluses in the CLASS Act trust fund pay for benefits later, in years when cash coming in is less than cash going out, it counts as a deficit increase in federal budget accounting, even as CLASS remains self-sustaining.

It is certainly true that CLASS could not have passed if it had scored as a substantial 10-year deficit increaser. But it would be hard to conclude that \$70B+ in the first 10 years made the sale, given the concerns that dominated so much of the CLASS debates over assuring that funds are available when participants in large numbers start drawing benefits. There were serious issues over the CLASS funds; there was also understandable confusion among even the better reporters who misled by taking phrases out of context from complicated budget analyses. There was also much mischief (Google for "the CLASS Act" with "ponzi scheme"). In February, Congress took an additional step important to CLASS and the nation, adopting rules for future accounting that require calculating budget deficits with CLASS funds off the table (Keith, 2010). We need better talking points and reporting to get the CLASS financial story right.

Will CLASS work? No one knows. It hasn't been tried before. What we have tried is not working. We need to try something different. By design, the law has built-in flexibility for the details to be created by rule. Obviously, even the best plan will surely fail if poorly implemented. More talking points needed; volunteers welcome.

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The Circular Relationship Between Enrollment and Premiums: Effects on the CLASS Program Act

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The Affordable Care Act (ACA) contains a provision, the Community Living Assistance Services and Supports (CLASS) program, which creates a national, public, and voluntary long-term care insurance program. When implemented, working adults will be eligible to participate, either through their employers or directly through an alternative mechanism. Employers will be permitted to enroll their workers automatically, much like they would auto-enroll workers in 401(k) plans; if auto-enrolled, workers will be free to opt out. Additionally, full-time students and people under the Federal Poverty Limit will receive significant discounts to participate. The program then will pay cash benefits averaging at least \$50 per day over the lifetime of anyone who is vested in the program and becomes disabled. These benefits can be used to pay for long-term services and supports such as home care, durable medical equipment, or home modifications.

This new law is the first major attempt to address this nation's lack of widespread insurance protection for long-term care. Before the ACA, the U.S. lacked any vehicle to spread the financial risk of long-term care throughout the population and provide a reliable funding source for the care some people will need. While Medicaid acts as a safety net for individuals with few resources or whose resources have been exhausted by out-of-pocket medical and long-term care costs, most people have little protection against the possibility of impoverishment. Likewise, state budgets are strained by the lack of widespread insurance coverage. More than one-third of Medicaid spending is devoted to long-term care for people who have neither insurance nor the resources to pay for all of their care out-of-pocket.

The federal government faces a number of challenges in implementing this new law. Perhaps most significantly, it must set premiums in a manner that ensures the program has funds adequate to pay benefits. At the same time, it must keep the premiums low enough to attract a sufficient number of enrollees over whom to spread risk and ensure that premiums can remain affordable into the future. Central to the question of setting premiums is the initial assumption program actuaries make about how many people eligible to enroll in the program choose to participate (called the "participation rate"). This brief explains the relationship between this assumption and the calculation of premium levels. We present data showing the premium levels we calculate for different participation rate assumptions.

Participation Assumptions as a Key Driver of the Program's Premiums and Enrollment

The CLASS Act has generated a great deal of interest because it does not exclude individuals from enrollment based on health status, and yet it does not mandate that individuals participate. In a voluntary insurance program without underwriting, the possibility exists that certain individuals will have better knowledge than others of their own likelihood for developing a severe disability. People with this better knowledge or people who already have severe disabilities will be more likely to enroll in a program that covers costs of long-term supports and services. The enrolled population may therefore receive benefits at a higher rate than would occur if the entire population eligible for the program enrolled. This pattern, called adverse selection, leads to higher total program costs, which must be balanced via higher premiums.

Assuming overall participation rates of three-and-a-half and two percent respectively, the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services Office of the Actuary (OACT) calculated premiums the program would require from each enrolled individual in order to cover the costs generated by enrollees using benefits. In doing so, these agencies estimated the impact of adverse selection on the CLASS program, which at such low overall rates of participation likely would be fairly high. The ultimate premium estimates that CBO and OACT generated using the three-and-a-half and two percent participation rate assumptions

The Circular Relationship Between Enrollment and Premiums

are \$123 and \$240 respectively. These premiums are based on cash benefits averaging \$75 per day.

These premium calculations are unable to capture fully the circular nature of the relationship between participation rate assumptions, premiums, and the actual enrollment levels that likely will be affected greatly by the initial premium amount. The CBO and OACT used very low participation rate assumptions, which led to high premium calculations because of presumed adverse selection. On the face of things, very few people would enroll in the CLASS program if its average premiums actually were \$240 per month. This premium likely would deter enrollment in CLASS, since private insurance policies would be less expensive (LifePlans, Inc, 2007). The premiums generated by CBO and OACT seem to preordain the participation rate assumptions used to calculate them.

Unfortunately, these agencies were not able to provide information on how the premiums would decrease under more liberal participation rate assumptions. We do not know how much higher the participation rate assumption would need to be to produce a substantially lower premium calculation. In other words, we do not have a sense of the relationship between these rates and the premiums in the CBO and OACT premium models. Such information would give policymakers and CLASS implementers the opportunity to assess the participation rate assumption at which premiums would fall into an “affordable” range.

In order to provide some information about the relationship between participation rates and premiums, we used the analytics underlying The SCAN Foundation’s (TSF) Long-Term Care Policy Simulator (LTC-PS) to explore how premium levels change under varying participation rate assumptions. The LTC-PS, which can be found at www.ltcpolic

www.ltcpolic.org, produces premium estimates for a range of long-term care reform options, including a voluntary cash benefit. While the policy parameters in the simulator differ from the CLASS specifications in some important ways (e.g., the LTC-PS assumes spouses are covered by the benefit), we are able to use the underlying analytics to test how different participation rate assumptions relate to different premium calculations for a social insurance cash-based program. The model’s technical report (Hammelman, Tumlinson, Broyles, & Weier, 2010)

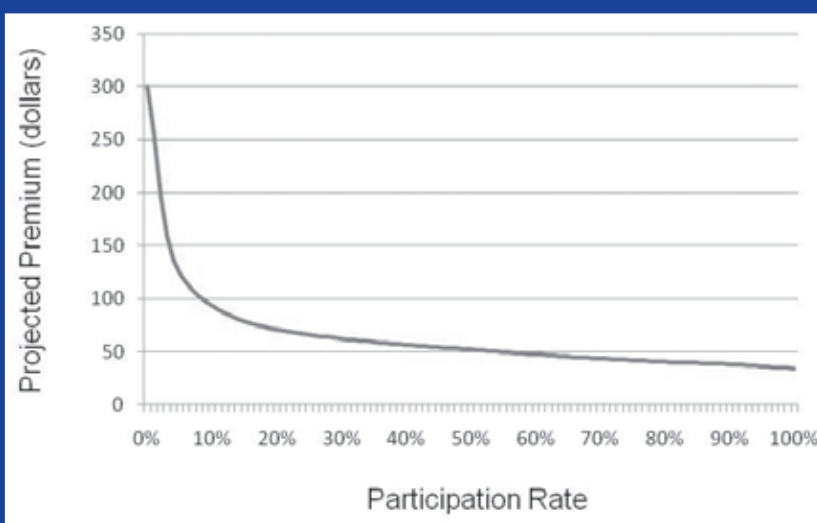
contains more detail on how we created these participation rates and is available on the website.

For the premium estimates that the LTC-PS generates (on TSF’s website), we have created modeling rules that produce different participation rate assumptions depending on the relative affordability of the set of policy parameters a user chooses. Therefore,

LTC-PS users cannot vary participation rate assumptions explicitly, but when they choose less costly policy parameters, the underlying participation assumption goes up and when they choose more costly policy parameters, the assumption goes down. For the purposes of this article, we use the underlying model to alter the participation rate assumption for one unchanging set of policy parameters.

We examine the relationship between premiums and participation rates for a \$50-per-day, cash, lifetime benefit for individuals with two or more activities of daily living (ADL) limitations. This analysis assumes that enrollees must pay premiums for five years before qualifying to receive benefits but will face no waiting period for benefits once they satisfy the five-year vesting requirement and meet the disability level. We assume enrollees must be working at the time of enrollment and that non-working spouses of employed individuals are eligible to enroll. This analysis also

Figure 1 Premiums Go Down as Participation Goes Up



Source: Avalere Health, LLC (2010)

assumes no low-income subsidy.

Using the underlying LTC-PS model, we estimate that under the parameters described above, a mandatory program with 100 percent participation would require premiums of \$37 per month. As the figure below shows, we calculate rising premiums as assumptions of participation go down. These rising premiums illustrate the impact of presumed adverse selection on premiums. As participation rates drop, a greater proportion of those enrolled in the program have a disability or are likely to have one in the future. Assuming a 30 percent participation rate would lead to a premium of \$62, a 15 percent rate would require a premium of \$79 and a 5 percent rate would require a premium of \$124.

This analysis shows, not surprisingly, that low participation rate assumptions lead to high premiums. Using the underlying LTC-PS model and the program specifications we describe above, we see that adverse selection most dramatically increases premiums below a six percent participation rate assumption. If we assume participation to be under three percent, then we also assume enrollment will be dominated by people who already have or will probably develop ADL limitations. These assumptions result in higher premiums, probably to the point where it would be less expensive for potential enrollees to buy private policies. Very likely, few healthy individuals would choose to enroll in the program as a result. In the worst case, the program could enter an adverse selection “death spiral,” as higher premiums lead to lower participation, which again lead to the need for higher premiums.

The analysis also shows that, with a more generous assumption about participation, a program’s premiums likely are to be affordable to a greater number of Americans. If we assume enrollment levels are relatively high, say over 20 percent of the eligible population, we presume that healthy individuals participating in the program offset our projections of adverse selection. It is not that fewer persons with severe disabilities will receive benefits under the program, but instead, that the group of people with disabilities comprises a smaller percentage of the total enrolled population. This higher participation rate assumption effectively allows for the calculation of a lower premium, which subsequently could help ensure actual robust enrollment and program stability. In other words, ensuring adequate participation and offering an

initial premium that assumes adequate participation will be important for the program’s success.

Conclusion

In setting premiums for the CLASS program, the federal government will have to acknowledge and take into account that very pessimistic participation rate assumptions will lead to high initial premiums, which very likely could set up a vicious cycle of low and declining enrollment. Given how little we know about participation, we believe experts may consider a wide range of participation assumptions to be plausible. Although we do not have certainty about how potential enrollees will react to various price points, the lower end of possible participation rate assumptions (e.g., two percent) would seem almost certainly to ensure very low participation among healthy individuals.

As our example above demonstrates, implementing the CLASS program in such a way as to attract a larger percentage of the population, and plausibly to allow for more liberal participation rate assumptions, will in turn lead to lower premiums. These lower premiums undoubtedly will allow for higher participation and program sustainability that will go a long way towards helping to accomplish the underlying goal of the CLASS program of “providing a means for individuals with functional limitations a way to maintain their personal and financial independence” (Patient Protection and Affordable Care Act, 2010).

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Community Living Assistance Services and Supports (CLASS) Program and Medicaid Home and Community-Based Services Improvements in the Federal Health Care Reform Law

Rhonda Richards

Earlier this year, the Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law, containing provisions that could help millions of Americans not only access quality affordable health care, but also access long-term services and supports to help them live independently in their homes and communities. These provisions could help older Americans and persons with disabilities of all ages who need help with daily activities such as eating, bathing, and dressing.

Enacted earlier this year, the health care legislation and some of its provisions have drawn much attention in the national media, but among its lesser known attributes is that in the long run, it could help many Americans remain living in their homes and communities, which they prefer over nursing homes and assisted living facilities. The vast majority (89 percent) of Americans age 50 and older want to remain in their homes for as long as possible (AARP Public Policy Institute, 2006).

However, limited options currently are available to pay for long-term services and supports (LTSS) or long-term care (LTC). Most care is provided by unpaid family members, friends, and neighbors (collectively referred to as family caregivers), who make up the backbone of LTSS in this country. About 29 percent of the U.S. adult population, or 65.7 million people, are caregivers (Barrett, 2009). In fact, the estimated economic value of family caregivers' unpaid contributions was about \$375 billion in 2007, more than the total Medicaid spending in 2007 (Houser & Gibson, 2008). Medicare generally does not cover LTSS—despite many people's beliefs to the contrary. Medicare covers limited home health and skilled nursing facility care. Individuals pay for services out-of-pocket and some individuals have private long-term care insurance to help cover their LTC costs. Not all individuals, however, can afford such insurance or qualify for it due to pre-existing conditions.

The largest payer of LTSS is Medicaid, the joint federal-state program to help those with limited incomes and assets or very high costs of care. Medicaid, like Medicare, has an institutional bias. Federal law requires that Medicaid pay for institutional care, such as nursing homes, but most home and community-based services (HCBS) are

“optional,” meaning that states are not required to cover them and can limit the number of people receiving services and the services provided. States do provide Medicaid HCBS to varying degrees and with great variation among states, but these services are subject to cuts and reductions in general, and especially during tough economic times, in a way that institutional services are not. An example of Medicaid's institutional bias is that nationally in 2007, 73 percent of Medicaid's LTC spending for older adults and adults with physical disabilities went toward nursing homes, while only 27 percent went toward HCBS (Houser, Fox-Grage & Gibson, 2009). Both states and the federal government are dealing with the financial challenges of growth in Medicaid spending overall, and not just from LTC.

It is against this backdrop that Congress considered health care reform legislation and whether or not to include provisions regarding LTSS. The inclusion of LTSS provisions in health care reform legislation was far from a forgone conclusion. Some legislators were concerned that there were so many issues to address in health care reform that Congress could not also devote attention to LTSS. Some were concerned that including LTSS in health care reform might slow or hinder the passage of health care reform or cost too much. Some wanted Congress to address LTSS separately after health care reform. Congress, however, often faces immediate pressing issues that they must address, so issues that are longer-term in nature or not part of an immediate crisis can be harder for Congress to devote significant time to address. This also shows why it is important for any bill or issue to have legislative champions in the House and Senate who, with persistence and determination, work with their colleagues and the Administration to enact

it. Champions need to be in a position to push forward the proposal themselves and work with others who are able help them get it across the finish line.

Advocates in the aging and disability communities strongly believed that provisions addressing LTSS should be part of health care reform legislation and made their voices heard in Congress. In November 2008, the Senate Finance Committee released a blueprint for health care reform that included a modest discussion of LTSS issues and later released options papers that included LTSS options. The Senate Special Committee on Aging held a hearing in March 2009 focusing on the issue of LTSS and health care reform. AARP and other groups submitted written statements for the hearing record, and multiple other conversations and events were held that addressed to include LTSS in health care reform. Advocates began to urge both Congress and the Administration to address this issue in health care reform. In May of 2009, AARP announced six priority elements for inclusion in health care reform, including increasing federal funding and eligibility for HCBS through Medicaid so that older Americans can live in their homes and avoid more costly institutional settings as they age. Helping older adults live in their homes is an important priority to AARP's members.

A number of members of Congress had already introduced or were working to introduce legislation that would help older adults and persons with disabilities get the services and supports necessary to live in their homes and communities. Some bills already had been introduced in multiple Congresses and others would be introduced for the first time in 2009. In general, proposals ranged from the creation of a national insurance program for LTSS to improvements in Medicaid HCBS to other proposals to address HCBS outside of Medicaid.

Among the proposals that had been around for a few years was the Community Living Assistance Services and Supports (CLASS) Act (S. 697/H.R. 1721), sponsored by the late Senator Kennedy (D-MA) and Representatives Pallone (D-NJ) and Dingell (D-MI). This Act initially was introduced by Senator Kennedy and Senator DeWine (R-OH) in 2005. The CLASS Act was referred to the Health, Education, Labor and Pensions (HELP) Committee in the Senate and the Energy and Commerce, Ways and Means, Budget, and Rules Committees in the House of Representatives. Senator Kennedy initially chaired

the HELP Committee, but due to his declining health, asked Senator Dodd (D-CT) to take the overall lead on health care reform within the HELP Committee.

The CLASS Act would establish the CLASS Program, a voluntary national insurance program for long-term services and supports. Under the CLASS Program, individuals would pay a monthly premium and after a five-year vesting period, if they met other eligibility criteria, they would be eligible for a daily cash benefit to help them pay for the services and supports they need to help them live in their homes. The benefit could pay for services such as home care, respite care, home modifications, assistive technology, accessible transportation, and nursing support. The benefit also could pay for services in other settings, such as assisted living or nursing homes. The cash benefit in CLASS would give consumers greater choice and control over the services and supports they need to maintain their independence. The program aimed to cover a large number of individuals and spread the risk over a significant size risk pool, some of whom may not have coverage for LTSS otherwise. Many aging, disability, and other stakeholder groups had endorsed CLASS in the years prior to health care reform, and in 2009, sponsors of CLASS, their staffs, and supporters focused on passing CLASS as part of health care reform legislation.

One of the ongoing concerns raised about CLASS was its long-term financial sustainability. Would the program as designed be sustainable in the long term? Would the premiums pay for the benefits and the number of people that would enroll in the program? As with many bills in Congress, the CLASS proposal was modified as it moved through the legislative process to address concerns raised. Without Senator Kennedy's physical presence in the Senate, Senator Dodd took on a lead role championing CLASS in the HELP Committee and in the Senate. Senator Dodd included the CLASS Program in the HELP Committee's health care reform bill that they would consider and amend ("mark up") in Committee. CLASS was modified heading into the Committee mark up, such as by changing the premium and giving the Department of Health and Human Services (HHS) more flexibility in setting the benefit amounts (rather than benefit amounts defined in statute).

During the HELP Committee mark up, another important development occurred; the Congressional Budget Office released a budget score of the CLASS

proposal that showed CLASS reducing the deficit in the 10-year budget window (largely due to the fact that premiums would be collected for five years before any benefits would be paid out). This was important since there was sensitivity to the cost of health care reform legislation. In the 10-year budget window, CLASS was projected to come at no cost to the federal government, and in fact, was projected to show some savings to the federal government in Medicaid. Proposals with high projected costs were harder to include in health reform. The fact that CLASS did not cost the federal government, at least in the short term, was helpful.

During the HELP Committee mark up, AARP sent a letter to the HELP Committee endorsing the CLASS provisions in the HELP Committee's bill and urging that the CLASS provisions be included in any final health care reform bill. During the HELP Committee mark up, a number of amendments to the CLASS provisions were adopted, including an amendment by Senator Gregg (R-NH) requiring that CLASS premiums be based on an actuarial analysis of the 75-year costs of the program that ensures solvency over those 75 years. This helped to further ensure the program was designed to be solvent over the long term. The CLASS program passed the HELP Committee in July 2009 as part of the Committee's health reform bill and would await the passage of the Finance Committee's health reform bill for the two committees' bills to be merged into one combined bill for consideration by the full Senate.

After the Finance Committee passed its bill, Senate Majority Leader Harry Reid (D-NV) took the lead in merging the HELP and Finance Committees' bills. He faced pressure from some Senate Democrats not to include CLASS in the Senate bill due to their concerns about the long-term impact on the deficit, the potential creation of an entitlement that would result in long-term spending increases that exceeded revenue, and the use of deficit reduction dollars from CLASS as an offset to pay for other provisions in health care reform. Some long-term care insurers also raised concerns about CLASS. Advocates who supported CLASS urged the Majority Leader to include CLASS in the merged Senate bill, as it could help people live independently in their own homes, begin to save money in Medicaid, and create a new option for people to plan and pay for LTSS. Aging and disability advocates met with Senate offices to make the case for

why CLASS was important and should be included in health reform, answering questions, and sometimes helping to clear up misinformation or confusion about CLASS. Ultimately, Majority Leader Reid included CLASS—with some modifications to address concerns raised—in the Senate health care reform bill that would be considered on the Senate floor.

Meanwhile in the House of Representatives, at the July Energy and Commerce Committee mark up, Health Subcommittee Chairman Pallone offered a shell (placeholder) of CLASS as an amendment that required the Secretary to establish the CLASS Program that met certain specific criteria. The amendment passed by voice vote and received verbal support from Ranking Member Joe Barton (R-TX) and former Health Subcommittee Ranking Member Nathan Deal (R-GA). Thus, a version of CLASS passed the House Energy and Commerce Committee as part of its health care reform bill that later would be merged with the health care reform bills passed by the Ways and Means Committee and the Education and Labor Committee. Supporters urged the House to include CLASS in the merged health care reform bill that would come before the full House. Ultimately, the full CLASS Program was included in the House health care reform bill that passed the House on November 7, 2009.

Back in the Senate, supporters of CLASS continued to push to make sure the CLASS provisions stayed in the Senate bill; the Leadership Council of Aging Organizations and the Consortium for Citizens with Disabilities organized a briefing for Senate staff on the LTSS provisions in health care reform. In early December, during floor debate on the Senate bill, Senator Thune (R-SD) offered an amendment to strike the CLASS provision from the Senate bill. The amendment was debated by speakers on both sides of the issue. Supporters of CLASS went to the Senate to show their support. AARP issued a press statement that was read on the Senate floor by Senator Harkin (D-IA) reaffirming AARP's support for the CLASS program and its enactment. The amendment needed 60 votes to pass and delete CLASS from the bill. The final vote was 51 votes for the amendment and 47 votes against; it did not pass. The CLASS provisions stayed in the Senate bill and passed the Senate as part of the overall health care reform bill on December 24, 2009. CLASS had passed both the House and Senate.

On a parallel track, advocates for LTSS

provisions also pushed for improvements in Medicaid that would expand beneficiaries' access to HCBS. Several bills were introduced on this issue in the House and Senate. In February, Senators Kerry (D-MA) and Grassley (R-IA) reintroduced their bipartisan Empowered at Home Act (S. 434) from the previous Congress. Among other provisions, the bill would make improvements to the Medicaid HCBS state plan option that only a few states had adopted to date. For example, the bill would allow states to cover a broader scope of HCBS, increase the income eligibility limit for individuals to receive services under the option, and allow provision of services under the HCBS state plan option to individuals eligible for HCBS waiver services. Importantly, the bill also required that the spousal impoverishment protections for the spouses of nursing home residents on Medicaid also be provided to the spouses of individuals receiving Medicaid HCBS. Representatives Pallone (D-NJ) and DeGette (D-CO) reintroduced a similar version of the Empowered at Home Act (H.R. 2688) in the House in June. AARP endorsed both of these bills, as did other aging and disability advocates.

Also in the Senate, Senators Cantwell (D-WA) and Kohl (D-WI) introduced the Home and Community Balanced Incentives Act (S. 1256) in June. This bill would offer temporary financial incentives to states to expand HCBS and balance their LTSS systems. To be eligible to participate, states must be spending less than 50 percent of their Medicaid LTSS spending for non-institutionally based LTSS. States with lower levels of LTSS spending on non-institutionally based LTSS would receive higher levels of funding (limited overall to \$3 billion in federal dollars). States that participate would have to make certain structural changes to their LTSS systems, including development of a statewide single-point-of-entry entry point, conflict-free case management, and core standardized assessment instruments. The bill also included provisions that improved the Medicaid HCBS state plan option, among other provisions.

Also pending in both the Senate and House was the Community Choice Act (S. 683/H.R. 1670) from longtime sponsors Senators Harkin (D-IA) and Specter (D-PA) and Representative Danny Davis (D-IL). This bill would require states to offer Medicaid coverage of community-based attendant services and supports to individuals who are Medicaid eligible, require an institutional level of care, and choose to receive

such services and supports. Under the bill, financial incentives would be available to states that adopt the requirement early. This bill had strong support from the disability community, especially, but also support in the aging community.

Heading into the Finance Committee health reform mark up, the Committee's bill included modest provisions on HCBS, but none of the provisions in the bills referenced above. Several Senators on the Finance Committee who sponsored or supported the above bills filed amendments to the Committee's bill. Senator Kerry filed an amendment that included several provisions from the Empowered at Home Act; Senator Cantwell filed an amendment reflecting the Home and Community Balanced Incentives Act; and Senator Schumer filed an amendment that was a modified version of the Community Choice Act, giving states the option to provide coverage of community-based attendant services and supports and receive an enhanced federal Medicaid matching rate for these services. Many aging and disability groups supported these amendments and urged their inclusion in the Committee's bill. During the mark up, Chairman Max Baucus (D-MT) accepted these amendments or modified versions of them. When the Finance Committee passed its bill, it included these amendments as well as other LTSS provisions on nursing home transparency, criminal background checks for certain employees of long-term care providers, and the Elder Justice Act.

As with the HELP Committee CLASS provisions, the aging and disability communities and individual organizations urged the inclusion of the Finance Committee HCBS provisions in the merged Senate health reform bill. Ultimately, Majority Leader Reid included the Finance Committee's HCBS provisions in the merged Senate bill, except for financial incentives for states to balance their LTSS systems that were later included in the Manager's Amendment to the Senate bill. The bill that passed the Senate included the HELP Committee's CLASS provisions, the Finance Committee's HCBS provisions, and other important LTSS provisions. While the health reform bill that passed the House included several LTSS provisions, including CLASS, it did not include significant HCBS provisions due to cost.

After both the House and Senate passed their respective health care reform bills, the aging and

disability communities—including AARP—continued to work together to include the CLASS and HCBS provisions in any final health care reform law. Due to dynamics beyond and generally separate from these provisions, Congress enacted health care reform by sending the Senate health care reform bill (H.R. 3590) to the President followed by an additional bill (H.R. 4872) that made modifications to the Senate bill. They are now law, and AARP is working to help its members and the public understand the new health care law so they can make the best decisions for themselves and their families, including how provisions may provide them with new options to help them live in their homes and communities.

The new law contains significant provisions on LTSS due to the individual and collective efforts of the aging and disability communities; champions in the Senate and House, their staff, and committee staff who advocated for these provisions; leaders who listened and acted; some factors beyond our control; and the compelling personal stories of individuals and their families across the country who need services and supports and the loved ones who care for them. This is no longer an abstraction. Members of the House and Senate deal with this in their own families and so do their staffs. It is not a partisan issue. It affects Republicans, Democrats, and Independents. It is about living independently, living the fullest and most productive life possible, living at home, caring for loved ones, and aging with dignity, purpose, choice, and control. It was and it is time to act.

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The CLASS Act: A New Paradigm for Aging in America

Kathryn R. Roberts

For many Americans, the CLASS Act is still a relatively little-known piece of legislation, but as the future unfolds, it could become one of the most transformative and beneficial aspects of health care reform. The CLASS Act has the possibility to change the paradigm of how we provide and pay for long-term care services in America. Collaboration of the public and private sectors around the CLASS Act will benefit our country in major ways: it will provide a long-term care insurance option for people who have none and can't afford or qualify for private insurance; it will empower more people to stay where they most want to live—in their homes—when they experience disabilities or long-term illnesses while at the same time preserving a Medicaid safety net for those who can't escape poverty.

Many Americans incorrectly believe that the government covers their long-term care. They believe that if they suffer from Alzheimer's disease or another chronic illness or disability, Medicare will cover home services or assisted living. Although it might pay for some short-term services, such as rehabilitation following joint replacement surgery, it will not to pay for the long-term services many Americans need to live fully, such as help with bathing and eating.

When Medicare and Medicaid were passed in 1965, policymakers didn't anticipate today's record longevity, smaller family sizes, and dual-earner households. Consequently, as we face an unprecedented demographic shift from young to old in America, states already are struggling to pay Medicaid obligations and are not equipped with alternative solutions.

Some Americans have purchased private long-term care coverage, but it is a small minority. Passage of the CLASS Act alone will not assure universal compliance in paying premiums for the first voluntary public long-term care insurance plan. But it will focus a national spotlight on long-term care needs and services, the need to plan for them, and the opportunity to gain coverage.

Many people still think of long-term care insurance as “nursing home” insurance, which is not exactly a motivating incentive to purchase coverage. In 2007, Ecumen commissioned a statewide poll of Minnesota baby boomers. More than 99 percent said they didn't want to live in a nursing home; it's very much like being asked, “Do you want to live in a hospital?” Of course we don't.

As the CLASS Act's details and national roll-out

plan are developed, designers should keep foremost in their mind that human beings are hardwired for independence. The CLASS Act must be positioned as a solution that helps preserve independence and allows individuals to live as fully as possible with chronic health conditions or physical disabilities. It is a tool that will keep Americans out of the place that they say they fear most – the nursing home.

The CLASS Act enrollment campaign has to break the myth that Americans already have long-term care coverage. American citizens need to understand there is very limited coverage, and Medicaid only kicks in when a person has become impoverished. If citizens want more control over how they will live with disabilities or illnesses and want to prevent overburdening loved ones with financial loss, they need CLASS Act or other coverage.

Aging is not a partisan issue. We all do it. The CLASS Act is a call for the common good, highlighting that planning for the possibility of long-term care helps us individually, it helps our families, and it makes America stronger by slowing our movement to Medicaid and preserving a safety net for our most vulnerable.

Approaching long-term care in this new way also would benefit from new voices. Actor George Clooney recently lent his support and celebrity to advocate against the closure of a Hollywood nursing home. I suspect that Clooney might not realize that many American nursing homes close because they lack a long-term care financing system. Government dollars come nowhere near covering the cost of providing care. Clooney and other high-profile stars could help educate and engage all Americans in a

national campaign to take individual responsibility for our futures and how we live during our senior years by turning to the CLASS Act and/or private insurance coverage.

The most effective place to deliver these messages to the most people is in the workplace during annual benefit enrollment. The CLASS Act is designed as an automatic enrollment program with an opt-out choice—the same approach that has increased 401K participation in many companies. But first, companies have to offer the CLASS Act. As the legislation currently stands, it is not a mandated benefit. Part of the national CLASS Act education campaign must make clear that in this new era of aging, long-term care is in fact a business issue.

Caring for a loved one while simultaneously working is extremely difficult to juggle. Caregiving often inflicts a heavy health toll on the caregiver. Studies show caregivers at high risk for hypertension, pulmonary disease, diabetes, and depression, all of which ultimately contribute to higher health premiums.

Caregiving impacts productivity. Significant costs are incurred by absenteeism, unpaid leave, and replacing employees. The MetLife Study of Employer Costs for Working Caregivers puts the total cost to employers for all full-time employed caregivers in the U.S. at \$33.6 billion, which undoubtedly will rise unless people have easy access to care services (MetLife Mature Market Institute & National Alliance for Caregiving, 2006).

Another player needed to leverage fully the CLASS Act is private insurers. The CLASS Plan does not provide comprehensive coverage. Its cash benefit will be about \$50 per day at a minimum. Although that doesn't sound like much, it could help pay for up to half a year of assisted living services in some states or significant home care services. As we elevate the need for personal planning for long-term care, private insurers have the opportunity to create supplemental wrap-around policies, much like supplemental Medicare policies, so that people can extend their CLASS benefits to get more coverage. This would benefit customers and the insurance companies.

State governments could collaborate in this effort by providing online long-term care information hubs that lay out the various options available—from the CLASS Act to Long-Term Care Partnership Plans to private insurance. State information hubs

could endorse private insurance plans with “Good Housekeeping” seals. This would build trust in the products and aid consumers in the confusing purchase process. Such consumer information hubs would benefit consumers as well as company human resources benefit directors seeking credible answers for their employees as they make benefit enrollment choices.

The CLASS Act promotes increased consumer empowerment. CLASS Act beneficiaries, and those with high-quality private plans, will direct their own dollars and will be able to vote with their feet, which isn't always possible with a governmental-funded long-term care program because reimbursement requirements likely limit a customer's options. This will create more flexibility for the customer, increase competition for the customer's loyalty, drive increased innovation in senior services, and lead to more choices for the next generations of seniors. Below, I highlight several ways I see this paradigm shift impacting long-term care delivery.

At-Home Services. People always have desired to live in the places they call home. As more people have CLASS Act benefit dollars and/or private insurance benefits, they will demand more service options that enhance their lives in their own homes. This consumer selectiveness is no different than selectivity applied consumers of any other service.

While the CLASS Act will not pay for every service, we as senior housing and services providers must be prepared to meet the market-defined needs and services. Senior housing has a tremendous opportunity to adapt and offer expertise and skills found within their existing bricks and mortar and bring it to the larger community via a variety of at-home services.

As more senior housing providers bring home health services outside their facilities and into people's homes, consumers will seek services beyond physical health care. Wellness also includes a person's intellectual, spiritual, social, emotional, and vocational health, and increasingly, home health services will distinguish themselves by going beyond medical services and fully integrating other aspects of wellness to meet customers' desires, not just their needs.

At-Home Technology. Several years ago, Ecumen adopted GE sensor technology in its assisted living communities and home services. These are very small sensors located in a person's home, such

as in doorways, the refrigerator door, and bathrooms. They unobtrusively track a person's motion patterns and send the data to a care professional or family member's computer. The data then help identify small health issues before they become critical.

Such devices just scratch the surface of technological possibilities for aging in place. More technologies are in development, and companies such as Intel, GE, and Philips are working in this space. At the same time, our customers increasingly are expecting technology to enhance their living experiences. We now are serving the last senior cohort that didn't experience personal technology as a ubiquitous part of their lifestyle. Home services providers increasingly will include technologies among their services, and the CLASS Act and other insurance could help pay for those technologies and keep people living more independently.

Virtual Villages. From Beacon Hill Village in Boston to Mill City Commons in Minneapolis—which Ecumen helped create—virtual villages are expanding nationally. These are grassroots communities where residents in close proximity join together and typically pay a yearly membership fee for social activities and access to contracted services such as home or computer repair, grocery shopping, and other services. While many such villages include a health care component, the communities lead with a social connectivity rather than a medical model. I envision these village concepts expanding to other vibrant communities such as churches, synagogues, and other faith communities. And, as with at-home services, the CLASS Act can provide dollars for village members to self-direct services they deem most important to maintaining their optimal wellbeing.

The Chronic Care Center. Changing the paradigm of long-term care financing through the CLASS Act will help focus on the individual with simple or complex needs. This new focus will position care centers even more fully as short-term stay chronic care centers.

Here's an example of how this might work: A person with diabetes has hypoglycemia, and rather than going to the emergency room, she comes to our care center where we stabilize her, consult with her primary care physician, and then complete a discharge home. We will provide a self-care plan for her to follow and perhaps will offer in-person or computer check-ins with our dietary team or others to

provide wellness checks and answer questions. Such an approach builds upon what many nursing homes already do with short-stay, sub-acute rehabilitation services, and can improve the individual's experience and save money by preventing bounce backs to the hospital emergency room. It would use resources more collaboratively and smartly to provide the right care in the right place at the right time and empower people in managing their own wellness.

Aging is changing America in unprecedented ways. The CLASS Act provides a tremendous opportunity to ensure that aging changes for the better.

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