



# Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)

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## Summary

Under current law, the majority of paid long-term care (LTC) services are funded by public programs, such as Medicaid and Medicare. However, these programs are limited in scope and continue to face increased financial pressures. Although private LTC insurance is available to provide some financial protection against an individual's risk of the potentially high cost of LTC, fewer than 10% of individuals aged 50 and older own such a policy. Thus, for the majority of older Americans, the out-of-pocket cost of obtaining paid help for these services may far exceed their financial resources. To address gaps in LTC coverage and assist individuals and families in paying for such services, the recently enacted Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) establishes a federally administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program. PPACA creates a new Title XXXII of the Public Health Service Act (PHSA) titled Community Living Assistance Services and Supports.

Once established, employed individuals aged 18 and older can voluntarily enroll in the CLASS program. CLASS enrollment would not be subject to medical underwriting, so coverage would be available to all persons who enroll, regardless of pre-existing conditions. Employers can choose to participate in the CLASS program. In doing so, they must automatically enroll eligible employees. Employees would then have the opportunity to "opt-out" if they do not want to participate. The Secretary of Health and Human Services (HHS) is required to develop an alternative enrollment process for self-employed individuals, those with more than one employer, and those who have an employer that does not elect to participate.

Premiums for the CLASS program are to be determined by the Secretary based on 75-year actuarial estimates of expected future use and expenditures. Premiums would vary by age at enrollment. PPACA also includes premium subsidies for workers with incomes below the federal poverty level and full-time students aged 18 to 21 who currently are working. To be eligible to receive benefits an individual must be an active enrollee who meets the five-year vesting and minimum earnings requirements. In addition, an eligible individual must have a functional limitation, as certified by a licensed health care practitioner, that is expected to last for 90 days. Benefits to eligible recipients include a cash benefit of at least an average of \$50 a day (based on the reasonably expected distribution of beneficiaries receiving benefits at various levels). Other benefits include advocacy services, and advice and assistance counseling on accessing and coordinating LTC services.

This report first discusses the cost and financing for LTC services as well as the current market for private LTC insurance. It then details those CLASS program requirements for enrollment, premiums, eligibility, benefits, administration and oversight as specified in PPACA. This report then discusses the federal budget implications of the CLASS program, as estimated by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS). Finally, the report provides a timeline of CLASS program provisions enacted under PPACA.

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## Introduction

The aging of the population is expected to increase the demand for long-term care (LTC) services over the next three decades. The cost of obtaining paid help for these services may far exceed many individuals' financial resources. Also, public programs that finance this care, such as Medicaid or Medicare, are limited in scope. To address gaps in LTC coverage and assist individuals and families in paying for such services, on March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148, as amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010 [HCERA]). PPACA establishes a federally administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program.

This report first discusses the cost and financing for LTC services as well as the current market for private LTC insurance. It then details those CLASS program requirements for enrollment, premiums, eligibility, benefits, administration and oversight. The report also discusses federal budget implications, as estimated by the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS). Finally, the report provides a timeline of the CLASS program provisions enacted under PPACA.

## Cost and Financing of Long-Term Care Services

Unlike medical treatments, LTC services and supports primarily assist individuals in their day-to-day activities of daily living (ADLs).<sup>1</sup> While medical services are typically provided to treat specific acute and chronic conditions in a health care setting, these services are different from LTC services. Specifically, LTC services include a wide range of health and social services and supports provided to individuals who have functional disabilities or cognitive impairments over an extended period of time, with the goal of maximizing their ability to live independently.<sup>2</sup> The probability of needing LTC services increases with age. One study has estimated that more than two-thirds of individuals who reach the age of 65 will require LTC services at some point before they die.<sup>3</sup>

For those individuals who need LTC, the costs of providing such care will depend on the setting, intensity (including the skill level of the provider), and the duration of LTC services provided. For example, the care may be provided in an individual's private home, in a community-residential care setting such as an assisted living facility, or in an institutional setting such as a nursing home. For those receiving care at home, the cost will vary depending on the skill level of the paid caregiver. In 2009, the average cost of personal unskilled care at home (such as bathing, dressing, and transferring from a bed or chair) was \$19 an hour, whereas skilled care from a visiting nurse was \$46 an hour.<sup>4</sup> In addition, the cost of care will also vary by intensity and duration of care.

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<sup>1</sup> These "activities of daily living" or ADLs include bathing, dressing, eating, toileting, and transferring (from a bed to a chair or vice-versa). Instrumental activities of daily living include things like food preparation, medication management, and housekeeping.

<sup>2</sup> C. Evashwick, "The Continuum of Long-Term Care: An Integrated Systems Approach," 2004.

<sup>3</sup> P. Kemper, H.L. Komisar, and L. Alecxih, "Long-Term Care Over An Uncertain Future: What Can Future Retirees Expect?" *Inquiry* 42, winter 2005-2006.

<sup>4</sup> Genworth Financial 2009 Cost of Care Survey, April 2009, at [http://www.genworth.com/content/etc/medialib/genworth\\_v2/pdf/ltc\\_cost\\_of\\_care.Par.20922.File.dat/USA\\_gnw.pdf](http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.20922.File.dat/USA_gnw.pdf).

Studies have found that individuals use on average about 17 hours a week of paid care, which would result in an annual cost of about \$16,800 a year in 2009 for unskilled care. Assisted living facilities, which provide hands-on personal care for those who are not able to live by themselves (but do not require constant care provided by a nursing home), cost on average \$33,900 annually in 2009. Nursing home care, on the other hand, generally costs more in that it provides LTC assistance 24 hours a day and includes the cost of room and board. In 2009, the annual cost of a nursing home stay was \$66,886 for a semi-private room and \$74,208 for a private room.<sup>5</sup> However, these estimates are national averages and can vary widely by geographic region.

Under current law, the majority of paid LTC services are funded by public programs, but these programs are limited in scope. For example, nearly half of LTC spending is financed by the Medicaid program, and is intended to provide a safety net for those who cannot afford to pay for LTC services. Because Medicaid is administered and partially financed by each state, there is wide variation in eligibility and benefits across the nation.<sup>6</sup> Medicare, which provides health care to older Americans, finances nearly one-fourth of LTC spending. But Medicare funding of LTC services is predominantly for post-acute care services and is not intended to cover LTC over an extended period of time.<sup>7</sup> Although private LTC insurance is available to provide some financial protection against the risk of the potentially high cost of LTC, fewer than 10% of individuals aged 50 and older own a policy.<sup>8</sup>

Individuals who seek paid LTC services but do not qualify for public funding or do not have private LTC insurance must pay for these services directly out-of-pocket. In 2007, about 18% of LTC spending was paid out-of-pocket.<sup>9</sup>

## **Current Market for Private Long-Term Care Insurance**

Private LTC insurance policies may be sold to an individual directly or to a group as part of an employer-sponsored policy. The premiums charged for LTC insurance vary by age at purchase, with higher premiums charged to those purchasing at older ages. This age differential reflects the higher risk of needing LTC services at advanced ages. In addition, private LTC insurance policies are subject to underwriting, and individuals who have pre-existing conditions often are denied coverage.

In 2008, there were about 6 million to 7 million LTC insurance policies that were active (often called “in-force”).<sup>10</sup> The growth in the number of LTC insurance policies in both the individual

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<sup>5</sup> Ibid.

<sup>6</sup> See CRS Report R40718, *Long-Term Care (LTC): Financing Overview and Issues for Congress*, by Julie Stone.

<sup>7</sup> Medicare covers up to 100 days of post-hospital care for skilled nursing or rehabilitative services on a daily basis (after a three-day hospital stay). There is no beneficiary cost-sharing for the first 20 days. Days 21-100 are subject to daily coinsurance charges (\$133.50 in 2009).

<sup>8</sup> J. Feder, H. Komisar, and R. Friedland, “Long-Term Care Financing: Policy Options for the Future,” Washington, DC: Georgetown University, 2007.

<sup>9</sup> See CRS Report R40718, *Long-Term Care (LTC): Financing Overview and Issues for Congress*, by Julie Stone.

<sup>10</sup> Estimates by Marc Cohen reported in Testimony before the U.S. Congress, House Committee on Energy and Commerce Subcommittee on Oversight and Investigation, *Long-Term Care Insurance: Are Consumers Protected for the Long-Term?* July 24, 2008.

and group markets increased at double-digit rates from 1995 to 2002 before slowing in more recent years. The composition of the market has also changed as employer-sponsored LTC insurance has grown as a share of the total LTC insurance market. In 2007, employer-sponsored LTC insurance represented one-third of all active policies, compared with fewer than 3% in the mid-1990s. Employer-sponsored LTC insurance is distinct from employer-sponsored health insurance in that employers typically do not contribute to LTC insurance premiums. However, employer-sponsored LTC insurance provides a larger risk pool and generally lower premiums than if LTC insurance is purchased in the individual market. The federal government is one of the largest employers offering group LTC insurance.

After 15 years of growth, demand for private LTC insurance has slowed considerably since 2004.<sup>11</sup> As of 2005, less than 10% of the population aged 50 and older owns a LTC insurance policy.<sup>12</sup> The weakening of this market has occurred despite enhanced tax incentives (especially at the state level), increased emphasis on consumer protections, and the enactment of a private LTC insurance program for federal employees.

The factors affecting the demand for LTC insurance can be viewed by comparing two cohorts: those under the age of 65 and those aged 65 and older. For those under the age of 65, annual LTC insurance premiums are generally lower.<sup>13</sup> However, this cohort also faces competing demands of raising families and saving for retirement. Many do not fully understand their future risks or coverage options for LTC services. According to AARP, nearly four in five respondents between the ages of 45 and 64 incorrectly assume that the Medicare program will also pay for their LTC needs.<sup>14</sup>

For those individuals who reach the age of 65 and have not sufficiently planned for their LTC needs, the cost and complexity of the policies become major barriers to purchase. In addition, increased concerns have arisen about the adequacy of consumer protections for LTC insurance, in part, as a result of inconsistencies in LTC insurance laws and regulations across the states. More recently, adverse publicity about potential problems with claims denials by LTC insurers and heightened concerns about the future solvency of LTC insurers in the current economic environment have further dampened demand.<sup>15</sup>

## **The Community Living Assistance Services and Supports Program**

PPACA establishes a federally administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program. Specifically, Section 8002(a) of the law creates a new Title XXXII of the Public Health Service Act (PHSA) titled

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<sup>11</sup> J. Douglas and K. Fisherkeller, "U.S. Individual Long-Term Care Insurance: 2008 Supplement," LIMRA, 2009.

<sup>12</sup> J. Feder, H. Komisar, and R. Friedland, "Long-Term Care Financing: Policy Options for the Future," Washington, DC: Georgetown University, 2007.

<sup>13</sup> Once the policy is purchased, premiums cannot increase with age, but they can increase for other reasons.

<sup>14</sup> AARP, "The Costs of Long-Term Care: Public Perceptions Versus Reality in 2006," December 2006, at [http://assets.aarp.org/rgcenter/health/ltc\\_costs\\_2006.pdf](http://assets.aarp.org/rgcenter/health/ltc_costs_2006.pdf).

<sup>15</sup> See CRS Report R40601, *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*, by Janemarie Mulvey.

“Community Living Assistance Services and Supports.” Title XXXII establishes a process for the Secretary of Health and Human Services (HHS) to develop the CLASS program to provide a cash benefit that eligible enrollees can use to purchase various long-term care services and supports, such as home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. The stated purpose of the CLASS program is to

- provide individuals with functional limitations tools that allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;
- establish an infrastructure that will help address the nation’s community living assistance services and support needs;
- alleviate burdens on family caregivers; and
- address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

This section of this CRS report discusses key features of the CLASS program with respect to the CLASS Independence Benefit Plan; coordination of the CLASS program with other federal programs; program oversight and reporting requirements; and the tax treatment of the CLASS program. In addition, this section discusses provisions relating to the personal care attendant workforce for CLASS beneficiaries. Unless otherwise specified, references to “the Secretary” refer to the Secretary of HHS.

## **CLASS Independence Benefit Plan**

PPACA establishes a process for the development of the CLASS Independence Benefit Plan. Accordingly, the Secretary is required to develop at least three actuarially sound benefit plans in consultation with appropriate actuaries and other experts. These three benefit plans will be considered for designation as the CLASS Independence Benefit Plan. The CLASS Independence Advisory Council (Advisory Council) is required to evaluate the proposed benefit plans and make a recommendation to the Secretary based on the plan that best balances price and benefits to meet enrollees’ needs in an actuarially sound manner, while optimizing the program’s sustainability. The Secretary is required to take into consideration the Advisory Council’s recommendation and to designate a benefit plan no later than October 1, 2012. The Secretary’s designation is to be published, along with details of the plan and the reasons for its selection, in a final rule that allows for a period of public comment. The CLASS Independence Benefit Plan is required to provide eligible beneficiaries with benefits consistent with certain requirements related to premiums, vesting and benefit triggers, and benefits provided. The following describes requirements for enrollment in the CLASS program and the CLASS Independence Benefit Plan.

### **Individuals Eligible to Enroll in the CLASS Program**

Those eligible to enroll in the CLASS program are actively employed individuals aged 18 and older who receive wages that are taxable under the Old Age Survivors and Disability Insurance (OASDI) program or Railroad Retirement Tier 1 Benefits. This includes the self-employed. The CLASS enrollment would not be subject to medical underwriting, so coverage would be available to all persons who enroll, regardless of pre-existing conditions.

## **Enrollment and Disenrollment**

Similar to the employer-sponsored private LTC insurance market, PPACA relies heavily on employers for enrollment into the CLASS program. Employers may choose to participate in the CLASS program. In doing so, they must automatically enroll eligible employees. Employers would be responsible for withholding CLASS premiums through payroll deductions. Employees would then have the opportunity to “opt-out” if they do not want to participate.

These enrollment procedures for employers in the CLASS program are intended to be similar to those currently established for 401(k) and other similar retirement plans by the Internal Revenue Service. The key difference, however, is that employers who choose to offer a 401(k) retirement plan are not required to automatically enroll employees in the plan. Instead employers have the option to choose either voluntary or automatic enrollment. Under the CLASS program, however, employers who choose to participate are required to use automatic enrollment procedures. The Secretary, in coordination with the Secretary of Treasury, is required to establish such procedures.

In addition, the Secretary is required to develop procedures for an alternative enrollment process for an individual (1) who is self-employed, (2) who has more than one employer, or (3) whose employer does not elect to participate in the automatic enrollment process.

## **Premiums**

Beginning in the first year of the CLASS program and each subsequent year, the Secretary is required to establish premiums based on a 75-year actuarial estimate of expected costs to ensure solvency of the program. Premiums would vary by age at enrollment. Once an individual is enrolled in the CLASS program, future premiums do not increase as long as the individual is an active enrollee.<sup>16</sup> However, certain exceptions exist if premiums are found to be insufficient to cover future benefits or individuals lapse their policies. With respect to premium increases related to the program’s solvency, those active enrollees who have attained the age of 65, paid enrollment premiums for at least 20 years, and are not actively employed are exempt from such increases. The CLASS provisions prohibit medical underwriting, so coverage would be available to all persons who enroll regardless of pre-existing conditions.

PPACA allows low-income workers and employed full-time students to pay only a minimal premium to enroll in the CLASS program. Specifically, individuals with incomes below the federal poverty level (FPL) and employed full-time students aged 18 to 21 must pay a monthly premium of \$5. This premium is indexed to inflation in subsequent years. These individuals are required to self-attest that (1) their income does not exceed the FPL or (2) they are employed full-time students. Moreover, their income must also be verified using procedures similar to those used by the Commissioner of Social Security, as specified in the Social Security Act (SSA). Once an individual is no longer a full-time student, he or she is subject to the same monthly premium as an individual of the same age who first enrolls in the program.

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<sup>16</sup> An active enrollee is defined as an individual who is enrolled in the CLASS program in accordance with PHS Section 3204 (related to Enrollment and Disenrollment Requirements) and who has paid any premiums due to maintain such enrollment.

In determining monthly premiums, the Secretary is authorized to factor in the program's administrative costs. Administrative costs are limited to 3% of all premiums paid during each year for all years of the program.

**Table 1** shows premium estimates by the CBO and the CMS. CBO estimates that the average monthly premium in 2011 will be \$123 (with premiums for new enrollees increasing for inflation in later years) for an average benefit of \$75 per day. These estimated premiums were calculated to be adequate for the program to remain solvent for 75 years, taking into account the interest income that would be generated on unspent balances in the CLASS Independence Trust Fund. CBO assumes that 3.5% of the adult population would participate in the program.

**Table 1. Estimates of Average Monthly Premiums Under CLASS Program**

CBO Estimate	\$123 per month for \$75 per day average benefit
CMS Estimate	\$240 per month for \$50 per day average benefit

**Source:** CMS estimates available in Memorandum from the Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as amended*. April 22, 2010, CBO estimates available in Memorandum to Senator Reid, dated March 11, 2010, at <http://www.cbo.gov>.

As shown in **Table 1**, CMS estimates that the initial average premium would be about \$240 per month for an average benefit of \$50 per day.<sup>17</sup> Premium estimates from CMS are higher than CBO's, largely reflecting assumptions about increased adverse selection and a lower participation rate of 2.0% of the adult population. CMS states that

in general, a voluntary, unsubsidized, and non-underwritten insurance program such as CLASS faces a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases.<sup>18</sup>

According to CMS, the problem of adverse selection would be intensified by requiring participants to subsidize the \$5 premiums for students and low-income enrollees.

Estimates of CLASS program premiums cannot be directly compared with current premiums in the private LTC insurance market because of the differences in the daily benefit levels and duration of the policies. The CLASS program premiums would purchase a minimum daily cash benefit of \$50 (on average), as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various levels. The actual benefit amount would vary by the degree of limitation in a beneficiary's ADLs or cognitive impairment. In the private LTC insurance market, the average daily benefit is \$150 and does not vary by functional limitation (but

<sup>17</sup> Memorandum from the Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as amended*, April 22, 2010.

<sup>18</sup> An analysis of the potential adverse selection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. This memorandum entitled "Actuarial Issues and Policy Implications of a Federal Long-Term Care Insurance Program" was issued on July 22, 2009 and based on the CLASS provisions in S. 1679, the Affordable Health Choices Act, which is similar to the CLASS provisions in PPACA.

does vary by setting of care).<sup>19</sup> The CLASS program does not limit the duration of the benefit. That is, an individual is able to receive a cash benefit under CLASS for as long as he or she is determined eligible. This would be equivalent to a lifetime benefit in the private long-term care insurance market, which is not a common feature. The majority of individuals who purchase private LTC insurance have a benefit duration between three and five years. Individuals with lower annual incomes (below \$25,000) often choose shorter benefit periods in the private market.<sup>20</sup>

For illustration purposes, **Table 2** shows what the average \$150 per day private LTC insurance benefit would be if it were divided by three in order to estimate a comparable private LTC insurance premium to that of an average \$50 per day benefit.<sup>21</sup> In addition, to provide a comparison to the CBO premium estimate of an average benefit of \$75 per day, a similar calculation is done by dividing the premium for \$150 per day benefit by two. These calculations are intended to be rough estimates and do not account for any fixed administrative costs that might be applied to these premiums. The estimated average (non-weighted) monthly premium for a \$50 per day private LTC insurance policy that offers lifetime benefits is about \$91 in 2010. The estimated average (non-weighted) monthly premium for a \$75 per day policy in the private LTC insurance market for lifetime benefits is about \$137 a month.

**Table 2. Premiums in Private LTC Insurance Market, 2010**  
(in dollars)

Lifetime Benefit with 5% Compound Inflation Adjustments			
Age at Purchase	Monthly Premium for a \$150 Daily Benefit	CRS Estimated Monthly Premium for a \$75 Daily Benefit	CRS Estimated Monthly Premium for a \$50 Daily Benefit
Age 40	\$152	\$75	\$57
Age 50	214	107	64
Age 60	317	158	86
Age 70	416	208	167
Average (non-weighted)	274	137	91

**Source:** Premiums for the \$150 a day benefit based on premiums reported by age from the premium calculator for the Federal Long-Term Care Insurance Program at <http://www.ltcfed.gov>.

### Vesting and Benefit Triggers

To trigger benefit eligibility, PPACA requires that an eligible beneficiary be an active enrollee that has paid premiums for at least five years. In other words, the new law requires a five-year

<sup>19</sup> America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance?,” April 2007.

<sup>20</sup> Ibid.

<sup>21</sup> The \$50 per day benefit is the minimum average benefit provided by the CLASS program, with benefits varying based on a scale of functional ability. This example compares the cost of purchasing a \$50 per day policy in the private LTC insurance market with the \$50 minimum average CLASS benefit.

vesting period before enrolled individuals are eligible for CLASS program benefits. In addition, there is a minimum earnings requirement that states that an individual must have earned enough to be credited with one quarter of Social Security coverage for that year (e.g., for 2010, this amount is \$1,120). Finally, there must be a determination that an individual has a functional limitation that is expected to last for a continuous period of 90 days, as certified by a licensed health care practitioner, in any of the following areas where the individual

1. is unable to perform at least the minimum number (which may be 2 or 3) of ADLs without substantial assistance (as defined by the Secretary) from another individual;
2. requires substantial supervision to protect against threats to health and safety due to substantial cognitive impairment; or
3. has a level of functional limitation similar (as determined under regulations prescribed by the Secretary) to the level described in (1) or (2) above.

Active enrollees are deemed presumptively eligible for CLASS benefits if they are a patient hospitalized for long-term care or a patient in certain specified long-term care facilities, and in or about to begin the discharge planning process or within 60 days from being discharged. In addition, they must have applied for the maximum available cash benefit.

## **Benefits Provided**

The CLASS program provides a cash benefit as well as advocacy services and advice and assistance counseling. These services are considered to be administrative expenses and subject to the limits on administrative costs discussed earlier (i.e., 3% of all premiums paid during each year for all years of the program). The Secretary is required to designate an entity (other than the state's Disability Determination Services used by SSA) to serve as an Eligibility Assessment System to provide eligibility assessments of active enrollees who apply to receive CLASS program benefits. The Secretary would be required to establish procedures for benefit applicants to be guaranteed the right to appeal an adverse determination. An eligible beneficiary must periodically, as determined by the Secretary, recertify for continued eligibility of benefits. The following discusses the CLASS benefits in greater detail.

### *Cash Benefit*

A cash benefit is available to eligible individuals. As previously mentioned, cash benefits are initially to be no less than an average of \$50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various levels). In subsequent years, this minimum benefit is indexed for inflation. The cash benefit also varies based on the severity of the beneficiary's functional or cognitive impairment, with no fewer than two, and not more than six, benefit-level amounts. Cash benefits are to be paid on a daily or weekly basis with no lifetime or aggregate limit.

The CLASS program's average minimum daily benefit amount of \$50 is about one-third of the average daily benefit of \$150 provided by most LTC insurance policies today.<sup>22</sup> When compared

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<sup>22</sup> A. Tumlinson, C. Aguiar, and M. O'Malley, *Closing the Long-Term Care Funding Gap: The Challenge of Private Long-Term Care Insurance*, the Kaiser Commission on Medicaid and the Uninsured, June 2009.

with the current cost of LTC services, the CLASS program's average minimum daily benefit most likely would cover some basic home care services (see **Table 3**). The minimum benefit is not likely to fully cover full-time home care, adult day care, or more expensive institutionalized care in a nursing home. However, as noted earlier, the actual benefit amount will vary by degree of limitation in ADLs or cognitive impairment, so the comparison in **Table 3** is only in contrast to the minimum.

**Table 3. Estimated Cost of Long-Term Care Services**  
Average Cost Per Day, 2010

Type of Care	Cost Per Day
Home Health Aide (licensed)	\$48 (assumes 2.5 hours a day of care) <sup>a</sup>
Nursing Home Room (Semi-private)	\$185
Nursing Home Room (Private)	\$206
Adult Day Care	\$60

**Source:** CRS estimates based on the Genworth Financial 2010 Cost of Care Survey, <http://www.genworth.com>.

- a. Daily estimate based on assumption from studies that show individuals use on average 17 hours of care a week or 2.5 hours a day and the cost per hour is \$19.

The Secretary is required to establish procedures for administering the provision of cash benefits, including payment of cash benefits into a Life Independence Account established on behalf of each beneficiary. Funds in the Life Independence Account are electronically managed with procedures for allowing beneficiaries to access the account through debit cards. Cash benefits paid into this account can be used to purchase nonmedical services and supports that beneficiaries would need to maintain their independence at home or in another residential setting of their choice, including, but not limited to, home modifications, assistive technology, accessible transportation, homemaker services, respite care, personal assistance services, home care aides, and nursing support. Beneficiaries may also use their cash benefit to obtain assistance with decision making concerning medical care.

Beneficiaries are allowed to defer benefits on a month-to-month basis but are not allowed to roll-over accumulated funds in the account from one year to the next. The applicable period for determining a year for which the accumulated funds in the Life Independence Account must be used is the 12-month period that begins with the first month in which the beneficiary became eligible to receive the cash benefit. At an average minimum benefit of \$50 per day, individuals could accumulate up to \$18,200 per year, and then withdraw those funds at the end of the year.

### *Advocacy Services*

The Secretary is also required to enter into agreements with state's Protection and Advocacy (P&A) Systems to provide advocacy services to beneficiaries. To obtain these services, beneficiaries would be assigned an advocacy counselor who would provide them with

- information regarding how to access the appeals process established for the program;

- assistance with respect to the annual recertification and notification process for eligibility; and
- other assistance with obtaining services as required by the Secretary.

### ***Advice and Counseling Services***

The Secretary is required to enter into agreements with public and private entities to provide advice and assistance counseling services. To obtain these services, beneficiaries are assigned an advice and assistance counselor who provides beneficiaries with

- access and coordination of LTC services and supports in the most integrated setting;
- possible eligibility for other benefits and services;
- development of a service and support plan;
- information about programs established under the Assistive Technology Act of 1998 and the services offered under the program;
- available assistance with decision making concerning medical care, including the right to formulate advance directives or other written instructions recognized by state law (such as a living will or a durable power of attorney); and
- other services as required by the Secretary.

## **Coordination of CLASS Provisions with Medicaid and Other Programs**

The CLASS program benefits are to be coordinated with Medicaid and other programs. PPACA requires the CLASS program's cash benefit to cover certain LTC costs for those beneficiaries who are also enrolled in Medicaid, with separate payment rules applying to Medicaid beneficiaries (1) receiving institutionalized care, (2) receiving Medicaid home and community-based services, or (3) enrolled in Medicaid Programs of All-Inclusive Care for the Elder (PACE). Specifically, those receiving institutional care (e.g., in a hospital, nursing facility, or intermediate care facility for the mentally retarded) are able to retain 5% of the CLASS program's daily or weekly applicable cash benefit (in addition to Medicaid's personal needs allowance). The remainder of the benefit is applied to the facility's cost of providing care, and Medicaid is required to provide secondary coverage of such care.

For those receiving Medicaid home and community-based services (HCBS) or Medicaid PACE program services, the beneficiary may retain 50% of the CLASS program's daily or weekly applicable cash benefit, with the remainder of the benefit applied toward the cost to the state of providing such assistance. The benefit cannot be used to claim federal matching funds under Medicaid.<sup>23</sup> Medicaid is required to provide secondary coverage for the remainder of any costs

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<sup>23</sup> A state would be paid the remainder of a beneficiary's daily or weekly cash benefit only if the state's HCBS waiver (under either Section 1115 or 1915(c) or (d), or the state plan amendment under 1915(i) of the SSA) does not waive requirements relating to statewideness or comparability. Thus HCBS waivers must be offered statewide and benefits must be comparable in amount, duration, or scope for individuals in particular eligibility categories. In addition, the state must also offer at a minimum case management services, personal care services, habilitation services, and respite (continued...)

incurred in providing such assistance. Institutionalized Medicaid PACE recipients are treated similarly to those other institutionalized Medicaid recipients described above.

With respect to these Medicaid payment rules, any CLASS program benefits received by an eligible beneficiary are to supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other federally funded program that provides health care benefits or assistance. PPACA does not address how deferred funds that a beneficiary accumulates in a Life Independence Account prior to Medicaid eligibility interact with Medicaid payment rules.

PPACA also requires CLASS benefits to be disregarded for the purposes of determining or continuing the beneficiary's eligibility for benefits under any other federal, state, or locally funded assistance program, including benefits paid under Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Medicare, Medicaid, the Children's Health Insurance Program (CHIP), veterans benefits, low-income housing assistance programs, or the Supplemental Nutrition Assistance Program (SNAP).

## **Funding, Oversight, and Reporting Requirements**

PPACA establishes a trust fund entitled "The CLASS Independence Fund," within the U.S. Department of Treasury. The Secretary of the Treasury is required to invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplementary Medical Insurance Trust Fund under Medicare. PPACA also creates a Board of Trustees of the CLASS Independence Fund composed of the Secretary, Commissioner of Social Security, the Secretary of the Treasury, the Secretary of Labor, and two members of the public nominated by the President. The Board of Trustees is required to (1) hold the fund; (2) report to Congress on the operation and status of the fund, as specified; (3) report immediately to Congress whenever the board is of the opinion that the amount of the fund is not actuarially sound with regard to specified projections; and (4) review the general policies followed in managing the fund, and recommend changes in such policies, as specified.

PPACA also establishes a CLASS Independence Advisory Council that consists of up to 15 individuals appointed by the President. The Advisory Council is required to advise the Secretary on matters of general policy in the administration of the CLASS program and in the formulation of regulations, including the development of the CLASS Independence Benefit Plan and the determination of monthly premiums under the plan. The Advisory Council also formulates regulations regarding the financial solvency of the program. PPACA authorizes such sums as may be necessary for FY2011 and each fiscal year thereafter to carry out the Advisory Panel's duties, to remain available until expended.

The Secretary is required to promulgate regulations as necessary to carry out the CLASS program, including regulations concerning fraud and abuse. In addition, the Secretary is required to submit an annual report to Congress on the CLASS program beginning January 1, 2014, to include

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(...continued)

care under such a waiver or state plan amendment.

- the total number of enrollees in the program;
- the total number of eligible beneficiaries during the fiscal year;
- the total amount of cash benefits provided during the fiscal year;
- a description of instances of fraud or abuse identified during the fiscal year; and
- recommendations for such administrative or legislative action as the Secretary determines necessary to improve the program or to prevent fraud and abuse.

In addition to these specifications, the report includes recommendations for such administrative or legislative action as the Secretary determines necessary to ensure solvency of the program. The HHS Inspector General is required to submit an annual report to the Secretary and to Congress relating to the overall progress of the CLASS program and the existence of waste, fraud, and abuse in the program.

PPACA also includes provisions relating to solvency and financial independence. Regarding solvency, the Secretary is required to regularly consult with the Board of Trustees and the Advisory Council to ensure that enrollee premiums are adequate to ensure the financial solvency of the CLASS program. With respect to financial independence, PPACA explicitly prohibits “taxpayer funds” from being used for payment of benefits under the CLASS program. “Taxpayer funds” are defined as federal funds from a source other than premiums by CLASS program participants and interest earnings on those premiums.

## **Tax Treatment of CLASS Program**

Under PPACA, CLASS premiums and benefits are treated for tax purposes similarly to current tax-qualified LTC insurance contracts. Under current law, benefits from a “qualified” LTC insurance policy are excluded from the gross income of the taxpayer (that is, they are exempt from taxation).<sup>24</sup> The exclusion for LTC insurance benefits paid on a per diem or other periodic basis is limited to the greater of (1) \$280 a day (in 2009) or (2) the cost of LTC services. Employee contributions to LTC insurance premiums are not deductible except as itemized deductions to the extent they, and other unreimbursed medical expenses, exceed 7.5% of adjusted gross income (AGI).<sup>25</sup> Employer contributions, however, are not considered as taxable income to the employee. LTC insurance premiums are subject to age-adjusted limits. In 2009, these limits ranged annually from \$320 for persons aged 40 or younger to \$3,980 for persons over aged 70 and older. In addition, under current law, employer contributions toward the cost of tax-qualified LTC insurance policies are excluded from the gross income of the employee. Self-employed individuals are allowed to include LTC insurance premiums in calculating their deductions for health insurance expenses. Only amounts not exceeding the age-adjusted limits can be deducted or excluded from taxable income.

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<sup>24</sup> Health Insurance Portability and Accountability Act, P.L. 104-191 and Section 7702B(b) of the Internal Revenue Code.

<sup>25</sup> See Section 213(d) of the Internal Revenue Code.

## **Personal Care Attendant Workforce**

PPACA also includes two provisions related to personal care attendant workers (Section 8002(b)). These provisions address the infrastructure for the provision of personal care attendant workers for CLASS beneficiaries, and establish a Personal Care Attendant Workforce Advisory Panel, as described below.

### **Adequate Infrastructure**

The stated purpose under PPACA is to assure an adequate infrastructure for the provision of personal care attendant workers to individuals receiving benefits under the CLASS program. It amends Medicaid statute to require a Medicaid state plan for medical assistance to assess the extent to which certain entities have the capacity to serve as fiscal agents for, employers of, and providers of employment-related benefits for such workers who provide services to CLASS beneficiaries. PPACA designates or creates such entities to serve in this capacity for such workers for the stated purpose of ensuring an adequate workforce supply for CLASS beneficiaries and ensuring that such entities will not negatively alter or impede existing service delivery that provides for consumer-controlled or self-directed home and community-based services, impede the ability of individuals to direct and control their home and community-based services, or inhibit CLASS beneficiaries from relying on family members for the provision of personal care services.

### **Advisory Panel**

PPACA also includes a provision requiring the Secretary, within 90 days of enactment, to establish a Personal Care Attendants Workforce Advisory Panel. The purpose of the panel is to examine and advise the Secretary and Congress on workforce issues related to personal care attendant workers, including adequacy with respect to the number of personal care workers; their salaries, wages, and benefits; and access to the services they provide.

The Secretary is required to ensure that membership on the panel include seniors and individuals with disabilities of all ages, as well as representatives of individuals with disabilities, seniors, workforce and labor organizations, home and community-based service providers, and assisted living providers.

## **Budget Implications of the CLASS Program**

CBO and CMS have estimated the federal budget impact of the CLASS provisions. Their estimates differ due to different assumptions about participation rates. CBO estimates that the CLASS program will reduce federal deficits in the short run, while increasing costs in subsequent decades. Specifically, CBO estimates that the CLASS program provisions will reduce the deficit by \$70 billion over the 10-year period from 2010 through 2019. These estimates include \$2 billion in savings to the Medicaid program.<sup>26</sup> Cost savings would largely be generated as a result

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<sup>26</sup> Congressional Budget Office, Letter to Senator Harry Reid From Douglas Elmendorf, CBO Director, dated March 11, 2010.

of the five-year vesting requirement under which the program pays out far less in benefits than it would receive in premiums over the next 10 years.<sup>27</sup>

As noted earlier, an important assumption in CBO’s estimates is that premiums would be set (and updated over time) to ensure that they cover the full cost of the program as measured on an actuarial basis. CBO also assumes a 3.5% participation rate in the program. This compares with a 4% participation rate in the current employer-sponsored private LTC insurance market.

CMS provided independent estimates of the CLASS provisions in PPACA. CMS’s estimate includes a net federal savings of about \$38 billion over 10 years. Differences between the CMS and CBO estimates are due to different assumptions about participation rates in the CLASS program. CMS assumes a 2% participation rate, which is lower than CBO’s assumption noted above. According to CMS, this lower than average participation rate is due to (1) the voluntary nature of the program; (2) the lack of a federal subsidy; (3) a minimal premium of \$5 for working students and low-income individuals; (4) a relatively high premium as a result of adverse selection and subsidizing those paying a \$5 premium; (5) a new and unfamiliar benefit; and (6) the availability of lower-priced private LTC insurance for many.<sup>28</sup>

## Timeline for CLASS Provisions

**Table 4** provides a timeline of key dates for implementation of CLASS program provisions, as specified under PPACA. Notably, by October 1, 2012, the Secretary must designate a benefit plan as the CLASS Independence Benefit Plan and publish such designation in a final rule that allows for a public comment period. However, the new law does not specify a date for CLASS program implementation or enrollment.

**Table 4. Timeline of Key Implementation Dates for CLASS Provisions in PPACA**

Implementation Date	Section Number	Provision
By June 21, 2010 <sup>a</sup>	Sec. 8002(c)	Requires the Secretary to establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendants.
January 1, 2011	Sec. 8002(a)	Establishes the CLASS Program, as specified.
January 1, 2011	Sec. 8002(b)	Addresses adequate infrastructure for the provision of personal care attendants. Specifically, requires states, no later than March 23, 2012, to (1) assess whether certain providers have the capacity to serve as fiscal agents and provide employment-related benefits to personal care attendants who provide services to CLASS beneficiaries; (2) designate or create entities to serve as fiscal agents; and (3) ensure such designation does not alter or impede existing consumer-directed home and community services delivery systems or inhibit individuals from relying on family members for personal care services.

<sup>27</sup> These revenue estimates were prepared by the Joint Committee on Taxation.

<sup>28</sup> Memorandum from the Office of the Actuary, Centers for Medicare and Medicaid Services, *Estimated Financial Effects of the Patient Protection and Affordable Care Act, as amended*, April 22, 2010.

<b>Implementation Date</b>	<b>Section Number</b>	<b>Provision</b>
January 1, 2011	Sec. 8002(d)	Requires the inclusion of information on supplemental coverage from the CLASS program in the National Clearinghouse for Long-Term Care Information.
By January 1, 2012	Sec. 8002(a)	Requires the Secretary to (1) establish an Eligibility Assessment System; (2) enter into agreements with the Protection and Advocacy System for each state; and (3) enter into agreements with public and private entities to provide advice and assistance counseling.
By October 1, 2012	Sec. 8002(a)	Requires the Secretary to designate a benefit plan as the CLASS Independence Benefit Plan and publish such designation, along with details of the plan and the reasons for the Secretary's selection, in a final rule that allows for a public comment period.
Beginning January 1, 2014	Sec. 8002(a)	Requires the Secretary to submit an annual report to Congress on the CLASS program, as specified.

**Source:** Table prepared by the Congressional Research Service based on the text of PPACA (P.L. 111-148).

**Notes:** Unless otherwise specified, references in this section to “the Secretary” refer to the Secretary of HHS.

- a. Requires the establishment of a Personal Care Attendants Workforce Advisory Panel within 90 days of enactment.

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