



Community Living Assistance Services and Supports (CLASS): Overview and Summary of Provisions

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Summary

Under current law, the majority of paid long-term services and supports (LTSS) 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 long-term care (LTC) insurance is available to provide some financial protection against an individual's risk of the potentially high cost of LTSS, 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. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) initially established a federally administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program. The stated purpose of the CLASS program, among other things, was to provide a financing mechanism for long-term care services that supports personal choice and independence to live in the community. However, a number of concerns were raised about the long-run sustainability of the program and as a result on October 14, 2011, the Department of Health and Human Services (HHS) sent a letter to Congress stating that after careful examination of how the Administration might implement a long-term financially stable CLASS program, HHS did not see a viable path forward for implementation at that time.

With administrative implementation of the CLASS program stalled, the 112th Congress took legislative action to repeal the CLASS program provisions under the ACA. On January 3, 2013, President Obama signed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among its provisions, Sec. 642 of ATRA repealed Title XXXII of the Public Health Services Act entitled "Community Living Assistance Services and Supports" (CLASS). In doing so, it also made certain conforming statutory changes to the ACA by repealing Title VIII related to the CLASS program and certain provisions in Medicaid statute (Title XIX of the Social Security Act). Sec. 642 also rescinded the unobligated balance of ACA's funds to the National Clearinghouse for Long Term Care Information (ACA had provided \$3 million in mandatory funding for each of fiscal years 2011 through 2015 for this activity).

Despite the repeal of the CLASS program provisions, and with it the establishment of a voluntary federally administered long-term care insurance program, the issue of comprehensive long-term services and supports (LTSS) reform will likely be of consideration in the 113th Congress. Within 30 days of enactment, Sec. 643 of ATRA established a Commission on Long-Term Care (LTC). The new LTC Commission, composed of 15 members representing the interests of certain LTSS stakeholders and organizations, will be appointed by the President and other specified congressional leaders. The commission is required to develop a plan and legislative recommendations for the establishment, implementation, and financing of a LTSS system.

This report first discusses the cost and financing for LTSS and the current market for private LTC insurance. It then details the various CLASS program requirements, which, although now repealed, may remain of interest to Congress and are relevant to ongoing discussions of LTC proposals. Finally, it provides a discussion of the long-run sustainability concerns and the status of administrative implementation.

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Introduction

Update: Legislative Activity in the 112th Congress

The 112th Congress took legislative action to repeal the CLASS program provisions under the ACA. H.R. 1173, the Fiscal Responsibility and Retirement Security Act of 2011 (introduced by Representative Boustany), was passed by the House on February 1, 2012. The bill would have repealed the CLASS program (Title VIII of the Patient Protection and Affordable Care Act ACA, P.L. 111-148, as amended). A companion bill (S. 720, Repeal the CLASS Entitlement Act, by Senator Thune) was introduced in the Senate on March 4, 2011. On January 3, 2013, President Obama signed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among its provisions, Sec. 642 of ATRA repealed Title XXXII of the Public Health Services Act entitled "Community Living Assistance Services and Supports" (CLASS). In doing so, it also made certain conforming statutory changes to the ACA by repealing Title VIII related to the CLASS program and certain provisions in Medicaid statute (Title XIX of the Social Security Act). Sec. 642 also rescinded the unobligated balance of ACA's funds to the National Clearinghouse for Long Term Care Information (ACA had provided \$3 million in mandatory funding for each of fiscal years 2011 through 2015 for this activity).

Despite the repeal of the CLASS program provisions and with it the establishment of a voluntary federally administered long-term care insurance program, the issue of comprehensive long-term services and supports (LTSS) reform will likely be of debate in the 113th Congress. Within 30 days of enactment of ATRA, Sec. 643 established a Commission on Long-Term Care, which is required to develop a plan and legislative recommendations for the establishment, implementation, and financing of a LTSS system. The commission, composed of 15 members representing the interests of certain LTSS stakeholders and organizations, will be appointed by the President and other specified congressional leaders. No later than six months after its appointment, the commission will vote on a report based on the developed plan and any proposals for legislative action, referred to as the commission bill. The commission will terminate 30 days after a vote on the plan and proposed commission bill. If approved by a majority of commission members, the commission bill must be introduced in the Senate and the House.

The aging of the population is expected to increase the demand for long-term care services and supports (LTSS) 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. The ACA established a federally administered voluntary long-term care (LTC) insurance program entitled the Community Living Assistance Services and Supports (or CLASS) program. The stated purpose of the program, among other things, was to provide a financing mechanism for long-term care services that supports personal choice and independence to live in the community. As noted in the text box above, the CLASS program provisions in ACA have subsequently been repealed.

This report first discusses the cost and financing for LTSS 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 & Medicaid Services (CMS). Finally, the report provides a discussion of the concerns regarding the long-run sustainability of the CLASS program and efforts toward administrative implementation and subsequent repeal of the CLASS program provisions established under the ACA.

Cost and Financing of Long-Term Services and Supports

Unlike medical treatments, LTSS primarily assist individuals in their day-to-day activities of daily living (ADLs).¹ While medical services are typically provided to treat specific acute and chronic conditions in a health care setting, these services are different from LTSS. Specifically, LTSS 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.² The probability of needing LTSS increases with age. One study has estimated that more than two-thirds of individuals who reach the age of 65 will require LTSS at some point before they die.³

For those individuals who need LTSS, the costs of providing such care will depend on the setting, intensity (including the skill level of the provider), and the duration of care 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 2011, the average cost of personal unskilled care at home (such as bathing, dressing, and transferring from a bed or chair) was \$19 an hour.⁴ In addition, the cost of care will also vary by intensity and duration of care. The most recently available research has found that individuals use on average about 18 hours a week of paid care,⁵ which would result in an annual cost of about \$17,000 a year in 2011 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 in a nursing home), cost on average \$39,000 annually in 2011. Nursing home care, on the other hand, generally costs more in that it provides custodial care with nursing assistance available 24 hours a day. In 2011, the annual cost of a nursing home stay was \$70,000 for a semi-private room and \$78,000 for a private room.⁶ However, these estimates are national averages and can vary widely by geographic region.

Under current law, the majority of paid LTSS are funded by public programs, but these programs are limited in scope. For example, over 40% of LTSS is financed by the Medicaid program, and is intended to provide a safety net for those who cannot afford to pay for LTSS.⁷ Because Medicaid

¹ 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 (IADLs) include things like food preparation, medication management, and housekeeping.

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

³ 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.

⁴ Genworth Financial, *Genworth 2011 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes*, 2011.

⁵ M.P. LaPlante, C. Harrington, and T. Kang, "Estimating Paid and Unpaid Hours of Personal Assistance Services in Activities of Daily Living Provided to Adults Living at Home," *Health Services Research*, vol. 37, no. 2 (April 2002), pp. 397-415.

⁶ Genworth Financial, *Genworth 2011 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes*, 2011.

⁷ CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, prepared March 2, 2011.

is administered and partially financed by each state, there is wide variation in eligibility and benefits across the nation. Medicare, which provides health care to older Americans, finances another one-fifth of LTSS. But Medicare funding of LTSS is predominantly for post-acute care services and is not intended to cover care over an extended period of time.⁸ Although private LTC insurance is available to provide some financial protection against the risk of the potentially high cost of LTSS, fewer than 10% of individuals aged 50 and older own a policy.⁹ Individuals who seek paid LTSS but do not qualify for public funding or do not have private LTC insurance must pay for these services directly out-of-pocket. In 2009, about 18% of LTSS spending was paid out-of-pocket.¹⁰

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 LTSS 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, 7.6 million Americans aged 55 and older had private LTC insurance.¹¹ The growth in the number of LTC insurance policies in both the individual and employer-sponsored (i.e., 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 2004.¹² As of 2008, less than 10% of the population aged 55 and older owns a LTC insurance policy.¹³ The weakening of this market has occurred despite enhanced tax incentives at the state

⁸ 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 (\$141.50 in 2011).

⁹ J. Feder, H. Komisar, and R. Friedland, "Long-Term Care Financing: Policy Options for the Future," Washington, DC, Georgetown University, 2007.

¹⁰ CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, prepared March 2, 2011.

¹¹ R. Johnson and J. Park, *Who Purchases Long-Term Care Insurance?*, Urban Institute Issue Brief, Number 29, March 2011.

¹² J. Douglas and K. Fisherkeller, "U.S. Individual Long-Term Care Insurance: 2008 Supplement," LIMRA, 2009.

¹³ R. Johnson and J. Park, *Who Purchases Long-Term Care Insurance?*, Urban Institute Issue Brief, Number 29, March 2011.

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.¹⁴ 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 LTSS. 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 LTSS needs.¹⁵

For those individuals who reach the age of 65 and have not sufficiently planned for their LTSS 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.¹⁶

The Community Living Assistance Services and Supports Program

The ACA established a federally administered voluntary LTC insurance program entitled the Community Living Assistance Services and Supports (CLASS) program. Specifically, Section 8002(a) of the law created a new Title XXXII of the Public Health Service Act (PHSA) titled “Community Living Assistance Services and Supports.” Title XXXII established a process for the Secretary of Health and Human Services (HHS) to develop the CLASS program to provide a cash benefit that eligible enrollees could 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 was 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.

¹⁴ Once the policy is purchased, premiums cannot increase with age, but they can increase for other reasons.

¹⁵ 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.

¹⁶ See CRS Report R40601, *Factors Affecting the Demand for Long-Term Care Insurance: Issues for Congress*, by Janemarie Mulvey.

Although the CLASS program has been repealed by P.L. 112-240, its provisions remain of interest and may be relevant in current and future considerations of LTSS policy. This section of the 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. For an overview of the CLASS Program, see text box entitled “Class Program: A Brief Summary.”

CLASS Program: A Brief Summary

The CLASS program provided employed individuals aged 18 and older the option to enroll in the program. This was a voluntary program, and employers would have the option of participating. The ACA specified two processes for enrollment into the CLASS program. The first was an automatic enrollment process. Within the automatic enrollment process, employers who chose to participate would be responsible for withholding CLASS premiums through payroll deductions. Employees would then have the opportunity to “opt-out” if they did not want to participate. These enrollment procedures for employers in the CLASS program were intended to be similar to those established for 401(k) and other similar retirement plans by the Internal Revenue Service. The second was an alternative enrollment process developed for self-employed individuals, individuals with more than one employer, and individuals who had an employer that did not elect to participate in the automatic enrollment process.

Premiums for the CLASS program were 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. The ACA also included premium subsidies for workers with incomes below the federal poverty level and full-time students aged 18 to 21 who currently were working. To be eligible to receive benefits an individual must have been an active enrollee who met the five-year vesting and minimum earnings requirements. In addition, an eligible individual must have had a functional limitation, as certified by a licensed health care practitioner, which was expected to last for at least 90 days. Benefits to eligible recipients included a cash benefit of at least an average of \$50 a day. Other benefits included advocacy services, and advice and assistance counseling on accessing and coordinating LTSS.

CLASS Independence Benefit Plan

The ACA established a process for the development of the CLASS Independence Benefit Plan. Accordingly, the Secretary was required to develop at least three actuarially sound benefit plans in consultation with appropriate actuaries and other experts. These three benefit plans were to be considered for designation as the CLASS Independence Benefit Plan. The CLASS Independence Advisory Council (Advisory Council) was 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 was 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 was to be published, along with details of the plan and the reasons for its selection, in a final rule that allowed for a period of public comment. The CLASS Independence Benefit Plan was 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 were actively employed individuals aged 18 and older who received wages that are taxable under the Old Age Survivors and Disability Insurance (OASDI) program or Railroad Retirement Tier 1 Benefits. This included the self-employed. The CLASS enrollment would not have been subject to medical underwriting, so coverage would have been available to all persons who enroll, regardless of pre-existing conditions.

Enrollment and Disenrollment

The ACA specified two processes for enrollment into the CLASS program. The first was an automatic enrollment process. The Secretary, in coordination with the Secretary of the Treasury, was required to establish procedures for the automatic enrollment of eligible employees by electing employers. This was a voluntary program and employers would have had the option of participating. Within the automatic enrollment process, employers who chose to participate would be responsible for withholding CLASS premiums through payroll deductions. Employees would then have the opportunity to “opt-out” if they did not want to participate. These enrollment procedures for employers in the CLASS program were intended to be similar to those currently established for 401(k) and other similar retirement plans by the Internal Revenue Service.

In addition, the Secretary was required to develop procedures for an alternative enrollment process for an individual (1) who was self-employed, (2) who had more than one employer, or (3) whose employer did 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 would have been 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 was enrolled in the CLASS program, future premiums would not increase as long as the individual was an active enrollee.¹⁷ However, certain exceptions existed if premiums were 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 attained the age of 65, paid enrollment premiums for at least 20 years, and were not actively employed were exempt from such increases. The CLASS provisions prohibited medical underwriting, so coverage would have been available to all persons who enrolled regardless of pre-existing conditions.

The ACA allowed 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 would have paid a monthly premium of \$5. This premium was indexed to inflation in subsequent years. These individuals were required to self-attest that (1) their income did not exceed the FPL or (2) they were employed full-time students. Moreover, their income must also be verified using procedures

¹⁷ An active enrollee was to be defined as an individual who would have been enrolled in the CLASS program in accordance with PHSA §3204 (related to Enrollment and Disenrollment Requirements) and who would have paid any premiums due to maintain such enrollment.

similar to those used by the Commissioner of Social Security, as specified in the Social Security Act (SSA). Once an individual was no longer a full-time student, he or she would have been subject to the same monthly premium as an individual of the same age who first enrolled in the program.

In determining monthly premiums, the Secretary was authorized to factor in the program's administrative costs. Administrative costs were 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 estimated that the average monthly premium in 2011 would have been \$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 assumed 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 estimated that the initial average premium would have been about \$240 per month for an average benefit of \$50 per day.¹⁸ Premium estimates from CMS were higher than CBO's, largely reflecting assumptions about increased adverse selection and a lower participation rate of 2.0% of the potential participants. CMS stated 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.¹⁹

According to CMS, the problem of adverse selection would have been 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 have purchased a minimum daily

¹⁸ 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.

¹⁹ 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 was based on the CLASS provisions in S. 1679, the Affordable Health Choices Act, which were similar to the CLASS provisions that were under the ACA.

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 have varied 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 does vary by setting of care).²⁰ The CLASS program did not limit the duration of the benefit. That is, an individual would have been able to receive a cash benefit under CLASS for as long as he or she was 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.²¹

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.²² 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.ltcfeds.com>.

²⁰ America’s Health Insurance Plans, “Who Buys Long-Term Care Insurance?,” April 2007.

²¹ Ibid.

²² The \$50 per day benefit was the minimum average benefit that would have been 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 and Benefit Triggers

To trigger benefit eligibility, the ACA required that an eligible beneficiary be an active enrollee that had paid premiums for at least five years. In other words, the law required a five-year vesting period before enrolled individuals were eligible for CLASS program benefits. In addition, there was a minimum earnings requirement that stated that an individual must have earned enough to be credited with one-quarter of Social Security coverage for that year (e.g., for 2011, this amount was \$1,120). Finally, there had to be a determination that an individual had a functional limitation that was 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 were deemed presumptively eligible for CLASS benefits if they were 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 provided a cash benefit as well as advocacy services and advice and assistance counseling. These services were 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 was 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 applied to receive CLASS program benefits. The Secretary was required to establish procedures for benefit applicants to be guaranteed the right to appeal an adverse determination. An eligible beneficiary was required periodically, as determined by the Secretary, to recertify for continued eligibility of benefits. The following discusses the CLASS benefits in greater detail.

Cash Benefit

A cash benefit was available to eligible individuals. As previously mentioned, cash benefits were 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 was to be indexed for inflation. The cash benefit also varied 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 were 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.²³ When compared with the current cost of LTSS, the CLASS program’s average minimum daily benefit most likely would have covered some basic home care services (see **Table 3**). The minimum benefit was 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 would have varied 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 Services and Supports
(Average cost per day, 2011)

Type of Care	Cost Per Day
Home Health Aide	\$48 (assumes 2.5 hours a day of care) ^a
Nursing Home Room (Semi-private)	\$193
Nursing Home Room (Private)	\$213
Adult Day Care	\$60

Source: Genworth Financial, *Genworth 2011 Cost of Care Survey: Home Care Providers, Adult Day Health Care Facilities, Assisted Living Facilities and Nursing Homes*, <http://www.genworth.com>.

- a. CRS estimates based on *Genworth 2011 Cost of Care Survey*. Daily estimate based on assumption from research that shows individuals use on average 18 hours of care a week or an estimated 2.5 hours a day at a cost of \$19 per hour.

The Secretary was 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 were to be electronically managed with procedures for allowing beneficiaries to access the account through debit cards. Cash benefits paid into this account could 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 could also use their cash benefit to obtain assistance with decision making concerning medical care.

Beneficiaries were allowed to defer benefits on a month-to-month basis but were 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 was 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 have accumulated up to \$18,200 per year, and then withdraw those funds at the end of the year.

²³ 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.

Advocacy Services

The Secretary was also required to enter into agreements with states' Protection and Advocacy (P&A) Systems to provide advocacy services to beneficiaries. To obtain these services, beneficiaries would have been 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 was required to enter into agreements with public and private entities to provide advice and assistance counseling services. To obtain these services, beneficiaries were to be assigned an advice and assistance counselor who would provide beneficiaries with

- access and coordination of LTSS 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 were to be coordinated with Medicaid and other programs. The ACA required the CLASS program's cash benefit to cover certain LTSS costs for those beneficiaries who were 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) would have been 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 would be applied to the facility's cost of providing care, and Medicaid was 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 could 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 could not be used to claim federal matching funds under

Medicaid.²⁴ Medicaid would have been required to provide secondary coverage for the remainder of any costs incurred in providing such assistance. Institutionalized Medicaid PACE recipients were 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 were to supplement, but not supplant, other health care benefits for which the beneficiary was eligible under Medicaid or any other federally funded program that provides health care benefits or assistance. The ACA did not address how deferred funds that a beneficiary accumulated in a Life Independence Account prior to Medicaid eligibility would interact with Medicaid payment rules.

The ACA also required 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

The ACA established a trust fund entitled "The CLASS Independence Fund," within the U.S. Department of the Treasury. The Secretary of the Treasury was 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. The ACA also created 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 was 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 was of the opinion that the amount of the fund was 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.

The ACA also established a CLASS Independence Advisory Council that consisted of up to 15 individuals appointed by the President. The Advisory Council was 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 was to formulate regulations regarding the financial solvency of the program. The ACA authorized 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.

²⁴ A state would have been paid the remainder of a beneficiary's daily or weekly cash benefit only if the state's HCBS waiver [under either §1115 or 1915(c) or (d), or the state plan amendment under 1915(i) of the SSA] did 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 would have to also offer at a minimum case management services, personal care services, habilitation services, and respite care under such a waiver or state plan amendment.

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

- 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 determined necessary to improve the program or to prevent fraud and abuse.

In addition to these specifications, the report was to include recommendations for such administrative or legislative action as the Secretary determined necessary to ensure solvency of the program. The HHS Inspector General was 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.

The ACA also included provisions relating to solvency and financial independence. Regarding solvency, the Secretary was required to regularly consult with the Board of Trustees and the Advisory Council to ensure that enrollee premiums were adequate to ensure the financial solvency of the CLASS program. With respect to financial independence, the ACA explicitly prohibited “taxpayer funds” from being used for payment of benefits under the CLASS program. “Taxpayer funds” were 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 the ACA, CLASS premiums and benefits were to be treated for tax purposes similarly to current tax-qualified LTC insurance contracts. However, under current law, itemized deductions for employee contributions to LTC insurance premiums are limited. Specifically, these premium contributions are not deductible except as itemized deductions to the extent they, and other unreimbursed medical expenses, exceed 7.5% of adjusted gross income (AGI).²⁵

Employer contributions toward LTC insurance premiums are excluded from taxable income of the employee. In addition, self-employed individuals are allowed to include LTC insurance premiums in calculating their deductions for health insurance expenses. Both of these are subject to age-adjusted limits on the amount that can be excluded from gross income. In 2010, these limits ranged annually from \$330 for persons aged 40 or younger to \$4,110 for persons aged 70 and older.

Benefits from a “qualified” LTC insurance policy are excluded from the gross income of the taxpayer (that is, they are exempt from taxation).²⁶ The exclusion for LTC insurance benefits paid

²⁵ See §213(d) of the Internal Revenue Code. Under the ACA the threshold will increase to 10% for those under the age of 65 in 2013 and for those aged 65 and older in 2017.

²⁶ Health Insurance Portability and Accountability Act, P.L. 104-191, and §7702B(b) of the Internal Revenue Code.

on a per diem or other periodic basis is limited to the greater of (1) \$290 a day (in 2010) or (2) the cost of LTSS.

Personal Care Attendant Workforce

The ACA also included two provisions related to personal care attendant workers [§8002(b)]. These provisions addressed the infrastructure for the provision of personal care attendant workers for CLASS beneficiaries, and established a Personal Care Attendant Workforce Advisory Panel, as described below.

Adequate Infrastructure

The stated purpose under the ACA was to assure an adequate infrastructure for the provision of personal care attendant workers to individuals receiving benefits under the CLASS program. It amended 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 would provide services to CLASS beneficiaries. The ACA designated or created 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 would not negatively alter or impede existing service delivery that provided 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

The ACA also included a provision requiring the Secretary, within 90 days of enactment, to establish a Personal Care Attendants Workforce Advisory Panel. The purpose of the panel was 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 was required to ensure that membership on the panel included 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.

National Clearinghouse for Long-Term Care Information

The National Clearinghouse for Long-Term Care Information (Clearinghouse) was established under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171). Under Section 6021(d) of the DRA, the HHS Secretary is required to establish the Clearinghouse to (1) educate consumers with respect to the availability and limitations of coverage for long-term care under Medicaid; (2) provide objective information to assist consumers in the decision about whether to purchase LTCI; and (3) maintain a list of states with state long-term care partnerships under Medicaid. Congress provided \$3 million in mandatory funding for the Clearinghouse for each of fiscal years 2006 to 2010. The ACA amended Section 6021(d) of the DRA to extend this mandatory funding

of \$3 million per year for FY2011 through FY2015 for the Clearinghouse. ACA also required the Clearinghouse to include information regarding how benefits provided under a CLASS benefit plan differ from disability insurance benefits.

Budget Implications of the CLASS Program

CBO and CMS have estimated the federal budget impact of the CLASS provisions if the program were implemented. Their estimates differ due to different assumptions about participation rates and adverse selection. CBO estimated that the CLASS program would reduce federal deficits in the short run, while increasing costs in subsequent decades. Specifically, CBO estimated that the CLASS program provisions would reduce the deficit by \$70 billion over the 10-year period from 2010 through 2019. These estimates included \$2 billion in savings to the Medicaid program.²⁷ Cost savings would largely be generated as a result of the five-year vesting requirement under which the program paid out far less in benefits than it would have received in premiums over the next 10 years.²⁸

As noted earlier, an important assumption in CBO's estimates was 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 assumed 3.5% of the adult population would participate in the program (or slightly less than 10 million people by 2019). 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 the ACA. CMS's estimate included a net federal savings of about \$38 billion over 10 years. Differences between the CMS and CBO estimates were due to different assumptions about participation rates in the CLASS program. CMS assumed 2% of potential participants would enroll (or roughly 2.8 million people by the third year of the program), which is lower than CBO's assumption noted above. According to CMS, this lower than average participation rate was 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.²⁹

Implementation of CLASS Program

After enactment of the ACA, the Obama Administration, Members of Congress, and the actuarial community voiced concern about the long-term viability of the CLASS program. Because the CLASS program was to be funded entirely by premium contributions, the long-term solvency of the program would depend primarily on the extent of participation among workers, especially individuals who are young and in good health.³⁰ In turn, two key factors affecting participation

²⁷ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Senator Harry Reid, March 11, 2010, http://www.cbo.gov/ftpdocs/113xx/doc11307/Reid_Letter_HR3590.pdf.

²⁸ These revenue estimates were prepared by the Joint Committee on Taxation.

²⁹ 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.

³⁰ Munnell, Alicia H. and Josh Hurwitz, *What is 'CLASS'? And Will it Work?* Research Brief, Center for Retirement (continued...)

were affordability and marketing of the program.³¹ Specifically, certain design features of the program could reduce affordability. According to the American Academy of Actuaries, design features of the program, such as guaranteed issue (i.e., no pre-existing condition exclusions), and the voluntary nature of the program could lead to those most likely needing the benefit to opt-in and healthy individuals, who may not need the benefit, to opt-out. This phenomenon is called adverse selection. It was anticipated that adverse selection would likely lead to higher than average premiums and further reduce demand for the CLASS program among young and healthy individuals. At the same time, other design features such as a low minimum earnings requirement, subsidized premiums for the poor, and potential gaming of the system could likely exacerbate the adverse selection problem.³²

As various stakeholders were raising concerns about the long-term viability of the CLASS program, the Obama Administration moved forward with program implementation and the process of proposing various CLASS plan design options. On January 5, 2011, HHS Secretary Sebelius announced that the office administering the CLASS program would be placed in the Administration on Aging (AOA).³³ The CLASS office, under the direction of the Assistant Secretary for Aging, had primary responsibility for implementation and oversight of the program. The office also supported two federal advisory committees, the Personal Care Attendants Workforce Advisory Panel and the CLASS Independence Advisory Council.³⁴ However, after examining the actuarial, marketing, and legal issues for a financially solvent program over the next 75 years, Sebelius sent a letter to Congress on October 14, 2011, stating that the Administration did not see a viable path forward for implementation of the CLASS program at that time.³⁵

In response to this announcement, CBO clarified that it would assume that the CLASS program would not be implemented (unless there were changes in law or other actions by the Administration that would supersede this announcement) in its next baseline budget projections, which were to be issued in January of 2012. Furthermore, following longstanding procedures, CBO took new administrative actions into account when scoring proposed legislation—even if no new baseline projections had been published. Therefore, beginning immediately, CBO said it would estimate proposed legislation to repeal the CLASS provisions in current law as having no budgetary impact.³⁶

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Research at Boston College, February 2011, Number 11-3.

³¹ Testimony of Allen Schmitz, Principal Consulting Actuary, Milliman, before the Subcommittee on Health of the House Energy and Commerce Committee on March 17, 2011.

³² Ibid.

³³ Letter from Kathleen Sebelius, HHS Secretary, to The Honorable Harold Rogers, Chairman, Committee on Appropriations, U.S. House of Representatives, January 5, 2011, http://www.nasuad.org/documentation/aca/HHS_Letters/HHS%20Letter%20on%20CLASS%20Office.pdf.

³⁴ Funding for implementation of the CLASS program in FY2010 and FY2011 was provided under the ACA Implementation Fund (§1005 of P.L. 111-152); The FY2012 Budget requests \$120 million for start-up administrative costs. According to AOA, “CLASS requires funds from a discretionary appropriation in FY2012 to bridge the period between FY2011 when funding is covered under §1005 of P.L. 111-152 and the point at which administrative funding can be drawn statutorily from premiums received.” HHS, AOA, *Fiscal Year 2012 Justification of Estimates for Appropriations Committees*, p. 162.

³⁵ Letter from Kathleen G. Sebelius, Secretary of Health and Human Services, to Representative John Boehner, Speaker of the House, October 14, 2011, <http://www.hhs.gov/secretary/letter10142011.html>;

³⁶ Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Senator John Thune, October 31, (continued...)

The decision to halt implementation of the CLASS program was in response to a report commissioned by the HHS Secretary on the *Actuarial, Marketing and Legal Analysis of the CLASS Program*.³⁷ This report provided analysis of various options for the CLASS plan design. While the report included discussion of up to eight proposed plan options, it provided premium estimates for four out of the eight plan options described. Premium estimates and proposed plan details for two of the proposed plan options are described in detail below. A brief summary of the six remaining plan options and statutory limitations is also provided.

According to the HHS report, the first plan option, entitled the Basic CLASS Plan Option, most closely followed the statute. This plan option included the following features:

- eligible enrollees must be at least 18 years old and actively employed;
- no underwriting requirement for enrollment;
- a primary benefit that is a lifetime \$50/day (on average) cash payment; and
- eligibility for benefits begins after paying premiums for five years and an individual must be working for three of the five years, earning at least \$1,250 annually.

Under this Basic Option, monthly premiums for an individual with two or more limitations in ADLs and full waiver of premium while claiming the benefit were estimated to range from \$235 per month to \$391 per month assuming a 2% participation rate. However, the HHS report found that assuming even this low rate of participation may not be possible given the estimated level of premiums.

The second plan that the HHS report analyzed was the Modified CLASS Plan Option. This plan differed from the Basic CLASS Plan Option discussed above in the following areas:

- the work requirement was increased from at least three of five years to all five years;
- the earnings requirement was increased from \$1,120 per year to \$12,000 per year; and
- the monthly premium was indexed by a fixed percentage for inflation (which was assumed to be 2.8% in the report's actuarial analysis).

According to the HHS report, increasing the work and earnings requirement over the five-year vesting period would significantly mitigate adverse selection, thus reducing the average premium. In addition, indexing the premium would also lower the required initial premium. As a result, under the Modified CLASS Plan Option the HHS report estimated that monthly premiums would range from an estimated \$114 per month to \$160 per month assuming a 2% participation rate. The report found, however, that there was still a great deal of uncertainty in the participation rate and that the statutory 3% limit on administrative costs could make it challenging to market the product and achieve the expected level of participation. The other six proposed plan options

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2011, <http://www.cbo.gov/ftpdocs/125xx/doc12516/s720.pdf>.

³⁷ U.S. Department of Health and Human Services, *A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program*, Prepared by the Offices of CLASS, ASPE, and the General Counsel, October, 2011, <http://aspe.hhs.gov/daltcp/Reports/2011/class/index.shtml>.

detailed in the HHS report included some of the following variations on plan design: phasing in enrollment; a tiered-benefit; a 15-year waiting period before benefits could be paid; a pre-paid benefit option; and some combination of these options.

The report's legal analysis found that the Basic CLASS Plan Option would fall well within the statutory requirements. However, this analysis also found that the Modified CLASS Plan Option, which would raise the earning requirement, might face legal challenges with this interpretation if implemented. Specifically, the report stated that "while there is plausible statutory basis for the proposed minimum earnings requirement, we have concerns that there could be a successful legal challenge to this interpretation." The report also raised legal questions about whether the other six plan options would be consistent with statutory requirements, especially since some of these options included changes to the earnings requirement. Another legal issue raised under some of the proposed alternative plan options was an extension of the waiting period (i.e., the period between eligibility and receipt of benefits). The HHS report concluded that there was no statutory authority under the CLASS Act for a plan to adopt the proposed waiting period.

While administrative implementation of the CLASS program had stalled, Congress took action to repeal the CLASS program. On January 3, 2013, President Obama signed the American Taxpayer Relief Act of 2012 (ATRA, P.L. 112-240). Among its provisions, Sec. 642 of ATRA repealed the CLASS program as established under Title XXXII of the Public Health Services Act. In doing so, it also made certain conforming statutory changes to the ACA by repealing Title VIII related to the CLASS program and certain provisions in Medicaid statute. Sec. 642 also rescinded the unobligated balance of ACA's funds to the National Clearinghouse for Long Term Care Information (ACA had provided \$3 million in mandatory funding for each of fiscal years 2011 through 2015 for this activity).

Despite the repeal of the CLASS program, the issue of comprehensive LTSS reform will likely be of consideration to the 113th Congress. In particular, ATRA established a Congressional Long-Term Care (LTC) Commission, which is required to develop a plan for the establishment, implementation, and financing of a LTSS system. For the purposes of developing the plan, the commission must provide recommendations for addressing the interaction of LTSS with existing programs, such as Medicare and Medicaid, and private insurance, among other things. Thus the CLASS program provisions remain of interest and may be relevant in current and future considerations of LTSS policy.

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