NATIONAL HEALTH POLICY FORUM

THE BASICS

The Community Living Assistance Services and Supports (CLASS) Act:

Major Legislative Provisions

JANUARY 3, 2013

UPDATE (JANUARY 3, 2013) — *In 2010, Congress enacted the Community Living Assistance Services and Supports (CLASS) Act as part of the Patient Protection and Affordable Care Act (P.L. 111-148). The CLASS Act was repealed as part of the American Taxpayer Relief Act of 2012 signed by the President on January 2, 2013.*

During 2011 the Department of Health and Human Services (HHS) conducted an analysis of possible CLASS implementation options consistent with the statutory requirements that the program be actuarially solvent over a 75-year period and self-funded. After a 19-month period of analysis, HHS officials stated in testimony before the House Committee on Energy and Commerce on October 26, 2011, that the Department had "not identified a way to make CLASS sustainable, legal and attractive to potential buyers…" and therefore "decided not to move forward with CLASS …." (HHS testimony before the House Energy and Commerce Committee, October 26, 2011, www.hhs.gov/asl/testify/2011/10/t20111026a.html.*)*

This publication describes the major provisions of the CLASS Act as originally enacted in 2010.

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, enacted March 23, 2010) established the Community Living Assistance Services and Supports (CLASS) program, a new federally administered voluntary insurance program to help adults age 18 and over with disabilities pay for long-term services and supports (LTSS).

Added as a new title XXXII of the Public Health Service Act, the CLASS program would have been a departure from the way the federal government currently supports LTSS.[1] Unlike other federal LTSS programs, CLASS program benefits would have been financed entirely by individuals' age-adjusted premiums. Individuals eligible for CLASS program benefits would have received cash payments to help them pay for services and supports they need to live in the community, or in a residential or institutional setting.

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ENROLLMENT IN THE CLASS PROGRAM

Individuals who met certain conditions could have voluntarily enrolled in the CLASS program. Eligibility requirements included being age 18 or older, receiving taxable wages or self-employment income, and being actively employed.[3] Patients in hospitals or mental institutions, or residents of nursing homes or intermediate care facilities for individuals with mental retardation (ICFs/MR), receiving Medicaid would not have been eligible to enroll.[4] The law prohibited the use of underwriting requirements that would have prevented an individual from enrolling (see also section on premiums, below).

Employers, at their option, could have chosen to automatically enroll employees in the CLASS program and to deduct CLASS premiums from employee wages. Employees could have elected to waive enrollment in the CLASS program, referred to as the "opt-out" provision. The law required the Secretaries of the Department of Health and Human Services (HHS) and Treasury to establish an alternate enrollment process for individuals with employers electing to not participate, and others.

ELIGIBILITY FOR CLASS PROGRAM BENEFITS

In order to have been eligible to receive CLASS program benefits, an individual must (i) have voluntarily enrolled and been an active enrollee[5]; (ii) had paid premiums for five years (that is, meet a five-year vesting period requirement); and (iii) had minimum earnings sufficient to be credited for one quarter of Social Security coverage ($1,120 in 2010)[6] in at least three of the first five years of enrollment.[7]

Functional Eligibility Requirements

An individual would have been eligible to begin receiving CLASS program benefits when the eligibility assessment system (see below) determined that he or she had a functional limitation (as certified by a licensed health care practitioner) expected to last for a continuous period of 90 days or more. An individual was defined to have a functional limitation if he or she met at least one of the following criteria:

- Was unable to perform at least the minimum number (the law specified that the number may be two or three) of activities of daily living[8] without substantial assistance (to have been defined by the Secretary of HHS) from another individual
- Required substantial supervision to protect him or her from threats to health and safety due to substantial cognitive impairment
- Had a level of functional limitation similar (as determined by HHS regulations) to the level of functional limitations specified above

Beneficiaries would have been required to periodically[9] recertify their eligibility status by submitting medical evidence regarding continued eligibility.

Eligibility Assessment System

The Secretary of HHS would have been required to establish an eligibility assessment system to determine the eligibility of active enrollees for CLASS program benefits. The Secretary would have also been required to promulgate regulations for an "expedited nationally equitable eligibility determination process."[10] The law did not specify the types of entities to make eligibility determinations, but excluded state disability determination services [which make eligibility determinations for Social Security or Supplemental Security Income (SSI) disability payments] from serving as those entities.

CLASS PROGRAM BENEFITS

The Secretary would have been required to define the CLASS Independence Benefit Plan to set forth program benefits and the premium structure. Prior to publishing the final benefit plan, the Secretary was to develop at least three actuarially sound benefit plan alternatives, in consultation with actuarial and other experts. Each plan alternative would have been designed to provide eligible beneficiaries with a cash benefit, advocacy services, and advice and assistance counseling. The CLASS Independent Advisory Council (described below) was to evaluate the alternatives and recommend the plan that best balanced price and benefits to meet enrollees' needs in an actuarially sound manner and that optimized the long-term sustainability of the CLASS program.

Unlike most other public LTSS programs where recipients receive services authorized, provided, and/or paid for by an agency or other entity, eligible CLASS program beneficiaries would have received cash benefits to purchase services.[11]

Cash Benefits

Benefits would have been based on a functional ability scale with at least two, but not more than six, benefit levels. The average benefit was to be at least $50 per day (plus an annual inflation adjustment), based on the expected distribution of beneficiaries receiving the varying benefit levels. A lifetime or aggregate limit on benefits was prohibited by the law.

Purchase of services by beneficiaries — The Secretary would have been required to establish procedures for administering benefits for beneficiaries under the plan. This was to include payment of cash benefits into a Life Independence Account on behalf of each eligible beneficiary. Beneficiaries could have used cash benefits paid into his or her account to pay for nonmedical services and supports needed to maintain independence at home or in a residential setting. These were to include home modifications, assistive technology, accessible transportation, homemaker and personal assistance services, home care aides, respite care, and nursing support. Beneficiaries could have used CLASS cash benefits to compensate family caregivers who provide community living assistance.

Cash benefits for beneficiaries enrolled in Medicaid — CLASS beneficiaries who received Medicaid-financed institutional care[12] or home- and community-based services (HCBS),[13] or who were enrolled in Program of All-Inclusive Care for the Elderly (PACE), would have been allowed to retain part of their CLASS cash benefit. Institutionalized beneficiaries, including those in PACE, would have been able to retain 5 percent of their CLASS cash benefit, and the remainder was to be applied to the cost of the institutional care, with Medicaid providing secondary coverage.[14] HCBS beneficiaries, including those in PACE, would have retained 50 percent of their CLASS cash benefit and the remaining 50 percent would have been applied, under certain circumstances,[15] to the state's Medicaid costs. Medicaid would have provided secondary coverage for the remainder of a beneficiary's costs.

Election for rollover of cash program benefits — Eligible beneficiaries could have elected to defer benefit payments and to roll over benefits from month to month (but not from year to year). Beneficiaries could have received a lump sum benefit up to the lesser of either the total accrued deferred benefit amount or the annual benefit amount.

Disregard of CLASS program benefits in determining eligibility for other public programs — The law stipulated that an individual's CLASS cash benefits could not have been considered income for the purpose of determining (or redetermining) his or her eligibility for any other federal benefit programs, including Social Security, Supplemental Security Income, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), Veterans Administration programs, low-income housing assistance programs, or the Food and Nutrition Act Supplemental Nutrition Assistance Program.

Tax treatment of program benefits — For tax purposes, the CLASS program was to be treated like a qualified long-term care insurance contract for qualified long-term care services.[16]

Advocacy Services

Under an agreement developed between the Secretary of HHS and each state's Protection and Advocacy (P&A) System,[17] each enrollee was to be assigned (as needed) an advocacy counselor who was to provide beneficiaries with information on ways to access the CLASS appeals system, assistance on annual recertification and notification systems, and other required assistance.

Advice and Assistance Counseling

Under an agreement between the Secretary and public and private entities, each beneficiary was to receive (at his or her request) information and advice from an assistance counselor regarding access to and coordination of LTSS, eligibility for other benefits and services, development of a service and support plan, programs and services under the Assistance Technology Act of 1998, and decision making on medical care and advance directives.

PREMIUMS

The Secretary would have been required to establish annual age-adjusted premium amounts to be paid by enrollees. The premiums were to be based on an actuarial analysis of 75-year program costs to ensure the program's solvency over that period. Nominal premium amounts of $5 (plus an annual inflation adjustment) would have been applied to individuals with income below the federal poverty level, and to those age 18 to 21 who were full-time students and actively employed.[18] No underwriting factors, other than age, could be used to determine an individual's premium amount.

Once an individual was enrolled and as long as he or she remained active in the program, his or her premiums were not to be increased. There were certain exceptions to this general prohibition. First, the Secretary could have increased premiums upon a determination[19] that premium collections[20] would have been insufficient for an upcoming 20-year period. Second, any increase in the premiums made as a result of that determination were not to apply to people age 65 and older, who had paid premiums for at least 20 years, and who were not actively employed. Third, the Secretary would have been required to maintain nominal premiums for low-income individuals and actively employed full-time students. The law did not specify whether beneficiaries would have been required to continue paying premiums once they start receiving benefits.

The Secretary of HHS, in coordination with the Secretary of the Treasury, would have been required to set up alternative procedures for payment of premiums by enrollees whose employer did not choose to participate or who did not earn wages or have self-employment income.

ADMINISTRATIVE COSTS

Up to 3 percent of premiums collected from enrollees could have been used for administration of the CLASS program. Advocacy services and advice and assistance counseling were to be considered administrative costs.

CLASS INDEPENDENCE FUND

The law would have established the CLASS Independence Fund in the U.S. Treasury with the Secretary of the Treasury to serve as the managing trustee. The Fund would have consisted of premiums collected, any cash benefits recouped from enrollees, and income derived from the investment of funds held.

The Board of Trustees would have been composed of the Secretaries of Treasury, HHS, and Labor as ex-officio members. Two public members of different political parties would have been nominated by the President for four-year terms and confirmed by the Senate. Trustees were not to be considered fiduciaries and not held liable for Independence Fund actions.

SOLVENCY AND FISCAL INDEPENDENCE

The Secretary of HHS would have been 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 over the short term, as well as over 20- and 75-five year periods.

No taxpayer funds were to be used for CLASS program benefits. The law defined taxpayer funds as "any Federal funds from a source other than premiums deposited by CLASS program participants in the CLASS Independence Fund and any associated interest earnings."[21]

CLASS INDEPENDENCE ADVISORY COUNCIL

The CLASS Independence Advisory Council was to advise the Secretary of HHS regarding the administration of the CLASS program and the development of governing regulations, including the CLASS benefit plan, the monthly premiums, and financial solvency. The Council was to be composed of up to 15 members appointed by the President. A majority of the members were to be CLASS participants or those likely to participate, including both older and younger workers; individuals with disabilities; family caregivers of those who need services and supports at home or in a residential setting; and individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines.

ENDNOTES

1. For information on LTSS spending, see "National Spending for Long-Term Services and Supports (LTSS)," National Health Policy Forum, March 15, 2011, by Carol V. O'Shaughnessy; available at www.nhpf.org/library/details.cfm/2783.

2. This report does not describe all provisions and is not intended to be a section-by section analysis of the legislation.

3. An individual was defined as "actively employed" if he or she was reporting for work at his or her usual place of employment, and was able to perform the usual and customary duties of employment; or another location where he or she was assigned due to employment-related travel requirements; or if the individual was a member of the uniformed services, on active duty, and physically able to perform the duties of his or her position.

4. Also ineligible were those who are confined to jail, prisons, penal institutions, or other correctional facilities.

5. An "active enrollee" was defined as an individual who is enrolled in the CLASS program and has paid premiums to maintain enrollment.

6. The Secretary would have been required to issue regulations that specify exceptions to this minimum earnings requirement.

7. Eligible beneficiaries included those who failed to pay premiums for three months or more during enrollment, but were determined to have a functional limitation as long as they paid premiums for at least two years.

8. "Activities of daily living" were defined by the law as eating, toileting, transferring, bathing, dressing, and continence.

9. As determined by the Secretary of HHS.

10. Section 3205(a)(2)(B) of the law.

11. Some Medicaid LTSS services are delivered to beneficiaries in the form of cash under various state consumer direction programs.

12. Institutions included hospitals, nursing facilities, ICFs/MR, or institutions for mental diseases.

13. Medicaid home- and community-based services were defined as those that the state provides under section 1115, sections 1915(c) or (d) of the Social Security Act, or under a Medicaid state plan amendment.

14. The CLASS program benefit retained by an institutionalized individual would have been added to the personal needs amount for those in institutions allowed by Medicaid.

15. In the case of home- and community-based services, the remaining 50 percent of the CLASS benefit would have been used to reimburse the state's Medicaid costs for the beneficiary, only if a state's services under section 1115 or sections 1915(c), (d), or (i) of the Social Security Act were statewide,

comparable to other services the state offers, and if the state provided, at a minimum, case management, personal care, habilitation, and respite care.

16. Under provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), long-term care insurance benefits are exempt from taxation, up to certain limits, and long-term care insurance premiums can be counted as unreimbursed long-term care expenses subject to age-adjusted limits and other requirements. HIPAA defines qualified long-term care insurance and qualified long-term care services.

17. Protection and Advocacy (P&A) Systems are established by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 and are administered at the federal level by the Administration on Developmental Disabilities (ADD) within HHS. For further information, see www.acf.hhs.gov/programs/aidd/programs/pa/about.

18. The HHS Secretary would have been required to establish procedures to permit people who have income below the poverty level and full-time students who are actively employed to self-attest, and annually confirm, their status. The Secretary would have been required to verify and validate the self-attestation information using procedures similar to those used for SSI eligibility determinations.

19. The HHS Secretary's determination was to be based on the most recent report of the CLASS program Fund's Board of Trustees, Advisory Council advice, the HHS Inspector General's report; waste, fraud, and abuse reports; and other appropriate information.

20. And other income paid to the Fund.

21. Section 3208(b) of the law.

2011 HHS IMPLEMENTATION RESOURCES

- "Memorandum on the CLASS Program" to Secretary Sebelius from Kathy Greenlee, CLASS Administrator, October 14, 2011, available at http://aspe.hhs.gov/daltcp/reports/2011/class/CLASSmemo.pdf.
- U.S. Department of Health and Human Services, "A Report on the Actuarial, Market, and Legal Analyses of the CLASS Program," available at http://aspe.hhs.gov/daltcp/reports/2011/class/index.pdf.
- Statement of Sherry Glied, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, on the Community Living Assistance Services and Supports Act (CLASS), before the House Committee on Energy and Commerce, October 26, 2011, available at www.hhs.gov/asl/testify/2011/10/t20111026a.html.

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