

**A REPORT ON THE ACTUARIAL,
MARKETING, AND LEGAL ANALYSES
OF THE CLASS PROGRAM**

APPENDIX H:

**POLICY PAPERS DISCUSSED BY
THE LTC WORK GROUP**

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OPT-OUT AND PAYROLL DEDUCTION OPTIONS

The Issue: At the LTC Work Group's June 14 meeting we discussed the issues of program opt-out and payroll deduction. The group asked to look at various combinations of opt-out/no opt-out, yes/no and payment options. This issue paper examines these combinations.

Option 1: Automatic Enrollment with Opt-Out Plus Payroll Deduction

This option implements the law as written, relying on employers electing to participate in CLASS.

PROS:

- This is how the law is written.
- Employers could choose to subsidize CLASS premiums.
- Individuals who either opt out or work for an employer who has not elected to offer CLASS could enroll using the alternative mechanisms that the program must offer.

CONS:

- Because the Internal Revenue Code was not amended, employee contributions are not protected.
- Estimates are that approximately 0-1% of employers will elect to offer CLASS.
- A decision would have to be made about returning premiums to employees who are enrolled without their own knowledge then drop coverage.

Recommendation: This approach, while it will not bring many employers or employees into the program, has to be included since it is spelled out in the law. Behavioral and legal barriers would likely result in few participating employers.

Option 2: Employer Mandate to Offer Information to Employees about CLASS, Including Information About How to Enroll

This option mandates that every employer offer every employee information about the CLASS program and how to enroll.

PROS:

- Ensures that every employed person will be made aware of the opportunity to enroll and could thus increase participation and reduce premiums for all enrollees.
- Eliminates the need for extensive (and probably not very productive) marketing to employers to encourage them to participate in CLASS.

- Employers have the opportunity to offer something extra to employees at no or little cost to themselves.
- Preserves good will by offering employees choice to enroll and how to pay premiums.
- Easier for employers to participate when they do not run the risk of enrolling employees without their knowledge.
- Overcomes concerns about coordinating enrollment for individuals with multiple employers.
- Overcomes some payroll deduction concerns.
- Could be combined with employer participation and opt-out.
- Essentially blends the “alternative enrollment” process and employer activities
- May raise employee awareness of the need to plan for potential long-term care needs in the future.

CONS:

- Enforcement of employer mandate would be difficult if not impossible.
- Could anger advocates who were counting on high employer participation and automatic enrollment through opt-out.
- When raising awareness of the need to plan for long-term care may drive employees to comparison shop and CLASS would have to compete head on with private insurance.

Recommendation: None.

Option 3: Employer Mandate to Offer Yes/No Enrollment Choice with a Choice of Payment Options; Employers Required to Submit Employee Choices to CLASS Program

This option mandates that all employers offer all employees an opportunity to enroll in CLASS (a “yes/no choice”). Employers could choose whether or not to do payroll deduction, with required warnings for employees about potential concerns. Employers could be required to inform the CLASS office of each new employee’s decision about enrollment. Employees who decide to enroll in CLASS could elect how to make payments.

PROS:

- Ensures that every employed person will be made aware of the opportunity to enroll and could thus increase participation and reduce premiums for all enrollees.
- Eliminates the need for extensive (and probably not very productive) marketing to employers to encourage them to participate in CLASS.
- Employers have the opportunity to offer something extra to employees at no or little cost to themselves (depending on requirements after the yes/no choice is made).

- Preserves good will by offering employees choice to enroll and how to pay premiums.
- Easier for employers to participate when they do not run the risk of enrolling employees without their knowledge.
- Overcomes some payroll deduction concerns.
- Could be combined with employer participation and opt-out.
- Essentially blends the “alternative enrollment” process and employer activities
- May raise employee awareness of the need to plan for potential long-term care needs in the future.

CONS:

- Enforcement of employer mandate would be difficult if not impossible.
- Could anger advocates who were counting on high employer participation and automatic enrollment through opt-out.
- The process or processes for employers to submit employee decisions would be challenging and expensive to create and put in place, and administratively complex to manage.
- Adds costs, depending on what employers and employees are required to do once the yes/no choice has been made.
- Adds administrative burden for employers and potential additional costs. Could engender employer backlash.
- When raising awareness of the need to plan for long-term care may drive employees to comparison shop and CLASS would have to compete head on with private insurance.
- Employees who want nothing to do with CLASS and are opting out would have to give personal information to employers who would, in turn, submit it to the CLASS office. Privacy concerns might be raised.

Recommendation: None.

PENALTIES FOR LAPSING

The Issue: The CLASS program requires all enrollees to vest in the program by paying premiums for at least the first 60 months (five years) and working for at least three of those five years. At the back end, in order to be eligible for assessment and possible program benefits, the individual must have been paying premiums for 24 consecutive months. There are a few opportunities for gaming (or strategically skipping premium payments) the CLASS program after this initial period.

First, after vesting, the law permits an individual to skip payments (or lapse) for up to three months with no penalty. Thus, if the person rejoins (i.e., pays a premium) in less than three months, his or her premium remains the same as it was when they originally joined. It would be possible to game enrollment by vesting for five years, then paying one premium every three months (at the original enrollment rate). In this scenario, the individual must calculate his or her own tolerance for risk to know when to start paying the back end continuous payments, to try to have the 24 months before disability assessment paid.

Another gaming scenario involves rejoining after more than three months but less than five years; in this case the law requires the individual's premium to be readjusted according to their new age. Thus, this individual could strategically "game" the program by: (1) vesting for 5 years, as required; then, (2) paying premiums for one month out of every five years at the new age adjusted rate.

These two gaming possibilities could significantly undermine the solvency of the program. Estimates made by the SSA actuary and economists at the Treasury suggest that strategic lapsing is highly likely and that it represents a significant threat. This is reflected in the SSA actuary's preliminary estimates of CLASS and the impact of the Senate amendments. The economists at the Treasury noted that their experience studying pension schemes led them to a similar conclusion.

The law includes significant penalties in the form of increased premiums and a requirement to pay for every month of missed premium payment for those who lapse for more than five years.

The Work Group will need to have a future conversation about how to treat lapsations during vesting.

Option 1: Assume this to be a problem of modest significance and do not address the issue in regulations.

PRO:

- Adding new provisions to the administration of a complex enrollment process increases the administrative burden generally and would potentially reduce employer participation, which is already expected to be very low.

CON:

- The SSA actuary suggests that addressing the lapsation issue may have important impacts on premiums and consumer take-up of the CLASS product.

Option 2: Include penalties in the regulation for enrollees who miss premium payments at any time during their enrollment. For example, a provision could be included to subtract one month of vesting for every premium missed. If needed for program solvency, the penalty could be made even more punitive (e.g., 2 months vesting lost for every 1 month lapsed). Additional discussions will be needed to identify how an individual who has been penalized becomes re-vested.

Further variations are possible to reduce the burden of this penalty structure. For instance, an individual could be given some credit for previously paying premiums by reducing the attained-age premium by the amount of months they had been paying premiums prior to lapsing. For example, if an individual paid premiums between age 35 and 40, lapsed for four years, and re-enrolled at age 44, their new premium amount would be based on the prevailing age 42 (attained age of 44 minus two years of payment status). This feature would create an incentive for those who lapse to reenroll quickly in the program.

PRO:

- Applying penalties for lapsation will reduce gaming and significantly reduce premiums thereby increase the probability the program will be solvent.

CONS:

- The program's complexity is increased and administrative costs are driven upward.
- Exceptions will have to be created for lapsation that is not deliberate gaming.

Recommendation: Option 2.

DELAYS IN ENROLLMENT INTO THE CLASS PROGRAM

The Issue: Working adults will have the opportunity to enroll in the CLASS program beginning at age 18. Currently the Act states that after the first opportunity to join the CLASS program subsequent opportunities will be limited to a biennial open season. (The law does not speak to how long the open season must be, only that it can occur every two years.) The plain language of the Act indicates that the only consequences for delaying enrollment are: (a) having to wait up to two years; and (b) starting with a potentially higher premium base. One concern is that people may strategically delay joining the CLASS program until they learn more about their health status (e.g., experiencing a significant chronic disease like diabetes, MS or Parkinson's). This form of strategic delay in enrollment serves to aggravate adverse selection and weaken the CLASS trust fund. In addition, during the start up period information diffusion about the program may be slow and therefore it may impede appropriate take up of the CLASS program to impose the two year waiting period for people that miss the initial opportunity.

Option 1: Extend the initial open season to a two year period so as to allow sufficient time for various outreach efforts and marketing to have their effects. Rely on the likely increased cohort specific premiums to create incentives for earlier enrollment.

PRO:

- This allows for extra time for information to diffuse and for people to consider the benefits and costs of what will be a very new and different long-term care insurance product, the CLASS program. There will be some financial reason to enroll early.

CON:

- It is unlikely that the expected cross cohort premium increases will be sufficient to address the types of strategic gaming that might threaten the program.

Option 2: Extend the initial open season to a two year period so as to allow sufficient time for various outreach efforts and marketing to have their effects. After the initial opportunity to join CLASS employed adults would have to join CLASS within 30 (other suggestion) years or by age 60 (other suggestion) whichever comes first. This option significantly reduces the number of older individuals who enroll in CLASS, regardless of their work status.

PRO:

- Many insurance programs subject to adverse selection that do not permit underwriting (like Medicare Part D) penalize delayed enrollment. In this case,

rather than imposing a financial penalty a limit is placed on the ability to delay. It is expected that this will attenuate adverse selection and result in reduced premiums and increased take-up of the CLASS program.

CONS:

- This provision will add administrative complexity and may not be sufficiently stringent to blunt the impact strategic delays. Making them much more stringent may dampen take-up by desirable enrollees.
- If an exceptions policy that allows those over age 62 (for example) to be the “rule” for earnings amount, this open season option reduces the number of individuals who are not exceptions.

Note: Financial penalties would be a preferred policy tool because they can be titrated to the duration of the delay; but such penalties appear not permissible under the Act.

Recommendation: Option 2.

EMPLOYMENT EARNINGS AMOUNT

The Issue: Adverse selection is a fundamental threat to the solvency of the CLASS program. Because the Act prohibits underwriting except by age and work status, one of the few mechanisms for addressing the threat posed by adverse selection is through the earnings requirement that qualifies one for the CLASS benefit. The ACA establishes a \$1,120 a year earnings standard for purposes of vesting and eventual eligibility. This standard must be met on a per-year basis for at least three years within the first five years of enrollment. Public and private actuaries see this as too low to significantly stem adverse selection thereby leading to a program with relatively high premiums and low take-up rates. The language of the law allows the Secretary to create, through regulation, exceptions to the minimum earnings requirement.

When the LTC Work Group met on Monday, June 14, members agreed to recommend using the Secretary's exception policy allowed in the law to write a regulation that raises the earnings that constitute eligibility for enrollment. One issue is how much to raise earnings to; the current choices under discussion are \$9,000 per year (approximately 75% of SGA) or \$12,000 per year (SGA) or higher.

A second set of issues relates to how many exception groups to create and what the age cutoffs should be for the exceptions. This will be dealt with separately.

Option 1: For working aged individuals, require that they earn at least \$9,000 per year to qualify to enroll in CLASS.

PROS:

- This interpretation will be consistent with what was negotiated with most of the advocacy organizations that lobbied for CLASS during the discussion of legislative fixes (though the fixes were not included in the final bill).
- This amount reinforces that CLASS is an insurance program for individuals who work.

CONS:

- At the present time we do not have actuarial estimates upon which to base this decision (though it is likely to increase program solvency).
- There will be advocates who believe this amount is too high, particularly those who represent individuals with intellectual disabilities.
- Those earning \$9,000 are still earning under the poverty line and will only pay \$5 premiums.

Option 2: For working aged individuals, require that they earn an amount that is between \$9,000 and \$15,000 per year to qualify to enroll in CLASS. This proposal is based on models showing a significant effect on premiums; \$15,000 was shown by the

SSA Actuary to reduce premiums by 36%. Pros and cons for this option are the same as option one, except the following:

CON:

- This is a “new” number that is higher than the \$9,000 that was negotiated with the advocates and the Senate.

PAYMENT OF PREMIUMS IN BENEFIT STATUS

The Issue: The Act is silent on whether enrollees that qualify for benefits must continue to pay premiums. Conversations with Senate HELP staff suggest the intent was to require payment of premiums while in benefit status. Further conversations with the Senate legislative counsel noted that there was no record of this intent and that the statute was silent on the matter.

Option 1: The CLASS program would follow current industry practices and not charge premiums to people in benefit status.

PRO:

- Since common industry practice involves suspending premium payments while in benefit status; the CLASS product would be competitive with industry products on this attribute.

CON:

- Since the CLASS program cannot underwrite enrollment or premiums the program faces greater upward pressure on premiums than the products with which it is likely to compete. Thus by not charging a premium to people in benefit status an opportunity to reduce premiums is foregone.

Option 2: The CLASS program would charge people in benefit status that are not institutionalized their usual monthly premium.

PRO:

- According to preliminary estimates made by ARC, requiring people that qualify for benefits (evaluated at 2 ADLs) that are not institutionalized to pay premiums would reduce premiums by about 11%. It would not impose any costs on people that are institutionalized, many of whom would only receive 5% of their daily benefit from CLASS.

CON:

- It effectively reduces the value of the average benefit by 1 to 2 days per month. This may make CLASS less competitive in the market place.

Recommendation: Agnostic.

ENROLLMENT AND PREMIUM COLLECTIONS UNDER THE CLASS ACT

Bill Requirements

Enrollment--Section 3204(a) of the Affordable Care Act requires the Secretary, in coordination with the Secretary of Treasury, to establish two enrollment procedures. The first is a procedure for automatic enrollment in CLASS through electing employers similar to the automatic enrollment for 401(k) plans. Section 3204(b) gives workers the right to opt-out in a manner prescribed by the Secretary of HHS and Treasury. The second is a procedure for the self-employed; those with more than one employer and workers whose employers do not elect to participate in auto enrollment.

Premium collection--Section 3204(e) of the Affordable Care Act requires the Secretary, in coordination with the Secretary of Treasury, to establish two premium collection procedures. The first is payroll deduction from wages or self-employment income in a manner established by the Secretary, in consultation with the Secretary of Treasury for employers who elect to deduct and withhold premiums. The second is an alternative payment mechanism for those who are self-employed; workers whose employers do not elect to participate in auto enrollment and individuals who do not earn wages or self employment income. The legislation is silent on the method of premium collection.

Transfer of Premiums Collected--Section 3204(f) of the Affordable Care Act requires the Secretary of the Treasury to deposit 100% of premiums collected into the CLASS Independent Fund. The transfers will be monthly and based on estimates with subsequent adjustments based on actual collections.

Parallel to Automatic Workplace Pensions

The Administration's Automatic Workplace Pensions budget proposal involves many of these same issues. While this proposal has been included in the President's budget, legislation has not yet moved. As a result not all of these issues have been fleshed out or resolved. Please find attached an earlier memo discussing some of these issues.

CLASS Specific Discussion

Enrollment--Both overall participation and voluntary employer participation could be low. Therefore, the two processes should be as similar as possible so as to minimize administrative costs. Enrollment design should also pay particular attention to the timing of initial and continued enrollment as both are important in terms of the vesting and waiting periods in the bill.

Premium collection and transfer--Options for premium collection include piggybacking on the payroll deposit system for employers while requiring monthly or quarterly premium remittance for others and designing a completely new collection system which is consistent with the requirement that the funds be transferred to the CLASS Independence Fund on a monthly basis.

One important issue to keep in mind is collection enforcement. The Labor Department's Employee Benefit Security Administration (EBSA) conducted a study of employer compliance with 401(k) plan contribution requirements and found that 68% of plans failed to remit employee contributions for at least one pay period during the period examined. Plans with fewer than 25 participants were more likely to have delinquent or unremitted contributions.

However, a mitigating factor here maybe voluntary employer auto enrollment in CLASS. Unlike 401(k) rules where the non-discrimination rules play some role in the decision on the part of employers to offer a plan in order to provide benefits for owners and highly compensated employees, no such rules apply to employers and CLASS. In fact, CLASS offers owners and the highly compensated the opportunity to purchase benefits as individuals. Therefore, the relatively low number of employers who are expected to participate may be more highly motivated and thus more likely to remit funds in a timely manner. On the other hand, if employee take up at a given employer is very low, the employer may be more likely to simply forget to transmit the funds and/or enrollment information. This may be less of a problem with employers who utilize payroll providers. We suggest aggressive CLASS outreach to that community in addition to any participating employers.

Premium collection enforcement will be very important to CLASS because deposits are made based on estimates but subsequently adjusted based on actual collections. This is different from Social Security where transfers are based on estimates liabilities and never actual collections and means that while Social Security forgoes interest and penalties on payroll taxes, the OASDI Trust Funds receives a net subsidy from the general fund to the extent liabilities exceed collections. The CLASS Administrator may wish to consider interest and/or penalties on late premium collections.

The attached paper briefly mentions IRS versus Department of Labor enforcement. The IRS doesn't usually pursue small collections amounts due to resource constraints. Additional legislative authority would be required to place CLASS Act enforcement under EBSA's purview; EBSA is currently charged almost exclusively with enforcement of ERISA. EBSA's enforcement program is also fairly reactive -- usually only responding to complaints -- and faces similar resource constraints. And both agencies face expanded duties under the Affordable Care Act. The CLASS Administrator should carefully consider these issues and initiate discussions with IRS and DoL.

A related issue is reconciliation. To administer CLASS effectively the Administrator will need a timely flow of enrollment information and premiums as well as the ability to

match them. The enrollment and collection mechanisms must provide a mechanism for this reconciliation. For instance, Social Security payroll taxes are matched to individual earnings record on the W-2. And the employer's W-3, which is a summary of all W-2s, is matched with Form 941, the employer's quarterly tax return. Even if the decision is made to utilize the payroll tax system, effectively putting aggregate CLASS premiums on the 941, it will be necessary to match the dollars with individuals they cover. There is no requirement that employers include CLASS information on the W-2. Therefore, a reconciliation mechanism needs to be created. In addition, reconciliation must also include information on the timing of enrollment and ongoing participation for the effective administration of the lapse and minimum earnings provisions.

INDEXING OF PREMIUMS AND ACTUARIAL BALANCE

The Issue: The CLASS Act specifies that the cash value of benefits will be indexed by the inflation rate (CPI-U), but premiums would remain level. As a result, the CLASS program's solvency over time could be threatened if inflation increases at a higher rate than what was assumed when the program began. In order to maintain solvency under this scenario, premiums for current and future enrollees would have to be raised, possibly by substantial amounts. This could increase adverse selection over time, as healthy people will be less and less likely to enroll.

Potential Remedy: Indexing the premium would tend to reduce initial cohort specific premiums (since the premiums instead grow over time), which will contribute to increasing the initial take-up rate. It also would reduce the amount of any necessary premium increases over time if unexpected threats to program solvency emerged (discussed further below). The Act allows the Secretary to alter premiums in order to preserve solvency and actuarial balance. Specifically under section 3203(b)(B)(i) it is stated that if the Secretary determines that "*the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20 year period that begins with that year, the Secretary shall adjust monthly premiums for individuals enrolled in the CLASS program as necessary...*". Therefore indexing of premiums would have to be justified by demonstrating the threat to program solvency from failing to do so. In addition, transparency requires informing consumers of a price schedule. One approach to this would be to construct a premium schedule based on the projected CPI-U rate for the five years following initial enrollment.

Analysis: We obtained preliminary (pre-passage of the ACA) actuarial analysis of the consequences of indexing assuming a 6% participation level, with 5 year vesting at the \$1200 earnings requirement level and a \$50 daily benefit that is indexed. We evaluated initial premiums for a new 50 year old enrollee. Indexing of the premium at an expected inflation rate of 2.8% resulted in a decline in the initial premium of 23.4%. Our recent modeling efforts show that when combined with the \$12,000 earnings requirement and the anti-gaming provisions, indexing the premium results in a 62% decline in premiums when evaluated at the 2% take up level or a 46% decline when evaluated at the 5% take up level.

Option 1: Implement the law as written, which follows common practices in private long-term care insurance and maintain a flat initial premium and make adjustments for new cohorts and on an ad hoc basis when financial problems occur.

This approach has the advantage of making premiums appear predictable and it follows prevailing practices in the private long-term care insurance market. It also implements the Act precisely as written. However, as has been seen in the private long-

term care insurance market, unexpected declines in reserves or substantially higher program costs often necessitate large premium hikes.

Option 2: Index the premium at CPI (or a percentage of CPI) so that the initial age-rated premiums are as low as possible to encourage participation in CLASS. Potential enrollees would be provided with information that clearly illustrated what their future premiums would be over time. The information would be provided both in writing and presented graphically so that enrollees would clearly understand how premiums would change over time.

Indexing the premium will substantially reduce initial age-rated premiums and increase take-up rates and mitigate adverse selection. (Since block and continuous indexing would likely have the same actuarial impact, it could be determined in the marketing phase which one would be more appealing to the consumer). This will result in a more financially viable insurance pool. It will also reduce the likelihood that unexpected premium increases will be required in the future. The policy would differ from private insurance practices and may create some competitive effects (depending on marketing and transparency).

In addition, the lower initial premiums will mean that the CLASS contribution to deficit reduction may be lower than has been projected. This depends critically on the elasticity of demand for coverage that is highly uncertain.

An Additional Consideration: There are other structural threats to solvency in the CLASS Act. For example, the aging of the population will lead to dramatic increases in the number of older Americans. If the prevalence and/or duration of functional disability at older ages increase, the payout of cash benefits under CLASS will be much higher than anticipated. This is a very real possibility given the recent increases in obesity in mid-life and impact on chronic conditions like diabetes. The main consequence is that there is potentially an actuarial imbalance in much the same way that inflation does for a plan where benefits are indexed and premiums are not. Again, this means that current and later cohorts may experience sharp premium increases. It may be worth considering options for adjusting premiums based on disability trends/forecasts.

CLASS ELIGIBILITY: ROLE OF “LICENSED HEALTH CARE PRACTITIONER”

Sec. 3203(a)(1)(C):

“a benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner...”

While the CLASS statute does not include an explicit definition of “licensed health care practitioner” we can look to the definitions used in other programs including and the federal long-term care insurance program. The U.S. tax code, in its section on treatment of qualified long-term care insurance defines licensed health care practitioner as: “any physician (as defined in section 1861(r)(1) of the Social Security Act) and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.” The federal long-term care insurance program defines licensed health care practitioner as: “a physician, registered professional nurse, or licensed social worker.”

The Issue: What is intended by the statutory language: “*as certified by...*”

Option 1: The statute intended that there will be a single assessment of an enrollee to determine whether that person has met the benefit trigger to be eligible for benefits, conducted by a person who is authorized to conduct such an assessment. We are simultaneously exploring the question of whether the CLASS program will be utilizing third administrators. On the private side, many long-term care insurance companies use TPAs. It is not uncommon for a TPA to conduct assessments using their own network of nurses, and this could be a model CLASS could pursue.

PRO:

- Administratively and financially efficient.

CON:

- May not have been statutory intent.

Option 2: One party does the initial assessment and a licensed health care practitioner does a secondary review of the assessment in order to “certify” this decision.

PROS:

- May be more likely to meet statutory intent.
- Provides for a second layer of review.

CON:

- More costly and administratively inefficient.

The Issue: What shall be the process for obtaining/ensuring certification by a licensed health care provider?

Option 1: The assessment of the enrollee shall be done in person or by telephone.

PROS:

- Allows the enrollee to provide information that has not been filtered through another party.
- One on one conversations might allow the enrollee time to learn of other supports and services available outside of the CLASS program.

CON:

- This could be costly, since the CLASS program would need to have individuals on staff who could conduct the assessment interviews.

Option 2: Allowable methods of assessment include a review of paperwork and medical records of the enrollee applying for benefits.

PRO:

- Less costly since an interviewer would not need to be involved.

CONS:

- Information is not garnered directly from the enrollee and is instead filtered through another party.
- Less personalized and no opportunity for supplemental information to be provided.

CLASS BENEFITS MANAGEMENT

The Issue: How should CLASS beneficiaries access and use their benefits? Should the program offer “pure cash” and how? Should a fiscal management service be utilized, and if so, should it be mandatory?

Guiding Principles:

- Beneficiaries should be guaranteed autonomy and self-determination.
- CLASS should have administrative safeguards for coordination with Medicaid, management of unspent funds, and to protect beneficiaries from financial exploitation.
- Safeguards should be easy to understand and administratively simple.
- The program should have safeguards to ensure compliance with tax, labor and immigration laws.

Facts and Lessons Learned:

- A report from Univita shows that pure cash is expensive to administer because without a requirement to use paid services and to document spending, it is necessary to reassess disability status and continued eligibility more frequently.
- In other countries (Italy, Austria) where cash benefits are used for similar programs, a black market in migrant workers has developed, which not only is illegal but also can lead to suppression of a robust formal workforce sector.
- The Netherlands “personal budget” program experienced some embarrassing media scandals in recent years, including fraud on the part of representative payees. This resulted in tightening the accountability rules, decreasing the amount of the budget that can be spent without documenting use of funds.
- All Medicaid *Cash and Counseling* programs, except one small Oregon-based program that covers only about 300 people, mandate use of a fiscal agent. This results in prevention of tax, labor and immigration law violations, with no significant instances of fraud or abuse of funds in the program in the past twelve years. Moreover, research shows that beneficiaries greatly value this service.

Statutory Guidance:

- The guidance provided by the statutory language is somewhat unclear. The statute does include the phrase ‘cash benefit.’ But the statute also includes language requiring ‘Life Independence Accounts’; mandates that unused funds do not roll over into the following year; and requires periodic recertification (including a requirement that the beneficiary submit records of expenditures) for continuation of benefits. Moreover, the statute states that benefits ‘shall be used to purchase nonmedical services and supports that the beneficiary needs to

maintain his or her independence at home or in another residential setting of their choice.'

Option 1: Allow beneficiaries completely unfettered use of cash benefits through their own bank accounts (i.e., "pure cash").

PROS:

- Offers complete choice, autonomy and self-direction.
- Might be more competitive with private insurance, since most policies do not offer pure cash.
- Consistent with some international models.
- Treats CLASS benefits as an income supplement.
- Minimizes administrative burden, since there would be no need to require accountability regarding how funds were spent.

CONS:

- Makes it easy to hire workers in violation of tax, fair labor and immigration laws.
- Places burden of complying with tax, labor and immigration laws on beneficiary.
- Makes CLASS beneficiaries potential targets for financial exploitation.
- A system will have to be put in place to determine which beneficiaries must have a representative payee (e.g., those with dementia).
- Administratively more costly, since reassessments must continually be conducted.
- Enrollees have strong incentive to begin collecting lifetime cash benefits as soon as possible and at the highest amount they can qualify for.
- May create work disincentives.
- Significant risk of problems with optics.

Option 2: Mandate use of fiscal agent for all beneficiaries. Secretary establishes a national network of fiscal agents and promulgates broad rules for access to and use of funds. Fiscal agents ensure compliance with tax, labor and immigration laws. Beneficiaries have access to set amount of "pure cash" and fiscal agents take care of payroll and review larger acquisitions to ensure they relate to CLASS goals.

PROS:

- Ensures that most CLASS funds will be used for the purposes outlined in the statute, without impeding beneficiary choice for legitimate use of cash.
- Fiscal agents can take quick action to address fraud and exploitation.
- Research demonstrates that the most likely use of cash benefits for individuals with multiple ADL needs is to pay personal assistants; fiscal agents take care of the administrative burden.
- Costs can be held to 3-5% of monthly benefits; no draws on the CLASS 3% administrative cap fund.

CONS:

- Advocacy groups may not be satisfied with anything other than “pure cash.”
- The more restrictions on cash use, the higher the administrative burden and costs.
- Individuals may be prohibited from spending on some consumer items that could help them live more independently.

Option 3: Offer beneficiaries capable of managing their own funds the option to use a fiscal agent; those opting not to use a fiscal agent would have “pure cash.” Require use of fiscal agent for those assessed not capable of managing their own funds. Secretary promulgates broad rules for use of funds.

PROS:

- Minimal restrictions on beneficiaries who want “pure cash.”
- Optional access to fiscal agent to ensure compliance with tax, labor and immigration laws.
- Assured compliance with tax, labor and immigration laws for those using the fiscal agent.
- Fiscal agent costs built into benefit, not 3% administration fund.
- Popular with advocates of complete choice who would likely understand need for those with cognitive impairments being required to use fiscal agent services.

CONS:

- Additional administrative burden and expense to assess cognitive function and ability to manage own funds.
- Additional CLASS program dimension that is appealable.
- Additional administrative burden and expense to track use of funds by “pure cash” receivers.
- Does not ensure adherence to tax, labor and immigration laws.

Option 4: Establish a national network of fiscal agents for all CLASS beneficiary accounts. If beneficiaries are cognitively impaired or hire workers, mandate use of the fiscal agent for compliance with tax, labor and immigration laws. Otherwise, place few restrictions on use of cash, but require retrospective documentation.

PROS:

- Allows choice and autonomy while promoting compliance with tax, labor and immigration laws.
- Retrospective documentation provides accountability and may help avoid optics problems.
- Fiscal agents can monitor debit cards for unusual patterns that may indicate fraud or exploitation.

- Fiscal agent can offer additional payment options for items that cannot be purchased with a debit card.
- Cost of the fiscal agent can be built into the benefit rather than the 3% administrative cap.
- Fiscal agents can coordinate with Medicaid and provide a safe harbor for state Medicaid agencies to meet their obligations under CLASS.

CONS:

- Advocates for a “pure cash” income support framework may not support this approach.
- Administratively more costly, since reassessments must continually be conducted.
- Enrollees have strong incentive to begin collecting lifetime cash benefits as soon as possible and at the highest amount they can qualify for.
- Program has no way to know if beneficiaries are hiring paid workers, thereby not ensuring adherence to labor, tax and immigration laws.

CLASS ADVICE AND ASSISTANCE COUNSELING

Background on A&A under CLASS

This paper sets out for discussion purposes only a series of policy questions, options, and recommendations for the structure of Advice and Assistance (A&A) program associated with the CLASS insurance option. The memorandum examines:

- the primary role and functions of an A&A program,
- the potential elements of an A&A program, and
- policy questions, options, and recommendations for the CLASS workgroup's consideration.

Role and Functions of Advice and Assistance (A&A) under CLASS

The CLASS law directs the Secretary to "...enter into an agreement [by 1/1/12] with public and private entities to provide advice and assistance counseling..." Those entities are required to assign, as request by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with **information** regarding--

1. accessing and coordinating long-term care services and supports in the most integrated setting;
2. possible eligibility for other benefits and services;
3. development of a service and support plan;
4. information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;
5. available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and
6. such other services as the Secretary, by regulation, may require.

The law stipulates that A&A is a "mandated" component of the CLASS Benefit. Therefore, similar to the "mandated" P&A provision under CLASS, the subgroup recommends defining the A&A benefit as narrowly as possible in regulations. The more clearly A&A can be defined, the firmer ground the CLASS program will stand on to deliver it, reduce liability risks and limit program operation costs.

Elements of the A&A Program

The development of an Advice and Assistance program would be a major objective during the first five years of the CLASS program's operation. Currently, there are a variety of public and private entities that may be interested in providing A&A information and referral services under the CLASS program. These include, but are not limited to: Third party administrators that offer similar services for private LCT insurers; ADRCs, Centers for Independent Living, I&R service organizations, and other one-stop LTC service providers

The Advice and Assistance program could have the following structure/characteristics:

- The CLASS Office could provide A&A directly or contract it out to one or more providers, or a network of providers.
- The program could be developed nationally, state-wide, regionally or locally,
- CLASS eligibles could access the A&A services using a 1-800 number, a website, and/or through local offices.
- A national training and technical assistance contract could be used to support all the A&A providers/networks to ensure nationwide consistency.
- The A&A provider(s) would have specific data collection and reporting requirements as required by statute "...reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries received services from the entity or another entity."
- Performance standards and performance measures would be developed for the A&A provider(s) that related to each function/service provided.
- As part of the CLASS quality assurance program, an independent evaluation contract could be used to assess the quality of the A&A program, including the quality across various A&A providers if multiple providers are used--this evaluation plan would include specific program performance standards.
- The CLASS IT system will need to support the A&A program; and additional start-up funding and training might be needed for the A&A provider(s) (for interfacing with and/or inputting data into any centralized information, case management or data system necessary for data collection by the CLASS office).
- Contract provisions/grant requirements will need to ensure that there is non-duplication and coordination with other information and referral services that are similar in scope.
- A&As awarded CLASS contracts would be precluded from providing services -- or charging fees -- to any CLASS enrollees to minimize any potential conflicts of interest.

Policy Questions & Options

DEFINING WHO IS ENTITLED TO A&A BENEFITS

The CLASS Act states: “...entities are required to assign, as request by an eligible beneficiary that is covered by such agreement, an advice and assistance counselor who shall provide an eligible beneficiary with information regarding...”
(advice and assistance services)

The Issue: “Eligible beneficiary” is defined as individuals who have vested, met the employment criteria, and have been determined to have the applicable level of functional limitation. Can/should the CLASS A&A program serve all active beneficiaries or only those who specifically request A&A services?

Option 1: Provide access to CLASS Advice and Assistance services for all beneficiaries who are deemed eligible to receive CLASS benefits (as defined in statute).

PROS:

- Ensures all eligible beneficiaries will have access to this benefit.

CONS:

- Making all CLASS beneficiaries eligible for the A&A benefits regardless of whether they actually “request” them could create an administrative burden for the A&A provide(s), especially if they are required to assign counselors and track services for all eligible beneficiaries regardless of need. Does not focus advice and assistance information and referral support to the most vulnerable populations struggling with accessing services, technology, and/or integrated care choices/issues. May exclude those who are not deemed eligible-such as presumptively eligible beneficiaries. May not be consistent with Congressional intent.

Option 2: Provide access to CLASS Advice and Assistance services to only those beneficiaries who are deemed eligible to receive CLASS benefits and specifically request Advice and Assistance counseling, and those who are presumptively eligible for a CLASS benefit. There would be no proactive requirement to ensure active participation for every enrollee.

PROS:

- Provides more targeted use of CLASS funds, minimizes liability. Narrow interpretation is consistent with interpretation of eligibility for P&A services. Reduces likelihood of administrative/case management burden on A&As for individuals not in need of A&A services and supports. As functional needs change for beneficiaries, allows the A&A benefit to be targeted to those most in need.

CONS:

- Does not guarantee support for all CLASS beneficiaries who might be struggling with information, referral issues, program eligibility issues, or ways to prevent going into claim through access to other HCBS programs. May not be consistent with Congressional intent.

Recommendation: Option 2.

WHAT SERVICES SHOULD A&A COUNSELORS PROVIDE?

The Issue: The CLASS law specifies that the Advice and Assistance Counselor will provide eligible beneficiaries with information regarding--

1. accessing and coordinating long-term care services and supports in the most integrated setting;
2. possible eligibility for other benefits and services;
3. development of a service and support plan;
4. information about programs established under the Assistive Technology Act of 1998 and the services offered under such programs;
5. available assistance with decision making concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and
6. such other services as the Secretary, by regulation, may require.

To what extent should the A&A services be limited to information-only versus other more robust benefits counseling and assistance and case management services?

Option 1: Restrict use of CLASS Advice and Assistance benefit to general information and referral -- a minimal counseling benefit (e.g., up to some specified number of hours of "one on one" counseling each time a benefit eligibility assessment is performed).

PROS:

- Reduces the costs associated with A&A and makes the function/role more simple to contract for nationwide.

CONS:

- May conflict with Congressional intent. Creates a question of who will be responsible for on-going care planning, care coordination and case management

and how will those services be paid for (e.g., by the beneficiary themselves directly to a local provider agency, legal resource in the community).

Option 2: Create a more robust A&A benefit to include case management and on-going benefits counseling and assistance services. This would require that any contracted A&A provider would have a fully developed capacity to provide expanded counseling assistance services to eligible beneficiaries who request the A&A services.

PROS:

- Provides greater assistance for eligible beneficiaries and enhances opportunities for better care coordination. Provides all beneficiaries a case manager/care coordinator who has no conflicts of interest related to care planning and can provide independent, objective advice and assistance. May be what was envisioned under Congressional intent.

CONS:

- May create duplication and role confusion with long-term care management team and other health care professionals. May duplicate existing benefits and services offered through other programs, including OAA, Medicaid, private insurers, and other health care providers.

Option 3: Allow A&As providers flexibility to provide information to needed services, as well as assistance (such as case management, care management, benefits application assistance, legal assistance) on an episodic basis when needed by eligible program beneficiaries prior to, during or immediately proceeding being in claim, if the A&A provider determines it is in the best interest of ensuring the safety, quality of care, or coordination of services for a CLASS enrollee. This option would allow individuals to use the benefit as they are transitioning into benefit, and transitioning off of benefit (front-end and back-end support) that may be needed to assist individuals in connecting to LTC services and supports that might be needed in between benefit periods.

PROS:

- Avoids individuals going back into benefit prematurely. Helps coordinate services most efficiently when needed by an individual to remain in the community. Provides “just-in-time” services and supports to help individuals identify and qualify for a continuum of care in the most integrated setting without having to coordinate and liaison with a variety of other long-term care providers or service delivery systems.

CONS:

- Would be difficult to create a clear line in regulations or in contracts on when it would be appropriate to provide more services to information and referral. May not be the Congressional Intent of the A&A benefit.

Recommendation: Option 1.

HOW WILL THE SECRETARY ESTABLISH THE A&A PROGRAM?

The Issue: The statute requires the Department to enter into an agreement with public and private entities to provide advice and assistance counseling. How will the Department do this?

Option 1: Hire federal workers in the CLASS Office to provide information and referral services, similar to 1-800-Medicare. The program could either be centralized in one location, or located in the HHS regional field office structure and have jurisdictions divided up based upon regional areas in which eligible beneficiaries live.

PROS:

- Would create a uniform workforce that is similarly trained. Administrative costs could be considerably lower due to centralization. Can be built off of existing information and referral models run by the government.

CONS:

- May not comply with Congressional intent to have A&A services provided by public and private entities. May not be the most effective or efficient way to provide A&A services, especially when the information is local in nature that individuals will be seeking.

Option 2: Create a nationwide competitive solicitation for the development of A&A service delivery models in regions, states, or local service delivery systems. Encourage partnerships, collaboration, and integration of already existing I&R service providers, ADRCs, one-stop shops, and private care coordination and information service providers.

PROS:

- Would encourage innovation and flexibility across states, regions and localities. Would help build a new system using the best ideas competitively on how to provide information and referral on long-term care services and supports. Would also leverage existing providers who offer similar services to partner and develop coordinated systems that build off of what is already existing/in-place.

CONS:

- May create a patchwork of different systems across states without a uniform benefit or method of access to the benefit. May create barriers for individuals to obtain the needed information and referral services and supports as envisioned

by Congress. Some subpopulations may not have sufficient focus--resulting in disparate access to A&A services across states.

Option 3: Narrow the competition and create a state-based competitive solicitation process whereby each state would be awarded one contract for A&A services to be provided to a state-designated lead agency or contractor in that state. Multiple contractors/vendors would be encouraged to apply to provide A&A services in each specific state.

PROS:

- Would leverage existing state-based systems already in place as designated by many Governors offices for administration of long-term care services and one-stop shop entry points, such as ADRCs. This process may help create partnerships across the aging, disability and long-term care communities for coordinated information and referral resources. Could be structured in a unified way, based upon the solicitation.

CONS:

- May not be flexible or creative, and funds may be used by states for non-CLASS related information and referral for eligible beneficiaries. Some states may use existing general information and referral system that are not uniquely designed for CLASS or long-term care.

Option 4: Limit the competition to Third Party Administrators who current provide similar services for private LTC insurance programs.

PROS:

- Would leverage existing capacity developed by LTC insurance industry. May be most cost effective and efficient approach and easiest to ensure quality of services provided. Could be done so that referrals are made to existing state-based and local providers who could offer their services, including expanding A&A services, to CLASS beneficiaries on a “fee for services” basis.

Recommendation: ?

WHAT WILL BE THE PROFESSIONAL QUALIFICATIONS FOR A&A COUNSELORS?

The Issue: Will A&A counselors be trained in a unified way and be certified by a national entity?

Option 1: Yes, each A&A counselor will be certified by the CLASS program Office or external certification entity. The certification requirements will be developed by the government. A training curriculum, and national training program will be developed by the CLASS office for A&A service counselors either directly or by contract to ensure national consistency in administration of the information and referral services provided by A&A counselors.

PROS:

- National consistency. Potential for standardized forms, training, referrals and information that can help subgroups of eligible CLASS beneficiaries. Higher specialized training through on-going training and technical assistance contracts. Greater federal oversight, and more consistent performance standards and measurement system.

CONS:

- Greater costs. Less flexibility and innovation potential, especially in an area where the Government does not yet know best practices.

Option 2: No, certification will not be a requirement for A&A provider entities. Each state or contracted entity will be required to have its own plan for training of A&A counselors. The Secretary can establish minimum requirements for training, but not require certification.

PROS:

- Less costly or administratively burdensome for vendors/contractors. Could allow multiple best practice models to develop in the early years of the program, that can be replicated in the future.

CONS:

- Lack of consistency in the skill and training levels of A&A counselors across states. Can increase Agency's liability risks.

WHAT WILL THE EARLY AGREEMENTS/CONTRACTS FOR A&A SERVICES INCLUDE?

The Issue: The law states that the "Not later than January 1, 2012, the Secretary shall ...enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e)." Since individuals will not need Advice and Assistance Counseling until at the earliest 2018, what will the agreements include and how will the Secretary contract with vendors in 2012 for services delivered in 2018?

Option 1: Establish agreements in 2012. Each agreement would be for planning and development contracts for public and private entities to establish systems that will provide comprehensive, coordinated and integrated information and referral resources for eligible CLASS beneficiaries.

PROS:

- Complies with requirements. Would be a nominal amount of funds for development and planning, without committing the Agency to any one vendor if the service delivery system changes over time. Would generate information that the CLASS Office could use to inform further A&A development and investments.

CONS:

- Could waste federal funds if the entities do not wind up as the contractors chosen to provide A&A services. May grow dust on the shelf--since the service delivery system and trainers would not be in place for over 5 years.

Option 2: Establish state agreements, one with each state, between HHS and the Governor appointed Agency in each state that would be in charge of coordinated A&A services. No funding or contracts would need to be made until 6 months before actual beneficiaries would be eligible for the A&A benefit.

PROS:

- No monies or funds would need to be expended until a year before needing the service delivery system up and running. Would comply with Congressional requirement.

CONS:

- Could lock the agency into using the state as a conduit for funds which could create additional administrative pass-through expenses for the program, with potential reductions for the CLASS benefit.

Option 3: Minimal state grants for planning and development would be provided in 2012 to a Governor appointed agency in each state that would be in charge of developing an A&A network/system in each state. Grants would be based upon estimated number of program enrollees and claimants who would be eligible for the A&A services in each state.

PROS:

- Would comply with Congressional requirements while minimizing the outlay of costs for initial years.

CONS:

- Would lock the agency into using the state as a conduit for funds, and would create additional administrative pass-through expenses for the agency, with potential reductions for the CLASS benefit.

Option 4: Issue a “request for information and ideas” in mid-2011 to solicit broad input from public or private entities on approaches for providing the CLASS A&A benefit and the existing capacity of potential providers; and select one or more proposals by January 1, 2012 for “further development.

PROS:

- Would meet the statutory deadline but not bind the program to a specific approach or vendor(s) and would allow for more deliberate planning.

CONS:

- May not meet Congressional Intent.

Recommendation: ?

Additional Data and Information Requests for the Future

Additional Cost Analysis: For the determination of how much costs are associated with operation of a nationwide A&A network, we would request additional information from ASPE or CMS on the costs associated with 1-800-Medicare. If it is determined that the costs are relatively inexpensive, and the 3% CLASS Administrative costs are sufficiently large to support enhanced A&A functions, consider expanding the A&A benefit beyond information and referral only.

Environmental Scan of Existing Information and Referral Infrastructures: For the determination of how best to design the solicitation for public and private entities to provide advice and assistance services, the CLASS Office could contract to conduct an assessment of the infrastructures that already exist in States that can be built off of to support advice and assistance functions described in CLASS. These include one-stop HCBC service providers, SHIPs, targeted case management structures/system in Medicaid, ADRCs, CMS and HRSA sponsored information and referral systems, family to family resource centers, etc.

ADMINISTRATIVE COST CONSTRAINTS AND THE CLASS ACT

The Main Issues: Section 3203(b)(D)(2) states that: “in determining the monthly premiums for CLASS the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3% of all premiums paid during the year.” This requirement raises two key issues: (1) whether 3% is likely to be sufficient to cover expected administrative costs; and (2) if 3% is not sufficient what does that imply for HHS planning efforts so that the potential shortfalls can be addressed.

Is 3% likely to be sufficient to meet administrative needs of the CLASS program? To investigate the adequacy of the 3% administrative cost budget we have interviewed people from the third party administration (TPA) of long-term care insurance industry, contracted with the Actuarial Research Corporation (ARC) and examined the experiences of several long-term care insurance schemes (e.g., the federal program). Most of the individuals with whom we spoke said that administrative costs for LTCI products run between 5 and 7 percent of premiums.

Experts from the TPA industry made several important points about administrative costs. The first is that a cash benefit such as that set out in the CLASS program generally carries high administrative costs. The main reason for this is that a cash benefit typically requires more frequent in person assessments and reassessments of impairment levels. The cash benefit creates a strong incentive to claim long durations of impairment and also high levels of impairment. Moreover, having limited requirements for documenting service use and needs means that reassessments are required more frequently under cash benefits. This creates the potential for significant fraud and abuse. The fact is that between 30% and 40% of cases in private coverage that trigger benefits recover (fall below the ADL threshold). This has led some in the TPA industry to question whether 3% of premiums will be sufficient to effectively administer the program.

We have gathered some actual experience from the long-term care insurance industry. We have relied on the federal employees’ experience, filings by long-term care insurers to state insurance commissioners, and reports from private actuaries. The federal employees’ long-term care insurance plans for 2008 and 2009 had administrative costs of 6% and 6.7% respectively. We examined insurance industry filings to the State of North Carolina from several insurance carriers. The filings in North Carolina suggest administrative estimates of between a bit over 5% and 7.4% for an inflation protected policy (such as CLASS), once a policy has been in place for some time (rates are much higher initially). We also spoke with actuaries from the American Academy of Actuaries they provided composite estimates of administrative costs based on a number of individual firm experiences. The estimates ranged from... (We will receive data by Tuesday). [**NOTE:** we may also be able to add CalPers data here.]

The ARC constructed a synthetic estimate costing out individual administrative elements based on their experiences and observations. Thus they estimated that marketing costs and capital costs related to IT would be off budget. The estimates they obtained varied according to program take-up and premium levels. They made estimates for the following pairs of premium and take-up rates: \$150 and 1%; \$100 and 6%; and \$75 and 8%. During the first five years when there are no claims made on benefits the estimates ranged from 3.4% to 4.35% of premium. In years 5 to 10 when people begin making claims the administrative cost estimates ranged from 5% to 7.28%.

Implications: In the early years, the ACA funds have been requested to cover initial implementation costs such as personnel, building the IT system and marketing. The evidence we have been able to obtain suggests that once the program is up and running and has started to assess people and pay benefits, it is highly unlikely that administrative costs reflecting common practices in the long-term care insurance industry would fall under 3% of premium revenues. In fact it is unlikely that administrative costs will fall under 5%.

Option 1: Assume a 3% cap on administrative costs.

If we assume that we are limited to 3% of premium for administrative costs, there are several areas where program costs that do not entail beneficiary payments could potentially be placed off budget. These fall into cost categories not identified as administrative costs within the Act, such as including financial services as part of the benefit paid to eligible individuals. If such measures are to be taken premiums may have to be higher or benefits lower.

Option 2: Assume a 3% cap and seek authorities to exceed it.

Given that it may be quite difficult to bring administrative costs below the 3% constraint, even after moving key items off-budget, a question remains as to whether there are authorities given to the Secretary to relax the constraint if program solvency is threatened. OGC will provide additional guidance on this. Alternatively, the administrative constraint might be the subject of a technical correction.

Option 3: Assume 3% cap only limits premium revenue for administration and seek supplemental funds

The section restricting the use of tax dollars (“(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.--No taxpayer funds shall be used for payment of benefits under a CLASS Independent Benefit Plan”) can be interpreted to cap the premium charge for administration while allowing the use of other federal non-premium dollars for

administration. Given that 3% of premium for administration is insufficient, other funds could be sought to cover additional costs. Each year the CLASS office would request a budget that fills the gap between the projected total administrative cost and the estimated revenue from 3% of premiums. This interpretation would allow for overall premiums to remain low (through administrative cost subsidy) and allows for a year-to-year funding stream that changes as the program matures and administrative demands change. In effect this subsidy is already in place for the early years through the ACA funds for CLASS HIT and marketing. That said, it should be noted that this is inconsistent with how budget planning has been moving forward thus far.

A related operational concern is how CLASS evaluates the budget for administrative costs. It is desirable for planning reasons to have relatively stable administrative budgets especially during the start up phase of a major program. Moreover, it is desirable to set administrative budgets prospectively. In order to meet these aims and also honor the 3% of premiums paid in the year constraint requires developing a method that smoothes the “all premiums paid during the year” definition. There are several ways that this can be accomplished. A simple moving average (5 or 10 year) of the projected flow of premiums would serve to smooth the premium flow and would result in relatively stable budgets if the 3% was applied to the yearly value of the moving average. Since smoothing implies that the program has to borrow from itself, it may be desirable to incorporate the “time cost of money” into the calculation. That would imply calculating the present discounted value of the projected premium flow (for say 10 years) and applying the 3% figure to that estimate in each year. The discount rate would likely be based on the average return of the funds invested in the CLASS Trust (SSA funds also).

A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM

For additional information, you may visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the office at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201. The e-mail address is: webmaster.DALTCP@hhs.gov.

Files Available for This Report

Main Report	[48 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/index.shtml http://aspe.hhs.gov/daltcp/reports/2011/class/index.pdf
APPENDIX A: Key Provisions of Title VIII of the ACA, Which Establishes the CLASS Program	[6 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appA.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appA.pdf
APPENDIX B: HHS Letters to Congress About Intent to Create Independent CLASS Office	[11 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appB.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appB.pdf
APPENDIX C: <u>Federal Register</u> Announcement Establishing CLASS Office	[2 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appC.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appC.pdf
APPENDIX D: CLASS Office Organizational Chart	[2 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appD.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appD.pdf
APPENDIX E: CLASS Process Flow Chart	[2 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appE.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appE.pdf
APPENDIX F: <u>Federal Register</u> Announcement for CLASS Independence Advisory Council	[3 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appF.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appF.pdf
APPENDIX G: Personal Care Attendants Workforce Advisory Panel and List of Members	[6 PDF pages]
Full Appendix	http://aspe.hhs.gov/daltcp/reports/2011/class/appG.htm http://aspe.hhs.gov/daltcp/reports/2011/class/appG.pdf
Ga: <u>Federal Register</u> Announcement for Personal Care Attendants Workforce Advisory Panel	http://aspe.hhs.gov/daltcp/reports/2011/class/appGa.pdf
Gb: Advisory Panel List of Members	http://aspe.hhs.gov/daltcp/reports/2011/class/appGb.pdf

APPENDIX H: Policy Papers Discussed by the LTC Work Group	[36 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appH.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appH.pdf
APPENDIX I: CLASS Administration Systems Analysis and RFI	[10 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appI.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appI.pdf
APPENDIX J: Additional Analyses for Early Policy Analysis	[150 PDF pages]
Full Appendix	http://aspe.hhs.gov/daltcp/reports/2011/class/appJ.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appJ.pdf
Ja: A Profile of Declined Long-Term Care Insurance Applicants	http://aspe.hhs.gov/daltcp/reports/2011/class/appJa.pdf
Jb: CLASS Program Benefit Triggers and Cognitive Impairment	http://aspe.hhs.gov/daltcp/reports/2011/class/appJb.pdf
Jc: Strategic Analysis of HHS Entry into the Long-Term Care Insurance Market	http://aspe.hhs.gov/daltcp/reports/2011/class/appJc.pdf
Jd: Managing a Cash Benefit Design in Long-Term Care Insurance	http://aspe.hhs.gov/daltcp/reports/2011/class/appJd.pdf
APPENDIX K: Early Meetings with Stakeholders	[4 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appK.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appK.pdf
APPENDIX L: In-Depth Description of ARC Model	[62 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appL.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appL.pdf
APPENDIX M: In-Depth Description of Avalere Health Model	[23 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appM.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appM.pdf
APPENDIX N: September 22, 2010 Technical Experts Meeting	[37 PDF pages]
Full Appendix	http://aspe.hhs.gov/daltcp/reports/2011/class/appN.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appN.pdf
Na: Agenda, List of Participants, and Speaker Bios	http://aspe.hhs.gov/daltcp/reports/2011/class/appNa.pdf
Nb: Presentation Entitled "Actuarial Research Corporation's Long Term Care Insurance Model"	http://aspe.hhs.gov/daltcp/reports/2011/class/appNb.pdf
Nc: Presentation Entitled "The Long-Term Care Policy Simulator Model"	http://aspe.hhs.gov/daltcp/reports/2011/class/appNc.pdf
Nd: Presentation Entitled "Comments on 'The Long-Term Care Policy Simulator Model'"	http://aspe.hhs.gov/daltcp/reports/2011/class/appNd.pdf
APPENDIX O: Actuarial Report on the Development of CLASS Benefit Plans	[47 PDF pages]
	http://aspe.hhs.gov/daltcp/reports/2011/class/appO.htm
	http://aspe.hhs.gov/daltcp/reports/2011/class/appO.pdf

APPENDIX P: June 22, 2011 Technical Experts Meeting
Full Appendix

[46 PDF pages]

<http://aspe.hhs.gov/daltcp/reports/2011/class/appP.htm>

<http://aspe.hhs.gov/daltcp/reports/2011/class/appP.pdf>

Pa: Agenda and Discussion Issues and
Questions

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPa.pdf>

Pb: Presentation Entitled "Core Assumptions and
Model Outputs"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPb.pdf>

Pc: Presentation Entitled "Actuarial Research
Corporation's Long Term Care Insurance
Model"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPc.pdf>

Pd: Presentation Entitled "The Avalere Long-
Term Care Policy Simulator Model"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPd.pdf>

Pe: Presentation Entitled "Alternative Approaches
to CLASS Benefit Design: The CLASS
Partnership"

<http://aspe.hhs.gov/daltcp/reports/2011/class/appPe.pdf>

APPENDIX Q: Table 2: Actuarial and Demographic Assumptions

[2 PDF pages]

<http://aspe.hhs.gov/daltcp/reports/2011/class/appQ.htm>

<http://aspe.hhs.gov/daltcp/reports/2011/class/appQ.pdf>

APPENDIX R: Figure 1: Daily Benefit Amount for Increased Benefit

[2 PDF pages]

<http://aspe.hhs.gov/daltcp/reports/2011/class/appR.htm>

<http://aspe.hhs.gov/daltcp/reports/2011/class/appR.pdf>