

**CLASS CANCELED: AN UNSUSTAINABLE PROGRAM
AND ITS CONSEQUENCES FOR THE NATION'S
DEFICIT**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
AND THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
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C O N T E N T S

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	3
Hon. Lee Terry, a Representative in Congress from the State of Nebraska, opening statement	5
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	5
Prepared statement	8
Hon. Cliff Stearns, a Representative in Congress from the State of Florida, opening statement	10
Prepared statement	12
Hon. Diana DeGette, a Representative in Congress from the State of Colorado, opening statement	14
Hon. Phil Gingrey, a Representative in Congress from the State of Georgia, opening statement	15
Hon. Marsha Blackburn, a Representative in Congress from the State of Tennessee, opening statement	16
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement	17
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	18
Hon. Tim Murphy, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	20
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	20
Hon. Donna M. Christensen, a Representative in Congress from the Virgin Islands, opening statement	22
Hon. Janice D. Schakowsky, a Representative in Congress from the State of Illinois, opening statement	22
WITNESSES	
Hon. Denny Rehberg, a Representative in Congress from the State of Montana	25
Prepared statement	27
Hon. Theodore E. Deutch, a Representative in Congress from the State of Florida	30
Prepared statement	32
Patrick J. Kennedy, a former Representative in Congress from the State of Rhode Island	39
Prepared statement	41
Hon. Charles W. Boustany, Jr., a Representative in Congress from the State of Louisiana	45
Prepared statement	47
Kathy Greenlee, Assistant Secretary for Aging, Administration on Aging, Department of Health and Human Services	49
Prepared statement	52
Answers to submitted questions	193
Sherry Glied, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services ¹	52
Prepared statement	52
Answers to submitted questions	194

VI

SUBMITTED MATERIAL

Page

Statement, dated October 26, 2011, of Senator John Thune, submitted by Mr. Pitts	23
Letter, dated November 25, 2009, from Douglas W. Elmendorf, Director, Congressional Budget Office, to Senator Tom Harkin	105
Subcommittee exhibit binder	114

¹Ms. Glied did not present an opening statement. Ms. Greenlee and Ms. Glied submitted a joint prepared statement for the record.

CLASS CANCELED: AN UNSUSTAINABLE PROGRAM AND ITS CONSEQUENCES FOR THE NATION'S DEFICIT

WEDNESDAY, OCTOBER 26, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
JOINT WITH
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:05 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph Pitts (chairman of the Subcommittee on Health) presiding.

Members present: Representatives Pitts, Stearns, Shimkus, Terry, Myrick, Sullivan, Murphy, Burgess, Blackburn, Bilbray, Gingrey, Scalise, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Gardner, Griffith, Dingell, Pallone, Green, DeGette, Schakowsky, Gonzalez, Matheson, Christensen, Castor, and Waxman (ex officio).

Staff present: Stacy Cline, Counsel, Oversight and Investigations; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Todd Harrison, Chief Counsel, Oversight and Investigations; Sean Hayes, Counsel, Oversight and Investigations; Debbie Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Carly McWilliams, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Krista Rosenthal, Counsel to Chairman Emeritus; Chris Sarley, Policy Coordinator, Environment and Economy; Alan Slobodin, Deputy Chief Counsel, Oversight and Investigations; Alvin Banks, Democratic Investigator; Phil Barnett, Democratic Staff Director; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Advisor; Alli Corr, Democratic Policy Analyst; Ruth Katz, Democratic Chief Public Health Counsel; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; and Anne Tindall, Democratic Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The subcommittee will come to order.

The Chair recognizes himself for 5 minutes for an opening statement. On October 14, 2011, after 19 months of review and \$15 mil-

lion, HHS announced what most people, including many Members of Congress, independent analysts, and CMS's own actuary, have known about the CLASS program since before the health care bill became law: It is completely unsustainable.

After determining that the CLASS program cannot meet the law's 75-year solvency requirement, HHS has decided not to implement this provision of the law. This shouldn't be a surprise. Months before PPACA became law, the warning was being sounded.

On July 9, 2009, CMS actuary Richard Foster wrote, "36 years of actuarial experience lead me to believe that this program would collapse in short order and require significant Federal subsidies to continue."

Also that month, the American Academy of Actuaries wrote to the Senate HELP Committee, "The proposed structure and the premium requirements within the CLASS Act plan are not sustainable."

And Kent Conrad, the Democratic chairman of the Senate Budget Committee famously called the CLASS Act "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."

All of this was before PPACA was signed into law. So why was the CLASS Act included? Quite simply, PPACA's authors needed savings, and the CLASS Act provided a convenient budgetary gimmick. Since participants would have to pay into the program for 5 years before becoming eligible for any benefits, CBO estimated including the CLASS Act would reduce the 10-year cost of the legislation by \$70 billion.

By February 16 of this year, even Secretary Sebelius publicly admitted that the CLASS Act is "totally unsustainable."

The CLASS Act was doomed from the start. We have a very serious long-term care problem in this country. Costs are driving people into bankruptcy, and weighing down an already overburdened Medicaid program. The CLASS Act should not only be shelved; it should be repealed. And I would like to at this time yield to the gentleman from Nebraska, Mr. Terry, the remainder of my time.

[The prepared statement of Mr. Pitts follows:]

**Opening Statement of the Honorable Joseph R. Pitts
Joint Hearing of the Energy and Commerce Subcommittee on Health
and the Subcommittee on Oversight and Investigations
Hearing on "CLASS Cancelled: An Unsustainable Program and Its
Consequences for the Nation's Deficit"
October 26, 2011**

On October 14, 2011, after 19 months of review and \$15 million, HHS announced what most people – including many Members of Congress, independent analysts, and CMS' own actuary – have known about the CLASS program since before the health care bill became law: it is completely unsustainable.

After determining that the CLASS program cannot meet the law's 75-year solvency requirement, HHS has decided not to implement this provision of the law.

We didn't need to waste 19 months of time and \$15 million of taxpayer money to arrive at this conclusion. Months before PPACA became law, the warning was being sounded.

On July 9, 2009, CMS Actuary Richard Foster wrote: "Thirty-six years of actuarial experience lead me to believe that this program would collapse in short order and require significant federal subsidies to continue."

Also that month, the American Academy of Actuaries wrote to the Senate HELP Committee: "Our actuarial analysis demonstrates that the proposed structure and the premium requirements within the CLASS Act plan are not sustainable."

In October 2009, Senators Kent Conrad, Joe Lieberman, Blanche Lincoln, Mary Landrieu, Evan Bayh, Mark Warner, and Ben Nelson asked Harry Reid to strip the CLASS Act out of the pending health reform legislation.

And Kent Conrad, the Democratic Chairman of the Senate Budget Committee, famously called the CLASS Act "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."

All of this was before PPACA was signed into law. So why was the CLASS Act included?

Quite simply, PPACA's authors needed savings, and the CLASS Act provided a convenient budgetary gimmick.

Since participants would have to pay into the program for five years before becoming eligible for any benefits, CBO estimated including the CLASS Act would reduce the 10-year cost of the legislation by \$70 billion. (Incidentally, CBO also estimated massive deficits for the program outside the 10-year window.)

By February 16th of this year, even Secretary Sebelius publicly admitted that the CLASS Act is "totally unsustainable."

The CLASS Act was doomed from the start. It should not have been included in PPACA, and it should not have taken eight months after the Secretary publicly discredited the program for the Department to pull the plug.

We have a very serious long-term care problem in this country. Costs are driving people into bankruptcy and weighing down an already over-burdened Medicaid program.

The CLASS Act should not only be shelved; it should be repealed.

###

OPENING STATEMENT OF HON. LEE TERRY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. TERRY. Thank you, Mr. Chairman.

And the failure of the CLASS Act really is of no surprise. I think most people in this room knew that the CLASS Act, the CLASS program was flawed from its inception. There is no way that the incoming premiums could ever cover the benefits to be paid out. Also, the unhealthy and disabled would have rushed into this program in such great numbers that they would have immediately increased premiums for everyone enrolled.

Health care policy analysts raised a red flag on CLASS because they saw these flaws and understood the high likelihood of taxpayers later financing a CLASS bailout. So the ultimate question is, was that a purposeful ruse by HHS and the administration to make the Affordable Care Act look better, therefore passing? Or is this just plain old administrative incompetence? Hopefully, we will get a clearer view on which one of those it is.

Yield back to you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes the ranking member of the Subcommittee on Health, Mr. Pallone, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

On March 23, 2010, our government made a promise to the American people to improve health care in this country by enacting the Affordable Care Act, landmark legislation that expanded and strengthened health coverage in this country.

This promise included the CLASS Act, which gives HHS the authority to develop a voluntary long-term care insurance option for working families. The goal of CLASS is to provide Americans with an affordable method of obtaining long-term care benefits.

Unfortunately, Secretary Sebelius has announced that HHS will not move forward with implementing CLASS. But I am here to tell you that if we do not move forward with the implementation of the CLASS Act, we will be turning our backs on the millions of Americans that are in need of a solution for finding long-term care support.

An estimated 15 million people are expected to need some form of long-term care support by 2020. Today, more than 200 million Americans lack long-term care insurance. And currently, Medicaid pays 50 percent of the costs of long-term services. And that price tag is quickly rising every year. Persons that develop functional impairment are often forced to quit their jobs or spend down their incomes in order to qualify for the long-term care supports and services they need. The CLASS Act program is designed to allow people to plan in advance, to take personal responsibility for their own care, and obtain the support that they need in order to potentially remain in their communities and even remain active in their jobs.

Now, instead of allowing this population an opportunity to remain self-sufficient, we are sentencing them to unnecessary poverty to receive the care that they need. If we as a country do not invest

in fixing long-term care, people with functional impairments will keep returning to costly acute settings to address potentially preventable conditions. And I don't think we can sit back and do nothing.

I do not agree that HHS has completed their work on trying to implement CLASS. Mr. Bob Yee, whose dismissal last month as the CLASS actuary, first signaled that HHS was abandoning this program, gave the Department a path forward to implement CLASS. His report to HHS states, "That the CLASS benefit plan can be designed to be a value proposition to the American workers as the CLASS Act prescribed it."

Mr. Yee has developed options that address adverse selection and premium support. One of Mr. Yee's options is what he calls phased enrollment, in which large employers offer the plan first before individuals can sign up. Another option is temporary exclusion, no benefits for 15 years if the need for help arises from a serious medical condition that already existed when someone enrolled.

Mr. Yee is an optimist. He explains how HHS should move forward. So why does the Department take such a negative approach and close the door on implementation when the work has not been completed? The Affordable Care Act requires that the CLASS Act implementation proposals be reviewed by the CLASS Independence Advisory Council, which HHS has yet to establish. This council should be convened immediately in order to better inform the efforts of the Department and to represent the interests of stakeholders that have been invested in CLASS for over a decade. The Department is not supposed to unilaterally abandon CLASS without convening the advisory council. The council may reveal other workable options for long-term care that the Department has not considered.

The CLASS Act is the first step towards improving our Nation's long-term care problems. It provides an infrastructure that can be implemented. And this was an important part of health care reform. I refuse to give up on CLASS, just as I refuse to give up on the health care reform.

Now, I know my colleagues on the other side want to give up on it all. They want to repeal everything. They want to repeal the whole Affordable Care Act.

But I have to say, Mr. Chairman, I am tired of the Republican rhetoric that says Congress and the government in general can't do anything. The last two speakers on the other side, and I wrote it down, used terms like gloom, failure, can't do, no way.

You know, why can't we do things? Part of what makes us as Americans is that we are can-do people. We can have universal affordable health insurance. We can provide long-term care insurance. I certainly don't think that the Department should play into the same negative theme that I keep hearing every day from my opponents on the other side. And that is what is so disappointing to me today, is to see HHS play the same negative thing; we can't do this, we can't do that.

You know, I look on the floor today, Mr. Chairman, what are we doing this week in Congress? We are not doing anything. And this is the attitude that is pervasive around here, that we can't do anything.

Well, I think we can do things. We can have affordable health care. We can have a plan for long-term care. And I just wish that we would understand that the American people expect us to do something and not just sit back and say, we are failures, we can't do this, we can't do that.

Let's do the CLASS Act. I would ask the Department go back to the drawing board, be optimistic, and come up with a plan that implements the CLASS Act.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Pallone follows:]

The Honorable Frank Pallone, Jr.**House Energy and Commerce Subcommittee on Health and Subcommittee on Oversight and Investigations Joint Hearing***"CLASS Cancelled: An Unsustainable Program and Its Consequences for the Nation's Deficit"*

Opening Statement - October 26, 2011

Thank you Mr. Chairman. On March 23, 2010, our government made a promise to the American people to improve health care in this country by enacting the Affordable Care Act, landmark legislation that expanded and strengthened health coverage in this country. This promise included the CLASS Act, which gives HHS the authority to develop a voluntary long term care insurance option for working families.

The goal of CLASS is to provide Americans with an affordable method of obtaining long term care benefits. Unfortunately, Secretary Sebelius has announced that HHS will not move forward with implementing CLASS. But I am here to tell you that if we do not move forward with the implementation of the CLASS Act, we will be turning our backs on the millions of Americans that are in need of a solution for finding long term care support.

An estimated 15 million people are expected to need some form of long term care supports by 2020. Today, more than 200 million Americans lack long term care insurance. Currently, Medicaid pays 50 percent of the costs of long-term services and that price tag is quickly rising every year. Persons that develop functional impairment are often forced to quit their jobs or spend down their income in order to qualify for the long term care supports and services that they need. The CLASS program is designed to allow people to plan in advance – to take personal responsibility for their own care – and obtain the support that they need in order to potentially remain in their communities and even remain active in their jobs.

Instead of allowing this population an opportunity to remain self-sufficient, we are sentencing them to unnecessary poverty to receive the care that they need. If we, as a country, do not invest in fixing long term care, people with functional impairments will keep returning to costly acute care settings to address potentially preventable conditions. We cannot sit back and do nothing.

I do not agree that HHS has completed their work on trying to implement CLASS. Mr. Bob Yee, whose dismissal last month as the CLASS actuary first signaled that HHS was abandoning the program, gave the Department a path forward to implement CLASS. His report to HHS states that the "CLASS Benefit Plan can be designed to be a value proposition to the American workers as the CLASS Act prescribed it." Mr. Yee has developed options that address potential adverse selection and premium support. One of Mr. Yee's options is "phased enrollment," in which large employers offer the plan first before individuals can sign up.

Another option is “temporary exclusion:” no benefits for 15 years if the need for help arises from a serious medical condition that already existed when someone enrolled. Mr. Yee is an optimist. He explains how HHS should move forward. So why does the Department take such a negative approach and close the door on implementation when the work has not been completed?

The Affordable Care Act requires that CLASS Act implementation proposals be reviewed by the CLASS Independence Advisory Council, which HHS has yet to establish. This Council should be convened immediately in order to better inform the efforts of HHS and to represent the interests of stakeholders that have been invested in CLASS for over a decade. HHS is not supposed to unilaterally abandon CLASS without convening the Advisory Council. The Council may reveal other workable options for long term care that the Department has not considered.

The CLASS Act is the first step towards improving our nation’s long term care problem. It provides an infrastructure that can be implemented. This was an important part of health care reform. I refuse to give up on CLASS just as I refuse to give up on health care reform. I’m tired of the Republican rhetoric that says Congress and government in general can’t do anything. And, I certainly don’t think that HHS should play into that same theme.

Americans are a “can do” people. We can have universal, affordable health insurance. And we can provide long term care insurance. I suggest that the Department go back to the drawing board, be optimistic and come up with a plan that implements CLASS.

Thank you.

Mr. PITTS. The Chair thanks the gentleman and recognizes the chairman of the Subcommittee on Oversight and Investigations, Mr. Stearns, for 5 minutes.

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. STEARNS. Thank you, Mr. Chairman.

And I welcome this opportunity to have a joint hearing between your subcommittee and mine.

And I would address the gentleman from New Jersey. He refuses to give up. Of course, this is something that all of his Democrat colleagues, many of his Democratic colleagues, both in the House and Senate, all indicated they have grave concerns about this new entitlement program. It is too much spending. And I suspect that he wishes to continue this program in light of the fact that it is going to be a budget buster.

And we are doing something here in Congress; we are trying to balance the budget. So we convene this joint hearing of the Oversight and Investigations and Health subcommittees to address the Energy and Commerce Committee's long-standing inquiry into the circumstances under which the CLASS Act was passed, a program that was recently pronounced dead by Secretary Sebelius.

The Community Living Assistance Service and Support Act, or the CLASS Act as we call it, is a long-term care program that was included in the President's health care law. It was meant to be self-funding. Individuals paying premiums into the program would cover the costs of individuals receiving benefits.

However, my colleagues, even before the passage of Obamacare, Republicans recognized the CLASS Act had a critical design flaw. CLASS would never be self-sustaining, and would eventually go bankrupt. Some Senate Democrats even joined us, saying they, "had grave concerns that the real effect of the CLASS Act would be to create a new Federal entitlement program with large, long-term spending increases that far exceed the revenues."

Perhaps the most damning indictment came from Senate Budget Chairman Kent Conrad, who characterized the CLASS Act as a "Ponzi scheme of the first order," as the gentleman from Pennsylvania mentioned when he was quoting him, "the kind of thing that Bernie Madoff would have been proud of."

As with other provisions of Obamacare, Democrats didn't bother to fix the CLASS Act. They had every opportunity, and they didn't work with Republicans to find common ground. They were too busy using procedural tricks to cram through a law before even the public could realize what was in it. But they didn't just quietly sneak the CLASS Act in. They had the audacity to claim that it would provide \$70 billion in deficit savings. Democrats brazenly stated, even though they knew better, that the CLASS Act would actually, actually save the American people money.

They were deliberately ignoring the truth about the CLASS Act. Democrats overstated the fiscal conditions of this program intentionally. The \$70 billion in alleged savings from the CLASS Act was crucial, crucial to passing the health care law. And this administration promised the American people that the bill would result in \$140 billion in savings. Half of those savings were from the

CLASS Act, and the other half were from tax increases and cuts to Medicare.

So after 19 months of trying, Secretary Sebelius announced she does not, “see a viable path forward for CLASS implementation at this time.”

Now, the question is, why did it take the administration so long to figure out what everybody else, even the CMS chief actuary, has known for many, many years? HHS and the administration seem to have gone to extraordinary lengths to ignore the truth so that they can continue to sell the false savings on this program to the American people. Even staff at HHS knew long ago that the CLASS Act was a financial disaster and that it would cost money and simply not save it.

This committee conducted a comprehensive investigation with Senator Thune, Congressman Rehberg, and a working group of other Republicans from both the House and the Senate. We discovered 150 pages of emails and documents from HHS questioning the sustainability of the CLASS Act as early as May 2009. Staff and officials within HHS called the program a “recipe for disaster” that would “collapse in short order.” Now, this is going back to 2009. These are 150 pages of detailed documents and emails.

But while voices of reason questioned the program privately, Secretary Sebelius and other administration officials publicly proclaimed their support. As we have seen before, first with the waivers, now with the CLASS Act, the Obama administration overpromises, underdelivers, and waits until implementation to admit its policy failures.

Under CBO rules, the CLASS failure will cost the American taxpayers \$86 billion, the most recent CBO projection of the supposed savings from the CLASS Act. If CLASS had gone into effect, it would have increased our deficit by the third decade. How much will the rest of Obamacare cost us? What are the hidden long-term costs? And when will the administration tell us the truth about that?

[The prepared statement of Mr. Stearns follows:]

**Opening Statement of the Honorable Cliff Stearns
Joint Hearing of the Energy and Commerce Subcommittee on Health
and the Subcommittee on Oversight and Investigations
Hearing on "CLASS Cancelled: An Unsustainable Program and Its
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We convene this joint hearing of the Oversight and Investigations and Health Subcommittees to address the Energy and Commerce Committee's longstanding inquiry into the circumstances under which the CLASS Act was passed, a program recently pronounced dead by Secretary Sebelius. The Community Living Assistance Services and Support Act, or CLASS Act, is a long-term care program that was included in the president's health care law. It was meant to be self-funding —individuals paying premiums into the program would cover the costs of individuals receiving benefits.

However, even before the passage of Obamacare, Republicans recognized the CLASS Act had a critical design flaw. CLASS would never be self-sustaining and would go bankrupt. Some Senate Democrats even joined us, saying they had "grave concerns that the real effect of the [CLASS Act] would be to create a new federal entitlement with large, long-term spending increases that far exceed revenues." Perhaps, the most damning indictment came from Senate Budget Chairman Kent Conrad who characterized the CLASS Act as "a ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of."

As with other provisions of Obamacare, Democrats didn't bother to fix the CLASS Act, and they didn't work with Republicans to find common ground. They were too busy using procedural tricks to cram through a law before the public could realize what was in it. But they didn't just quietly sneak the CLASS Act in. They had the audacity to claim that it would provide \$70 billion in deficit savings. Democrats brazenly stated, even though they knew better, that the CLASS Act would actually SAVE the American people money. They were deliberately ignoring the truth about the Class Act.

I'd like to take a minute to show a clip from the Washington Examiner of our Democratic colleagues praising the CLASS Act.

As we see in the video clip, Democrats overstated the fiscal condition of this program. The \$70 billion in alleged "savings" from the CLASS Act was crucial to passage of the health care law and this Administration promised the American people that the bill would result in \$140 billion in savings—half of those savings were from the CLASS Act, the other half were from tax increases and cuts to Medicare.

After 19 months of trying, Secretary Sebelius announced that she does "not see a viable path forward for CLASS implementation at this time." Why did it take the Administration so long to figure out what everyone else, even the CMS Chief Actuary, has known for years? HHS and the Administration seem to have gone to extraordinary lengths to ignore the truth so that they could continue to sell the false savings story to the American people.

Even staff at HHS knew long ago that the CLASS Act was a financial disaster that would cost money, not save it. This Committee conducted a comprehensive investigation with Senator Thune, Congressman Rehberg, and a working group of other Republicans from the House and Senate. We discovered 150 pages of emails and documents from HHS questioning the sustainability of the CLASS program as early as May 2009. Staff and officials within HHS called the program a "recipe for disaster" that would "collapse in short order."

But while voices of reason questioned the program privately, Secretary Sebelius and other Administration officials publicly proclaimed their support. As we've seen before, first with the waivers, now with the CLASS Act, the Obama Administration over-promises, under-delivers and waits until implementation to admit its policy failures.

Under CBO rules, the CLASS failure will cost the American taxpayers \$86 billion — the most recent CBO projection of the supposed savings from the CLASS Act. If CLASS had gone into effect, it would have increased our deficit by the third decade. How much will the rest of Obamacare cost us? What are the hidden long-term costs? When will the Administration tell us the truth about that?

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Mr. PITTS. The Chair thanks the gentleman.

Now recognizes the ranking member of the Subcommittee on Oversight and Investigation, Ms. DeGette, for 5 minutes.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman.

I particularly want to welcome our colleagues present and past here today, in particular our friend Patrick Kennedy. It is so good to see you here today. And I know we all feel that way.

I hope this hearing will help us to find a path forward to develop a plan to provide and pay for the ongoing burden of long-term care. Millions of seniors, disabled individuals, and their families face this challenge today, and tens of millions more will face it in the future. The CLASS Act was an effort to address these burdens. The program was added to the health care bill in this committee on a bipartisan voice vote. It was designed as a voluntary insurance program to provide beneficiaries with a cash benefit to help pay for institutional care or assistance to live independently in the community. Now, as we have all been discussing, the administration announced last week that it would not move forward with the implementation of the CLASS program because it was currently unable to do so in an actuarially sustainable fashion.

I am interested in hearing from the administration's representatives about how they came to this conclusion and what potential they have for moving forward.

Now, from this side of the aisle the reaction has primarily been one of disappointment. We understood the scope of the Nation's long-term care problems and the impact that these problems had on seniors and the disabled and their families. And we were hopeful, when we passed the Affordable Care Act, that the CLASS program would be the solution.

Now, as you can hear from today's opening statements, some on the other side of the aisle seem positively gleeful that this CLASS program has been set aside. And that view, in my opinion, is really shortsighted because we have got to keep looking for solutions to the long-term care problem, and we have got to do it in a bipartisan way. We cannot and we should not give up.

Ten million Americans need long-term care right now. And this number is expected to grow by 50 percent over the next decade. Long-term care, as we also know, is expensive. It wipes out seniors' savings, and it forces many to go on Medicaid, which in turn costs States and taxpayers billions of dollars. So the present situation is both fiscally and morally wrong.

Mr. Chairman, many opponents of the health care law are using this CMS announcement about CLASS as an opportunity to attack the entire law. In the context of those claims, I want to set the record straight on two important subjects. First, with or without CLASS, the health care reform bill continues to be a financially responsible law that will reduce the Nation's debt. When we passed that bill, CBO told us it would save about \$200 billion over the next decade. CLASS was responsible for about \$70 billion of that savings. That means, even without CLASS, the numbers still add

up. The health care law will save taxpayers over \$120 billion over the next decade and even more in the decade after that.

Second, I want to address the myth that the administration announcement somehow hobbles the health care law. It does not. The CLASS program was an important part of the law that provided a new and important long-term benefit. But even though the administration has decided not to move forward with this program, the rest of the bill's benefits continue to pile up. Millions of seniors are enjoying discounts on prescription drugs in the part D doughnut hole. Young adults are able to retain their health insurance through their parents' plans. Taxpayers are saving money because of the bill's initiatives to cut Medicare and Medicaid fraud, waste, and abuse. Millions of Americans are protected from the worst abuses of the insurance industry. Small businesses are receiving valuable tax credits to provide health care coverage. And by the time the health care bill is fully implemented, over 30 million otherwise uninsured Americans will have access to good, affordable health care law—or health care coverage.

Now, I am disappointed about the outcome of CLASS. But even without this part, the health care law will continue to provide critical benefits for tens of millions of Americans. My hope was that CLASS would solve our growing problems in providing and paying for long-term care. And I still hold out hope that it can be part of the solution. It really has to be. I want to hear from the administration today exactly where we are. But more importantly, I want both of these subcommittees and the full committee to explore together how we move forward. Can the administration ultimately find a way to make CLASS a workable solution? Are there legislative solutions that can help make CLASS a workable and sustainable program? The committee and the Congress have a responsibility to help the elderly and disabled in our society who need long-term care. I hope this hearing will help us meet this responsibility.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes.

OPENING STATEMENT OF HON. PHIL GINGREY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. GINGREY. Mr. Chairman, thank you.

And I will admit to being gleeful this morning. It is hard not to be gleeful when we just rescued \$80 billion from a Democratic sink hole and now are returning that money to the American taxpayer. Yes, indeed I am gleeful.

But to quote the President of the National Coalition on Health Care in a Politico story yesterday, "The best strategy is to keep CLASS Act on the books until health reform takes hold and hope the political environment changes enough so that the program can be tweaked into shape." That, frankly, sounds like a recipe for disaster.

Mr. Chairman, when a pharmaceutical drug does not work as intended it isn't kept on the market with the hope that one day it might be tweaked. It is recalled, clean and simple. And this CLASS program is not unlike a defective drug. And its repeal is a necessary step toward successful long-term care reform. And I agree with Ms. DeGette on that.

CLASS does not work. The administration cannot fix it without massive taxpayer bailouts. And as long as it survives and is still on the books, it is a threat to the current entitlement programs and especially to Medicare. Additionally, a congressional report released last month on CLASS presents evidence that former Senator Kennedy's senior staffers and administration officials ignored CMS actuary Rick Foster's repeated warnings on the insolvency of the program. They also ignored studies conducted by the American Academy of Actuaries and the Society of Actuaries supporting Rick Foster's concerns.

According to the report, the Kennedy staff response was, "decided she doesn't think she needs additional work on the actuarial side." And then allegedly told administration staffers she had a score from CBO on CLASS that was actuarially sound. And yes, it kept going.

One month later, Richard Frank, Deputy Assistant Secretary for Planning and Evaluation at HHS stated publicly that we in the department have modeled CLASS extensively, and we are entirely persuaded that financial solvency over the 75-year period can be maintained. Yet to my knowledge, no model from CBO or the administration suggesting that CLASS is solvent has ever been produced publicly, even after repeated requests made by this committee, Mr. Chairman.

That is simply unacceptable. If the warnings of CMS actuaries were ignored, this committee and the American public need to know why they were ignored. We simply cannot afford to let this administration hide behind any backroom deals and secret handshakes any longer.

Mr. Chairman, I believe that this committee must continue to seek the truth from the Obama administration on the economic modeling used to sell us on the CLASS Act and Obamacare and, indeed, on the entire bill that was sold to the American people.

And further, I would once again call on this Congress to pass H.R. 1173, a bill that my good friend and fellow physician Dr. Boustany has introduced to repeal the CLASS Act.

And Mr. Chairman, with that, I would like to yield the balance of my time to my colleague from Tennessee, Ms. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And I thank the gentleman from Georgia. We appreciate having the hearing today and reviewing what is taking place with the CLASS Act. I think that it is apparent that, despite the best efforts of the Federal Government, it is very clear to all of us that there is no way that the Federal Government more effectively or efficiently runs a health care program than the private sector.

Indeed, as we went through this entire debate—and for my colleagues across the aisle, I will remind you—there is no example in the United States of where the Federal Government has run this effectively, has saved money. Indeed, when you look at TennCare, you see cost overruns. There is no example where these near-term expenses yield you a long-term savings. It has not happened, not

in Tennessee, not in Massachusetts, not in New Jersey with guaranteed issue.

And it does bring up other problems that exist with the CLASS Act, indeed the budget gimmickry that was there throughout the entire Obamacare bill. What else is within this bill that would be gimmickry that was there to yield a savings? This is something that we need to look at as a committee, get to the bottom of. I think also the other thing that it highlights is the red flags that many of our colleagues have mentioned, indeed this being called a recipe for disaster, which now it is quite apparent that it is.

And then I think that another concern that we will want to address is the lack of transparency that existed in HHS as they moved forward with discrepancies in public statements and private statements. And we will want to get to the bottom of that. Indeed, they have spent 19 months trying to implement an unworkable program—program. And I appreciate that we are having a hearing to get to the bottom of it.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Well, the Republicans are gleeful, and they are happy to admit that. If they are gleeful, it is because they want to repeal the Affordable Care Act and this particular provision, which attempts to deal with the issues of long-term care.

A lot of people around the country don't realize that if they have health insurance, even Medicare, it doesn't pay for their assistance when they need what is called long-term care. And if they repeal the CLASS Act, they will have the following status quo continued.

Right now, over 10 million Americans are in need of some form of long-term care, and this number is expected to increase to 15 million by 2020. Seven in 10 people in the country will need help with basic daily living activities at some point in their lives because of a functional disability.

The cost of long-term care is astronomical. The average nursing home bill currently stands in excess of \$70,000 a year. Monthly charges for home health services averages out at \$1,800. Private health insurance, which my Republican colleagues says is the way to solve the problem, a lot of those private insurance policies often are too expensive or difficult to purchase. As a result, less than 10 percent of the population holds these policies.

By far and away, the largest spender for long-term care comes through the Medicaid program. In fiscal year 2010 alone, the combined Federal and State price tag for these services was some \$120 billion. That is a publicly-financed program.

So the Republicans would allow this program that is publicly financed to be the only hope for seniors that can't afford a policy to cover them for their long-term care needs. They started off this year by saying, we want to repeal the Affordable Care Act, and

then we will replace it. We have never heard what their replacement is.

They have no idea how to deal with this problem, only to tear down the attempts to make the problem more manageable for the millions of Americans who face the dilemma of how to pay for their long-term care or the long-term care costs of their family.

Well, it was for this problem that Congressman Pallone and Congressman Dingell and Senator Kennedy worked to establish an effort to meet the long-term care needs of our elderly and disabled citizens and their families, as well as to provide fiscal relief to the Medicaid program. The Community Living Assistance Services and Supports initiative, which is the CLASS program, was made part of the Affordable Care Act. This represented the first real attempt at the national level to tackle the country's long-term care puzzle. And it has eluded us for decades because of the complexity and the expensive price tag. We should not lose sight of all this, even as the program struggles to get off the ground.

Now, no doubt the CLASS program is not crafted perfectly. No piece of legislation is, especially one that is as novel and as unique as CLASS. Everyone acknowledges that. But regrettably, Republicans have called this hearing today to dwell on the problems that have stymied implementation of CLASS, not how to fix those problems to deliver the promising future that could and should lie ahead for the CLASS program.

Ten days ago, Secretary Sebelius announced she is putting CLASS on hold. That is because of unintended flaws in the statutory authority. She feels she could not at this time fully implement the law. I find that disappointing. But until she finds a path forward, the action she has taken is the responsible thing to do, fiscally and otherwise. But calling for a timeout is not the equivalent of throwing in the towel, as Republicans would have the public believe.

Contrary to the Republican title this hearing, CLASS has not been canceled; rather, it simply stands in recess.

The Republicans complain we are ignoring the truth. Well, they are ignoring the truth of the plight of millions of people to finance their long-term care. They talk about the financial disaster. What about the financial disaster for those families facing this issue? Recipe for disaster. Doing nothing and repealing the CLASS Act is a recipe for disaster.

They talk about overpromising and underdelivering. They have promised to repeal and replace, and they have never told us what they would do. All they have done is pass a law that would make the Medicare program not a guarantee, but something that may be available in the future, but for most people, it may not.

I want to put all this in perspective, and look forward to the hearing today.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes the vice chairman of the Health Subcommittee, Dr. Burgess, for 5 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chairman for yielding.

Welcome to our panelists this morning. A great bipartisan group of Members and former Members.

And I also want to welcome the second panel from the agencies. We certainly look forward to hearing your testimony this morning.

I am a believer in long-term care insurance. And really, this hearing is more about the budgetary gimmicks that were used to force through the Affordable Care Act, which really if I can't remove the Affordable Care Act, I would like to at least remove the word affordable from the title. But nevertheless, this is a hearing about the classic Washington whodunit; what did you know, and when did you know it?

But I am a believer in long-term care insurance. I purchased a long-term care insurance policy long before I came to Congress, after I turned 50, on the advice of my mother. And I encourage other people to do the same.

Now, Mr. Waxman says that it is going to be too expensive for seniors to do that. My premium is a little less than \$100 a month. I don't know what the premiums would have been in the CLASS Act, but they certainly would not have been benefits as substantial as the ones that I have purchased in the private sector. And I am not always dependent upon the Federal Government to end up doing the right thing.

We heard Mr. Pallone talk about a 15-year exclusion. Well, I didn't have a 15-year exclusion on the policy that I bought. Now, Congress could do something to make it easier. You could let me pay for that with pretax dollars, full deductibility of long-term care insurance. Why don't we do that? You could let me pay for it out of my health savings account. Why do don't we do that? These are simple things that are within our reach and grasp that I frankly do not understand why we won't tackle.

And Mr. Pallone talked a little bit about some of the words that were used. I was encouraged to hear him use the word premium support. Yes, that is a good idea, Frank. We have got some place to talk about there. But he also referred to us as opponents.

And I remember that night in July of 2009 when the CLASS Act first appeared in this hearing room. The CLASS Act appeared at the last minute as a placeholder language that Mr. Pallone brought to the markup, never had a hearing on it, never called a witness on it. We were just presented with this information, and oh, well, we will fill in the details later. Well, now it is later, and we are filling in those details. And some of those details don't look too encouraging.

It looks like the CLASS Act was a budgetary deception to mask the actual cost of the Affordable Care Act. And people are rightly asking now, would we have passed the Affordable Care Act had the true extent of the budgetary impact been known? Again, what did they know, and when did they know it? Because in the spring of 2009, May 19 to be precise, the chief actuary for the Center for Medicare and Medicaid Services talked about the financial structure of this program would be "a terminal problem." So he knew that in May 2009.

Why didn't we discuss that in July of 2009 when we were doing the markup on H.R. 3200? I think that would have been a service to the committee and a service to the people if we could have had

those hearings, but we didn't. So here we are. It is a fact of life. We all age, and at some time, we are going to rely on some form of long-term care insurance. I will just say, again, I can think of no more loving gift for parents to leave for their children than to take care of their needs if that need were to arise and relieve the children of that burden.

We never got a chance to fully debate this.

Mr. Waxman, I would say CLASS dismissed, and then we need to work on canceling.

I am going to yield the balance of my time to Mr. Murphy of Pennsylvania.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you.

You know, I have been for some time concerned about the way this program was double counting premiums as both funding long-term care insurance and contributing to the so-called savings in the health care law. As far back in March, I said if any insurance company began collecting premiums, then tried to spend \$86 billion before paying out a single penny in benefits, they would rightly be prosecuted as a Ponzi scheme.

What is of particular concern here today is the lack of forthrightness on the behalf of HHS and the administration regarding the insolvency of the program. Throughout the debate over the health care bill, I, other Republicans, and even some Democrats, again and again questioned the long-term solvency of this program. But the administration insisted that long-term solvency was not in question, and that the program would significantly reduce the deficit.

In fact, the original CBO score of the CLASS Act projected savings of \$70 billion, accounting for almost half of the total deficit reduction we were told the bill would achieve. And now Secretary Sebelius tells us it is totally unsustainable and the promised savings have evaporated.

But even of greater concern is that this committee's investigation has uncovered evidence that the administration knew the program was not sustainable as early as the spring of 2009, prior to the passage of the health care law. We are left with serious questions about what the administration knew and when they knew it. It certainly appears that the administration knowingly promoted the CLASS Act as a cost saver when they knew those savings would never be achieved.

I yield back.

Mr. PITTS. The Chair thanks the gentleman, and now recognizes the gentleman from Texas, Mr. Green, for 5 minutes.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

And I thank my colleagues for the time.

First, I want to welcome our colleagues here. I know three of them we see all the time still.

But I want to particularly welcome our former colleague Patrick Kennedy.

And Patrick, we worked together on lots of mental health issues over the years. And I want to thank you for your service to the American people, and particularly to your district in Rhode Island. But also I want to thank you for the service of your father. Without your father's work in the Senate, I don't have enough fingers and toes to list the issues that would not be in the law today, including the CLASS Act. And just, generally, thank you for the service of your family. And I think all of us thank you for that, and particularly knowing you and your service in the House.

I think it is correct the CLASS Act was added by voice vote when we were working on the Affordable Care Act. But I don't want to use the CLASS Act as a reason to oppose the Affordable Care Act. There are thousands of people in our country who do not have the same opportunities that Federal employees have, or State employees, or bar association members, or American Medical Association members to purchase a long-term care plan. And that is what the CLASS Act was supposed to be about, to give a lot of people to do what Dr. Burgess talked about, to give a gift to our children, so we have that opportunity. It is difficult to fund it. And I know we have heard the quote of a Ponzi scheme. I thought up until today I heard a Ponzi scheme was only what the Republicans thought about Social Security. But insurance could be considered a Ponzi scheme, because you hope you pay these premiums for all these years and you will be able to collect it.

But that is not what this is about. It was to give people an opportunity who may not have the same opportunity as we do as Federal employees, or State employees in the State of Texas I know have that opportunity. And a lot of businesses have that. But most people don't through their employer. And that is what the CLASS Act was about.

Is it perfect? Nothing in the Affordable Care Act is perfect. In fact, I continue to disagree with calling it Obamacare because this committee drafted that bill. The President didn't send us up a bill. Now, I know it is popular to call it Obamacare because it is a good message. But we are the ones that drafted that bill in this committee after a lot of markup, late night markups, that was not dissimilar to what we went through in 2003 when we had the prescription drug plan that the majority now pushed, that a lot of us didn't support because of problems in the bill. But you haven't seen us repealing that prescription drug plan. We want to perfect it.

And I know we need to perfect the Affordable Care Act. And so that is what we need look at. If we can perfect the Affordable Care Act and make it better, then let's sit down across the aisle.

But for 10 months in this Congress, all we have seen is repeal. I guess that happened after Social Security was passed in 1935. There were a lot of people who said, we need to repeal Social Security. Thank goodness the Congress in 1935 and 1936 didn't do that.

I would like to yield the rest of my time to my colleague, Dr. Christensen.

OPENING STATEMENT OF HON. DONNA M. CHRISTENSEN, A REPRESENTATIVE IN CONGRESS FROM THE VIRGIN ISLANDS

Ms. CHRISTENSEN. Thank you, Congressman Green.

I want to welcome my colleagues.

And it is good to see you, Patrick.

A lot of claims have been made about a proposed repeal of CLASS saving taxpayer dollars. But it is my understanding that the CBO director has reported that repealing CLASS would have no impact on the Federal budget. So to claim otherwise is just not true.

But repeal would have a profound effect, as Howard Glickman at The Urban institute recently wrote, and I agree, while the CLASS Act is deeply flawed, it is an opportunity to transform long-term care from the means-tested Medicaid program to an insurance-based system. If CLASS is repealed, that opportunity will be lost, and millions of Americans will find themselves with only a shrinking Medicaid benefit to support them in their frail old age or if they become disabled at a younger age.

So our seniors and our disabled need this amended, not ended.

And I would like to yield the balance of my time to Congresswoman Schakowsky.

OPENING STATEMENT OF HON. JANICE D. SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you so much.

We don't have a long-term care policy in the United States of America. The only thing we really have is finally Medicaid when people run out of all their money. And so the 10 million Americans who are in need of long-term care and services and support really need a program like this.

And it is disturbing to me that when my colleague says, CLASS dismissed. No, if there are some problems with this legislation, we are all willing to sit down and figure out how to perhaps do it better. But the very idea that we are going to take away better choices for Americans—you know, already one out of six people who reach the age of 65 will spend more than \$100,000 on long-term care. In this country, that is really a disgrace. We need a long-term care policy. The CLASS Act is a good start.

I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

That concludes the opening statements.

The Chair has a unanimous consent request to enter into the record a statement by Senator John Thune. The ranking member has looked at this.

Without objection, so ordered.

[The information follows:]

House Energy and Commerce Committee
Subcommittees on Health and Oversight and Investigations
Wednesday, October 26, 2011 9:00 a.m.
2123 Rayburn House Office Building

“CLASS Cancelled: An Unsustainable Program and Its Consequences for the Nation’s Deficit.”

Statement Submitted by Senator John Thune

Thank you to Chairman Pitts and Chairman Stearns for allowing me to submit a statement for the record. The U.S. Senate is in a home-state work period this week, so I regret that I am unable to be present for this hearing. Given my involvement in this issue over the last 22 months, I have great interest in the issues that will be explored by today’s hearing. Over the last 22 months, I have repeatedly questioned Obama Administration officials about this program at every opportunity and offered several pieces of legislation to repeal the Community Living Assistance Services and Supports (CLASS) program. I am pleased that other Members of the House and Senate share my grave concerns about CLASS and that these Energy and Commerce subcommittees are holding this joint hearing today.

On October 14, 2011, American taxpayers received good news. Secretary of Health and Human Services Kathleen Sebelius announced that she was dumping the CLASS program because she was unable to design a program that met the solvency requirements of the law.

As the son of two elderly parents, I fully appreciate the concerns families across America have about the high costs of long-term care. These costs are rising quickly, and that is a serious problem.

However, this particular solution—CLASS—was fatally flawed from the beginning. CLASS was financially unsustainable. Sick people who needed the benefits would quickly outnumber healthy people paying into the system, leading to an “insurance death spiral.” With premiums unable to keep up with payouts, the new entitlement program would have gone bankrupt, requiring untold billions of dollars in taxpayer bailouts. Or worse, it would have been shut down after people had paid their premiums and were beginning to rely on the program for help.

The only way the White House and congressional Democrats could make CLASS work on the books was with a budget gimmick. For the first few years, CLASS would actually raise money to help pay for the rest of the Patient Protection and Affordable Care Act (PPACA). But down the line, the numbers would flip and it would start adding to the federal debt. Democrats knew that, but they cynically pretended it would not happen.

With such obvious flaws, why did the Obama administration try so hard to ignore the math and prop up CLASS for the past year and a half? Perhaps it is because the rest of PPACA has the same defects that made CLASS's collapse inevitable.

Both CLASS and the rest of PPACA rest on faulty assumptions. CLASS assumed a lot of healthy people would sign up for the program, outnumbering the sick people who would collect benefits. Likewise, PPACA assumes that employers will continue to pay for health insurance that gets more and more expensive as the law requires greater benefits. Surveys of employers now show that many of them plan to drop their insurance plans and shift their workers into government-run insurance markets. When this happens, costs to taxpayers to subsidize the insurance premiums for all those people will skyrocket.

The White House and congressional Democrats used similar kinds of budget gimmicks to hide the costs of the rest of the law as they did with CLASS. PPACA assumes that doctors would be willing to take a 30 percent pay cut to treat Medicare patients, and that Washington could successfully implement reductions amounting to hundreds of billions of dollars from Medicare payments to nursing homes, hospitals, and home health care workers.

Republicans warned from the beginning that CLASS would not work, and some Democrats joined us—including 12 who voted for my amendment to strip CLASS from PPACA in 2009. Even people in the administration knew all along that there was no way the program could survive. A congressional investigation that I lead with Representative Upton, Chairman of this Committee, and Representative Rehberg has turned up emails showing that while HHS officials were insisting in public that the program would be financially solvent, they were confessing amongst themselves that CLASS “seems like a recipe for disaster.”

When I asked Secretary Sebelius about CLASS when she was before the Senate Finance Committee last February, she finally admitted that CLASS was “totally unsustainable” but that the law gave her the flexibility to make it sustainable. It is clear this statement was not accurate, since HHS announced they are unable to move forward with CLASS. I hope this issue of legal authority to change CLASS is an issue this committee explores today.

Now that HHS has come clean, Congress should move to repeal CLASS and the rest of PPACA and replace them with common-sense reforms that achieve the goal we all share: a sustainable plan to truly lower health care costs.

Mr. PITTS. Our first order of business today will be our Members panel.

I would like to welcome our Members and former Member, and all the witnesses today.

But our first panel includes Congressman Rehberg from Montana. Congressman Rehberg is the chairman of the Subcommittee on Labor, Health, and Human Services, Education, and Related Agencies at the House Appropriations Committee.

Next is Congressman Boustany from Louisiana. As we all know, Congressman Boustany is a doctor. So he will have plenty of company here at the Energy and Commerce Committee.

Also with us is Congressman Ted Deutch from the great State of Florida.

And finally, the former Congressman from Rhode Island, and no stranger to the Energy and Commerce Committee, Patrick Kennedy.

Welcome.

We are happy to have each of you here today. And we will start with Chairman Rehberg. You are recognized for 5 minutes.

**STATEMENT OF HON. DENNY REHBERG, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF MONTANA**

Mr. REHBERG. Thank you, Chairman Pitts, and members of the House Energy and Commerce Committee for the invitation to testify here today. I also want to thank the members of the CLASS Act working group, especially Chairman Stearns, Representatives Burgess and Gingrey, Chairman Pitts, and I see Mr. Upton is not here. He probably has something else on his mind at this time. Senator Thune's leadership has also been extraordinary.

This hearing is really the culmination of a lot of hard work. And if you think about it, it has unfolded a lot like an episode of Law and Order. Those shows always begin with a mystery. Well, on March 23, 2010, the American public was handed a mystery when President Obama signed the so-called Patient Protection and Affordable Care Act. Weighing in at more than 2,500 pages, it calls for thousands of pages of more regulatory rulemaking. Even the bill's authors didn't read it. We were told we had to pass the bill before we could find out what was in it. That is what the CLASS Act working group was all about. We followed clues, questioned witnesses, and used the oversight authority of the Congress to track paper trails.

As the chairman of the House Appropriations Committee that oversees the Department of Health and Human Services, I requested internal HHS documents that revealed the insolvent nature of the program. When it passed, we were told that CLASS is a true insurance program where the premiums collected would cover the benefits paid out. But as we dug deeper, that cover story began to fall apart. New facts came to light. Every actuarial expert, including HHS staff and the chief actuary himself, agreed that, as currently written, CLASS simply won't work. It won't pay for itself.

So the government is exposed to tens of billions of dollars of costs, according to the CBO. And then earlier this month, we got the equivalent of a full confession. The Department of Health and Human Services has rightfully decided to cancel the program. This

was a profound development. Once we stripped away the political spin, brushed off budget gimmicks, and cut through the bureaucratic jungle, we saw a foundational pillar of the President's health care law for what it really was, truly a Ponzi scheme that apparently was included in the bill solely to help the bill appear deficit neutral.

But there is a problem. CLASS is not gone, not yet. The Secretary can claim that she has the authority to, in effect, rewrite it. There will be temptation for some in Congress to simply slip additional authority into an unrelated bill to turn CLASS into something it was never intended to be. And that is why we are here today. The facts are out. Now we have to decide what is to be done.

I am here because I don't think CLASS should be rewritten or redesigned by the bureaucracy. At a time when we are struggling to save the entitlement programs we already have, good programs like Social Security and Medicare, we simply can't afford massive new government programs like CLASS. The potential costs to the government and the employers is so great that any consideration of a program of this type needs to be fully considered in a transparent and open way by the public and by Congress. And just as with the other entitlements in PPACA, a new program of this type makes the task of saving existing entitlement programs for existing beneficiaries even more difficult.

This week I introduced a bill to repeal CLASS and other new entitlement programs in PPACA, as well as cosponsoring Mr. Boustany's CLASS repeal bill.

Colleagues, the most important responsibility Congress has today is to create an environment for the economy to thrive, to do what we must do to reduce government spending and onerous regulations. Out-of-control government spending leads to higher taxes, lower government debt ratings, and uncertainty. And onerous regulations lead to higher costs of doing business and barriers to business growth.

We have come to the final act in any Law and Order episode. We have seen the crime. We have uncovered what happened. We have got the confession. Now it is time to pass sentence. Congress has a chance to act decisively to protect the hardworking American taxpayer from the consequences of an unsustainable new government program.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Rehberg follows:]

Testimony of Rep. Denny Rehberg
Before the Joint Energy and Commerce Committee
Subcommittee on Health and Subcommittee on Oversight and Investigations
CLASS Cancelled:
An Unsustainable Program and Its Consequences on the National Deficit
October 26, 2011

Thank you, Chairman Pitts and members of the House Energy and Commerce, for the invitation to testify here today.

I want to also thank the members of the CLASS Act Working Group – especially, Chairman Sterns, Rep. Burgess, Rep. Gingrey, Rep. Boustany, Chairman Pitts and Chairman Upton who are here with us today. Senator Thune's leadership has also been extraordinary.

This hearing is really the culmination of a lot of hard work, and if you think about it, it's unfolded a lot like an episode of Law & Order.

Those shows always begin with a mystery. On March 23, 2010, the American public was handed a mystery when President Obama signed the so-called Patient Protection and Affordable Care Act. Weighing in at more than 2,500 pages, it calls for thousands more in regulatory rule-making, even the bill's authors didn't read it. We were told that we had to pass the bill before we could find out what was in it.

That's what the CLASS Act Working Group was all about. We followed clues, questioned witnesses and used the oversight authority of the Congress to track paper trails. As the Chairman of the Appropriations Committee that oversees the Department of Health and Human Services, I requested internal HHS documents that revealed the insolvent nature of the program.

When it passed, we were told that CLASS is a true insurance program where the premiums collected would cover the benefits paid out. But as we dug deeper, that cover story began to fall apart. New facts came to light. Every actuarial expert - including the HHS staff and the Chief Actuary himself - agree that, as it's currently written, CLASS simply won't work. It won't pay for itself, so the government is exposed to tens of billions of dollars of cost according to the CBO.

And then, earlier this month, we got the equivalent of a full confession. The Department of Health and Human Services has rightfully decided to cancel the program.

This was a profound development. Once we stripped away the political spin, brushed off budget gimmicks and cut through the bureaucratic jungle, we saw a foundational pillar of the President's Health Care Law for what it really was: A ponzi scheme that, apparently, was included in the bill solely to help the bill appear deficit neutral.

But there's a problem. CLASS is not gone. Not yet. The Secretary can claim she has the authority to, in effect, re-write it. There will be temptation for some in Congress to simply slip additional authority into an unrelated bill to turn CLASS into something it was never meant to be.

And that's why we're here today. The facts are out. Now we have to decide what is to be done.

I'm here because I don't think CLASS should be re-written or re-designed by the bureaucracy.

At a time when we are struggling to save the entitlement programs we already have - good programs like Social Security and Medicare - we simply can't afford massive new government programs like CLASS.

The potential cost to the government or to employers is so great that any consideration

of a program of this type needs to be fully considered in a transparent and open way by the public and the Congress.

And just as with the other new entitlements in PPACA, a new program of this type makes the task of saving existing entitlement programs for existing beneficiaries even more difficult.

This week, I introduced a bill to repeal CLASS and other new entitlement programs as well as co-sponsored Mr. Boustany's CLASS repeal bill.

Colleagues, the most important responsibility Congress has today is to create an environment for the economy to thrive. To do that we must reduce government spending and onerous regulations.

Out of control government spending leads to higher taxes, lower government debt ratings, and uncertainty. And, onerous regulations lead to higher cost of doing business and barriers to business growth.

We've come to the final act in any Law and Order episode. We've seen the crime, we've uncovered what happened. We've got the confession. Now it's time to pass sentence. Congress has a chance to act decisively to protect the hardworking American taxpayer from the consequences of an unsustainable new government program.

Mr. PITTS. The Chair thanks the gentleman.

We will just go in the order in which you are seated.

And the Chair recognizes Congressman Deutch for 5 minutes at this time.

STATEMENT OF HON. THEODORE E. DEUTCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. DEUTCH. Thank you, Chairman Pitts, Chairman Stearns.

Thank you for the opportunity to discuss the CLASS Act. I am privileged to be joined on this panel with our former colleague, Mr. Kennedy.

I am also grateful to Mr. Pallone for his commitment to making the late Senator Kennedy's dream of dignity and hope for elderly, sick, and disabled Americans a reality.

Senator Kennedy so eloquently captured the failure of our long-term care system when he said, too often, they have to give up the American dream, the dignity of a job, a home, and a family so they can qualify for Medicaid, the only program that will support them.

CLASS brought so many Americans hope because it was the first real path to delivering real, affordable long-term care. Just 10 percent of Americans over age 50 have long-term care insurance, yet 70 percent of them will need long-term care at some point.

The remaining 90 percent of Americans rely on Medicaid. That is why over a third of its dollars go toward long-term care, and why cuts to Medicaid at the Federal and State levels demand that we make affordable, cost-effective long-term care insurance available to the American people.

The current system incentivizes poverty. It forces seniors to blow through their life savings and spend down in order to qualify for Medicaid. This perverse incentive forces struggling families into unthinkable positions. Take, for example, a man in his 50s with early-onset Alzheimer's. He is ineligible for long term care through Medicaid due to his wife's salary as a teacher. At \$50,000 a year, her salary is too high for Medicaid but not nearly enough to pay for the nursing home care that can cost up to \$90,000 annually in Florida. She could leave her job so they could fall into poverty. She could divorce her sick husband, leaving him destitute but eligible for expensive long-term care through Medicaid.

These choices are not unique. These are the current system's incentives. Save nothing, pass what you do have onto your children before you get sick, own little property, do not purchase long-term care insurance. Follow this plan, and you will be eligible for expensive long-term care through Medicaid.

Triumphant statements from opponents of health care reform at the suspension of CLASS do nothing for the grandmother in my district who must choose between helping her grandson pay for college or paying her own tuition at a nursing home. Cheering the halted implementation of CLASS does nothing for working families I represent with no way of paying for the long-term care their elderly loved ones need.

I visit nursing homes in Florida and am pained to hear constituents tell me they miss their homes in Century Village, Kings Point, and other retirement communities. Sadly, Medicaid steers them

into institutional care, despite their preference for less costly in-home care and other community-based options.

I have heard from seniors facing foreclosure due to a spouse's exorbitant nursing home bills. I have heard from young families who cannot afford quality care for the ailing parents they love, yet long-term care insurance remains out of reach for most Americans.

No one is immune from the frailty of old age. Anyone can fall ill or become disabled. Take, for example, the case of Alan Brown, a 20-year-old in 1988, when he was struck by a strong ocean wave that severely damaged his spinal cord, leaving him a paraplegic. From wheelchairs to transportation to long-term care, his costs are astronomical. Even with two jobs, he struggles to get by.

Those who are young and healthy may not always be. Any one of us could become disabled like Mr. Brown. And if that is not compelling enough, the inevitability of aging should be. Critics of CLASS primarily focus on sustainability. If that is a concern, let's fix it. HHS was given statutory latitude. And I join the CLASS actuary and CLASS advocates in believing that the Secretary has enough authority to make the program work.

Others disagree and imply that a legislative fix is needed. So let's fix it. Just as Social Security succeeded as a wage insurance, reducing elderly poverty from 50 percent to 10 percent, Americans should have an affordable way to finance long-term care.

For the 200,000 seniors I represent, the jovial reaction to the suspension of CLASS was both disheartening and predictable.

Mr. Chairman, my constituents, our constituents deserve more. We must seize this opportunity to get long-term care right in America. Together, I believe we can improve upon an incredibly promising idea: Reduce entitlement spending and ensure Americans' greater financial security.

Thank you, Mr. Chairman, and I yield back.

[The prepared statement of Mr. Deutch follows:]

Representative Theodore E. Deutch

**Testimony before the
Subcommittees on Health and Oversight and Investigations Hearing on
“CLASS Cancelled: An Unsustainable Program and Its Consequences for the Nation’s
Deficit.”**

Wednesday, October 26, 2011

Mr. Chairman, I am thankful for the opportunity to discuss the Community Living Assistance Services and Supports Act, commonly referred to as the CLASS Act, and the critical issue of long-term care in America. I would also like to thank Mr. Dingell and Mr. Pallone for their commitment to carrying forward the late Senator Edward Kennedy’s dream of ensuring dignity and hope for elderly, severely ill, and disabled Americans through affordable access to long-term care.

Senator Kennedy eloquently captured how our long-term care system is failing the American people when he said, “too often, they have to give up the American Dream – the dignity of a job, a home, and a family – so they can qualify for Medicaid, the only program that will support them.”

The reason that CLASS has brought hope to so many Americans is the undeniable fact that for most families, long-term care insurance is out of reach. For the first time, CLASS provided our nation with a framework for helping families, disabled Americans, and seniors afford long-term care insurance and in doing so, improve their financial security.

CLASS was included within the Affordable Care Act with the stipulation it could be implemented in a fiscally sustainable way. The Obama Administration's difficulty in meeting this requirement is the reason we find ourselves here today.

Before I go any further, I want to emphasize that, in spite of recent statements to the contrary, the CLASS Actuary Report has outlined ways that this program can be made sustainable with existing statutory authority. It even details various paths to fiscal sustainability, such as phased enrollment, temporary period exclusion, and various underwriting options. These alternatives demand a serious look because the outlook for the private long-term care insurance market is grim.

Only 10% of Americans over the age of 50 carry long-term care insurance. Yet we all know that more than 10% of Americans over the age of 50 will at some point need long-term care. While Medicare pays for home health services under limited circumstances, for the remaining 90% of Americans, Medicaid is the only option for comprehensive long-term care. The fact Medicaid is on the chopping block in many states and in Washington only underscores our urgent need to provide Americans with a more cost-effective, affordable option for financing long-term care. Over a third of Medicaid's dollars go towards expensive long-term care, and using Medicaid, a state and federally funded entitlement, to pay for long-term care for the majority of Americans is unsustainable. We can save a substantial amount of money by shifting long-term care costs from Medicaid to a premium-funded, social insurance program.

This model will also yield substantial savings by shifting patients from costly, institutionalized care to less costly, and far more popular, community-based care. It is no wonder that the CLASS Act is supported by over 75% of Americans, who want the ability to secure community-based and home-based care.

We cannot afford to endorse the status quo. Currently, Medicaid forces elderly Americans and in many cases, their spouses, to blow through their life savings and “spend down” in order to qualify for long-term care paid for by Medicaid. Incentivizing poverty is not a viable long-term care strategy. This perverse incentive puts families already struggling with enormous challenges into unthinkable positions.

Take as an example the husband of a couple in their late fifties who is suffering from early onset Alzheimers. He is in need of long-term care but is ineligible for Medicaid because of his wife’s salary as a public school teacher. At \$50,000 a year, her salary is far too high for Medicaid, but nearly enough to pay for nursing home care in Florida that costs each year on average between \$75,000 and \$90,000. Every year, couples like this one are faced with impossible choices. She could leave her current job so they can fall into poverty, or divorce her sick husband so he becomes destitute but finally eligible for long-term care through Medicaid.

This system of forcing seniors into poverty so they can be cared for properly also defeats the entire purpose of Social Security, a program designed to lift seniors out of poverty. America has thrived through social insurance programs that provide benefits but incentivize personal responsibility and work.

Under the current system, long-term care incentives for seniors are as follows:

Save nothing, pass what savings you do have onto your children years in advance of serious illness, own little property, and do not purchase long-term insurance. Follow this plan, and you will be eligible for the most costly form of long-term care available, paid for by Medicaid.

Unlike Medicaid, CLASS would not be an entitlement. To the contrary, it is a voluntary, premium financed and affordable option for families that is required by statute to achieve sustainability in administration. For anyone to assert that the CLASS Act would be a new entitlement is irresponsible and misleading. I have to wonder if my colleagues would be more open to fixing CLASS had it not passed as part of the Affordable Care Act.

Triumphant statements from opponents of the Affordable Care Act at the announcement HHS would suspend implementation of CLASS does nothing for the seniors in my district who must make the choice between helping a grandchild finance a college education or paying their own tuition instead at a nursing home. Cheering the suspension of CLASS does nothing for the working families in my district who are already under the enormous stress that comes when a parent falls seriously ill and who have no way of paying for the around-the-clock care their loved one needs. Missing from these press releases are the faces of elderly and disabled constituents of mine who have been failed by the current system.

Florida is home to some of the best skilled nursing facilities. But often when I visit them, I am pained to hear my constituents tell me they would so much rather be home in retirement

communities of Century Village, Kings Point or Wynmoor. Sadly, they often have no choice because Medicaid is strongly biased towards institutional nursing home care when patients and their families so strongly prefer less costly in-home care.

Like countless Americans who need long-term care, these constituents of mine would prefer the care options of CLASS and the dignity of retaining choices rather than the mandate to spend down to poverty required to be eligible for institutionalized nursing home care paid for by Medicaid.

Suspending implementation of CLASS means millions of elderly and disabled will lose community-based long-term care insurance.

I have heard from seniors who are on the verge of foreclosure as a result of the nursing home costs of their spouses. I have heard from young families desperate for a way to afford the dignity of quality care for elderly loved ones in their final years. My colleagues, these stories prove that the failure to move forward with CLASS is nothing to cheer about. As I mentioned earlier, private long-term care insurance is unaffordable and out of reach for too many and this problem is not going away.

Mr. Chairman, everyone grows older, and no one is immune from the frailty of old age. After all, 7 out of 10 Americans need long-term care at some point after turning 65. Likewise, anyone can become ill. Anyone can become disabled.

Take for example the case of Floridian Alan Brown, who on January 2nd, 1988, at the age of twenty, was hit by a strong wave at the beach that caused a catastrophic spinal cord injury that leaves him as a quadriplegic to this very day. Mr. Brown has an endless list of expenses – from his wheelchair and medication, to disability accessible transportation, and long term nursing care. Even while holding two jobs, he struggles to support his family in the face of rising health care costs.

As lawmakers it is our responsibility to remember that those who are young and healthy may not always remain so, and act on the fact that long term health care is out of reach for a majority of Americans. Any one of us could experience an unpredictable accident like Mr. Brown did. And if that is not compelling enough, the inevitability of aging should be.

Critics of CLASS primarily focus on fiscal sustainability. If that is truly a concern, let's fix it.

Both critics and supporters of the CLASS Act feared that as drafted, adverse selection threatened the program's fiscal outlook. While we are all susceptible to disability and old age, it is often only those who immediately need long-term care who seek a plan to pay for it. How to pay for long-term care is rarely a priority for the young and healthy, but a functional insurance market requires incentives for everyone to participate.

This is why HHS was given latitude in implementation. I join the CLASS Actuary and CLASS advocates in believing that the Secretary has enough authority to make the program work.

Others disagree and imply that a legislative fix is needed. So let's fix it.

Supporters of CLASS are not looking for an unearned entitlement. The promise of CLASS is everyone in America could have long-term care insurance, and it would be financed by workers' premiums. As wage insurance, Social Security has succeeded at reducing elder poverty from 50% to 10%, and we achieved near universal coverage with no adverse selection. The universal risk of falling into destitution during one's golden years demanded a universal risk pool.

For the 200,000 seniors I represent, the recent announcement and the predictable political reaction was disheartening. Mr. Chairman, my constituents deserve more. This program could provide a lifeline to millions of elderly and disabled Americans, and if it is not going to move forward, we need to find an alternative. My constituents – our constituents – expect and deserve that we treat these challenges an opportunity to get long-term care right in America.

I urge my colleagues to work to improve upon an incredibly promising idea that can reduce entitlement spending and provide the American people with greater financial security.

Mr. PITTS. The Chair thanks the gentleman and is pleased to welcome our former colleague, Congressman Patrick Kennedy, for 5 minutes.

STATEMENT OF PATRICK J. KENNEDY, FORMER REPRESENTATIVE IN CONGRESS FROM THE STATE OF RHODE ISLAND

Mr. KENNEDY. Thank you, Chairman Pitts and Chairman Stearns, and Ranking Members Pallone and DeGette, and all of my colleagues who welcomed me back today. I appreciate the opportunity to testify.

Let's just think for a moment and step back and use our common sense. All of our family members are going to need supportive living services. And the question is not how and what program we are going to put those costs on. Is it going to be at the State level, the local level, or the Federal level? The notion is you can't turn away from this problem and think that the problem is going to go away. Someone is going to have to be there for our people and our families who are going to need supportive living services.

So the question for Congress is really, how are they going to address this problem? And so you can say that actuaries say, oh, CLASS Act is going to cost money, but the whole point of health care reform is that we take a broader look at all the costs associated with health care and really see the forest from the trees.

So we are well aware that our health care system has been about cost shifting. You take the uncompensated care and you put it on the private pay and you hope that someone pays for the bills of those who can't afford to pay. When are we going to start to be realistic about this? Because just turning away from the problem is not going to make the problem go away. So people will say, oh, this is a program that costs money. You know, in my father's case, who needed supportive living services, and my Uncle Sarge Shriver's case, who needed it when he had dementia, it was nonmedical supportive living services that helped them in their lives. It was the guy that helped my Uncle Sarge up from the living room and into the dining room, and who helped him, you know, get transported around. This was someone who didn't have a medical degree, doesn't have big student loans because they went to get a doctor's degree or a nursing degree. But they were the most essential person in my Uncle Sarge's life in giving him dignity and giving him a life.

And guess what? It is the least expensive. I should be getting all the chorus of support from my Republican friends. If you want to reduce medical costs, try using nonmedical support services. So you will hear a lot about, oh, you know, this is going to cost money. Let's just step back and understand, someone is going to pay. Someone is going to pay. And so let's be realistic here. Let's also do the right thing by our family members, and give them the kind of lives of dignity that they deserve, that we would want for any one of our family members.

And I hope that we get away from this notion that, let's place the blame game, because Washington is good at that.

But at the end of the day, our country is facing a demographic tsunami. It is going to bury this country in red ink. And the question is, do you want to take all of your tools out of your toolbox

now? Because CLASS Act can be one of the tools that you use to help address the overall costs of trying to take care of long-term care. And in my mind, you can either pay high-priced acute care, institutionalized care costs, or you can pay for nonmedical supportive living service costs that will keep people out of acute care settings. The whole notion of health care reform was to move us from a sick care system to a health care system. Because it is less expensive at the end of the day to keep people independent and not dependent, if you will, on our medical system, which is costly. CLASS Act is a tool. And let's make it work for all of your constituents who are going to need the supportive services that are going to give them the human dignity that each of us would want for our own family members.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Kennedy follows:]

Statement of former Congressman Patrick J. Kennedy

House Energy and Commerce Committee

Subcommittee on Oversight and Investigations and the Subcommittee on Health

CLASS Cancelled: An Unsustainable Program and Its Consequences for the Nation's Deficit

October 26, 2011

Our family was very fortunate. We had the resources to provide my father with any long term services and supports that he needed, as he approached the end of his life --- but he knew that most working families are not as fortunate.

The inclusion of the long term care infrastructure (CLASS) in health care reform was a signature issue for my father. As Raymond Scheppach, Executive Director for NGA noted, "failure to reform the under-funded, uncoordinated patchwork of long-term care supports and services is a failure to truly reforming health care." This failure defines the revolving door of our health care system.

An estimated 10 million Americans currently need long term services, and that number is projected to reach 26 million by 2050. Nearly half of all funding for these services is now provided through Medicaid, which is a growing burden on states and requires individuals to become and stay poor to receive the help they need.

Roughly 70% of seniors will need help at some point because they cannot take care of themselves independently. However, 66% of Americans cannot afford to pay for more than

three months of nursing home care, and 53% can not pay for more than three months of care from a part-time licensed personal care aide.

Even before he became ill, my father saw a need for an alternative solution, realizing that for persons with disabilities and older Americans long term services and supports ARE their primary unmet care need, and that while 45 million Americans lack medical insurance, 200 million adult Americans lack any insurance protection against the costs of these services.

He introduced the CLASS Act, in partnership with Republican Senator Mike DeWine, with a subsequent introduction along with Congressman Pallone and Congressman Dingell. The intent was to provide a framework under which HHS could develop an innovative public-private partnership to address this issue --- to initiate a classic American solution to this problem, one grounded on the principles of self-sufficiency and personal responsibility.

Let's talk about self-sufficiency: The goal of this program is to support people to live in their own homes and be as productive as their conditions will allow them to be. In many cases, the very services and supports CLASS was intended to pay for is enough to allow people to continue working and carry out the activities in their daily life. However, in other cases where the needs and demands are more significant, CLASS funds can be an adjunct to other existing insurance options. In either case, the alternative to at-home assistance is full-time institutional care. For many Americans, the option of taking care of ourselves or being cared for by our loved ones is at the core of our beliefs and values. CLASS supports these values.

And let's talk about personal responsibility: CLASS wasn't designed as a handout, but as a vehicle for people to protect themselves against the financial devastation that major illnesses or injuries can bring. For whatever reason, the private insurance market does not offer an affordable opportunity to many families, especially those that are most at risk and in need of services or supports. CLASS provides that option – creating an insurance policy anyone could get, to a risk each of us face every day.

It is time in this nation to support family caregivers and ensure adequate wages and benefits to direct care workers so our most vulnerable citizens can live at home and in their communities;

It is time to stop forcing people to become poor to qualify for the services they need;

and,

It is time that the Administration take the authority and flexibility given to them in this legislation to develop an innovative program that promotes independence and dignity and ensures the right of every citizen to control and choose what services they receive, how and where they are delivered, and who provides them.

I was pleased when CLASS was signed into law as part of the Affordable Care Act. I knew there was a lot of work to be done to design the insurance program that would be offered and make sure it would be financially sustainable. But I was pleased not only that an important piece of

my father's legacy was brought to fruition, but that the families he cared so passionately about would have an opportunity for protection.

Sadly, the Administration – **despite the fact that its own actuaries indicated that CLASS could work on a sustainable basis** – could not find a path forward on this important project. They chose to dismiss it prematurely thus failing to examine every possible option. They offered no alternative for families who need this opportunity.

The CLASS Act provides a ray of hope to aging and disabled Americans. I can assure you that if my father was alive today, he would argue to continue this exploration and find that path forward.

My question is simple: If not this, then what? What will you do to help people help themselves against the costs of long term care? What will you do to keep people from falling into poverty and into the Medicaid rolls when a small amount of support could have kept them going? What do you say to the families who've been waiting so long for a solution?

I urge the Congress and the Administration to let the committed actuaries, policy planners and advocates help you find that path forward that works. Let's keep the policy on the books and keep working to define the program. It is wrong to send the families who need an alternative back to square one.

Mr. PITTS. The Chair thanks the gentleman and now is pleased to recognize Dr. Boustany for 5 minutes.

STATEMENT OF HON. CHARLES W. BOUSTANY, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF LOUISIANA

Mr. BOUSTANY. Thank you, Chairman Pitts and Ranking Member Pallone, members of the Energy and Commerce Committee, for allowing me to testify today.

Chairman Pitts, I ask unanimous consent that my full statement be made a part of the record.

Mr. PITTS. Without objection, so ordered.

Mr. BOUSTANY. I appreciate you allowing me to testify in support of H.R. 1173.

The bill is really simple. It repeals the CLASS Act, as the program has been shown to be fatally flawed, fiscally irresponsible, and irreparable. I opposed the CLASS Act and have worked to highlight the problems and fatal flaws of the program.

And I can tell you as chairman of the Oversight Subcommittee on the House Ways and Means Committee, the bicameral congressional oversight efforts were vigorous, extensive, committed, and necessary to expose the truth about this program.

In fact, Mr. Chairman, this is a victory, a congressional oversight victory on behalf of the American taxpayer.

Leaving the statute on the books is irresponsible, and it must be removed. Keeping the law on the books gives bureaucrats a creative license to keep trying to implement it. And it is an opening for Congress to keep trying to tweak a failed program. CLASS is unsustainable and a new unfunded entitlement that we cannot afford. I agree with employer groups and taxpayer advocates who have no doubt CLASS will return if Congress fails to strike it from the books.

Liberal special interest groups insist that HHS has the broad legal authority to fix the program by excluding eligible Americans from the program.

Mr. Chairman, I have to say that I am deeply disappointed that Secretary Sebelius refused to testify today. She should come here. She should explain why she ignored warnings of the insolvency of this program and falsely claimed that she had the authority to change the program.

Lawmakers consistently ignored warnings by the Congressional Budget Office, the chief Medicare actuary, and the American Academy of Actuaries when they inserted this budget gimmick in the Affordable Care Act. After months of refusing to answer questions, HHS finally—finally—conceded it lacks the legal authority to make CLASS sustainable. Congress should repeal it instead of waiting for bureaucrats to change their mind.

Mr. Chairman, CBO's credibility should also be called into question for scoring the program as a saver when they knew it would need a bailout. And in fact, I want to quote from former CBO official Jim Capretta. Capretta wrote, "What remains most perplexing in this whole episode is why CBO played along with the CLASS charade. They had access to all the same actuarial data as everyone else. Their own numbers showed the program was unstable be-

yond 10 years. The Gregg amendment gave them the perfect excuse to conclude that CLASS would never be launched because it could never be viable without massive taxpayer subsidies. And yet they kept showing the \$70 billion, 10-year surplus in their estimate. Among the many questions about the sorry episode that are worth pursuing, the role of CBO is surely one.”

Mr. Chairman, as a physician who has dealt with many, many patients—I was a cardiac surgeon, and I saw a lot of these very complex conditions, and saw the entire spectrum of care and the needs that are out there. I can surely tell you as a physician there are many, many other options that are much more responsible, fiscally responsible and sustainable than what this program was.

My colleague Dr. Burgess mentioned a number of options that were never entertained as we went through this process. So beyond CLASS, we must continue to encourage middle class Americans to plan. That is the fundamental issue here, is planning ahead, starting at an early age and planning for these kinds of things. You can’t do this at a late stage.

Planning for retirement security, purchasing long-term care insurance policies. We can do a number of things to make that even better if we look at these options very carefully.

And finally, on a personal note, I can tell you, from having dealt with my own father and my wife’s stepfather, there are viable ways to deal with this. And what we need to do now is be responsible. Let’s repeal this failed program. Let’s move forward and come up with responsible policies and move the ball forward in health care.

[The prepared statement of Mr. Boustany follows:]

Rep. Charles W. Boustany, Jr., MD
Testimony to Energy and Commerce Subcommittees on Health and
Oversight and Investigations
October 26, 2011

Chairman Upton, Ranking Member Waxman, Members of the Committee:

Thank you for the opportunity to testify before you today in support of H.R. 1173, legislation to repeal the unsustainable CLASS Act. I introduced this bill in March, 2011 with Reps. Phil Gingrey and Bill Lipinski and we have gained more than 70 cosponsors. The bill is simple – it repeals the CLASS Act as the program is fatally flawed, fiscally irresponsible and irreparable.

Since the program was debated and added to President Obama’s health care legislation, I opposed the initiative and argued against it. Once it became law I worked to highlight the problems and fatal flaws of the program. The bicameral Congressional oversight efforts were vigorous, extensive, committed and necessary to expose the truth about this program.

In response to many of these probing questions and serious concerns, Health and Human Services Secretary Kathleen Sebelius provided Congressional testimony stating she had administrative authority to make changes and implement the program. This was false and I am pleased to see in HHS’ announcement to terminate the program they cited the lack of authority to make changes necessary to make the program sustainable and implement it.

Leaving the statute on the books is irresponsible and it must be removed. Keeping the law on the books gives bureaucrats a creative license to keep trying to implement it and is an opening for Congress to keep trying to tweak the program. CLASS is unsustainable and a new unfunded entitlement we cannot afford.

I agree with employer groups and taxpayer advocates who have no doubt CLASS will return if Congress fails to strike it from the books. Liberal special interests groups insist HHS has broad legal authority to fix the program by excluding eligible Americans from the program. They say HHS simply lacks “guts.” What’s more, HHS attorneys have already identified ways a Secretary might navigate around legal concerns raised by the Congressional Research Service. And, Bob Yee, the former CLASS actuary, insists the program could work if HHS ignored the risk of being sued.

Early in the process, CBO warned: “the CLASS program would inevitably add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiums would be set to ensure solvency of the program.”

Lawmakers ignored these and other warnings from the Medicare Actuary and the American Academy of Actuaries when they inserted this budget-gimmick in PPACA. After months of refusing to answer questions, HHS has finally conceded it lacks legal authority to make CLASS sustainable. Congress should repeal it, instead of waiting for bureaucrats to change their minds.

CLASS is the wrong solution to America's long-term care needs. This budget gimmick will collapse without mandatory enrollment or a taxpayer bailout. I urge this committee to hold a mark up on H.R. 1173 and for Congress to approve the measure.

Beyond CLASS, we must continue encouraging middle-class Americans to plan ahead for their retirement security and purchase long-term care coverage. Medicaid exists for the truly needy; however, it is in serious financial difficulties and cannot afford to cover higher income individuals. Medicare is an important and critical program but is limited and many seniors are disappointed to learn what the program actually covers.

To correct these myths, there must be an earnest and sincere public education campaign to get people to plan for retirement and understand different retirement and health care options. CLASS distracts from this larger problem with empty promises and a false sense of security.

Thank you for giving the opportunity to testify and discuss my legislation.

Mr. PITTS. We will call the second panel to the witness table, and the Chair will turn over the chair to Mr. Stearns for the second panel.

Mr. STEARNS. We have the Honorable Kathy Greenlee, who is assistant secretary for aging, the Administration on Aging, U.S. Department of Health and Human Services. The other individual is the Honorable Sherry Glied, assistant secretary for planning and evaluation, U.S. Department of Health and Human Services.

STATEMENTS OF KATHY GREENLEE, ASSISTANT SECRETARY FOR AGING, ADMINISTRATION ON AGING, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND SHERRY GLIED, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Mr. STEARNS. Good morning. You are aware that the committee is holding an investigative hearing and, in doing so, has had the practice of taking testimony under oath.

Do you have any objection to testifying under oath?

No, OK.

The Chair then advises you that under the Rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Thank you. You are now under oath, and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. You are now welcome to give your 5-minute summary of your written statement.

Please begin, Ms. Greenlee.

STATEMENT OF KATHY GREENLEE

Ms. GREENLEE. I apologize, I was expecting questions for the first panel.

So I thank you, Chairman Pitts, Chairman Stearns, Ranking Members Pallone and DeGette, and members of the subcommittees.

Thank you for the opportunity to discuss with you today the CLASS Act. I'm pleased this morning to be joined by my colleague, Sherry Glied, who serves as assistant secretary for the Office of Planning and Evaluation for the Department of Health and Human Services.

As our population ages, there is an increasingly urgent need to find effective ways to help Americans prepare for and finance their individual long-term care needs. Almost 7 out of 10 people turning 65 today will need help with daily living activities at some point in their remaining years. And many younger people, particularly those living with significant disabilities may also need assistance.

But this care is expensive. Nationwide, the median annual cost of a nursing home in 2010 was \$75,000. An attendant who provides home care and no medical tasks, like the dispensing of medication, is paid approximately \$19 an hour.

As this committee knows well, Medicare only covers short-term and limited long-term care services, and the Medicaid safety net is only available to those who have depleted virtually all of their re-

sources. And long-term care insurance, by and far the most popular private option, can be costly and difficult to purchase, particularly for those people who have preexisting health conditions or disabilities.

The status quo is unacceptable, which is why Congress created the CLASS program. The program's distinguishing features include an offer of lifetime benefits, a prohibition on underwriting, and availability of a cash benefit.

Congress also made clear that no taxpayer funds could be used to pay those benefits and the program must be solvent over a 75-year period. Over the last 19 months since the passage of the CLASS Act, HHS has worked steadily to find a financially sustainable model for CLASS. We conducted substantial analysis of a wide variety of possible implementation options. We examined the long-term care market, modeled possible plan designs, and studied the CLASS statute, and consulted with actuaries, including an in-house actuary and two outside actuarial firms, insurers and consumer groups.

On October 14, as you know, we submitted to Congress a report indicating that we have not identified a way to make CLASS sustainable, legal, and attractive to potential buyers at this time. For all of us working on this urgently needed program, it was a very difficult conclusion, but one we had to make.

It's crucial to recognize that this does not affect the Affordable Care Act. Our Department continues to work across the administration to implement the provisions of the law that will provide coverage for millions of Americans and will eliminate the worst of abuses of the insurance industry and work to control health care costs.

Even without the CLASS programs upfront revenue, the Affordable Care Act will reduce the deficit. And we will also continue our work to improve America's long-term care choices. By 2020, we know that an estimated 15 million Americans will need long-term care. If we want our family members, friends, and neighbors to be able to live with the maximum amount of freedom and independence, we need to make sure they have access to the long-term supports that make that possible.

In addition to the CLASS Act, to the Affordable Care Act included other policies to strengthen the choices for long-term care, such as Community First Choice, the new home and community based options and an extension of the successful program of Money Follows the Person.

We believe that our CLASS implementation has shed valuable light on long-term care challenges. And in the months to come, we look forward to having a healthy and substantive dialogue with all interested stakeholders as we continue to seek real solutions to those challenges.

For that reason, we welcome the opportunity to discuss this important topic with you today. Thank you for the opportunity to testify. Assistant Secretary Glied and I are prepared to answer your questions.

Mr. STEARNS. Thank you.

Dr. Glied, you are welcome.

Ms. GLIED. I have no statement.

[The prepared statement of Ms. Greenlee and Ms. Glied follows:]

52

Statement of the

Honorable Kathy Greenlee

Assistant Secretary for Aging

Administration on Aging

and

Honorable Sherry Glied

Assistant Secretary for Planning and Evaluation

U.S. Department of Health and Human Services (HHS)

on

The Community Living Assistance Services and Supports Act (CLASS)

before

The Committee on Energy and Commerce

Subcommittee on Oversight and Investigations and

Subcommittee on Health

U.S. House of Representatives

October 26, 2011

Chairmen Pitts and Stearns, Ranking Members Pallone and DeGette, and Members of the Subcommittees, thank you for the opportunity to discuss the Community Living Assistance Services and Supports Act or the CLASS Act.

As our population ages, there is an increasingly urgent need to find effective ways to help Americans prepare for – and finance – their individual long-term care needs. Almost seven out of ten people turning age 65 today will need some help with daily living activities at some point in their remaining years. While most people who need long-term care are in their 70s and 80s, many younger people, particularly those living with a significant disability, also may need assistance. Forty percent of long-term care users today are between the ages of 18 and 64.

Long-term care is expensive, and can quickly wipe out hardworking families' savings. While costs for nursing home care can vary widely, they average about \$6,500 a month, or anywhere from \$70,000 to \$80,000 a year. People who receive long-term care services at home spend an average of \$1,800 a month. The average lifetime long-term care spending for a 65 year old is \$47,000; 16 percent will spend \$100,000 and 5 percent will spend \$250,000. Nationwide, the median annual cost of a nursing home in 2010 was \$75,000; room and board in an assisted living facility, with no additional help, was \$37,500; an attendant that provides home care and no medical tasks, like the dispensing of medication, is paid approximately \$19 an hour. These expenses are left to America's seniors and people with disabilities (and their adult children) to pay for out of pocket until their pockets are all but empty.

As this Committee knows well, Medicare only covers short-term and limited long-term care services, and the Medicaid safety net is only available to those who have depleted virtually all their resources as a result of being frail or suffering from dementia. Today, there are many

Americans with disabilities who want to and are able to work and thereby maintain independence and contribute financially to their families. However, if they depend upon an attendant to drive them to their job or help them shop, use the toilet, or bathe, they must have enough additional financial resources to pay for such assistance, or have low enough incomes to qualify for Medicaid.

Few private mechanisms are available to help people plan ahead to pay for their future care. Long-term care insurance, by far the most popular private option available, can be costly and difficult to purchase, particularly for those with pre-existing health conditions or disabilities. Less than three percent of Americans currently have a long-term care policy. For workers who already experience a disability, or pre-existing condition, the options are even more limited due to underwriting.

The status quo is unacceptable for those with disabilities or those who want to remain financially independent in the future, without government assistance, and their families. For that reason, Congress created the CLASS program. In passing the CLASS Act, Congress sought to establish a voluntary insurance program for American workers to help them pay for long-term care services and supports that they may need in the future. The program would help those choosing to participate in the program live independently in their communities.

The CLASS Act establishes solvency and self-funding as central components of the program. To that end, Congress made clear that no taxpayer funds may be used to pay benefits and that the program must be solvent over a 75-year period. The CLASS program's distinguishing features include an offer of lifetime benefits, a prohibition on underwriting, and the availability of a cash benefit.

We agree with the core principles of the statute regarding solvency and self-funding. For that reason, Secretary Sebelius and I stated on a number of occasions that the Department would not go forward with implementing the CLASS program unless we could identify a benefit plan that was actuarially solvent over the next 75 years and consistent with the other statutory requirements of the CLASS Act.

Over the last nineteen months, since passage of the CLASS Act, HHS has worked steadily to find a financially sustainable model for CLASS. We conducted substantial analysis of the CLASS statute and a wide array of possible implementation options for a long-term care insurance program that are consistent with the requirements Congress laid out in the CLASS Act. Secretary Sebelius charged my office, the Assistant Secretary for Planning and Evaluation, and the Office of the General Counsel with performing a broad and thorough analysis to design potential benefit plans and to determine if those plans met the twin tests of solvency and consistency with the statute. We examined the long-term care market, modeled possible plan designs, and studied the CLASS statute, consulting at every step of the way with actuaries, including an in-house actuary and two outside actuarial firms, insurers, and consumer groups. We subjected our actuarial modeling to expert peer review and subjected our potential benefit plans to thorough legal review.

On October 14, 2011, we submitted to Congress a 48-page report and over 450 pages of appendices (<http://aspe.hhs.gov/daltcp/reports/2011/class/index.shtml>) describing the results of actuarial and policy analyses of the CLASS Act and the legal analysis of various benefit plan options. Recognizing the enormous need in this country for better long-term care insurance options, we cast as wide a net as possible in searching for a model that could succeed. We looked at a broad range of approaches. When it became clear that benefit plans consistent with

the plain language of the statute would not meet the solvency test, we looked at other potential benefit design options. But, at this time and as the report shows, we have not identified a way to make CLASS sustainable, legal and attractive to potential buyers at this time. For all of us working on this urgently needed program, it was a very difficult conclusion, but one we had to make in an effort to be as transparent and accountable as possible with Congress and, most importantly, to those who would be counting on this program if it were launched.

It is crucial to recognize that this does not affect the rest of the Affordable Care Act. The Department, along with our colleagues in other Departments across the Administration, are hard at work implementing the provisions of the law that will provide coverage for millions of Americans who are uninsured, eliminate the worst abuses of the insurance industry, and work to control health care costs. And even without the CLASS program's up-front revenue, the Affordable Care Act will reduce the deficit.

We will continue our work to improve Americans' long-term care choices. One of the main reasons we decided not to move forward with CLASS at this time is that we know no one would be hurt more if CLASS started and failed than the people who had paid into it and were counting on it the most. As prudent stewards of taxpayer dollars and the people we serve, we simply cannot let that happen.

By 2020, we know that an estimated 15 million Americans will need long-term care. If we want our family members, friends, and neighbors to be able to live with the maximum amount of freedom and independence, we need to make sure they have access to the long-term supports that make that possible. We will continue to work with the Congress, advocates, health

care providers, employers, insurers and other stakeholders to ensure that all Americans have access to long-term care choices that best meet their needs.

While we have had to suspend our work on implementing CLASS, we remain committed to making sure that people will be able to get the long-term care they need, whether it is a working-age mom with disabilities who needs daily support right now or a young man at his first job who wants to protect himself and his family against the possibility of financially-consuming long-term care costs in the future.

We believe that our work on CLASS implementation has shed valuable light on the need for workable solutions to our long-term care challenges. We want to have a healthy and substantive dialogue with all interested stakeholders, including people with disabilities, workers trying to plan for their future, private insurers, and Members of Congress as we continue to seek real solutions. This is a challenge that we must work to solve as a nation. For that reason, we welcome the opportunity to discuss this important topic with you today.

Thank you for the opportunity to testify. I will be happy to answer any questions you may have.

Mr. STEARNS. That is fine.

OK, I will start with my opening questions.

I guess the first question we are all just waiting with baited breath is, has the CLASS activity been shut down?

Ms. GREENLEE. If I may respond by first describing what that activity has consisted—

Mr. STEARNS. No, no, I am just asking. You answer the question. The way we work in O&I, we ask a question, and hopefully, you can give a yes or no.

Ms. GREENLEE. We are moving to stop implementation and reassign the staff that have been working on implementing the program.

Mr. STEARNS. Could I interpret that to mean that you have shut down the program?

Ms. GREENLEE. The program that remains within the CLASS office is a long-term care awareness campaign. That project—

Mr. STEARNS. So it is now shut from the actual CLASS Act to now an awareness program? Would that be a fair statement?

Ms. GREENLEE. That was continued both in the CLASS program and the deficit reduction act—

Mr. STEARNS. Dr. Glied, the question to you, have we shut down the CLASS Act program?

Ms. GLIED. We don't have a CLASS Act program in ASPE.

Mr. STEARNS. Right now, we do not have a CLASS Act program.

Ms. GLIED. We never had a CLASS Act program at ASPE.

Mr. STEARNS. So when we passed the legislation for the CLASS Act, you didn't interpret that as legislation that for implementation of the—

Ms. GLIED. We don't implement programs within ASPE, so we conduct analysis of all sorts of things, but we don't actually implement programs.

Mr. STEARNS. So can I interpret your answer as—will the—is the CLASS Act shut down now in your opinion?

Oh, would the clock start to make sure my time is moving.

Yes, I am sorry.

So we heard from Ms. Greenlee.

Dr. Glied, the question is, has the CLASS Act been shut down as a program? Just your answer.

Ms. GLIED. Secretary Greenlee runs the CLASS Act office.

Mr. STEARNS. So she has interpreted that way.

To follow up, another area that I am concerned about is the very high level uncertainty that was surrounding assumptions in the actuarial models.

Were you familiar with those back in 2009, Dr. Glied?

Ms. GLIED. I was not familiar with them in 2009.

Mr. STEARNS. Are you familiar with them now?

Ms. GLIED. Yes, sir.

Mr. STEARNS. And Ms. Greenlee, were you familiar with those, the uncertainties surrounding those assumptions back in 2009?

Ms. GREENLEE. No, sir. I did not begin working until 2010 in May on the CLASS program.

Mr. STEARNS. When you came in May, how soon afterwards were you aware of the uncertainty surrounding those assumptions? Or are you aware of them today?

Ms. GREENLEE. I am aware of them now. It was several months after I began working on them that I got up to speed on the activity prior to enactment.

Mr. STEARNS. OK, 2011 was more than a year after—in June of 2011, more than a year after Obamacare passed and 2 years since initial concerns were raised about the CLASS, what did HHS do to make the public aware of this uncertainty when projecting \$70 billion in saving before the bill was passed?

Now you were not there, but Dr. Glied, perhaps you can answer that question?

Ms. GLIED. I was not there either. I would just point out that the HHS actuary, the CMS actuary, Mr. Foster, published three separate analyses of the CLASS Act before and during the time that it was passed. Those were publicly available on the HHS Web site. They were frequently quoted in the news media, and in fact, several of the statements already this morning have referred to them. So the uncertainty about the estimates was very evident before the legislation passed.

Mr. STEARNS. Do you know of any other government actuaries that discussed this and when, and in your opinion, do you know of any other besides Rick Foster?

Ms. GLIED. The Congressional Budget Office also conducted analyses of the program, and they came up with a different—they used different assumptions and had a different result.

Mr. STEARNS. Now, as I understand, they made those assumptions before the Obamacare passed. Is that your understanding?

Ms. GLIED. So, both Mr. Foster and the CBO actuaries and analysts analyzed various versions of the CLASS Act and other provisions as the legislation was moving along.

Mr. STEARNS. I think, as you have pointed out, Rick Foster raised concerns about the \$70 billion in savings, and you said other sources did, too, so I guess the question perhaps is difficult for you to answer, but how is it possible that Health and Human Services didn't figure out the problem with the CLASS Act until 2 month after passage of the law?

Is that a question either one of you posed while you were working there, while you were going forward with the bill in which Rick Foster and other government agencies indicated that it was not sound financial, long term, kind of make it actuarial is not there? Were you aware of that after you were working there?

Ms. GLIED. There was robust and vigorous debate about the assumptions and the modeling behind CLASS before it passed with very respected analysts arguing that it was viable and other respected analysts arguing that it was not viable. That is a quite common occurrence when you talk about a program that is as novel and unique as the CLASS Act.

What was different about the CLASS Act and I think special is that included in it this twin test that required that the Secretary only proceed if she could show that it was solvent over 75 years and that it was entirely self-sustaining. So I think—

Mr. STEARNS. So if I can interrupt you, Dr. Glied, what you are saying is that after the bill passed, based upon Rick Foster's analysis as well as CBO and others, you started an analysis of your own. Is that correct to say?

Ms. GLIED. As we've—we've sent over documents.

Mr. STEARNS. You started doing an analysis to see if it would pay for itself?

Ms. GLIED. We actually had done analyses in the fall as well.

Mr. STEARNS. Did your analysis show anything different than Rick Foster or—

Ms. GLIED. Yes, our analysis was completely consistent with the CBO estimates.

Mr. STEARNS. So, actually, it became apparent to you that this was not actuarially sound?

Ms. GLIED. No. CBO actually thought the program was sound, and the estimates that we had conducted in the Department that we sent over to you already, sir, are completely consistent with the CBO.

Mr. STEARNS. Do you state here today that you think it is financially sound, too?

Ms. GLIED. No. I state here today that at the time, in the fall of 2009, based on the models that we had available at that time, we believed the program was actuarially sound. We were dealing in the area where there was considerable uncertainty.

Mr. STEARNS. From our standpoint, at least, I would say, from this side, we are a little concerned that it appears that there was sort of a deliberative effort on the part of HHS before passage of the law to avoiding these unpleasant realities. And of course, as pointed out on our side, Senator Gregg and Senator Conrad were very concerned and indicated the whole thing wouldn't work. Was Secretary Sebelius aware of the uncertainty in the models during the Obama debate for health care? Were they aware before we passed it of these uncertainties in your opinion?

Ms. GLIED. I think that Mr. Foster's analyses had been published very widely. I wasn't here, so I can't say precisely, but his analyses were published very widely in the news media and spoken about in Congress. It seems unlikely that people were not aware of them.

Mr. STEARNS. All right. My time is up.

The ranking member of the subcommittee, Mr. Pallone, is recognized for 5 minutes.

Mr. PALLONE. Mr. Chairman, without undue respect, I mean, I know the clock didn't start until almost a minute after you started your questioning, and then you went 30 seconds over. So just keep that in mind in terms of the rest of us as we proceed here with the time.

You know, I just, again, I heard from my colleague, the chairman from Florida, again, all of this negative stuff: Let's shut down. Shut down. Repeal. Gloom, failure, can't do.

I have to tell you, when I go home—and we just had another one of those recesses because the Republicans never meet. We meet for two weeks, and then we go home for a week, and then we come back, and they don't have anything to vote on. But when I go home, I hear this over and over again: Why doesn't Washington do something? Why are you guys so negative? Why don't you take action?

I am not going to beat up on you guys today. But I do want to say that I am looking for a path forward. I don't want to accept this doom and gloom that we can't do it, OK? And I am trying to find a way through my questioning to get to actually move forward

and not go into recess or hold or whatever it is that is being described here today.

So, Secretary Greenlee, my hope is that this CLASS Independence Advisory Council, which is established under the statute, can be a way to move forward and implement the CLASS Act. The law stipulates that members of the council are to be appointed by the President; the council is to be comprised of important stakeholders, people with expertise in long-term care insurance and actuarial science and those who may participate in the program, to name a few.

Now you testified that the Department wants to have dialogue with stakeholders like these as you continue to seek solutions. I understand that HHS has received over 140 nominations for this 15-member council. Yet the council members have not been appointed. Why hasn't that been done? And is this a pathway forward? You seem to say you are putting this in recess or on hold. Can we appoint this council, and let them look at the methods of implementation, so that we don't just put this on hold?

Ms. GREENLEE. Congressman, you are correct in your statement that we are very interested in working with stakeholders of all types, with Congress; with the consumer advocates, who fought so hard for this bill; with employers, who are critical to a success. We do want broad engagement and recently met with the advocates and made that most sincere gesture and overture to them that we do want to have broad conversation.

Mr. PALLONE. Yes, but can we move—

Ms. GREENLEE. The Secretary has announced that we are suspending implementation. The Independence Advisory Council because it is a part of the CLASS act has not been implemented. At this point, when we seek broad dialogue, we would like to discuss both CLASS and issues broader, more broadly than CLASS. I don't see right now moving the Independence Advisory Council because we want to discuss this in a more broad perspective.

Mr. PALLONE. Well, see, I disagree with you completely because you seem to be suggesting that you are going to decide whether to move forward, and if you decide not to, then you don't need to have this council because they would look at what you are proposing.

But the way I see this council, they are charged—and I am now quoting directly from the statute—with advising “the Secretary on matters of general policy in the administration of the CLASS program.” So it seems to me that this council could be not just there to implement what you decide or not to decide but actually a way of looking at alternatives and coming up with suggestions and come back to you or the President and say, look, maybe HHS doesn't think we can move forward, but we have got some ideas, and we can show you the way to move forward.

I think that the President—and you make that suggestion that this is the way we move forward. We maybe right now don't think we can do anything. I disagree. But let this other group take another look and take a try.

Let me just ask you, would you agree that this expert group could be useful in helping the Secretary looking at options for moving forward, even though you now feel that there aren't any?

Ms. GREENLEE. Congressman Pallone, we are most sincere in saying that we have suspended implementation. I do not want to send a mixed message by saying we are continuing to work on CLASS when we are not. We do want to engage with stakeholders. All of the type of stakeholders that were mentioned in the statutory section that you read we would be glad to have further conversation with.

Mr. PALLONE. I don't think it is going to be very effective engaging us or engaging everyone, based on what you said today. I really would urge this administration to move forward with naming the members of this panel and using this panel as a way to move forward. I personally and many of us do not agree with your decision to put this on hold. And I think if you have this advisory council in place, hopefully they can look at alternatives and come back and make some additional suggestions.

I am just looking for something here, Madam Secretary. I am not trying to be difficult, but too many of us have worked too hard on this, and we feel very strongly that this can be implemented. And we don't want to give up. And I am not just speaking for myself. And I have got to be honest: The American people want this Congress to take action on long-term care and on so many other things. And it is not a good thing to simply say, we are going to put it on hold. Let this advisory council meet and find a way forward. And I will follow up further on that.

Mr. STEARNS. Thank the gentleman.

I recognize the chairman of the Subcommittee on Health, the gentleman from Pennsylvania, Mr. Pitts.

Mr. PITTS. Thank you.

Secretary Greenlee, why did it take until 11 months after PPACA passed for the Secretary to publicly acknowledge that there were flaws with CLASS?

Ms. GREENLEE. Chairman Pitts, I believe that Secretary Glied has acknowledged that there was broad discussion at the time the law was passed about both the opportunities and the potential problems with the law. What the Department began to do immediately after the law was passed was further develop models that truly modeled the law as it was presented, because there were various options before the law was passed.

It took some time for us to put those models together, and we began what was an iterative process to look at the basic plan, the bare law, the natural reading, and to begin from there finding if there were other methods that could help us achieve solvency and legality. It took just a matter of time to do that detailed and very thorough work.

Mr. PITTS. You testified before the committee in March. Why didn't you indicate at that time there were significant problems with the program?

Ms. GREENLEE. Mr. Chairman, at the time I testified in March, we, in dialogue with the committee, discussed the degree that the Secretary may have some discretion to modify the program. That is a good reflection of where we were at that point in time. We had done the basic analysis and knew that the statute, the bare bones statute, would produce a premium that was unworkable.

We were at that point exploring the degree to which the Secretary had discretion to make a few modifications. Following that work, we did additional developmental work that led us to this conclusion. So what I had explained at that point in time was very accurate with regard to the work that we were doing last spring.

Mr. PITTS. Now, at our last hearing on CLASS, you and Chairman Emeritus Dingell had the following exchange, and I will quote:

“Dingell: I begin by welcoming the Secretary, and I ask, do you have all of the authority you need in the Department to ensure that this program gets off to a start in an actuarially sound manner?”

Ms. Greenlee: “Yes, we do.”

Mr. Dingell: “And you lack nothing?”

Ms. Greenlee: “No. We can make it solvent. We have the authority.”

Why did you think that the Secretary had the legal authority to make the CLASS program solvent?

Ms. GREENLEE. At that time, we were looking at three different items that we discussed, that I testified about in front of the committee: The anti-gaming provisions; the need to possibly index premiums; and the need to raise the earnings level. We felt that in that area, the Secretary had some degree of flexibility or discretion. And I was truthful when I talked about that we were exploring that and felt very positive.

We did further analysis that led us in a different direction after we made those initial changes to the model. We found that even with those, we would still produce a premium that we felt like was higher than could produce a reasonable take-up rate.

Mr. PITTS. This question is—and when did the legal analysis come?

Ms. GREENLEE. The final legal analysis was prepared earlier this month as we did the final report. We had been engaged with our legal counsel all along as we have surfaced different ideas, such as the three that I just explained, and asked them for initial guidance. We didn’t get the full guidance until we did the final report.

Mr. PITTS. Now, for both of you, can you please provide an overview of how much has been spent by the Department during this administration to review, analyze and implement the CLASS program to date?

Ms. GREENLEE. Yes, sir, I can respond to that.

The Department in fiscal year 2010 and 2011, between the two offices that Assistant Secretary Glied and I run spent just under \$5 million. That is a reflection of the work from both endeavors.

Mr. PITTS. Now according to the e-mails, Secretary Glied, and other documents obtained by a bicameral working group, the Office For Planning and Evaluation, which you now run, had prepared technical comments on the CLASS program in December of 2009 for congressional consideration.

During your time at HHS, have you been briefed by your colleagues or staff regarding ASPE’s 2009 analysis of CLASS and the process under which the ASPE comments were received and reviewed by congressional offices, and what happened with these technical comments?

Ms. GLIED. I am somewhat aware of what happened. I was not here at the time. And I don't know the precise details of what happened. I have seen some of the of documents that were turned over to you, sir.

Mr. PITTS. Were any of the 75-year actuarial analyses conducted before PPACA passed?

Ms. GLIED. Before the legislation passed, we had a contract, an ongoing contract, with Actuarial Research Corporation, and we sent over to you the estimates of premiums and prices that they calculated at the time. They did not have a full model with which to calculate 75-year solvency. In fact those were the models that were developed in the subsequent 19 months. They had a model to calculate premiums, and that was the model that we were using to provide technical assistance. We were focused on looking at how different changes in the law would affect those premiums over time.

Mr. PITTS. And finally, the \$5 million you mentioned, does that include contract work?

Ms. GLIED. Yes, it does.

Mr. STEARNS. The Chair recognizes the gentlelady from Colorado, the ranking member of the Oversight and Investigations Subcommittee, Ms. DeGette.

Ms. DEGETTE. Secretary Greenlee, you testified that it is urgent to find effective ways to help Americans prepare for and finance their long-term care needs. And I think it is safe to say that all of us agree with that statement.

Now, I believe that you stated that 15 million Americans will need long term care by 2020 is that correct.

Ms. GREENLEE. Yes.

Ms. DEGETTE. And there are a range of long-term care options now, nursing homes, assisted living, and home health care to name a few. The previous panel talked about some of those. But most of Americans with long-term care needs live at home. And so, in your testimony, you talked about the importance of Americans with disabilities living the maximum amount of freedom and independence. Can you briefly describe some of the benefits of receiving long-term care services within the community?

Ms. GREENLEE. Congresswoman, I certainly can.

I would also like to say that I thought Congressman Kennedy did also an excellent job of framing the two critical issues. One is it is less expensive to provide services in the community. Regardless of the payer source, whether it is the individual, the family, Medicaid, it is cheaper in the community. It is also the setting that overwhelmingly people desire, regardless of age. It helps most preserve a quality of life, dignity, independence, connection to their families and communities, the important things in life and that is why community service is so critically important to people.

Ms. DEGETTE. Right. Now, you were the former administrator of Kansas' Medicaid program, so I know you have some experience on the topic of Medicaid, which is the primary payer of long-term care in this country. And I am assuming that you have experience in the impact of long-term care spending on State and Federal governments; is that correct?

Ms. GREENLEE. Yes.

Ms. DEGETTE. So if we rely on—and I agree with you. I thought former Representative Kennedy and also Representative Deutch spoke quite eloquently about the impact of having to rely primarily on Medicaid for funding long-term care on families. In other words, middle class families having to make these terrible decisions about having to get divorced or putting themselves in poverty or something. Did you see some of that when you were the—when you were administering this program in Kansas?

Ms. GREENLEE. Yes, ma'am.

As you mentioned, currently Medicaid pays for half of the long-term care services in this country. This has a very significant effect on State budgets that many are just really laboring under at this point. Not just State budgets but the Federal budgets in terms of the Medicaid program.

But the opportunity that CLASS presents is a way for people to take responsibility for some of their own long-term care financing, a way to help working Americans so that they can afford to provide some protection, so that they are not in a situation where they have to spend down and impoverish themselves in order to get care.

Ms. DEGETTE. So the concept of the CLASS system is that people will buy long-term insurance and be able to take care of their needs without making these terrible decisions, right?

Ms. GREENLEE. Yes. It will provide additional cash assistance so that they have more flexibility for their needs.

Ms. DEGETTE. So it seemed to me from listening to the testimony on the last panel, from what my colleagues on the other side are saying, is we don't need CLASS to do that. We would just have everybody go out and buy long-term health insurance. Is that the sense you get?

Ms. GREENLEE. The private long-term care insurance market I believe is an option for some individuals, but the private long-term care insurance market will not be the solution for everyone.

Ms. DEGETTE. Why not?

Ms. GREENLEE. There are some of their premiums that are not affordable, and the private long-term care market underwrites their product, meaning many people with chronic conditions or disabling conditions do not qualify to purchase the insurance.

Ms. DEGETTE. I was just telling the staff I have had two hip replacements myself, and when I went to buy long-term health insurance for myself, the insurer said, well, we will sell it to you, but we are going to exclude anything from your hips, which, you know, if someone has a preexisting condition and that is excluded, then they are going to end up either having to pay out of their own pocket for care related to that or go on to Medicaid, right?

Ms. GREENLEE. Yes. And that is why I think we are all looking for broad options—

Ms. DEGETTE. Right.

Ms. GREENLEE [continuing]. Single options, so that we can tailor to each person.

Ms. DEGETTE. Now, let's go back to the States' budgets. Let's say we don't have something like the CLASS Act, some kind of a viable solution to helping people get long-term health insurance that they

can afford and that doesn't exclude preexisting conditions, what is going to be the impact on the States' budgets?

Ms. GREENLEE. Well, you mentioned that I had worked in Medicaid in Kansas. I have not seen recent kind of trends in my home State. But I know that we continue to pay half of the long-term care costs through Medicaid. We have increasing numbers of seniors in this country which will help drive up further demand for Medicaid services, whether they are in institutions, like nursing homes, or in community, that we need to have other options so people have somewhere else to go to help finance long-term care.

Ms. DEGETTE. Thank you. Thank you very much.

Mr. STEARNS. Recognize the gentleman, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. It's kind of good to follow my friend from Colorado with my line of questions. But first, I want to say that I am not gleeful that CLASS got shelved, but I am kind of relieved because of the—it was actuarially unsound that the Secretary even agreed to. And I agree. So I am actually pleased that HHS and Secretary Sebelius did make what I thought was the proper decision.

But following up on long-term care, I do believe that if you incentivize individuals early in the system, like any insurance product, you have effective costs. But we don't have a system right now to adequately reinforce long-term care insurance. And that is, I think, something that would be beneficial to all of the questions my colleague from Colorado asked.

So I would be willing to work with anyone on this issue. Congressman Deutch and Congressman Kennedy both noted that HHS had studied scenarios to make the problem solvent. And of course, in the report that I have would kind of identify some of these, so I am going to go on a question of three, which I think is pretty telling just about the whole actuary process and on insurance itself, is that, is it true that the Department looked into a 15-year waiting period for the receipt of benefits for enrollees with certain health conditions or what can be classified as preexisting conditions?

Ms. GREENLEE. Congressman, that proposal that you are mentioning had been presented and developed by the CLASS actuary, Mr. Yee. It was contained in the overall document as well as in his report. It wasn't an idea that he suggested as a way to mitigate or manage the adverse selection. We never modeled it extensively because we had concerns about the legality of being able to use a preexisting condition.

Mr. SHIMKUS. Right. And in the report here, I mean, it does identify this as an option but was ruled that you had no legal authority to implement this.

Ms. GREENLEE. That is correct.

Mr. SHIMKUS. So my point is, there was consideration of using preexisting conditions as an enrollment process to make CLASS affordable. And for, you know, my friends on the other side to say, don't do preexisting conditions, and then actuarially, in a government-run program, we can't do it, then obviously there is a reason why the insurers do that.

Let me go to another question. Is it true that the Department looked into providing lower benefit amounts for individuals who become eligible in the first 20 years of their enrollment in the program? Yes or no.

Ms. GREENLEE. Yes.

Mr. SHIMKUS. And another way to adjust and modify—and these are the same practices that insurers do that we get—that the private insurance markets get attacked for. What about, is it true that the Department looked into a possible plan with premiums nearing \$400 a month? Yes or no.

Ms. GREENLEE. Yes, that reflects the basic CLASS program unamended any in any way.

Mr. SHIMKUS. That is correct. And it says here, with full waiver of premium, while in the claim ranging from \$235 a month to \$391 a month. So I guess, you know, the point is, to make this financially sound, you had to actuarially do adjustments that many times a private insurance market is attacked for. And it is just a statement. And the report, in essence, supports that.

The \$70 billion of savings when passed, when we passed H.R. 2, it was up to \$86 billion. Now, to my friends who say that the health care law still has real dollar savings, go back to our first hearing this year with Secretary Sebelius when she admitted that we had double counted Medicare. The \$500 billion Medicare cuts were scored for health care and they were scored for extending Medicare solvency.

Now you add the \$70 billion double counting or that is going to be revenue to help make this affordable—now, you are at the \$570 billion of money that was planned to help fund Obamacare that isn't available. Then you talk about the \$800 billion in tax increases. You get 1.37 and that is where we are moving with the health care law today. I appreciate your time. I yield back.

Mr. STEARNS. The gentleman yields back. I recognize the ranking member of the full committee, Mr. Waxman, the gentleman from California.

Mr. WAXMAN. Let me follow up with the last questioner's comments. I understand the health care reform bill cuts the long-term debt. I know that is hard for the Republicans to accept, but it is the facts. The new benefit of the bill—the new benefits of the bill are entirely paid for and more by new revenues and by improvements that cut the overall cost of health care, cut waste, fraud, and abuse from the Medicare and Medicaid programs.

When the health care reform law passed, the CBO said it would save \$200 billion over the next decade. About \$70 billion of this savings was from the CLASS program, savings that obviously will not materialize.

Dr. Glied, the Republicans have stated if the \$70 billion in savings was crucial to the passage of the health care law. Let me ask you, even without the CBO-scored savings from the CLASS program, do you still anticipate that the health care reform law will cut the debt over the next decade.

Ms. GLIED. Absolutely, sir. We anticipate that the health care reform law, without the CLASS program, will save \$127 billion in the next decade and over a trillion dollars in the decade following that.

Mr. WAXMAN. Now critics of the CLASS program have also raised the fact that the program's costs will explode in future years and that CLASS will set saddle taxpayers with future debt. Those worst-case scenarios obviously will not happen if the program does not go into effect; isn't that correct?

Ms. GLIED. That is correct, sir.

Mr. WAXMAN. Of course, the benefits of having something in place for long-term care won't happen either.

We are going to hear a lot of rhetoric complaining about budget gimmicks and budget deficits today, but there is a difference between the Republican rhetoric and the facts. The facts are that even with the news about the CLASS program, the health care reform law will cut the long-term deficit and save taxpayers money.

As you know, the Republicans' bicameral CLASS working group released a report last month which included documents obtained through an investigation of the CLASS program. The report asserts that the administration supported the CLASS Act because the Congressional Budget Office or CBO scored the program as reducing the deficit over the first 10 years. I would like to ask you a few questions about this decision.

Secretary Glied, why did the Obama administration support the CLASS program during the health care reform debate?

Ms. GLIED. The administration supported the program because of the indisputable need to protect people from the cost of long-term care services, to allow them to buy themselves protection, and to ensure that disabled people would have opportunities to work and to get themselves the services to do that, and because the law included this twin test that required that it be entirely self-financing and fiscally solvent over 75 years, so that it was also fiscally prudent for us to do so.

Mr. WAXMAN. What role of any about the CBO score play in the administration's analysis of the program and ultimate support for the program?

Ms. GLIED. It was certainly encouraging that the CBO analysts also believed that the program would be viable, fiscally viable, fiscally solvent and therefore able to address the needs that we had set forth to address with the program.

Mr. WAXMAN. Without the Affordable Care Act, people with pre-existing medical conditions can't get insurance, or they have to pay an extraordinary amount for their insurance, which means that many people with preexisting conditions don't have insurance.

One of the purposes of the Affordable Care Act was to say that we are not going to allow that discrimination against people with preexisting conditions. The way the act handled that matter is to say if everybody got insurance, then we could spread the costs and not have those with preexisting medical conditions as a group charged so much that they can't afford it. My colleague on the other side of the aisle raised this issue. Wasn't that the approach that we took in the Affordable Care Act for insurance? Either one of you.

Ms. GLIED. Yes.

Mr. WAXMAN. Now that solved the problem for people who want to get acute care insurance, medical insurance as we know it. But medical insurance, even Medicare, doesn't cover the long-term care

needs of people who are disabled. It may for a short while if they go to a nursing home after some spell of illness, but that is only for a short period of time. After that, if they need to be in a nursing home or they need home health care, the Medicare doesn't pay for that assistance that they may need. Isn't that correct?

Ms. GLIED. Yes.

Mr. WAXMAN. Well, one of the problems people have in trying to buy insurance for long-term care is that if they had any kind of preexisting condition, they can't buy it.

Ms. GLIED. That is right.

Mr. WAXMAN. That is the issue, isn't it?

Ms. GLIED. Yes, sir.

Mr. WAXMAN. That was never solved—and the Republicans have offered no solution to it, except to say, isn't it a terrible problem? But that wasn't even solved by the CLASS Act, except it would have allowed people to buy into a program even with their disabilities. Isn't that correct?

Ms. GLIED. Yes, sir.

Mr. WAXMAN. So we still need to address this long-term care insurance?

Ms. GLIED. Very much, sir.

Mr. WAXMAN. Thank you.

Thank you, Mr. Chairman.

Mr. STEARNS. Thank the gentleman.

And the gentleman from Nebraska, Mr. Terry, for 5 minutes.

Mr. TERRY. Thank you, Mr. Chairman.

Thank you, Secretary Greenlee and Glied, whichever, the ACA included money. I think your testimony is that that money has stayed in for the provisions on educational efforts on long-term care, that CLASS has been shelved, but you said the educational component is still going forward, right?

Ms. GREENLEE. That is correct. The Deficit Reduction Act in 2005 first provided money so that we could do public outreach and education about the need for long-term care, long-term care awareness campaign. Many States have used this to provide kind of an own-your-futures campaign. That was picked up.

Mr. TERRY. Is that what this awareness program is? Since CLASS doesn't exist or isn't going to be rolled out, the only thing left to become aware of would be private long-term health care plans. Is that what the campaign is doing, is telling people that they should get a policy for long-term health care?

Ms. GREENLEE. I think there are two issues. One is to educate the people about the need as well as the misconception that Medicare covers long-term care when it doesn't, and then provide education about how individuals may take responsibility for meeting that need.

So it covers all of the different options and really raises awareness.

Mr. TERRY. So it does include the private sector.

Ms. GREENLEE. Yes.

Mr. TERRY. Which right now is the only thing that, if the person becomes aware, that they can go out and purchase. So—well, other than Medicaid, buying down your assets or purging.

So you plan to continue to go forward with the awareness campaign.

Ms. GREENLEE. Yes, sir.

Mr. TERRY. All right. How much is put aside per year this year?

Ms. GREENLEE. Just about \$3 million a year set aside for the long-term care awareness campaign. That was provided for separately in the Affordable Care Act.

Mr. TERRY. And you were moved, as I was, in Patrick Kennedy's testimony, especially it hit—was his testimony about his uncle, Sargent Shriver, and the companion care that he was given at home, which is different than skilled nursing care or a nursing facility; you know, the person that would help him get from the living room to the dining room so he could eat. Was companion care part of CLASS?

Ms. GREENLEE. The cash benefit that was provided in CLASS would have allowed the consumer to direct their own choice of services. We fully anticipated that that type of companion care or attendant care would be one of the primary items that someone would—

Mr. TERRY. That is good, and I really believe that companion care can keep somebody like Sargent Shriver out of a skilled nursing facility that would be on a daily basis probably 20 times more expensive.

Ms. GREENLEE. I agree with you, sir.

Mr. TERRY. Are you aware, have you had any contact or work with the Department of Labor, who is trying to pass a rule to make all caregivers subject to the FLSA, therefore making it unaffordable for many middle class families to use caregivers?

Ms. GREENLEE. No, sir. I have not engaged with the Department of Labor on that issue, either in my role as assistant secretary with the Older Americans Act or—

Mr. TERRY. I would think that the Department of Labor, if they are going to affect senior care so dramatically, that they would have reached out to your Department. I think that is odd that they haven't.

Ms. Glied, have they asked you to run any models about how FLSA will make the companion care more expensive, therefore making it unaffordable?

Ms. GLIED. I am not sure, but we can get back to you on that.

Mr. TERRY. I would appreciate that.

Also, then, I agree with home health care. My personal—my mother battled cancer, and she was always bouncing between hospital to skilled nursing when my father and I felt that she would be better off at home with some home health care, but Medicare wouldn't pay for those health home care, changing IVs, those types of things. So we had to go with the more expensive option. So home health care, unfortunately, though, has been—costs for home health care and access—has actually been cut over the last 2 years. And within the savings in Medicare from the ACA, home health care has been diminished. Have you been working with the administration, the White House, to champion home health care?

Ms. GREENLEE. I am looking at Dr. Glied. The main conversations I have had in this area are actually not Medicare-related but

Older Americans Act-related because that has also been another critical support.

Ms. GLIED. There have also been substantial increases in Medicaid programs that provide home and community based services. So those have been a major focus within the Affordable Care Act. We have got more money going to Money Follows the Person, and we have new community first choice options for Medicaid programs that are all intended to help people stay in the community. So we have actually expanded access to home health care for most people.

Mr. STEARNS. The Chair thanks the gentleman, recognizes the ranking member emeritus, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. Madam Secretary, long-term care insurance helps American workers to prepare for future long-term care needs. Do you believe that the private market is currently providing long-term care options for working Americans? Yes or no.

Ms. GREENLEE. Primarily, no. It is very limited.

Mr. DINGELL. All right. As you know, the CLASS Act is designed to be a voluntary insurance program to help American workers to pay for long-term care services that they will need in later years.

The program was created to help address the needs of ailing Americans, both young and old, because alternatives can be impossibly costly to American families. And Medicaid is only accessible after they have exhausted all of their savings.

Do you agree that the CLASS Act was intended to help fill a need in affordable options for long-term care for working Americans? Yes or no.

Ms. GREENLEE. Yes, sir. Definitely.

Mr. DINGELL. Now, Madam Secretary, when you testified before this committee, you will recall I asked you whether you had all of the authority you needed in the Department to ensure the program gets off to the start in an actuarially sound manner. At the time you answered you did.

However, the report issued on October 14th tends to indicate that the Department does not have the authority it needs to develop a program that will meet the solvency tests. I would like to ask you again, then, whether you have the authority you need in the Department to implement the CLASS Act so that it is actuarially sound and provides a an affordable, long-term care to working Americans? Yes or no.

Ms. GREENLEE. Mr. Dingell, may I respond other than yes or no—

Mr. DINGELL. All right. If you please, but quickly.

Ms. GREENLEE. My statements were correct at the time I made them in March, that we were very optimistic about the types of flexibility through the discretion that the Secretary might have—

Mr. DINGELL. I am not coming down. I just want the answer.

Ms. GREENLEE. After we did further analysis, we found that that was not the case. We do not have the authority we need at this point.

Mr. DINGELL. All right. Then, if you would, please, tell us what additional authority do you need to implement the CLASS Act in a fashion that results in an actuarially sound plan?

Ms. GREENLEE. Sir, I would need to refer you back to the reports to look specifically at the type of actuarial modelling we were looking at as well as the legal issues that were raised as we continued to model the program.

Mr. DINGELL. All right. I would ask you, along with my friend Mr. Pallone and others, that you submit to me a list of the authorities that the Department needs to properly implement this plan.

Ms. GREENLEE. We do not currently have a list. I will take your request back, so we can be responsive. We don't have a list at this time.

Mr. DINGELL. OK.

Madam Secretary, in your memorandum on the CLASS program to Secretary Sebelius stated, quote, you do not see a path to move forward with CLASS at this time, close quote. Until a list of needed authority is provided to this committee, will you commit to working with the Congress, industry, and the consumers to continue to work to find options for affordable long-term care options for Americans? Yes or no.

Ms. GREENLEE. Yes, we are committed to working with you.

Mr. DINGELL. Now, Mr. Chairman, I want to make a couple of observations here. I heard my Republican colleagues in this committee, on the floor, and in speeches in and outside the Congress, tell everybody what an evil thing the health insurance bill, Affordable Care Act, is. And I, quite frankly, don't agree.

But I am curious. What is it that our Republican colleagues suggest to us we ought to do? What should we do, my dear friends, about the CLASS Act, so that we provide long-term care programs for Americans who desperately need it? So that they won't be destitute, and so that they can have an actuarially sound program which will enable them to have a program of long-term care to take care of themselves and their families.

What is it my Republican colleagues want to do to see to it that we get ourselves a program which addresses problems like pre-existing conditions and all of the other things that they have been introducing legislation to repeal, to strip the American public of the rights and opportunities we have given them in a piece of legislation which they opposed with enormous vigor and which they continue to oppose, without any particular apparent care, other than that we continue the reliance on the same unworkable situation that we have.

Mr. GINGREY. Will the distinguished gentleman yield?

Mr. DINGELL. I will be happy to yield if I have time. But I want to make this observation. We have a serious problem that the American people confront. All we hear from my Republican colleagues is no, no, no, no. They sound like—

Mr. GINGREY. Mr. Chairman, the gentleman's time has expired, but he did ask a specific question of members on this side of the aisle, and if you would allow me 10, 15 seconds to respond to that.

Mr. STEARNS. Any objection? Do you have any objection?

Mr. PALLONE. Why doesn't he use his own time?

Mr. DINGELL. I would love to have it if it can be done.

Mr. GINGREY. The gentleman is requesting that we respond to that.

Mr. STEARNS. The gentleman seeks unanimous consent for what 15, 30 seconds.

Mr. GINGREY. Sure.

Mr. STEARNS. To respond to Mr. Dingell.

Without objection.

Mr. GINGREY. Sure. I thank all members for the unanimous consent.

You know, in regards to the question, what could we do, Mr. Pallone earlier in his line of questions asked about the advisory council on long-term care. Secretary Greenlee talked about that and said that implementation has been stopped, and therefore, we are not going to go forward with that advisory council. I think that was my understanding. I don't see any reason in the world not to have Mr. Dingell and Mr. Pallone to come forward, make a stand-alone bill creating an advisory council on long-term care and let us look at it and essentially start over and get it right this time.

Mr. STEARNS. The Chair thanks the gentleman. The Chair yields to Dr. Burgess for 5 minutes for questions.

Mr. BURGESS. I thank the chairman for yielding. Let's just for a moment go back, Ms. Greenlee, to Mr. Dingell's questioning. He talked about—he had questioned you and your previous appearance here and you said you had everything you need. Then, apparently, you didn't. And he asked, what did you lack as far as being able to provide the tools? Really there are only two variables you have to manipulate, and that is the premium and the benefit. Is that correct? When you are structuring a program, when Richard Foster was looking to provide the actuarial information as to whether this was sound or not, you can alter the premium. You can restructure the benefit. Mr. Pallone said you can have a 15-year vesting period as opposed to 5. But really those are the variables that you have got to manipulate. Is that correct?

Ms. GLIED. As you can see in our report, sir—I am sorry. Is it OK—I mean, we actually considered a lot of different options, and they varied—

Mr. BURGESS. Maybe this is—perhaps this is how I need to ask the question. Ms. Greenlee, did you do modeling to look at what the premium point would have to be to support the CLASS Act?

Ms. GREENLEE. Yes, sir.

Mr. BURGESS. And what is that number?

Ms. GREENLEE. It depended, depending on the different model that we were running. The CLASS Act, as modified—

Mr. BURGESS. Give us a range. Can you give us a range?

Ms. GREENLEE. May I refer to Ms. Glied. I mean, the modeling numbers are really something that she is more equipped to answer for you correctly I think.

Ms. GLIED. So I would like to emphasize that there isn't a single number out there that we know.

Mr. BURGESS. Great. Look, my time is very limited. I don't mean to be rude. I am not allowed extra time, like other members are. Can you get this for me?

Ms. GLIED. There is not a number.

Mr. BURGESS. There is not a number?

Ms. GLIED. There is not a single number. There are a lot of numbers in the report—

Mr. BURGESS. Now, initially, when Mr. Pallone brought this to us, the number was \$60 a month. Is it likely to be higher than \$60 a month for the premium?

Ms. GLIED. If you could look at the report, the premiums are in there. They are all higher than \$60 a month.

Mr. BURGESS. Let me ask you this. Let me ask you a couple of questions. You referenced \$5 million in money that has already been spent in the implementation of this program. And please, if it is information that you need to get back to us with, I am going to ask that you do that. But how—of that \$5 million, does that include the money that has been spent on outside contractors?

Ms. GREENLEE. Yes, sir.

Mr. BURGESS. And will you be willing to provide us a balance sheet showing how and when and for what purpose the money was expended?

Ms. GREENLEE. Certainly.

Mr. BURGESS. The figure of \$5 million is helpful, but it is not all that useful in understanding where the expenditures occurred.

Ms. GREENLEE. We will be glad to. We think we may have provided it already, but we are willing to provide if we have not.

Mr. BURGESS. Then how much money has ASPE itself expended in this regard? Is it different from the \$5 million?

Ms. GLIED. It is included in that figure.

Mr. BURGESS. How much money is available for further planning in ASPE?

Ms. GLIED. ASPE doesn't have a separate budget for CLASS. We have a Division of Aging and Long-Term Care Policy. We have had it for 30 years, and that continues.

Mr. BURGESS. Do you have a budgetary line item for CLASS?

Ms. GLIED. No, we don't.

Mr. BURGESS. Let me ask you this: We talked—Mr. Terry talked some about the informational aspects of long-term care insurance. And in 2005, when the Deficit Reduction Act was being debated in this committee, I think we got information that if one-third of the projected seniors moved off of Medicaid into a private long-term care product, that the savings would be substantial. I think \$160 billion was the figure this committee received over 10 years. I guess that would be even larger now a few years later. \$160 billion is, even today, a significant amount of money. Have we harmed the long-term care, the private long-term care market with the activities of the CLASS Act over the last 19 months? Has it made it more difficult for companies to develop these products and market them?

Ms. GREENLEE. Sir, I don't think so in any way.

Mr. BURGESS. Would it not, if someone were developing a product in the private market, and they are looking over their shoulder at what is occurring within the administration, wouldn't that alter their thinking on what type of product to offer?

Ms. GREENLEE. Because you have acknowledged that you have private insurance, I know you are aware that the private market offers a comprehensive product, which is far different than what the minimum benefit is, the minimal support that CLASS would provide. I don't believe we have, in any way, hampered the ability of the market to learn from what we have learned and modify their

products. They also have other tools available to them that we would not have had in the CLASS program.

Mr. BURGESS. Let me just ask you this, Ms. Glied. Did you serve on President Clinton's health care task force?

Ms. GREENLEE. I did not.

Ms. GLIED. I did.

Mr. BURGESS. You did. And as I recall, when President Clinton had his comprehensive health care reform, there was a long-term care piece to that. Is that correct?

Ms. GLIED. Yes, there was.

Mr. BURGESS. Did you encounter any of these same questions or concerns during the development of that product for the Clinton administration?

Ms. GLIED. I was not involved in that part of the reform proposal at all.

Mr. BURGESS. But you have been involved in these discussions before. Did any of the information you got during that time inform any of the decisions that are being made now?

Ms. GLIED. I am quite sure they did, but I don't—can't point to specifics.

Mr. BURGESS. Mr. Chairman, I hope we have time for a second round. I will yield back at this point.

Mr. PITTS. The Chair thanks the gentleman, and recognizes the gentleman from Texas, Mr. Green, for 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman. It is no secret that our colleagues on the other side of the aisle don't like the historic health care reform law that we passed in 2010. And they have been eager to jump on the problems of the CLASS Act to imply that the entire health care reform law is a failure. Dr. Glied, can you offer us some perspectives here? And I don't want to minimize the CLASS Act. It was an important part of the bill. And whether the CLASS Act or another approach, we need to find a solution for long-term care in our country. With the huge increase in Alzheimer's, with dementia, that needs to be part of the solution, even though the CLASS Act may not be that solution. But my understanding is there are many critical benefits of the health care law that have nothing to do with CLASS. And I would like you to walk through with me on the benefits. My first question is how are seniors benefiting from the health care reform law now?

Ms. GLIED. We have made many changes already that have benefited seniors. For one thing, we are working on closing the doughnut hole in Medicare part D. And already about 4 million seniors have benefited from that.

Mr. GREEN. I will just interrupt you. I probably would have voted for the 2003 plan if it hadn't been for that doughnut hole in there. So I am glad we are closing it.

Ms. GLIED. We are also providing seniors with new preventive benefits that are free of cost sharing. There is a new annual wellness visit in the Medicare program thanks to the Affordable Care Act. We have taken aggressive steps to reduce fraud in the Medicare program. And that is a benefit to everyone. And as we mentioned earlier, in the Medicaid program, we have also expanded opportunities for home- and community-based services.

Mr. GREEN. How about small businesses? We hear a lot about that. In fact, having helped manage a small business, outside of basic payroll, our insurance costs was one of our biggest issues in a 13-employee company. Can you say how the health care reform law deals with small business?

Ms. GLIED. We have already put in place a small business tax credit to help small businesses provide health insurance to their workers. And that tax credit is actually going to expand beginning in 2014.

Mr. GREEN. How about young adults?

Ms. GLIED. So one of the very, very first provisions in the Act to take effect was a provision that allowed young adults to stay on their parents' health insurance coverage. We have now got back responses from three separate national surveys. And they all show that the number of young adults in this country who are uninsured has dropped by a million because of that policy.

Mr. GREEN. Well, and I am getting calls, how about Americans with insurance? Because I know we heard this last week that WalMart was increasing their premiums. We all get calls every day saying my insurance premium from my company insurance is going up. What are the new protections that we have under the health care reform law to protect Americans who actually have insurance?

Ms. GLIED. So some of the provisions that have already taken effect will eliminate some of the most egregious behaviors of the private insurance industry like rescissions. So that has already taken effect. As well, there are now provisions that allow States to take a very careful look at unreasonable rate increases and negotiate with insurance companies to keep those down.

Mr. GREEN. OK. And I know the uninsured and how they benefited from the new health care law. And let me give you some perspective. In the 2000 census, I had 33 percent of my constituents who had insurance through their employer. Forty-three percent of them worked and didn't qualify for Medicaid, but they were uninsured because their employer did not provide insurance coverage. How will the health care reform law help that 43 percent in my district?

Ms. GLIED. So we are expecting that over 30 million people will gain health insurance coverage when full implementation of the Affordable Care Act starts in 2014.

Mr. GREEN. Are there any of these benefits by the administration's decision on the CLASS program?

Ms. GLIED. No, the CLASS program is really a stand-alone and distinct part of the health care reform bill. It addresses a very important need, but it is quite distinct from the rest of the legislation.

Mr. GREEN. So whether it is the decision of the Department or decision of Congress, everything else in the law is working and functioning and going into effect as we are moving?

Ms. GLIED. Absolutely, sir.

Mr. GREEN. I am disappointed that the new CLASS program as currently constructed will not be in effect because we have to have a solution. And I hope we can reach across the aisle legislative-wise and come up with something that will deal with long-term care. Because like I said earlier, a lot of my constituents don't have the same opportunities that Federal employees have, State employees

have. I don't know of many companies except very large ones that apply some long-term—allow for long-term care for their employees. It means that we have to continue to work to address the solution of our long-term care needs. But it does not have the impact on the success of the health care reform law that you just expressed. Millions of Americans, young and old, will continue to benefit from this law even though the CLASS Act may not be part of it.

Ms. GLIED. Yes, sir.

Mr. GREEN. Mr. Chairman, I actually yield back my 23 seconds.

Mr. PITTS. The Chair thanks the gentleman, and recognizes Dr. Murphy for 5 minutes for questions.

Mr. MURPHY. Thank you, both Secretaries. It is good to meet with you. Particularly, Assistant Secretary, I appreciate your forthrightness during our hearing last March, where you and I discussed this, and discussed the administration was double counting funds from the CLASS program as funding both the CLASS program and the health care bill. And I appreciate your forthrightness at that time we had that discussion. I want to ask you a couple questions, though. Did members of the CLASS working group or the CLASS office ever discuss the CLASS Act with the White House, including White House Office of Health Reform, the White House Counsel's office, or the Office of Management and Budget about the problems with resolving the program within your authority? Was there any discussions that took place like that?

Ms. GREENLEE. As typical with large policy issues, especially those as important as health reform, we are in contact with the White House as policy issues arise. This is no exception.

Mr. MURPHY. Can you tell us who was involved with those conversations and what was said?

Ms. GREENLEE. Sir, over the 19 months that we have been working on the program, I honestly don't have a list.

Mr. MURPHY. Is that something you can get to the committee? I wouldn't expect you to remember all that. I appreciate that. I wasn't trying to quiz you on that part of it. If you could let us know, I would really appreciate that. Thank you.

Ms. GREENLEE. I will see how to follow up, sir.

Mr. MURPHY. Thank you. Do you have any idea who at the White House was consulted before Secretary Sebelius decided that, as was cited before, she didn't see a path forward for implementation at this time? Do you have any idea who she met with or consulted with at the White House?

Ms. GREENLEE. No. As I mentioned, this is a major policy decision. So it is something that we would want to talk to the White House and get their guidance. I can't tell you who specifically the Secretary has spoken to.

Mr. MURPHY. When you say it was a major policy decision, who made the decision?

Ms. GREENLEE. The Secretary did.

Mr. MURPHY. The Secretary did. And it was also a decision she had in consultation with the White House?

Ms. GREENLEE. They certainly needed to be informed of this decision, and involved as she was making it.

Mr. MURPHY. And who at the White House agreed with her decision?

Ms. GREENLEE. Sir, I would have to—I can't answer that specifically, because it was the Secretary's decision. And her—she was the primary one who would have been involved.

Mr. MURPHY. What I am trying to find out, and again I appreciate your forthrightness here, I mean something of this magnitude on which the health care bill really hinged on in terms of trying to balance the books on it, of which the CBO I think told us—I think when you were here before I think this is the number, correct me if I am wrong—that withdrawing it from the health care bill would leave a gap in the health care bill of \$80 or \$85 billion or something like that. It is a decision of some magnitude. And so I am wondering if there were someone else in the White House very high up that would have to say, OK, well, we are going to pull the plug on this.

Ms. GREENLEE. It clearly was the Secretary's decision. That is what it lines up in the law. She is the one that has submitted the report, based on my recommendation. I can't respond to or be responsive with regard to else she may have consulted as she was making that decision.

Mr. MURPHY. Thank you very much. Mr. Chairman, I have no more questions. But I would be glad to yield to my colleague, Dr. Burgess.

Mr. BURGESS. And I thank the gentleman for yielding. Just to follow up on some of the budgetary questions, the committee staff does not believe that they do have the breakdown of the expenditures. That may have gone to the Appropriations subcommittee. So would you be sure to work with our staff to make certain that we have that? And really, we are kind of looking for some of the fine detail. Even the money that was spent on staples and staplers, we would like to see that.

And again, a breakdown or a breakout of the dollars that were expended for outside contracting. Because my understanding is there was, some of this work that had to be done on the modeling did require the participation of outside contracts. Is that correct?

Ms. GREENLEE. Yes, sir. And we are willing to provide that information to you.

Mr. BURGESS. Now, Ms. Greenlee, I think you mentioned that both Chief Actuary Foster and Doug Elmendorf at the CBO performed an analysis on the cost of the total health care bill that included, of course, the offset that was going to be provided by CLASS. It has been said that in the last Congress we didn't do a lot of oversight over the implementation of the health care law. But there were two resolutions of inquiry that were heard by this committee, and one of them dealt with exactly this set of facts, that is, was the Congress provided accurate financial information before the actual vote on the bill that became law occurred March 21 of 2010?

Now, in retrospect, to me at least, it does not seem like Congress had all of the information. And now with the information that we are getting out of the documents provided that Mr. Foster, in fact, questioned himself in June of 2009. So do you see why some of us are uncomfortable with the notion that you couldn't have known

until after the bill was signed into law how much it actually was going to cost?

Ms. GREENLEE. Congressman Burgess, as Secretary Glied has said, the work that was done by Mr. Foster was publicly available before the bill was passed, as was work done by other outside professionals such as the American Academy of Actuaries. So the information was in the public domain at the time the law was passed.

Mr. PITTS. The Chair thanks the gentleman, and yields to Dr. Christensen for 5 minutes for questions.

Ms. CHRISTENSEN. Thank you, Mr. Chairman. Good morning—

Ms. GREENLEE. Good morning.

Ms. CHRISTENSEN [continuing]. Secretaries. Ms. Greenlee, as you have heard, I am not the only person in this room who is disappointed by the HHS announcement that you will not be moving forward at this time to implement the CLASS program. It has been 18 months since the Affordable Care Act was passed, and we were really hoping that this part of the legislation would allow the Nation to begin addressing the burden of long-term care. That is not the case. But I hope that we can at least say that the amount of time and the money that we have spent on CLASS to date has not been wasted.

And we have had a lot of questions about how much money you have spent, and you are supposed to supply documents on even the staples that you bought and all of that. So can you tell us a bit about the expenses? And in particular, can you assure this committee that you have used those funds in a manner that is consistent with the statute and in a way that has advanced our understanding of long-term care?

Ms. GREENLEE. Yes. I am certainly willing to provide the information that Congressman Burgess has requested. We have been prudent and practical, very responsible, and also done at the same time a very thorough analysis of the law that we think will help advance the conversation about how a voluntary insurance program could work, what the problems are with the law that we have seen. We have learned a lot, and have gained from this investment in a positive way.

Ms. CHRISTENSEN. That is what I thought. Because just the information that you have gathered going through this has been, I am sure, worth the expenditure. What are some of the lessons that we have learned as we have sought the solutions to the Nation's long-term care problems? Are we back at square one, or can we build on the CLASS framework and the work and the analyses that you have done?

Ms. GREENLEE. I don't think we are back at square one. I think we can continue to move from here. There is much to be learned by looking at the report as well as the different modeling exercises. There are real critical needs that this program is meant to address. And as we move forward, one of the reasons we are suggesting that we have as broad a conversation as possible is that the CLASS program would serve a lot of different kind of people. And we want to make sure that we as a Nation cover the waterfront in terms of having solutions and options for all of those individuals.

Ms. CHRISTENSEN. Thanks. Mr. Chairman, the HHS announced that last week was not the end of this story. And I would say that to my colleagues as well. The burden of long-term care, as was said very clearly by our colleague Congressman Kennedy, it is not going to go away. Millions of Americans will need long-term care, and we have to figure out a way to help them. So I wish the CLASS Act had not been the final answer. But to the extent it is not, we need to work as a committee and as a Congress to find out how to provide and pay for long-term care.

And I just want to add that one of the reasons that I am so much in support of the CLASS Act is as a family physician, we have the opportunity to take care of patients in many different ways. And one of those is when they are chronically disabled or at end of life. And I always encourage my patients to stay at home if that was at all possible. And the benefits of that to the individual who was sick, to be able to be cared for in familiar surroundings with their family, and with the proper support, the family really got a lot of satisfaction out of taking care of their loved ones at home. And so I am looking forward to working with the Department and my colleagues to find a way forward. Thank you. I yield back the balance of my time.

Mr. PITTS. The Chair thanks the gentlelady, recognizes the gentleman from Georgia, Dr. Gingrey, for 5 minutes for questioning.

Mr. GINGREY. Mr. Chairman, thank you. And my colleague, Dr. Donna Christensen's line of questioning and comments kind of segues into what I am going to say. I want to, at the outset, tell you that I am for closing this office down and not leaving a remnant, a crack in the door, if you will. And I am going to ask you a few questions to show you why I feel that way. Secretary Glied, you testified earlier that your office had conducted studies in 2009 that were consistent with the CBO's findings that the program was actuarially sound. Were those studies modeled just on the first 10 years of the program, or were there any studies you modeled on, say, the 50- or 75-year estimates?

Ms. GLIED. We did not have a model at that time that could estimate fiscal solvency over a 75-year period. We only had a model that could calculate premiums. That is the information that we have provided to you. So what we were able to do was calculate premiums based on different takeup rates. And what was reassuring to us at that time was that we got premiums that were very similar to the ones that CBO was reporting. We did not have a full actuarial solvency model.

Mr. GINGREY. Not modeled out 75 years. Because Richard Frank, the deputy assistant for planning and evaluation, I guess someone who works under you, stated publicly that we in the Department have modeled CLASS extensively, and we are entirely, entirely persuaded that financial solvency over the 75-year period can be maintained. That is a direct quote from him.

Ms. GLIED. Correct. And I think that he was—I was not there yet, but I think that what he was saying was that the CBO had run a very similar model with the 75-year projection and came up with very similar premiums so that the consistency—

Mr. GINGREY. Well, if that modeling is available, and you didn't see it, but I would very much appreciate it if you would get that to this Member or Members on both sides of the aisle.

Ms. GLIED. We provided those to you, they are actually in your report.

Mr. GINGREY. Let me go to the second question. IOS, Immediate Office of Secretary of HHS, cited in the working group report as stating that Senator Kennedy's staffer, and this is a quote, "had CBO do lots and lots of runs out to 50 years to ascertain solvency. She is going to send to me to forward on." Have either of you ever seen such a report from CBO on the 50-year solvency of the CLASS program?

Ms. GREENLEE. I have not.

Ms. GLIED. No.

Mr. GINGREY. Are you aware that any such CBO report ever existed? Because this is a quote from a senior staffer in Senator Kennedy's office in regard to seeing those studies, those models.

Ms. GLIED. It is quite possible they existed. I wasn't at HHS at the time, so I do not see them.

Mr. GINGREY. OK. Secretary Greenlee, you stated in testimony before this committee on March 17, 2011, that we should not repeal CLASS until we have made every effort to reform the program. Just this month, HHS concluded in a report that the administration has, quote, "not identified a way to make CLASS work at this time." In light of this announcement, will HHS now support repeal of the CLASS program?

Ms. GREENLEE. Congressman Gingrey, we feel that repealing CLASS would serve no useful purpose at this point.

Mr. GINGREY. Would you say that again?

Ms. GREENLEE. We feel that repealing the law would serve no useful purpose at this point. We have stated publicly we do not intend to implement, and have no plans to move forward on implementation.

Mr. GINGREY. Let me then suggest a useful purpose to you that you may want to take under consideration. Section 3203 of the Patient Protection and Affordable Care Act requires the Secretary to designate a benefit plan as the CLASS Independence Benefit Plan no later than October 1, 2012. That is a year from now. Absent repeal, if the Secretary cannot find a way to make CLASS work by October 1, 2012, I am concerned that some private citizen or interest group, for instance, one very vocal in the press lately, could sue the Secretary for not following the statute.

Has the Secretary of Health and Human Services created any contingency plans in case she can not make CLASS solvent and is sued for not following the statute? Now, before you answer that, obviously if we repeal CLASS, that would not be a problem.

Ms. GREENLEE. As you know, the statute requires that the Secretary determine that the program could be solvent over 75 years. She can not make that determination, so she will not be moving forward. So even though the law states the October 2012 date, she does not have a way to achieve that, and will not be working to implement.

Mr. GINGREY. That is my point, Madam Secretary. You are saying exactly what I said, that she can't do it. So why leave this stat-

ute on the books there just almost begging someone to come forward and sue the Department and the Federal Government for not providing something that we have a law that has been passed and has been pledged by a date certain? It would be a lot safer to just go ahead and have a very clean like 1173, Dr. Boustany's bill, and repeal the CLASS Act.

Ms. GREENLEE. Again, I don't think that serves a helpful purpose. We need to talk with people about the broader issue instead of focusing on repealing the law.

Mr. GINGREY. I know my time has expired. Mr. Chairman, thank you for your patience.

Mr. PITTS. The Chair thanks the gentleman. And recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. To me this conversation is so incredibly unrelated to the real lives of real Americans. As former Representative Kennedy said, repealing the CLASS Act doesn't mean that the widespread financial and physical and emotional suffering of older and disabled Americans goes away. Somebody is going to pay. And we can talk about actuarial tables, and we can talk about staples and staplers all we want to, but it seems to me that we would be a heck of a lot better talking about how we address this problem. And if we want to talk about actuaries, by the way, we can go back to 2003 when the Republicans shut down the actuary when we were talking about the prescription drug bill, and actually said if the actuary puts out the costs that he has actually estimated for the program, there were threats that were made on that person. Some of us actually remember that. But I actually want to quote some of the conversation that I think would be more productive of some of our Members.

Chairman Pitts, you said, I believe we can all agree that we do have a serious long-term care problem in this country, as the costs are driving people into bankruptcy and weighing down the Medicaid program. We do need to address this issue. Chairman Emeritus Barton said long-term care is a serious issue. I believe myself and all Republicans are very willing to support some sort of program for long-term care, but it must be one which is sustainable and fiscally responsible. And Congressman Shimkus, my colleague from Illinois said, but if we would like to work on Medicaid dollars following the individual and not incentivizing institutional care, and freeing up the disabled to choose the areas where they want to live and how they want to live, I am willing to work with you. That is the kind of conversation that we need to have. Because the status quo, does it not, Ms. Greenlee, say that we end up with the most expensive possible way to fund long-term care, and as you point out, the least desirable for most Americans?

Ms. GREENLEE. That is correct. If people have only the choice of nursing home care, it is the most expensive setting, and their least preferred setting. We need to explore all the options.

Ms. SCHAKOWSKY. In the time I have remaining, my understanding, and I think you just mentioned it about the 75-year solvency that you want, so are private long-term care insurance companies required to meet the same standards that the CLASS Act required? Are they required to be actuarially sound and financially

solvent for 75 years to ensure that those who pay for this insurance and who count on it most have access to long-term care services when they need them? The way I see it, so in other words, in the status quo now, if you have long-term care insurance, you pay all the way, and then somehow the company disappears, there is no recourse. Am I right about that?

Ms. GREENLEE. Congresswoman, of course the rate setting for the private long-term care insurers would be handled at the State level. So I can't answer your question specifically with regard to the length of time. You mentioned 75 years. Certainly as a former insurance regulator, I can tell you they are required, when they seek approval, to demonstrate that their models are actuarially sound. I can't give you the specific State by State or the length of time.

Ms. SCHAKOWSKY. And is that by law?

Ms. GREENLEE. Yes, it would be the individual State laws.

Ms. SCHAKOWSKY. OK. It seems to me that we have, at hand, a number of things that are in the CLASS Act that we don't want to repeal it and throw out every single piece of the CLASS Act, and that we need to continue to have this conversation. How do we do that if the CLASS Act is not implemented? How do we go forward?

Ms. GREENLEE. I believe that, as I mentioned to Congresswoman Christensen, we have learned a lot from the investment that we have made. And now is the best opportunity that we have possible to talk to as many different people from every sector, to share with what we have learned, and figure out if there is more solution that people want to explore from Congress with CLASS, if there is other kinds of proposals that would meet this need. That this is the time to broaden our approach rather than to narrow it. The need continues.

Ms. SCHAKOWSKY. Let me just say from 1985 to 1990, I was the director of the Illinois State Council of Senior Citizens. And the number one issue that we were dealing with then was long-term care and the failure of our country to have any kind of policy that made it possible for people to live their lives in dignity and get the kind of care that they needed, persons with disabilities and all of those of us who are going to age, we hope. And I think the time is long past that we do that. Thank you.

Mr. PITTS. The Chair thanks the gentlelady, recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes for questions.

Mr. LATTI. Thank you, Mr. Chairman. And thank you very much for appearing before us today. I really appreciate you being here and hearing your testimony today. If I could just go back to our last hearing, one of the things that I had asked, and this was a statement that was in your testimony at that time, you said President Obama and Secretary Sebelius have acknowledged the CLASS program needs improvement. Many of the changes proposed to the Senate health reform bill that would have improved the CLASS program's financial stability were not included in the final legislation reflected in the Congressional Budget Office assumptions that scored the CLASS program. If I could, I heard you a little bit earlier, if I understood it correctly, that about \$5 million has been spent on the CLASS to date. Is that correct?

Ms. GREENLEE. That is correct.

Mr. LATTI. From the time of our last hearing until, I believe it was October 14, do you have any idea how much of that \$5 million was spent in that period of time?

Ms. GREENLEE. I would have to go back and break it down. Our expenses, they were primarily staffing.

Mr. LATTI. But it is still \$5 million of taxpayers' money. What was the date that it was actually determined that the CLASS Act could not go forward?

Ms. GREENLEE. I don't have a specific date. The final report was October 14. So it was—

Mr. LATTI. Wasn't there something before that that somebody had to make a determination before the 14th? Before October 14, didn't there have to be a determination?

Ms. GREENLEE. We received the final report from Mr. Yee on September 20, began working on the comprehensive Department report, including finalizing the legal analysis. I can't give you a specific date, but because we produced the report on the 14th of October, I would say earlier this month, the Secretary made her final decision so we could prepare a report to present to you.

Mr. LATTI. OK. Let me ask this either to either one of you. On page 14 of your report you say that HHS contractor ARC began preliminary modeling of CLASS in late 2009. Did the CBO see the preliminary work from ARC?

Ms. GREENLEE. I am sorry, would you just said that again?

Mr. LATTI. Did the CBO see the preliminary work of your contractor ARC, A-R-C?

Ms. GLIED. I was not there, but I doubt it. I don't know. I can get back to you. I don't think so.

Mr. LATTI. You say you don't think they saw it?

Ms. GLIED. It would be unlikely that they would, but I wasn't there, so I could get back to you on that.

Mr. LATTI. OK. If I could find that out, because my question would be why didn't CBO see the report? OK. Let me just go on. Following passage of the ACA, ARC began to systematically review previous assumptions and premium calculations for accuracy, and made major revisions to the model. Question. Whose previous assumptions and premium calculations were reviewed?

Ms. GLIED. So ARC had a long-term care insurance model that they had been using for other purposes. And I think, I am not actually sure exactly what purpose, some State programs, I believe. And we didn't have any model in house, so we asked them if we could use that model, they could use that model to do some preliminary technical assistance for us.

Mr. LATTI. OK. If I may, did they find any problems as they were doing their calculations, do you know?

Ms. GLIED. So at the end of the day—they revised their model comprehensively. And at the end of the day last June, we had a technical expert panel that reviewed both their model and a separately contracted model with Avalere Health, and actually pronounced that the parameters were pretty good, in their view.

Mr. LATTI. Let me go on, if I may. On page 12 of your report you state, that by April 2010, it became clear that existing actuarial models that had been used before enactment of the CLASS Act would be insufficient to provide CLASS estimates, and new

models would have to be developed. Which models were insufficient?

Ms. GLIED. At that point we only had the ARC model. And I think we had the ARC model—

Mr. LATTA. I am sorry, could you say that again, please? Which model?

Ms. GLIED. At that point we had the ARC model. And that was the one that needed revision. I am not sure, I think Avalere might have done something already. I am not sure.

Mr. LATTA. Do you know why they were insufficient?

Ms. GLIED. Well, one of the reasons that we have come to realize is the challenge of a program like CLASS is actually in the details of the program. And those models didn't have enough granularity to capture all the details of the program.

Mr. LATTA. Let me ask this: Did anyone warn the Secretary that the models were insufficient? Was the Secretary brought into the loop?

Ms. GLIED. We were doing modeling. I don't know that we ever told her anything—I mean, modeling is an iterative process. You are always improving the models. The actuary's office improves their models all the time. We were doing it too. I don't think it would have been a special conversation.

Mr. LATTA. So what you are saying is she was not informed of this?

Ms. GLIED. There wasn't some fatal flaw in the model. We were improving the model consistently over time. I don't think we briefed her on that.

Mr. LATTA. Thank you. Mr. Chairman, my time has expired, and I yield back.

Mr. PITTS. The Chair thanks the gentleman, and recognizes the gentlelady from Florida, Ms. Castor, for 5 minutes.

Ms. CASTOR. Thank you, Mr. Chairman. And thank you both for being here today. And I would really like to urge my colleagues to use this as an opportunity for all of us to work together to tackle this very daunting challenge of how we can become smarter in addressing the long-term care needs of American families. Our goal really should be to work together to design better solutions, and not give up. I mean, we have this, under the CLASS Act, this voluntary initiative, not based on taxpayer dollars, but on the health care dollars of American families. It faces some challenges. The Department doesn't have all the authority it needs to make it work.

Fortunately, we have leaders like Frank Pallone and John Dingell who have been at this for some time, and I can tell from their remarks today they are not going to let us give up. And really that should be a call for all of us to work together, because the demographics are daunting, particularly coming from the State of Florida.

I am going to borrow Patrick Kennedy's language of a demographic tsunami because here comes the baby boom generation. And if we don't get in front of this, he is absolutely right, we are going to be paying on the back end on Medicaid. And that is not entirely smart. In the State of Florida alone right now, we already have \$3 billion of our State budget that goes to long-term care. And we have heard a lot of testimony today, and I know my colleagues

appreciate this, that that skilled nursing is very expensive. It is necessary for many who are disabled who need that. But let's turn this system around and begin to invest maybe a portion of those dollars, and I know we have had testimony that we are doing more on in-home care and providing families with the tools they need so that their family members can stay in the home at a much more cost-effective rate. But we can't just play ostrich on this and turn it into a political football and say this isn't going to be a problem. We have got to work together constructively to address it.

And just, if we can, come up here in the near term with some other plan of action to give families this modest bridge to be able to live their lives in dignity when they are disabled or elderly, that would be the best-case scenario. But I am concerned that it has been turned into a political football because some of my Republican colleagues on the committee released a report last month that made some very alarming allegations, charging that the administration ignored and silenced the HHS actuary when he raised concerns about the financial viability of the CLASS program. And Ms. Greenlee, I would like to provide you with an opportunity to address those allegations head on.

In the report that was released in September, the Republicans published a series of internal CMS emails describing concerns that the actuary and other CMS staff had about the financial sustainability of the CLASS program as it was being drafted. But that didn't strike me as unusual in the legislative process. Is it unusual for these kind of concerns to arise as legislation is being drafted and debated?

Ms. GREENLEE. Congresswoman, as Secretary Glied and I have testified, we were, neither one, at the Department at the time the bill was being considered. But the work that you are referring to did occur in the Department section that she leads. So if I could have her respond to kind of the pre-decisional pre-passage issue.

Ms. GLIED. Mr. Foster's actuarial analyses were actually publicly released. They were posted on HHS's own Web site. They were widely reported in the news media. They were discussed in Congress. He was in no way silenced.

Ms. CASTOR. And is it unusual, you all have been around the legislative process for many years, is it unusual that during the debate over legislation, there are discussions over financial viability of certain programs and that changes are made?

Ms. GLIED. Not at all. There is frequently robust and vigorous debate around programs. And I think as the Congresswoman from Illinois pointed out, in some cases, especially with novel programs, the CMS actuary and CBO can have very, very different estimates, which was the case in this situation as well, where the CMS actuary had one set of assumptions, and the assumptions at CBO were different. That is not at all unusual.

Ms. CASTOR. Did you all review that report that my Republican colleagues sent out? It struck me that there were a lot of unfair allegations. I think they understand the legislative process just as well as we all do, and they understand that legislation changes as it is drafted. Do you have any other comments on that report?

Ms. GLIED. So I think it is also important to note that the CMS actuary released those reports over time, and there were changes made to the CLASS Act over time in response to his concerns.

Ms. CASTOR. Ms. Greenlee?

Ms. GREENLEE. No, nothing further.

Ms. CASTOR. OK. Well, I just wanted to allow you all an opportunity to address that. Because, you know, in the legislative process changes are made, updates, financial reviews are a natural part of the legislative process. And I thought their allegations that something untoward was happening because changes were being made simply was not accurate.

And again, I really want to urge everyone to work together to address the real challenges facing every family across America, and urge us all to develop some solutions for the elderly, folks with Alzheimer's, the disabled, and how they are cared for in a dignified, cost-effective manner. Thank you.

Mr. STEARNS. [presiding.] Thank the gentlelady. Mr. Guthrie, the gentleman from Kentucky, is recognized for 5 minutes.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you for coming today. It has been good testimony, I think. I have enjoyed listening and trying to learn more, because I do think we have a long-term care issue that we are going to have to address this in country, and what it is doing to families. But one thing first, Secretary Glied, when you were talking with Mr. Green from Texas, he went through a list of benefits. And I think I heard, I am not sure that I heard, but I think it was like the policy, you are 26, preexisting conditions for children, and the end of the caps, that that hasn't been reflected in premiums? Did you say premiums haven't increased?

Ms. GLIED. I don't think I spoke to premiums at all.

Mr. GUTHRIE. He said something about WalMart and premiums. That is what I wanted to clarify, that those mandated benefits, you didn't say they haven't reflected premium increases in the private market. I thought I heard him say something about WalMart's premiums.

Ms. GLIED. I don't think I said anything about that.

Mr. GUTHRIE. OK. OK. I just wanted to clarify then. All right. So the issue isn't whether or not we want people to have long-term care insurance, it is the issue of how you pay for it. And that was concerning if you look at different things in the health care bill, that people were paying into this program for 5 years, and that was just going to offset other costs in the health care bill before it was going to be recouped on the back end.

And so my concern, as you look into the third decade, this is just kind of overall, it showed that this was going to be an unsustainable program, which I appreciate you all making that declaration and saying we can't go further with the way that we have. I think that was the right way to go. Because I am 47, my daughter is 18, she will be 48 in 30 years. And 30 years, if you look at all the CBO projections if we don't change, is when 100 percent of Federal revenues will be Social Security, Medicare, and Medicaid.

And so if you are putting a new policy in place, which you are not doing, I understand that would be unsustainable, that was the

concern that a lot of us were raising. It is not that we are gleeful that we are not going to have long-term care insurance. And that is not the case at all. But if you create a program that people pay into that is not sustainable, and they believe they are going to get a benefit in the end, and then we are here 30 years from now, or somebody that follows me is trying to make it balance and trying to take benefits away from people with plans, we do have to come up with a way that is sustainable that people know the money is going to be there when they get there. Because I think Secretary Greenlee, you said that you were in Kansas? Is that where you were the insurance commissioner?

Ms. GREENLEE. The Secretary was the insurance commissioner. I was her general counsel.

Mr. GUTHRIE. OK. When you were in the insurance commissioner's office, that you make sure plans are sustainable before you approve a private plan. And I think that is probably what we got into with this, is that unless you can mandate people purchase at a young age, all the different things, there is no way to make it affordable. Or it didn't appear like you could come up with a premium that you would consider affordable, given the conditions that you had. That is kind of what drove the final decision?

Ms. GREENLEE. Yes. There were three factors at play that we kept circling as we made the final decision: An actuarially solvent program or plan that we could market so that there would be take-up rate that complied with the statute that was passed and the intent of Congress. And we needed all three of those factors to line up together in order to be able to move forward, and could not find the right alignment of those three.

Mr. GUTHRIE. But when you mandate benefits—I am from Kentucky, and was in the general assembly. And we always wrestled with benefit mandates to the insurance policies, health insurance particularly. And as you allow more coverage, which everybody wanted, you also drove up the price, which left more uninsured. And so I think you saw—and you are an expert at this, in wrestling with how to come up with the proper benefits versus the costs, that that is another thing that, at least from my perspective and some of the health care benefit—the laws with benefits, one of the things we mentioned is that is going to drive more and more people, or make health insurance more unaffordable. Because I do think premiums—I am not sure what he said about WalMart. I am sorry if I implied that you said that. But I thought I heard a discussion with what he said about WalMart's premiums.

But that is the problem that we look at. And it is what Representative Kennedy said, who is going to pay in the end? And it is a question of who is going to pay. And as we drive up insurance policy rates, that is my concern. More people are going to fall out of the market, therefore they are they are going to end up in the exchange, and it is going to be a more expensive bill on them than we think. But you all have had a forthright conversation. I appreciate you coming here and sharing what you have done today. I have 20 seconds. Mr. Burgess, you are looking for 20 seconds?

Mr. STEARNS. Dr. Burgess, we are going to do a second round here.

Mr. GUTHRIE. I will yield back.

Mr. STEARNS. You will yield back. OK. We will keep moving Mr. Griffith from Virginia is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. Your report says on page 12, "By April 2010 it became clear that existing actuarial models that had been used before enactment of the CLASS Act would be insufficient to provide CLASS estimates, and new models would have to be developed." I am guessing that, based on the report, that the new models would be all of the things other than the basic model. Is that correct? Looking at the report, there were like seven or eight different models that were looked at. Is that not correct?

Ms. GLIED. I just want to clarify two things. The word "model" is used in two different ways in the report. And I think the way that you are referring to it is talking about an actuarial model, which is like a mechanical Excel spreadsheet sort of thing, whereas the plan options, those were developed over the full 18 months.

Mr. GRIFFITH. All right. I guess what I am trying to get at is that you all developed over the 18 months you spent a sum of money, what did I hear, about \$5 million working on putting together these various options. And I heard you say earlier that the full, and I am speaking to Secretary Greenlee, that the full legal opinion wasn't known until fairly recently. I guess I am wondering why you would pursue models, referring to options, why you would pursue options that you hadn't had fully cleared as to whether or not those options would be legal under the bill?

Ms. GREENLEE. I had addressed this briefly in a prior question, that as the Assistant Secretary said, we had to build the models based on the law that actually passed, not on iterations that were there before. And after those were built, we started with the basic design of the law. And then knew, because those premiums were so high, that we would need to make adjustments.

As we began surfacing ideas of possible adjustments, we did engage with counsel internally to talk to them about what our ideas were, and continued to talk to them until the final product. The final product is the culmination of all of those different ideas pulled together in one place for final analysis. But we did need to consult with counsel about things that were very important to us. What is absolutely prohibited? No underwriting. It must be cash. Some of those things are well known. Where might we have some flexibility or discretion so we could do additional work. It was a dynamic process that involved various experts within the Department to come to a final conclusion, and over a course of time.

Mr. GRIFFITH. But at least some of those things, I know that some of them are questionable, but some of those things, in reading the report, legal counsel says, well, there is no authority at all for the Secretary to do that. I am just wondering why that some of those options would have been pursued even for a brief period of time if there was no legal basis in the statute for them.

Ms. GLIED. I mean both of these things had to happen. We had to figure out whether it would be solvent, and we had to figure out whether it was legal. So sometimes we figured out whether it was legal before we figured out whether it was solvent, and sometimes we figured out whether it was solvent before we figured out whether it was legal. Both of those tasks had to be completed. And so

I am not sure why it would have mattered which way we went at it.

Mr. GRIFFITH. Here is why it matters to me. If it is not legal and you make that determination first, then you don't spend the money finding out whether they are solvent.

Ms. GLIED. Once we built the model—it costs money to build the model, which allows to you test many different things. Once you have the model, it costs almost nothing to test a different option. So it makes fiscal sense to do it in the direction we did it.

Mr. GRIFFITH. All right. Having asked that, earlier—I forget which one of you said it, and I apologize for that—you said that you didn't have some of the tools that were available to the private sector. What tools that are available to the private sector did you not have that you would have liked to have had?

Ms. GREENLEE. I can respond. I can't respond in saying I would have liked to have had them. I mean, the primary difference that is generally known is that the private sector uses underwriting, which was not available to this program. They have a mechanism, by doing so, to address adverse selection that was not available as we developed the CLASS program. So we needed to look for other types of options to deal with adverse selection. And that is reflected in the various ideas that we have about different models. That is, and there may be others, that is the clear distinction between what the private market can do and what we could not.

Mr. GRIFFITH. All right. And because of that, doesn't it make some sense to go with the option that the doctor mentioned earlier in regard to having private pay long-term care be paid for with pretax dollars or allowed to use your medical account? Doesn't that make sense? Because it looks like even though the products are substantially different, and I understand that, it looks like that the government can't compete with the private sector because you have to take on so many people. I understand that. But wouldn't it make sense then to enhance the ability of the private sector?

Ms. GREENLEE. As we move forward with more conversations and pull insurers in, I think a component of that is, with support, what could the private market do? But because they use these mechanisms, like underwriting, they will never be able to, with that mechanism, serve all of the people that CLASS was designed to serve. So not everyone will be taken care of. I don't know better how to say that. So we need to move forward on multiple options, coming back to who are we trying to serve and what is the best solution for those individuals. It may not be one thing for every single person. There may need to be different options.

Mr. GRIFFITH. I yield back.

Mr. STEARNS. I thank the gentleman. Dr. Cassidy is recognized for 5 minutes.

Mr. CASSIDY. Thank you, Mr. Chairman. Really the question, one, everybody agrees we need to come up with a solution for the problem of long-term care. I don't think any of us argue that. But as a physician who works in a public hospital caring for the uninsured on the receiving end of poorly planned programs enacted by posturing politicians, a nice alliteration there, I am aware if we don't come up with something sustainable, we end up worse off.

Now, clearly, this was not sustainable. Secretary Sebelius's letter said that you ended up testing premiums of \$3,000 a month, and still clearly it was not sustainable if you are looking at that. The question before us isn't whether or not we need to do something about long-term care. We all agree. The question before us is whether or not the American people were almost duped into thinking that this was \$70 billion of revenue that folks, reasonable folks would have assumed not. Now, that is the question before this committee. Now, I note—and by the way, this is more than just a partisan issue. I am looking here at a book, *Fresh Medicine*, by Phil Bredesen, Democratic former Governor of Tennessee, which goes on to say in our government it is as important to have honest work presented to the American people.

He goes on to say the CLASS Act is a great example of how that was not done. Now, this is a Democrat casting aspersions upon this. Now, that said, it is clear, as you mentioned, before the CLASS Act was passed that there were concerns. I note that Ezra Klein recently—Ezra Klein, the liberal—recently had a blog in which he said the administration was concerned that the CLASS Act was not fiscally sustainable. As Secretary Sebelius points out in her testimony, or in her letter, even before PPACA was passed, there was concerns regarding the CLASS Act's fiscal responsibility. You point out that actuaries were there. Frankly, the fact that Klein is saying that it was internal debate in the administration and the Secretary is acknowledging concerns, Paul Ryan pointed it out in February of 2010, why did the administration insist that this was fiscally responsible? Why does Phil Bredesen have to write a passage in his book saying this is a great example of how the American people were deceived in terms of how an important bill was financed?

Ms. GLIED. Sir, we had every reason to believe it was fiscally responsible when we moved forward. And indeed, it was fiscally responsible. After we did our analysis—

Mr. CASSIDY. Wait a second. We just heard from your associate that without the ability to medically underwrite, that inevitably there would be anti-selection, as Mr. Foster said, and that you would end up with something without an individual mandate would not be sustainable. Now, this was a first-pass read. You are telling me, you are telling me now that the very construct of it meant that it was unsustainable. So tell me why, in retrospect, it was sustainable.

Ms. GLIED. Actually, if you—first of all, there was considerable differences of opinion at the time that the legislation passed about whether it was possible to make this model work. But at the same time—

Mr. CASSIDY. Let me ask you, your colleague, I don't mean to interrupt, but we have kind of been covering this, and yet when I hear your testimony, that without the ability to have an individual mandate and without the ability to have a medical underwriting, it is a nonsustainable model.

Ms. GLIED. Actually, our report shows that there are sustainable models that don't have medical underwriting and that don't have an individual mandate.

Mr. CASSIDY. OK. What I read from Sebelius is that you had to test premiums up to \$3,000 a month.

Ms. GLIED. That was not one of those, but there are eight options in there.

Mr. CASSIDY. And that the only way it would be sustainable if premiums were less than \$100 a month, I am reading your material, and yet it could not be done for anything less than \$300 a month.

Ms. GLIED. That is not the case, sir. If you read our report, you can see that some of those options would have been actuarially sustainable, but they were not viewed as being—the legal counsel informed us they were not consistent with the statute. That is not the same thing as saying that it would be impossible to do this.

Mr. CASSIDY. Now, Mr. Foster apparently knew this before the bill was passed. The Moran report said the only way it worked basically is with an individual mandate. Others were pointing it out. It was kind of a critical issue to come to the answer that was apparent to so many so long after the fact. Again, going back to what Bredezen says, this really is a concern regarding how honest we are with the American people.

Ms. GLIED. As Joe Antos testified before this committee—

Mr. CASSIDY. I am sorry, I didn't hear you.

Ms. GLIED. Joe Antos testified before this committee last March, and he pointed out the difference between the CBO and CMS estimates of the cost of this bill. And he noted that that was a good reflection of the tremendous uncertainty—

Mr. CASSIDY. CBO actually said, though, it was only sustainable in the first 10-year window because you didn't pay—you collected premiums for the first 5 years. And so that was clear that their \$70 billion-plus was only because they could only grade for the first 10 years. It is a little disingenuous to suggest that they thought that long term that was a viable model.

Ms. GLIED. They made a projection that it was—I believe they made a projection it was fiscally sustainable.

Mr. CASSIDY. No, they did not. Would you show me that? I don't mean to be rude, but please, if you can show that to me, I don't see evidence for that.

Ms. GLIED. I will have to follow up, because I do not have the CBO analysis memorized.

Mr. CASSIDY. Let me ask one more thing. I am out of time. I apologize. Thank you very much. I didn't mean to be hostile, but it is such an important issue, and again, the American people frankly do feel duped. I yield back.

Mr. STEARNS. The gentleman yields back. Mr. Bilbray from California is recognized for 5 minutes.

Mr. BILBRAY. Thank you, Mr. Chairman. Mr. Chairman, let me just say this to my colleagues on both sides of the aisle. I hope that we address this issue and remember the bigger picture here. As somebody who just went through 25 years of home services to a grandparent, and then my mother who just passed away, I think we have got to remember that people like Mr. Pitts talks about the family unit being essential in this Nation, we talk about it like it is an abstract.

Here is a situation where family units really do matter. And the breakdown in those family units are creating crises not just for the individuals in those families, but also the community at large. And so maybe when we talk about how important the family is, we remember it is just not an abstract, it is dollars and cents and quality of life. And maybe we ought to be reminding all of us that we have just as much responsibility to take care of our mother and father in their later years as they had to take care of us in our early years. And we approach that as being some strange antiquated concept. And that is why I always remember be nice to your children, they are going to choose your retirement home. And hopefully, they won't choose a retirement home, they will allow you to live like I did.

I moved in with my—actually, my wife and I moved in to take care of my mother as part of a not only a responsibility, but a privilege of being a child. That aside, addressing that, Ms. Greenlee, don't we have the answer to this problem right in front of us? And that is all we have to do, rather than suspend the program, is go back to the basic assumption that all we have to do is mandate that every able-bodied young person in this country pays \$100 to \$200 a month and we can finance this program, be able to guarantee the program within 75 years?

Ms. GREENLEE. Congressman, if I could make two points. What you described with your family is actually very typical. In addition to running a CLASS program, of course, as the Assistant Secretary, I know that 80 percent of long-term care is still provided by family members. We did not have the option, it was clear to us in this law, that mandates for individuals or employers were not options.

Mr. BILBRAY. But Congress does have the option of revisiting, if we maintain this program and not put it on ice, if we do not eliminate it, Congress does have the option to go back and revisit this and modify the law to allow or to require that every able-bodied person in the United States be required to contribute a portion of their salary, \$100 to \$200, to guarantee this program will be available whenever they need it.

Ms. GREENLEE. Well, of course, if Congress passes a law Congress can revise the law. I don't want to make a commitment on any particular revisions that you may consider. That is why I believe we need to all keep talking. It was clear to us that a mandate was not an option, and it is not something that we have developed or pursued in any way.

Mr. BILBRAY. Wait a minute. When you said that, when you say that it was not an option, the issue was the law didn't allow that option. But I will allow you to jump in on this. Then that was the law, the law limited you there. Why wasn't that identified as being the Achilles heel in this before we were asked to vote on this legislation, before we were asked to assume this huge amount of revenue generation? Why wasn't that up front that this was a desperately needed mandate if you were going to have the system work?

Ms. GREENLEE. As we both testified, we weren't at the Department when the debate was happening. In the conversation about adverse selection the reason why that conversation was so important, regardless of perspective, is that this is a voluntary program.

So adverse selection is different. You must overcome it with large participation, how to achieve large participation if there is no mandate. All of those components work together. They can't be separated.

Mr. BILBRAY. I don't understand, though, the big picture of the law. This is one small section, but it was a huge part of the savings. The rest of the bill was built on the assumption that if you mandate every able-bodied person in the United States to participate in a program, there will be such huge savings, and now—and then we were sold that this small little side one was not going to have the mandate that the rest of the program had and was going to be 50 percent of the savings. That doesn't sound like somebody really doesn't follow a continuum of thought and reason. It's sort of going over that the great secret of the Affordable Care Act was mandate everybody had to play and participate and pay in except for a part that was 50 percent of the savings.

Ms. GREENLEE. It was voluntary. That is correct. I can't be more responsive than that. That's different from other sections of the law. This law always was designed to be a voluntary program.

Mr. BILBRAY. Do you think that that was a reason why it had to be put on ice is because you don't have the mandatory revenue flow to be able to support the long-term commitment.

Ms. GREENLEE. With the voluntary program, the key to participation is having a price that will sell in the market so you can get high participation. And that's the way to achieve the law of large numbers.

Mr. BILBRAY. Wouldn't a mandate eliminate the problem if we just mandate that able-bodied people had to pay into a requirement and eliminate the voluntary program?

Ms. GREENLEE. I can't take a position on a specific change because we've not identified specific changes. You can certainly go back and look at the problems that we have identified, and then have a conversation about which of those might be the most approachable, but we have not done that. We knew that this was not something we could pursue.

Mr. BILBRAY. Thank you very much, Mr. Chairman. I would just point out there is an answer here. It is an answer that nobody wants to talk about. And we should be up front. The mandate could avoid this problem, but it also eliminates the selling point for the program. I yield back.

Mr. STEARNS. I thank the gentleman, and I would say to our witnesses we have a few more people with questions. We appreciate your forbearance here. So we are going to go a second round. There is a few of us who would like to ask questions. So we should be through shortly. So I will start with my questions.

Secretary Glied, and I guess also Ms. Greenlee, the question is, our investigative report from September 15 uncovered e-mails in which the Health and Human Service staff discussed the possibility of using employer mandates to make certain employers offer enrollment in the CLASS program. Is that an option you are still considering, yes, or no.

Ms. GREENLEE. No. It was never considered.

Mr. STEARNS. Dr. Glied?

Ms. GLIED. No.

Mr. STEARNS. Was this option discussed among the people modeling class and drafting its regulations ever?

Ms. GREENLEE. No. In the draft regulation, it is always very clear that this was an option for employers and employees both. We never pursued a different path.

Mr. STEARNS. And during and after the bill passed, you never discussed that? Yes or no?

Ms. GREENLEE. No.

Mr. STEARNS. Dr. Glied?

Ms. GLIED. I never discussed it.

Mr. STEARNS. You never discussed it. Did your staff ever discuss it?

Ms. GREENLEE. I am not aware of any discussion that took place. I think there was a working group. I don't know what they talked about.

Mr. STEARNS. Did Secretary Sebelius ever talk to you or do you know if she understood that discussing employer mandate as an option for the CLASS program?

Ms. GLIED. I don't believe she did.

Mr. STEARNS. You say no?

Ms. GREENLEE. I have no other reason otherwise.

Mr. STEARNS. Let me read an email to you that we actually have. It is in the book here. HHS explain this in December 2009. "One possible alternative is to move to a mandated offer approach where employers over a certain size, for example, 50 employees, would be required to offer enrollment." Had you ever heard of that?

Ms. GLIED. Before I saw that that email went to you, I hadn't seen it at any other time, but I know that many, many options were considered as a robust policy.

Mr. STEARNS. Many options is one thing. But this is a distinct departure that I think many Americans don't realize—

Ms. GLIED. But we didn't pursue it, Mr. Stearns.

Mr. STEARNS. No, but I have an email that it is discussed here in an email.

Ms. GLIED. Mr. Stearns, we discuss all sorts of things all the time.

Mr. STEARNS. So your position is this morning that this was never, after the bill passed, it was never discussed in your opinion?

Ms. GLIED. In my opinion, it was not discussed after the bill passed. The bill did not include a provision for an employer mandate.

Mr. STEARNS. Ms. Greenlee, is that true that it was never discussed by you or anyone else?

Ms. GREENLEE. It was never discussed unless it was inapposite. We don't have this option, so we must do this instead. It was never a viable option to us once the bill was passed. It was always very clear that we were working with a program that was voluntary. To the degree that it was discussed, it was discussed as a door that was closed to us, not something that we could pursue.

Mr. STEARNS. Let me just ask—I have a little extra time here and just talk to you a little briefly. I am a little concerned in our discussion about Rick Foster and his release of his analysis which came after the bill was passed. I think many of you were aware of

his concern before the bill passed. And then coincidentally, almost 30 days after the bill passed, his analysis came.

Did you or anyone on your staff, either one of you know about his analysis, shall we say, he projected in 2025 that expenditures would exceed premium receipts. Did all of you know that from his analysis? Did you read and fully understand that?

Ms. GLIED. He made various analyses. He published them in December of 2009. He published several before the bill passed. He also published a comprehensive analysis of the entire bill after it passed. That is what I think you are referring to.

Mr. STEARNS. I think his analytics were not that definite back before the bill passed. It just seems coincidental to us that what he projected for 2025 were the expenditures would exceed premium receipts was clear, but it came 30 days after, and the question would be, did anyone on your staff know about this analysis before April 22, 2010?

Ms. GLIED. Before he published it? No. I don't believe so.

Mr. STEARNS. So part of his concern, never a draft of this before was ever provided?

Ms. GLIED. He had expressed many concerns. He had not shared the last analysis he did with us before he published them. He certainly vocally shared his concerns with many people.

Mr. STEARNS. In your opinion then, Rick Foster was not asked to hold off his analysis publishing?

Ms. GLIED. Not only was he not asked but he actually responded to a reporter and said he was not silenced in any way.

Mr. STEARNS. OK. Well, it is obvious if we had his analysis before the bill passed I think that would have had a big impact.

Ms. GLIED. He didn't have that analysis either, that April analysis wasn't done until after the bill was passed. It was actually reflecting what was in the bill.

Mr. STEARNS. On April 22, barely after a month the bill passed, he released this report saying the CLASS program projected savings are due to the initial 5-year period during which no benefits would be paid. Over the long run expenditures would exceed premiums, receipts, and he projected in 2025 expenditures would exceed premium receipts.

Ms. GLIED. He disagreed with CBO. He had a very different estimate.

Mr. STEARNS. OK. My time has expired. And with that, the gentleman from Pennsylvania, Mr. Pitts.

I need to go to a Democrat. I thought you told me you folks didn't want to participate. But if you want to, we are very glad to have you.

Mr. PALLONE. Mr. Chairman, you asked if we wanted to have a second round. We said no. But that doesn't mean if you have one, that we don't speak?

Mr. STEARNS. Absolutely, you get every opportunity. We recognize the gentleman from New Jersey for 5 minutes.

Mr. PALLONE. I think part of my problem here with the panel is that I just disagree with I guess HHS counsel or whoever is advising you both with regard to the CLASS independence advisory council and also with regard to what authority you have under the law. So maybe at some point, I will have an opportunity to meet

with the counsel and talk to them, because I simply disagree with whatever recommendations they are making.

Secretary Greenlee, you said that because you suspended implementation of the CLASS program, that the council could not be appointed. But in the statute it says the CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration, and I stress “in the administration” of the CLASS program, and then it talks about the various categories of the administration.

So it doesn’t say that they are only there for implementation once you decide that the program is sustainable and can be implemented. It says in the administration. So you are still administering the CLASS program. So why would you say that the council couldn’t be involved in the administration and the development of the benefit plan and the determination of monthly premiums and the financial solvency.

It just seems to me that precluding this council which exists under the law is wrong, and I don’t understand if they are supposedly involved in the administration, you are still administering the program, why they can’t be convened?

Ms. GREENLEE. Mr. Pallone, this is similar to the concern you raised earlier. I am willing to go talk to the Secretary about your concern. Like I said, she has been very clear that we have suspended implementation of the CLASS Act. The only item that is in the CLASS Act that we will continue to work on is what I have referred to as the long-standing, long-term care awareness campaign. So to the degree that you are talking about—

Mr. PALLONE. I understand what you are saying.

Ms. GREENLEE. I don’t want to be contrary to what the Secretary is saying. I will take to her your concern.

Mr. PALLONE. My point is that it seems that since you are still administering the program, there is an obligation to start this council and get it moving. I would ask and you have now said, and I appreciate that, you will go back to the Secretary and ask that, because that is one way for us to look at alternatives and keep this alive.

Now, the second thing is, I know that Ms. Glied mentioned the models that were outlined in the report and there were several that I think you said in response to some of my Republican colleagues that were sustainable, but for legal counsel saying there was insufficient authority. Now again I disagree with the legal counsel about the sufficiency of authority.

But could you tell us, in terms of those models that you outlined were sustainable, was there one or more that you felt were preferable, that you thought would be the most sustainable, if you, in fact, had the authority and the council said you had the authority, leaving that aside for the time being, what would you have recommended? Which one of those would be best, or maybe talk about one or two that would be best, because we are not even getting that opportunity now, if you would. Just tell us a little bit about one, and if there is one that you think was better, or one or two that you think would be better than the others, I would like to know what you thought.

Ms. GLIED. Several of them looked like they might be actuarially solvent, they usually had many changes from the natural language of the statute, generally increasing the earnings requirement, altering the benefit design, phasing in benefits over time so that only some people could participate in the program initially. Those were all options that were incorporated in the programs that seemed to be more actuarially solvent.

Mr. PALLONE. Did the counsel ever explain why he thought there wasn't sufficient authority to move on some of these? Did they explain that?

Ms. GREENLEE. The report actually describes the legal opinion. I am not a lawyer, so I can't speak much more to it than what is in the report.

Mr. PALLONE. I think at some point if you could ask the Secretary, I would like to also meet with the counsel because I simply disagree with those recommendations. I think it can—that some of those options would meet the legal authority. If you could meet with the Secretary, I would like an opportunity to meet with the Secretary.

Ms. GREENLEE. I will convey your request, sir.

Mr. PALLONE. Thank you.

Mr. STEARNS. The gentleman yields back the balance of his time, and the gentleman from Pennsylvania is recognized for 5 minutes.

Mr. PITTS. Your report says that in December of 2009 and January of 2010, Senate staff asked HHS to begin developing a list of technical corrections to the bill. We have seen drafts of those technical corrections and none of your corrections made it into the final bill. Do you know why?

Ms. GREENLEE. My understanding is there was a procedural mechanism that allowed them not to be amended. But again, I was not here. I am telling you second-hand information. It was offered, but I can come back and tell you.

Mr. PITTS. And provide us the information, provide the committee the information?

Were the concerns of career HHS staff that were raised in 2009 and early 2010 over the sustainability of the CLASS program ever relayed to Congress prior to the passage of the PPACA?

Ms. GLIED. I am not sure exactly what you are referring to, but I believe the concern about adverse selection in the program that was raised by a member of the staff in the ASPI office, and that was the same concern that Rick Foster had raised many times in his published report as well. So that was a concern that had been very vocally voiced.

Mr. PITTS. That was relayed to Congress?

Ms. GLIED. I believe Mr. Foster published his reports and Congress was well aware of them and he actually raised exactly that point. So the concern about adverse selection had been very widely discussed prior to passage of the legislation.

Mr. PITTS. The recommendations, the American Academy of Actuaries, were these recommendations provided to Congress?

Ms. GLIED. I believe the American Academy of Actuaries published those recommendations, and they were discussed in the committee, I believe. I am not sure. I wasn't here.

Mr. PITTS. They weren't adopted, these technical corrections. Was your office ever given an explanation as to why these recommendations were not accepted?

Ms. GREENLEE. Again, Mr. Chairman, I will get back to you on that. My understanding is it was a procedural issue with regard to the offering of the amendment and not being able to move it. But we can certainly answer that.

Mr. PITTS. Your report said that "Many of the regulations related solely to operational aspects of the CLASS program have been drafted." Why did you have staff do the work of drafting regulations before you had determined whether it was possible, or it would be possible to implement the program?

Ms. GREENLEE. In order to meet the time line set out in the statute that the Secretary would designate a final benefit plan in October 2012, we needed to begin the initial analysis of how we would operationalize the program and do that at the same time as we were exploring the models and benefit designs in order to have a chance of being able to meet the statutory deadline. That is also very well described in the report that we, aside from the policy issues, needed to issue or look at potential regulations, how we would bill an assessment system, an IT system. These were the other functions that the staff were initially looking at as required by law in order to meet the deadline.

Mr. PITTS. Can you send us a list of the offices to which you forwarded, or the offices that received the technical corrections? Can you send us a list of those offices that received those from you?

Ms. GREENLEE. I want to make sure I am clear. Are we talking about the technical corrections to the statute, not the regs that you just asked me about?

Mr. PITTS. Yes.

Ms. GREENLEE. I will go find out. This is an area that I don't know. So I will tell you what I can about the procedural and how that was presented.

Mr. PITTS. You have talked several times, you have mentioned long-term care awareness campaign. I think we can agree that the long-term care market is a vulnerable one; as to the long-term insurance product is difficult to sell, and it can often be expensive and more commonly attracts the most sick.

Implementation of the CLASS program may have been a lesson for the Federal Government in how not to meddle with the private industry. What impact do you believe the mishandling of the CLASS program implementation and the suspension of all CLASS program activity will have on consumer confidence in long-term care insurance overall?

Ms. GREENLEE. Mr. Chairman, I do just note that I don't agree with the mishandling characterization, but I would like to be responsive. I believe that there is great opportunity through the long-term awareness campaign to continue to work with private insurers, and that the investment that we make to tell the American people about this issue benefits that private market, as well as the general public. So I don't find that there is a negative or chilling impact on the private market at all because of our studied look at the CLASS program.

Mr. PITTS. OK. Thank you, Mr. Chairman.

Mr. STEARNS. And the gentleman from Texas, Dr. Burgess. I am sorry.

The gentlelady from Colorado is recognized for 5 minutes.

Ms. DEGETTE. Here is what I have been sitting here thinking about as we have been having this discussion today, and I want to ask both of you your honest opinion about this.

My colleagues on the other side of the aisle have talked about kind of two ways we can help older Americans get, and also disabled Americans get long-term care. One of them is if we somehow do what I help my children do, which is have some kind of moral and familial responsibility towards aging parents or disabled relatives, and I think that is a noble hope that we would have, but not one—I don't think anybody in this room would think that we should legislate some kind of personal mandate that individuals provide those care responsibilities.

So then that leaves us with a second alternative, which is to try to encourage people to purchase long-term care insurance. And this is one thing that the agency is trying to do right now, but the issue with the long-term care market is two-fold. Number one, since it is not widely—since people don't widely take advantage of it, premiums are very expensive because only the more risky population is involved in this market. And the second problem is people with preexisting conditions under current law are excluded from that market.

So long-term care insurance solely through private insurance really isn't an option.

And then I get to the report that the Department prepared that said that the CLASS plan option is not going to be sustainable from an actuarial standpoint because it is not going to attract a broad enough population because of the high estimated monthly premiums. And also because it is not a mandatory program.

So as I sit here and think about what our options are, I guess I would ask the both of you to just tell me what you think we can do to enroll more people either in private insurance or some kind of insurance program because we do see, all of us, on both sides of the aisle, see this tsunami coming towards us, and I haven't heard any real good practical solutions suggested here in the last 3-1/2 hours we have been sitting here.

Ms. GREENLEE. Congresswoman, to me it makes sense to explore, if there is a way, for the private market to do more. I am not someone who is opposed to the private market. It will never solve the whole need. If there is things we can do and continue to talk to Congress about the private market, then we are certainly willing to have that conversation. But we must understand that there will be a group of people for whom that is not the right solution for a number of reasons, from affordability to preexisting conditions to the fact that that is a product that is different than what the CLASS product. It is comprehensive in the private market. CLASS is a more minimal benefit. We need to analyze how everything could blend together to meet the whole range of needs. And I think we are willing to have that conversation.

Ms. DEGETTE. Thank you. I yield back.

Mr. STEARNS. The gentleman from Texas, Dr. Burgess, is recognized for 5 minutes.

Mr. BURGESS. Let's keep on that same line of thinking. How do we enhance the availability of this type of insurance to the private market? I talked about tax consequences in my opening statement. Certainly in the Deficit Reduction Act of 2005, we expanded the partnership program so that those people who do spend their own money on their own private long-term care insurance product, if they outlive their benefit, which is rare, but if they do, then they don't have to spend down to get into the Medicaid program. I am oversimplifying it. But States now have the option of opting into that long-term care partnership, and I think that is certainly something if we want to work on the awareness side, to work on the awareness at the State level.

I do think, and Mr. Pitts brought it up again, I think the activities of the CLASS, the implementation of the CLASS Act, I think that has had, if not a chilling effect, at least caused some stagnation in the private market, because if I am working on a long-term care product or I have got one on the market, I am kind of holding back to see what you guys are going to do.

I would be interested to know did you ever talk with any of the larger players in this market to see if there was a way to also partner with those products that are already out there, those projects that are already offered?

Ms. GREENLEE. We are both nodding because we did.

Ms. GLIED. One of the options in the report actually includes an option for CLASS that would involve a partnership with the private market. So that was something that we did actively pursue.

Mr. BURGESS. What happens now in that, and again, I am concerned that the people that do provide this in the private market, again, they are going to be waiting for Congress or the agencies to do something, and they are kind of frozen in time while that happens.

Ms. GREENLEE. I was just looking at data on sales of long-term care insurance recently, it doesn't look like beyond the effects of the weak economy that there has been any particular effect of the CLASS.

Mr. BURGESS. Maybe it is a positive aspect for us doing the hearing today, and maybe someone out there will recognize that perhaps this is an activity that they should undertake for themselves.

Just a couple of things to tie up some loose ends we are getting asked from the other side. Losing half of the savings from the CLASS Act for the Affordable Care Act, but there were still savings. The savings, of course, come from Medicare cuts, certainly cuts in the Medicare Advantage program and the Home Health benefit that was cut in Medicare, the device tax, which is likely to be problematic for our device manufacturers, the changes in the income tax law where people have a lower deductibility of their actual medical expenses, the Cadillac tax, and then always my favorite, the tanning tax. And the recent evidence that the tanning tax receipts are lower than expected because people do behave in a rational fashion and if you tell them you are going to tax your tanning activity, sunlight is free and people will go that route.

On the issue of the premiums, and I have asked you for a premium range, I did find it in your HHS report, the premium range, \$235 a month to \$391 a month, this was under the assumptions

designated as scenario two, average premium of—for \$50 a day with the two-plus activities a day living trigger, that is a pretty stout premium for what really isn't a really long-term care policy.

So I can certainly understand that people would be reluctant to voluntarily opt into that program. That is going to be an enormous barrier to participation.

Now, the issue of pre-existing conditions came up, and honestly, I think the whole concept of the individual employer mandate for the CLASS Act would be wrong. But I honestly don't see how you get there without that because unless you coerce people to spend what is that multiply up to \$4,700 a year, unless you coerce that purchase, I can't see anyone in the world making that purchase, particularly when you can go to one of the large insurers and buy an individual policy, middle of the road as far as its benefits and get that for just a little over \$1,000 a year. on the issue of the independent advisory council, has that been named?

Ms. GREENLEE. No, sir.

Mr. BURGESS. Do you have a list of people from which you are expecting to draw, or were expecting to draw on their expertise to name for that?

Ms. GREENLEE. We had quite a number of people respond to the Federal Register notice. A final—a list was never finalized. We looked at those names when they first came in. I have not looked at them for a while.

Mr. BURGESS. You didn't have a preferred list of people that were going to be contacted?

Ms. GREENLEE. We had looked at the list. There are some specific requirements in the law that different interest groups or sectors be, I guess that is a better description, sectors be covered, but I don't have a final list that this was narrowed down to.

Mr. BURGESS. Do you think that if this program is unfunded, but still in existence, will you still proceed with naming those people?

Ms. GREENLEE. I just refer back to my conversation with Mr. Pallone. The Secretary said very clearly that we are suspending implementation of the program. We want to have a broad conversation with a wide range of individuals. I will carry Mr. Pallone's request back to the Secretary. I believe we can do that in a number of fashions. I don't know that she wants to set up an advisory committee when she has already said we are not going to move forward to implement.

Mr. STEARNS. The gentleman from Virginia, Mr. Griffith, is recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman, I appreciate that. A couple of things just in comment to some of the things that have been said. I notice that in reading the legal counsel's opinion that while they may have been conservative and there were areas where they were definitely said you can't go, they also had some of the options they said you might be able to make an argument, but I appreciate the fact they were conservative in the sense that they said, but it is clearly challengeable and if it goes to court, and the court rules that the program is not set up correctly, it could void the program. And that one of the options the court might have is to just say whatever moneys are not yet expended get returned to

the people who bought in, but obviously, a big chunk of the money would have already been expended.

So I do appreciate that because we have had some other situations in front of this committee where folks just charged in and didn't come back to Congress to get the legal changes necessary. And while we may agree or disagree on some of those legal changes, if we are going to go forward with something, I think it needs to come back to Congress. So I appreciate the legal counsel taking a position that recognizes the position of Congress. I did also notice that in one of the options, at least, there was a preexisting condition requirement that if you had a preexisting condition, you had to wait, I think, 15 years. Seems like an awful long time. And again, it is just, I recognize the Secretary's frustration because it is going to be hard to get there from here, even if we change some of that law.

I did note one thing in some of the notes that are in front of me, and that is, that it appears that ASP's analysis is that the administrative costs should run somewhere between 6 and 20 percent, with the code on after 3 percent. I would have to assume—would I be correct in assuming that that is part of, even if it is a small part, that is a part of what makes the financial models, the actuarial models not work is that there is not a large enough administrative component?

Ms. GLIED. It was a concern that the Federal actuaries raised when they met and reviewed the various options that the 3 percent was not going to be sufficient.

Mr. GRIFFITH. And then one thing that I might suggest that you all take a look at in various programs. I just came from the Virginia legislature about a year ago, and just before I left, I patroned a bill that allowed us to have Statewide zoning ordinances for med cottages. As we look at this issue and work together, this is a facility that you put in the backyard of a family member for somebody who has two tasks that they need assistance on for daily living requirements. It kind of is a mix for the person that doesn't have the ability to stay in their own home and their family member doesn't have room in their home. This gives you kind of a mix. There are certain requirements that are required by the Virginia Statewide zoning that we got through.

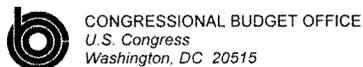
But needless to say, it brings jobs to Virginia because we are manufacturing these items. And it does it at a lower cost than a permanent assisted living facility can do and keeps the individual close to their loved ones. So I would recommend that maybe not on this program, but on other programs that you all keep that in mind or take a look at that as an option. As I understand it, North Carolina, with minor exceptions, adopted the Virginia law this year. It may be a way that we can save money and provide quality care for people, if not in their own home, at least in the yard of a family member. I thank you, Mr. Chairman, and I yield back.

Mr. STEARNS. And Dr. Cassidy is recognized for 5 minutes.

Mr. CASSIDY. Yes. First, for the record, I would like to submit the testimony from Richard Foster, I believe—from the CBO, at least—to Tom Harkin's committee dated November 25, 2009, and I think there was a little bit of an issue as to—

Mr. STEARNS. By unanimous consent, so ordered.

[The information follows:]



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 25, 2009

Honorable Tom Harkin
Chairman
Committee on Health, Education,
Labor, and Pensions
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In response to several questions that CBO has received, this letter provides additional information on the budgetary effects of proposals to establish the Community Living Assistance Services and Supports (CLASS) Program.

H.R. 3962, the Affordable Health Care for America Act, as passed by the House of Representatives, and the Patient Protection and Affordable Care Act proposed by Senator Reid contain very similar proposals regarding a new federal program for long-term care insurance. Both proposals would establish a voluntary program for such insurance, termed the Community Living Assistance Services and Supports program. The key difference between the two proposals is in the population eligible to enroll: H.R. 3962 would allow both active workers and nonworking spouses to enroll, while the Senate proposal would allow only active workers to participate. For both the House and Senate versions of CLASS, the Congressional Budget Office (CBO) estimates that the cash flows under the new program would generate budgetary savings (that is, a reduction in net federal outlays) for the 2010-2019 period and for the 10 years following 2019, followed by budgetary costs (an increase in net federal outlays) in subsequent decades.¹ Because participation in the program would be voluntary, collections of insurance premiums under CLASS would be recorded as offsetting receipts (a credit against direct spending).

On balance, CBO estimates that the version of CLASS specified in H.R. 3962 would reduce deficits by \$102 billion over the 2010-2019 period, while the version contained in the Senate proposal would reduce deficits by \$72 billion over that period. The following discussion provides additional information on CBO's estimates for those proposals, including information on their longer-term effects.

¹ See Congressional Budget Office, cost estimate for H.R. 3962, the Affordable Health Care for America Act (November 20, 2009); and cost estimate for the Patient Protection and Affordable Care Act (November 18, 2009).

Honorable Tom Harkin

Page 2

Description of the CLASS Proposals

The Community Living Assistance Services and Supports proposals in H.R. 3962 and under consideration in the Senate would each establish a voluntary federal program for long-term care insurance that would be administered by the Secretary of Health and Human Services (HHS). Under both proposals, individuals could purchase coverage that would provide specified future benefits, with premiums set so that the program would be in actuarial balance over 75 years. (Actuarial balance means that expected insurance premiums plus the interest earned on such premium income would equal or exceed the expected cash payments for future benefits and the administrative costs of operating the program.) Premiums would vary only according to the enrollee's age when he or she enters the program. Once enrolled, an individual's premium would generally remain the same for as long as that individual remained in the program. H.R. 3962 would allow active workers and their nonworking spouses to enroll, while the Senate proposal would allow only active workers to participate.

In general, enrollees would have to pay premiums for five years to be vested in the program (that is, eligible to receive benefits in the event they become functionally disabled). Vested enrollees who need assistance performing at least two or three common daily activities such as dressing, bathing, and eating would receive cash benefits to pay for support services in a community setting. Severely impaired enrollees could apply their benefit toward the cost of residential care in a nursing home facility. The benefit would be at least \$50 per day (indexed for inflation); the Secretary of HHS would set benefit levels based on the extent of enrollees' impairment. CBO assumed that the Secretary would initially establish an average daily benefit of about \$75 (indexed for inflation). That figure includes an average benefit of \$50 per day for impaired enrollees living in the community and larger amounts for enrollees who become institutionalized. Benefit payments made through the CLASS program would not be considered as income in determining an enrollee's eligibility for Medicaid.

Both the House and Senate legislation would provide considerable authority to the Secretary to adjust premiums for both current and future enrollees and to reduce benefits to the daily minimum of \$50 in order to maintain the solvency of the program.

Budgetary Effects Over the Next 10 Years

CBO's estimates of the CLASS provisions in H.R. 3962 and in the Senate proposal differ because of the treatment of nonworking spouses in the two proposals. CBO estimates that the inclusion of nonworking spouses in the House proposal would increase expected future benefit payments (and would increase premiums correspondingly) because nonworking spouses who enroll in the program would be expected to be less healthy, on average, than active workers, and therefore more likely to become functionally impaired in later years and qualify for benefits.

Honorable Tom Harkin

Page 3

H.R. 3962. CBO estimates that under the House-passed version of the CLASS program, the average monthly premium in 2011 would be about \$146 (premiums for new enrollees would increase with inflation in later years). Expected enrollment in the program would reach slightly more than 10 million people by 2019 (or about 4 percent of the adult population). The estimated premiums are calculated to be adequate for the program to remain solvent for 75 years, taking into account the interest income that would be generated on unspent balances in the program's trust fund. (Because most enrollees would not receive benefits for many years, the fund would accumulate significant balances in the early years of the program.)

Over the 2010-2019 period, CBO estimates that the House-passed version of the CLASS program would reduce federal budget outlays by about \$102 billion (see Table 1). This deficit reduction would occur in part because no benefits would be paid out during the first five years the program was in operation. Premium receipts would total about \$123 billion over the 10-year period, and benefit payments would amount to \$20 billion, CBO estimates. For those 10 years, administrative costs associated with operating the program would be 3 percent of premiums, as specified in the legislation, or about \$4 billion. The program would generate about \$2 billion in savings (over the 2010-2019 period) in the Medicaid program because, once an individual became eligible to collect benefits under both the CLASS and Medicaid programs, a portion of the CLASS benefit would go toward offsetting Medicaid costs. Medicaid would continue to provide the full array of long-term care benefits—to the extent that the individual was eligible—but the CLASS program would defray some costs that Medicaid would have otherwise paid.

Table 1. Estimated Budgetary Impact of Section 2581 of H.R. 3962, the Affordable Health Care for America Act

	Outlays in Billions of Dollars, by Fiscal Year											2010-	2010-
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2014	2019	
Premiums	0	-5.3	-9.3	-12.6	-14.4	-16.2	-16.0	-16.2	-16.4	-16.5	-41.7	-123.1	
Benefit Payments	0	0	0	0	0	0	2.3	4.3	6.1	7.3	0	20.0	
Administrative Costs	0	0.2	0.3	0.4	0.4	0.5	0.5	0.5	0.5	0.5	1.3	3.7	
Medicaid Savings	0	0	0	0	0	0	-0.3	-0.5	-0.7	-0.8	0	-2.2	
Net Outlays	0	-5.2	-9.0	-12.3	-14.0	-15.8	-13.5	-11.9	-10.4	-9.5	-40.5	-101.6	

Honorable Tom Harkin

Page 4

The Senate Proposal. CBO estimates that under the current Senate proposal for CLASS, the average monthly premium in 2011 would be about \$123 (premiums for new enrollees would increase with inflation in later years), and enrollment in the program would be slightly less than 10 million people by 2019 (or about 3.5 percent of the adult population). The slightly lower enrollment expected under the Senate proposal stems from the exclusion of nonworking spouses (as would be allowed under H.R. 3962). However, a higher percentage of those eligible would be expected to enroll under the Senate proposal because of the lower estimated premium.

Over the 2010-2019 period, CBO estimates that the Senate version of CLASS would reduce federal outlays by about \$72 billion (see Table 2). Premium receipts would total about \$88 billion over the 10-year period, and benefit payments would amount to about \$14 billion, CBO estimates. For that period, administrative costs associated with operating the program would be 3 percent of premiums, as specified in the legislation, or less than \$3 billion. The program would generate almost \$2 billion in savings in the Medicaid program over the next 10 years.

Table 2. Estimated Budgetary Impact of Section 8001 of the Patient Protection and Affordable Care Act

	Outlays in Billions of Dollars, by Fiscal Year											2010-	2010-
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2014	2019	
Premiums	0	-3.8	-6.6	-9.0	-10.2	-11.5	-11.4	-11.6	-11.7	-11.8	-29.6	-87.6	
Benefit Payments	0	0	0	0	0	0	1.6	3.0	4.3	5.2	0	14.1	
Administrative Costs	0	0.1	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.9	2.6	
Medicaid Savings	0	0	0	0	0	0	-0.2	-0.3	-0.5	-0.6	0	-1.6	
Net Outlays	0	-3.7	-6.4	-8.7	-9.9	-11.2	-9.6	-8.6	-7.5	-6.8	-28.7	-72.5	

Effects Beyond the First 10 Years

Projections of premium receipts and benefit payments beyond the 10-year budget window (2010-2019) are subject to more uncertainty than projections for the first 10 years, and detailed year-by-year projections of those amounts would not be meaningful. Among other factors, a wide range of changes could occur—in people's health and disability status, in the evolution of private long-term care insurance, and in the delivery of medicine—that are likely to be significant but are very difficult to predict, both under current law and under the House and Senate proposals. As a result, CBO is only able to give a broad assessment of the potential budgetary outcomes in future decades, based on the underlying structure of the long-term care proposals.

Honorable Tom Harkin

Page 5

CBO estimates that both the House and Senate versions of the CLASS program would reduce the federal budget deficit in the second decade following enactment of the legislation (2020-2029), but by smaller amounts than in the initial decade. By the third decade, the sum of benefit payments and administrative costs would probably exceed premium income and savings to the Medicaid program. Therefore, the programs would add to budget deficits in the third decade—and in succeeding decades—by amounts on the order of tens of billions of dollars for each 10-year period. The House-passed version of CLASS, which would reduce the federal budget deficit in the first 10 years by an estimated \$30 billion more than would the Senate version, would likewise add somewhat more to the deficits in the third decade and beyond than would the Senate proposal. (That is, the greater participation and poorer health status of enrollees under the House version would lead to larger benefit payments in those later years.)

The CLASS program would add to budget deficits in future decades even though the proposals require the Secretary of HHS to set premiums to ensure the program's solvency for 75 years. Because of the extended time horizon involved in long-term care insurance and the build-up of unspent premium receipts, income from interest on accumulated fund balances would play a large role in financing the program's benefits. Typically, enrollees pay premiums for many years before some of them become disabled and qualify for benefits. Private issuers of long-term care insurance finance benefit payments from their reserve of accumulated premium receipts and the income they derive from investing those premiums. Similarly, the Secretary would invest CLASS program premium receipts in federal securities and would incorporate that expected income into calculations of appropriate premiums to charge. However, trust fund income from investments in federal securities would be an intragovernmental transfer within the federal budget. As a result, from a budget scorekeeping perspective, the CLASS program would inevitably add to future deficits (on a cash basis) by more than it reduces deficits in the near term, even though the premiums would be set to ensure solvency of the program.²

Key Caveats. These estimated effects of the CLASS proposals are subject to considerable uncertainty, for several reasons. The budgetary impact would depend importantly on the number of people who would enroll in the program and the health status of those enrollees later in life. That would depend, in turn, on peoples' perceptions about their need for long-term care insurance and their comparison of the premiums they would have to pay in the CLASS program with the value of the future benefits the program would provide. CBO's estimate of the premiums that would be required to ensure the programs' actuarial soundness over 75 years is based on projections of future trends in the prevalence of disabilities and in the ways that care for people with disabilities will be provided. Though some insight can be obtained from the experience of

² Because premium income in the early years would reduce the amount that the government has to borrow from the public, interest on the public debt would also be reduced during that period, but that type of effect is not included in the estimates used in the Congressional budget process.

Honorable Tom Harkin
Page 6

private-market insurance, both of those trends are subject to substantial uncertainty. Moreover, under the CLASS proposals, the Secretary of HHS would be given great latitude in administering the program, which adds to the uncertainty about the program's cash flows because benefit and premium levels could be set at different levels than CBO has estimated and could be adjusted over time in a variety of ways.

The CLASS program could be subject to considerable financial risk in the future if it were unable to attract a sufficiently healthy group of enrollees. Relatively healthy enrollees would ensure that the program's premiums and the interest on those premiums would be adequate to pay for future benefits. However, attracting healthy enrollees could be challenging for several reasons. One reason is that the administrative costs of the program are limited to 3 percent of premiums, which might mean that the Secretary would not have sufficient funds to effectively market the program to a large number of people. A relatively small enrollment would increase the risk of adverse selection and could undermine the long-run stability of the program. (On the other hand, by keeping administrative costs to a minimum, the CLASS program might attract relatively healthy enrollees because the resulting premiums could be lower than the premiums that would be charged for many private policies that have substantially higher administrative costs and devote a share of their premiums to profit.)

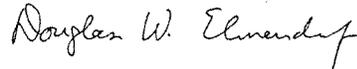
Another reason why attracting health enrollees could be a challenge is that the CLASS program would have to enroll all eligible people who apply, making it likely that some enrollees would be people who were unable to obtain coverage in the private market because of their poor health status. To avoid insuring people with a higher-than-average probability of eventually receiving benefits, private insurers employ extensive underwriting of policies sold in the individual market (that is, people are charged different premiums depending on their expected future need for care), and market coverage selectively in the employer market.

The program includes provisions that would allow employers, at their option, to automatically enroll employees in the CLASS program. That feature could help to boost participation in the program and thereby mitigate the risk of adverse selection. However, the proposals would not require employers to auto-enroll their employees, and employees would have the right to opt out of the coverage altogether, reducing the likely effects of auto-enrollment to stimulate participation in the program.

Honorable Tom Harkin
Page 7

I hope you find this information helpful. If you have any questions, please contact me.
The CBO staff contacts are Bruce Vavrichek and Stuart Hagen.

Sincerely,



Douglas W. Elmendorf
Director

cc: Honorable Michael B. Enzi
Ranking Member

Honorable Harry Reid
Majority Leader

Honorable Mitch McConnell
Republican Leader

Honorable Christopher J. Dodd

Identical letter sent to the Honorable George Miller.

Mr. CASSIDY. Thank you. I think there were some concerns, some questions as to whether CBO had concerns.

And technically you are right. In the second decade, it said it might be cost neutral, but if I go on, and again in the spirit of what Governor Bredesen is saying how forthright are we being with the American people. The CLASS program would add to the budget deficit in the third decade and succeeding decades by amounts on the orders of tens of billions of dollars for each 10-year period, and the CLASS Act would inevitably add to future deficits on a cash basis by more than it reduces deficits in the near term, etc., etc.

Ms. GLIED. Is that Mr. Foster speaking?

Mr. CASSIDY. This is the CBO. In my mess of papers, I have lost the last page, but it came out of CBO. And this is November 2009. So again, were you—I don't know this. I am asking. Were you part of the deliberation as to include the CLASS Act in the final?

Ms. GLIED. No. I hadn't come to Washington.

Mr. CASSIDY. So you wouldn't know whether Mr. Klein was correct in saying that the administration was initially opposed to including it, perhaps on the basis of fiscal concern?

Ms. GLIED. I do know that the fact there was this twin test in legislation was something that certainly gave the administration more reason to go ahead. We were not going to proceed. I am struck by the fact that everyone agrees this was an enormous need, and that we passed a piece of legislation that said given a great deal of uncertainty, we are going to let you explore this, figure out if you can make it work and then go ahead and address this need. We realize we can't do that.

Mr. CASSIDY. The only thing that gives me pause on that is that I heard you speak, Ms. Greenlee in times past, very impressed with your body of knowledge, as I am with yours, and you clearly know what is key to what is a successful program, and it is not just us. The GAO has a report that for fiscal solvency, you need to have an accrual basis of accounting, not a cash flow basis. That is GAO talking about entitlements in general.

We have here on page 39 of your report on the Actuarial marketing and legal analysis of the CLASS program, a list of the things that would make the program viable as it turns out they are everything that the private sector employs, and yet you are not allowed to do. So I think that CBO and CMS's initial concerns were so kind of grounded in practical experience, that it concerns me that that practical experience was ignored as a credit of \$70 billion was counted towards the overall cost of the President's health care bill. That is just an aside.

That said, my concern about that leads me to a concern about other things. Clearly a way that insurance is provided to others is by an expansion of Medicaid. Ms. Greenlee, I think you are from Kansas?

Ms. GREENLEE. Yes.

Mr. CASSIDY. And I think I heard you earlier that you work in the Medicaid program?

Ms. GREENLEE. Yes.

Mr. CASSIDY. And I saw that it is bipartisan, that we know that there is a problem here. Mr. Deutch, in his testimony, spoke about Medicaid being on the chopping block on State budgets and stress-

ing Federal, somebody else spoke about the labor of the budgets under the cost of Medicaid. What is it going to do to the State of Kansas' budget to expand Medicaid as the President's health care plan does, and knowing that many more people potentially go on long-term care because of this expansion. Will that be positive or negative for the State of Kansas' budget?

Ms. GREENLEE. Mr. Cassidy, I have been here now for over 2 years, so I can't give you current information about the impact on the State of Kansas. The lieutenant governor from the State visited me several months ago, and I know that they, like other States, are looking at a managed care option for Medicaid in the State of Kansas. I don't have a current budget information.

Mr. CASSIDY. So knowing that you have to be careful in how you speak, but let's just again kind of resort to common sense. If already, I think as Deutch said, it is on the chopping block because of the fiscal strain Medicaid is playing, specifically the long-term care aspect of Medicaid, if we are about to expand the eligibility thereof, knowing that we also have, as former Representative Kennedy said, a tsunami of people who are going to qualify, so older population, more people and more people eligible, can that do anything but further strap a budget which is laboring under the cost of Medicaid?

Ms. GREENLEE. I am sorry, sir, I really can't be responsive to the current Kansas situation.

Mr. CASSIDY. I keep on thinking about what Breseden said. It is hard to get the American people an honest answer. Not that you are being dishonest. Lastly, you are just being so totally honest that it is a little disingenuous, I must say. I am sorry. That is just my impression.

Lastly, let me ask—I am out of time. I yield back.

Mr. STEARNS. We have finished our hearing. By unanimous consent, I would like to put the document binder in the record. Any objection? If not, so ordered.

[The information follows:]

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
Subcommittee on Health
CLASS Cancelled: An Unsustainable Program and Its Consequences
October 26, 2011

Exhibits Index

TAB	DESCRIPTION	DATE
1	CLASS' UNTOLD STORY: Taxpayers, Employers, and States on the Hook for Flawed Entitlement Program, Co-Chairs: Senator John Thune, Rep. Fred Upton, Rep. Joe Pitts, Rep. Cliff Stearns, Rep. Denny Rehberg	09.15.2011
2	Letter to The Honorable John A. Boehner from the Honorable Kathleen Sebelius, Secretary of Health and Human Services	10.14.2011
3	Memorandum to Secretary Sebelius, From Kathy Greenlee, CLASS Administrator, Re: Memorandum on the CLASS Program	10.14.2011
4	A Report on the Actuarial, Marketing, and Legal Analyses of the CLASS Program by the U.S. Department of Health and Human Services	10.14.2011



**CLASS' UNTOLD STORY:
Taxpayers, Employers, and
States on the Hook for
Flawed Entitlement Program**

Co-Chairs:

Senator John Thune, Chairman
Republican Policy Committee

Rep. Fred Upton, Chairman

Rep. Joe Pitts, Chairman, Subcommittee on Health

Rep. Cliff Stearns, Chairman, Subcommittee on Oversight and
Investigations

Committee on Energy and Commerce

Rep. Denny Rehberg, Chairman, Subcommittee on Labor, Health
and Human Services, and Education
Committee on Appropriations

Working Group:

Senator Jeff Sessions
Ranking Member
Committee on the Budget

Senator Richard Shelby
Ranking Member
*Committee on
Appropriations
Subcommittee on Labor,
Health and Human Services,
and Education*

Senator Lindsey Graham
*Committee on
Appropriations*

Senator Tom Coburn, M.D.
Ranking Member
*Permanent Subcommittee
on Investigations*

Rep. Darrell Issa
Chairman
*Committee on Oversight
and Government Reform*

Rep. Trey Gowdy
Chairman
*Committee on Oversight
and Government Reform
Subcommittee on Health
Care, District of Columbia,
Census and the National
Archives*

Rep. Charles W. Boustany, M.D.
Chairman
*Committee on Ways and
Means
Oversight Subcommittee*

Rep. Michael C. Burgess, M.D.
*Committee on Energy and
Commerce*

Rep. Phil Gingrey, M.D.
*Committee on Energy and
Commerce*

September 2011

**CLASS' UNTOLD STORY:
Taxpayers, Employers, and States On the Hook For Flawed
Entitlement Program**

INTRODUCTION

The Patient Protection and Affordable Care Act¹ (PPACA), the Obama administration's keystone health care legislation, established a new long-term care insurance entitlement known as the Community Living Assistance Services and Supports (CLASS) Act. Documents uncovered through a bicameral congressional investigation show that well before the law's passage, warning flags were raised within the Department of Health and Human Services (HHS) about the CLASS program's sustainability in the long-term. The documents also describe the extent to which the Administration may shift costs and administrative burdens for the program onto states and employers.

The CLASS Act created an optional, government-backed, long-term care insurance program that would pay a daily or monthly benefit to enrolled subscribers if they become unable to perform activities of daily living, such as dressing, meal preparation, and personal grooming. Because the program requires a five-year vesting period before subscribers can collect any benefits, the Congressional Budget Office (CBO) calculated that in the first 10 years of the program, the CLASS Act would account for \$70 billion in deficit reduction. This calculation was based on the premise that during the initial years of the program, it will take in more revenue in premiums than it pays out in benefits, including the first five years of the program in which no benefits are paid at all.

This \$70 billion in CBO-scored "savings" was crucial to garnering support for passage of the health care law. CBO did not make public any estimates on what would happen as the population of subscribers to the program age and the CLASS Act requires increasing amounts of money to be paid out in benefits.

It is now widely acknowledged that the alleged savings from the CLASS Act are illusory. The month after PPACA passed, Rick Foster, Chief Actuary of HHS' Centers for Medicare and Medicaid Services (CMS), released a report indicating that the CLASS Act was not fiscally sound.² The chief actuary is a non-partisan, high-ranking official in CMS whose estimates are critical in understanding current health care law and proposed changes to the law.

¹ P.L. 111-148; P.L. 111-152

² Foster, Richard. "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act' As Amended." Office of the Actuary, Centers for Medicare and Medicaid Services, April 22, 2010. https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

Senate Budget Committee Chairman Kent Conrad, a supporter of the PPACA legislation, publicly called the CLASS program “a Ponzi scheme of the first order, the kind of thing Bernie Madoff would be proud of.”³ In testimony before Congress, HHS Secretary Kathleen Sebelius conceded that the CLASS program is “totally unsustainable” in its current form.⁴

But these concessions came long after PPACA had been signed into law. As a result of this investigation, it is now clear that some officials inside HHS warned for months before passage that the CLASS program would be a fiscal disaster. Within HHS the program was repeatedly referred to as “a recipe for disaster” with “terminal problems.” As this report will show, the chief actuary stated on numerous occasions that the program was not fiscally sustainable and would result in what he referred to as an “insurance death spiral.”

According to emails and other documents obtained pursuant to this investigation, senior leadership of HHS and Democratic staff in the Senate and House reviewed these warnings but did not change the law and did not inform the public of the doubts about the CLASS Act. Instead, the officials continued to claim that the program would be sound, sustainable, and actually produce budget savings that could help pay for other parts of the health care law.

While there has been little public discussion of the costs PPACA imposes on employers and states, this investigation revealed for the first time the extent to which HHS both anticipated these costs and yet tried to impose even more burdens. The documents we have obtained demonstrate that officials at HHS knew that the CLASS Act would saddle employers and states with, at minimum, a heavy administrative burden. The emails also reveal discussions inside HHS about combating low participation in the program by *requiring* employers to participate. HHS anticipated this mandate could be imposed at some future date, and it is possible they will still attempt to impose such a mandate through regulation.

The documents that were produced as part of this investigation were reviewed and analyzed by a working group of Republicans in both houses of Congress. This report is the product of our joint investigatory research and analysis.

³ Montgomery, Lori “Proposed Long-Term Insurance Program Raises Questions.” Washington Post, October 27, 2009.

<http://www.washingtonpost.com/wp-dyn/content/article/2009/10/27/AR2009102701417.html>

⁴ Roy, Avik. “Sebelius: CLASS Act is ‘Totally Unsustainable,’ Mandate Possible,” Forbes, February, 23, 2011.

<http://www.forbes.com/sites/aroy/2011/02/23/sebelius-class-act-is-totally-unsustainable-mandate-possible/>

Internal HHS Documents Questioned Fiscal Viability of CLASS

While PPACA established the long-term care program, it left many of the important details about the CLASS Act to be decided by HHS through regulation. HHS is required to issue those regulations by October 1, 2012. Until HHS issues those regulations, the public does not know how much subscribers will have to pay in premiums to enroll in the program, what benefits they will receive if they become disabled, or what level of disability will trigger the benefits.

When balancing premiums collected against benefits paid, internal HHS documents show that regulators have long been concerned about the problem of “adverse selection.” If CLASS suffers from adverse selection (also called “antiselection”), a high proportion of people with long-term care needs enroll in the program and initial premiums will need to be very high to cover costs. Those high premiums will encourage healthy people to drop out of the program, causing premiums to rise again for the sicker individuals who remain. This could result in what is called a premium “death spiral” and massive taxpayer losses.

Internal emails from HHS and CMS show a number of officials raised alarm about the sustainability of the CLASS Act program. Between May and September of 2009, the CMS chief actuary repeatedly stated his concerns to CMS leadership. It appears from the documents that he was later cut out of the discussions regarding the CLASS Act. CMS and Democratic staff on the Senate Committee on Health, Education, Labor and Pensions (HELP) instead turned to CBO, which produced more favorable estimates than the chief actuary. But others within HHS continued to question the viability of the CLASS Act.

What follows is a timeline of how these discussions progressed.

May 2009

The Chief Actuary Predicted “Insurance Death Spiral”

The CMS chief actuary first analyzed the adverse selection problem in a May 19, 2009, email. (See [Exhibit A](#).) Commenting on a draft legislative proposal from Senator Kennedy’s office, the chief actuary said, “let me offer a few preliminary comments:

I didn’t see any provision for a Federal subsidy of this program; in other words, the intention appears to be that it would be financed solely through participant premiums and interest earnings. Nonsubsidized, voluntary insurance programs generally involve substantial “antiselection” by those who choose to participate. As summarized below, *this could be a terminal problem for this proposal.*⁵

⁵ Bold/italic emphasis throughout this report not necessarily in the original.

The program is intended to be “actuarially sound,” but at first glance this goal may be impossible. Due to the limited scope of the insurance coverage, the voluntary CLASS plan would probably not attract many participants other than individuals who already meet the criteria to qualify as beneficiaries. While the 5-year “vesting period” would allow the fund to accumulate a modest level of assets, all such assets could be used just to meet benefit payments due in the first few months of the 6th year.

The resulting substantial premium increases required to prevent fund exhaustion would likely reduce the number of participants, and *a classic “assessment spiral” or “insurance death spiral” would ensue.*

Alternatively, suppose that a significant number of people without any limitations in [activities of daily living] could be persuaded to participate in the program. How many people would be needed to cover the benefit costs for those qualifying as beneficiaries? For the sake of illustration, suppose 10 million people qualify for benefits of \$50 per day (annual cost of \$182.5 billion). About 234 million people, paying premiums of \$65 per month, would be needed to cover this cost (ignoring administrative expenses). The size of the U.S. population aged 20 and over is about 225 million, and about 165 million of these are employed. This rough—but probably not unrealistic—example further calls into question the feasibility of the maximum financing versus the minimum benefits.”

The problem identified by chief actuary at the earliest stages of the bill’s consideration remained in the legislation through subsequent drafts. The chief actuary’s concern was that it would not be possible to attract enough people to the program to maintain it as a self-funding program.

The chief actuary’s email does not include the text of the draft language from Senator Kennedy’s office, but it appears from the premium and benefit example used that the first draft of the statutory language may have required \$50 a day in benefits and/or premiums of \$65 per month. The final version of the CLASS Act gives the Secretary of HHS discretion to set the premiums and benefit levels as long as premiums allow the program to be fiscally sound over 75 years and benefits are at least \$50 per day.

June - July 2009

The Administration Supported the CLASS Act Based on Budgetary Gimmicks, Not Long-Term Actuarial Analysis

In the summer of 2009, a series of email exchanges between the chief actuary and the CMS Office of Legislative Affairs show that support for the long-term care program was growing within the Obama administration and among Democrats in Congress, while the chief actuary’s concerns were becoming more emphatic. Despite these concerns,

supporters of the CLASS Act continued to rely on budgetary gimmicks and flawed modeling.

On June 29th, a staffer in the CMS Office of Legislative Affairs forwarded a news story to the chief actuary that discussed how the CLASS Act allegedly would save money. The email noted, "Bottom line, the CLASS Act was scored by CBO with a savings of \$58 billion over 10 years, including a \$2.5 billion savings in Medicaid." A follow up email from CMS Legislative Affairs on July 8 said, "the Administration is now officially on record supporting the CLASS Act." (See Exhibit B.)

The chief actuary responded with a critique of two studies that had been offered in support of the insurance program:

I've finished reviewing the two studies provided by Sen. Kennedy's staff regarding the CLASS proposal. *I'm sorry to report that I remain very doubtful that this proposal is sustainable at the specified premium and benefit amounts.*

The actuarial study conducted for AARP assumed participation rates based on a portion (40% to 100%) of current rates for 401(k) plans. In practice, I think current experience for participation in employer based long-term care plans would be much more applicable, and such participation is far lower than for 401(k)'s (for fairly obvious reasons). The AARP study emphasized the sensitivity of premium levels to the number of healthy participants. Although the actuaries didn't model a plan with participation in the few-percentage range, I strongly suspect that the resulting premiums would be so large as to further diminish the number of participants and to fail to achieve the critical mass of participants in average health needed to cover the selection and subsidy costs.

All the analysis in the Moran study is based on an assumption that the CLASS program would be mandatory. The results look legitimate for such a program, but they are not applicable to the voluntary plan proposed for CLASS.

I haven't been able to talk to CBO yet regarding their participation assumptions. Unless they have a compelling reason to expect greater-than-[long-term care] levels of participation, however, I can't see how there would be enough workers participating to cover the selection costs for those with existing [activities of daily living] limitations plus the costs for the internal subsidies for students and low-income persons. *Thirty-six years of actuarial experience lead me to believe that this program would collapse in short order and require significant federal subsidies to continue.* (See Exhibit B.)

The comments by the chief actuary demonstrate that any reduction in the federal budget deficit identified by CBO would be a function of budgetary time-shifting rather than true savings. While programs like Social Security are often analyzed on a 75-year basis of long-term actuarial solvency, congressional rules require CBO to analyze legislative proposals, like the CLASS Act, over a 10-year budget window.

But the CLASS program likely will not even begin collecting premiums until 2013, and five years of participation are required before subscribers are vested in CLASS, so the program is not likely to begin paying out any benefits until 2018. CLASS was therefore scored as a revenue raiser. Using this budget gimmick, the true costs of the program—the subsequent benefit payments—were essentially ignored, because only a few years of benefit payments were within the official 10-year CBO scoring window of 2010-2019.

CLASS Supporters Relied on Flawed Modeling

The internal documents show that advocates of the CLASS program relied on strikingly unrealistic participation estimates. One study noted above, commissioned by AARP and dated March 3, 2008, assumed nearly 50 million Americans would join the program, a level well above current participation in private long-term care insurance. The second, by the Moran Group, assumed participation would be mandatory for everyone.⁶

As the chief actuary pointed out, those are completely invalid assumptions on which to base estimates of a long-term care insurance program. CBO's own estimate also assumed participation rates that were higher than long-term care insurance currently has, and higher than the chief actuary believed could plausibly be expected. By relying on unrealistic estimates of how many people would participate in the CLASS program, its supporters masked the program's underlying viability problems.

Even with these unrealistic assumptions, the AARP-commissioned analysis also concluded that the program's design flaws "will ultimately lead to ... an unsustainable situation with respect to the premiums." (See [Exhibit C.](#)) Emails between Obama administration officials and congressional staff show that AARP, which publicly supported PPACA, has refused to release the entire study. (See [Exhibit D.](#))

To further rebut the AARP and Moran studies, the chief actuary also forwarded to CMS Legislative Affairs staff a report by the American Academy of Actuaries and the Society of Actuaries that substantiated his concerns about the long-term viability of the proposed

⁶ The documents provided did not include the study completed by the Moran group despite it being referenced by the chief actuary and a senior democrat staff member for the Senate Health, Education, Labor, and Pensions Committee. The senior democrat staff member referenced the Moran report on October 20, 2009 at the Kaiser Family Foundation event "The Sleeper Issue: Long-term Care and the CLASS Act," page 78.
http://www.kff.org/healthreform/upload/102009_KFF_CLASS_Act_Transcript_Final.pdf

CLASS program. (See [Exhibit E.](#)) The American Academy of Actuaries provided their report to the Senate HELP Committee on July 22, 2009. (See [Exhibit E.](#))

August - September 2009

CMS and Senate HELP Democrats Ignored Warnings about Actuarial Soundness and Pressed Forward with CLASS as a New Entitlement

The chief actuary remained concerned about the soundness of the CLASS program throughout the summer of 2009, and he sought to ensure that his concerns were communicated to the senior people working on health care reform inside HHS as well as the chief architects of the program in Senator Kennedy's office. On August 14, 2009, the chief actuary sent another email to the CMS Office of Legislative Affairs in which he said:

"As you know, I continue to be convinced that the CLASS proposal is not 'actuarially sound,' despite Sen. Kennedy's staff's good intentions. I assume you've conveyed these concerns to the staff but, if not, let me know and we can express the concerns in a memo."

The Office of Legislative Affairs responded, "Yes, both Amy and the HHS Office of Health Reform have been in communication with [a senior democrat staff member] of the HELP Committee relaying your concerns about the actuarial soundness of the CLASS Act." (See [Exhibit F.](#))

A few weeks later, on August 24, 2009, the chief actuary again asked CMS to consider the American Academy of Actuaries report questioning the CLASS Act's viability. (See [Exhibit B.](#))

HHS Officials Effectively Silenced the Chief Actuary and Stopped Soliciting His Input

After receiving consistent negative information from the chief actuary about the financial viability of the program, Senator Kennedy's staff moved to cut out the chief critic of the CLASS Act within HHS from providing any further analysis of the bill. On September 10, 2009, the Director of Policy Analysis in the Immediate Office of the Secretary of HHS emailed the Deputy Assistant Secretary for Planning and Evaluation saying, [a senior democrat staff member] "got back to me, and decided she does not think she needs additional work on the actuarial side." (See [Exhibit G.](#))

An email the following week, September 16, reiterated Democrats' position: [a senior democrat staff member] "at HELP has done a lot of work changing the program and per CBO it is now actuarially sound." (See [Exhibit H.](#)) There had been a clear shift from relying on the chief actuary's 36 years of experience in favor of the flawed 10-year timeframe of CBO.

Despite the shift, the chief actuary continued to be involved in discussions as late as September 23, 2009, when he attended a meeting with CBO in which the structure and cost of the CLASS Act were discussed. (See Exhibit I.) After this date, there were apparently no other email communications from the chief actuary regarding the CLASS Act. There is no indication in the documents that the drafters of the legislation in Congress or HHS ever again sought the chief actuary's opinion on the program before the law was enacted. However, his questions about the sustainability of the program continued to be raised in published actuarial reports.⁷

CBO Produced Long-Term Analyses of CLASS; Models Have Yet to Be Made Public

At the same time CLASS supporters began to marginalize the warnings from the chief actuary about the long-term viability of the program, Democratic staff on the Senate HELP Committee worked with CBO to come up with an alternative model to analyze CLASS. On September 9, 2009, an HHS official e-mailed that HELP staff "had CBO do lots and lots of runs out to 50 years to ascertain solvency. [The HELP staff member] is going to send to me to forward on." (See Exhibit J.)

Congress relies on CBO to estimate the economic impact of proposed laws and in this role it is vital that CBO's models be completely transparent. The formulas, algorithms and assumptions should be explicitly defined so that Congress and the public can fully understand the basis for their estimates. Yet two years after it was providing analyses to HELP Committee staff, CBO has declined to disclose the models it developed to analyze the CLASS program's long-term solvency. CBO staff now say that they do not have the capacity to analyze the CLASS Act's long-term solvency, despite apparently undertaking that analysis for congressional Democrats before the bill's passage.

On August 15, 2011, HHS did provide an analysis by CBO that congressional staff gave to CMS in September 2009. That analysis is one page of a spreadsheet projecting net premium collections of \$59 billion through 2019 – a 10-year budget estimate, not the 50-year solvency estimates referred to by Senate HELP Committee staff. The document does not disclose what participation rates it assumed or how it established the assumed \$65 premium rate. (See Exhibit K.)

September – December 2009

HHS' Office of the Assistant Secretary for Planning and Evaluation Began To Question CLASS but Also Was Ignored

⁷ Foster, Richard. "Estimated Financial Effects of the 'America's Affordable Health Choices Act of 2009' (H.R. 3962), as passed by the House on November 7, 2009, November 13, 2009. http://www.cms.gov/ActuarialStudies/downloads/HR3962_2009-11-13.pdf
Foster, Richard. "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act' As Amended." Office of the Actuary, Centers for Medicare and Medicaid Services, April 22, 2010. https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf

Despite the chief actuary's email silence after September, others within HHS began to raise red flags about the soundness of the CLASS program. On September 25, 2009, just two days after the CBO meeting with the chief actuary, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) prepared talking points for the CLASS program, including the concern that the program "*is still likely to create severe adverse selection problems.*" (See Exhibit L.)

On October 22, 2009, ASPE again questioned the viability of the program. One staffer wrote in an email:

"You can get a policy through the [Federal Long-Term Care Insurance Program] (albeit underwritten) with a higher benefit, better inflation protection, and lower premium [than CLASS]. I don't see any reason why anyone would opt for CLASS if they could pass the underwriting. And if you couldn't make it through underwriting, you could simply enroll in CLASS to cover some of your current or likely future [long-term care] costs. *Seems like a recipe for disaster to me...*" (See Exhibit M.)

This staffer also said: "I can't imagine that CLASS would not have high levels of adverse selection given the significantly higher premiums compared to similar policies in the private market." (See Exhibit M.)

HHS Officials' Public and Private Statements on CLASS Solvency Conflict

During this entire time, public statements by HHS officials gave no hint of the internal concerns voiced within the agency. On October 20, 2009, Richard Frank, Deputy Assistant Secretary for Planning and Evaluation at HHS, gave a public speech at a Kaiser Family Foundation event in which he said:

"We've, in the department, have modeled this extensively, perhaps more extensively than anybody would want to hear about [laughter] and we're entirely persuaded that reasonable premiums, solid participation rates, and financial solvency over the 75-year period can be maintained. So it is, on this basis, that the administration supports it that the bill continues to sort of meet the standards of being able to stand on its own financial feet."⁸

It was around this same time that internal email from Frank's staff indicated the non-public opinion that prospects for the program's solvency looked more like "a recipe for disaster."

⁸Comments made on October 20, 2009 at Kaiser Family Foundation Event. "The Sleeper Issue: Long-term Care and the CLASS Act." Page 49-50
http://www.kff.org/healthreform/upload/102009_KFF_CLASS_Act_Transcript_Final.pdf .

Figures from the Social Security Chief Actuary Also Lead to Questions of Anti-Selection Problems within CLASS

HHS staff acknowledged that CLASS premiums would need to be less than \$100 for the program to be viable. On November 27, 2009, an ASPE staffer commented, "I suspect that these changes would decrease the premium to well under \$100, which seems to be the consensus threshold needed to get decent participation and avoid catastrophic adverse selection." (See Exhibit N.)

But on December 8, ASPE analyzed Social Security Chief Actuary Steve Goss' actuarial report and noted that estimated monthly premiums were approximately \$177 per month (if a certain reenrollment loophole were not closed) or \$140 per month (if the loophole were closed). They also noted that after five years, premiums could increase to \$332.53 per month. The office concluded its analysis by noting that adverse selection was a serious threat to the program's viability. (See Exhibit O.)

HHS Officials Question CLASS, but Their Concerns are not Addressed in the Legislation

On December 1, 2009, ASPE had prepared technical comments on the CLASS Act, in which, even before its analysis of the Social Security data, the Office pointed out:

"Unlike most private insurance that reimburses policy holders for long-term care expenses, the CLASS benefit is a lifetime cash payment paid daily or weekly once a person meets the eligibility criteria of the program. ... *The end result could be severe adverse selection that would in turn threaten the long-run solvency of the program.*" (See Exhibit P.)

The technical comments also included several recommendations from the American Academy of Actuaries to increase the solvency of the program. These included adding a waiting period before benefits kick in; reducing the benefit from lifetime to a fixed number of years; using an established list of activities of daily living to determine the trigger for benefits; and moving from a daily cash benefit to one that makes reimbursements based on services used.

None of those recommendations were adopted in the final language of the bill, and the concerns expressed by ASPE were not addressed or shared with the public.

January 2010

HHS Officials Privately Conceded CLASS May Be Unsustainable, but Failed to Disclose Their Concerns Publicly

In January 2010, HHS staff prepared a list of suggested technical corrections to the CLASS Act that the Department wanted included as the House and Senate reconciled their separate versions of health care reform. However, for both political and procedural

reasons, the House was forced to accept the version of health reform – and the CLASS Act – adopted by the Senate on December 24, 2009, and none of the corrections were made.

Chief among the corrections the Department wanted to make was a so-called “failsafe,” which HHS staff described this way:

In the current bills, the Secretary can alter the premiums in response to threats to financial stability of the CLASS program. However, *it is possible the authority in the bill to modify premiums will not be sufficient to ensure the program is sustainable.* The failsafe provision gives the Secretary authority to alter earnings and vesting provisions of the CLASS Act to further decrease adverse selection and maintain long-run stability. (See Exhibit Q.)

The documents reveal HHS’ concern that the CLASS program as written in the Senate bill – and the version signed into law – would become fiscally unsustainable. Yet at no point between the date of the document – January 4, 2010 – and the day the House voted to pass the Senate health bill – March 21, 2010 – did Secretary Sebelius or any other HHS official publicly air the Department’s concerns that the CLASS program as drafted could be unsustainable.

It appears that the significant fiscal concerns surrounding CLASS may have been silenced within the Department for political reasons and the fear that publicly discussing concerns about CLASS’ sustainability could have jeopardized the bill’s passage in the House.

The technical comments on the January 2010 document raise additional contradictions between HHS’ public and private statements. Throughout 2011, Secretary Sebelius and other HHS officials have repeatedly expressed – and have testified before Congress about – their belief that the CLASS Act legislation gives them the authority they need to construct the program in a fiscally sustainable manner.⁹ This public assurance stands in marked contrast with the internal corrections document asserting that it is possible the Department’s authority “will not be sufficient to ensure the program is sustainable.”

⁹ Roy, Avik. “Sebelius: CLASS Act is ‘Totally Unsustainable,’ Mandate Possible,” Forbes, February, 23, 2011
<http://www.forbes.com/sites/aroy/2011/02/23/sebelius-class-act-is-totally-unsustainable-mandate-possible/>
 House Energy & Commerce Committee. Hearing entitled, “The Implementation and Sustainability of the New, Government-Administered Community Living Assistance Services and Supports (CLASS) Program,” March 17, 2011.
<http://republicans.energycommerce.house.gov/hearings/hearingdetail.aspx?NewsID=8332>

CLASS May Leave Employers On the Hook for a Failed Entitlement

Even before PPACA became law, HHS and the law's drafters began to look for ways to pass the costs on to other parties. While it was clear that some of the future projected shortfalls in the program would add to the federal budget deficit and be borne by American taxpayers, other costs would be shifted to employers and the states. The documents show a consistent effort by HHS to impose unfunded mandates on others, so that the cost of some of the questionable decisions made by the law's drafters would not fall on the federal government.

Employer Participation Creates Compliance and Administrative Burdens

To participate in CLASS, subscribers would pay a yet-to-be-determined premium each month that would be deposited into a trust fund established by the Secretary of the Treasury for the purpose of paying cash benefits to eligible claims. Premiums would be collected either through voluntary employer payroll withholding or by a mechanism determined by the Secretary for those who are self-employed, have more than one employer, or have an employer that does not participate in the automatic enrollment process.

The critical mechanics of how an employer would withhold CLASS program premiums from employees' paychecks and then transfer those premiums to the U.S. Treasury could place a significant compliance and administrative burden on employers. The complexity and cost of any new payroll deduction and enrollment process could be substantial, especially for small employers.

Documents show that HHS knew of the program's administrative burden on employers and pressed forward anyway. In the HHS ASPE office's technical comments on the draft CLASS Act legislation from December 1, 2009, the Department acknowledged:

“The collection of premiums is a fiduciary responsibility that requires employers to accurately collect and transmit premiums to the government. *Collecting premiums would require a nontrivial change to existing payroll systems and additional responsibilities that employers may be reluctant to take on.*” (See Exhibit P.)

HHS warned that employer participation in a voluntary enrollment program was likely to be low because CLASS premiums will be difficult for employers to calculate and “employee interest in CLASS may be minimal.” (See Exhibit P.)

What was more, because employers participating in the program would be taking on a fiduciary responsibility, they could be at risk of lawsuits from their workers for calculating premiums incorrectly. Because, as HHS acknowledged, calculating

premiums will be “complex” and difficult to implement, such lawsuits could become commonplace. HHS appears to have understood that the prospect of litigation and significant liability might make employers less likely to want to get involved in the program.

The Forthcoming Regulations on CLASS Could Require Employers, at a Minimum, to Provide Enrollment Information

In December 2009, HHS staff discussed how to use the regulatory process to change the not-yet-passed CLASS Act in a way that would make it even more burdensome for employers. Staff were concerned that low participation by employers would lead to fewer people signing up for the program.

One email chain included a discussion about requiring employers to play a more active part in enrollment by requiring them to issue enrollment forms to employees.

“A major enrollment issue that needs to be addressed is how to identify the relevant employers/employees (i.e., the self-employed, small employers, and large employers), and determine if statutory requirements are being met. The Department of Labor may be of some assistance.”
(See Exhibit R.)

Another email from the same month indicates that HHS tried to make last minute changes to a manager’s amendment, though the language never made it into the final version of the amendment. The Deputy Assistant Secretary for Planning and Evaluation suggested:

“Employer requirements: In the current formulation of the bill, employers have complete discretion regarding whether to participate in the CLASS program and auto-enroll employees The provision introduced in this amendment maintains the original optional participation in auto-enrollment, but adds a requirement that employers inform their employees about the CLASS program.” (See Exhibit S.)

Nothing in the documents suggests that the Obama administration ever conducted an analysis to quantify how much these proposed unfunded mandates would cost employers in time and resources.

The Administration Considers New Mandates on Employers as a “Solution” to Low Participation

The concern inside HHS about potentially low participation by employers led to an even more burdensome suggestion: mandate that employers over a certain size offer enrollment to employees. As HHS explained, “One possible alternative is to *move to a ‘mandated offer’ approach where employers over a certain size (e.g., 50 employees) would be required to offer enrollment.*” (See Exhibit P.)

Documents show that the idea that the Administration should solve its participation problem by requiring employers to offer enrollment to employees continued to be a major theme of communications regarding implementation of the program. On December 11, 2009, a staffer in ASPE commented:

"I am writing right now about whether we should integrate employers even more into the process by moving to a 'mandated offer' approach instead of just 'mandated information.' The major problem is that mandating that employers offer information about the program probably will not yield high enough participation; we need to have employers more integrated into the enrollment process and not have them drop off once they simply provide information about the program." (See Exhibit T.)

The recipient of that email responded:

"I agree that there is a risk to the entire program if we don't have a sufficiently robust outreach and educational campaign and one that is specifically targeted to employers. This employer notification mandate makes me think of Part D, whereby ... insurers are required to notify their Medicare eligibles whether their prescription drug coverage is creditable." (See Exhibit T.)

In numerous other emails, HHS staff argued that employers should bear the responsibility to enroll employees. (See Exhibit R.) HHS envisioned this requirement increasing participation in the program, but the documents do not discuss the unfunded mandate that would be imposed on employers. The final version of the CLASS Act is silent on employer requirements, but it is entirely within the HHS Secretary's discretion to impose the obligations on employers when she issues regulations for the program this fall.

Even if the Secretary does not require employer participation in the regulations to be released this fall, the email communications discussing mandatory employer participation and employer fiduciary responsibility foreshadow ways HHS could later modify the CLASS Act in a desperate attempt to make the program solvent.

CLASS Saddles States With Yet Another Mandate

In addition to the burdens placed on employers, the emails indicate that HHS believed many costs of implementation will be shouldered by the states.

HHS Knew CLASS Imposed Heavy Administrative Burdens and Unrealistic Deadlines

States will have a significant administrative role in the implementation of the CLASS program, including responsibility for establishing and helping to administer eligibility determination centers. For example, the CLASS Act requires the Secretary of HHS to establish an Eligibility Assessment System similar to the Social Security Disability Insurance (SSDI) program, to be administered by the states. That system is to be completed by January 1, 2012. The CLASS Act also requires the HHS Secretary to enter into agreements with each state's Protection and Advocacy System, which advocate for people with disabilities, and with other groups and state agencies to provide additional counseling services.

According to several internal emails, HHS and CMS staff noted the unreasonable burdens the legislation would impose on states by requiring implementation of the Act within two years. On April 19, 2010, one email said that requiring states within two years of enactment to "designate or create entities to serve as fiscal agents for CLASS beneficiaries" would "*create significant new burdens on the states.*" (See Exhibit U.)

Another email from even earlier, December 18, 2009, also warned of this problem, stating that a two year deadline for states "to build the direct care workforce capacity for CLASS enrollees" is "*flawed (and perhaps fatally so).*" (See Exhibit V.)

HHS Underestimated Administrative Costs, Leaving States to Bear Costs of Eligibility Determinations

Even if the deadlines can be met, HHS has not released any specific estimates of how much these implementation efforts will cost or how much money the federal government will be able to offer states to help pay for the services versus how much states will have to pay on their own.

It is clear from internal HHS emails that the Department always planned to impose a number of significant administrative burdens on states. The administrative costs are expected to be significant, and HHS officials pointed out several times that cost estimates of the CLASS Act did not allocate enough money to administer the program. CLASS Act estimates only allocated three percent of premiums to run the program, while the American Academy of Actuaries recommended three percent of premiums *plus* five percent of benefits. (See Exhibit P and Exhibit W.)

Rather than address inadequate funding for administrative expenses, the CLASS Act imposes many administrative expenses on already-struggling states. On March 3, 2010,

when asked whether CMS analyzed implementation costs for CLASS, one CMS employee responded:

“Hate to tell you but I am almost certain that we did not do this. I really thin[k] most of the administrative costs would be in doing eligibility determinations and payments split with nursing homes and waivers, however, I think little of it is really ours versus the states.” (See Exhibit X.)

CMS Knew States Would Be Saddled With Costs But Congress Did Not Make Changes during Reconciliation

In the last few weeks before final passage of PPACA, CMS’ Office of Legislative Affairs asked staff for edits to the Senate bill that CMS deemed absolutely necessary in order to implement the Act. In a March 4, 2010, exchange, CMS specifically asked for “Not ‘nice to have’ but ‘otherwise it won’t work’” fixes. One edit provided by staff read, “require the Secretary to assume responsibility for building workforce infrastructure; otherwise, *this will impose costs and burdens on states and potentially put CLASS at risk.*”

CMS proposed changing the implementation date to January 2015, as “states are not uniformly equipped to perform activities related to designating existing or new entities to ensure the service infrastructure is adequate to meet the needs of beneficiaries, which will likely pose significant and potentially costly administrative challenges, particularly in light of the implementation deadline.” (See Exhibit Y.) None of these edits were included in the final version of PPACA.

Administrative Burden Likely to Get Worse Over Time

The SSDI program, on which the CLASS Act administrative structure is modeled, is experiencing significant problems in both fiscal and administrative areas. The aging of the baby boom generation has caused SSDI administrative costs to nearly double since 2000. According to a CBO report, the SSDI program will become insolvent in 2017.¹⁰ In addition, the Social Security Administration anticipates nearly 3.2 million new applicants¹¹ for disability benefits in FY 2012. Even without those new applicants, SSDI has a huge backlog of appeals cases in which benefits have been denied. In 2007, some appeal cases had been lingering as long as 1,400 days.¹²

¹⁰ Congressional Budget Office, “CBO’s 2011 Long-Term Projections for Social Security: Additional Information,” August 2011. <http://www.cbo.gov/doc.cfm?index=12375>

¹¹ Social Security Administration. “Annual Performance Plan for Fiscal Year 2012,” page 21. <http://www.socialsecurity.gov/performance/2012/APP%202012%20508%20PDF.pdf>

¹² Astrue, Michael, Commissioner of the Social Security Administration. Statement before the House Committee on Ways and Means, Subcommittee on Social Security and the House Committee on the Judiciary, Subcommittee on the Courts, Commercial and Administrative Law. July 11, 2011. http://www.ssa.gov/legislation/testimony_071111.html

Conditions are so unstable that the Government Accountability Office (GAO) has placed federal disability programs on a High-Risk Watch List since 2003. According to GAO, “the largest disability programs – managed by the Social Security Administration, Department of Veterans Affairs, and Department of Defense – are experiencing growing workloads, creating challenges to making timely and accurate decisions.”¹³

As baby boomers start claiming CLASS Act benefits, program administrators can expect to see some of the problems of scale already being experienced by other federal disability programs, including rising administrative costs. However, the statute caps the program’s administrative expenses at three percent of premiums, leaving no wiggle room for states to accommodate the increased burden from an aging population. Without sufficient capital and stability from the start, it is likely the CLASS program will eventually join the other programs on GAO’s High-Risk Watch List.

The cost of administering the SSDI program state centers in 2011 was \$3 billion, a cost borne exclusively by the states.¹⁴ The burdens of CLASS implementation on the states are likely to exceed that amount, because the number of CLASS beneficiaries will be significantly larger than the number of SSDI beneficiaries due to more relaxed eligibility requirements under CLASS. While HHS has not shared estimates on the costs to states to administer the CLASS Act, we feel that \$3 billion per year is a conservative estimate, one that excludes additional expected start-up costs. Over the next ten years, states will be forced to bear at least \$30 billion dollars for implementation of CLASS. When added on top of the mandates from the Medicaid requirements in PPACA of at least \$118 billion, it is clear that states are being forced to pay the bills that Washington refuses to pay.

State Officials and Legislators Have Grave Concerns with the Solvency and Sustainability of the CLASS Act

On August 4, 2011, leaders of a key National Conference of Insurance Legislators (NCOIL) Committee expressed “grave concerns” with the CLASS Act in a letter to the HHS Secretary. The NCOIL letter asserts that the CLASS Act program “*fails to apply the principles of risk management that are essential to any financially sound insurance program*”. The letter went on to state, “*The CLASS program risks being under-capitalized on the front end, paying more in benefits than it collects in premiums*. This will drive rates up and cause adverse selection, as young and healthy consumers will not participate in the market. Also, the plan as currently configured offers little incentive for agents, brokers, and human resources professionals to encourage the enrollment needed to create a broad and stable risk pool.”¹⁵

¹³ Government Accountability Office. Report to Congressional Committees. “High-Risk Series: An Update.” February 2011, page 147. <http://www.gao.gov/new.items/d11278.pdf>

¹⁴ The 2011 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds. Table VI.C5. <http://www.ssa.gov/oact/tr/2011/tr2011.pdf>

¹⁵ National Conference of Insurance Legislators. Letter to the Honorable Kathleen Sebelius. August 4, 2011. <http://www.ncoil.org/Docs/2007430d.pdf>

The concerns of state legislators should be strongly heeded by HHS. Not only do states recognize that they will be on the hook for administering of the CLASS program, legislators whose policy expertise is in insurance markets recognize it is destined for failure at the expense of states, businesses, and tax payers.

Table of Hyperlinks to Exhibits

Exhibit	Link
A	http://go.usa.gov/0GR
B	http://go.usa.gov/0Gn
C	http://go.usa.gov/0GQ
D	http://go.usa.gov/0GU
E	http://go.usa.gov/0GP
F	http://go.usa.gov/0GE
G	http://go.usa.gov/0Gm
H	http://go.usa.gov/0Gy
I	http://go.usa.gov/0GV
J	http://go.usa.gov/0Gp
K	http://go.usa.gov/0Gd
L	http://go.usa.gov/0Gv
M	http://go.usa.gov/0Gw
N	http://go.usa.gov/0Gf
O	http://go.usa.gov/0GG
P	http://go.usa.gov/0G7
Q	http://go.usa.gov/0GA
R	http://go.usa.gov/0Go
S	http://go.usa.gov/0Gs
T	http://go.usa.gov/0GH
U	http://go.usa.gov/0G6
V	http://go.usa.gov/0GF
W	http://go.usa.gov/0GL
X	http://go.usa.gov/0GM
Y	http://go.usa.gov/0Ge



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

October 14, 2011

The Honorable John A. Boehner
Speaker of the House of Representatives
Washington, DC 20515

Dear Mr. Speaker:

Last year, the U.S. Department of Health & Human Services (HHS) initiated a comprehensive analysis of the Community Living Assistance Services and Supports (CLASS) program. The CLASS initiative – championed by the late Senator Edward M. Kennedy – was added as a separate program to health reform legislation with the goal of creating better long-term care insurance options for Americans. The Congressional Budget Office carefully analyzed this legislation and provided public estimates of how it would work and its effects on the Federal budget. And, the Administration worked with Congress to strengthen the program during Congressional consideration of the Affordable Care Act.

For 19 months, experts inside and outside of government have examined how HHS might implement a financially sustainable, voluntary, and self-financed long-term care insurance program under the law that meets the needs of those seeking protection for the near term and those planning for the future. The work has been groundbreaking in many ways and has taught us a great deal, much of which is captured in the attached report. But despite our best analytical efforts, I do not see a viable path forward for CLASS implementation at this time.

In 2009, the actuary at the Centers for Medicare and Medicaid Services released a report to Congress during the consideration of the legislation that raised concerns about the program's viability. Because of such concerns, the law passed by Congress required me to design a plan that would be actuarially sound and financially solvent for at least 75 years. The provision protected both taxpayers and beneficiaries. After all, if CLASS failed, no one would be hurt more than those who would pay into it and would be counting on it the most.

With this in mind, experts across HHS – including the CLASS Office, the Office of the Assistant Secretary for Planning & Evaluation and the Office of the General Counsel – have worked steadily to find a path forward on CLASS. We have undertaken a methodical and comprehensive analysis of the statute and plan design options. We have broadly considered how to design potential benefit structures and reviewed those designs carefully to determine if they meet the twin tests of solvency and consistency with the law. We hired a chief actuary for the CLASS Office, engaged with other government actuaries, and worked with two outside actuarial firms in order to maximize the reliability of solvency estimates. I am proud of the careful and thorough approach that we have taken, engaging talented professionals across the Department and in the private sector.

The Honorable John A. Boehner
October 14, 2011
Page 2

Our work is detailed in the comprehensive report being transmitted to Congressional leadership with this letter. In the report, you will find the results of our actuarial and policy analyses of the CLASS Act along with our legal analysis of multiple plan design options. While the report does not identify a benefit plan that I can certify as both actuarially sound for the next 75 years and consistent with the statutory requirements, it reflects the development of information that will ultimately advance the cause of finding affordable and sustainable long-term care options.

The challenge that CLASS was created to address is not going away. By 2020, we know that an estimated 15 million Americans will need some kind of long-term care and fewer than three percent have a long-term care policy. These Americans are our family, our friends and our neighbors. If they are to live productive and independent lives, we need to make sure that they have access to the long-term care supports that make that possible.

We also know that left unaddressed, long-term care costs to taxpayers will only increase. Without insurance coverage or the personal wealth to pay large sums in their later years, more Americans with disabilities will rely on Medicaid services once their assets are depleted, putting further strain on State and Federal budgets.

The CLASS program seeks to address the critical need that Americans have for affordable long-term care services. The current market does not offer viable options for those unable to access private long-term care insurance. We look forward to continuing our work with you and your colleagues in Congress, consumer advocates, health care providers, insurers and other stakeholders to find solutions that ensure all Americans have the choices that best meet their needs.

Sincerely,



Kathleen Sebelius

cc. The Honorable Fred Upton
Chairman, Committee on Energy and Commerce

The Honorable Henry A. Waxman
Ranking Member, Committee on Energy and Commerce

To: Secretary Sebelius
From: Kathy Greenlee, CLASS Administrator
Re: Memorandum on the CLASS Program
Date: 14 October 2011

The purpose of this memorandum is to transmit the attached comprehensive report written jointly by the Community Living Assistance Services and Supports (CLASS) Office, the Assistant Secretary for Planning and Evaluation, and the Office of General Counsel documenting policy, marketing, and legal analyses conducted on the CLASS Act. I have also included my recommendation as to how the Department should proceed with its responsibilities under the CLASS Act.

Background

The CLASS Act establishes a voluntary insurance program for American workers to help pay for long-term care services and supports that they may need in the future. The program seeks to help enrollees live independently in the community. By law, CLASS benefits must be funded entirely through enrollee premiums without any taxpayer subsidy, and requires that the program be solvent over a 75-year period.

There is a crucial need to find ways to help Americans prepare for their long-term care needs. Almost seven out of ten people turning age 65 today will experience, at some point in their lives, functional disability and need some paid or unpaid help with basic daily living activities. While most people who need long-term care are in their 70s and 80s, young people also can require care. Forty percent of long-term care users today are between the ages of 18 and 64.

Long-term care is expensive. While costs for nursing home care can vary widely, they average about \$6,500 a month, or anywhere from \$70,000 to \$80,000 a year. People who receive long-term care services at home spend an average of \$1,800 a month. The average lifetime long-term care spending for a 65 year old is \$47,000; 16 percent will spend \$100,000 and 5 percent will spend \$250,000. Medicare does not cover long-term care services. Since Medicaid pays only for services for people with limited financial means, individuals only qualify for Medicaid assistance after depleting all their resources.

Few private mechanisms are available to help people plan ahead to pay for their future care. Long-term care insurance, by far the most popular private option available, can be costly and difficult to purchase, particularly for those with pre-existing health conditions or disabilities. Only about 2.8 percent of Americans currently have a policy. For workers who already experience a disability, the options are even more limited.

Through the CLASS Act, Congress sought to add a new option for American workers. The CLASS program's distinguishing features include an offer of lifetime benefits, lack of underwriting, availability of a cash benefit, and the fact that the program would be administered by the federal government.

As you have stated on a number of occasions, you cannot go forward with implementation of the CLASS program unless you determine that the benefit plan to be offered is actuarially solvent over the next 75 years and is consistent with the other requirements of the CLASS Act.

Over the last nineteen months, the Department has conducted substantial analysis of the CLASS statute and possible implementation options for a Federal long-term care insurance program, consistent with the CLASS Act. All of us who have worked on this issue appreciate your commitment to finding options for those who cannot participate in the current market. We share your view that the current lack of alternatives available to many middle-class Americans is unacceptable, as it can force people into poverty and avoidable institutionalization.

You charged the CLASS Office, ASPE, and OGC with performing a broad and thorough analysis to design attractive benefit plans and to determine if those plans met the twin tests of solvency and legality. Consulting individuals with a broad range of expertise, we worked with an in-house actuary and two outside actuarial firms. We subjected our actuarial modeling to expert review, and subjected potential benefit plans to thorough legal review.

The report attached to this memorandum describes this work. The report contains the results of actuarial and policy analyses of the CLASS Act and the legal analysis of various benefit plan options. This report contains important findings that will help advance the cause of charting a path to affordable and sustainable long-term care options.

Analysis

In order to implement CLASS, we need to be able to identify a benefit design that is actuarially solvent (so that premiums are sufficient to fund the program given an assumed rate of participation), marketable (so that the assumed take up rate is reasonable), and consistent with the authorizing CLASS statute.

The design and implementation of the CLASS program involve two areas of tremendous uncertainty. First, because there is no precedent for the CLASS program in either the private market or in other government programs, such as Social Security or Medicare, there is great uncertainty around the assumptions used in the actuarial modeling to assess solvency. Second, while the CLASS statute requires that the CLASS plan be actuarially sound, and that no taxpayer funds may be used to pay plan benefits, it is silent about what would happen if, at some future point, actuarial soundness could no longer be achieved. It is uncertain whether, if the program could no longer go forward, those holding policies could be assured of receiving the benefits they had purchased, or could transition to other long-term care insurance programs (especially

since some might have developed medical conditions that mean they no longer can meet the underwriting requirements of private long-term care insurance). In light of these two types of uncertainty, it is critical that there be a high degree of confidence that the designated CLASS plan is fiscally sound and consistent with the statutory requirements.

We developed a broad range of alternative CLASS benefit plan options and used independent actuarial models and analysis by the CLASS Office Actuary to compute premium estimates and assessments of the actuarial soundness of the plans. These analyses indicate that the premium for the Basic CLASS Benefit Plan, which is the benefit design that follows from the most natural reading of the statute, produces a benefit costing between \$235 and \$391 dollars a month, and may cost as much as \$3,000 per month, if adverse selection is particularly serious. Moreover, the benefit in this plan, which calls for an average fifty dollar per day benefit for a beneficiary's lifetime, diverges significantly from the design most buyers in the private market choose. Most buyers prefer higher daily benefits over a few years. The benefit package described in the CLASS Act will make it difficult to attract purchasers who could otherwise meet underwriting requirements and obtain policies in the private market. If healthy purchasers are not attracted to the CLASS benefit package, then premiums will increase, which will make it even more unattractive to purchasers who could also obtain policies in the private market. This imbalance in the beneficiary pool would cause the program to quickly collapse.

We have identified potential benefit plans that could be actuarially sound and avoid the risk of adverse selection. These plans have benefit designs and premiums that appear marketable. Some of the characteristics of these plans include, for example, phased enrollment, higher earnings requirements for enrollees, and improved benefit design. All of these design options rely on the following strategies: they significantly increase the minimum earnings requirement specified in the statute, modifying it from \$1,120 to at least \$12,000 per year; they alter the benefit package so that it more closely resembles the typical package in the private market; and they phase enrollment in the plan, initially limiting eligibility to groups with better-than-average health risk profiles. While these benefit plan options show some promise in achieving actuarial solvency, they may be inconsistent with other provisions of the statute. There is concern regarding the legal authority for some of the plan features expected to increase solvency, and the more of those features that are incorporated into the plan, the greater the legal risk. In other words, as we take necessary steps to mitigate solvency risks, we concomitantly raise the legal risk that the plan could be found impermissible under the statute. If some of these solvency enhancements have to be changed, it is highly likely that the CLASS program could no longer continue and, as noted above, it is not clear whether the program could deliver on its commitment to those participants who had already enrolled.

Recommendation

For the reasons stated above, I do not see a path to move forward with CLASS at this time. I recommend that we work with Congress and stakeholders, including consumers, insurers, and

employers, to continue exploring all of the options to address the critical long-term care needs of Americans.

A Report *on the*
**Actuarial, Marketing,
and Legal Analyses**
of the **CLASS Program**

U.S. Department of Health and Human Services



INTRODUCTION

The Community Living Assistance Services and Supports (CLASS) Act was enacted as Title VIII of the Patient Protection and Affordable Care Act (ACA), P.L. 111-148 (Mar. 23, 2010), which amended the Public Health Service Act, 42 U.S.C. section 201 *et seq.*, by adding the CLASS Act as Title XXXII. The law was designed to establish a voluntary, national insurance program for American workers to help pay for long-term services and supports they may need in the future. The CLASS program seeks to help enrollees live independently in the community and to give them considerable freedom to determine the necessary services and supports they purchase with their coverage. By statute, CLASS benefits must be funded entirely through enrollee premiums; there is no taxpayer subsidy. Appendix A includes a description of the Act that was prepared by the CLASS Office to guide their work.

There is a critical need to find ways to help Americans prepare for their long-term care needs. Almost seven out of ten people turning age 65 today will experience, at some point in their lives, functional disability and will need some paid or unpaid help with basic daily living activities. While most people who need long-term care are in their 70s and 80s, young people also can require care, with 40 percent of long-term care users today between the ages of 18 and 64.

Long-term care is also expensive. While costs for nursing home care vary widely, they average about \$6,500 per month, or anywhere from \$70,000 to \$80,000 per year. People who receive long-term care services at home spend an average of \$1,800 per month. Expected lifetime long-term care spending for a 65 year old is \$47,000; sixteen percent will spend \$100,000 and five percent will spend \$250,000. Medicare does not cover long-term care services. Medicaid pays for such services only for people with limited financial means; qualifying for Medicaid often means exhausting all other resources.

Furthermore, few private mechanisms are available to help people plan ahead to pay for their future care. Long-term care insurance, by far the most popular private option available, can be costly and difficult to purchase for those with pre-existing health conditions or disabilities. Only about 2.8 percent of Americans have a policy. For workers who already experience a disability and a need for long-term services and supports, the options are even fewer.

The CLASS Act would add a new option for people who are employed. Among the unique and attractive features that differentiate it from long-term care insurance products available on the private market are that it offers lifetime benefits, is not underwritten, and provides a cash benefit.

The CLASS Act directs the Secretary of the Department of Health and Human Services (HHS), “in consultation with appropriate actuaries and other experts, [to] develop at least 3 actuarially sound benefit plans as alternatives for consideration for designation by the Secretary as the CLASS Independent Benefit Plan under which eligible beneficiaries shall receive benefits under” the law. The Act requires that each of the plan alternatives be designed to provide the benefits specified in the law consistent with a set of requirements, also specified in the law, concerning, among other things, premiums, the vesting period, benefit triggers, and the cash benefit. Of particular significance, the Act makes clear that the Secretary shall establish

premiums for each plan “based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.”

Consisting of two parts, this report documents the work undertaken by the Department of Health and Human Services (HHS) to fulfill the Secretary’s responsibilities under the law. Part One describes the organizational, analytical, policy, and implementation steps taken by HHS to develop the CLASS plan alternatives and prepare for implementation. Part Two provides legal analysis of the plans undertaken by the Office of the General Counsel.

This report also includes numerous links to material posted on the Web and over 200 pages of appendices. These materials more fully describe ideas that are only summarized in the report for the sake of brevity and readability. Complete descriptions of all the CLASS benefit designs that were considered can be found in the report of the CLASS Chief Actuary in Appendix O. We also include links to influential research briefs and analyses that helped shape the thinking behind the policies that are discussed in the report. In the interest of openness and transparency, we have also included relevant information about consultations and meetings with experts and stakeholders.

PART I: DEVELOPING THE CLASS PROGRAM

This Part describes the organizational, analytical, policy, and implementation steps taken by HHS to develop the CLASS plan alternatives and prepare for implementation. It consists of seven sections. Section One outlines the offices and divisions within HHS and the roles played by them, and the functions and status of two federal advisory committees created by the CLASS Act. Section Two briefly outlines the HHS process used for identifying policy issues and enumerates the issues identified. Significant documents (both internally and externally developed) that informed policy and implementation discussions are noted. Section Three lists public presentations, along with links to the relevant Congressional hearing record. Section Four discusses the work undertaken to draft proposed regulations. Section Five presents the activities conducted to support marketing the program to employers and individuals, as well as consumer research. Sections Six and Seven describe the development of two actuarial models for conducting estimates for CLASS premiums and the plan options that were developed and modeled, respectively.

SECTION ONE: HHS MANAGEMENT

PRE-ENACTMENT

The Office of Disability, Aging and Long-Term Care Policy in the Office of the Assistant Secretary for Planning and Evaluation (ASPE) led the analytical work relating to CLASS prior to enactment. For 30 years, ASPE has maintained the only office in the federal government dedicated to long-term care (LTC) policy research and analysis. ASPE’s LTC research portfolio includes, among other topics, an extensive array of projects on LTC reform, planning and awareness, insurance, community services and financing. ASPE originated and managed the Cash and Counseling demonstration, on which the CLASS cash benefit is based.

In the months leading up to the passage of the ACA, the Department was asked to provide technical assistance on the CLASS program to Members of Congress and staff. That technical assistance was provided by senior staff from the Administration. The technical assistance was based, in part, on analyses conducted by HHS using pre-existing actuarial and economic studies of CLASS and similar proposals (including analyses by the CMS Actuary, http://www.cms.gov/ActuarialStudies/Downloads/HR3962_2009-11-13.pdf, http://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2009-12-10.pdf and http://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf) and the American Academy of Actuaries, http://actuary.org/pdf/health/class_july09.pdf), data on disability rates among workers, and data based on state experiences with various LTC financing initiatives. These senior leaders were asked to brief House and Senate Committee members and their staff in person and by telephone during the fall of 2009.

In October 2009, prior to enactment, ASPE's Deputy Assistant Secretary for Disability Aging and Long-Term Care Policy discussed the bill at a meeting held by the Kaiser Family Foundation. There he emphasized the Department's support for the program but also recognized that it faced significant challenges that would need to be addressed (<http://www.kff.org/healthreform/kcmu102009pkg.cfm>).

In September and December 2009, HHS met with House and Senate staff about CLASS. During this same period, HHS also met to discuss CLASS with the Actuary for the Centers for Medicare and Medicaid Services (CMS) and with staff of the Congressional Budget Office (CBO). HHS also held meetings with the American Academy of Actuaries and the Social Security Administration (SSA) Actuary. In December and January, Senate staff asked HHS to begin developing a list of technical corrections to the bill, to address concerns on which there was broad consensus.

POST-ENACTMENT

Upon enactment of the ACA, the Secretary established implementation work groups, including the Long-Term Care Work Group, which was charged with overseeing the identification and analysis of policy issues related to CLASS and the multiple Medicaid long-term care provisions of the ACA. With participation from across HHS, this group was co-chaired by ASPE's Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy and the Director of the CMS Disabled and Elderly Health Programs Group. More details about the work group are provided below under "Identification, Analysis, and Discussion of Policy Issues."

On April 22, 2010, the CMS Actuary issued a memo on the estimated financial impact of the ACA. Regarding the CLASS program, he asserted that after fiscal year 2025:

The new Community Living Assistance Services and Supports (CLASS) insurance program would produce an estimated total net savings of \$38 billion through fiscal year 2019. This effect, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a very

serious risk that the program would become unsustainable as a result of adverse selection by participants.¹

In late spring 2010, Secretary Sebelius asked Kathy Greenlee, Assistant Secretary for Aging, to take the lead on implementing CLASS.² ASPE worked closely with the HHS Assistant Secretary for Administration to develop alternative designs for the location and structure of the CLASS office.

CLASS staff recruiting began in October 2010. A detailee from the U.S. Office of Personnel Management who had experience implementing and managing the Federal Long-Term Care Insurance Program led the effort. Also during this time, one staff person from the HHS Office of Medicare Hearings and Appeals (OMHA) began a three month detail to work at ASPE on the policy and implementation issues related to CLASS appeals. The first non-detailed CLASS staff member was hired September 27, 2010, the CLASS Chief Actuary began work in January 2011, and approximately 14 FTEs were hired by May 2011. As of October 15, 2011, there are seven individuals assigned part or full time to the CLASS office.

In late 2010 HHS decided to place the CLASS Office within the Administration on Aging (AoA), and published a notice of reorganization in the Federal Register on January 28, 2011 (Appendix C). The basis for that decision was that it would be the most cost-effective way of implementing and running the CLASS program. At that time, the Assistant Secretary for Aging was named the Administrator of the CLASS program. The Long-Term Care Work Group was disbanded in March 2011.

ASPE continues to conduct policy analysis and research to inform CLASS implementation and, most significantly, to maintain and run the two actuarial models that were developed to generate CLASS premium and participation estimates. Details on ASPE's research and on the actuarial models appear in subsequent sections of this report.

ORGANIZATION OF THE CLASS OFFICE

The CLASS Office was originally organized into six divisions:

- Actuarial Integrity and Benefit Design
- Benefits Administration and Enrollee Services
- Regulatory Affairs
- Information Systems
- Marketing and Employer Outreach
- Program Integrity, Evaluation, and Compliance

¹ Memo from Richard S. Foster, CMS Office of the Actuary, April 22, 2010, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended."

² The initial plan was to set up an independent CLASS Office in HHS. Secretary Sebelius sent letters to key members of Congress alerting them about the organizational change being contemplated. (See Appendix B for copies of the letters.) It was subsequently decided for budget and management reasons to establish the CLASS Office within the Administration on Aging.

An organizational chart is located in Appendix D. Each division developed work plans, delineating the steps and products necessary to move to full program implementation. These work plans were put together in a flow chart so that CLASS management could be coordinated across many functions. (Appendix E contains the summary flow chart.)

CLASS FEDERAL ADVISORY COMMITTEES

The CLASS Act authorizes two Federal Advisory Committee Act panels: the CLASS Independence Advisory Council and the Personal Care Attendants Workforce Advisory Panel. The CLASS Office has a contract in place to plan and manage the meeting logistics for both committees.

- CLASS Independence Advisory Council

Secretary Sebelius signed the charter for the CLASS Independence Advisory Council on November 9, 2010. This Council is charged with advising the Secretary on matters of general policy in administering the CLASS program and formulating regulations. A notice appeared in the Federal Register on November 16, 2010 announcing the establishment of the Council and soliciting nominations. (Appendix F) The nomination period was open from November 16, 2010 to December 1, 2010 and the CLASS Office received over 140 nominations. The Council has not been named yet.

- Personal Care Attendants Workforce Advisory Panel (PCAWAP)

The PCAWAP was authorized in the CLASS Act but is not directly related to the CLASS benefit. The purpose of the Panel is to “examine and advise the Secretary and the Congress on workforce issues related to personal care attendant workers.” Secretary Sebelius signed the charter for the PCAWAP on June 4, 2010. A notice establishing the Panel and a call for nominations appeared in the Federal Register on June 16, 2010.

An initial nomination package was sent to the Office of the Secretary (OS) in October 2010. Upon review, the list of proposed panel members was revised and a new nominations package was sent to the Secretary in April 2011. Secretary Sebelius approved the nominations and sent letters of invitation to the nominees. Thirteen of the fifteen nominees accepted, and those members have completed the HHS Human Resources on-boarding process required for Special Government Employees. Additional nominees have been identified to fill the two open seats, but final selections have not been made. Appendix G contains the PCAWAP announcement and membership list.

SECTION TWO: IDENTIFICATION, ANALYSIS, AND DISCUSSION OF POLICY ISSUES**LONG-TERM CARE WORK GROUP**

In addition to its chairs, ASPE's Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy and the Director of the CMS Disabled and Elderly Health Programs Group, membership in the Long-Term Care Work Group included representatives from: the Immediate Office of the Secretary; the Administration on Aging; the Offices of the Assistant Secretaries for Legislation, Financial Resources, and Administration; the Office on Disability; the Administration on Developmental Disabilities; the Office of the General Counsel; the Office for Civil Rights; the Substance Abuse and Mental Health Services Administration; the Indian Health Service; the National Institutes of Health; and the Executive Secretariat.

Members of the group took responsibility for preparing policy papers and presenting their work at weekly meetings. The group's primary purpose was to review the CLASS statute thoroughly, and to identify all of the policy issues that needed to be addressed. Leaders of the group briefed senior HHS leaders.

The issues presented and discussed are summarized below; the full papers are contained in Appendix H.

Enrollment and Vesting. This discussion covered five significant enrollment issues: (1) opt out and payroll deductions; (2) alternative enrollment processes; (3) penalties for lapsing; (4) delays in CLASS enrollment; and, (5) the definition of active employment. The group noted that both CBO and the Business Roundtable had identified the issue that the law mandated automatic enrollment only for employees whose employer had elected to participate in CLASS and that it was not likely that many employers would do so. Other options for enrollment such as employers offering information or a yes/no choice were discussed. Group members analyzed the implications of policy holders lapsing, or skipping multiple payments. Thus, individuals could strategically (and legally) "game" the program, threatening financial stability. The group considered a variety of strategies for addressing the lapsing issue. The group also considered different ways to approach the earnings requirement during the vesting period. The group discussed whether individuals would be required to pay premiums while in benefit status. In an early meeting with representatives from the IRS, HHS officials learned that the IRS code had not been amended to cover payroll deductions for CLASS premium payments so that the protections that addressed the potential failure of employers to pay money withheld from other payroll deductions would not apply to the automatic withholding of CLASS premiums. Enrollment options were discussed to address this concern.

Indexing of Premiums. Based on internal analyses and discussions with outside experts, there was a concern that structural imbalances created by the statutory requirement to index benefits but not premiums would result in threats to take-up and solvency. The group analyzed and discussed the implications of both indexing and not indexing premiums.

Eligibility. The group discussed a number of eligibility issues, including the definition of a "licensed health care professional" and how limitations in activities of daily living (ADLs)

would be assessed for individuals with dementia and other non-physical impairments. The group suggested that the actuaries model the program using as eligibility triggers two and three ADLs to support future decision making. The group also noted that the tiering provisions in the CLASS Act, which provide that there must be at least two levels of cash benefits depending on the individual's functional limitations, could create incentives to overstate ADL limitations. It was therefore important to consider the design of the benefit tiers carefully. The group also commissioned a paper on assessment of people with cognitive impairments. This paper is discussed under Additional Analyses, below.

Cash Benefits. The work group discussed cash benefits – including their structure and management and consumer privileges, responsibilities and issues related to using debit cards for cash benefits. Much of the analysis was based on extensive ASPE sponsored research on cash benefits and consultation with experts from other nations that use cash benefits for long-term services and supports.

Protection and Advocacy and Advice and Assistance. The group suggested that protection and advocacy (P&A) and advice and assistance services, which are required benefits under the CLASS Act, should be targeted to beneficiaries once they are in claim status.

Administrative Expenses. The group discussed various ways to analyze and implement the statutory three percent cap on administrative expenses provision. ASPE directly analyzed data from regulatory filings from several states, obtained information from outside actuaries and contracted for additional actuarial analyses from the Actuarial Research Corporation (ARC). It concluded that the range of administrative costs is six to twenty percent in the private LTC insurance industry.

Interaction with Medicaid. The group discussed how the Department could address the multiple interactions between Medicaid and the CLASS program.

Additional staff analyses provided to the work group on marketing and information systems are discussed in detail elsewhere in this report.

ADDITIONAL ANALYSES

ASPE procured four immediate analyses in order to address issues related to CLASS policy development and implementation; in addition, consistent with ongoing long-term care planning and awareness research done over the past eight years, ASPE contracted for a consumer survey and series of focus groups about LTC planning. The CLASS Office published a Request for Information on enrollment and premium administration systems (see Appendix I); no contracts have been awarded for administration systems.

The four analyses procured by ASPE, found in Appendix J, are:

- A paper on underwriting (specifically, on individuals who are typically precluded from buying private LTC insurance policies because of underwriting) from LifePlans. This paper provided insight into a potential target market, individuals who are interested in purchasing LTC coverage but are unable to do so due to underwriting. The paper concluded that additional research would need to be conducted on this pool of likely buyers to ensure that their risk profile is taken into account in setting program premiums.

- A paper on assessment instruments and procedures for identifying ADL impairment equivalents in individuals with cognitive impairments, by Katie Maslow, an independent consultant and nationally recognized expert in dementia. This work provided a thorough review of strategies for assessing the eligibility of people with dementia for LTC programs.
- A “Strategic Analysis of HHS Entry into the LTC Insurance Market,” in which business experts analyzed the LTC insurance industry and the CLASS statute and offered their views on how CLASS could be positioned and how private industry might respond. The authors noted the possibility that private companies might begin offering CLASS-like products.
- An exploration by Univita (a private company that provides administrative and management support to LTC insurance companies) about cash benefits in the private LTC insurance market. This paper concluded that consumers prefer cash for the flexibility it offers, but that cash benefits are more expensive to administer because of the recordkeeping involved.

REVIEW OF KEY EXTERNAL PAPERS AND ANALYSES

In addition to commissioning papers and conducting internal analyses, HHS staff and leaders reviewed a large number of papers and reports written outside the Department. These included:

- Kaiser Family Foundation briefs on CLASS
- A National Health Policy Forum brief on CLASS
- A series of papers commissioned by the SCAN Foundation (<http://www.thescanfoundation.org/commissioned-supported-work/class-technical-assistance-briefs>)
- An actuarial analysis by Milliman (<http://publications.milliman.com/publications/healthreform/pdfs/perspectives%20on-community-living.pdf>)
- The experience of the California Public Employees’ Retirement System
- An actuarial analysis of an earlier formulation of CLASS that had been commissioned by AARP.

MEETINGS WITH EXPERTS AND STAKEHOLDERS

To inform the policy development process, HHS staff met with a wide range of experts and stakeholders with an interest in CLASS, as well as others with related interests. These included:

- Groups focused on providers of aging and disability home and community based services
- Consumer organizations representing long-term care users with disabilities (including groups focused mainly on seniors and multiple subgroups within the disability community)
- Nursing home and other provider organizations
- Organizations representing the long-term care workforce, including organized labor

- Representatives of the insurance industry
- Foundations interested in long-term care
- Payroll management and support companies
- State Medicaid, mental health and intellectual disabilities officials and the associations that represent them
- Actuaries with expertise in disabilities or long-term care.

A detailed listing of these meetings can be found in Appendix K.

SECTION THREE: PUBLIC PRESENTATIONS

The Department presented and discussed its work on CLASS in numerous public meetings and Congressional hearings following enactment. Public presentations included forums and meetings sponsored by AcademyHealth, Alliance for Health Reform, AARP, the Long-Term Care Discussion Group, and the Kaiser Family Foundation (where Secretary Sebelius spoke about CLASS in February 2011; the speech can be accessed at <http://www.hhs.gov/secretary/about/speeches/sp20110207.html>).

CLASS leaders and staff spoke at national meetings (e.g., 17th Annual Policy Briefing of the National Association of Area Agencies on Aging, Intercompany LTC Insurance Conference) in March, April and May 2011. Administrator Greenlee spoke about CLASS to the American Health Lawyers Association in February 2011 and to the Society of Professional Benefits Administrators in March 2011.

In addition, CLASS was the focus of a hearing held by the House Energy and Commerce Committee, Subcommittee on Health on March 17, 2011. (Written testimony can be accessed at <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/031711/Greenlee.pdf>) Secretary Sebelius also discussed CLASS at a March 30, 2011 hearing before the Senate Finance Committee.

SECTION FOUR: REGULATION DEVELOPMENT

The CLASS Office began developing CLASS Act implementing regulations in January 2011, building on the policy option papers prepared by the LTC Work Group and legal advice from the HHS Office of General Counsel (OGC).

The CLASS Office prepared the CLASS Regulations Development Plan (CLASS RDP) document in February 2011. The CLASS RDP established a framework for rulemaking and compiled documents describing: the roles and responsibilities of the various entities participating in the regulation development process; the Secretary's rulemaking authorities and requirements; rulemaking steps; development activities; and other considerations.

Also in February 2011, the CLASS Office began forming the CLASS Regulations Project Team, an interdepartmental group of subject matter experts that included representatives from ASPE, the Centers for Medicare and Medicaid Services (CMS), the Office on Disability (OD), the

Office for Civil Rights (OCR), and the Office of the General Counsel (OGC). The team was tasked with providing initial informal review of draft regulations. Ultimately the CLASS Office determined that additional actuarial and legal work was required prior to drafting the appropriate regulatory language needed for the Notice of Proposed Rulemaking (NPRM). After the CLASS Chief Actuary was hired, the CLASS Office recognized that several critical issues needed to be more fully developed internally before regulations could be developed.

Many of the regulations related solely to operational aspects of the CLASS program have been drafted. For example, the CLASS staff has made significant progress in drafting regulations in the following areas: enrollment; waiver of automatic enrollment; lapse in enrollment and disenrollment; reenrollment; payment of premiums; and benefit eligibility. The draft regulations did not address key benefit design issues because policy and legal analysis were still underway.

SECTION FIVE: MARKETING RESEARCH AND LTC PLANNING

Secretary Sebelius and Administrator Greenlee have clearly stated on multiple occasions that the CLASS program will not go forward unless it is solvent, sustainable, and consistent with the law. Program solvency depends on premiums, benefit payouts, and take-up rates — enough people buying CLASS policies. Attracting enrollees with lower health risks, people who pay premiums over a long period of time before needing long-term services and supports, is also critical. Achieving sufficient take-up rates and attracting an average mix of enrollees with respect to their health status both depend heavily on marketing.

To prepare for implementing the CLASS program, the Department made a targeted set of investments in consumer awareness and marketing of possible CLASS benefit options that are described below. Not all of the findings from the marketing research are available yet. The research will provide an understanding of: how potential buyers think about long-term care planning; how they make decisions about what and when to buy and how much they are willing to spend; and, how employers think about whether to offer LTC coverage and how they would respond to the opportunity to offer CLASS to their employees. HHS commissioned this research in order to understand whether potential CLASS plan designs would be attractive to a large enough group of buyers. The observations about marketing that are made later in this report rest on preliminary analyses of the marketing research conducted thus far or consultations that HHS has had with experts in long-term care insurance.

In addition, HHS has conducted research for the past fifteen years to understand consumers' knowledge about long-term care, their experiences arranging or providing care, their attitudes about planning ahead, and their assessment of their own risk for needing long-term care. HHS has considered findings from this research in formulating and modeling premiums and take-up rates for the proposed plan options.

Initial CLASS Marketing Strategy. Initial planning for a CLASS marketing strategy identified two primary sets of customers -- employers and consumers. For CLASS to obtain a sufficient level of enrollment, marketing campaigns would have to target both groups. To determine how best to market to each group, HHS sought to learn more about their respective attitudes and preferences, then identify those within each group who were most likely to participate in the CLASS program. To prepare for developing marketing strategies for both groups, several

research and message development procurements were conducted by ASPE and the CLASS Office in the three following areas: Consumer Research, Employer Research and Long-Term Care Awareness Activities.

Long-Term Care Awareness Survey. In 2010, ASPE awarded a contract to RTI International to design a large, nationally-representative survey to study the attitudes, experiences, opinions and actions of Americans related to planning for long-term care services. The data collection contract was awarded to Knowledge Networks. At the time of contract award, ACA had not yet passed and the purpose of the contract was to gain knowledge for future phases of existing long-term care policy (such as the Own Your Future campaigns). Upon passage of ACA, ASPE expanded the scope of the project to include background research for CLASS. The survey, which is not yet completed, will also employ a discrete choice experiment that will measure individuals' preferences for various attributes of plans at specific price points.

Qualitative Research. ASPE contracted with Thomson Reuters to conduct a number of in-person focus groups and interactive discussions as part of the background research for both the CLASS program and the larger survey effort. Participants in the focus groups, which took place in three cities (Baltimore, MD, St. Louis, MO and Edison, NJ) considered the value to consumers of various CLASS program proposals, consumers' cost/benefit analyses and their reaction to federal government sponsorship. The research sought to help identify factors that facilitate or inhibit planning for long-term care. Knowledge Networks convened the interactive discussions using members of their KnowledgePanel[®]. The data from the interactive discussions informed hypothetical questions for the design and administration of the survey mentioned above. Each interactive and in-person discussion solicited from participants reactions, opinions and ideas related to various aspects of long-term care planning and awareness.

Highlights of the findings from the focus groups include: (1) women are more likely to believe that they will need care in their older years compared to men; (2) the belief that one will need long-term care does not necessarily translate into purchasing LTC insurance; (3) many people believe that postponing the purchase of insurance will save money; and (4) many people think that an insurance policy should cover all costs of care; anything less is inadequate. Respondents reacted negatively to vesting periods and complicated benefit plans. Respondents reacted positively to the absence of underwriting, and the option of a cash benefit. Reasons for not purchasing insurance involve cost, first and foremost, but also involve other expenses (such as college tuition and weddings), a perception that insurance is akin to gambling, and the lack of a perceived need for it (particularly among men). Respondents also believed that there should be incentives to purchase long-term care insurance, such as tax deductions.

Development of a Strategic Brand for CLASS. The CLASS Office released a solicitation to develop a strategic brand for CLASS, but no procurement was awarded.

Employer Research. The CLASS Office released a solicitation to assess the potential for employers of all types and sizes to sponsor the CLASS program as a voluntary employee benefit, but no procurement was awarded.

LONG-TERM CARE AWARENESS ACTIVITIES

The CLASS Office released a solicitation to design a plan for a national long-term care awareness campaign to be implemented over a five-year period and to enhance and continue the operation of the National Clearinghouse for Long-Term Care Information (Clearinghouse) as authorized by Section 6021 (d) of the Deficit Reduction Act of 2005, and extended by Section 8002 (d) of the Affordable Care Act. The Clearinghouse Procurement represents the Department's longstanding effort to increase consumer awareness of the need to plan ahead for long-term care. This procurement will facilitate consideration of a broader awareness effort while also enhancing the Department's existing awareness activities. Clearinghouse enhancements include a transition from direct mail to web-based outreach, and a refinement of the long-term care planning calls to action.

SECTION SIX: ACTUARIAL MODEL DEVELOPMENT

By April 2010, it became clear that existing actuarial models that had been used before enactment of the CLASS Act (both those already relied on by HHS and those being developed by outside groups such as Boston College) would be insufficient to provide CLASS estimates and new models would have to be developed. Actuarial modeling of the CLASS program was undertaken by staff in ASPE, and reviewed by the CLASS Office. The model development and modeling were largely supported through a long-standing contract between Actuarial Research Corporation (ARC) and ASPE, and a new contract with Avalere Health that began in September 2010. The rationale for developing two models was to compare premiums and other program dynamics using different methodological approaches and data and to assess the sensitivity of results to varying model assumptions. This is standard practice in the insurance industry when developing new products. Further, the ARC model does not include Medicaid offset estimates, while the Avalere model does. The key economic and demographic/actuarial assumptions are largely the same. This section briefly describes the two actuarial models, and model development and estimation across three phases: early model development and estimation; model refinement and development of preliminary benefit options; and final model development and estimation.

Both models adopted conservative assumptions that would tend to produce higher premiums and lower take-up rates than the best existing empirical evidence might suggest. For example, in modeling adverse selection it was assumed that potential enrollees would sort themselves perfectly by health status and join CLASS in reverse order (the most disabled first). The models used conservative assumptions because the existing empirical evidence is relatively sparse and there is great uncertainty around the existing estimates.

SUMMARY OF ACTUARIAL RESEARCH CORPORATION'S LONG-TERM CARE PREMIUM MODEL

The ARC Long-Term Care Premium Model is designed to calculate long-term care insurance premiums for a government-operated, self-financing program and to project cash flow to assist policymakers in understanding program dynamics (see Appendix L for an in-depth description of the model). It can model various CLASS benefit structures under user-selected assumptions related to: program options, economic and demographic/actuarial assumptions (including

antiselection/adverse selection), and long-term care utilization. The latter two sets of assumptions do not vary according to the program options, but are parameters used in the formulas to calculate premiums. Input and output are in Microsoft Excel Worksheets with program calculations performed in Visual Basic for Applications (VBA). The computer code underlying these calculations can be viewed by simply opening Excel's Visual Basic Editor.

The key program options that can be modeled include alternative formulations of the following provisions of the CLASS program:

- vesting and work requirements
- earnings requirements
- benefit triggers
- daily benefit amount
- duration of benefits
- scheduled increase in premiums (i.e., indexing to a specific percentage increase or none);
- waiver of premium while on claim (full, partial, or none)
- participation rate
- administrative expense load on premiums.

Two approaches to adverse selection are built into the model: a theoretical approach and a first-year assumption regarding additional claims (a.k.a. the "first-in" method). The theoretical approach is based on a formula that assumes that adverse selection is greatest at the time of issue and declines the longer an individual is enrolled in the program. The second approach is based on observed data and an estimate of the number of people who are immediately eligible to enroll in the program and who also meet the ADL or cognitive requirement to qualify for benefits. This alternative method assumes that 100 percent of the population with limitations in ADLs or severe cognitive impairment would: (1) choose to enroll in the CLASS program the first year policies are offered, (2) survive the 5-year vesting period, (3) meet the work requirements during the vesting period, and (4) file a claim as soon as possible. After the first year in which benefits are paid, incidence rates for policyholders are assumed to be the same as general population incidence.

The model uses the 2011 OASDI Trustees Report, the Current Population Survey (CPS), the National Health Interview Survey (NHIS), the National Long-Term Care Survey (NLTC), and the National Nursing Home Survey (NNHS). The model uses the 2011 OASDI Report and the CPS to set input parameters related to future inflation, mortality, interest rates, and labor force participation. The model uses the NHIS, NLTC, and NNHS to estimate initial long-term care utilization by age and sex. Program options, economic and demographic/actuarial assumptions, and utilization can be saved and retrieved so that estimates can be replicated easily, and the impact of individual assumptions, or sets of assumptions, can be determined.

SUMMARY OF AVALERE HEALTH'S REVISED LONG-TERM CARE POLICY SIMULATOR

Avalere Health's Revised Long-Term Care Policy Simulator (LTC-PS) is an Excel-based model that tracks age-specific groups of CLASS program enrollees for 75 years (see Appendix M for an

in-depth description of the model). The LTC-PS builds off a long-term care premium calculator originally developed under a grant from The SCAN Foundation. ASPE contracted with Avalere Health in the fall of 2010 to expand the capacity of the original model to incorporate key features of the CLASS program and a wider set of assumptions.

The basic approach to estimating premiums is similar to ARC's Long-Term Care Premium Model in that the present value of total expected costs of the program (including administrative costs) must equal the present value of total expected income (premiums plus interest on accumulated reserves). The estimated premium represents the average premium required in the initial year for each age of enrollment to accomplish an actuarially balanced model. The model estimates the impact on premiums of different benefit triggers and benefit amounts, program enrollment rates, low-income premium subsidies, and various benefit structures (including cash vs. service reimbursement).

The model incorporates adverse selection through an approach that is a hybrid of that used in the ARC model. Specifically, the LTC-PS estimates the number of people by age that will develop a severe disability over the next five years, and given a rate of assumed overall participation in the program, compares the number of people that would enroll in the program against the total estimated incidence of disability for the entire eligible population over the next five years. Under a pure adverse selection scenario, the model assumes that all people who would develop a severe disability will enroll in the program; this is similar to the ARC "first-in" method. However, because perfect adverse selection is unlikely to occur, the model builds in several factors that dampen the impact of adverse selection at initial enrollment and over time.

The LTC-PS uses many of the same sources of data as the ARC Long-Term Care Premium Model. For example, the model bases key economic and demographic assumptions on the 2011 OASDI Trustees Report, and uses data from the NNHS and NLTCs on the older population with disabilities, both living in the community and institutions. However, unlike the ARC model that relies on the CPS and NHIS for labor force participation and core disability data, the LTC-PS uses the American Community Survey and the Survey of Income and Program Participation.

PHASE I. EARLY MODEL DEVELOPMENT AND ESTIMATION (March 23, 2010 to September 22, 2010)

EARLY WORK ON THE ARC LONG-TERM CARE PREMIUM MODEL

ARC began preliminary modeling of CLASS in late 2009 to help HHS and other federal staff understand how premiums would vary based on different levels of participation and program options that were being considered by Congress at that time. Most of this work relied on an existing premium calculator that ARC had previously developed for a different purpose, and had quickly revised to model the major program features of the CLASS Act. Following passage of the ACA, ARC began to systematically review previous assumptions and premium calculations for accuracy. Major revisions to the model were undertaken through early summer 2010 to incorporate several aspects of the program that were not previously modeled in-depth, most notably the impact of the nominal premiums for low income persons and full-time students. In addition, staff at ARC began to update program parameters, the approach to adverse selection, demographic and actuarial assumptions, and input data. The ARC staff made these revisions

with the goal of having independent technical experts review the methodology, assumptions, and data used in the model during the summer of 2010.

The first draft describing the model was produced in early April 2010 and preliminary premium estimates were completed in late August. At that point, the estimated baseline average premium at 2 percent program participation for a \$50/day benefit based on a 2+ ADL trigger (or similar level of cognitive impairment) with full waiver of premium while in claim was \$354/month. Changing the parameters of the program to increase the work and earning requirements during the vesting period, and indexing the premium reduced the premium to an average of \$134/month. The impact on premiums of other changes to the program (e.g., increasing the vesting period to seven years; having enrollees continue to pay premiums if receiving home care; changing the duration of the benefit to seven years; and adding a 90 day elimination period) were also explored.

EARLY WORK ON THE AVALERE HEALTH MODEL

In early 2009, ASPE staff learned that Avalere Health was developing a long-term care premium calculator under a grant from The SCAN Foundation. Although the calculator was not intended to directly model the CLASS program, many of the components could be adapted to develop a more robust model that could more fully analyze aspects of CLASS. This was recognized by ASPE staff following the passage of the ACA as an opportunity to develop an alternative model to compare output from ARC, and to better understand how differences in methodology, assumptions, and input data affected premium estimates and CLASS program dynamics. After briefly considering revising the model in-house, ASPE decided to pursue a contract with Avalere Health directly. ASPE developed the Statement of Work and other contract documents over the summer of 2010; the contract was formally awarded to Avalere Health on September 17, 2010. The first contract activity was for staff at Avalere Health to attend a meeting five days later at HHS on actuarial modeling of the CLASS Act.

CLASS ACT MODELS MEETING

A half-day meeting of technical experts was held on September 22, 2010 to discuss progress on modeling the CLASS program (see Appendix N for the agenda, list of participants, and presentations). Participants included actuaries, economists, and analysts in health and long-term care in HHS, and members of several outside organizations, both public and private. The purpose of the meeting was threefold: (1) to describe the updated ARC Long-Term Care Premium Model and critically review the methods, assumptions and data underlying the model; (2) to describe and review Avalere Health's Long-Term Care Policy Simulator developed for The SCAN Foundation and plans for its revision to better model the CLASS program; and (3) to discuss outstanding technical issues and get feedback on such critical questions as:

- Do the models incorporate realistic assumptions related to incidence/continuance of functional limitations and trends in disability? Are the assumptions related to the prevalence and trends in cognitive impairment reasonable?

- Are there alternative approaches to modeling the relationship between CLASS participation and premiums?
- Is potential adverse selection adequately incorporated into the models?

Because the models were still being developed, the preliminary premiums that ARC produced in late August were not presented; the discussion was focused exclusively on how the two models could be improved going forward. Several suggestions that were raised in the meeting led to substantive changes in the models. For example, ARC expanded its approach to adverse selection, adding a second approach that eventually became the “first-in” method. Staff at ARC also further revised and updated key assumptions and data on long-term care utilization. Suggestions for ways to improve the Avalere Health model’s estimation of age-specific participation were also eventually incorporated.

PHASE II. MODEL REFINEMENT AND DEVELOPMENT OF PRELIMINARY BENEFIT OPTIONS (September 23, 2010 to June 22, 2011)

Actuarial work over this period focused on further revisions and testing of the ARC model, and the completion of a revised LTC-PS that could more completely model the CLASS program. HHS sought to have both models in “near final” condition (with extensive documentation) so that preliminary benefit options could be developed and tested, and a Technical Expert Panel (TEP) could thoroughly vet both models in spring 2011.

During this time period, the CLASS Office hired its Chief Actuary, also known as the Director of Actuarial Integrity and Benefit Design. He began developing potential plan designs to mitigate the effects of adverse selection. He also worked to review and understand the ARC and Avalere models and provided his perspective on those. He focused on program provisions having a significant influence on the benefit design, including that: (1) participation in CLASS is voluntary; (2) actuarial soundness is a requirement; (3) any successful benefit design must present a clear value proposition to attract enrollees; (4) no underwriting other than age can be used to set premiums or prevent enrollment; and, (5) CLASS is not an entitlement program. The CLASS Office brought in an actuary from the U.S. Office of Personnel Management on a temporary detail. He and the Chief Actuary coauthored a report, *Actuarial Report on the Development of CLASS Benefit Plans* (see Appendix O), which discusses their analyses and findings, and describes benefit plans that have the potential of being actuarially sound.

PROGRESS ON THE ARC LONG-TERM CARE PREMIUM MODEL

Staff at ARC continued to revise the model and update the input data based on suggestions made by the CLASS Chief Actuary and the participants in the CLASS Act Models Meeting in September 2010. In early January 2011, another set of baseline premiums was estimated along with several benefit options with various work and earnings requirements during the vesting period (at this point almost all estimation assumed that premiums would be indexed, i.e., increase according to a fixed schedule such as CPI-U). The estimated baseline average (indexed) premium was now slightly lower: \$339/month assuming 2 percent program participation for a \$50/day lifetime benefit that used a 2+ ADL trigger (or similar level of cognitive impairment)

with full waiver of premium while in claim. Increasing both the work requirement (to five years instead of three of five years) and earning requirement (to \$12,000 per year instead of \$1,120 per year) during the vesting period produced a slightly lower average premium compared to the \$134 estimate from April 2010: \$127/month. These premium estimates were forwarded to the Chief Actuary at the CLASS Office on February 17, 2011. Contemporaneously, staff in ASPE and the CLASS Office began to explore alternative benefit options that might lead to reduced premiums. Several of these were formally modeled (discussed further below and in the *Actuarial Report on the Development of CLASS Benefit Plans* which can be found in Appendix O) and eventually presented at the TEP meeting. Analyses of the implications of changes to key economic and demographic/actuarial assumptions continued in preparation for the TEP meeting as well as the development of final estimates to present to the TEP.

PROGRESS ON AVALERE HEALTH'S LTC-PS

Because the original LTC-PS was not designed to model CLASS, work by staff at Avalere Health concentrated on developing a thorough CLASS baseline prior to the planned TEP meeting and building in as much flexibility to model alternatives as possible. The first preliminary estimates were produced in late January 2011. The average premiums were very similar to those being estimated by the ARC model, although the distribution of premiums by age was different. Actuarial work in late winter and the spring, as well as drafting documentation, focused on preparation for the TEP Meeting which was scheduled for June 2011.

TECHNICAL EXPERT PANEL MEETING ON ACTUARIAL MODELING OF THE CLASS PROGRAM

The full-day meeting of the TEP took place on June 22, 2011 (see Appendix P for the agenda and meeting materials). As with the previous meeting, participants included actuaries, economists, experts in disability data, and analysts in health and long-term care; none of the formal members of the TEP were federal employees, although participants included the CLASS Chief Actuary, actuaries from SSA and CMS, and other technical experts. Time during the morning was devoted to presentations on the two models and a review of methods, assumptions, and data. The agenda in the afternoon consisted of a review of the premiums produced by each model under different sets of assumptions and alternative benefit designs. The TEP reached consensus that the models' methods and demographic/actuarial assumptions were credible and that the estimates were plausible. There was some debate as to whether the incidence rates in the ARC model were too high, and thus premium estimates also too high. The TEP also extensively discussed issues of adverse selection and suggested follow up work to improve the models' handling of adverse selection; however, TEP members reiterated that there was no definitive way to determine the impact of participation and adverse selection *a priori* because CLASS is such a unique program, and CLASS modeling would thus be inherently uncertain. The discussion of alternative benefit designs was brief and there were no strong opinions voiced one way or the other about specific options.

PHASE III. FINAL MODEL DEVELOPMENT AND ESTIMATION (June 23, 2011 to Present)

Model development at this stage has focused on further improvements to the ARC Long-Term Care Premium Model to take into account situations of extremely low enrollment (e.g., under 1 percent), modeling of an alternative benefit design contained in the *Actuarial Report on the Development of CLASS Benefit Plans* (Appendix O and further described in the next section), and additional reviews of both models' calculations and assumptions. Two independent actuaries are undertaking the latter effort as part of ASPE's ongoing contract with Avalere Health. The CLASS Actuary also explored an alternative approach based on information derived from Genworth's net premium rates, with adjustments (see page 14 of the *Actuarial Report on the Development of CLASS Benefit Plans*, Appendix O).

FEDERAL ACTUARIES MEETING

The CLASS Actuary convened a meeting of government actuaries on June 28, 2011 to discuss actuarial modeling on CLASS and alternative plan options. Attendees included actuaries from the CMS Office of the Actuary and the Center for Consumer and Insurance Oversight, the Social Security Administration, and the Office of Personnel Management. Additional attendees included CLASS and ASPE staff members. The group discussed plans outlined in detail in the next section of this report. The consensus was that some benefit options under consideration could theoretically reduce adverse selection and have the potential to be actuarially sound. However, concerns were raised about: how to interpret the three percent administrative cost provision contained in the law; the policy and administrative complexities associated with some of the options; the unique marketing challenges of offering a federal benefit to large employer groups; and the very high level of uncertainty around assumptions in the actuarial models.

SECTION SEVEN: PLAN OPTIONS

Since the passage of the ACA, numerous CLASS plan options have been considered (see the *Actuarial Report on the Development of CLASS Benefit Plans*, Appendix O, for the CLASS Chief Actuary's description of several of the benefit options). Those plan options whose parameters could be well-specified were modeled using the actuarial models described above, or by the Chief Actuary of the CLASS Office, under various assumptions about adverse selection, and different economic and demographic/actuarial parameters. Although a large number of plans have been modeled, the options can be grouped into roughly three categories: (1) those that are closest to the natural reading of the CLASS statute (benefit plan option one below); (2) benefit options that vary in limited, but important ways from the baseline (benefit plan option two below); and (3) benefit designs that vary much more from the baseline, either because of the sheer number of changes or because of modifications to key features of the program (benefit plan options three through eight).

The models described above estimate premiums for plans under a set of specific assumptions. The most critical of these assumptions are the assumptions around participation rates and adverse selection. Given these assumptions, the estimated premiums are, by definition, actuarially sound. However, the question of long-term solvency of the program depends on whether the

assumptions around take-up and adverse selection, as well as other model assumptions, are plausible. As neither the CLASS program nor any other program like it has existed before, there is much greater uncertainty around these assumptions than is the case around the corresponding assumptions for either private long-term care insurance or existing programs, such as Social Security and Medicare. As a consequence, less confidence can be placed in actuarial judgments about the long run solvency of the CLASS program than about corresponding assessments of private insurance or existing government programs.

Existing data sources provide an uncertain picture of what the CLASS claims experience would be. Survey data, such as those used in the ARC and Avalere models, provide information on the entire population but do not provide information on the future claims experience of the CLASS program. Private insurers' claims data provide information for those who qualify for private insurance (either underwritten or large group) but do not provide information for the CLASS benefit, which is very different from the typical private market product and targets a more diverse population.

Table 1 presents a summary of the actuarial model estimates for four representative plan options (Options 1-4) that were either modeled for the TEP meeting in June 2011 and the federal actuaries meeting convened by the CLASS Chief Actuary or estimated over the last few months. Because of the uncertainty around parameter assumptions, a range of average premiums is presented rather than a point estimate. Below, we describe each of these benefit plans, provide estimates of premiums, discuss actuarial soundness, and summarize points made in the discussion of these plan options.

Table 1. Summary of CLASS Plans Recently Modeled

Program Features	1. Basic CLASS	2. Modified CLASS	3. Enhanced CLASS Plan w/ Phased Enrollment	4a. Family of Options: Variation 1		4b. Family of Options: Variation 2	
				Modified CLASS	Increasing Benefits (CLASS Partnership)	Enhanced CLASS Plan w/ Phased En	Increasing Benefits (CLASS Partnership)
Enrollment Requirements:							
- Age 18+	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Taxable Wages/Income	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Actively Employed	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Not in Institution	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Coverage/Benefits:							
- Primary Benefit	Cash	Cash	Cash	Cash	Cash	Cash	Cash
- Daily Benefit Amount (DBA)	\$50 (Average)	\$50 (Average)	\$57.5 (Average) ¹	\$50 (Average)	Varies - Up to \$150 ¹	\$57.5 (Average) ²	Varies - Up to \$150 ²
- Unit of Payment	Daily or Weekly	Daily or Weekly	Daily or Weekly	Daily or Weekly	Daily or Weekly	Daily or Weekly	Daily or Weekly
- Minimum Duration in Years	NA - Lifetime	NA - Lifetime	NA - Lifetime	NA - Lifetime	3 Years	NA - Lifetime	3 Years
- Total Value	TBD	TBD	TBD	TBD	\$164,250	TBD	\$164,250
- Inflation Protection	CPI-U (2.8%)	CPI (2.8%)	CPI (2.8%)	CPI (2.8%)	CPI (2.8%)	CPI (2.8%)	CPI (2.8%)
- Advocacy Services	Yes	Yes	TBD	Yes	TBD	TBD	TBD
- Advice and Asst. Counseling	Yes	Yes	TBD	Yes	TBD	TBD	TBD
Eligibility for Benefits:							
- 5 Year Vesting Period	Yes	Yes	Yes	Yes	Yes	Yes	Yes
- Work Req. Over Vesting Period	At Least 3 Years	5 Years	5 Years	5 Years	5 Years	5 Years	5 Years
- Earnings Req. Over Vesting Period	\$1,120/Year	\$12,000/Year	\$12,000/Year	\$12,000/Year	\$12,000/Year	\$12,000/Year	\$12,000/Year

- 24 Months of Prior Prem. Payment	Yes						
- Minimum Benefit Trigger	2 or 3 of 6 ADLs ⁴	TBD	TBD	TBD	TBD	TBD	TBD
- Tiered Benefit	Yes	Yes	Yes	Yes	TBD	Yes	TBD
- Elimination Period in Days	0	0	0	0	0	0	0
- Presumptive Eligibility	Yes - if in Inst. ⁵						
- Administrative Expenses	3%	3%	3%	3%	3%	3%	3%
Monthly Premium:							
- Underwritten (Other Than Age)	No						
- Increasing Premium (Indexed)	No	Yes (2.8%)					
- Low Income Premium	Yes	No	No	No	No	No	No
- Full Time Student Premium	Yes	No	No	No	No	No	No
- Waiver of Premium	TBD						
- Level Premium	After Age 65 ⁶						

¹ Initial enrollment limited to group (employer) settings first; individual enrollment will begin after meeting target goals in the group market

² Initial \$50/day cash benefit for persons with 2-3 ADLs; \$60/day cash benefit for persons with 4+ ADLs or cognitive impairment; cash benefit is reduced by 80% after five claim years

³ The inflation-adjusted DBA increases over a 25-year period to the final amount; years 0-10=0%; years 11-15=5%; years 16-20=10%; years 21-25=29.5%

⁴ Or equivalent level of cognitive impairment

⁵ An active enrollee is presumed to be eligible for benefits if they are a patient in a long-term care hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental disease and are in the process of being discharged, or are within 60 days from the date of discharge

⁶ Enrollees age 65 and older who have paid premiums for enrollment for 20 years and are not actively employed are exempt from premium increases

1. BASIC CLASS PLAN

This plan option is based on the most natural reading of the statute and incorporates the key features of the plan described in law (e.g., eligible enrollees must be at least 18 years old and actively employed; there is no underwriting required for enrollment; the primary benefit is a lifetime \$50/day [on average] cash payment; before being eligible to receive a benefit, enrollees must wait five years and meet certain work and earnings requirements; etc.). Estimates for this option were produced by ARC and Avalere Health, and are described in Column 1 of Table 1 (“baseline”). Though the plan’s cash benefit would increase by the annual percentage change in the consumer price index for all urban consumers (CPI-U), the plan modeled by the actuaries assumes that the cash benefit would increase annually by a fixed percentage, 2.8 percent, which is equal to the long-range inflation forecast published in the 2011 OASDI Trustees Report. The actuaries did this because actuarial models cannot easily estimate future costs when benefits increase by an unknown and variable amount. It is important to emphasize that the 2.8 percent inflation adjuster is for actuarial modeling purposes only; for this option it is contemplated that CPI-U would be used for ongoing program operations.

Under the set of assumptions designated as Scenario II (Expected) (see Appendix Q for Table 2) discussed at the June 2011 TEP meeting, the average premium for a \$50/day lifetime benefit with a 2+ ADL trigger (or similar level of cognitive impairment) with full waiver of premium while in claim range from \$235/month to \$391/month. These estimates are based on a take-up assumption of 2 percent.

In the current private long-term care insurance market, most buyers choose products that provide a substantial daily benefit (e.g., \$150/day to \$200/day) for three to five years of coverage—daily benefit amounts that are significantly higher than the \$50/day lifetime benefit. This could be an issue for marketing CLASS to a broad population as participants in focus groups specifically mentioned that they preferred a benefit that covered more of the total cost of long-term care. Moreover, premiums for products similar to the CLASS benefit, when they are sold to an underwritten population in the private market, would cost much less than the estimated premiums above. Thus, most discussion of this Basic CLASS Plan suggested that the assumed take-up rates used to compute premiums could not be achieved and were not plausible.

2. MODIFIED CLASS PLAN OPTION

The benefit plan shown in Column 2 modifies three key aspects (highlighted in yellow) of the baseline CLASS benefit: first, the work requirement during the vesting period is increased from at least three of five years to five of five years; second, the earnings requirement during the vesting period is increased from \$1,120 per year to \$12,000 per year (the amount of earnings that SSA uses to determine whether a nonblind person is engaged in “substantial gainful activity”); and finally, the monthly premium is increased annually by a fixed percentage (modeled at 2.8 percent in this example). The latter

feature is sometimes referred to as an increasing premium schedule or “indexed” premium.

Increasing the work and earnings requirement over the vesting period significantly mitigates adverse selection, thus reducing the average premium. In addition, moving to an indexed premium instead of a constant (level) premium lowers the initial premium required to balance expected costs and expected income.

Under the set of assumptions designated as Scenario II (Expected) discussed at the June 2011 TEP meeting, the average premium for a \$50/day lifetime benefit with a 2+ ADL trigger (or similar level of cognitive impairment) with full waiver of premium while in claim declines significantly; premium estimates range from \$114/month to \$160/month. These estimates assume a take-up rate of 2 percent.

The reduction in premiums achieved under this option make the take-up assumption more plausible for the Modified CLASS Plan than for the Basic CLASS Plan. However, the ultimate take-up level is still unknown. The daily benefit amount remains lower than what is prevalent in the private market, which likely increases the risk of low participation rates, especially by those who are able to purchase private policies. In addition, as the federal actuaries noted, the statutory 3 percent limit on administrative costs could make it very challenging to market the product and achieve the expected level of participation. Thus, while the assumed take-up rate used to compute premiums under this model is plausible, there is a high degree of uncertainty about the long-run solvency of this option.

3. ENHANCED CLASS PLAN WITH PHASED ENROLLMENT

Column 3 of Table 1 shows the key features of a benefit option described in detail in the *Actuarial Report on the Development of CLASS Benefit Plans*. In various documents it is referred to as the Enhanced CLASS Plan with Phased Enrollment or simply Phased Enrollment. This benefit plan builds off the Modified CLASS Plan, but differs in two important respects (highlighted in blue). First, it uses an explicit two-tiered benefit structure for the first five years that a person is on claim:

- an initial \$50/day cash benefit for persons with 2-3 limitations in ADLs
- an initial \$60/day cash benefit for persons with 4+ limitations in ADLs or cognitive impairment.

After the fifth year, the daily benefit amount declines by 80 percent. Beneficiaries would therefore receive \$10/day and \$12/day for the above two tiers, respectively. For modeling purposes, it is assumed that the amount of the cash benefit is equivalent to a lifetime \$57.50 daily benefit.

The second difference between the Modified Class Plan and the Enhanced CLASS Plan is that initial enrollment in the program would be limited to certain group settings first, such as large employers; individual enrollment would begin after “group enrollment

meets a pre-set threshold,” explained in more detail by the CLASS Chief Actuary on page 10, *Actuarial Report on the Development of CLASS Benefit Plans*, Appendix O).

Early modeling of the Enhanced CLASS Plan with Phased Enrollment using the ARC Long-Term Care Premium Model produced an average indexed premium that ranges from \$99/month to \$106/month for a \$57.50/day lifetime benefit with full waiver of premium. A preliminary comparison of age-specific premiums is also shown on p. 14 of the *Actuarial Report on the Development of CLASS Benefit Plans*.

As observed by the CLASS Chief Actuary, this plan achieves a greater reduction in premiums than does the Modified CLASS Benefit. The range of estimated premiums is also more similar to what is observed in the private LTC insurance market, although the daily benefit is lower in CLASS. Successfully marketing the program remains a serious challenge due to the changing benefit amounts for beneficiaries. The phased enrollment approach could substantially reduce the degree of uncertainty around the rates of enrollment by healthier individuals. By opening the program to individual subscribers only when take-up has reached a threshold level, this approach could manage the risk of adverse selection and potential insolvency.

4. FAMILY OF OPTIONS: MODIFIED CLASS PLAN & SCHEDULED INCREASING BENEFITS

Columns 4a and 4b of Table 1 describe a set of benefit plans referred to as the “Family of Options.” One of the options would be consistent with the CLASS statute (e.g., the Modified CLASS Plan in the case of Variation 1). The structure of the other options would vary more extensively, but would continue to incorporate similar requirements for enrollment; a primary benefit that is cash; a five year vesting period; and no underwriting except for age. The Family of Options would be structured to offer either one or two tiers of eligibility for benefits. The Family of Options would be actuarially sound, either at the individual option level or, through cross-subsidization in their entirety. Finally, one of the options within the family would be designed so that purchasers could buy a private (underwritten) insurance product to “wrap around” this option and provide a higher level of benefit.

Column 4a shows one variation of the Family of Options that includes the Modified CLASS Plan and the Scheduled Increasing Benefits Plan discussed above. (Column 4b shows the corresponding Family of Options with the Enhanced Class Plan with Phased Enrollment paired with the increasing benefit option.) Several features of this plan (highlighted in orange) differ from aspects of the plans presented in Column 1 and Column 2. Specifically, the daily benefit amount increases the longer the CLASS policy is held without going into claim, rising from approximately \$20/day after the vesting period to \$150/day after 25 years. Also, the duration of coverage is limited to three years, although the expected payout for this benefit option could be designed in such a way as to be actuarially equivalent to that of the Modified CLASS Plan.

Figure 1 illustrates how the basic daily benefit amount (dark blue area) increases over a 25-year period to \$150/day (see Appendix R for Figure 1). This plan is sometimes referred to as the “CLASS Partnership” because the structure of the benefit provides an opportunity for private insurers to develop products that would naturally “wrap around” and supplement the underlying basic benefit (light blue area in Figure 1).

If there is no subsidization across benefits options, then the individual plans that make up any set of Family of Options can be priced independently (although specific assumptions related to participation and adverse selection could be adjusted to take into account expected interactions). The range of estimates for an average premium at 2 percent participation assuming a 2+ ADL trigger (or similar level of cognitive impairment) with full waiver of premium is \$112 per month to \$148 per month. These estimates do not include the cost of a supplemental policy. The total cost of an initial combined policy, for example, for a 50 year old enrollee who could pass underwriting, is currently estimated to be \$154 per month (\$118 per month for the basic policy and \$36 per month for the supplement).

This model achieves a somewhat greater reduction in premiums than does the Modified CLASS Plan. Because of the choice of benefit structure, this option offers benefits more similar to those available in the private market. With private supplementation, purchasers could achieve coverage comparable to that in the private market at similar prices. The design significantly mitigates adverse selection, and premiums do not vary much even under alternative assumptions about take-up rates.³ There were varying opinions about the marketability of the Family of Options design. Some believed that offering choice would be attractive; others thought that it would be burdensome and confusing, especially since the low administrative load for marketing permitted under CLASS would limit the ability to explain the plan. The great uncertainty about the marketability of this option means that uncertainty about the long run solvency of this option is very high.

5. TEMPORARY EXCLUSION PLAN

This benefit option addresses adverse selection through the claims process rather than the enrollment process. Specifically, any person who meets the enrollment requirements could join CLASS, but no benefits would be paid for the first fifteen years in the program if a limitation in ADLs or cognitive impairment during this period resulted from a serious medical condition that existed at the time of enrollment. The CLASS program would provide enrollees with a list of possibly exclusionary medical conditions, but no health information would be collected at enrollment. Only when a person sought benefits would a review of medical records occur to ensure that the limitation was not the result of an underlying condition at enrollment. Existing data available to the modeling team did not

³ This occurs for two reasons: first, persons who are likely to go on claim early are unlikely to enroll in an option that pays a small benefit during the initial years of the policy. Second, even if the CLASS Partnership option is selected against, the smaller payouts and three year duration of the benefit significantly bound the actuarial risk.

provide sufficient longitudinal information about underlying conditions and subsequent disability to model this option.

This plan would likely reduce premiums substantially because potential buyers with existing health conditions would recognize that they would not be able to claim for pre-existing conditions for fifteen years. There was concern that uncertainty about future benefit receipt would make it challenging to market this option (as purchasers could not be certain that a subsequent disability would not be tied to an underlying condition). Those who could meet an underwriting standard would likely prefer to buy a policy where there was no subsequent uncertainty. See Appendix O (*Actuarial Report on the Development of CLASS Benefit Plan*) for additional information on this plan option.

6. TEMPORARY EXCLUSION PLAN WITH PHASED ENROLLMENT

This benefit option combines the features of Temporary Exclusion with phased enrollment as described above. Because the Temporary Exclusion Plan was not modeled, this option was not modeled either. Clearly, the combination of temporary exclusion and phased enrollment would provide substantial protection for the program against actuarial risk. It might, however, be challenging to market this package. See Appendix O (*Actuarial Report on the Development of CLASS Benefit Plan*) for additional information on this plan option.

7. LIMITED INITIAL BENEFIT PLAN WITH PHASED ENROLLMENT

This benefit option is analogous to the Enhanced CLASS Plan with Phased Enrollment but has a different benefit structure. While the Enhanced CLASS Plan has a two-tiered benefit that is reduced after five years on claim, this benefit option starts with a low daily benefit amount (e.g., \$5 per day or \$10 per day) for a fixed period of time (e.g., 20 years) before increasing to its ultimate \$50 per day value.

This plan was not formally modeled. While the approach would certainly mitigate adverse selection to a great extent, the initial low benefit and extended period before the benefit increases are unlikely to be very attractive, especially to healthy older workers. See Appendix O (*Actuarial Report on the Development of CLASS Benefit Plan*) for additional information on this plan option.

8. PRE-PAID BENEFIT PLAN

Under extreme levels of adverse selection when 100 percent of the enrolled population is eligible for benefits, the monthly premium is essentially the amount that is required for enrollees to pre-pay their future benefit. Because the cost of a pre-paid plan is too high to make it marketable, it is not a viable benefit design. However, the exercise of determining the cost of a pre-paid plan can be instructive, since it provides us with the high end of the range of costs for a plan. The Chief Actuary of the CLASS Office estimated that a pre-paid plan would cost approximately \$3,000 per month in premiums. Because enrollees are essentially pre-paying their future long-term care costs, this plan

does not include a nominal premium for low income persons and full-time students. See Appendix O (*Actuarial Report on the Development of CLASS Benefit Plan*) for additional information on this plan option.

In addition to evaluating the formal benefit options discussed above, HHS staff also considered several features, either individually or together, to determine their impact on premiums and program dynamics. The goal was to add specific aspects that would mitigate adverse selection, lower premiums, and increase the marketability of the CLASS program. These features included adding incentive payments for delaying claim, combining CLASS with disability insurance, using variable inflation protection for the benefit instead of a fixed percentage, and possibly returning all or a portion of an enrollee's accumulated premiums if he or she died at an early age before going on to claim. Most of the features were eventually discarded because they either did not significantly lower premiums or were deemed to be too complicated to implement.

PART II: LEGAL ANALYSIS

This Part provides the legal analysis of the proposed plans. It consists of two sections. Section One analyzes the legal basis for each of the individual features of the eight plans summarized in Part I. In identifying these features, we rely on the discussion in the prior section and the charts and documents in the appendix. Section Two provides an overall analysis of the legal authority for the plans themselves and discusses the likelihood that the plans would survive a legal challenge. It also discusses the substantial uncertainty about what would happen if the CLASS program were implemented and then a decision were made that the CLASS program had to be closed.

SECTION ONE: LEGAL ANALYSIS OF PLAN FEATURES

1. BASIC CLASS PLAN

The Basic CLASS Plan meets the requirements in the CLASS Act, 42 U.S.C. § 30011—30011-9. Under the Act, an active enrollee becomes an eligible beneficiary if, at the time the individual is determined to have a qualifying functional limitation or cognitive impairment, the individual: 1) has paid premiums for at least five years; 2) has earned, during at least three calendar years of the first sixty months in which the individual has paid premiums, at least the amount necessary to earn one quarter of Social Security coverage; and 3) has paid premiums for twenty-four consecutive months, if the individual has had a lapse in premium payments for more than three months. *Id.* § 30011-1(6)(A). The plan provides eligible beneficiaries with the three-part benefit package of a cash benefit, advocacy services, and advice and assistance counseling. *Id.* § 30011-4(b)(1)–(3). The cash benefit also tracks the statutory language: the benefit amount meets the prescribed \$50 per day average, there are between two and six benefit levels that vary with level of functional ability, benefits are paid on a daily or weekly basis, and benefits are not subject to any lifetime or aggregate limits. *Id.* § 30011-2(a)(1)(D).

To be clear, the actuarial models based on Basic CLASS assumed a fixed 2.8 percent rate of inflation for the cash benefit. As we understand it, the cash benefit under Basic CLASS will increase by the percentage increase in the consumer price index for all urban consumers (CPI-U). This is significant because section 3205(b)(1)(B) sets the percentage increase in the CPI-U as the minimum amount by which the cash benefit must increase each year. *Id.* § 30011-4(b)(1)(B).

2. MODIFIED CLASS PLAN

The Modified CLASS Plan differs from the Basic CLASS Plan in three material respects. First, it increases the amount of the minimum earnings requirement. Second, it increases the duration of that requirement. And third, it raises premiums annually according to a schedule set at the time of enrollment. While there is a plausible statutory basis for the proposed minimum earnings requirement, we have concerns that there could be a successful challenge to this interpretation. While such concerns alone would not preclude the implementation of a program with this requirement, it is appropriate that they be considered in conjunction with information about whether the program meets the statutory requirements of solvency in making decisions about the CLASS program. With respect to the schedule of premium increases, we believe that the Secretary may reasonably interpret the statute to authorize such a schedule.

Minimum Earnings – Amount. Section 3202 of the CLASS Act provides, in relevant part:

The term ‘eligible beneficiary’ means any individual who is an active enrollee in the CLASS program and . . . [among other things] has earned, with respect to at least three calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year.

Id. § 300//1(6)(A)(ii). The most straightforward reading of this provision is that in order to become an eligible beneficiary, an active enrollee in the CLASS program must, among other things, earn at a minimum an amount sufficient to qualify for one quarter of coverage under the Social Security Act for three years. The current amount of earnings necessary to be credited with one quarter of coverage for Social Security is approximately \$1,200. See Quarter of Coverage, <http://www.ssa.gov/oact/cola/QC.html> (last visited Oct. 12, 2011). Thus, under the statute, an active enrollee who earned about \$1,200 for at least three calendar years during the first sixty months in which he or she paid premiums would meet the earnings requirement for eligible beneficiary status in the CLASS program.

It is possible to read the statutory language in a way that authorizes the Secretary to adopt a minimum earnings requirement of \$12,000. Section 3202(6)(C) provides, in relevant part, that “[t]he Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements . . . for purposes of being considered an eligible beneficiary for certain populations.” Id. § 300//1(6)(C). This exception language could be interpreted to allow the Secretary to raise the minimum earnings requirement for certain populations. She could do so for specific populations, such as those who are not students or not low-income, or for all populations; to support the latter conclusion, the term “certain populations” would be interpreted not as circumscribing the Secretary’s authority, but instead only as clarifying the Secretary’s authority to make distinctions among populations.

Reliance on the Secretary’s exceptions authority could be challenged on the ground that the interpretation is in tension with the natural reading of the statutory language. An “exception” is “a case to which a rule does not apply,” Webster’s New Collegiate Dictionary 432 (9th ed. 1985), or “something that is excluded from a rule’s operation.” Black’s Law Dictionary 604 (8th ed. 2004). In this case, the relevant rule would be that an active enrollee must meet the specified minimum earnings requirement. Though requiring an individual to earn more than the statutory minimum would technically meet the definition of making an exception to the rule, one would ordinarily interpret the authority to make exceptions to a minimum earnings requirement as the authority to waive or lessen the requirement, not to raise it—that is, the authority to say that the requirement need not be met, not that the requirement may be made more stringent. See Edward C. Liu, Cong. Research Serv., 7-5700, Authority of the Secretary of HHS to Make Exceptions to

Minimum Earnings Requirement for Eligibility Under the CLASS Act (2011) (reaching a similar conclusion).

There is a related, alternative way of achieving a type of higher minimum earnings requirement. Instead of focusing on minimum earnings per se, this alternative would focus on the definition of “actively employed.” Only individuals who are “actively employed” may enroll in the CLASS program. *Id.* § 300*ll*-3(c). The term “actively employed” refers to an individual who “is reporting for work at the individual’s usual place of employment or at another location to which the individual is required to travel because of the individual’s employment . . . and is able to perform all the usual and customary duties of the individual’s employment on the individual’s regular work schedule.” *Id.* § 300*ll*-1(2). It could be argued that the Secretary has authority to define the term “actively employed” further, setting forth, for example, a minimal weekly wage or work hours requirement. Though the Supreme Court has rejected agencies’ attempts to define terms further when the statutory definitions are “unusually detailed,” *INS v. Hector*, 479 U.S. 85, 88 (1986), or are “explicitly and comprehensively defined . . . by including . . . discrete definitions,” *Carcieri v. Salazar*, 129 S. Ct. 1058, 1066 (2009), it could be argued that those cases are inapplicable here because the CLASS statute’s definition of “actively employed” is minimal. By defining the term “actively employed” to require a minimum level of wages or work hours, the Secretary may effectively institute a minimum earnings requirement for individuals enrolling in the program.

There could, however, be a successful challenge to the Secretary’s authority to adopt this alternative. Beyond the issue of whether the Secretary has authority to add terms to the definition of “actively employed,” concerns about tension with the statutory purpose to provide opportunities to purchase long-term care insurance to a very broad group of individuals, would apply to the heightened enrollment conditions. Yet the more detailed definition of “actively employed” may be on a firmer legal footing than a \$12,000 minimum earnings requirement. Insofar as the active employment requirement applies only as a condition of enrollment, and not as an ongoing requirement during the vesting period,⁴ it would be reconcilable with the minimum earnings provision, which applies only during the vesting period.

Minimum Earnings – Duration. The CLASS Act also specifies a time component of the minimum earnings requirement. Section 3202(6)(A)(ii) requires that an eligible enrollee earn the stated amount for “at least 3 calendar years during the first 60 months for which the individual has paid premiums for enrollment in the program[.]” *Id.* § 300*ll*-1(6)(A)(ii). Modified CLASS would extend the duration of the minimum earnings requirement from three calendar years to five years. The argument that the proposed five-year requirement is legally authorized focuses on the same statutory provision as the arguments in favor of the \$12,000 minimum earnings

⁴ There is a colorable argument that the Secretary could establish active employment as an ongoing requirement during the vesting period. Upon stating the four conditions for enrollment, including the active employment requirement, section 3204(d) states that “[n]othing in this title shall be construed as requiring an active enrollee to continue to satisfy” one of the four conditions, which concerns taxable income. 42 U.S.C. § 300*ll*-3(d). In light of that provision, one might argue that the Secretary may require active enrollees to continue to satisfy the other three conditions, including active employment status. However, for the reasons discussed above, we have concerns about whether doing so in order to adopt a minimum earnings requirement for the vesting period would survive a challenge.

amount: the provision authorizing the Secretary to create exceptions to the minimum earnings requirement. *Id.* § 300//2(6)(C). Because the analysis of that provision in the foregoing section applies equally in this context, we have reached the same conclusion for the five-year minimum earnings requirement. Although there is a plausible statutory basis for the requirement, we have concerns that there could be a successful challenge to this interpretation.

Fixed Premium Increase – Schedule and Amount. Modified CLASS would adopt a premium schedule in which enrollees’ premiums rise according to a fixed rate over time. We believe that the Secretary may reasonably interpret the statute to authorize such a schedule.

Section 3203 is the principal section of the statute setting forth requirements applicable to the premiums in the CLASS program. *Id.* § 300//2. Section 3203(a)(1)(A)(i) provides, in relevant part, “Beginning with the first year of the CLASS program, and for each year thereafter . . . , the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.” *Id.* § 300//2(a)(1)(A)(i). Section 3203(b) further provides, with limited exceptions inapplicable here, that “the amount of the monthly premium determined for an individual upon such individual’s enrollment in the CLASS program *shall remain the same* for as long as the individual is an active enrollee in the program”⁵ *Id.* § 300//2(b)(1)(A) (emphasis supplied). We assume that under Modified CLASS, the premium schedule would be based on an actuarial analysis of the seventy-five-year costs of the program that ensured solvency throughout the seventy-five-year period. The question raised by the plan’s design is whether the proposed premium schedule, which rises at a fixed rate over time, satisfies the requirement that the amount of the monthly premium remain “the same.”

The language requiring that the monthly premium “remain the same” during an individual’s active enrollment is unclear. One reading of the statute is that the amount of the monthly premium must be the identical amount every month throughout the individual’s active enrollment. In other words, if the monthly premium is \$75 when an individual enrolls, then the monthly premium must remain \$75 throughout the period of active enrollment. Under this interpretation, the CLASS program could not adopt a premium schedule in which the premium amount rises over time.

There is an alternative, reasonable interpretation of the statutory provision. Under Modified CLASS, the monthly premiums rise over time, but all present and future premiums are set at the time of enrollment and do not change thereafter. In other words, when an individual enrolls in the CLASS program, he or she would receive a premium schedule that would remain in effect for as long as the individual is an active enrollee. Because the schedule is fixed or unchanging, one could reasonably argue that “the amount of the monthly premium determined for an individual upon such individual’s enrollment” remains “the same.”

In Chevron, the Supreme Court held that, if a statute is silent or ambiguous, it will defer to the agency’s interpretation of the statute, so long as it is reasonable. See Chevron, U.S.A., Inc. v.

⁵ Section 3203(b)(1)(B) authorizes the Secretary to adjust premiums if certain types of information show that an adjustment is necessary to ensure the solvency of the program. *Id.* § 300//2(b)(1)(B). We do not consider these adjustments in our analysis of this feature.

Natural Resources Defense Council, 467 U.S. 837, 842–43 (1984). Because of our conclusions that the statutory provision requiring premiums to remain the same is ambiguous and that it is reasonable to interpret the provision as requiring only that the monthly premium be determined and fixed at the time of enrollment, we believe that the Secretary has discretion to interpret the statute as authorizing the proposed premium schedule.

3. ENHANCED CLASS PLAN

The Enhanced CLASS Plan builds on the features of the Modified CLASS Plan. It adopts the three features analyzed above of the Modified CLASS Plan. In addition, Enhanced CLASS features two levels of cash benefit scaled to levels of functional ability. The cash benefit would decrease in amount after five claim years. Furthermore, the Enhanced CLASS Plan’s enrollment process would be conducted in phases, with individuals employed by large employers being given the initial opportunity to enroll.

Minimum Earnings – Amount. For an analysis of this feature, see supra pp. 29-30.

Minimum Earnings – Duration. For an analysis of this feature, see supra pp. 30-31.

Fixed Premium Increase – Schedule and Amount. For an analysis of this feature, see supra pp. 31-32.

Two-Tier Benefit Structure and Decreased Benefit After Five Years. The Enhanced CLASS Plan would establish two benefit levels, one for eligible beneficiaries unable to perform two or three activities of daily living (ADLs) and one for beneficiaries unable to perform four or more ADLs. Additionally, the plan would pay 100 percent of the daily benefit for an initial period (e.g., five claim years) and then only twenty percent of the daily benefit amount for the remainder of the beneficiary’s lifetime. We believe that the Enhanced CLASS Plan may adopt the proposed benefit structure if the benefits meet the minimum required benefit amount discussed below.

Under the CLASS statute, a benefit plan must include a “benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation” such that an individual (1) is unable to perform at least two or three ADLs without substantial assistance from another individual; (2) requires substantial supervision to protect the individual from health and safety threats due to substantial cognitive impairment; or (3) has a level of functional limitation similar to that described in subparagraphs (1) or (2). 42 U.S.C. § 300ll-2(a)(1)(C). ADLs are defined as eating, toileting, transferring, bathing, dressing, and continence, as specified in the Internal Revenue Code. Id. § 300ll-1(3). The plan must pay a cash benefit that satisfies the following requirements. First, “[t]he benefit amount provides an eligible beneficiary with not less than an average of \$50 per day (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various levels).” Id. § 300ll-2(a)(1)(D)(i). Second, “[t]he benefit amount is varied based on a scale of functional ability, with not less than 2, and not more than 6, benefit level amounts.” Id. § 300ll-2(a)(D)(ii). Third, “[t]he benefit is paid on a daily or weekly basis.” Id. § 300ll-2(a)(1)(D)(iii). Fourth, “[t]he benefit is not subject to any lifetime or aggregate limit.” Id. § 300ll-2(a)(1)(D)(iv).

As an initial matter, setting two benefit levels tied to two different ranges of limitations is authorized by the statutory requirement that there be at least two and not more than six benefit level amounts based on a scale of functional ability. *Id.* § 300ll-2(a)(1)(D)(ii). The authority to establish an initial benefit for a finite period and a decreased benefit, at twenty percent of the initial rate, to be paid for the remainder of the beneficiary’s lifetime could be problematic. Its legality depends, in part, on the amount of the proposed benefits. At all times—including when individuals are receiving the initial reduced benefit—the daily cash benefit must meet the \$50 per day average.⁶ To be clear, the statute does not require that any one beneficiary receive, on average, \$50 per day during the period of beneficiary status. Rather, it requires that, on any given day, the sum total of all beneficiaries receive, on average, \$50 per day. In other words, whether the \$50 per day average is met is “determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels.” *Id.* § 300ll-2(a)(1)(D)(i).

Assuming that that \$50 per day average requirement were met, the question remains whether the reduced benefit meets the requirement that “[t]he benefit is not subject to any lifetime or aggregate limit.” Formally, there are no “lifetime” or “aggregate” limits, as those terms are normally understood. Undefined in the statute, in the insurance context, “lifetime limit” refers to a cap on the total amount of benefits, either overall or for a specific set of services, that a plan will pay for a beneficiary over the beneficiary’s lifetime. See Glossary, p. 11, HealthCare.gov, <http://www.healthcare.gov/glossary/04262011a.pdf> (last viewed Sept. 28, 2011). “Aggregate limit” means the total dollar amount that a plan will pay for a beneficiary within a specified period (e.g., a plan will pay no more than \$50,000 toward a beneficiary’s care during a calendar year period). See, e.g., Glossary of Insurance and Risk Management Terms, International Risk Management Institute, Inc., <http://www.irmi.com/online/insurance-glossary/terms/a/aggregate-limit-of-liability.aspx> (last viewed Oct. 6, 2011). Although the Enhanced CLASS Plan would reduce a beneficiary’s daily benefit amount by eighty percent after a specified period of time, it would pay some benefits, free from any predetermined capped amount, throughout a beneficiary’s lifetime. It can be argued that such an approach does not impose aggregate or lifetime limits.

There is, however, a sound argument that the proposed benefit reduction violates the no lifetime or aggregate limit provision. The argument would be that paying only twenty percent of the full daily benefit to a subset of the period of beneficiary status is effectively an aggregate or lifetime limit. On this view, the restriction of the full benefit to a limited period of time sets caps, or an aggregate limit, on the amount that a beneficiary may receive over time; the fact that it does so by setting a reduced percentage, rather than an absolute dollar value, is not a sufficient answer. If a plan may reduce the amount paid after a set period of time—for example, by paying \$1 or two percent after the first three years⁷—then it can render the aggregate or lifetime limits prohibition virtually meaningless. Moreover, reducing the benefit over time, rather than starting

⁶ The CLASS Act provides that the per day average benefit amount will increase by CPI-U in years subsequent to the first year in which enrollees receive benefits. 42 U.S.C. § 300ll-4(b)(1)(B). For ease of reference, we refer to the \$50 per day average benefit based on the assumption that it takes into account this mandatory statutory increase.

⁷ Of course, the plan would still have to meet the average \$50 per day requirement. However, it could do so, even with a \$2 per day limit, by raising the full benefit by a sufficient amount.

with a lower percentage of the daily benefit amount and increasing it to the maximum, appears contrary to the purpose of the CLASS Act. The Act seeks to provide eligible individuals with the opportunity to purchase an affordable long-term care insurance plan that would provide meaningful cash benefits to help them to obtain the services and supports they need to live independently in the setting of their choice. Reducing the plan's payments as individuals are likely to grow sicker runs counter to the statutory purpose.

Notwithstanding the forceful challenge that may be made to the proposed benefit structure, in light of the relevant statutory provision and the deference ordinarily accorded to the agency in interpreting such provisions, we conclude that the proposed benefit structure might be permissible. We caution that the greater the reduction in benefits over time, the more likely a challenge to the reduction as an impermissible end-run around the lifetime and aggregate limit prohibition could succeed.

Phased Enrollment. The Enhanced CLASS Plan would permit enrollment of different categories of individuals in phases. In particular, individuals working for large employers, who employ a specified minimum number of employees, or some subset of those individuals, would be able to enroll in the first phase. Other individuals, including self-employed persons and those who work for smaller employers, would be able to enroll in subsequent phases, after the initial enrollment meets a pre-set threshold. Though the statute does not expressly contemplate phased enrollment, we believe that the Secretary has statutory authority to establish phased enrollment procedures, subject to certain conditions described below. The phased enrollment process described in the Enhanced CLASS Plan would open enrollment to all statutorily-eligible individuals only if the initial group satisfied a predetermined risk profile. Because opening enrollment is subject to a condition that may never be met, this enrollment structure does not comply with the law.

Section 3204 sets forth the statutory requirements for enrollment in the CLASS program. This section requires, among other things, that the Secretary, in coordination with the Secretary of the Treasury, establish procedures to enable employers to enroll employees in the program automatically; establish alternative procedures for individuals who are self-employed, who have more than one employer, and whose employers do not elect to participate in the automatic enrollment process; and establish procedures to ensure that an individual is not automatically enrolled by more than one employer. 42 U.S.C. § 30011-3(a)(1)-(3). Section 3204 further provides that “[e]nrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to ensure ease of administration.” *Id.* § 30011-3(a)(3)(B). With a limited exception inapplicable here,⁸ the statute is silent on the time at which individuals must be able to enroll and the duration of the enrollment period. The statute also does not establish a deadline by which the CLASS program must be fully implemented. In light of that silence, the absence of a deadline, and the Secretary's authority to establish enrollment procedures, we believe the CLASS program may institute a phased-in enrollment process, so long as the process aims “to ensure ease of administration” and is otherwise consistent with the statutory design of the CLASS program.

⁸ See *id.* § 30011-3(g) (requiring the Secretary to establish enrollment procedures for individuals who opted out of enrolling when they were first eligible, and specifying that the individuals' enrollment periods may not occur more frequently than biennially).

The statute does not define “ease of administration.” The Secretary has authority to interpret that term, and we believe it would be within her discretion to interpret it to encompass the effective and efficient functioning of the program. As we understand it, the proposed phased enrollment process is attractive for many reasons. It would allow program administrators to test actuarial projections about matters such as take-up and claim rates on a small scale, so that any necessary premium or other adjustments could be made before taking the program to a larger scale. It would also allow for a more controlled enrollment process, helping program administrators to secure a sufficient reserve of initial funds from premiums paid by individuals who are assumed to be at low risk for entering benefit status immediately after the vesting period. In addition, the efficiencies of scale that could be achieved through marketing to and enrolling employees of large employers would help make initial enrollments more manageable and control start-up expenses. All of these purposes can reasonably be interpreted to serve the aim of easing the administration of the CLASS program.

The phased enrollment process must be consistent with the statutory design of the CLASS program. To be consistent, the process would have to ensure, at a minimum, that (1) at least some representation of all classes of statutorily eligible enrollees have the opportunity to enroll in each phase; and (2) the process becomes fully open and *all* statutorily eligible enrollees have an opportunity to enroll within a reasonable period after start-up. Relatedly, the Secretary’s obligation to designate a program that will be actuarially sound for seventy-five years cannot rest on the assumption that the program can control enrollment throughout the seventy-five-year period or any significant part of that period. To the contrary, the Secretary’s designation (and the plan’s premium estimates) must rest on the assumption that, within a reasonable period of time, all statutorily eligible enrollees will have the opportunity to enroll in the program. The proposed phased enrollment process does not meet the two conditions, and hence would be inconsistent with the statute.

To be clear, even if a phased enrollment plan allowed some representation of all classes of statutorily eligible enrollees in each phase, it could not adopt a “wait-and-see” approach like the one proposed here. The requirement that the CLASS program eventually opens enrollment to all statutorily eligible individuals within a reasonable time period means that the program must be designed from the outset to do so. The phased enrollment process must ensure that the program will fully open, not that the program will fully open only if there are manageable take-up and claim rates. Making fully open enrollment contingent on the successful enrollment of only certain classes of individuals, particularly individuals who are expected to be healthier than those excluded, or certain distributions of classes of individuals, is inconsistent with the statutory scheme. The statute contemplates a program open to all statutorily eligible individuals. While the Secretary’s authority to make regulations consistent with the title and to prescribe enrollment procedures can reasonably be interpreted to permit her to have enrollment proceed in phases—particularly if doing so were deemed necessary to adopt an actuarially sound and fiscally solvent program—we do not believe that authority extends to making certain statutorily eligible individuals’ ability to enroll in the program contingent upon specific enrollment or fiscal criteria goals being met. Because the proposed phased enrollment process would not provide certainty

that all eligible individuals will be able to enroll in the program within a reasonable time, we conclude that there is no statutory basis for this type of approach.⁹

4. FAMILY OF OPTIONS PLAN (MODIFIED CLASS PLAN + SCHEDULED INCREASING BENEFIT PLAN)

The Family of Options Plan would establish the statutorily required CLASS Independence Benefit Plan as a single plan that has two plan options within it: the Modified CLASS Plan and the Scheduled Increasing Benefit Plan. Any individual enrolling in the Partnership Plan would have the option to enroll in the plan that he or she prefers. While a reasonable argument can be made that the statute allows the designated plan to encompass multiple plan options, we believe that at least one plan option must be consistent with all of the statutory requirements, and both plan options must, at a minimum, be consistent with the statutory requirements applicable to cash benefits and eligible beneficiaries. Because the Scheduled Increasing Benefit Plan option conflicts with those requirements, we do not believe that there is legal authority for the proposed Family of Options Plan.

Family of Options. Section 3203(a)(1) of the CLASS Act directs the Secretary to develop at least three actuarially sound alternative plans for designation as the CLASS Independence Benefit Plan. *Id.* § 300//2(a)(1). Each of the plan alternatives must be designed “to provide eligible beneficiaries with the benefits described in section 3205 consistent with” a set of requirements concerning premium amounts, a five-year vesting period, benefit triggers, and a cash benefit. *Id.* Section 3205 establishes that the plan shall provide three types of benefits: the cash benefit “established by the Secretary in accordance with the requirements of section 3203,” advocacy services to assist beneficiaries with accessing the appeals process and complying with the annual recertification process, and advice and assistance counseling.¹⁰ *Id.* § 300//4(b)(1)–(3).

The statute is silent on the question of whether there may be a family of options under one plan, and we believe the Secretary has discretion to designate such a plan, subject to certain conditions. According to section 3203, the plan “shall be designed to provide eligible beneficiaries with the benefits described in section 3205 [concerning the three types of benefits described above] consistent with the” requirements in section 3203 concerning premiums, vesting period, benefit triggers, and the cash benefit. *Id.* § 300//2(a)(1). We understand that the family of plans design rests on the assumption that one option would satisfy all of the statutory requirements in sections 3203 and 3205 while the other option need not. The argument here is that section 3203 establishes only that the designated plan provides a set of benefits consistent with the section 3205 requirements, not that the specified benefits exhaust the range of permissible options, or constitute the only benefits that a plan may provide. In other words, the designated plan must be designed, at a minimum, to provide the specified benefits, but it may, in

⁹ Because the phased enrollment process would prevent otherwise statutorily-eligible individuals from enrolling immediately in the CLASS program, there is a significant likelihood that such a process would incur a legal challenge.

¹⁰ Advice and assistance counseling includes the provision of information about assistive technology, accessing and coordinating services and supports, and accessing other Federal benefit programs for which a beneficiary may be eligible. *Id.* § 300//4(e).

addition, provide other benefits that need not be consistent with sections 3203 and 3205. Because the statute is silent on this issue, and a reasonable argument can be made that such an interpretation is consistent with the statute, we have concluded that the Secretary has authority to designate such a plan.

We have two caveats to our conclusion. First, as mentioned above, at least one of the plans must satisfy the statutory requirements in section 3203 concerning premiums, vesting period, benefit triggers, and the cash benefit and in section 3205 related to plan benefits. Second, in light of the appropriations provisions of the CLASS Act, for any plan option, the Secretary's discretion to stray from the statutory requirements concerning the cash benefit and eligible beneficiaries is limited. In particular, in each plan option, the cash benefit must meet the statutory requirements applicable to cash benefits, see id., §§ 300*ll*-2(a)(1)(D), 300*ll*-4 (b)(1) (\$50 per day average minimum, rising annually with the CPI-U percentage increase; two to six benefit levels, scaled to functional ability; daily or weekly payments; and no lifetime or aggregate limits), and the cash benefits may be paid only to beneficiaries who meet the statutory definition of "eligible beneficiaries." See id., § 300*ll*-1(6) (prescribing, for example, the minimum earnings requirement).

Section 3206(a) establishes the CLASS Independence Fund, which receives all premiums and any unpaid, accrued benefits that have been recouped, as well as any investment gains from those moneys. Id., § 300*ll*-5(a). Section 3206(a) further provides that the amounts held in the fund are appropriated and shall remain available for three purposes: to be held for investment on behalf of individuals enrolled in the CLASS program; to pay administrative expenses associated with the Fund and its investments; and "to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan." Id. (emphasis supplied). It is a cardinal principle of appropriations law that appropriated funds may be used only for the purposes specified in federal law. See, e.g., 31 U.S.C. § 1301(a) ("Appropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided in law."); General Accounting Office, GAO-04-261SP, Principles of Federal Appropriations Law 4-6 – 4-13 (3d ed. 2004). Though one might argue that the appropriations provision authorizes *any* cash benefits that are paid to *any* individuals who have enrolled in and achieved beneficiary status under the plan designated by the Secretary, we think that that argument is unpersuasive. The statute makes clear in its definitions section that the term "eligible beneficiary" in the Act has the meaning prescribed in section 3202(6). Although the statute does not include the term "cash benefit" in its definitions section, the statute frequently references the term, and courts generally do not approve of agencies defining terms one way in one part of the statute and a different way in another part. See Sullivan v. Stroop, 496 U.S. 478, 484 (1990) (applying the "normal rule of statutory construction that 'identical words used in different parts of the same act are intended to have the same meaning'" (internal quotations omitted)). Accordingly, we conclude that the appropriations provisions mean that the designated CLASS plan may pay only those cash benefits that meet the prescribed statutory standards to eligible beneficiaries who also meet the prescribed statutory standards.

Modified CLASS + Scheduled Increasing Benefit. The Family of Options Plan would offer the Modified CLASS Plan and the Scheduled Increasing Benefit Plan.¹¹ We do not, however, believe that the Family of Options Plan satisfies the essential statutory requirements of the CLASS Independence Benefit Plan. First, the plan rests on the assumption that one of the plan options, the Modified CLASS Plan, satisfies the specified statutory requirements. It is unclear, however, whether this option does so. The Modified CLASS Plan includes a minimum earnings requirement of \$12,000, a requirement that that amount be earned during the first five years of enrollment, and an indexed monthly premium that rises at a fixed rate of 2.8 percent. As described above, although there is a plausible statutory basis for a \$12,000, five-year minimum earnings requirement, we have concerns that there could be a successful challenge to this requirement. See supra pp. 29-31.

Second, the Scheduled Increasing Benefits option would not satisfy the requirements applicable to cash benefits. Incorporating the increased minimum earnings requirement and the fixed schedule of premium increases of the Modified CLASS Plan, the Scheduled Increasing Benefit Plan would provide benefits for a maximum of three claim years. It would provide for a low daily cash benefit amount to beneficiaries who become eligible to claim benefits within the first twenty years of enrollment. The available daily benefit would rise by a set amount each year for twenty years until it reached a maximum of \$150 per day. To be more specific, if enrollees were to receive benefits in the sixth year of enrollment (i.e., in the first possible year to qualify after the five-year vesting period), individuals with functional limitations in two or three ADLs would receive benefits of \$20 per day and individuals with four or more ADL limitations, \$24 per day.¹² The benefit amounts would rise each year by \$6.50, plus a three percent automatic compound inflation (ACI) factor. Without taking inflation into account, if that enrollee were to receive benefits during the seventh year of enrollment, the individual would receive a benefit of \$26.50 per day; during the ninth year of enrollment, a daily benefit of \$39.50 ($\$20 + (\$6.50 * 3)$). In the twenty-sixth year of enrollment, without taking inflation into account, the daily benefit would reach its maximum amount of \$150 and would remain at that level in subsequent years.¹³ Beneficiaries with two or three functional ADLs who begin receiving benefits before their twenty-fourth year of enrollment would never receive the maximum, however, because the benefit term would be only thirty-six months.

The three-year benefit term would violate the statutory prohibition on lifetime limits for cash benefits. 42 U.S.C. § 300ll-2(a)(1)(D)(iv). Additionally, unless the benefits provided in the Modified CLASS Plan are sufficiently high to compensate for the low initial daily benefits in the Scheduled Increasing Benefit Plan, the Family of Options Plan's benefits would violate the \$50 per day average minimum requirement. See id. § 300ll-2(a)(1)(D)(i). Even if the requirement

¹¹ Another proposed family of options, the Enhanced CLASS plan plus the Scheduled Increasing Benefit plan, was also presented. The analysis of each of the individual plans and the overall family of plans containing those options reaches the same conclusions as the analysis above. Therefore, we do not present that analysis separately.

¹² For clarity, we perform the computations for the 4+ ADL benefit level in footnote 13.

¹³ The yearly increase amount for the benefit level corresponding to 4+ ADLs is \$7.80. This would result in a daily benefit of \$39.60 for a beneficiary who claims benefits in year seven of enrollment and $\$55.20 (\$24 + (7.80 * 3))$ in year nine. The maximum daily benefit for a beneficiary with 4+ ADL limitations is \$180. All figures are subject to increase by the 3 percent ACI factor in each subsequent year.

were met, it bears emphasis that this benefit structure is likely inconsistent with the statute in another way. The CLASS Act's stated purpose is to provide beneficiaries with tools that will allow them to ensure their personal and financial independence and exercise their options to live in the community for as long as possible. See id. § 300*ll*. Because initial daily benefit amounts that are as low as \$20 or \$24 may well be inadequate to ensure any meaningful level of services or supports for an individual with substantial functional limitations, setting benefits that low would likely be seen as defeating the statutory purpose.

As discussed above, the family of plans approach may allow some deviation from the statutory requirements unrelated to cash benefits and eligible beneficiaries for one plan if the other plan meets all the statutory requirements. We have concerns about whether the Modified CLASS Plan meets all the statutory requirements. Even if it does, the Scheduled Increasing Benefits option violates the prohibition of lifetime limits on the cash benefit. Accordingly, we conclude that there is no legal authority for the Family of Options Plan.

5. TEMPORARY EXCLUSION PLAN

The Temporary Exclusion Plan would impose a fifteen-year waiting period for the receipt of benefits on enrollees whose functional limitations that trigger benefits result from a serious health condition that existed at the time of enrollment. We believe that there is no legal authority to implement the Temporary Exclusion Plan.

The CLASS Act sets forth detailed criteria concerning the minimum earnings and premium payments requirements that an active enrollee must meet to become an eligible beneficiary, the benefit triggers that allow for the provision of benefits, and the process of determining eligibility. As discussed above, concerning minimum earnings and premium payment requirements, section 3202(6) provides that, in order to become an "eligible beneficiary," an active enrollee must have paid premiums for at least sixty months and have met other earnings and premium payment requirements. Id. § 300*ll*-1(6)(A). With respect to benefit triggers, section 3203 provides that benefits are triggered when an individual is determined to be unable to perform a specific number of ADLs or is determined to have the requisite level of cognitive impairment. Id. § 300*ll*-2(a)(1)(C).

Concerning eligibility determinations, the statute requires the Secretary to establish procedures under which an active enrollee may apply for benefits. Id. § 300*ll*-4(a)(1). The statute further provides that "[a]n active enrollee shall be deemed presumptively eligible if the enrollee:

- (i) has applied for, and attests is eligible for, the maximum cash benefit under [the plan];
- (ii) is a patient in a hospital (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases; and
- (iii) is in the process of, or about to begin the process of, planning to discharge from the hospital, facility or institutions, or within 60

days from the date of discharge from the hospital, facility, or institution.

Id. § 300ll-4(a)(1)(C).

The statute does not explicitly address whether the CLASS Plan may impose a waiting period for receipt of benefits on enrollees whose functional limitations resulted from serious health conditions at the time of enrollment. Although it might be possible to argue that the statute's silence on the issue means that the Secretary has authority to establish a waiting period, we think that such a waiting period is inconsistent with the statute. While the statutory provision concerning benefit triggers does not specify that a functional limitation determination triggers immediate benefits, another provision states that "[b]enefits shall be paid to, or on behalf of, an eligible beneficiary beginning with the first month in which an application for such benefits is approved." Id. § 300ll-4(b)(3). Although the Secretary has the authority to establish procedures for the application process, the statute does not permit her to delay the approval of any applicants, including those with serious health conditions at the time of enrollment. The statute prescribes very detailed criteria concerning eligible beneficiary status and benefit triggers. Establishing any additional factors for eligibility, or that would delay eligibility, is precluded by the clarity with which Congress spoke on this issue. Likewise, in authorizing the Secretary to prescribe regulations for the eligibility determination process, nowhere does the statute discuss, or even intimate, waiting periods for individuals with serious health conditions at the time of enrollment. To the contrary, the statute explicitly addresses the eligibility of enrollees who have been hospitalized for long-term care or have been patients in "nursing facilit[ies], intermediate care facilit[ies] for the mentally retarded, or institution[s] for mental disease." Id. § 300ll-4(a)(1)(C). In making such enrollees presumptively eligible for receipt of benefits, the statute aims to make access to benefits for them easier, rather than more difficult. Put another way, one of the statute's underlying assumptions is that individuals who have already demonstrated a need for long-term care or live with intellectual disabilities, developmental disabilities, or mental illness deserve benefits in an expedited fashion. As the statute aims to help individuals purchase insurance that will provide them with monetary benefits to help them secure the long-term care options of their choice, a requirement that eligible beneficiaries who have an immediate need for long-term care after the vesting period wait fifteen years before receiving benefits is at cross-purposes with the statutory objectives and the plain language of the statute.

Another provision of the statute, which prohibits underwriting, also supports the argument that the proposed waiting period is inconsistent with the statute. Section 3203(b)(3) provides in relevant part that "[n]o underwriting (other than on the basis of age . . .) shall be used to (A) determine the monthly premium for enrollment in the CLASS program; or (B) prevent an individual from enrolling in the program." Id. § 300ll-2(b)(3) It is true that the waiting period does not technically violate this prohibition; individuals with health conditions that lead to functional limitations may enroll in the program, and their monthly premium is not determined by the health condition. Yet, the waiting period conflicts with the prohibition's underlying goal. The waiting period treats individuals with specific health conditions at the time of application differently than individuals without such conditions while the underwriting prohibition seeks to make all factors other than age irrelevant to an individual's ability to participate in and benefit

from the program. Accordingly, we conclude that there is no authority under the CLASS Act for a plan to adopt the proposed waiting period.¹⁴

6. TEMPORARY EXCLUSION PLAN WITH PHASED ENROLLMENT

This plan combines the Temporary Exclusion Plan with the phased enrollment feature. Consistent with our prior analysis, *see supra* pp. 39-41 (Temporary Exclusion), pp. 34-36 (Phased Enrollment), because of the incorporation of the fifteen-year waiting period for pre-existing conditions, we do not believe that there is legal authority to implement this plan.

7. LIMITED INITIAL BENEFIT PLAN WITH PHASED ENROLLMENT

With the exception of its benefit structure, this plan is the same as the Enhanced CLASS Plan with Phased Enrollment, the Limited Initial Benefit Plan would provide a very low benefit

¹⁴ We note that the proposed waiting period might also be understood to raise civil rights concerns under section 504(a) of the Rehabilitation Act of 1974, which applies to federally conducted programs. That section provides, in relevant part, that “[i]n]o otherwise qualified individual . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency [.]” 29 U.S.C. § 794(a). Although section 504 does not explicitly address insurance programs, section 504’s prohibition has been interpreted in a manner similar to the prohibition on disability discrimination in the Americans with Disabilities Act (ADA), 42 U.S.C. §§12101 et seq. *See, e.g., Bragdon v. Abbott*, 524 U.S. 624, 631 (1998) (holding that the ADA’s and Rehabilitation Act’s discrimination prohibition should be interpreted similarly). Section 501(c) of the ADA explicitly provides that the Act does not prohibit entities that administer bona fide insurance or benefit plans from underwriting, classifying, or administering risks. 42 U.S.C. § 12201(c). Those actions, however, must be based on evidence that distinctions are necessary to ensure a plan’s viability or to prevent untenable premium increases or benefits decreases, and may not be used as “subterfuge” to get around the ADA’s nondiscrimination provisions. *Id.*

In its guidance on the applicability of the ADA to employer-provided benefits, the Equal Employment Opportunity Commission (EEOC) stated that not all health-based distinctions are disability-based. *See* EEOC Compliance Manual, Chapter 3: Benefits (Oct. 3, 2000), available at [http://www.eeoc.gov/policy/docs/benefits.html#III.Disability-Based Distinctions](http://www.eeoc.gov/policy/docs/benefits.html#III.Disability-Based%20Distinctions). Generally, a health-related distinction in a benefit plan is not disability-based if it broadly applies to a multitude of dissimilar conditions, and constrains both individuals with disabilities and individuals without disabilities. *Id.* Of particular relevance here, the EEOC provided, as an example of a program that would not involve a disability-based distinction, a long-term disability plan that placed a six-month waiting period for all pre-existing conditions. *Id.* The waiting period would apply to all individuals who have a pre-existing health condition, regardless of whether it leads to a disability. By contrast, a health-based pre-existing condition requirement that singled out a particular disability (e.g., HIV infection), a discrete group of disabilities (e.g., cancers), or disability in general (all individuals with disabilities) would be a disability-based distinction.

In light of the EEOC guidance, we believe that a reasonable argument can be made that the proposed CLASS plan waiting period does not involve a disability-based distinction and thus does not implicate the Rehabilitation Act. The proposed waiting period broadly applies to a multitude of dissimilar conditions and would be in place for individuals with health conditions that lead to disabilities, regardless of whether the individuals eventually develop those disabilities. In any event, even if the waiting period were understood to involve a disability-based distinction, the waiting period would be permissible if, consistent with section 501, the CLASS program could show that it is necessary to ensure the plan’s viability or to prevent untenable premium increases or benefit decreases; a showing that the waiting period is necessary to ensure the fiscal solvency of the program would be sufficient.

amount to individuals who become eligible for benefits in the first twenty years of their enrollment. Enrollees who become eligible after the twentieth year of enrollment would receive a \$50 per day average benefit. We believe that this plan is inconsistent with the statute.

Limited Initial Benefit. The Limited Initial Benefit Plan with Phased Enrollment would offer one or two benefit levels. Because the statute requires at least two benefit level amounts, scaled to functional ability, see 42 U.S.C. § 300ll-2(a)(1)(D)(ii), we assume, for purposes of this analysis, that the plan offers two such benefit level amounts. If a beneficiary were to enter benefit at any time during the first twenty years after enrollment, the beneficiary would receive a low benefit, for example, \$5 or \$10 per day, for each benefit level, respectively. Thereafter, beneficiaries would receive a “regular benefit,” for example \$50 to \$60 per day, for each benefit level. The proposed benefit structure is inconsistent with the statute because of its effect on the first twenty years of the program’s operation. As discussed above, the CLASS Act requires that the cash benefit amount meet or exceed the \$50 per day average, taking into account the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels, for the first year in which beneficiaries receive benefits under the plan. Id. § 300ll-2(a)(1)(D)(i). For each subsequent year, the benefit amount must increase by not less than the percentage change in CPI-U over the previous year. Id. § 300ll-4(b)(1)(B). The Limited Initial Benefit plan’s proposal to provide initial low daily benefits would not satisfy this requirement. During the first twenty years of the plan’s operation, all enrollees that become eligible for beneficiary status would receive only the limited \$5 or \$10 per day. Because both of those amounts are less than \$50, it would be impossible for the per day average to meet the minimum requirement. Moreover, as with the Scheduled Increasing Benefits Plan, see supra pp. 38-39, the Limited Initial Benefit structure is inconsistent with the statute’s purpose. Because initial daily benefit amounts that are as low as \$5 or \$10 would be inadequate to ensure any meaningful level of services or supports for an individual with substantial functional limitations, setting benefits that low would defeat the statutory purpose to provide beneficiaries with tools that will allow them to ensure their personal and financial independence and exercise their options to live in a community for as long as possible. See 42 U.S.C. § 300ll. Accordingly, we conclude that there is no statutory authority for the Limited Initial Benefit Plan with Phased Enrollment.

8. PRE-PAID BENEFIT PLAN

The Pre-Paid Benefit Plan rests on two basic assumptions. First, because the CLASS program is voluntary, a disproportionate number of people who are at high risk of needing long-term care services will enroll. Second, nearly every enrollee will become eligible for benefits shortly after vesting. To ensure the financial viability of the program, the Pre-Paid Benefit Plan would set the premium level for each individual to cover the expected payout for that individual; in other words, individuals would essentially “pre-pay” their benefits. Similar to the Enhanced CLASS Plan, the Pre-Paid Benefit Plan would provide beneficiaries with 100 percent of the daily benefit amount for the first five claim years and twenty percent of the daily benefit amount thereafter. We have concluded that the Pre-Paid Benefit Plan is not consistent with the statute.

Section 3203(a)(1)(A)(i) of the CLASS Act requires the Secretary to set initial premiums based on an “actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.” Id. § 300ll-2(a)(1)(A)(i). Subject to limited exceptions not relevant here,

the statute requires that “the amount of the monthly premium determined for an individual upon such individual’s enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.” *Id.* § 300ll-2(b)(1)(A). In addition, the statute requires that there be a nominal premium, not to exceed \$5 per day, to be paid by the poorest individuals and actively employed full-time students. *Id.* § 300ll-2(a)(1)(A)(ii).

The Pre-Paid Benefits Plan would establish a premium at the time of an individual’s enrollment, and the premium would not change. We understand that because the plan would not control for adverse selection and assumes that nearly everyone who enrolls will receive benefits shortly after vesting, the plan would have to set the premium between \$400 and \$3,000 per month in order to be actuarially sound. Though such premium might satisfy the Secretary’s obligation to set initial premiums based on actuarial analysis to ensure solvency for seventy-five years and would meet the requirement that the premium remain the same, it does not account for a nominal premium. The statute explicitly creates a nominal premium for individuals with incomes below the poverty line and actively employed full-time students, and does not authorize a waiver or elimination of the nominal premium. *Id.* § 300ll-2(a)(1)(A)(ii). In fact, it requires the Secretary to maintain a nominal premium even if the standard premium rate must be adjusted to ensure the solvency of the program. *See id.* § 300ll-2(b)(1)(B)(i) (authorizing the Secretary to adjust premiums as necessary upon a showing that the premiums will be inadequate to meet the twenty-year demands of the program “but maintaining a nominal premium for enrollees whose income is below the poverty line or who are full-time students actively employed”). Because the Pre-Paid Benefits Plan violates the statutory provision for a nominal premium, it is inconsistent with the statute.

Decreasing Benefit After Five Claim Years. For an analysis of this feature, *see supra* pp. 32-34.

SECTION TWO: OVERALL ANALYSIS

LEGAL RISKS

In our analysis thus far, we have principally analyzed the legality of each of the plan’s individual features. Some proposed features, such as the two-tier benefit structure and the fixed rate of premium increase, fall within the Secretary’s authority to implement the CLASS Act. Some other features, such as the temporary exclusion, the prepaid plan premium, and the limited initial benefit, fall outside the Secretary’s authority. Whether the Secretary has legal authority to adopt many of the other features, such as the five-year, \$12,000 minimum earnings requirement and the phased enrollment process, is not clear. Although there are arguments that can be made that the Secretary can implement those features, there are also arguments, and in some cases strong arguments, that she cannot. As we have described above, our view on the legal permissibility of each of those features varies along a spectrum.

Concerning the legal risks that would accompany implementing any of these plans, it bears emphasis that the more features of a plan that are on questionable legal grounds, the greater the risk of a successful legal challenge to the plan, because each aspect of a particular CLASS plan would have to be lawful in order for the plan to be sustained. As we understand it, the proposed

features deviating from or going beyond a plain reading of the statutory language help to minimize the solvency risks and thereby contribute to the actuarial soundness of a plan. But as the plans incorporate more features of a questionable legality to improve the risks against solvency, they increase the risks that such plans, if challenged, would be invalidated. Finally, we turn now to an analysis of what would occur if, for any reason, HHS needed to shut down the CLASS program.

PROGRAM SHUTDOWN

While the designated CLASS Plan is operational, solvency or legal problems may prevent the CLASS Program from continuing to implement the plan. The Secretary might determine that the CLASS plan could no longer be reasonably expected to remain solvent, even if she were to make statutorily authorized changes to the plan, or a court might conclude that the designated CLASS Benefit Plan violates the CLASS Act. In those circumstances, there is substantial uncertainty about both what the Secretary would have authority to do and what a court would require. If such a circumstance occurred, there is a risk that the CLASS program would have to be entirely shut down, rather than simply closed to future enrollment, and then-existing enrollees or eligible beneficiaries would have no opportunity to receive the anticipated benefits, although it is possible—though by no means guaranteed—that they may be able to recoup some portion of their paid premiums.

The Secretary and the statutorily created Board of Trustees for the CLASS Independence Fund have a continuing obligation to monitor and take steps to ensure the solvency of the program. See 42 U.S.C. §§ 30011-2(b)(1)(B), 30011-5(a)(2), 30011-7(a), 30011-7(d)(5). Based on actual take-up or claims rates, rather than the ones that were originally assumed when the program was developed and tested for solvency, the Secretary and the Board might conclude that the program will become insolvent and the reasonable premium increases or other means authorized by the statute are inadequate to avoid insolvency. The statute requires the Secretary and the Board to submit annual reports to Congress on the CLASS program and fund, and to recommend legislative action as they deem to be appropriate. Id. §§ 30011-5(a)(2)(C), 30011-7(d)(5). For the Board of Trustees, the statute expressly provides that it should recommend legislative action, “including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.” Id. § 30011-5(c)(2)(C). There are no guarantees, however, that Congress will enact any legislative changes necessary to ensure program solvency. Absent any necessary legislative changes, the Secretary might conclude that it is necessary to close down, at least in part, the then-operational plan.

The Secretary might also reach that conclusion because of a court decision. If a court concluded that the designated plan violated the statute, a court might order a range of remedies, from simply invalidating specific elements found to violate the statute to shutting down the entire program. The remedy required will depend in significant part on the nature and extent of the violation. Even if a court only invalidated specific features, such as the heightened minimum earnings requirement or the phased enrollment process, and did not order closure of the CLASS program, the Secretary might nonetheless conclude that there is no statutorily authorized manner in which the CLASS program could proceed and remain solvent.

Under any of these circumstances, the Secretary might prefer to close the CLASS program to future enrollment while leaving the existing program intact, insofar as it already has enrollees or beneficiaries and could remain solvent. This preference might be motivated by a concern that wholesale closure of the program could leave enrollees or beneficiaries worse off than they would have been had they never enrolled in the CLASS program. In particular, enrollees who would have bought private long-term care insurance in the absence of the CLASS plan might no longer be able to purchase such insurance after the CLASS program terminates because of health conditions that developed after they had enrolled in the CLASS program, or because their more advanced age at termination may make the premiums that they would now have to pay for private insurance unaffordable. Yet whether the Secretary would be permitted by a court, or has the independent authority to choose, to close the CLASS program only for new enrollments is not clear.

The CLASS Act itself does not define the scope of the Secretary's authority in this context. It specifies only that she must submit an annual report to Congress and include "[r]ecommendations for such administrative or legislative action as the Secretary determines is necessary to . . . ensure the solvency of the program." *Id.* § 300ll-7(d)(5). It is true that the statute has a general provision requiring the Secretary to "promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title." *Id.* § 300ll-7(d)(5). We think that that authority may reasonably be interpreted to include shutting down the program, if the program cannot be made solvent through statutorily authorized changes. It is less clear whether that provision would authorize the Secretary to keep the program operational for existing enrollees or beneficiaries while imposing a moratorium on future enrollments. The statute's express reference to that option as legislative action that the Board of Trustees should recommend, if appropriate, could support the view that continued operation of the program, with the moratorium, requires legislative action.¹⁵ In any event, as stated above, the Secretary's authority to allow the continued operation of the program for individuals already enrolled, or in beneficiary status, at the time of the decision would likely depend in part on the features of the program.

Beyond the CLASS Act, other relevant sources also do not illuminate what the Secretary may do, or may be required to do. On the one hand, an argument can be made that, insofar as the government contracts to provide individuals with benefits in exchange for premium payments, it may not unilaterally repeal the contract. On this view, although the CLASS program could halt future enrollment, it would have to honor its contract with enrollees, or at least active beneficiaries, to provide benefits. *Lynch v. United States*, 292 U.S. 571 (1934), provides some support for this view. There, after Congress enacted the Economy Act, the relevant section of which provided that "all laws granting or pertaining to yearly renewable term insurance are hereby repealed," beneficiaries of war risk insurance policies challenged the United States' refusal to pay out on their policies. *Id.* at 575 (quoting 38 U.S.C. § 717). The United States responded by claiming that, through the Economy Act provision, it had withdrawn its consent to suit for claims relating to the insurance policies. *Id.* The Supreme Court, however, rejected the United States' argument, holding instead that the Economy Act repealed laws establishing or

¹⁵ One could counter, however, that that provision has no bearing on the Secretary's authority under the CLASS Act. On this view, while legislative action might be necessary to require the Secretary to freeze enrollment, it would not be necessary to authorize the Secretary, in her judgment, to freeze enrollment.

governing insurance policies, not laws waiving sovereign immunity for the purpose of making claims under those policies that were otherwise authorized. *Id.* at 585. In reaching its decision, the Court stated in *dicta* that “Congress [is] without power to reduce expenditures by abrogating contractual obligations of the United States. To abrogate contracts, in the attempt to lessen government expenditure, would be not the practice of economy, but an act of repudiation.” *Id.* at 580.

On the other hand, an argument can also be advanced that the CLASS program may be closed in its entirety. Courts have broad remedial powers and may shut down programs that lack statutory authority. The less the CLASS plan resembles the plan envisioned by the statute, the more reasonable it would be for a court to order the plan shut down in its entirety. *Lynch*, moreover, does not address whether the government must continue to honor its obligations under an insurance program; it simply interpreted the Economy Act to address the question of sovereign immunity. Even if a court were to conclude that the government was obliged, in some way, to honor its contractual obligations, the court could use its equitable power not to force the program to remain in operation for existing enrollees and beneficiaries, but instead to order the distribution of, or direct the Secretary to distribute, the amounts held in the CLASS Independence Fund among enrollees, beneficiaries, and any other relevant parties. This possibility is heightened by the statute’s express prohibition on the use of any federal funds from a source other than premiums to pay for benefits.

The CLASS program, if implemented, might be required to disclose these uncertainties to potential enrollees. Although such disclosures might make marketing the program more challenging and impair the chances that any of the potential plans would be solvent, the disclosures would dispel any claims that the CLASS program had misled the public or had encouraged reliance on its program under false pretenses.

Accordingly, we conclude that there is substantial uncertainty about what would follow if solvency or legal problems prevented the CLASS program, once operational, from continuing to implement the plan. We cannot with any confidence predict that the CLASS program would be able to honor its commitments to individuals who had already enrolled or entered beneficiary status in the program, or avoid leaving them worse off, or that such individuals would be able to recoup their paid premiums.

LIST OF APPENDICES

- Appendix A: Key provisions of Title VIII of the ACA, which establishes the CLASS program
- Appendix B: HHS Letters to Congress About Intent to Create Independent CLASS Office
- Appendix C: Federal Register Announcement Establishing CLASS Office
- Appendix D: CLASS Office Organizational Chart
- Appendix E: CLASS Process Flow Chart
- Appendix F: Federal Register Announcement for CLASS Independence Advisory Council
- Appendix G: Federal Register Announcement for Personal Care Attendants Workforce Advisory Panel and List of Members
- Appendix H: Policy Papers Discussed by the LTC Work Group
- Appendix I: CLASS Administration Systems Analysis and RFI
- Appendix J: Additional Analyses for Early Policy Analysis
 - a) A Profile of Declined Long-Term Care Insurance Applicants
 - b) CLASS Program Benefit Triggers and Cognitive Impairment
 - c) Strategic Analysis of HHS Entry Into the Long-Term Care Insurance Market
 - d) Managing a Cash Benefit Design in Long-Term Care Insurance
- Appendix K: Early Meetings with Stakeholders
- Appendix L: In-Depth Description of ARC Model
- Appendix M: In-Depth Description of Avalere Health Model
- Appendix N: September 22, 2010 Technical Experts Meeting: Agenda, List of Participants and Presentations
- Appendix O: Actuarial Report on the Development of CLASS Benefit Plans
- Appendix P: June 22, 2011 Technical Expert Panel: Agenda and Meeting Materials
- Appendix Q: Table 2: Actuarial and Demographic Assumptions
- Appendix R: Figure 1: Daily Benefit Amount for Increased Benefit

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	[46 PDF pages]
Full Appendix	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

Mr. STEARNS. Also I would say to the gentleman from New Jersey if indeed he meets with the council as he requested from Ms. Greenlee, perhaps we can assume that the Republicans will be invited and will be part of that conference. Is that fair to say?

Mr. PALLONE. First of all, I would like to see whether or not we are even going to have a meeting. I know today I struck an optimistic note. So we will see if the optimism holds and we actually have a meeting, and then I will get back to your question.

Mr. STEARNS. With that optimism, we will close the hearing. And I thank you very much for your testimony.

[Whereupon, at 11:42 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Kathy Greenlee, Assistant Secretary for Aging, HHS
Questions for the Record
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations and Subcommittee on Health
October 26, 2011

The Honorable Cliff Stearns

1. In response to questions from Mr. Murphy about whether members of the CLASS working group or the CLASS office ever discussed CLASS with the White House, you said, "As typical with large policy issues, especially those as important as health reform, we are in contact with the White House as policy issues arise. This is no exception."

- a. In response to a follow-up question about who Secretary Sebelius consulted in the White House before deciding that she did not see a path forward for CLASS implementation at this time, you responded, "As I mentioned, this is a major policy decision. So it is something we would want to talk to the White House and get their guidance. I can't tell you who specifically the Secretary has spoken to... [The White House] certainly needed to be informed of this decision, and involved as she was making it."
- b. Please provide a summary of what discussions the CLASS working group, the CLASS office, and individuals within ASPE working on CLASS issues had with the White House about implementing the CLASS program. Please include which individuals in the Executive Office of the White House or the Office of Management and Budget were involved in those discussions. Please also follow up with a summary of what discussions HHS had with the White House about the decision not to go forward with implementation at this time.

Answer: HHS briefed staff from the Executive Office of the President (EOP) on several occasions about the CLASS program and implementation, including the various potential plan designs released in the October 14, 2011 CLASS program report, the process for release of public information regarding the CLASS program, and the Secretary's decision not to proceed with implementation. EOP officials with relevant policy expertise attended these meetings, including staff from the Domestic Policy Council and OMB.

2. As per Dr. Burgess' request during the hearing, please provide a detailed budget of expenditures related to the CLASS program.

Answer: Please see the attached spreadsheet.

Sherry Glied, Assistant Secretary for Planning and Evaluation, HHS
Questions for the Record
House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations and Subcommittee on Health
October 26, 2011

The Honorable Cliff Stearns

1. In an exchange with Dr. Gingrey about 75-year solvency and HHS' model that could calculate premiums, you said "the CBO had run a very similar model with the 75-year projection and came up with very similar premiums ..." In a similar exchange with Dr. Cassidy, he asked you to provide the CBO projection that showed the CLASS program could be fiscally sustainable over the long term. Can you please provide us with a copy of CBO's 75-year projections? If you do not have a copy of the model, please describe what this model showed and what assumptions were used that turned out to be incorrect.

Answer: Dr. Glied's statement referred to premiums published by CBO in November 2009 (http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf). Specifically, CBO stated in its letter to Senator Tom Harkin dated November 25, 2009:

[U]nder the House-passed version of the CLASS program, the average monthly premium in 2011 would be about \$146 (premiums for new enrollees would increase with inflation in later years). Expected enrollment in the program would reach slightly more than 10 million people by 2019 (or about 4 percent of the adult population). The estimated premiums are calculated to be adequate for the program to remain solvent for 75 years, taking into account the interest income that would be generated on unspent balances in the program's trust fund. (p. 3)

CBO estimates that under the current Senate proposal for CLASS, the average monthly premium in 2011 would be about \$123 (premiums for new enrollees would increase with inflation in later years), and enrollment in the program would be slightly less than 10 million people by 2019 (or about 3.5 percent of the adult population). The slightly lower enrollment expected under the Senate proposal stems from the exclusion of nonworking spouses (as would be allowed under H.R. 3962). However, a higher percentage of those eligible would be expected to enroll under the Senate proposal because of the lower estimated premium. (p. 4)

2. In an exchange with Ms. Castor, you testified that "Mr. Foster's actuarial analyses were actually publicly released. They were posted on HHS's own website. They were widely reported in the news media. They were discussed in Congress. He was in no way silenced." However, our investigatory report revealed an email from Senate staff in September 2009 saying "we do not need additional work on the actuarial side," and an email from the following week that said the program was actuarial sound as per CBO's estimates.

a. Did Mr. Foster participate in any meetings about the CLASS Act with Congressional staff in October 2009 or after? Was Mr. Foster's opinion sought on technical comments prepared by HHS in October 2009 or after?

Answer: Mr. Foster participated in meetings with staff from Congress, CBO, and HHS in October 2009 and after. The purpose of the meetings was to discuss technical issues related to actuarial modeling of the CLASS program and assumptions.

b. You also stated that "the CMS actuary released those reports over time, and there were changes made to the CLASS Act over time in response to his concerns." What changes were made after his November 2009 or December 2010 reports were published?

Answer: There were many revisions to the CLASS program from the point that it was introduced in the U.S. Senate Committee on Health, Education, Labor, and Pensions in the summer of 2009 until its eventual inclusion in the final bill that was signed into law in March 2010. Many of these changes were designed to address concerns about adverse selection specifically raised by Mr. Foster, actuaries at the American Academy of Actuaries (see http://www.actuary.org/pdf/health/class_july09.pdf), and other experts. One concrete example noted by CBO in its letter to Senator Tom Harkin was the elimination of nonworking spouses from CLASS eligibility in the Senate proposal. In addition, also noted by CBO, both the House and Senate legislation "provided considerable authority to the Secretary to adjust premiums for both current and future enrollees and to reduce benefits to the daily minimum of \$50 in order to maintain the solvency of the program." (p. 2) The authority given to the Secretary was in large part due to concerns over adverse selection and the long-run solvency of the CLASS program raised by Mr. Foster and other actuaries.

3. Please provide a list of the offices that received HHS' technical corrections to the Patient Protection and Affordable Care Act before the bill became law.

Answer: Prior to the enactment of the Affordable Care Act, the Administration provided technical assistance to the committees of jurisdiction, including the Senate Health, Education, Labor and Pensions Committee.

4. As per Dr. Burgess' request during the hearing, please provide a detailed budget of expenditures related to the CLASS program.

Answer: Please see the attached spreadsheet.

Spending on CLASS Implementation in FY 2010 & FY 2011

Total AOA + ASPE Spending **\$4,995,410.34**

Administration on Aging (AOA) - Health Reform Implementation Fund

FY 2010

Staff/Travel/Misc	\$34,517.35
Contracts	\$147,465.52
FY 2010 AoA Total	\$181,982.87

FY 2011

Staffing	\$2,537,420.96
Travel	\$21,111.16
Rent, Supplies, and other program support	\$1,049,663.00
Contracts	\$157,788.86
FY 2011 AoA Total	\$3,765,983.98

Total AoA Spending in FY 2010-2011 **\$3,947,966.85**

Assistant Secretary for Planning & Evaluation (ASPE)

Staffing	\$198,084.49
Contracts	\$849,359.00

Total ASPE Spending **\$1,047,443.49**