

Long Term Care Insurance Beyond the CLASS Program

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The Community Living Assistance and Supports (CLASS) program, created under the Patient Protection and Affordable Care Act, established a federally-administered, voluntary insurance program that allows for working adults to purchase insurance to cover the cost of long term support services. The CLASS program is the first step towards moving away from a welfare-based system, improving consumer choice, and creating a stable funding source for long term care needs. Enrollees in the CLASS program who meet benefit eligibility requirements and need care assistance will receive a cash benefit to pay for supportive services such as home health care, adult day services, assisted living, nursing home care, housing modification, assistive technologies, and transportation assistance. The authors apply David Gil's (1992) model of social policy analysis to assess the effectiveness of this policy alternative to aid in the development of a viable national long term health care solution for the anticipated ongoing health and support service needs of the older adult population.

Key words: CLASS program, Gil model of analysis, long term care, older adults, equality

As the baby boomers age, the need for long term services and supports for individuals living in the community will increase dramatically. Today, approximately 10 million Americans need long term care (LTC) services to assist with

Journal of Sociology & Social Welfare, September 2012, Volume XXXIX, Number 3

carrying out activities of daily living, and this number is expected to increase to 15 million by 2020 (National Council on Aging, 2010). Issues of LTC are gaining more attention due to the rapid aging of the population taking place in the United States as well as many other developed countries as a result of low fertility rates and increased longevity. Along with increases in the average lifespan, old age is often accompanied by chronic illness that may cause physical or cognitive frailty for an extended period of time. Approximately 80% of adults 65 and above in the United States have one or more chronic illnesses (National Center for Chronic Disease Prevention and Promotion, 2004). Nearly two-thirds of the current health care expenditures for the overall population are devoted to treating chronic illnesses; however this proportion could reach as high as 95% for older adults (Hoffman, Rice, & Sung, 1996). The lifetime probability of an American either becoming physically disabled in at least two activities of daily living (e. g., bathing, dressing, transferring, or eating) or becoming cognitively impaired is 68% for people 65 years and above (AARP, 2003).

The United States heavily relies upon unpaid family member caregivers and the welfare-based Medicaid program to provide a safety net of LTC services for older adults. Families are the primary informal providers of eldercare, and their unpaid caregiving contributions are estimated at \$350 billion per year (Houser & Gibson, 2008). The bulk of LTC expenditures for formal services in 2005 were funded through Medicaid (49%) and Medicare (20%), with the remaining amount paid through out-of-pocket expenses (18%), private insurance (7%) and other means (6%) (AAHSA, 2009a). In order to qualify for the means-tested Medicaid program, individuals must either be poor or become impoverished through spending down assets. As a social insurance program, Medicare offers time-limited benefits that cover short-term nursing home or home care services. Private LTC insurance is often too costly for most Americans, and the option of taking out a policy is dependent upon the individual's current health status and absence of pre-existing conditions. Without substantial financial resources or informal help from a spouse or other family caregivers, older people with chronic and debilitating health conditions are vulnerable.

While many older people will need some LTC services, the majority cannot afford to pay for these services out-of-pocket over an extended period of time. For the lower and middle classes, the costs for nursing home care or in-home care are too high in comparison to available personal resources (Administration on Aging, 2010). In 2011, annual nursing home care costs are estimated to average \$77,745 for a private room and \$39,132 for assisted living (Genworth Financial, 2011). Average costs for LTC services in 2009 were: \$198/day for a semi-private room in a nursing home; \$219/day for a private room in a nursing home; \$3,131/month for assisted living; \$21/hour for a home health aide; and \$67/day for adult day services (MetLife Mature Market Institute, 2009). The recent economic downturn and the collapse of the housing market significantly decreased the net worth of baby boomers. The median household wealth for a person between 45 and 54 years old fell by 45% between 2004 and 2009 (\$94,200 in 2009) and the median household wealth for a person between 55 and 64 years old fell 50% (\$159,800 in 2009) (Rosnick & Baker, 2009). A full 42 percent of Americans 45 years and older have saved less than \$25,000 for retirement (Helman, Copeland, & VanDerhei, 2010). Further, the availability of personal financial resources has serious implications for service gaps. A study among adults over 50 years old with a disability found that financial barriers were the most important predictor of unmet LTC needs (Gibson & Verma, 2006).

In an initial effort to encourage individuals to plan ahead for potential LTC expenses, the government has provided federal and state tax advantages to incentivize the purchase of private LTC insurance. The Internal Revenue Service allows a tax deduction for private LTC insurance premiums, on a graduated basis according to age. In 2008, a person at age 55 could claim a maximum tax deduction of \$1,190, and the amount would increase to \$3,980 at age 70 or above (IRS Bulletin, 2008, p. 1113). Tax deductions or credits from state income taxes are allowed for either a partial or full amount paid on policy premiums in a number of states including Ohio. However, most policyholders of private LTC insurance do not receive federal tax subsidies because they do not meet criteria for itemizing deductions, having a tax liability, or having medical expenses

that exceed 7.5% of adjusted gross income (Baer & O'Brien, 2009). Since 2003, individuals could pay for LTC insurance through tax-free health savings accounts, yet only 8 percent of adults 50 years old or above reported holding a LTC insurance policy (Feder, Komisar, & Friedland, 2007).

The Community Living Assistance Services and Supports (CLASS) Program

As part of the Obama administration's Patient Protection and Affordable Care Act of 2010 (PPACA, P.L. 111-148), the Community Living Assistance Services and Supports (CLASS) Act was enacted on March 23, 2010 (H.R. 3590–111th Congress). The CLASS program forges the creation of a new federally-administered voluntary insurance program that allows working adults to contribute premium payments towards future long-term services in exchange for a cash benefit provided to enrollees if such supports are needed. The Secretary of the Health and Human Services will announce the details of the benefit by October 1, 2012 and it is anticipated that working adults 18 years and above will be eligible to enroll in the CLASS program shortly thereafter (Administration on Aging, 2011). The CLASS program will provide a cash benefit for support services in the community or residential settings, advocacy services, and advice and assistance counseling to eligible enrollees (O'Shaughnessy, 2010). In comparison to private LTC insurance companies, the CLASS program will not exclude enrollment based on pre-existing medical conditions, the cash benefit is provided directly to enrollees rather than contracted to an agency, and there are no lifetime benefit limitations.

To receive the CLASS program benefits, enrollees must initially contribute monthly premiums for at least five years to be vested, earn enough to be credited for one quarter of Social Security coverage (e.g., approximately \$1,120 in 2010) during at least three of the first five years, and qualify for the benefit through a measure of functional or cognitive limitations that demonstrate a need for assistance with two or more activities of daily living (Administration on Aging, 2011). Employers can decide whether to offer the CLASS program to employees, and self-employed individuals may also enroll. Depending on the degree of need, anticipated benefits are estimated to provide

an average cash benefit of at least \$50 per day per enrollee, and payments can rollover from month to month.

This cash benefit may be used for a variety of community-based or residential care services, including home health care, adult day services, assisted living, nursing home care, housing modification, assistive technologies, and transportation assistance. Access to supportive services can allow older people to remain living in the community as well as provide respite to informal caregivers. Since the vast majority (86%) of older adults who need LTC services are living in community settings rather than institutions (Henry J. Kaiser Family Foundation, 2009), the CLASS program will enable greater access to LTC services while remaining at home. Plus, those who enroll in the CLASS program will also remain eligible for Medicaid (Administration on Aging, 2011). At the earliest, benefits may be available to enrollees in 2017, after the five year vesting period has been fulfilled.

In this insurance model, the fiscal solvency of the CLASS program balances premium income from voluntary worker enrollment and investment income with spending for direct benefits. The Congressional Budget Office (2009) has estimated that the CLASS program will reduce deficits by \$72 billion over 2010-2019. With affordable premiums, estimated from \$85 to \$100 per month, the CLASS program is considerably less expensive than the amount older adults were willing to pay for LTC insurance in 2005 (America's Health Insurance Plans, 2007). Like private LTC insurance, younger enrollees will pay less than older enrollees, but unique to the CLASS program, lower income individuals can participate through a sliding scale fee for premium costs. For example, CLASS program enrollees below the poverty level and full-time students age 18 to 21 will pay no more than \$5 per month (AAHSA, 2009b).

Aspects of the CLASS program may be modified in response to concerns about the program's financial solvency over a 75 year period. Various strategies to ensure fiscal solvency have been proposed, including: (1) increasing enrollment to diversify risk (e.g., through providing attractive incentives for employers to participate); (2) building in allowances for increasing premium payments if necessary; and (3) setting more strict eligibility criteria through income or employment requirements (Kenen, 2011). As policymakers struggle with

decisions about how to create and support a sustainable health-care system that includes long term care, insurance coverage is an attractive strategy to reduce health care spending and the federal deficit. The authors contend that the most effective strategy to improve individual care options, the quality of care available, and to reduce health care spending is through expanding the coverage of the CLASS program to establish a universal federal program of LTC insurance.

The Gil Framework of Analysis and Development of Social Policies

This prospective social policy analysis of the CLASS program is based on David Gil's (1992) framework for social policy analysis. Gil's approach enables "governmental and other formal and informal societal units to engage in analysis and development of social policies in a more effective manner than is possible at present, and to design more comprehensive and internally less-inconsistent systems of social policies" (Gil, 1992, p. xviii). Philosophically, the Gil model acknowledges that social policies are both potential causes and potential solutions of social problems, and both of which cannot be separated from economics. The three main objectives of this analysis include: (1) to gain an understanding of how issues related to the financing of LTC affect individuals, service providers, and the welfare state; (2) to identify the expected outcomes through discerning the chain of effects expected to result from the policy's implementation; and (3) to provide recommendations for the development of alternative policies. To date, the authors are not aware of any other policy analysis of this topic using the Gil model.

The Gil framework contains five elements that apply to the evaluation and development of a social policy (Gil, 1992, pp. 71-74). The first element identifies the two primary issues that are intended to be dealt with by the CLASS program, including: (1) improving the access and affordability of LTC insurance; and (2) increasing the expectation of personal responsibility among working adults to plan for their potential future care needs. The second element of the model identifies the effects of this policy as applied to the value of personal responsibility among the target segment of working adults. The third element

includes the implications for groups within society who are at risk of exclusion from CLASS program provisions, such as women, the non-working disabled, racial minorities, and the unemployed. The fourth element of the model identifies the interactions of the policy on different social forces which affect its evolution. This involves examining demographic, economic, and sociopolitical issues in the LTC system, as well as a brief comparison of the United States to Germany's national LTC insurance program. Finally, the fifth element includes policy recommendations for the LTC system, including the expansion of the CLASS program to achieve greater equity.

Current Issues with the Financing of LTC

Individuals

From the perspective of the individual, the CLASS program improves three of the main issues with private LTC insurance by enhancing the affordability, access, and understanding of LTC services and funding for Americans. First, private LTC insurance is not an affordable option for most Americans. A recent study identified common concerns about purchasing private LTC insurance, including: (1) cost; (2) skepticism about the viability and integrity of private insurance companies; and (3) insufficient information from unbiased sources (Curry, Robison, Shugrue, Keenan, & Kapp, 2009). The Health and Retirement Study (2006) conducted by the University of Michigan found that the average annual LTC premium for individuals under 65 was \$1,337 and the average cost for those over 65 was \$2,862 in 2006. However, the cost of LTC insurance varies considerably based on the age at which the policy is taken out. In 2008, if a policy was purchased at age 40, the average cost was \$1,512 as compared to the cost of \$4,515 for purchasing the same policy at age 70 (Henry J. Kaiser Family Foundation, 2009). While initially a younger person may be able to afford premium payments, the rapidly increasing annual cost may become unaffordable in late life. In response to criticism from dramatically rising premium rates among existing policyholders, legislation in 36 states has been enacted to help protect consumers from excessive rate increases (Baer & O'Brien, 2009). Other options to reduce the cost of existing premiums include altering policies to limit care options and

removing provisions that allow for benefits to keep pace with inflation.

As a financial product, private LTC insurance is designed to meet the basic and perceived needs of affluent middle-aged and older people. On average, the purchaser of private LTC insurance is a married, college-educated, 61 year-old with an income of over \$75,000 per year and \$100,000 in liquid assets who is interested in protecting assets, preserving financial independence, avoiding depending on family members for care, and ensuring the affordability of flexible care options through inflation protection (America's Health Insurance Plans, 2007). A financial planning article from AARP suggested that unmarried individuals with \$1 million or more in investments, or a couple with more than \$1.5 million, may want to consider purchasing a LTC insurance policy (Pond, 2009).

The CLASS program prohibits the exclusion of enrollees due to health status. In order to maximize profitability and diversify risk, private insurance companies prevent enrollment of high risk individuals through routine screening for pre-existing or chronic health conditions. In fact, private LTC insurance companies excluded 15-40% of the population based on pre-existing health conditions (AAHSA, 2009b).

The accessibility and affordability of long term care insurance secured through the CLASS program will provide working adults with the option to plan for potential needs and access higher quality services. A recent survey indicated that 59% of Americans over 45 incorrectly believe that Medicare will pay for extended nursing home stays, and close to 20% of Americans "don't know" what funds will cover their LTC costs (AAHSA, 2009a). Another public opinion survey by Met Life Mature Market Institute (2009) found that most Americans understand what LTC is and how much it costs, but many: (1) underestimate how many people need LTC services; (2) do not understand who pays for long term care; and (3) are not planning for their own future expenses (p. 5).

Service Providers

Organizations that provide services to older adults often rely upon Medicaid reimbursement, although disparities between the Medicaid reimbursement and the total cost of care

are common. All states are required to balance their budgets, and the most frequently used strategy to control Medicaid spending for older adults has been to reduce provider payments (Smith et al., 2006). The resulting funding gap may require scaling back services to provide only the basics, or on the other hand, restricting services for those who can pay privately. Nursing homes primarily funded by Medicaid provide lower quality care (Cohen & Dubay, 1990; Cohen & Spector, 1996; Grabowski, 2001; Moses, 1994), and have lower staffing levels (see Castle, 2008 for a review). Another trend in LTC financing is a shift in Medicaid spending away from institutional care towards an increased emphasis on home and community-based services (Burwell, Sredl, & Eiken, 2008). Still, over three-quarters of nursing home residents rely on Medicaid to cover their care needs (CDC/National Center for Health Statistics, 2009).

Government

The projected long term health care needs of older people have substantial financial implications for government programs. Estimates project that the need for LTC is expected to more than double in the next 30 years (AAHSA, 2009b). Although the Medicaid program provides an important public safety net, the eligibility requirements and benefits vary from state to state (Feder et al., 2007). "Many states are finding it difficult to maintain Medicaid services in the face of continuing tax and revenue shortfalls, and budgetary pressures are likely to intensify as the population ages" (Kenen, 2011, p. 2). According to the CBO (2008), federal spending on Medicare and Medicaid will increase from around 4 percent of the GDP in 2009, to 6 percent in 2019, to a projected 12 percent by 2050 (p. 9). Increased expenses are related to the increased cost of health care and the growth of the aging population, which taken together will "pose a serious threat to the future fiscal condition of the United States" (CBO, 2008, p. 9). The Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (2010) estimate that the Medicare trust will be exhausted in 2024. The Medicare program is funded through payroll taxes and beneficiary contributions and pays for intermittent care, such as

short-term nursing home care stays to recover from surgery and limited home health care benefits (U.S. Department of Health and Human Services, 2009).

Overall, the CLASS program is an attractive strategy to offset some of the reliance of individuals upon government assistance for long-term health care needs. As a self-sustaining program, economists expect the CLASS program to reduce deficits in other health care entitlement programs for older adults. Also, private LTC insurance companies can increase their market share through selling additional supplemental insurance products to enhance benefits.

Policy Objectives, Value Premises, Theoretical Positions, Target Segments, and Substantive Effects of Proposed LTC Policies

While private insurance companies still provide policies within government guidelines, the establishment of a government-sponsored voluntary LTC insurance trust through the CLASS program transfers a greater amount of decision-making and control over resources from private insurance companies in the free market to the government. Gil suggested that social policy analysis should focus on “value dimensions which are most likely to affect attitudes, decisions, and actions concerning resource control, work organization, and rights distribution” (Gil, 1992, p. 79). The repositioning of the LTC insurance product from for-profit companies to the federal government is likely to influence the public perception of LTC insurance. Instead of its previous endorsement as a financial tool to preserve assets exclusively for the wealthy, the government’s leadership is likely to help legitimize the insurance product with the value-based appeal of personal responsibility.

Accessibility and affordability is secured through the CLASS program in order to provide an option for working adults to save for potential future needs and access higher quality services. Inherent in the social insurance design of the CLASS program, personal responsibility is accompanied by the government’s extended responsibility to administer a LTC system and pay out benefits over the lifetime of policyholders. The CLASS program is projected to save Medicaid \$2.5 billion in the first ten years without taxpayer dollars, and for enrollees

who are also eligible for Medicaid, the CLASS program will serve as the primary payer (Henry J. Kaiser Family Foundation, 2010).

Projections of CLASS program solvency depend on the balance between the revenue generated from premium payments, the general health of enrollees, and their LTC needs. Thus, estimates suggest that an enrollment of 2% is required for solvency. If fewer enroll, a government subsidy may be needed to offset the cost of claims. Estimated effects of the cost-effectiveness and solvency of the voluntary CLASS program are less accurate beyond the first ten years, and it is plausible that deficit spending may be necessary to continue the program. However, legislation allows for flexibility on behalf of the government to adjust premiums for current and future enrollees and to reduce benefits to the daily minimum.

Incremental policies that provided tax incentives to encourage individual responsibility for care needs in old age were targeted for wealthy individuals, required minimal administration on the part of the government, and reinforced traditional models of insurance in the marketplace. The establishment of a voluntary, national LTC insurance trust provides a means for many more working adults to consider this option. Distinct from the welfare-based Medicaid program, enrollees are likely to have high expectations of receiving goods and services in exchange for what has been previously paid. Consequently, individuals may demand more decision-making power and flexibility in selecting among different types of care, such as in-home health services or other community-based care. Service providers also stand to benefit from additional revenue from LTC insurance payments that may improve quality and assist with building a stronger infrastructure for community-based services and supports that are consistent with the preferences of the expanding older adult population.

Implications of the Policies

Supporters of the CLASS program emphasize its capacity to serve as a mechanism for workers to increase personal control over planning for LTC for more Americans than ever before. The economic downturn and loss of net worth among middle-aged and older persons may be countered through planning to delay retirement. Yet many personal, economic and social

factors can limit an individual's ability to complete the five-year contribution period and three-year work requirement to become vested in the CLASS program. These eligibility criteria discriminate against a large number of older people and individuals with disabilities who are not able to work, such as retirees, non-working spouses, and people with disabilities. Further, older people have been hit particularly hard during the current recession with high rates of unemployment compounded with longer time periods between jobs compared to younger workers (Schmidt, 2011). For example, more than 2.1 million people age 55 and older were out of work in May 2010 (U. S. Bureau of Labor Statistics, 2010). Plus, early retirement may be forced due to poor health or other factors (Kiefer, 2001).

As family members provide the majority of long term care, it is imperative they have adequate supports to prevent burnout from the caregiving demands placed upon them. The National Alliance for Caregiving and AARP (2009) estimated that 19% of all adults 18 and over provided unpaid care to a family member or friend who is 50 years old or above. Families devote 35.4 hours per week on average to caregiving responsibilities (Evercare/National Alliance for Caregiving, 2007). Greater economic instability may also result from these responsibilities. One study found that around a third of family caregivers quit their jobs or reduced working hours; many lost health insurance benefits and retirement savings; and some suffered from chronic stress (Houser & Gibson, 2008). Among family caregivers, women in mid-career are most likely to leave the workforce entirely (Pavalko & Henderson, 2006).

Gil (1992) suggested that another important policy issue concerns the use of resources—whether the goods and services provided respond to the actual levels of need among members of the community or reflect the “purchasing power” of selected individuals in the free market. Thus, the benefits of the policy must be available to the majority of older persons in need of LTC services and these benefits must remain adequate. In a cost comparison of national averages for the costs of common health care and supportive services for older adults, the CLASS program benefit of \$50-\$75 per day seems a meager amount in comparison to the expense of nursing home care, however this amount could feasibly pay for one day of adult

day services or between 2 and 3 hours of in-home health care (MetLife Mature Market Institute, 2009). For older people who require more intensive services such as nursing home care due to a higher acuity of medical need, the CLASS program funding will offset \$1,500-\$2,250 of Medicaid spending per month for every dually-eligible older person (MetLife Mature Market Institute, 2009). Based on the daily benefit amount, the CLASS program will contribute from \$18,000 to \$27,000 annually towards nursing home or assisted living care costs.

Interactions of the Policy with Forces Affecting Social Evolution

A variety of demographic, economic and sociopolitical issues converge in the debate about LTC options for older adults. "Changes in population size and in age distribution can cause conflicts related to emerging imbalances concerning resources, production, and distribution of goods and services," (Gil, 1992, p. 91). Demographically, as the baby boomers age, the proportion of adults 65 and above will grow by 89%, or four times as fast as the overall population between 2007 and 2030 (Administration on Aging, 2008). Between 2007 and 2015, the number of Americans who are 85 and above—the fastest growing group of older adults—will increase by 40% (AAHSA, 2009a). This rapid increase of persons 85 and above will triple LTC expenditures from 1997 to 2040 (Niefield, O'Brien, & Feder, 1999). In addition to the increased numbers, the diversity among older adults is growing. Between 2004 and 2030, the proportion of older minorities is expected to increase by 183% in comparison with an increase of 81% for white older adults (Administration on Aging, 2008).

The society's value positions about family, market, and state responsibility for social welfare converge on the issue of LTC. Family caregivers are the primary provider of LTC, responsible for about 80% of all elder care in the United States (Pandya, 2005). The family structure, as a result of industrialization, has changed from an extended family system to a nuclear or a blended structure (Bell, 1973; Blumer, 1990). Industrialized societies often boast increased lifespan and greater wealth, but changes in family and community structure may also lead to

vulnerabilities, such as the increasing number of older people living alone (United Nations, 2005).

Changes to the availability and affordability of LTC services could allow family caregivers, who are primarily women, to stay in the workforce rather than quitting work to care for older loved ones. Between 59% and 75% of family caregivers are women who regularly provide instrumental help such as bathing and dressing for older relatives (Henry J. Kaiser Family Foundation, 2002). Middle-aged women make up the majority of American family caregivers and balance work with the demands of caregiving for children and aging parents (Spillman & Pezzin, 2000). In 2009, the average U.S. caregiver was a 48-year-old employed woman with a median household income of \$57,200 annually, who spends 20.4 hours per week providing unpaid care to a relative (National Alliance for Caregiving/AARP, 2009). Other important demographic changes, such as more childless women, changes in divorce and marriage patterns, more women in the workforce, and a smaller number of adult children in future cohorts will decrease the availability of family caregivers (Wolf, 2001). While some may argue LTC insurance shifts responsibility from the family to the welfare state, the LTC insurance strategy offers a tool through which individuals can take greater ownership in the process of planning for future care needs. Without this tool, fewer financial resources will be available for a larger population of older adults, increasing the potential for greater conflicts regarding rights among the classes and intergenerational tensions between age cohorts.

Development of Outcomes and Alternatives

An important element of the Gil framework for social policy analysis is to identify the intended as well as the unintended consequences of a given policy. The CLASS program facilitates a means for individuals who are participating in the workforce to plan for their own care and services in old age through government-sponsored lower cost premiums than are currently available in the marketplace. Further, greater availability of purchasing power among older adults in the marketplace will lead to more choice in selecting health care and supportive services, and support a growing infrastructure of

flexible services for older adults.

A balanced view of the potential unintended consequences of this new policy alternative is merited—particularly as applied to its eligibility criteria. The program encourages currently working individuals to enroll and contribute to the CLASS program over the vesting period (and beyond) in order to qualify for benefits. Thus, retirees and the majority of people with disabilities are excluded from the CLASS program. According to the U. S. Bureau of Labor Statistics (2012), the reported labor force participation rate in May 2012 was only 20.7% among people with disabilities, compared to 69.4% among those who did not have disabilities. External forces such as unemployment threaten to further constrict the pool of eligible enrollees, especially during economic downturns. And, interruptions in personal work histories may present a challenge to the vesting requirement.

The inclusion of vulnerable groups such as women who are likely to need ongoing health care in their later years is an important issue. Women make up the majority of nursing home residents (75% female) and home health care users (65% female) according to the Centers for Disease Control and Prevention/National Center for Health Statistics (2009). In 2001, women age 65 and above made up 71% of the Medicaid rolls (Henry J. Kaiser Family Foundation, 2005). Several factors are known to increase the risk of needing long term care, including being a woman, growing older, being single, making unhealthy lifestyle choices, along with health and family history (Administration on Aging, 2010). Recently, the AARP Public Policy Institute reported that millions of women cannot afford to pay for LTC: 70% of women 75 and above were widowed, divorced, or never married, and among the 48% who were living alone, their median income was only \$14,600 in 2004-2005 (Houser, 2007).

In the CLASS program, women and men must meet all eligibility requirements individually, regardless of marital status. Therefore at this point in time, spouses cannot be added to the vested spouse's LTC insurance policy. Policymakers must consider if the requirements for the CLASS program restrict eligibility to the extent that those who need the program most are placed at a disadvantage. The CLASS program must do more to ensure gender equality as well as work towards eliminating

gaps in coverage.

Another unintended consequence of this policy lies in its potential to create a two-tier LTC system in which the “have-nots” are further removed from those who have access to more resources. As we enter a time of limited supply of LTC services and unprecedented demand, those with more resources, whether that is from personal wealth or some kind of insurance, will have preferential access to a broader array of presumably higher quality services. Those who cannot afford the insurance premiums will be stuck in the same crisis that exists today—the practice of the “spend down policy” in order to obtain LTC support until they are picked up by the Medicaid program. At the same time, fiscal pressures are forcing many states to reduce Medicaid spending and are limiting resources despite growing needs. Further, Medicaid could become seen as “welfare” by society, adding stigma and blame towards older adults or disabled individuals who are poor or cannot work to pay for LTC insurance or qualify for the CLASS program. Thus, this policy fails to address LTC needs among older adults who are ineligible to enroll in the CLASS program.

Although the CLASS program is a national strategy to support LTC services, it is inadequate due to the limited scope of eligible enrollees. As Gil (1992) stated, “A society’s changing concepts of the levels of minimum rights which it guarantees to all its members is an important aspect of its system of rights distribution” (p. 86). A variety of supports will be needed to help all citizens age with dignity and deal with functional limitations, including personal or support services offered in the community to more intensive services such as assisted living or nursing home care. A national LTC insurance program available to every citizen offers a mechanism by which older Americans can plan ahead for their care needs in later life without exorbitant out-of-pocket payment, unaffordable LTC insurance premiums, or the financial and emotional sacrifices involved with surrendering all assets in exchange for care.

Other industrialized countries, including Japan and many countries in Europe, have developed universal LTC systems through a social insurance model that is administered by the government and usually funded through payroll taxes. A recent review of the LTC systems by the Urban Institute

in Germany, the Netherlands, Japan, France, and the United Kingdom suggest that replacing a means-tested model similar to the U.S. Medicaid system with a social insurance model that provides some benefits to all with ongoing medical needs is feasible, popular, and fiscally manageable (Gleckman, 2010). Nonetheless, the CLASS program currently differs in its approach through its voluntary nature of enrollment. The social insurance model has been proven to be viable with mandatory enrollment, but never before has a social insurance model been implemented through a voluntary enrollment. This introduces the potential that higher risk individuals with more needs will enroll while healthier individuals will decline participation, creating a situation of adverse selection that can result in rapidly rising costs (Schmitz, 2009). To limit the degree of adverse selection, enrollment for the CLASS program has been restricted to people currently working, and enrollees must pay premiums to become vested in order to qualify for benefits. A universal program for LTC would also reduce this potential risk.

The universal LTC insurance program in Germany provides an innovative mixed model of ongoing health care for older people that supports formal and family caregivers. Germany's approach to social insurance served as a model for the development of the United States' Social Security system, and both countries philosophically support a contributory strategy rather than taxation to financing social programs. In the 1990s, Germany and the United States faced similar challenges with systems of LTC, including: (1) a growing demand for care; (2) increasing costs for individuals; (3) a welfare-based public safety net that first required individuals to spend down their own resources; and (4) quality problems (Gibson & Redfoot, 2007). Population aging in both countries contributed to changes in family structure which reduce the availability of family caregivers and show greater numbers of older people living alone.

In response to these challenges, a universal LTC insurance program in Germany was enacted in 1995. In this system, all workers are required to have LTC insurance either through the government or a private insurance company. Currently 90% of Germans participate in the government-sponsored universal

program that allocates basic services depending upon on the individual's level of functional need, which is funded through a national payroll tax shared equally by employer and employees (Arntz, Sacchetto, Spermann, Steffes, & Widmaier, 2007). Enrollees with no children paid a slightly higher premium to compensate for the increased likelihood of needing more formal care services than others who may rely more on informal, unpaid care. Fiscally, the LTC system built a reserve early in its implementation, followed by a depletion of balances that required increasing the contributions and benefits in 2008 to keep up with inflation, which could be a challenge in the future (Gleckman, 2010). Thus far, the German model has been successful in reducing welfare-based spending. Since the inception of the universal LTC in Germany, spending for nursing home care for the poor in 2007 was less than one-third of the 1995 level (Rothgang & Igl, 2007).

Germany also has several programs to assist family caregivers, whether they are currently working or have already left the workforce through continuing pension contributions. One innovative program for family caregivers ensures that the social pensions (similar to U. S. Social Security benefits) are not reduced as a result of caregiving responsibilities. As long as family caregivers provide at least 14 hours of assistance each week and do not work more than 30 hours in formal employment, they continue their eligibility for social pension benefits.

Recommendations for Future Policy Development and Research

The modification of existing policies or the development of alternative policies, as Gil suggested, begins with "questions concerning the appropriateness of given policy objectives with respect to the issues to be dealt with by these policies" (1992, p. 96). It is essential that the analysis of any plan to improve the access, affordability, and quality of health care and supportive services for older adults include an evaluation of the needs and expectations of all constituents. As policies are being developed to provide for the growing numbers of older persons, it is imperative for policymakers to consider three important issues: (1) the adequacy of proposed benefits relative to the actual cost of supportive services; (2) equal access to

needed goods and services; and (3) affordability. The proposed benefits must keep pace with inflation and allow for adequate purchasing power to enable all older persons to obtain high quality LTC services. Additionally, policymakers must avoid creating a two-tiered system. Services available to poor older adults through the Medicaid program must be funded adequately to promote security, dignity, and respect to all older people in their final years.

At this point in time, conflicting estimations obscure clear projections of short- and long-term efficiency of the proposed CLASS program. The CBO (2009) acknowledges that a number of wider societal changes—such as older adults' health and disability status, the delivery of medicine, and the changing role of private LTC insurance—are difficult to predict. It is unlikely that the CLASS program could ultimately serve as a replacement for the Medicare and Medicaid programs, and a rigorous program of research and fiscal accountability are warranted going forward. Yet the German model provides some indication of the effectiveness of a universal LTC insurance program for providing access to affordable care options for individuals, and reducing welfare-based government health care spending.

One method to improve the CLASS program is to broaden eligibility criteria. Specifically, it is important to provide individuals who are not currently employed with the option to become part of the voluntary program. As traditional LTC insurance offered through for-profit companies is prohibitively expensive, the CLASS program would provide an affordable alternative. Financial projections are needed to understand how many more people could be served and if the CLASS program impacts the capacity of service providers.

Another concept that should be tested among enrollees in the CLASS program is to incentivize family member involvement in planning for their older parents' health care needs. Many family caregivers have a strong interest in ensuring the well-being of their older loved ones and finding options to help balance their caregiving responsibilities with work and other family commitments. Families may be willing to make affordable premium payments on behalf of their older loved ones. Further, universal caregiving support through labor market and continued social pension eligibility will enable a stronger mixed system of formal and informal caregivers.

Germany's lack of exclusion criteria in regard to health care status does not seem to lead to fiscal instability of their national LTC insurance program. Will the United States need to ration eligibility or benefits to control costs? This question remains unanswered. As medical technologies like genetic testing for common chronic disease in late life, such as dementia, hypertension, or cancer become readily available in doctors' offices and even local drug stores, criteria beyond the age of the enrollee may influence the longevity of benefits. A lack of exclusion criteria may lead to fiscal instability of the program, while the potential need to ration eligibility or benefits conflicts with values of equality and social justice. Policymakers must also cautiously evaluate the political will for a universal national LTC insurance plan, including the public's proclivity for another contributory approach to financing social insurance, an additional tax, or mandated participation.

Conclusions

A national and voluntary LTC financing system for older adults, as proposed by the CLASS program, is a positive development for individuals, families, service providers, and the government. With the enormity of the emerging older adult population and their ongoing health care needs, a universal LTC insurance program similar to Medicare holds the greatest potential to include women, retirees, and other non-working groups of older people who tend to have poor health and lower financial position. American society must balance the contributions of the family with social responsibility and take steps to reduce delineations of the quality or quantity of health care available among vulnerable populations and improve policies to support family caregivers. As Moss (2004) suggested, the American welfare state is the "ultimate risk manager" which functions to reallocate resources and reduce common social risks for all. A national LTC insurance system similar to Germany's system has the potential to build adequate financial resources to comprehensively and equitably respond to needs of all older persons and support consumer choice in old age.

Note: On October 14, 2011, the Health and Human Services Secretary Sebelius announced that the implementation of the CLASS Program

has been suspended, citing concerns of fiscal solvency. Issues of financing long term care will continue to be a major social welfare issue, as over 15 million Americans will need these services and supports to carry out basic activities of daily living by 2020. The establishment of a financially stable and universal federal program of long term care insurance is an effective strategy to improve individual care options, enhance the quality of care available, and reduce health care spending.

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