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PUBLIC OPTIONS: THE NEED FOR LONG-TERM CARE, ITS COSTS, AND GOVERNMENT'S ATTEMPTS TO ADDRESS THEM

"Life would be infinitely happier if we could only be born at the age of eighty, and gradually approach eighteen."—Mark Twain¹

There is a profound moment in a person's life when the thought of growing old becomes real. With that moment comes the sadness of knowing that you are running out of time, that life is surprisingly short, and that there is no going back. Time seems to have vanished. Naturally, people cope with this moment in different ways. Some deny old age and go on living as though they are ageless. Others embrace the possibility of being an Elder and having the wisdom that comes only with age. Many people simply try to make the most of it, and look forward to retirement as a time of relaxation and reflection. A universal truth is that humans have a natural desire to live, and to live as long as they can, and as time marches on this becomes more and more difficult. We see ourselves getting old, but do not (or refuse to) fully see the *price* of age. Our bodies pay that price, and, unfortunately, so do our minds. The human desire to live has found new zeal in modern medicine, which has expanded the average life span by nearly two decades since 1900.² As more and more of us live longer, more and more of us are paying that price of age.

Because of longer life spans, we have time to plan for the end of life, and this is where things get complicated. People do not want to envision themselves at the end of their lives sitting in a wheelchair in the common area of a nursing home, idle, impoverished, half-mad, and at the mercy of meagerly-paid staff who must take care of your every need, including your diet, hygiene, and even the position in which you sleep. Many of these conditions are ones reserved in our society for felons and the criminally insane. It is only natural for people to reject the notion of living in this state. We would rather spend our final years at home.³ Therefore, as a nation, we

1. WILLIAM LYON PHELPS, AUTOBIOGRAPHY WITH LETTERS 965 (1939).

2. Elizabeth Arias, Ctrs. for Disease Control & Prevention, U.S. Dep't of Health & Human Servs., *United States Life Tables, 2006*, 58 NAT'L VITAL STAT. REP., no. 21, 2010 at 4.

3. Robert W. Stock, *Health Care Reform Will Impact Long-Term Care*, AOL NEWS (Mar. 26, 2010, 9:15 AM), <http://www.aolnews.com/healthcare/article/few-know-health-care-law-has-class/19413357> ("Surveys show that 90 percent of Americans want to age at home.")

do not sufficiently plan for a time when we may have to live in a nursing home.

Roughly one-third of Americans will spend some time in a nursing home during their lives.⁴ The cost of living in a nursing home is catastrophic for the average middle class American: \$72,000 per year.⁵ Assisted living environments, which provide long-term care at a less-intense level, cost \$38,000 per year.⁶ Although only 14% of long-term care recipients live in these institutions, the cost to care for them makes up 70% of all of the money spent on long-term care in the United States.⁷ The other 86% of long-term care recipients, comprised of disabled children and adults, as well as some elderly persons, receive their care in the home.⁸ Obviously, long-term care in the home is far less expensive than institutionalized care. However, due to the high costs of institutionalized care, a lack of planning by Americans to properly finance their own long-term care, and a government-bias in favor of nursing homes, the costs of long-term care threatens to become one of our society's greatest burdens in the coming decades.

Much has been said about gridlock in Washington. The two political parties seem locked in a perpetual state of fighting, at the expense of allowing long-term problems to fester to crisis levels. Funding of long-term care, however, has received some attention, and there is at least a consensus in the American political establishment that the future of long-term care funding is a problem.⁹ Pieces of legislation from both Republicans and Democrats have demonstrated a desire to address the issue.¹⁰ The Deficit Reduction Act of 2005 ("DRA") included a lengthy

4. Gary A. Simon, *Can Long-Term Care Insurance Be Fixed?*, J. HEALTH CARE FIN., Fall 2010, at 51, 51.

5. KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 2186-07, MEDICAID AND LONG-TERM CARE SERVICES AND SUPPORTS (2010) [hereinafter KFF MEDICAID LTC], available at <http://www.kff.org/medicaid/upload/2186-07.pdf>.

6. *Id.*

7. *Id.*

8. *Id.*

9. U.S. DEP'T OF HEALTH & HUMAN SERVS., LONG-TERM CARE FOR THE BOOMERS: A PUBLIC POLICY CHALLENGE FOR THE TWENTY-FIRST CENTURY 5 (1991); U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-06-401, LONG-TERM CARE INSURANCE: FEDERAL PROGRAM COMPARED FAVORABLY WITH OTHER PRODUCTS, AND ANALYSIS OF CLAIMS TREND COULD INFORM FUTURE DECISIONS 1 (2006); see also CONG. BUDGET OFFICE, FINANCING LONG-TERM CARE FOR THE ELDERLY ix, xi (2004).

10. See 124 Stat. 119 442-54 (2010) (to be codified at 42 U.S.C. § 30011); see also Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171, 120 Stat. 4, 54-155 (2005) (codified at 42 U.S.C. § 1396); see also *Dems Offer Mixed Views on CLASS Act's Demise*, KAISER HEALTH NEWS (Oct. 27, 2011), <http://www.kaiserhealthnews.org/Daily-Reports/2011/October/27/class-act.aspx>. The Patient Protection and Affordable Care Act was amended by

number of provisions limiting Medicaid eligibility and encouraging home and community-based care over more costly nursing home care.¹¹ The Patient Protection and Affordable Care Act (“ACA”)¹², however, was far more sweeping. Among other provisions, it established the Community Living Assistance Services and Support (CLASS) Act.¹³ CLASS was going to be the first government-sponsored long-term care insurance policy.¹⁴ It was unique. Unlike Medicare, which is funded by mandatory payroll taxes, CLASS was to be funded by voluntary payroll taxes.¹⁵ Unlike Medicaid, which is taxpayer-funded, CLASS was to be funded almost-exclusively by these voluntary premiums.¹⁶ Unlike private health insurance, CLASS enrollees would not be denied coverage once they were vested and had the requisite number of functional limitations to qualify for the benefit.¹⁷

Although CLASS was designed to expand the number of Americans covered by non-Medicaid long-term care insurance, it was set up in a way that made it very difficult, if not impossible, to remain a fiscally solvent program without an alternative source of funding. Consequently, in October 2011, the Obama Administration announced that it was abandoning the CLASS program.¹⁸ This article will show that there is certainly a need for a program like CLASS; however, under its current structure, the CLASS program could not have realistically remained fiscally solvent. Therefore, to reach the goals that CLASS was designed to achieve, the government must either make participation in the program mandatory or require that all Americans purchase private long-term care insurance. Failure by the government to take decisive action, and instead to continue to take the approach seen in the DRA, could allow an already-serious fiscal problem to grow into a crisis for both the public and private sectors.

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). These two laws will be hereinafter cited together as “ACA.”

11. See DRA, 120 Stat. at 54-155.

12. See ACA § 2406.

13. See ACA § 8002 (to be codified 42 U.S.C. § 30011); see also U.S. DEP’T OF HEALTH & HUMAN SERVS., A REPORT ON THE ACTUARIAL, MARKETING, AND LEGAL ANALYSES OF THE CLASS PROGRAM 1 (2011) [hereinafter HHS CLASS REPORT].

14. See John Inglehart, *Long-Term Care Legislation At Long Last?*, 29 HEALTH AFF., 8 (2010).

15. See HHS CLASS REPORT, *supra* note 13, at 1.

16. See *id.*

17. See *id.* at 1-2, 30.

18. Letter from Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., to Congress (Oct. 14, 2011), available at <http://www.hhs.gov/secretary/letter10142011.html>; see also Scott Sperry, *Obama Drops Long-Term Health Care Program*, CNN POLITICS (OCT. 14, 2010), http://articles.cnn.com/2011-10-14/politics/politics_health-care-program_1_long-term-care-sebelius-community-living-assistance-services?_s=PM:POLITICS.

I. THE PROBLEM OF LONG-TERM CARE

Unlike other areas of health care, the vast majority of long-term care in the United States, whether it is in skilled nursing facilities, assisted living, or in-home care, is funded by the federal government and the states. This is a unique area of the healthcare industry, as the private insurance industry accounts for only 9% of its funding.¹⁹ Another one-fifth of funding is paid out-of-pocket by private citizens.²⁰ Twenty-three percent of funding comes from Medicare, which covers “post-acute care through its skilled nursing facility benefit and its home health care benefit.”²¹ This coverage fully terminates after a maximum period of 100 days.²² The only other source left is Medicaid, the government’s health insurance program for the poor. Over half of long-term care coverage for periods exceeding 100 days,²³ and 80% of coverage exceeding three years,²⁴ comes from Medicaid. Therefore, in the world of long-term care, federal and state governments play much more important roles, and have much greater responsibilities, in ensuring that long-term care is both available for their citizens and affordable for their taxpayers. Medicaid is financed through a federal-state matching fund system.²⁵ The amount of money that a state pays for Medicaid is matched by the federal government at a set rate called the Federal Medical Assistance Percentage (“FMAP”).²⁶ The rate is designed to provide a matching fund appropriate to each state’s level of per capita income with the overall goal of achieving a funding system that distributes the financing of Medicaid at a relatively equal level, with a slightly greater share of spending made by the federal government in each state.²⁷

Since its inception in 1965, Medicaid has always covered long-term care in skilled nursing homes.²⁸ It has covered care at the intermediate level

19. KFF MEDICAID LTC, *supra* note 5, at 1.

20. *Id.*

21. *Id.*

22. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., MEDICARE COVERAGE OF SKILLED NURSING FACILITY CARE 3 (2007).

23. Melissa Baum & Jason A. Frank, *Level of Care Standard: Maryland Medical Assistance Long-Term Care & Medical Eligibility Issues*, MD. BAR J., March/April 2008, at 45, 46; KFF MEDICAID LTC, *supra* note 5, at 1 (51% of the remaining market share after removing Medicare).

24. H. Stephen Kaye et al., *Long-Term Care: Who Gets It, Who Provides It, Who Pays, and How Much?*, 29 HEALTH AFF. 11, 11, 17 (2010).

25. VICTORIA WACHINO ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, NO. 7000, FINANCING THE MEDICAID PROGRAM: THE MANY ROLES OF FEDERAL AND STATE MATCHING FUNDS 3 (2004), available at <http://www.kff.org/medicaid/upload/Financing-the-Medicaid-Program-The-Many-Roles-of-Federal-and-State-Matching-Funds-Policy-Brief.pdf>.

26. *Id.*

27. *Id.*

28. Baum & Frank, *supra* note 23, at 46.

(assisted living and residential care facilities) since the 1970's,²⁹ and has allowed states to cover home and community-based care through a waiver system since 1981.³⁰ Since it is designed to cover the poor, Medicaid applicants must meet a number of eligibility factors before qualifying for long-term care coverage. Eligibility requirements can vary significantly in each state. For example, thirty-eight states require a level of income at or below 300% of SSI.³¹ Another ten states have lower thresholds, and two states have no income limits.³² Resource guidelines vary as well, but are generally strict: although a homestead is usually exempt in the eligibility determination,³³ in most states a single person or a married couple can have no more than \$2,000–\$3,000 in assets.³⁴ Countable assets can include a variety of personal possessions: all liquid resources (cash, stocks, bonds, IRAs, etc.), burial lots with the exception of lots being used for the applicant's personal burial, extra vehicles, rental property, life insurance cash surrender value, jewelry, and even furniture in storage.³⁵ If an applicant has transferred any of these types of resources to a third-party (other than a spouse) within five years of applying for Medicaid, she or he may be denied nursing home or home and community-based ("HCB") care coverage for a certain period of time.³⁶ Therefore, to finally get to a point at which Medicaid will cover a person's nursing home stay or HCB care, that person must become impoverished, either through five or more years of continuous poverty or by spending down resources until they become sufficiently scarce to meet the guidelines. The result is a long-term care population, the majority of which is impoverished.

The demand for long-term care is already increasing.³⁷ First, it should be noted that there is a vast population of unpaid caretakers in this country. There are 9.9 million Americans receiving no compensation for caring for

29. *Id.*

30. *Id.* at 47.

31. KAISER COMM'N ON MEDICAID & THE UNINSURED, NO. 8048, MEDICAID FINANCIAL ELIGIBILITY: PRIMARY PATHWAYS FOR THE ELDERLY AND PEOPLE WITH DISABILITIES 3 (2010) [hereinafter KFF MEDICAID FINANCIAL ELIGIBILITY], available at <http://www.kff.org/medicaid/upload/8048.pdf>.

32. *Id.* (stating Missouri and Indiana have no income limits).

33. *Id.* (stating homesteads are exempt up to \$500,000 in equity in most states).

34. *Id.* at 5.

35. The definition of assets is determined by each state individually. See generally MO. CODE REGS. ANN. tit. 13, § 40-2.030 (2006) (outlining the types of assets that may be considered in eligibility determinations).

36. KFF MEDICAID LTC, *supra* note 5, at 2.

37. DANIEL I. SHOSTAK & PAUL A. LONDON, STRATEGIC AFFAIRS FORECASTING, STATE MEDICAID EXPENDITURES FOR LONG-TERM CARE 2008-2027, at 3, 4 (2008), available at <http://www.ahip.org/content/default.aspx?docid=24597>.

the Alzheimer's disease and dementia-suffering population alone.³⁸ The existence of such a population is likely to increase with the need for long-term care, creating an entire sector of the public that works in a capacity of "voluntary servitude (albeit for loved ones)" for little or no real compensation. The implications this situation has for the demand for public assistance, lack of productivity, and a decreased quality of life are obvious. Taxpayers fare no better. Nursing home coverage is the fastest growing area of Medicaid coverage,³⁹ and is likely to increase at a faster rate than "all health care expenditures, Medicare, Medicaid, and the national Gross Domestic Product."⁴⁰

Even in the most optimistic . . . scenario, which assumes that disability rates fall by 1 percent per year, the size of the disabled population will grow by more than 50 percent between 2000 and 2040 and the number of disabled older adults for every adult age 25 to 64 will increase.⁴¹

A doubling of long-term care expenditures, combined with expected increases in Medicare and Social Security spending over the same period of time, could become a catastrophic burden on the public sector. Moreover, when we consider that an additional one-fifth of long-term care spending is paid out-of-pocket by private individuals,⁴² long-term care could become a tremendous financial burden on all Americans, and will consume a larger and larger portion of the nation's wealth.

II. ATTEMPTS TO PROMOTE PRIVATE LONG-TERM CARE INSURANCE

In the years preceding the ACA, a number of laws enacted were designed to promote the use of private long-term care insurance. Section 6021 of the DRA attempts to expand the State Long-Term Care Partnership Program.⁴³ In participating states, Medicaid applicants who own long-term care policies are allowed an asset disregard equal to the amount of long-term care benefits received under the policy.⁴⁴ "For example, if a person uses \$50,000 of insurance coverage, the same amount of assets (up to the policy maximum) would be disregarded if that person applies for

38. ALZHEIMER'S ASS'N, 2009 ALZHEIMER'S DISEASE FACTS AND FIGURES 33 (2009).

39. SHOSTAK & LONDON, *supra* note 37, at 3.

40. *Id.*

41. CHANGES IN HEALTH CARE FIN. & ORG. INITIATIVE (HCFO), ROBERT WOOD JOHNSON FOUND., FINDINGS BRIEF: MEETING THE FUTURE LONG-TERM CARE NEEDS OF THE BABY BOOMERS 3 (2007).

42. KFF MEDICAID LTC, *supra* note 5, at 1.

43. Deficit Reduction Act (DRA) of 2005, Pub. L. No. 109-171, § 6021, 120 Stat. 4, 68 (2006).

44. NEB. DEP'T OF HEALTH & HUMAN SERVS., INFORMATION AND GUIDANCE ON LONG-TERM CARE PARTNERSHIP POLICIES, *available at* http://www.doi.ne.gov/lc/partnership_policies.pdf.

Medicaid.”⁴⁵ The DRA requires all states to honor “partnership policies” owned by Medicaid applicants from a partnership state, as long as the states involved have a reciprocity agreement with each other at the time the individual applies for Medicaid in the “non-partnership” state.⁴⁶ As a result of this provision, most states are now participating in the long-term care partnership program.⁴⁷ Section 6021 also establishes the creation of a national clearinghouse for long-term care information, designed to inform consumers on the availability and limits of Medicaid long-term care coverage, provide “objective information” to help consumers decide whether to purchase private long-term care insurance policies, and maintain a list of states that have long-term care partnership programs.⁴⁸ Moreover, since 2005 the Department of Health and Human Services (“HHS”) has promoted the purchase of private long-term care insurance through its Long-Term Care Campaign, the goal of which is “to increase consumer awareness about, and planning ahead for, long-term care.”⁴⁹

The DRA contained a number of provisions designed to discourage people from using Medicaid to pay for long-term care (presumably with the secondary intention of promoting the use of private policies and out-of-pocket spending). In fact, over 40% of the text of the DRA is dedicated to changes in Medicaid eligibility rules.⁵⁰ Sections 6011 and 6016 involve penalties for applicants who transfer assets in order to qualify for Medicaid coverage.⁵¹ Instead of looking back thirty-six months, state agencies are now required to look back sixty months from the month of application to determine if any transfers of assets occurred.⁵² A penalty applies to transfers in which the applicant received less than the fair market value for the asset.⁵³ For example, if a person signs a quitclaim deed to a friend for real property, essentially giving the property away, the fair market value of that property would be the amount of the penalty. If the property is assessed to be worth \$9,000, the penalty would be that amount divided by “the average

45. David G. Stevenson et al., *The Complementarity of Public and Private Long-Term Care Coverage*, 29 HEALTH AFF. 96, 99 (2010).

46. DRA § 6021.

47. Stevenson et al., *supra* note 45, at 99.

48. DRA § 6021.

49. *Long-Term Care Awareness Campaign: Own Your Future*, AGING & DISABILITY RESOURCE CENTER TECHNICAL ASSISTANCE EXCHANGE, 1, http://www.adrc-tae.org/tiki-download_file.php?fileId=1956 (last visited Dec. 30, 2011); *see also* U.S. DEPT. OF HEALTH & HUMAN SERVS., *National Clearinghouse for Long-Term Care Information*, LONGTERMCARE.GOV, http://www.longtermcare.gov/LTC/Main_Site/Index.aspx (last visited Dec. 30, 2011).

50. *See generally* DRA.

51. 42 U.S.C. §§ 1396p(D)(ii), 1396(H) (2006).

52. *Id.* § 1396p(c)(1)(B)(i).

53. *Id.* § 1396p(c)(1)(A).

monthly cost to a private patient of nursing facility services in the state . . . at the time of application.”⁵⁴ Therefore, if the average monthly cost is \$3,000, the person would not be able to use Medicaid to pay for nursing home coverage for three months. Under previous law, this transfer penalty period began the first day after the month the transfer occurred.⁵⁵ The DRA changed the penalty period to begin on the first day of the month of application or the first day of the month after the transfer, whichever is later.⁵⁶ States are also empowered to combine penalty periods for different transfers into one period covering all of them.⁵⁷ Although a somewhat morbid thought, creating longer, continuous transfer periods saves governments money, since it increases the likelihood that a resident will no longer be a nursing home resident by the time the transfer period expires. Medicaid applicants who attempt to transfer assets by “loaning” the money are also subject to more restrictions. Any loan that they issue must be actuarially sound, provide for equal payments with no balloon payments allowed, and prohibit the cancellation of the debt upon the death of the lender.⁵⁸ Finally, the purchase of a life estate in another individual’s home is now considered a transfer of property unless the purchaser resides in that home for at least a year after the sale.⁵⁹

Section 6012 limits eligibility for clients who have annuities.⁶⁰ Regardless of whether the applicant receives income from the annuity,⁶¹ the entire value of this asset counts as a resource (note that the Medicaid resource maximum for a single person is usually no more than \$2,000)⁶² unless it meets some very specific requirements. First, the state must be named the “remainder beneficiary” of the annuity to allow the state to recover any Medicaid expenditures it may make on behalf of the annuitant.⁶³ The state becomes a secondary beneficiary to the annuity if the Medicaid recipient has a spouse living in the community or a disabled child designated as a beneficiary in the annuity.⁶⁴ If either of these parties attempts to transfer or dispose of the proceeds from the annuity for less than

54. *Id.* § 1396p(c)(1)(E)(i)(II).

55. *Id.* § 1396p(c)(1)(D)(i).

56. 42 U.S.C. § 1396p(c)(1)(D)(ii) (2006).

57. *Id.* § 1396p(c)(1)(H)(i)-(ii).

58. *Id.* § 1396p(c)(1)(I)(i)-(iii).

59. *Id.* § 1396p(c)(1)(J).

60. *Id.* § 1396p(e)(1).

61. 42 U.S.C. § 1396p(e)(1) (2006); Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6012(d), 120 Stat. 4, 64 (2006).

62. KFF MEDICAID FINANCIAL ELIGIBILITY, *supra* note 31, at 5.

63. 42 U.S.C. § 1396p(e)(1) (2006).

64. *Id.* § 1396p(c)(1)(F)(ii).

fair market value, the state becomes the primary beneficiary.⁶⁵ Second, the annuity must be irrevocable and non-assignable, meaning that it cannot be cashed out or transferred.⁶⁶ Third, the annuity must be actuarially sound in accordance with the requirements of Office of Chief Actuary of the Social Security Administration.⁶⁷ Finally, the annuity must provide regular income in equal amounts to the annuitant, with no deferrals and no balloon payments allowed.⁶⁸ Individual Retirement Annuities under Section 408(b) of the Internal Revenue Code, or Deemed IRAs under “Qualified Employer Plans” under Section 408(q) are also not counted as resources.⁶⁹ If the annuity does not count as a resource, the income stream from the annuity counts as unearned income toward the applicant’s eligibility for Medicaid. These provisions tighten the ability of an applicant to shelter his assets by organizing them into an annuity, thus converting the assets into income.⁷⁰

If the annuity does not count as a resource, the income stream from the annuity counts as unearned income toward the applicant’s eligibility for Medicaid. These provisions tighten the ability of an applicant to shelter one’s assets by organizing them into an annuity, thus converting the assets into income.⁷¹ Section 6013 affects the “Income-First Rule,” which is used by many states to determine the portion of income and resources from an institutionalized Medicaid recipient that can be allotted to one’s spouse remaining in the community. A primary purpose of this provision is to allow the institutionalized spouse to receive Medicaid while not impoverishing the community spouse (a problem known as ‘spousal impoverishment’).⁷² To receive an income allotment, the community spouse’s income must be below a certain level.⁷³ The community spouse’s total share of the couple’s resources must also remain below a limit known as the Community Spouse Resource Allowance (“CRSA”), which, due to automatic adjustments, can be as high as \$100,000.⁷⁴ Any amount of resources over the CRSA counts against the institutionalized spouse.⁷⁵ In income-first states, if the

65. *Id.* § 1396p(c)(1)(F)(i).

66. *Id.* § 1396p(c)(1)(G)(ii)(I).

67. *Id.* § 1396p(c)(1)(G)(ii)(II).

68. 42 U.S.C. § 1396p(c)(1)(G)(ii)(III) (2006).

69. *Id.* § 1396p(c)(1)(G)(i)(I).

70. The Section 6012 provisions have been limited in scope by recent court decisions. *E.g.*, *Lopes v. Starkowski*, No. 3:10-CV-307 (JCH), 2010 U.S. Dist. LEXIS 81829, at *6-7 (D. Conn. Aug. 11, 2010).

71. *Id.*

72. 42 U.S.C. § 1396r-5(d)(6) (2006).

73. *Id.* § 1396r-5(d)(6) (2006).

74. *Id.* § 1396r-5(f)(2); see also Sandra L. Smith, 2011 *Elder Law Numbers*, LEXISNEXIS COMMUNITIES: EST. PRAC. & ELDER LAW COMMUNITY (Jan. 14, 2011, 3:55 PM),

75. See 42 U.S.C. § 1396r-5(f)(1)-(2) (2006).

community spouse's income is below a certain amount, he or she may be able to retain more resources than the CRSA usually allows.⁷⁶ The changes in section 6013 require that the community spouse's allotment be determined before considering one's resource allowance.⁷⁷ Therefore, it is more difficult for Medicaid applicants to shelter their resources through their spouse.

Section 6014 puts restrictions on the "homestead exemption."⁷⁸ Traditionally, a person's home and the surrounding property do not count as a resource against Medicaid eligibility. This section provides that, once a person's equity in his or her home exceeds \$500,000, the homestead counts as a resource.⁷⁹ States are given the option of increasing this limit to no more than \$750,000.⁸⁰ Starting in 2011, this limit will adjust with the Consumer Price Index "to the nearest \$1,000."⁸¹ Section 6032 requires that any provider that gets at least \$5 million per year in Medicaid payments must create written policies for its employees and contractors addressing Medicaid fraud and whistleblower protections.⁸² Section 6034 established the Medicaid Integrity Program, designed to create a dedicated government entity that regularly reviews and audits Medicaid-receiving providers to ensure that they comply with the law.⁸³ The Centers for Medicare and Medicaid Services ("CMS") defines its role under the Medicaid Integrity Program as twofold:

To hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues [and] [t]o provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse.⁸⁴

76. CTRS. FOR MEDICARE & MEDICAID SERVS., CTR. FOR MEDICAID & STATE OPERATIONS, SECTIONS 6011 AND 6016: NEW MEDICAID TRANSFER OF ASSET RULES UNDER THE DEFICIT REDUCTION ACT OF 2005, at 19 (2006), available at http://www.canhr.org/medcal/PDFs/TOA_Enclosure.pdf; see also *The Impact of the Deficit Reduction Act of 2005 on Medi-Cal for Long-Term Care*, CAL. ADVOC. FOR NURSING HOME REF., http://www.canhr.org/newsroom/newdev_archive/past/20060331_DFRA_analysis.html (last visited Nov. 3, 2011).

77. 42 U.S.C. § 1396r-5(d)(6) (2006).

78. *Id.* § 1396p(f).

79. *Id.* § 1396p(f)(1)(A).

80. *Id.* § 1396p(f)(1)(B).

81. *Id.* § 1396p(f)(1)(C).

82. 42 U.S.C. § 1396a(a)(68)(A)-(C) (2006); see also *The Deficit Reduction Act of 2005: New Medicaid Fraud and Abuse Provisions*, BASS BERRY & SIMS PLC (May 31, 2006), <http://www.bassberry.com/files/Publication/1ece9b4e-766d-4923-91f4-0f74895e37a6/Presentation/PublicationAttachment/efac6bcc-973c-4876-ac60-11d55a6fede9/Health%20Law%20Update%20May%2031%202006.pdf>.

83. 42 U.S.C. § 1396u-6(a), (b) (2006).

84. *Overview Medicaid Integrity Program*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <https://www.cms.gov/MedicaidIntegrityProgram/> (last visited Jan. 3, 2012).

These sections also include anti-fraud provisions that restrict deceptive practices by pharmacies,⁸⁵ require providers to report more information about their patients and claims,⁸⁶ and require Medicaid applicants to provide proof of identity and citizenship.⁸⁷

This laundry list of reforms was intended to reduce the number of long-term care recipients receiving Medicaid, and promote the expansion of the private long-term care insurance industry. The DRA was modestly successful in increasing the number of Medicaid long-term care recipients receiving cheaper home and community-based care as opposed to nursing home care.⁸⁸ However, these initiatives have had little to no impact on the sale of long-term care policies, which “have been flat or down” since the DRA was passed.⁸⁹ In 2006, the Lifespan Respite Care Act authorized HHS to award grants and “cooperative agreements” to state agencies for programs that “expand and enhance respite care services to family caregivers” and improve access to and coordination of these services.⁹⁰ Respite care services are designed to assist in-home caregivers, many of whom are unpaid, by providing care to allow the caregiver time away from his or her responsibilities. Although a relatively small piece of legislation, the Lifespan Respite Care Act does acknowledge the ever-growing population of unpaid caregivers who fill the void caused by the insufficient presence of long-term care insurance in the United States.⁹¹ It is clear, however, that laws like the DRA, which attempt to reduce reliance on Medicaid in favor of private insurance by limiting Medicaid eligibility requirements, are ineffective. Legislators would be wise to study the fundamental challenges facing the long-term care insurance industry, which go far deeper than anything the DRA attempted to address.

III. CHALLENGES TO THE PRIVATE INSURANCE INDUSTRY

Americans are woefully unprepared to pay for their own long-term care coverage. In a 2001 survey, only one-fourth of Americans age 45 and over

85. 42 U.S.C. § 1396b(i)(10)(D) (2006).

86. *Id.* § 1396a(a)(25)(l)(i).

87. *Id.* § 1396b(x).

88. AVALERE HEALTH LLC, MEDICAID-FINANCED HOME AND COMMUNITY-BASED SERVICES RESEARCH / A SYNTHESIS 2 (2007), available at http://www.ahcancal.org/research_data/funding/Documents/HCBS_Research_Synthesis.pdf.

89. HOWARD GLECKMAN, THE URBAN INST., LONG-TERM CARE FINANCING REFORM: LESSONS FROM THE U.S. AND ABROAD 20 (2010), available at http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2010/Feb/1368_Gleckman_longterm_care_financing_reform_lessons_US_abroad.pdf.

90. 42 U.S.C. § 300ii-1(a) (2006).

91. GLECKMAN, *supra* note 89, at 1.

could identify the cost of nursing home care within a range of 20%.⁹² Three-fourths of them mistakenly believed that Medicare either covers assisted living expenses or did not know whether it did or not.⁹³ This chronic lack of preparedness increases the likelihood that, when these Americans need long-term care, they will also need Medicaid, and need it for a longer period of time. On its face, private long-term care insurance is more desirable than Medicaid. Private policies generally pay more than Medicaid, so nursing homes benefit from them.⁹⁴ Also, if a person has private coverage, it is less likely he will need Medicaid, which saves taxpayer dollars. A person does not necessarily have to impoverish herself to use private long-term care insurance.

Scholars have found a diverse array of reasons why Americans avoid getting long-term care insurance. Part of the problem is the way long-term care insurance is structured. The typical health insurance policy covers most of the care a person receives, whether it is preventive care, hospital or emergency room treatment, tests, etc. (after any deductibles and co-pays that may apply). Long-term care, however, is a different phenomenon. It involves the need for daily care that can last for years, may not be necessary for decades, and that can take a variety of forms, including personal hygiene care, ambulatory care, and even housekeeping. Therefore, a person cannot approach a long-term care insurance policy from the perspective that it will cover all of her needs.⁹⁵ Long-term care benefits consist of cash payments, paid out daily or weekly, that can range from \$50-\$400 per day.⁹⁶ A more expensive indemnity policy allows the policyholder to spend the benefit money on whatever care is most appropriate for her (including reimbursement to unpaid caretakers). A less-expensive reimbursement policy restricts the type of care on which the benefit can be spent, and requires the policyholder to pay for the care up front and get reimbursed later.⁹⁷ Most policies have a deductible, or an "elimination cost."⁹⁸ Before benefits are activated, the policyholder must pay for her long-term care out-of-pocket for a designated time period, often sixty to ninety days.⁹⁹ Based on today's numbers, this can total over

92. AM. ASS'N OF RETIRED PERS., *THE COSTS OF LONG-TERM CARE: PUBLIC PERCEPTIONS VERSUS REALITY* 8 (2001) [hereinafter AARP].

93. *Id.* at 36.

94. Simon, *supra* note 4, at 53.

95. Simon, *supra* note 4, at 57.

96. *LTC Insurance Basics*, LONG TERM CARE INS. NAT'L ADVISORY, http://longtermcareinsurance.org/longtermcareinsurance.html#gpm1_3 (last visited Dec. 27, 2011).

97. *Id.*

98. Simon, *supra* note 4, at 57.

99. *Id.*

\$10,000.¹⁰⁰ However, since a policyholder can pay premiums for decades before actually using the benefit, inflation plays a much more important role. For example, a ninety-day elimination cost that is projected to cost \$18,000 when a policy is opened may end up costing over \$40,000 by the time the benefits are actually needed.¹⁰¹ To address this problem, long-term care policies come with inflation protection that, in exchange for a higher premium, increases the benefit amount according to a certain rate of inflation established when the policy was purchased.¹⁰² Long-term care insurance policies are usually time-limited, but more costly policies can be purchased that provide perpetual coverage.¹⁰³ Naturally, premium amounts vary, but as a result of this unique structure the average monthly premium is around \$200.¹⁰⁴ This is a significant amount of money for the average middle-class American, many of whom simply cannot afford to pay it. A 1993 survey indicated that 91% of Americans who did not have long-term care insurance said it was too expensive.¹⁰⁵ Another study indicates that, due to difficulties involved with anticipating inflation in medical costs, adverse selection,¹⁰⁶ and “imperfect competition” from Medicaid and other alternatives to conventional long-term care,¹⁰⁷ insurance premiums are “marked up about 18 cents per dollar of premium above actuarially fair levels” for people who buy a policy and keep it until they die.¹⁰⁸ Another possible reason why Americans tend to avoid private long-term care insurance may include a belief that their families will provide long-term care for them, and they are either ignorant of indemnity policies that provide cash benefits that can be used to reimburse caretaker relatives or feel the policies are too expensive to be justifiable in light of these alternatives.¹⁰⁹

More recent research suggests that a person is better off saving her money than putting it into long-term care insurance. For example, a 60-year-old paying \$2,500 per year in premiums for long-term care insurance

100. *Id.* at 58.

101. *Id.* (according to a 3% annual inflation rate and policy coverage that grows at 5% per year).

102. *LTC Insurance Basics*, *supra* note 96.

103. Simon, *supra* note 4, at 66.

104. *Id.* at 58.

105. PIERRE PESTIEAU & GRÉGORIE PONTHIÈRE, CTR. FOR OPERATIONS RESEARCH AND ECONOMETRICS, LONG TERM CARE INSURANCE PUZZLE 5 (2010), available at http://www.uclouvain.be/cps/ucl/doc/core/documents/coredp2010_23web.pdf.

106. See *infra* pp. 16-17.

107. Jeffrey R. Brown et al., *Medicaid Crowd-Out of Private Long-Term Care Insurance Demand: Evidence from the Health and Retirement Survey*, 21 TAX POL'Y & ECON. 1, 4-5 (2007) (including alternatives such as help from unpaid caretakers and money transfers from relatives).

108. *Id.* at 5.

109. PESTIEAU & PONTHIÈRE, *supra* note 105, at 8; Brown et al., *supra* note 107, at 5.

can make three times the amount in benefits she will receive under the policy by simply investing the money in a tax-free IRA instead.¹¹⁰ Instead of being subjected to restrictions from the insurance company, the invested money can be spent in any way the person wants.

The premium problem is part of a larger challenge faced by the private long-term care insurance industry called adverse selection. Adverse selection occurs when there are too many high-risk enrollees and not enough low-risk enrollees.¹¹¹ The private insurance industry relies on low-risk policyholders for its very survival. The time-honored tradition of underwriting “enables these insurers to determine eligibility for coverage and charge premiums that are in line with the risk.”¹¹² Therefore, low-risk individuals are encouraged to buy policies because of the prospect of a reasonable premium, while high-risk individuals are compelled to pay a higher premium or risk going without coverage.¹¹³ The insurance policy becomes profitable because the premium income from the low-risk enrollees is higher than benefits that are paid out. Some insurance companies even drop enrollees if they feel they have become too much of a risk.¹¹⁴ This has become a somewhat common practice in the private health insurance industry, and it was targeted by the ACA.¹¹⁵ However, the ACA takes into account the adverse effects of banning this policy and replaces it with the coverage mandate.¹¹⁶ It has no such provisions concerning long-term care coverage. Underwriting is frequently used in the long-term care insurance industry, but is less effective due to the lack of demand for coverage in the United States¹¹⁷ Numerous studies have shown that adverse selection is a particularly acute problem for the long-term care insurance industry.¹¹⁸ People who buy long-term care policies “have a higher probability of becoming disabled than those who do not.”¹¹⁹ Conversely, people who terminate their policies have a lower risk of becoming disabled.¹²⁰ The

110. Simon, *supra* note 4, at 58.

111. *Health Reform Glossary*, KAISER FAM. FOUND., <http://healthreform.kff.org/health-reform-glossary.aspx> (last visited on Jan. 3, 2012).

112. ALLEN SCHMITZ, MILLIMAN, INC., ADVERSE SELECTION AND THE CLASS ACT 1 (2009); GARY CLAXTON, KAISER FAMILY FOUND., HOW PRIVATE INSURANCE WORKS: A PRIMER 4 (2002).

113. SCHMITZ, *supra* note 112, at 2.

114. CLAXTON, *supra* note 112, at 5.

115. See *The Patients' Bill of Rights*, FAMILIES USA (Sept. 2010), <http://familiesusa2.org/assets/pdfs/health-reform/Patients-Bill-of-Rights.pdf> (discussing the practice of recession in the health insurance industry, where an insurer cancels a policy retroactively to avoid paying expensive current claims).

116. *Id.*

117. SCHMITZ, *supra* note 112, at 2.

118. PESTIEAU & PONTIÈRE, *supra* note 105, at 6-7.

119. *Id.* at 6.

120. *Id.*

bottom line is that, to prevent adverse selection, a self-sustaining insurance policy that is voluntary must have a mechanism for both attracting enrollees and managing risk, either through an underwriting system or by limiting the number of enrollees. If the policy guarantees coverage for anyone willing to pay a premium, then it must find a way to counter-balance this risk by becoming mandatory.¹²¹ This is an unusually difficult problem for long-term care insurance policies in the United States.

Also, unlike conventional health insurance, there is no guarantee that long-term care insurance will ever be needed, which encourages denial and use of potential premium dollars in alternative ways. “[D]enial of the risk of a potentially far-off event causes many healthy individuals to see little value in purchasing and paying premiums on LTC coverage.”¹²² The level of uncertainty and the cost of the insurance are high enough to generate a lot of doubt in Americans’ minds. In a recent study, it was found that, when it comes to long-term care insurance, people consider trade-offs that are more profound than they would when considering health or auto insurance.¹²³ For example, someone may be choosing between paying for long-term care insurance and putting enough money away for retirement.¹²⁴ Others, who would rather leave a legacy to their heirs than pay for long-term care insurance, decide to use potential premium money toward a life insurance policy instead.¹²⁵ Although most Americans will probably need long-term care at some point in their life, death is a certainty; so, the need for life insurance, not only as a bequest but to pay for burial and other costs, may seem more practical to someone with limited resources. Some people also cite the fact that their parents died at an early age and did not need long-term care, while others readily admit that they are in full denial of the need for it.¹²⁶ Taken in this context, the perceived level of uncertainty about needing long-term care can be a powerful force behind a decision to not insure against it.

Some scholars have noted “Medicaid crowding” as a barrier to the growth of the private long-term care insurance industry.¹²⁷ Medicaid crowding is a process by which the demand for private insurance decreases because of the expectation that Medicaid will be available to cover a

121. SCHMITZ, *supra* note 115, at 2.

122. *Id.*

123. Leslie A. Curry et al., *Individual Decision Making in the Non-Purchase of Long-Term Care Insurance*, 49 *GERONTOLOGIST* 560, 563-64 (2009).

124. *Id.* at 564.

125. *Id.* at 565.

126. *Id.*

127. See generally Brown et al., *supra* note 107 (providing “empirical evidence of Medicaid’s crowd out demand for private long-term care insurance”); see also PESTIEAU & PONTIÈRE, *supra* note 105, at 7.

person's long-term care needs when the time comes.¹²⁸ A study by Jeffrey R. Brown and Amy Finkelstein suggests that:

Medicaid may be able to explain the lack of private insurance purchases for at least two-thirds of the wealth distribution . . . This is because Medicaid imposes a substantial implicit tax on private long-term care insurance; for example, they estimate that about 60 to 75 percent of the . . . benefits that a median wealth individual would receive from a typical private long-term care insurance policy are redundant of benefits that Medicaid would have provided had the individual not purchased private insurance.¹²⁹

Brown and Finkelstein argue that the State Long-Term Care Partnership Program and the myriad of provisions of the DRA that restricted Medicaid resource eligibility will not increase demand for private coverage as long as Medicaid continues to provide the same coverage as private insurance provides.¹³⁰ Therefore, as long as Medicaid covers long-term care, it greatly restricts purchases of private long-term care insurance. Despite this exhaustive list of changes, demand for private long-term care insurance remains flat, which corroborates the assertions of the "crowd out" theory. Brown et al. estimate that, even if Medicaid resource requirements were restricted to the greatest extent possible, demand for private insurance would increase by only 2.7%.¹³¹ This would increase private insurance's share of long-term care funding from 9% to 9.2%.

IV. CLASS

In early 2010, after months of debate, Congress passed the Patient Protection and Affordable Care Act ("ACA").¹³² Dubbed the "Civil Rights Act of the 21st Century" by Rep. James Clyburn (D-SC),¹³³ its goal is to expand health care coverage to almost all Americans while controlling health care costs and not adversely affecting the budget deficit.¹³⁴ It is almost certainly the most significant piece of social reform legislation passed since Medicaid was established in 1965. If it survives challenges in the courts¹³⁵ and opposition from conservatives, the ACA could fundamentally change the role government plays in the American healthcare system.

128. See Brown et al., *supra* note 107, at 2-3; see also PESTIEAU & PONTIÈRE, *supra* note 105, at 7.

129. Brown et al., *supra* note 107, at 3.

130. *Id.* at 23-24.

131. *Id.* at 1.

132. Robert Pear & David M. Herszenhorn, *House Votes on Party Lines*, 219 to 212, N.Y. TIMES, Mar. 22, 2010, at A1.

133. *Id.*

134. *Id.* at A16.

135. David E. Sanger, *For Historic Stakes, a Big Obama Gamble on Partisan Victory*, N.Y. TIMES, Mar. 22, 2010, at A1, A16.

Section 2406 of the ACA sets the tone for the law's approach to long-term care, and provides a concise and comprehensive history of long-term care legislation:

Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also know[n] as the "Pepper Commission", released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report . . . In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their longterm services and supports in the community, rather than in an institutional setting . . . Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse . . . In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals . . . It is the sense of the Senate that . . . during the 111th session of Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and . . . long term services and supports should be made available in the community in addition to in institutions.¹³⁶

Title VIII of the ACA established the Community Living Assistance Services and Supports ("CLASS") Act.¹³⁷ CLASS was officially designated as Title XXIII of the Public Health Services Act (hence the provisions are listed in section 3200, not 8000).¹³⁸ Originally sponsored by Senator Edward M. Kennedy (D-MA),¹³⁹ CLASS established the first government-sponsored long-term

136. ACA § 2406.

137. ACA § 8001.

138. ACA § 8002 (amending 42 U.S.C. § 201).

139. *Community Living Assistance Services and Support Act (CLASS Act)*, CHANGES IN HEALTH CARE FIN. & ORG. INITIATIVE (HCFO) (Feb. 2010) [hereinafter HCFO], <http://www.hcfo.org/publications/community-living-assistance-services-and-support-act-class-act> (last visited Dec 28, 2011).

care insurance policy. The goals of CLASS were straightforward and very clearly described in Section 3201:

- (1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports; (2) establish an infrastructure that will help address the Nation's community living assistance services and supports needs; (3) alleviate burdens on family caregivers; and (4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.¹⁴⁰

A major goal of CLASS was to discourage the use of nursing homes and promote more independent living in the community.¹⁴¹ CLASS was "a consumer-funded insurance pool that provides people a cash benefit to help with simple chores of daily living so they can remain independent."¹⁴² Similar to a private long-term care insurance policy, CLASS required a monthly premium that vested after five years.¹⁴³ Once a policyholder developed two functional disabilities, he would qualify for a cash benefit to help pay for in-home care costs.¹⁴⁴ Section 3202 states that, to become vested, a person would have had to have paid a premium for sixty months, during which period he must have worked enough to earn at least one quarter of Social Security coverage in a three-year period.¹⁴⁵ The premium must also have been paid for twenty-four consecutive months during that period if there was a lapse in payments of more than three months.¹⁴⁶ These were significant requirements, in that they emphasized the importance of an enrollee being a wage earner. This differentiated CLASS from needs-based programs, and made it much more akin to Social Security and Medicare, meaning that a person need not impoverish herself to qualify for benefits.

Section 3203 required that the premium amounts be based on projections to keep CLASS solvent over the next seventy-five years.¹⁴⁷ It also required reduced premiums for individuals living in poverty and for full-time students (as long as they remained students).¹⁴⁸ Premiums were designed to

140. ACA § 3201.

141. JOANNE KENEN, HEALTH AFFAIRS, HEALTH POLICY BRIEF: THE CLASS ACT 1 (2011), available at http://healthaffairs.org/.healthpolicybriefs/brief_pdfs/healthpolicybrief_46.pdf.

142. John Iglehart, *Long-Term Care Legislation at Long Last?*, 29 HEALTH AFF. 8, 9 (2010).

143. Public Health Services Act (PHSA) § 3202(6)(B)(i), added by ACA § 8002 (to be codified at 42 U.S.C. § 300ll-1); PHSA § 3203(a)(1)(B), added by ACA § 8002 (to be codified at 42 U.S.C. § 300ll-2).

144. PHSA § 3203(a)(1)(C)(i), added by ACA § 8002.

145. PHSA § 3202(6)(B)(ii), added by ACA § 8002.

146. PHSA § 3202(6)(B)(iii), added by ACA § 8002.

147. PHSA § 3203(a)(1)(A)(i), added by ACA § 8002.

148. PHSA § 3203(a)(1)(A)(ii), added by ACA § 8002.

never change, although HHS reserved the right to adjust them in order to keep the program fiscally solvent, or if a person did not pay a premium for five or more consecutive years.¹⁴⁹ Individuals who reached age sixty-five or paid a premium for twenty years were exempt from any premium increases.¹⁵⁰ “Benefit triggers” were also established in this section. A vested individual could file a claim once she was determined to be unable to perform at least two or three basic daily living activities (listed in Section 3202), lacked the cognitive ability to protect herself from “threats to health and safety,” or had functional limitations similar to these two conditions.¹⁵¹ The cash benefit began at a minimum of \$50 per day (paid daily or weekly; Section 3205 allowed for monthly lump sums and rollovers, too) and was variable depending on the scale of the individual’s functional limitations.¹⁵² For example, a person with four functional limitations would receive a higher cash payment than someone with two limitations. There was no lifetime limit on cash benefits.¹⁵³

Section 3204 authorized employers to automatically enroll their employees in the CLASS program.¹⁵⁴ Premiums would have been paid through payroll deductions similar to Social Security and Medicare.¹⁵⁵ Everyone, however, had the option to opt-out of the program if he or she chose.¹⁵⁶

Section 3205 charged HHS with developing a system for enrollees to apply for benefits, and for HHS to determine if they qualified.¹⁵⁷ An enrollee could be considered presumptively eligible if he applied for and attested to being eligible for the maximum cash benefit, resided in a hospital or long-term care facility, and expected to leave within sixty days.¹⁵⁸ Cash benefits would be deposited directly into a beneficiary’s “Life Independence Account”¹⁵⁹ and would be accessible via a debit card.¹⁶⁰ Section 3205 allowed the benefits to be spent on a variety of needs (respite care, assistive technology, transportation, etc.) and did not establish any concrete limits on

149. PHS § 3203(b)(1)(A)-(B), (E), added by ACA § 8002.

150. PHS § 3203(b)(1)(B)(ii), added by ACA § 8002.

151. PHS § 3203(a)(1)(C), added by ACA § 8002.

152. PHS §§ 3203(a)(1)(D)(i), 3205(c)(4)(A)-(B), added by ACA § 8002 (to be codified at 42 U.S.C. §§ 300ll-2, -4).

153. PHS § 3203(a)(1)(D)(iv), added by ACA § 8002.

154. PHS § 3204(a)(1), added by ACA § 8002 (to be codified at 42 U.S.C. § 300ll-3).

155. HCFO, *supra* note 139, at 2.

156. PHS § 3204(b), added by ACA § 8002.

157. PHS § 3205(a)(1), (a)(2)(A)(i), added by ACA § 8002.

158. PHS § 3205(a)(2)(B), added by ACA § 8002.

159. PHS § 3205(c)(1)(A), added by ACA § 8002.

160. PHS § 3205(c)(1)(C)(ii), added by ACA § 8002.

what the beneficiary may or may not buy.¹⁶¹ Besides a cash benefit, CLASS beneficiaries would also receive advocacy and assistance counseling services.¹⁶² An enrollee who lived in a nursing home and received Medicaid would receive only 5% of her CLASS benefit, with the rest going to the nursing home.¹⁶³ Medicaid recipients who lived in home and community-based (“HCB”) settings would keep half of their CLASS benefit, with the other half going to the state to pay for Medicaid.¹⁶⁴

Section 3206 established the CLASS Independence Fund.¹⁶⁵ The CLASS Independence Fund was going to be a trust fund into which CLASS premiums were deposited.¹⁶⁶ The fund was to be used only to pay out CLASS benefits and administrative costs.¹⁶⁷ The U.S. Department of Treasury was authorized to invest money in the fund to enhance its value.¹⁶⁸ Section 3206 also established a Board of Trustees consisting of the Secretary of HHS, the Secretary of Labor, the Secretary of the Treasury, and two private citizens who could not be members of the same party.¹⁶⁹ The Board was intended to review the fiscal solvency of the CLASS Independence Fund and make annual policy recommendations regarding its use.¹⁷⁰ Besides the Board of Trustees, Section 3207 established the CLASS Independence Advisory Council, which was to be comprised of fifteen private citizens, “a majority of whom [would] be representatives of individuals who participate[d] or [we]re likely to [have] participate[d] in the CLASS program.”¹⁷¹ The Advisory Council, the members of which would be appointed by the President, was charged with overseeing the system and making its own recommendations as to premium amounts, fiscal solvency, and the development of the benefit plan.¹⁷²

To keep the program solvent, Section 3208 required the Secretary of HHS to regularly consult with the advisory council and the Board of Trustees “for purposes of ensuring that enrollees’ premiums [we]re adequate to ensure the financial solvency of the CLASS program.”¹⁷³ No taxpayer dollars were to be used to fund CLASS, so the program would have had to

161. PHS § 3205(c)(1)(B), added by ACA § 8002.

162. PHS § 3205(b)(2), (3), added by ACA § 8002.

163. PHS § 3205(c)(1)(D)(i), added by ACA § 8002.

164. PHS § 3205(c)(1)(D)(ii)(II), added by ACA § 8002.

165. PHS § 3206, added by ACA § 8002 (to be codified at 42 U.S.C. § 300II-5).

166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. PHS § 3206, added by ACA § 8002.

171. *Id.*

172. *Id.*

173. PHS § 3208, added by ACA § 8002 (to be codified at 42 U.S.C. § 300II-7).

rely completely on the premium payments from enrollees and any returns on the fund's investments to stay fiscally balanced.¹⁷⁴ The Secretary of HHS was charged with submitting an annual report on the state of the CLASS program beginning January 1, 2014.¹⁷⁵ Finally, information about CLASS was required to be added to the National Clearinghouse for Long-Term Care that was established in Section 6021 of the DRA.¹⁷⁶

V. SIZING UP CLASS AGAINST THE INDUSTRY'S PROBLEMS

Like all private industries, the private long-term care industry's purpose is to make money. It does not exist for the purpose of guaranteeing long-term care coverage for all Americans; only those who pay for it, and at a level commensurate with the likelihood that they will need the coverage. Due to adverse selection, it is not possible for the private insurance industry to cover all Americans who need coverage.¹⁷⁷ At the other end is Medicaid, which is designed to guarantee long-term care coverage for Americans who lack the income and resources to pay for it themselves. As long as a person is impoverished enough to meet the eligibility requirements, that person cannot be denied coverage. The cost of this program to taxpayers is not of primary importance. CLASS was an attempt at a middle option. It was designed to help all working Americans pay for long-term care without adding to the budget deficit. The two major barriers that prevented CLASS from achieving this goal were the fact that the program was voluntary, and that it guaranteed coverage.

The first problem to tackle is the fact that Americans are unprepared for their own long-term care.¹⁷⁸ Adding CLASS to the clearinghouse of long-term care policies was unlikely to have any effect on awareness, based on the findings cited above.¹⁷⁹ The provisions of the DRA had no real effect in either promoting the awareness of private long-term care insurance, or even its use. CLASS focused on wage earners, so it targeted the demographic group that seems to be the most unaware of the need for long-term care. Also, including CLASS premiums with Social Security and Medicare payroll taxes would have certainly drawn attention to the program, and therefore,

174. *Id.*

175. *Id.*

176. PHS § 3210, added by ACA § 8002 (to be codified at 42 U.S.C. § 30011-9); see also Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6021, 120 Stat. 4, 68 (2006) (codified at 42 U.S.C. § 1396p).

177. SCHMITZ, *supra* note 112.

178. AARP, *supra* note 92.

179. Compare SCHMITZ, *supra* note 112, at 3 (explaining that CLASS would be minimally marketed), with AARP, *supra* note 92, at 10 (contending that Americans know little about long-term care coverage, often mistakenly thinking they have long-term care coverage when they do not).

the issue of long-term care at large. CLASS premiums were expected to cost between \$160 and \$240 per month.¹⁸⁰ The fact that everyone with a paycheck would have been automatically enrolled¹⁸¹ was certain to draw attention. It may seem humorous (or tragic, depending on your perspective), but such a shock to workers' paychecks may have had the effect of starting a national debate on the issue of long-term care financing; one that the nation desperately needs to have.

CLASS was not structured in a way that made it so significantly different than a private insurance policy in order to encourage more Americans to get long-term care insurance. In fact, it may very well have resulted in higher premiums for its members. Unlike Medicaid, which is fee-for-service,¹⁸² CLASS was structured like a private long-term care indemnity policy. Indemnity policies are more costly than reimbursement policies, which restrict the services for which the cash benefit can be used. The CLASS benefit could have been used for any of the beneficiary's needs.¹⁸³ There was no lifetime limit to CLASS benefits, which is another feature of a high-end LTC policy.¹⁸⁴ There were also no "elimination periods" under CLASS—a rarity among private policies.¹⁸⁵ To deal with inflation, the CLASS premium was to be based on projections that kept the program solvent for the next seventy-five years.¹⁸⁶ Inflation protection is another "added feature" of private policies, which further adds to the premium amount.¹⁸⁷ Therefore, CLASS was structured like a top-of-the-line long-term care insurance policy. If the average LTC policy premium is \$200 per month,¹⁸⁸ it is not unreasonable to expect the CLASS premium to have been higher than that. Moreover, enrollees would have been subsidizing premiums for full-time students and the poor, who were projected to pay only \$5 per month in premiums.¹⁸⁹ The only provisions that may have kept the premium amount under control were the sixty-month vesting period,¹⁹⁰ the requirement that all members must be wage earners during those sixty months,¹⁹¹ and automatic enrollment.¹⁹² Assuming that wage earners are

180. SCHMITZ, *supra* note 112, at 3.

181. PHS § 3203, *added by* ACA § 8002.

182. KFF MEDICAID LTC, *supra* note 5, at 1.

183. PHS § 3205, *added by* ACA § 8002.

184. PHS § 3203, *added by* ACA § 8002.

185. *Id.*

186. *Id.*

187. See Simon, *supra* note 4, at 60.

188. *Id.* at 58.

189. SCHMITZ, *supra* note 112, at 3.

190. PHS § 3202, *added by* ACA § 8002.

191. *Id.*

192. PHS § 3204, *added by* ACA § 8002.

less likely to need long-term care, the sixty-month requirement should have helped to keep CLASS solvent in the short term. Automatic enrollment should also have helped initially with the collection of premiums, but would have become less effective over time as more enrollees opted-out of the program. In fact, the Congressional Budget Office projected that CLASS would have increased government revenues in its first ten years, and was a major reason why the ACA was considered deficit-neutral.¹⁹³ However, unless HHS found a way to keep the premiums lower-than-average, consumers would have likely continued to believe it is in their best interests to invest potential premium dollars in a retirement account, instead of locking them into a long-term care insurance policy.¹⁹⁴

Enter adverse selection. Despite automatic enrollment, there was no escaping the fact that the CLASS program was voluntary, which meant that an informed wage earner, not wanting to pay a premium, could opt-out of the program.¹⁹⁵ Participation rates in CLASS were estimated to be between 2% and 6%.¹⁹⁶ Individual reasons for opting-out are legion, and it is unlikely that the majority of the workers who refused to pay for CLASS would have done so because they had an alternative plan in place to pay for their own long-term care.¹⁹⁷ Critics of CLASS claim that this would have created a system in which younger and healthier wage earners opted out of paying the premium, leaving the people most likely to need CLASS as the only enrollees.¹⁹⁸ Since CLASS coverage was guaranteed and funded almost solely by premiums,¹⁹⁹ HHS would have been obliged to cover the vested enrollees, so the consequences to the solvency of the program are obvious. The Board of Trustees of the CLASS Independence Fund would have been charged with ensuring that premiums for this high-end indemnity policy were competitive with (if not lower than) private industry premiums.²⁰⁰ This would have been balanced with the need to keep the program fiscally sound, while guaranteeing benefits to recipients at the same time. The premium amounts were crucial to the program's survival:

Those who oppose the CLASS Act caution that to the extent premiums are set too high to attract enrollees or are raised over time to support the program, the program is likely to lose healthier individuals, while retaining

193. HCFO, *supra* note 139.

194. Curry et al., *supra* note 123, at 563-64.

195. PHS § 3201, *added by* ACA § 8002 (to be codified at 42 U.S.C. § 300ll).

196. SCHMITZ, *supra* note 112, at 3.

197. AARP, *supra* note 92.

198. SCHMITZ, *supra* note 112, at 2.

199. PHS § 3208, *added by* ACA § 8002.

200. NAT'L HEALTH POLICY FORUM, THE COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS) ACT: MAJOR LEGISLATIVE PROVISIONS 7-8 (2010), *available at* http://www.nhpf.org/library/the-basics/Basics_CLASSAct_06-09-10.pdf.

those with significant needs. This adverse selection could jeopardize the long-term viability of the program.²⁰¹

Frank Keating, CEO of the American Council of Life Insurers, contended that “the assumption underlying [CLASS’s] financing—that a very high percentage of working Americans will voluntarily participate—is unrealistic . . . overall participation is likely to be far lower . . . potentially leading to very high premiums.”²⁰² The major difference between CLASS, Medicare, and Medicaid is that CLASS was voluntary, and did not have access to taxpayer dollars. In this respect, it was more like a private insurance policy than any other government-sponsored healthcare program. However, since CLASS guaranteed coverage to anyone who enrolled—unlike private insurance—it appears to have had none of the protections necessary to prevent adverse selection.

Without making CLASS mandatory, workers would have to have been convinced to enroll in the program. There do not appear to be any provisions in CLASS that took into account the myriad reasons (besides the premium amount) why Americans avoid long-term care insurance in the first place. As has already been mentioned, the automatic enrollment feature would certainly make workers aware of the possibility that they may someday need long-term care.²⁰³ However, once people opted-out of the program, they could go right back into the state of denial that many of them confess to have.²⁰⁴ One segment of the public states that it avoids long-term care insurance because it does not trust insurance brokers to give them a fair deal.²⁰⁵ CLASS would have made long-term care coverage available to people without having to consult with brokers; however, people’s lack of trust in the solvency of CLASS, or in the government overall, may have erased any gains that could be made with this group. There were no provisions in the ACA to market CLASS, and there was no evidence that CLASS was designed to address most Americans’ beliefs that, when given a choice, they would rather spend potential premium dollars on life insurance, retirement, their children’s inheritance, or plan for events that are inevitable, instead of just “possible.”²⁰⁶

It is also unclear what effect CLASS would have had on the so-called Medicaid “crowd out” problem. The crowd out theory asserts that, no matter how restrictive eligibility rules become, Medicaid will always limit the size of the private long-term care insurance market as long as it covers the

201. HCFO, *supra* note 139.

202. Iglehart, *supra* note 142, at 9.

203. See SCHMITZ, *supra* note 112, at 4.

204. Curry et al., *supra* note 123, at 565.

205. *Id.*

206. *Id.* at 564.

same services.²⁰⁷ CLASS would have added a third player to this dynamic. On its face, it may seem that CLASS would have further crowded out private insurance. CLASS, however, was much more akin to a private policy than to Medicaid. Both CLASS and private policies would have been voluntary. A person chooses to buy these types of policies as part of the overall planning for her future. Medicaid is a program of necessity. It is the last resort. Although technically voluntary, Medicaid is needed when a person is impoverished and can no longer afford to pay for long-term care. Often, it comes down to a choice between Medicaid and a shorter life span. Focus groups and other data indicate that there is some credence to the argument that Americans expect the government to cover at least some of their long-term care.²⁰⁸ Based on its structure, CLASS would probably have done little to address this condition. “Crowd out” does not seem to be any more significant, however, than the numerous other reasons that are given for why more people do not have private coverage.²⁰⁹ The bottom line is that the cost of long-term care is incredibly high, and too few Americans buy long-term care insurance for a number of diverse reasons. Because of this, Medicaid ends up paying for more long-term care than any other funding source. To prevent this problem from getting worse, policymakers must more aggressively address the real problem: the public’s ambivalence toward buying long-term care insurance.

VI. CREATING A CLASS PROGRAM THAT WORKS

Since CLASS was voluntary, wage earners would have to have been persuaded to participate in the program to make it work. However, CLASS did little in the way of changing the conditions surrounding why Americans tend to avoid long-term care insurance. Since it guaranteed the equivalent of a high-end long-term care indemnity for all of its enrollees, it needed to counter-balance the costs of this provision by either taking in taxpayer dollars or, like health insurance under the ACA, making enrollment mandatory.

Making CLASS a taxpayer-funded program like Medicaid would defeat the purpose of the program, much of which was to decrease the number people relying on the government to pay for long-term care and thus reduce the budget deficit and the overall burden of the program on taxpayers. CLASS was a fundamental alternative to Medicaid. Moreover, opposition to CLASS as just another “big government entitlement program” was

207. Brown et al., *supra* note 107, at 2, 22.

208. Curry et al., *supra* note 123, at 564-65; see also AARP, *supra* note 92, at 26-27.

209. PESTIEAU & PONTIÈRE, *supra* note 105, at 7.

significant.²¹⁰ In 2009, a bipartisan group of Senators wrote a letter to Majority Leader Harry Reid requesting that CLASS be removed from the ACA.²¹¹ The letter states: “We have grave concerns that the real effect of the provisions would be to create a new federal entitlement program with large, long-term spending increases that far exceed revenues.”²¹² In addition to the problem of cost, it may have been easy for an opponent of CLASS to convince voters that it was an ostensible tax increase, and a hostile, or even a frugal Congress could have chipped away at its provisions over time.

In reviewing the effectiveness of CLASS, it is clear that the automatic enrollment requirement addressed the problems facing long-term care insurance in the United States more than any other provision in the law. It is the compulsory nature of this requirement that would have made it effective. However, since enrollees could opt-out of CLASS, automatic enrollment would have lost its effectiveness over the long-run and made the program vulnerable to opposition. A simple amendment to a bill stating that wage earners are not automatically enrolled in CLASS could have been devastating for the program’s financial condition and effectiveness. Therefore, to eliminate this vulnerability, CLASS enrollment would have to be mandatory.

Overall, the ACA is about guaranteeing health care coverage for as many Americans as possible. The law succinctly states that “each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”²¹³ Various other clauses of the ACA protect policyholders from being rejected for pre-existing conditions,²¹⁴

210. See, e.g., Editorial, *CLASS Dismissed: Killing an unaffordable new entitlement*, CHICAGO TRIB. (Oct. 18, 2011), <http://www.chicagotribune.com/news/opinion/editorials/ct-edit-class-20111018,0,5561459.story> (finding the CLASS Act to be “a big overreach on the part of the administration, which was too intent on expanding access to health insurance and not intent enough on containing costs”); Susan Berry, *Obamacare Has No CLASS: Administration Admits Entitlement Program Unsustainable*, BIG GOVERNMENT (Oct. 15, 2011, 11:03 AM), <http://biggovernment.com/sberry/2011/10/15/obamacare-has-no-class-administration-admits-entitlement-program-unsustainable/> (critiquing the CLASS Act as “an entitlement within an entitlement” that would have eventually needed government funds as it became “too big to fail”).

211. Letter from Kent Conrad, Sen., U.S. Senate, Joseph Lieberman, Sen., U.S. Senate, Mary Landrieu, Sen., U.S. Senate, Evan Bayh, Sen., U.S. Senate, Blanche Lincoln, Sen., U.S. Senate, Ben Nelson, Sen., U.S. Senate, and Mark Warner, Sen., U.S. Senate, to Harry Reid Sen., Minority Leader, U.S. Senate (Oct. 23, 2009), available at http://www.politico.com/static/PPM145_chris_memo1.html (last visited Dec. 30, 2011).

212. Iglehart, *supra* note 142, at 9.

213. PHSA § 2702, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-1).

214. PHSA § 2705, added by ACA § 1201 (to be codified at 42 U.S.C. § 300gg-4).

lifetime limits on coverage,²¹⁵ and excessive premiums and deductibles to name a few.²¹⁶ Medicaid eligibility is expanded to include everyone under age 65 with income less than 133% of the federal poverty level.²¹⁷ Most Americans with incomes above that amount who do not have employer-sponsored insurance will be able to get subsidized premiums for health plans through the exchange system.²¹⁸ In response to this vast expansion of coverage, Chapter 48 of the ACA establishes the “Requirement to Maintain Minimum Essential Coverage,”²¹⁹ commonly known as the individual mandate. Effective January 1, 2014, anyone who goes without “minimum essential health care coverage” for a month or more will pay a tax penalty of up to \$750 per person (with a limit at \$2,250) on an annual basis.²²⁰ If it survives in the courts,²²¹ this penalty will be phased in and will be fully effective after 2016.²²² Exceptions are made to take into account incarcerated individuals, people whose religious beliefs preclude them from getting health insurance, illegal immigrants, heads of household under age 18, and individuals claiming a hardship exemption.²²³ The purpose of the health care mandate is described very clearly in Section 1501:

if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will *minimize this adverse selection* and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that

215. PHS § 2711, *added by* ACA § 10101 (to be codified at 42 U.S.C. § 300gg-11).

216. PHS § 2701, *added by* ACA § 1201 (to be codified at 42 U.S.C. § 300gg) (prohibiting discriminatory premium rates); ACA § 1302(c)(2) (to be codified at 42 U.S.C. § 18022) (limiting deductibles in the small group market to \$2,000 for an individual and \$4,000 for any other plan).

217. ACA § 2001 (amending 42 U.S.C. 1396a).

218. ACA § 1401 (to be codified at I.R.C. § 36B).

219. ACA § 1501 (amending I.R.C. § 5000A).

220. *Id.*

221. *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, 565 U.S. ___ (Nov. 14, 2011) (No. 11-393) (granting review of the entire petition); *Florida v. U.S. Dep’t of Health & Human Servs.*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, 565 U.S. ___ (Nov. 14, 2011) (No. 11-400) (granting review of the third question presented on the issue of severability and the first question presented); *U.S. Dep’t of Health & Human Servs. v. Florida*, 648 F.3d 1235 (11th Cir. 2011), *cert. granted*, 565 U.S. ___ (Nov. 14, 2011) (No. 11-398) (granting review of the first question presented: “Whether the suit brought by the respondents to challenge the minimum coverage provision of the Patient Protection and Affordable Care Act is barred by the Anti-Injunction Act, 26 U.S.C. § 7421(a)”).

222. ACA § 1501.

223. *Id.*

are guaranteed issue and do not exclude coverage of preexisting conditions can be sold.²²⁴

This clause alone makes it very clear that the framers of the ACA were concerned about adverse selection when they guaranteed health insurance coverage for all Americans. It also makes it disturbingly clear that CLASS was unlikely to stay fiscally solvent without a coverage mandate of its own.

A coverage mandate would bluntly address Americans' lack of preparation for their own long-term care. All working Americans would have guaranteed long-term care insurance once they were fully vested in the program. Moreover, since the program was funded almost exclusively by premiums, people were less likely to view it as "welfare," and more likely to view it as a program similar to Medicare and Social Security. With the mandate in place, the structure of CLASS might have worked to its advantage. Premium payers were exclusively wage earners, most of whom are at a lower risk to need long-term care. The CBO estimated that CLASS enrollees would not start taking out benefits in a substantive way for at least ten years from the program's inception.²²⁵ Having an abundance of premium payers early on would enhance the program's fiscal solvency, and should have allowed it to charge lower premiums, possibly as low as \$37 per month.²²⁶ This not only addresses the ubiquitous complaint that long-term care insurance is too expensive,²²⁷ but it also would allow CLASS to stay structured like a high-end indemnity policy for a much longer period of time. The mandate would also weaken the argument that a person is better off putting potential premium dollars into a retirement fund, since premium payments may drop low enough to make long-term care insurance a more practical option. Most importantly, a mandate would address the adverse selection problem. As the ACA points out, when health care coverage is guaranteed, it must be counter-balanced with a mandate.²²⁸ The only other alternative is to limit coverage or fund the program with tax dollars, both of which defeat the purpose of the program. The mandate also eliminates the denial and uncertainty problems that Americans have with long-term care insurance planning.

This leaves the "Medicaid crowding" problem. The primary principle behind this theory is that, as long as Medicaid covers the same service that long-term care insurance covers, the long-term care insurance industry will

224. *Id.* (to be codified at 42 U.S.C. § 18091) (emphasis added).

225. Iglehart, *supra* note 142, at 9.

226. Edward Allen Miller, *Flying Beneath the Radar of Health Reform: The Community Living Assistance Services and Supports (CLASS) Act*, 51 GERONTOLOGIST 145, 152 (2011).

227. PESTIEAU & PONTIÈRE, *supra* note 105, at 5.

228. ACA § 1501 (to be codified at 42 U.S.C. § 18091).

be weaker.²²⁹ Even without a mandate, the Congressional Budget Office “projected the CLASS program to generate \$2 billion in Medicaid savings.”²³⁰ Clearly, mandatory participation in CLASS would augment this savings and insure a huge portion of the population against long-term care costs. Modifying the mandate to require long-term care insurance under a choice of CLASS or private insurance would, by definition, reduce the crowding problem. The experience of other countries supports this notion.

Mandatory CLASS-style long-term care policies exist in other countries and appear to be successful in meeting both their social and fiscal goals. Germany’s program is entirely comprehensive, and includes a choice of nursing home, HCB care, or cash benefit coverage.²³¹ There is no longer any “Medicaid” coverage of these services as it is known in the United States.²³² Germany has a dedicated fund similar to the CLASS Independence Fund, although “everyone (including employers)” contributes to it, not just wage-earning volunteers.²³³ If a person does not want to contribute to the government program, he must buy private long-term care insurance.²³⁴ When given the choice of these three options, the cash benefit is the most popular.²³⁵ Although the benefits of cash payments amount to less than those of HCB, they are sufficient enough to enable an otherwise-unpaid caregiver to provide care as often as she needs to.²³⁶ Some caregivers even get vacation time and are able to use the cash benefit to hire a personal attendant.²³⁷ Therefore, the German system has been at least somewhat effective in turning the role of unpaid caregiver into a form of employment. The options available to citizens are also well-integrated, so people can choose between hybrids of cash, HCB services, and nursing home care.²³⁸ Perhaps most importantly, the German model has no resource or income guidelines, so individuals do not have to impoverish themselves to qualify for coverage.²³⁹ This applies to all of the types of care, not just the cash benefit.²⁴⁰ Finally, the German system is fiscally

229. Brown et al., *supra* note 107, at 24.

230. Miller, *supra* note 226, at 149.

231. John Creighton Campbell et al., *Lessons from Public Long-Term Care Insurance in Germany and Japan*, 29 HEALTH AFF. 87, 86-88 (2010).

232. GLECKMAN, *supra* note 89, at 8.

233. Campbell et al., *supra* note 231, at 88; GLECKMAN, *supra* note 89, at 7 (“everyone” includes employers).

234. GLECKMAN, *supra* note 89, at 6.

235. Campbell et al., *supra* note 231, at 90.

236. *Id.*

237. *Id.*

238. *Id.*

239. *Id.* at 88.

240. Campbell et al., *supra* note 231, at 88.

solvent, although continued reforms are necessary to keep it solvent in the coming decades.²⁴¹ Japan's system is similar to Germany's, but does not include a cash option.²⁴² Providers of long-term care under the German and Japanese systems are overwhelmingly private entities,²⁴³ so, despite what some commentators may call a "socialist" model of coverage, a successful private-public partnership has been established. Other nations, like Britain,²⁴⁴ France,²⁴⁵ and the Netherlands,²⁴⁶ have similar systems: the long-term care coverage is comprehensive, mandatory, and, with the exception of Britain,²⁴⁷ does not have impoverishing eligibility requirements.²⁴⁸

The United States does not have to create a coverage system as elaborate as those in Europe and Japan to effectively address the problem of long-term care. Similar to the ACA, it could rely on private firms to provide the policies, while instituting a mandate for everyone to have long-term care insurance. CLASS could even be reformed into a "minimal coverage" program into which people would be enrolled if they did not get coverage on their own. The mandate, however, is what makes any of this possible. Scholarly commentary on CLASS had only just begun when the program was eliminated, but the consensus of those studying the program was that it would be largely ineffective without a mandate.²⁴⁹

VII. CONCLUSION

Long-term care is unique. As much as it is an issue for the person getting the care, it is an issue for someone else: a loved one, a friend, an attendant, a nurse, a physician, a neighbor. It is a public charge, almost exclusively funded by the care recipient's family or by taxpayers.²⁵⁰ No one wants it. It also seems, at times, that no one wants to address the challenges faced by an aging nation that will need more and more of it as the 21st Century progresses. There are, however, reasons to be optimistic. Democrats and Republicans both understand that there is a problem

241. GLECKMAN, *supra* note 89, at 8.

242. Campbell et al., *supra* note 231, at 90.

243. *Id.* at 88.

244. GLECKMAN, *supra* note 89, at 16.

245. See *id.* at 14-16.

246. See *id.* at 9-11.

247. *Id.* at 16.

248. *Id.* at 14-15 (France); *id.* at 9 (the Netherlands).

249. See Miller, *supra* note 226, at 151-52 (besides pointing out many of the same flaws discussed here, Miller points out that CLASS has a number of potentially useful features; particularly its accessibility to younger policyholders and the existence of cash benefits in place of service-based benefits).

250. KFF MEDICAID LTC, *supra* note 5, at 1.

funding long-term care. The conservative DRA attempted to address the problem and was not successful, but scholars have since been able to identify reasons why that was the case. The progressive ACA took significant steps toward reforming the American long-term care system through the CLASS Act. CLASS, however, was fundamentally flawed and was unlikely to remain fiscally solvent. A long-term care insurance mandate, similar to the ACA's health insurance mandate, would have given the program the vitality it needed to be effective. Perhaps more ambitious reforms, like those seen in Germany and other countries, will be attainable in the future. However, for now we are in a position to keep moving in that direction. In spite of the vitriol in politics these days, the inexorable march of time is still powerful enough to make Republicans and Democrats work together toward a common goal, particularly with the public debt expanding at ever-growing rates. After all, all of us want to live a long time, and, sooner or later, we will all have to pay the price of age.

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