

Health Care Reform— Long Term Care Coverage



PROVISIONS

2.1 TIME PERIOD

Takes effect January 1, 2011. There is a five year period during which participants must make payments before any benefit may be received.

2.2 PLANS

There must be three actuarially sound plans from which to choose. HHS must designate a plan that qualifies no later than October 1, 2012.

2.3 BENEFIT

Cash amount not to be less than an average of \$50 per day- there is no lifetime or aggregate limit. The amount varies based on a scale of functional ability with not less than two nor more than six benefit level amounts.

2.4 ELIGIBILITY

- 18 years or older
- Actively at work
- Receiving wages or income subject to Social Security tax, and not currently a patient in a hospital or nursing facility, or penal institution or facility.

New rules for fully insured health plans

Long Term Care (CLASS Act)

The new law calls for the creation of a national, voluntary insurance program for the purchasing of Community Living Assistance Services and Supports (CLASS.) Following a five year vesting period, the program will provide individuals with functional limitations (to be defined) a cash benefit of up to an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence.

The program is financed through voluntary payroll deductions, but all working adults will be AUTOMATICALLY enrolled unless they formally opt out.

Eligibility

An “eligible beneficiary” must meet all requirements listed in Sec. 2.4, and also must have:

- Paid premiums for at least 60 months; and
- Earned for at least three calendar years that occur during the first 60 months during which premiums were paid, at least an amount equal to the amount of wages and self employment income that an individual must have in order to be credited with a quarter of coverage under the Social Security Act for that year; and
- Paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payment of more than three months has occurred during the period that begins on the date of the individual’s enrollment and ends on the date of such determination.

Qualification

An enrollee qualifies if they have a functional limitation expected to last for a continuous period of more than 90 days. A functional limitation is defined as that where the individual cannot perform at least the minimum number (may be two or three) of “activities of daily living” as required under the plan.

Unanswered Questions

There are several questions which need to be answered:

1. Will this be a public or private market plan?
2. Will there be competition in the market to allow plan choice?
3. Does the employer or employee choose from the three plans, or are all three offered?
4. Assume the plans will be issued on a guaranteed basis?
5. Assume the plans will be issued without pre existing condition restrictions?
6. Tax law now in place for individual deductibility- assume that stays in place?
7. How will the cost of the plan be determined, by whom, and when/how reviewed?

Cost

Still to be determined, but rules say that the premium established for an individual enrollee must stay the same *unless* a change is deemed necessary for purposes of “program solvency.”

Costs may also be changed if someone disenrolls and then reenrolls after the five year vesting period.

Health and Human Services Department may also factor in costs for administering the program, not to exceed 3% of the total premium. Not only is there a five year payment period before benefits may be received, but the qualifying individual must have earned, with respect to at least calendar years during this payment period, an amount equal to the amount of wages of self employment income which an individual must have to credited with a quarter of Social Security for that year.

Any increase determined as necessary to retain fiscal solvency will not be applied to those who have attained age 65, paid premiums for at least 20 years and are not actively employed.