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LONG-TERM-CARE INSURABLE EVENTS: EMERGING PROMINENCE OF ADL BENEFITS

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- Academic beginnings
- Hierarchical structure
- Consumer/insurer impact
- The need for standardization
- An increasing emphasis on cognitive impairments (alternative benefit triggers)
- A practical example
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MS. DEBRA L. FULKS: I'm going to begin by taking you on a quick trip through time to give you a perspective on how an activity of daily living (ADL) benefit trigger fits into the larger picture, which is the use of ADLs as a way to describe the ability of an individual to care for his or her own needs. Then I'll give you some ideas on how to compare various ADL benefit triggers.

Thirty years ago, Dr. Sidney Katz was already doing research, looking for a relatively simple way to reliably and objectively evaluate the care needs of chronically ill and aging patients.

Why wasn't he satisfied with diagnosis, physician's judgment, and other medical tools at his disposal? Because he recognized that they weren't adequate to the task of differentiating among varying levels of the need for assistance. The range of severity within a *single* diagnosis was often greater than the range among *different* diagnoses.

Also, using the "medical approach" was particularly inadequate when applied to custodial care needs. Such patients could often be cared for by nonprofessionals, and it didn't really matter whether or not there was a clear illness or injury.

Unlike diagnosis, ADLs could be used to describe both the stage and severity of a condition as well as pinpoint the particular need for service.

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Dr. Katz isolated what he considered to be the most basic activities – those we learned as children – and showed that these were useful in segregating the elderly into classes with varying levels of needs. He developed a one-page assessment tool, called the "Katz Index of ADL," based on whether or not a person could independently bathe, dress, use the toilet, transfer in and out of a bed or chair, maintain continence, and eat.

Independence meant the patient could perform the activity alone, or with minimal assistance. Dependence meant that supervision, direction, or personal assistance was needed. A simple classification system was developed based on the number of impairments or dependencies a patient exhibited.

I'll be getting back to Katz later, but I need to point out that others followed him and developed alternative sets of ADLs, instrumental activities of daily living (IADLs), and more elaborate assessment tools. These were used for various purposes, including screening, monitoring patient progress, and prediction. One of the best sources I've found for a comprehensive discussion of these various tools is Kane and Kane's book on *Assessing the Elderly: A Practical Guide to Measurement*, Free Press, 1984. This book also contains an excellent bibliography for those of you who want to delve deeper into the subject.

Public programs were the first to use ADLs as benefit triggers. While many states still rely on a physician's evaluation of medical necessity (as do most in-force insurance contracts), the runaway cost of Medicaid programs has prompted the public sector to seek other, more objective ways to evaluate the needs of those vying for scarce public assistance dollars.

States like New York, Minnesota, and Illinois have developed complex tools to assess the care needs of those seeking entry into a nursing home or applying for state-assisted home health care. This method provides more control and a more equitable distribution of limited resources. Because many of the state tools use a scoring mechanism, objective cut-off points could be set for service eligibility. They can also be easily altered to change the trigger when budgets change.

Are you starting to get the idea that insurers have been a bit slow to latch on to ADLs as a benefit trigger for LTC insurance? There's a reason for that: tradition. The ancestors of today's LTC contracts began as convalescent-care policies, simple extensions of acute medical plans. They mimicked Medicare requirements then in place. Medical necessity language and links to doctor's orders and hospital stays made sense at the time.

When insurers finally began to look at ADLs as an objective measure of the need for care (and hence, benefit payments to pay for that care), they had to retreat a bit and take another look at the basics: the work of Katz and others. It was just not feasible to insert any of the complex assessment instruments the states and researchers were using into an insurance contract. So, let's take another look at Katz and his ADLs.

Key to the work of Sidney Katz and others is the idea that ADLs exhibit hierarchical tendencies; that is, people tend to lose independence in ADLs in a certain order, with the more complex activities becoming impaired earliest. In fact, most of us lose our

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abilities to care for ourselves in the reverse order in which we originally learned them. In the Katz Index that order, from first lost to last, is bathing, dressing, toileting, transferring, continence, and, finally, feeding oneself. An important point to remember is that the need for supervision was defined to be a dependency when this hierarchy was studied.

Before leaving Katz, there is one more point that will be important to remember once we begin to evaluate different ADL benefit triggers. Impairment in the toileting ADL was the strongest indicator for entry into a nursing home. In other words, those whose decline in the hierarchy was so far along as to already include toileting dependence were very strong candidates for nursing home confinement. The toileting ADL is very broad in scope, combining elements of mobility, hygiene, dressing, and even continence. Impairment in this ADL often signals the point at which informal caregivers become frustrated and feel they can no longer keep the patient at home.

Others have studied similar hierarchies for IADLs and combinations of ADLs and IADLs. The results have varied depending on the methods and definitions used. While the theoretical existence of such hierarchies doesn't mean everyone experiences a specific order of functional loss, clinical evidence and the literature on service use presents a strong enough case for us to use these findings to help evaluate various ADL triggers.

Piecing together the data you need to evaluate different ADL scales is not easy, and I don't pretend to have figured it out entirely, but after a while certain patterns emerge and study by study the pieces keep falling into place. The ADLs that are toughest to define and most subject to controversy are continence and walking or mobility. It is of note that even Katz eventually dropped continence from further study.

Let's take a quick look at two of the many studies that have been done on ADLs and IADLs. First, Table 1 presents data from a study done in Massachusetts that classified the impairments of those who qualified for home-health-care benefits from the state. Concentrate on the order of dependence and remember that all of these people had already been screened and qualified for help.

Note the following:

- a) IADLs aren't always above ADLs in the hierarchy, even though they are more complex. The hierarchy is more likely to hold true for those with cognitive impairments.
- b) In this sample, there was a slightly higher prevalence of difficulty with transferring than with toileting, which is a bit different from the Katz prediction.

The next study, recapped in Table 2, is more well-defined and probably closer to the kind of structure we seek as actuaries.

The numbers were derived from the 1984 National LTC Survey (NLTCs), projected to include all elderly living in the community.

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TABLE 1
 Massachusetts Executive Office of Elder Affairs
 Breakdown of Home Health Care Recipients for 1987

ADL/IADL	Able	Able with Help	Unable
Bathing	6%	75%	19%
Meal Preparation	7	41	52
Medications Management	42	45	13
Dressing	43	41	16
Transferring	62	31	7
Toileting	63	29	8
Mobility	69	21	10
Eating	79	17	4

The first column shows the percent of the noninstitutionalized elderly who required active, hands-on assistance for at least three months to perform the listed activity. The second column expands the definition of impairment to include the need for standby assistance. Note the substantial increase in prevalence. Also notice that problems with toileting have surpassed dressing difficulties.

TABLE 2
 1984 NLTCs

ADL/IADL	Needs Active Help	Needs Active or Standby Help
Medications Management	5.0%	N/A
Bathing	4.8	6.5%
Dressing	3.2	4.1
Toileting	2.2	4.7
Transferring	1.9	3.6
Eating	0.9	2.1

Note: Estimated percent of community-based elders (>65) in U.S. with impairment at this level.

Are you starting to see that the results are greatly impacted by the way ADL impairments are defined? The actuary needs to be aware of this so that pricing assumptions, contract language, and claim protocols are all in sync.

Some of the many ways studies have defined "unable to perform" include:

- a) has difficulty with
- b) needs a device (cane, walker, wheelchair)
- c) needs standby supervision
- d) needs occasional or intermittent help
- e) needs hands-on assistance
- f) needs continual help
- g) can't do at all

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Other factors impacting the study results and the ultimate usefulness of the data to actuaries include:

- a) Did the study use self-reporting, information from proxies, or a professional assessment?
- b) Did the study examine the patient's average performance, or his best?
- c) Is time of day important?
- d) Was there a time frame for completion of the assessed activity?

The bottom line is that none of the studies done to date are perfect due to the factors I just mentioned and the populations studied. However, even if we can't trust the absolute frequencies, we can get a feel for the relative "worth" of various benefit triggers. We can use the available data to establish upper and lower bounds on incidence rates.

A good study of how liabilities increase and decrease under various scenarios is "The Elderly Population with Chronic Functional Disabilities: Implications for Home Care Eligibility" by Robyn Stone and Christopher Murtaugh.

Knowing the hierarchical nature of ADLs and IADLs as well as the impact of varying definitions of impairment means that insurance policies can be configured to direct benefits toward a particular population. An actuary can also adjust the amount of liability assumed by changing the definition of impairment, or the particular set of ADLs used as a trigger.

Table 3 below represents three sample ADL triggers. For the sake of this exercise let's assume "unable to perform" means that one needs hands-on assistance to complete the task. I've arranged each set in hierarchical order and underlined the ADL that will be the "qualifying" ADL for the majority of insureds.

TABLE 3
Sample ADL Triggers

2 of 5	3 of 6	1 of 5
Medications Management <i>Dressing</i> Toileting Mobility Eating	Bathing Dressing <i>Toileting</i> Transferring Contenance Eating	<i>Dressing</i> Toileting Transferring Contenance Eating

The "1 of 5" criteria is not that much more liberal than the "2 of 5" due to the choice of ADLs. Those with highest frequency of impairment, bathing and managing medications are not included in the "1 of 5" set. In fact, if we used the ADLs in the last set with a "2 of 5" trigger, it would be comparable to the "3 of 6" trigger shown in the middle.

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The first two sets are nearly equivalent for those with physical impairments only, but the first set is clearly a more liberal trigger than the second for those who suffer cognitive impairments (due to the inclusion of an IADL).

Which set is best? It depends on the intent of the policy. The middle set is probably best for a "nursing home only" policy (remembering that impairment in toileting predicts institutionalization). The other two are suited for earlier intervention.

To give you a flavor of what it's like to be making decisions about ADL triggers, I'll tell you a story about what happened at CNA.

When we began to investigate an ADL trigger at CNA, there was a great deal of concern that moving away from medical necessity language would "open the floodgates" for claims. Our goal was to use a simple set of ADLs to illustrate our claim philosophy of providing LTC benefits when our insured could no longer manage his or her own safety and well-being. This meant dealing with cognitive as well as physical impairments. We were not necessarily trying to change the kind of claimants who received benefits or decrease the number of claims expected, but rather move away from relying only on the personal physician and diagnosis, toward a more objective measure.

As part of the decision-making process, we did a small study of claims we had paid under "medical necessity" contracts, determining which ADLs, IADLs, and behaviors had been impaired at the beginning of the claim. The ADLs were then combined and recombined into different sets to judge the resulting impact. The attitude about opening the floodgates went away quickly as we showed how some sets of ADLs would have rejected as many as 25% of the claims we had approved for payment.

As I said, we were not seeking to decrease our liability, so the restrictive sets of ADLs were quickly rejected. At the urging of our claim policy people, we decided to include an IADL, managing medications, in our final set rather than bathing. As they so eloquently pointed out, "You don't die from dirt." Due to the ambiguities in definitions, we eliminated incontinence. Then, in order to simplify the set, we combined transfer with walking and wheeling to get what we called mobility. The resulting set of five is the first column in Table 3.

"Unable to perform" our ADLs includes the need for supervision as well as hands-on assistance. As Sharon Sokoloff will be explaining, this is sufficient to satisfy our goal of giving equal access to benefits to the cognitively impaired. However, the perception in the marketplace was that a separate cognitive trigger was necessary, so we later added a provision based on behaviors that put the insured at risk. That enhancement did not impact expected claims.

My story was about our group product. In the group marketplace, ADL triggers are the norm. This is not true on the individual side. Some markets there are not as ready for ADL triggers. There is a great deal of comfort in the idea that your doctor's word is sufficient. As a result, we've eased into ADLs on the individual side by using a triple trigger: ADLs, cognitive impairment, or medical necessity.

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Clearly the industry is headed toward ADL triggers. You need only follow federal proposed legislation and NAIC proceedings to be aware of this fact. For those yet to take the plunge and those still uneasy about having done so, I give the following advice:

- a) Know the basis of your data, the definitions used, the population studied, and the source of the individual reports.
- b) Be sure that pricing assumptions, contract language and claim protocols are all in agreement.
- c) Be aware that the public perception of ADLs is changing.
- d) Work toward educating the public to understand that differences in ADL triggers exist, and that numbers of impairments do not tell the whole story.

This last point is crucial. There is such a lack of understanding about ADL triggers among insurance professionals and public policymakers we can rest assured that the general public is not in a position to evaluate the differences. In the long run, the public will be served well by the more objective, needs-oriented ADL approach. Unfortunately, in a rush to eliminate the current lack of understanding, I fear we will be forced into a standard ADL set without enough forethought.

I believe ADL and IADL definitions should be standardized. Based on a recent Health Insurance Association of America (HIAA) survey, that should not be a burden. There are only about 10 ADLs/IADLs in use as benefit triggers, and the majority share similar definitions already.

However, must we also standardize the level of assistance needed? Should every policy pay if supervision alone is needed, or should the trigger be the more restrictive need for continual hands-on assistance? I think there should be room for such variation in degree of impairment. This is not such a difficult concept to communicate to the public.

Given that we can define our terms, is it really appropriate to start standardizing sets of ADLs? Whose version should we use? Take a look at the variations in state Medicaid programs and proposed federal legislation. No one agrees, and any compromise this early in its development is most likely going to prove inadequate. It's one thing to standardize benefits under a mature coverage like Medicare supplement, but it's another story when you look at a very new concept like ADL benefit triggers.

There is clearly room for policies with more stringent ADL sets (for example, nursing home only policies, or those designed to provide catastrophic coverage), but we need leeway to also design early intervention triggers.

I fear the pace at which standards are forming, but I understand the need to protect the public from its own ignorance as well. We can only hope that well-informed experts are included in the decision-making process.

As difficult as it is to define the insured event when we are dealing with physical impairments, it is even harder to decide on a trigger that will give appropriate access to benefits to the cognitively impaired.

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DR. SHARON SOKOLOFF: The focus of my portion of this discussion addresses methods of incorporating cognitive status into the definition of the LTC insured event. However, because cognitive status is so critical to sound underwriting of LTC policies, I'll briefly touch on some key issues related to accounting for cognitive impairment during the underwriting process as well.

To begin with, why are we having a separate presentation about cognitive triggers in the benefit determination process? Why is this important? ADLs have been, and continue to be, the foundation of a clinically meaningful and fiscally viable LTC insured event. However, there is persuasive evidence that by using ADLs alone, we miss people who truly need LTC because of cognitive impairment. Two studies demonstrate this.

The first study uses data from a National Institute on Aging (NIA) sponsored study; the study collects longitudinal data on virtually all people who are 65 years of age and older who live in the community in five cities around the country. The data we used for our analysis (the analysis was done under the auspices of the Connecticut Public/Private Financing Partnership Project which is housed at the Office of Policy & Management in Hartford) was from the New Haven site of the NIA study. The study looked at the correlation between ADLs and cognitive impairment using the standardized 10-item Short Portable Mental Status Questionnaire (SPMSQ). It revealed that, of the individuals with more severe levels of cognitive impairment (seven or more errors), 78% had either zero or one ADL dependencies. Therefore, if the commonly used two or more ADL dependence benefit trigger was used, more than three-quarters of the people who made seven or more errors on the SPMSQ would be ineligible for LTC benefits.

The second study was conducted by Diane Rowland and her associates at Johns Hopkins and used the NLTCs data. The NLTCs is based on a nationally representative sample of people 65 years of age and older who live in the community and who have at least one ADL or IADL dependency. In this study, 32% of the people who had a moderate cognitive impairment (or worse) (i.e., the group who made five or more errors on the SPMSQ) had zero or one ADL dependencies.

These studies provide a rationale for expanding the focus of benefit determination models to ensure that people with cognitive impairments that put them at risk receive the care and/or supervision they need. This is particularly the case when ADL dependence is defined as (1) requiring hands-on assistance and/or (2) three or four ADL dependencies are used.

There are four options for identifying cognitive impairment at benefit determination that have either been used in public and/or private programs or examined for use:

1. Using a score on a standardized mental status exam as a benefit criteria as well as an ADL score: There are many standardized mental status exams. Some of the best known and most widely used instruments include two 10-item tests, the Mental Status Questionnaire (MSQ) (by Kahn and Goldfarb, 1960) and the SPMSQ (by Pfeiffer, 1975), and the Mini Mental Status Exam (MMSE) by Folstein and his colleagues.

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There are several advantages and disadvantages to this approach.

ADVANTAGES

- (a) Many brief standardized mental status exams have been shown to be reliable on repeated trials and when administered by different assessors.
- (b) The exams have also been shown to be a valid way of determining cognitive impairment when compared with clinical judgments.
- (c) Brief mental status exams are efficient.
- (d) Scores on mental status exams are "objective."

DISADVANTAGES

- (a) This approach tends to link benefit eligibility to specific categories of disease or disorders, e.g., Alzheimer's and other dementing illnesses. Robert Kane and other advocates who speak on behalf of people with cognitive impairment have voiced a preference to "avoid establishing the precedent of special handling for a single group" (Kane, R.L.; Saslow, M.G.; Brundage, T.; "Using ADLs to Establish Eligibility for Long-Term-Care Among the Cognitively Impaired," *Gerontologist*, 1991, Vol 31, N1, Pages 60-66) in benefit determination models.
 - (b) More importantly, there is no consensus about where to draw the lines (or establish the cut points) to distinguish the severity of cognitive impairment or to determine who should and should not be deemed eligible for benefits. There is simply no data to guide the decisions about whether a score on an MSQ or SPMSQ of four, five, or seven should be used to trigger benefits or whether a score of 21, 22 or 24 on the MMSE is appropriate.
2. Using the presence of a problem/disruptive behavior(s) as well as an ADL score: The kinds of behaviors we're talking about when we say problem and/or disruptive behaviors include wandering, abusive/assaultive behavior, behaviors that are health/safety risks, and poor judgment. The way this information is often collected is to determine if the behaviors are present and if so, how often they are exhibited and if supervision is required because of the behavior.

ADVANTAGE

- (a) This is an important point, like functional dependence behaviors that put individuals' health and safety at risk are direct indicators of need for care and/or supervision. This is in contrast to scores on mental status exams, which are direct indicators of compromised status but indirect indicators of need. Thus, a behavior such as wandering is the event for which an individual needs care or supervision. In contrast, a person doesn't need care or supervision because of a specific MSQ score, but

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rather, for the behavior and/or functional dependence caused by the cognitive impairment.

DISADVANTAGES

- (a) Behavior information is more subjective and qualitative than mental status exam scores.
 - (b) Although not well studied, the reliability of collecting behavior-oriented information is likely to be less than it is for standardized mental status exams.
 - (c) Using behavior problems as the benefit trigger could "under-identify" potential beneficiaries who live alone and/or do not have a support system to report their problems. (People who exhibit problems, e.g., wanderers, are unlikely to report they wander, and people who are abusive/assaultive are not likely to report it.)
 - (d) On the other hand, this approach could identify people with significant behavior problems who do not have a degenerative cognitive process, e.g., a person with a mental illness (as opposed to an "organic" cognitive impairment) who may not fall within the targeted population of LTC insurance policies.
- 2a. A hybrid of the first two approaches -- using a score on a standardized mental status exam and behavior indicators: Before moving on to the next approach (i.e., expanding the definition of ADL dependence to include supervision), I want to mention a hybrid approach, which is to use a mental status exam score and behavior indicators. This approach has been used quite a bit and has a lot of merit. One particularly well-thought-out model is used in the Connecticut Public/Private Financing Partnership definition of the insured event. The benefits of this approach follow.

If a score on a mental status exam is used alone, we are fairly confident that, if there is not an ADL, dependency then will be a behavioral problem that puts the claimant and/or others at risk. However, if the cut point is set high, e.g., seven or more errors, to ensure our confidence that the people we are identifying are at risk, we will miss people with moderate cognitive impairments, e.g., people who score four to six on the MSQ, but who may exhibit behavioral problems.

However, if we use behavioral indicators alone, we may identify people with behavior problems that are not caused by cognitive impairment, but rather by a mental illness. Thus, an approach that combines the two (i.e., that collects both behavioral information and one in which a standardized mental status exam is administered) enables us to capture people with moderate impairments who exhibit behavioral problems and to target benefits for people with behavioral problems secondary to a degenerative cognitive illness.

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3. Expanding the definition of ADL dependence to include supervision and verbal cues rather than hands-on assist only: The following underscore the advantages and disadvantages of this approach.

ADVANTAGES

- (a) The assistance requirements of the cognitively impaired are more often supervision and cuing than physical assistance. Therefore, this approach more readily identifies people who need long-term care because of cognitive impairment.
- (b) This approach eliminates the additional step of administering a mental status exam, which is perceived by some to be "administratively awkward."
- (c) Using ADLs alone eliminates the need to establish a cutoff point on a mental status exam, which is expected to distinguish between those who need long-term care or supervision and those who do not.
- (d) This approach does not single out individuals with specific diseases or disorders for eligibility -- rather, it keeps the focus for eligibility on functional performance.

DISADVANTAGE

- (a) While the *sensitivity* (the extent to which the criterion correctly identifies individuals who need care or supervision because of cognitive impairment) of this approach is high, a likely disadvantage is low *specificity* (the extent to which it correctly identifies the people who do not need supervision because of cognitive impairment). In practice, this is a very real problem with which a number of carriers are struggling.
4. Incorporating IADL indicators into the benefit eligibility criteria: This approach has received considerably less attention than the others discussed here. Its main advantage is that because IADLs are more complex than ADLs, they require better judgment and a more complex decision-making ability, both rather high-level cognitive functions. Certain IADLs, like managing finances and medication, and using the telephone, are highly correlated with cognitive impairment. Therefore, individuals with modest cognitive impairment are likely to be dependent in IADLs before they become dependent in ADLs.

The disadvantage of this approach is similar to, but more extreme than, the problem associated with expanding the definition of ADL dependence to include the need for supervision. The number of people who would be eligible for benefits using IADL triggers increases the eligible population to levels that public and private systems are unwilling to pay for. Again, many of the people who would become eligible for benefits by virtue of IADL dependence would be cognitively impaired, but many are not cognitively impaired.

Why is it important to consider cognitive status as it relates to underwriting? Cognitive status is a real concern to actuaries involved with LTC insurance. The bad news is, it is hard to deal with; the good news is, it can be dealt with. To deal with it, however, insurers have to go beyond "routine underwriting" including the application and attending physician statement (APS). To underwrite well, we must be on the alert for those issues that the family may know about before consumers apply for insurance, although the problems may not be evident to others yet, including the physician, a prime example being cognitive impairment. In this part of the presentation, I want to make two points.

First, as the early claim experience of a number of insurers shows, cognitive impairment is the primary reason why people are going to benefit status early on. A study conducted by the Long-Term-Care Group looked at the early claims of several insurers during the first 24 months. The study looked at 125,000 lives or policyholders. The analysis revealed that 44% of the "early claimants" went into benefit as a result of cognitive impairment. This was twice as many as the next common cause for early claims! That's the first point I want to make.

The second point is to demonstrate the fact that different standardized tools are better suited to underwriting as it relates to cognitive impairment than others. Table 4 demonstrates the number of people who were identified as being cognitively impaired using three methods, the typical APS, the standardized MSQ and another standardized mental status exam, the Delayed Word Recall (DWR) test.

TABLE 4
Detecting Early Cognitive Impairment:
Preliminary Results

	APS	MSQ	DWR
Cognitive Reject	4	5	12
Non-cognitive Reject	606	605	598
TOTAL	610	610	610

Sample: $N = 610$; mean age = 74; median age DWR rejects = 78.

In another study done by the Long-Term-Care Group, these three ways of screening for cognitive impairments at the time of underwriting were compared by using all three methods with 610, relatively old (mean age of 74) LTC insurance applicants. What the table shows is that the DWR detected 12 applicants with cognitive impairments while the MSQ identified five, and the APS identified four.

The DWR is more sensitive to detecting early cognitive impairment because it tests for the ability to encode information which, contrary to popular wisdom, is the first dimension of cognition that is affected by Alzheimer's Disease. (It is commonly, but erroneously, thought that short-term memory and orientation are the first cognitive functions to be adversely affected by Alzheimer's, but in fact, it is the ability to encode information.) This makes the DWR test particularly well suited to underwriting. Furthermore, Knopman of the University of Minnesota who, with his colleagues developed and tested the DWR, clinically validated the tool by identifying

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people with cognitive impairment at early stages and then tracked them over time to determine if the cognitive impairment became more severe. And, it did.

MR. JOSEPH J. HANCOCK: What I wanted to talk a little bit about is some more of the practical issues of using ADLs on a day-to-day basis. I think at this point in its development, Aetna probably has the most experience, having adjudicated over 200 claims on an ADL basis. Since 200 claims is not entirely credible, you cannot draw any concrete conclusions about the use of ADLs. I think, however, the number can give some indication of what is likely to happen.

I think there is a general consensus in the industry that ADLs from the clinical perspective are really the best way to trigger an LTC benefit. Chiefly because they allow us to establish parameters for effectively determining chronic illness. As an example, an individual with Parkinson's Disease can be as functional as you or I, or they can be very debilitated. The diagnosis, therefore, on its own does not really tell us much. ADLs will aid in determining at what stage the individual is in the disease development process. And, although from a clinical perspective the individual is felt to be the best indicator, he or she is still of questionable assistance in dealing with the practical aspects we are likely to see over time.

One of the main questions which arises is, will ADLs create frequent disputes between insureds and insurers? Will it be difficult to determine whether people can or cannot toilet or dress themselves? And if this happens on the individual side are we not going to see it having a dramatic impact on individual and group sales?

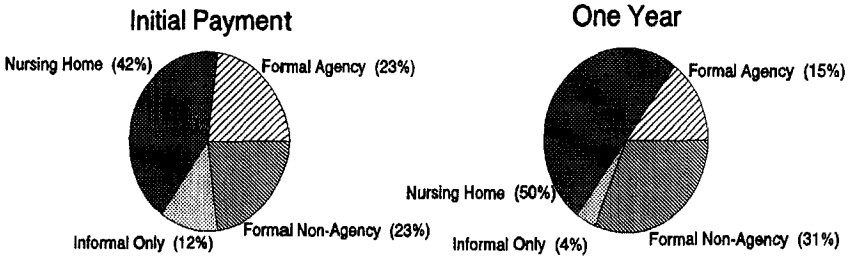
Another major question is, are ADL determinations defensible in a court of law? If not, I think we're going to find insurers left with programs with vastly expanded access to benefits and very little ability to control those benefits.

Unfortunately I don't have any pat answers to the above questions, but I can share with you some of Aetna's ideas and experiences which can be helpful in heading off, or minimizing, potential problems.

In 1985 when Aetna decided it was going to use an ADL approach, its objective was to broaden access to care, because that's what consumers were seeking. Aetna wanted broader access to care, while at the same time it wanted to make accurate, consistent, defensible claim determinations on a nationwide basis while continuing to control utilization. Unfortunately this approach can develop misunderstandings in the LTC population, especially if you are used to dealing with an acute care population involved in medical programs where you see very different characteristics. With the LTC population, you're measuring care in terms of months and years as opposed to days or weeks. You're looking at supervisory, supportive care instead of highly technical care. And the care providers are generally semiskilled or unskilled as opposed to skilled nurses, doctors, or therapists.

Chart 1 represents a graphic display of Aetna's long-term-care population in claim status for a year or more. "Formal nonagency" means the individual has not requested care from a specific agency.

CHART 1
Type of Care Received
(1 Year or More)



He or she contracted with a neighbor or a companion. What you will see over time is that half the population is still in the community after a year. The largest percent of the population receives supervisory care from companions, sitters, individuals they're paying, but who are not highly skilled or highly trained. Only 15% of the population receive services from an agency. And probably only 3% of those individuals receive "skilled care" from a nurse, occupational therapist, or physical therapist. As you can see, the care needs of the LTC population are significantly different from what is experienced under a medical program.

Based on these characteristics there needs to be established new and different ways of determining benefit eligibility, and also the protocols to accompany them. What we did by using ADLs was adapt a way of tracking people for months and years. Also as a way of making ongoing benefit determinations using a concept which has been in the public sector for the last 20 years known as case management. Case management for our purposes was defined as a formal process that involved linking eligibility determination, needs assessment, service coordination, and monitoring. You are likely to see many definitions of case management. Each means different things to different people. It is important to remember the two key elements to a successful case management program. These are the utilization of trained professionals in making claim determinations with the other being the use of a multilevel claim determination process.

Although I don't want to downplay the service component, I would like to first concentrate on eligibility determination. Basically in Aetna's program, you will see two components, one being the determining of eligibility, the other including care planning, monitoring, and on-site case management. All are important components in assisting the insured in maximizing their benefit dollars while keeping them in the community as long as possible.

I now would like to address what I see as the three key components to establishing benefit eligibility and what has to take place to determine if someone is functionally dependent or not.

The first involves reviewing medical documentation. This would include all information obtained by the case manager, nurse, or social worker. This point in the process is especially important since you can potentially adjudicate approximately 20 to 30%

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of your claims. As an example, consider an individual suffering a massive stroke. Given that the individual has to be tube fed, turned every few hours, and an eventual transition from a hospital stay to a nursing home is likely, you have a fairly clearcut claim decision. Unfortunately for about 60-70% of claimants, it is not that clearcut. It will generally involve a chronic, degenerative illness that does not involve a prior hospital stay. Determination will require a comprehensive case assessment, possibly involving the use of mental status testing to confirm the diagnosis. The benefit request form, which is used to obtain information from the claimant's primary physician, may not necessarily be relied upon. This may be the case since the physician will not fully grasp the patient's functional capacity. Your instincts would lead you to believe that physicians would overestimate the patient's dependency. What we found was just the opposite, physicians tended to underestimate the level of dependency. This, therefore, demands the use of professionals who are able to gather documentation and interpret the information to make clinical decisions. This can involve the analysis of hospital discharge summaries or any type of health-related data. Important also is input from the families. You must keep the families involved at all times.

The second component is on-site assessment. It is very important in an LTC program to have the capacity to actually see the individual firsthand. As an insurer, it is important to consider observed behaviors, the person's orientation and the impact of treatments and therapies. This will aid you in developing a comprehensive summary of the individual's overall level of functioning. Again I must stress the importance of including input from the families.

The final component is monitoring where it's important to have some mechanism in place to monitor this person for possible recovery. In general, when an individual claimant enters the LTC system, he or she becomes functionally dependent. The individual generally does it one time, and he or she is in it to stay. However we have found that today about 7 or 8% of our claimants do recover. The most common case is fractures where there's much more of a potential for the individual to recover. Here it is very important that you monitor on a regular basis. Generally those who do recover do go off benefits. Aetna's nurses and social workers or case managers follow-up with a person every other month, by a phone call, regardless of the diagnosis throughout the duration of the claim. If the situation remains unclear, we can fall back on the use of medical documentation and on-site assessments.

Aetna uses individuals in support companies to provide on-site assessments. We do not send nurses and social workers from Hartford, Connecticut to locations such as Los Angeles to do on-sites, but it is important to maintain internal control of the function. These providers do the assessment, but do not make the final decision. That should remain with the insurer. Your internal case manager would use the on-site assessment, combine it with all the medical documentation and then make a decision.

If all else failed (for example, we had collected all the information, performed an on-site assessment and still could not make an accurate determination), we would then use an independent medical exam. With the more than 230 claims we have experienced so far using ADLs, we have not as yet had to use this final step. We

have been able to make our decisions based solely on the information we have gathered and the on-site assessments.

I did want to mention just a little bit about Alzheimer's disease, since as Sharon has mentioned this is going to be the predominant diagnostic group you're going to see, constituting up to 40% of overall claim experience. In Aetna's four years of claim experience, it's accounted for about 25% of the total. We expect this number to increase, since what we have received to date are concentrated in the last couple of years. Another important illness to consider here is cancer and the fact that it constitutes about 20% of the initial diagnostic conditions.

When we look at people who are in claim status a year or more, we see that the number of dementia-related disorders is now running close to 35% of our experience. These individuals are going to constitute the longest duration claims and are going to represent the highest financial outlay. In an ADL environment, cancer claims will generally not exhibit the same characteristics. An individual who becomes functionally dependent with diagnosed cancer will usually enter and exit claim status quickly. The more ADLs impacted, the less likely the individual will survive to adversely impact your experience.

Of greatest concern is the inherent antiselection you will likely encounter in dealing with dementia in the underwriting process. The relative cost of LTC in the older age groups can lead families who sense impending difficulties due to memory loss, etc., to secure coverage as a safety valve. Although there is no firm diagnosis to rely upon, great care should be used in designing an underwriting program that will allow you to potentially uncover these cases through alternative means.

Once under coverage, the problem for the cognitively impaired is providing a meaningful benefit while controlling unintended liability. In our development work in 1985/86, we agonized over how to trigger a benefit for this population. We examined mental status testing, the possibility of looking at behaviors or incorporating ADLs. We felt for our unique disability-income-type benefit we had special concerns with developing benefit triggers which would hold up in a cash-benefit environment. For this reason, we felt ADLs were a more reliable determinant of the need for LTC services than the use of mental status testing. Cognitive dysfunction does not necessarily indicate a need for LTC services.

In Aetna's ADL approach, we attempted to build in flexibility to allow for alternative means of qualifying insureds for benefits. The use of ADLs in conjunction with the case manager's ability to analyze the relative impact of cognitive impairment allowed us to qualify insureds for benefit who would not normally fall within the parameters of the program. We feel this approach has served both Aetna and the insured population well. We found it very difficult to design a separate, distinct benefit trigger capable of clearly determining benefit eligibility for insureds exhibiting a combination of ADLs and cognitive impairment.

To date, given our more than 230 claims, we have only denied 15% due to an inadequate dependence under an ADL environment. You are, however, likely to see these "denials" reemerge under claim at a later date. We estimate that, if you reviewed these same cases over a period of time, the denial rate would be reduced to

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approximately 11%. So far, we have experienced only two appeals under our ADL approach. Much of this can be attributed to the expertise of the staff analyzing the information provided and a willingness to be flexible in interpreting the results obtained. Again, I would like to stress the usefulness of on-site assessments in qualifying borderline claimants.

As you can well imagine, this entire process is rather time-consuming. Initially, our turnaround time was about 45 days in adjudicating claims. So far, we have only been successful in reducing this by five days. The combination of obtaining sufficient medical documentation, conducting on-site visits, and soliciting paperwork from physicians lengthens the process.

I feel it is important to note that only a certain amount of objectivity can be developed in an ADL environment. This shortcoming further underlines the need for professionally trained staff to handle the subjective nature of the decision-making process. Even though Aetna is four years into the program, we still feel we are in the developmental stage. Although the process is developing credibility, we are still very much concerned with maintaining a program that provides meaningful benefits while simultaneously maintaining its objectivity.

MS. MARY ANN BROWN: Of your more than 230 claims, I would assume most of them are on the retirees in the group. How many retirees did you have insured?

MR. HANCOCK: It was roughly a 50/50 split. We have about 59,000 insureds, split 50/50 between actives and retirees.

MS. BROWN: Do you feel you may have a larger proportion of claimants involved in the more informal treatments than other companies may have because you do provide cash benefits?

MR. HANCOCK: Oh, definitely.

MS. FULKS: I have one other point to make. It is my hope that I will never again see a comparison of two products, one of which defines eligibility using two out of five ADLs, the other two out of six, in which reference is made to the two out of six being better since you only need to be 30% impaired instead of 40%. I hope that will not occur again.

