SOCIETY OF ACTUARIES

Article from:

Long Term Care Newsletter

October 2000 – Issue No. 3

Home Health Care Experience Analysis

by Bruce A. Stahl

We often hear that we have only experience for old policies with old benefit qualifications. While I am not going to challenge this premise, I am asserting that we do have usable experience for policies with more recent benefit qualifications than three day prior hospitalization.

Many companies began issuing three-fold benefit triggers around 1990 and 1991, and the exposure is not insignificant. BAS Actuarial Services had a group of clients that included a fairly sizable database of homogeneous stand-alone home health care benefits and underwriting. As of 1996, the data included more than 75,000 life years of exposure and more than 3,500 eligible claims.

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About the Data

The issue ages for more than 95% of the policies exceeded 64 and covered policy years of 1 through 7 (more with early durations; fewer with later durations). They all had relatively light underwriting (though some used underwriting classes to support it), with 90-95% of the applications being issued. The data did not include post-HIPPA policy forms, and the benefit qualifications allowed for medical necessity, cognitive impairment, and a normal deficiency in two of six ADL's. They did not require a certification of chronic disability.

As for benefits, 95% of them had no elimination period, and the remaining 5% had an elimination period of 30 days or fewer. This is important because the incidence rates could be understated for policy forms where users of care have shorter lengths of care, and are not recorded. Furthermore, the failure to identify the elimination period could overstate the continuance rates, as brief lengths of service may not be recorded.

Most of the data did not include case management, and the initial reporting time was longer than experienced today.

Overcoming Limitations in the Data

The database also had certain limitations that we needed to address. For example, we had to work with the initial date of service and then paid dates of claims. This required an adjustment to convert paid dates to service dates, which, without too much detail, we accomplished by measuring average times from the onset date to the first payment date, second payment date, etc.

A second example is the benefit period limitation. The data had benefit periods of 12-month intervals. We decided to analyze each month's probability of continuing to the next month, discounting the denominator for any claimants that would complete their benefit period that month.

Observations

We observed several significant items from our statistical analysis of the data.

First, we found that incidence rates were higher at the younger ages and lower at the older ages than most assume for home health care. It appears that the age incidence slope is flatter than that of nursing home stays. One possible explanation is that the medical necessity trigger drives up the younger age incidence, while the cognitive and activity deficiencies are more difficult to service at home when the insured is older.

Second, we observed a relatively short selection period for home health care. By the fourth policy year, the incidence rate was virtually the same as those of the fifth, sixth, and seventh policy years. Again, the medical necessity trigger could contribute to this, although

the light underwriting probably contributes more.

Finally, the average length of service was relatively short. It was five to six months, a sharp contrast to the 16-18 months for a nursing home confinement. The medical necessity trigger probably contributes short lengths of service that weigh the average differently. Yet it is probably also true that home health care recipients have a higher probability of entry into another form of care (i.e., a facility) than do those who have been confined. This can be true even for those only insured for home health benefits, as the informal caregiver may choose it despite the formal assistance received. Such a decision could include many factors, such as the sense of inability to provide adequate care and the desire to return to a more normal lifestyle.

This study was a start that we expect to improve or see others develop with enhanced procedures. In fact, following the completion of our study we found a study [1] of 1992 home health agency admissions (noninsured as well as insured) consisting of 2.6 million elderly. This study identified an average length of care equal to 7.4 months, a number which is much closer to our study than to nursing home confinements.

The BAS study may have had more weight from those qualifying by medical necessity, due to the higher weights of exposure in the early durations.

Application

Obviously, the results of the study will require adjustments to reflect differences in benefit qualifications, underwriting, and other contract provisions. Yet they offer a foundation for reasonable pricing assumptions and for projections of liabilities. This suggests that LTC insurers may find useful information from experience studies within four to seven years of rolling out a policy.

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Footnote

1) This is from *The Gerontologist,* Volume 39, Number 1, February, 1999.

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