



Long-Term Care News

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Managing Cognitive Claims: What's Next?

by Bruce Margolis

THE ISSUE

The dementias are a group of progressive degenerative brain disorders that, over time, impair an individual's cognitive abilities including memory, executive function and language, may result in significant behavioral changes and eventually impact one's functional capabilities. Though there are a number of dementia disorders, Alzheimer's Disease (AD) is the most common, accounting for 50 to 70 percent of all cases of dementia.

As a dementing disorder progresses, those affected become more dependent, requiring increasing personal care. Initially, family and friends may provide such care, but the need for professional caregivers and eventual facility placement is, in many cases, inevitable.

It is estimated that some 5.1 million people in the United States have AD, with an economic impact of some \$148 billion annually. If by 2050

there is no effective treatment, the number affected may triple.¹

THE IMPACT

To anyone in the long-term care (LTC) insurance business, the industry impact of cognitive claims is old news. The most recent report of the Society of Actuaries Long-Term Care Experience Committee Intercompany Study 1998-2004² includes a number of observations regarding cognitive claims. According to the study, AD claims accounted for 27 percent of nursing home and 17 percent of home care claims of the reporting companies.

In both instances, AD was the number one reported reason for claim. Nursing home claims for AD had the highest number of average days on claim (659 days) and the second highest average cost per day (\$89/day) exceeded only by other nervous system claims.

A Funny Thing Happened

ON THE WAY TO THE CLAIM FORUM

by Brad S. Linder



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Quite a few folks know that I really enjoy discussing the different perspectives in the general topic of LTC claims. I credit that pleasure to the people I've met through the years who are so passionate about our LTC industry. No, it's not just the folks dealing with claims on a daily basis; it includes members from all the special interest tracks. So it's not too far of a leap to offer our readers an issue of the LTC newsletter themed on claim perspectives.

I include articles on claim reserves, claimant perspectives, independent providers and caregiver perspectives. There's one on managing cognitive claims! And, to break the boundaries of what oftentimes appears in Section newsletters, I include two abstracts. They are brief, but are included to alert our readers to topics and presentations appearing on the forefronts of research. Also, our readers should know that there are some important LTC sessions that will appear at the upcoming Society of Actuaries (SOA) Annual Meeting this October. As you can see from the article in this issue, there are a number of hot topics appearing this fall.

Additionally, please know that the LTCI Section Council has decided to conduct our Section's first member satisfaction survey this fall. In addition to getting your feedback regarding the value of current Section activities and forums in furthering your professional development, the Council also wants your input on new ways to enhance the value of Section membership. This on-line survey should only take 5 to 10 minutes to complete and will be released in October, so please keep an eye out for it. Your input would be greatly appreciated.

I listened, I learned, I encourage our readers to do the same. I know you'll enjoy these articles. Please join me in thanking each of our esteemed authors! ■

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Though not quite as striking, the impact of AD on home care claims remained quite significant. AD had the third highest average number of visits per claim at 231, exceeded by stroke and nervous system disorders. AD accounted for the third highest average cost per visit at \$106. When considering all claims by diagnosis, AD was the number one cause of claim (24 percent) with the highest average number of day/visits per claim (558) and the highest average cost per day/visit (\$106). This translates into an average claims cost for AD of \$59,100, the most costly claim.

In 2006, Genworth Financial reported that nearly 40 cents of every dollar paid to caregivers was related to a dementia claim.³ The report goes on to state, “between 1993 and 2003, Genworth has seen an increase in the frequency of cognitive claims of 35 percent.” During the same period, the annual amount paid for cognitive claims increased 12-fold.

From a family perspective, caring for a loved one with dementia has enormous psychosocial, physical and economic impacts. The majority of individuals stricken with dementia are cared for at home by family and friends. A 2004 report from the Alzheimer’s Association and National Alliance for Caregiving⁴ found that almost one in four AD caregivers spend 40 hours or more per week as a caregiver and the majority also work at least part-time. Over 70 percent of these caregivers provide care for over a year and 32 percent for five years or more. Many of those who do work either cut back their employment hours, quit work, turn down a promotion or lose benefits. Vacations and social activities are also frequently sacrificed.

In addition, there is a significant physical toll paid by caregivers. The report goes on to note that 30 percent of caregivers get less exercise, and 40 percent report high levels of stress. Twenty percent of caregivers describe themselves as in either fair or poor health and 18 percent note that caregiving has worsened their health.

In 2006, the MetLife Mature Market Institute published a study comparing AD caregivers with caregivers for physically impaired individuals.⁵ The report concluded that AD patients needed more care, had more ADL/IADL limitations and had a higher cost of care than physically impaired individuals. In addition, AD caregivers suffered

a greater degree of stress than a caregiver of a physically impaired individual.

A study published in the *New England Journal of Medicine* in 2003⁶ evaluated 217 family caregivers during the last year of a patient’s life. Half reported spending over 45 hours per week assisting with ADL/IADLs and more than half reported that they felt on duty 24 hours/day. Two-thirds of these caregivers either reduced their hours worked outside the home or stopped working altogether. Many had high levels of depressive symptoms, and 72 percent actually felt relieved after the patient’s death.

Hiring paid caregivers or moving a loved one to a facility has even greater financial impact. The average hourly rate for home health aid services obtained through a certified home care agency is now over \$32.⁷ The rate for services provided by a licensed but not certified provider is over \$18/hour. The reported national average annual cost of an assisted living facility is over \$32,000 with the average annual cost of a nursing home reaching almost \$75,000.

In summary, dementing disorders have a tremendous impact on government, long-term care carriers, families and individuals, and the prospect that this will change any time soon is quite small.

THE CURRENT LTC INSURANCE PARADIGM

Though long-term care policies and company procedures may vary, there are some common threads in the current approach to adjudicating and managing cognitive claims. Typically, when a claim is filed with an LTC carrier, pieces of information are gathered in order to determine benefit eligibility as defined in the insured’s contract. Such information may include face-to-face assessments including cognitive screening tests, attending physician statements and/or medical records from primary care providers and specialists as needed.

Should an individual residing at home or in an assisted living facility be determined as benefit eligible, a plan of care is created outlining the type and intensity of services needed. Such services may include personal care and homemaker/chore services. Depending on the policy and company, recommendations for community services such as



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adult day care, transportation services and home delivered meals may be included in the plan of care. Policies with equipment benefits may cover such items as emergency call devices and personal monitoring devices. Many policies also offer caregiver training to a limited degree as well as respite benefits. Insurers may point families to local organizations for information and support.

As most LTC contracts sold today are reimbursement policies, the insured (often through his power of attorney) will be reimbursed for expenses incurred. This passive paradigm places the burden of primary management of the insured with dementia on the immediate family to arrange and monitor the care of their loved one with, in most instances, little knowledge or readiness to do so.

ON THE HORIZON

Unfortunately, once an individual is in the latter stages of dementia requiring facility placement, there is little a carrier can do to impact a cognitive claim. However, working more closely with an insured's family during the early stages of dementia may be of benefit for both the insured and the carrier. For example, as noted above, one of the most difficult aspects of caring for a cognitively impaired patient is the effect on the caregivers themselves. Though some policies do provide for caregiver training, more intensive caregiver training and follow up may be more effective.

A study published in the journal *Neurology* in 2006 found that a program of individual and family counseling along with support group participation and the availability of a telephone hotline resulted in a 28 percent reduction in the rate of nursing home placement during the study.⁸ This translated into a predicted delay in nursing home placement of 557 days when compared to the non-trained group. In addition, those who went through the program had better satisfaction and lower levels of depressive symptoms.

Though there are several medications available today for AD, their effectiveness is modest at best. The available drugs belong to one of two general classes of agents: cholinesterase inhibitors or glutamine receptor modulators. Cholinesterase inhibitors have been shown to delay cognitive decline in some AD individuals, but do not alter the ultimate course of the disease. In one study, donepezil (Aricept[®]) was shown to delay nursing home placement over one year.⁹ Such a delay in facility

placement could help a family conserve benefit utilization where the benefit pool is limited.

Looking forward, however, there is a lot of optimism that disease-modifying treatments for AD may be available within the next several years. There are several drugs in Phase III trials. The results of the Phase III studies released last year on one drug, tramiprosate (Alzhemed[®]), were disappointing; however the neuroscience community is hoping that the results of the Phase III trials on tarenflurbil (Flurizan[®]), which are expected to be released in July 2008, turn out more favorably. Tarenflurbil is a secretase inhibitor that is designed to lower production of A β , a protein felt to be integral to the pathology of AD. In addition, research on a vaccine continues and despite earlier setbacks, this concept still holds promise as an AD treatment.

Any drug or treatment that can alter the course of AD, slow the decline in cognition or delay facility placement has the potential for tremendous social and economic impact. The potential positive economic impact is quite broad reaching, not only for those affected by AD, but families, caregivers, governments and insurers. This impact is explored further in the next section, "The Potential Impact of Change."

There is an increasing body of research literature demonstrating that brain exercise can improve cognitive function. Research from the ACTIVE Study Group (Advanced Cognitive Training for Independent and Vital Elderly) has demonstrated that memory, reasoning and speed of processing training can have sustained positive effects as measured by improved cognitive abilities and less decline in IADLs.^{10,11} The big question for insurers, however is: Can cognitive training have an impact on individuals with mild cognitive impairment or even early AD? In a pilot study by Barnes et al., the use of a computer-based cognitive training program appeared to have some positive effect on learning and memory.¹² Similar trials are looking at the potential effects of cognitive training for those with early, mild dementia.

Another exciting field of research is home monitoring. When given the choice, most people with functional or even early cognitive impairments would prefer to remain at home. Issues surrounding medication management and home safety are foremost for those with early dementia. A number of devices are now available that

There is an increasing body of research literature demonstrating that brain exercise can improve cognitive function.

CONTINUED ON PAGE 6

can monitor medication use, track individual movements throughout the home and even detect an abnormal rise in temperature that, for example, could suggest a stove has been left on. Coupling such sensor technology coupled with computer-based analysis and transmission to a central monitoring station can serve to alert loved ones residing a distance away or at work of a potentially dangerous situation.

In a small study by Alwan et al., the use of such devices for a group of elderly assisted living dwellers resulted in a significant reduction in hospital days and the cost of caregivers.¹³ Whether such monitoring can be of value in those affected by dementia is yet to be determined. However, a small study utilizing televideo monitoring was shown to maintain the compliance of self-administration of medication in people with mild dementia where those that did not have the monitoring demonstrated a decline in medication compliance.¹⁴

THE POTENTIAL IMPACT OF CHANGE

So what can slowing the onset or progression of AD mean to the long-term care insurance industry? In a report prepared by the Lewin Group for the Alzheimer's Association in 2004, it was estimated that if a medication was available by 2010 that could delay the median age of onset of AD by 6-7 years along with a significant slowing of the progression of the disease, Medicare spending could be reduced \$51 billion by 2015 and \$126 billion by 2025 and that Medicaid spending on nursing care would be cut by \$10 billion and \$23 billion during the same years.¹⁵ These cost reductions represent savings from 27 to 60 percent. How such savings would translate into long-term care costs savings for insurers is uncertain, but even a fraction of these reductions could have a tremendous positive financial impact.

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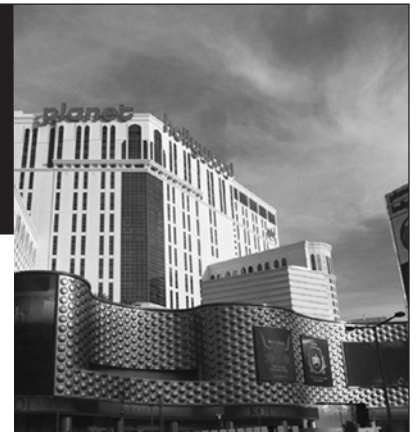
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THE NEXT LTC INSURANCE PARADIGM

Though many of the previously noted advances in dementia care are still on the horizon, some are available today. Examples include more intensive caregiver training and family support and basic medication/home monitoring devices. What role brain exercise/training programs can play in delaying the progression of early dementia remains to be seen. And the medical community remains optimistic that an effective disease modifying treatment for AD will reach the consumer market early in the next decade.

Insurers need to be following these advances, evaluating them and determining the cost-benefit of each new product. Changing the paradigm and process of claims management is not easy and significant up-front investment may be needed in order to implement such change, but the potential payoffs are very high. Insurers need to consider

what products and services may be worth supporting and even worth imbedding in their contracts.

One can envision the day when an individual with mild to moderate dementia can remain at home, taking their disease modifying drug, monitored for safety and medication compliance, spending part of her/his day on a computer exercising their brain and is cared for by family and friends who are able to keep their jobs while maintaining their physical, emotional and social well-being. Perhaps this is still a dream, but all indications are that this reality is not far away. ■

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Claim Reserve Model

HOW ACTUARIES RELY UPON THE CLAIM DATA THEY RECEIVE

by Bruce Stahl



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The last two newsletters included articles on claim reserves, specifically in regard to retrospective testing. In this context, it may be worthwhile to consider how actuaries rely upon the claim data they receive for calculating LTCI claim reserves.

CONTINUANCE TABLES

Sometimes actuaries can develop continuance tables with precision, using historical experience. Yet despite the quality of the tables, they may not apply them to consistent data.

Actuaries generally apply the continuance tables to claims that are known to be open at the valuation date. A relatively simple, fictitious, non-LTC illustration provides an example: Suppose that anyone who goes on claim may receive a total of \$100. Sixty percent of claimants will receive \$50 immediately and would receive the remaining \$50 after surviving a year. The other 40 percent of claimants will receive \$30 immediately and would receive the remaining \$70 after surviving a year. Yet only 25 percent of both groups are expected to survive six months, and only 10 percent are expected to survive a year. Then, suppose that on January 1, 500 people enter claim status—exactly 300 from the first group and 200 from the second. The payment to them totals \$21,000 ($300 \times \$50 + 200 \times \30). The expected second payment, based on our knowledge on January 1, is \$2,900 ($300 \times .10 \times \$50 + 200 \times .10 \times \70). The expected amount to be paid on January 1 of the following year does not change on midnight, June 30 if 125 people have survived (with 75 from one group and 50 from the other). But actuaries try to take advantage of additional information. If the number of survivors through six months is actually 80 from the first group and 45 from the second, the expected payment on January 1 will be revised. Instead of \$2,900, the expected payout is only \$2,860 ($80 \times .10/.25 \times \$50 + 45 \times .10/.25 \times \70).

Now let's turn to an example for long-term care. Let's say that the continuance pattern anticipates 50 percent reaching the fifth month,

and that of those who reach the fourth month, 92 percent reach the fifth month of disability. Assume 100 claimants began disability on January 1, and that 54 persisted through April 30. It is known that services were still rendered on May 31 for 50 of these 54. Fifty is precisely the number that was expected as of January 1 for May 31.

Now, instead of all last service dates being on May 31, assume that they are evenly distributed through the month of May. The number of open claims is now 52 instead of 50, so we assume that two more will close by May 31, by applying a formula that recognizes the probability that claims would have closed between the latest service date and May 31. Such formulas often reduce the reserves by approximately 4 percent on all 52 open claims, to estimate the full value of the reserves for the two extra claims.

Yet the many variables associated with claims administration usually cause distortions. Information about dates of loss (incurred dates), dates of service and paid dates is known accurately when the actuaries derive the continuance tables, but not when they apply those continuance tables. Actuaries usually use historical experience that is reasonably final when developing the tables, but they apply them to ongoing claims where the dates are not as well-identified for setting reserves. Benefit administrators are not usually able to accurately identify all of the information for an open claim file. For example, a care provider may have submitted the expenses for services that he already performed from May 19 to May 25, yet the latest payment was only for services through May 18. The administrator may not have paid the benefits for one week because he did not receive all of the information that was needed to verify payment. If this is the case, someone in the company may already know that services were provided. However the actuaries did not know this, as the May 25 date was not recorded in the system that generates the file that they use in the reserve calculation. In this case the reserve is reduced to accommodate the probability of claim termination from May 18 to

May 31, when in fact it is more accurate to reflect only the probability from May 25 to May 31. If this happens for a significant number of claims, the reserve calculation may be understated.

Sometimes administrators try to help by attempting to be as up-to-date as possible with the claim status. They may unintentionally create a stronger bias, as the information may be easier to update on certain classes of people. For example, it may be easier to close a claim for death or recovery than to update a surviving claimant's actual service dates and expenses. If the concluded claims are more up-to-date than the surviving claims, too many people contributing to shorter claims are removed from the population and the otherwise good continuance probabilities become biased toward understating the reserve.

Another example of a bias-generating practice is when administrators close claims upon hearing that a claim has terminated (either by death or recovery), without waiting for the last set of expenses to be submitted. Such claims may not make it to the open claim file, thus creating a twofold bias: first, a reserve may not be set up for their final payment; and second, these claims represent the claimants that are about to terminate, again causing the otherwise good continuance curve to be biased toward an understatement. If they had been on the open file, they would have generated reserves that were much higher than what was actually needed for them individually. This is appropriate because the others that actually made it to the open claim list are more apt to have reserves that are understated. With all claims remaining open, the average would be right. However in this case, the open claim list artificially removes the short claims and the overall reserve is understated.

When the benefit administrators have a practice of closing out claims early, it is important to make adjustments to the claim reserves for the closed claims. It is also important to make adjustments to the reserves of the remaining claims in order to address the bias in the continuance pattern that is created by the process.

To avoid a bias from administration processes, the actuaries may theoretically keep every claim open that has ever been open. In this case they need to set the last service date to the date of loss (incurred date), and then identify the expected remaining payout as of the valuation date. This should work if the continuance tables accurately reflect the claim population. To be clear, the reserve needs to be adjusted for interest from the incurred date to the valuation date. It also needs to have the anticipated claims from the true last service date to the valuation date added. If the average lag from the true last service date to valuation date is not long, the dollar value can be approximated reasonably by multiplying the number of days lagged by the average dollars paid per day in a recent period. A small adjustment may be appropriate to recognize that some of the claims would not have lasted through the entire lag period.

Many actuaries and company executives may find this approach unacceptable because they will not think they are using all of the available information, yet the method may be a way to test the reasonableness of the disabled lives reserve that is derived using the normal method.

PAID AMOUNTS

Identifying the continuance tables is only one component in the calculation of the known disabled lives reserve. Unless the benefit is an indemnity, the actuaries also need to estimate how much will be paid on each claimant. The variables that determine the paid amount are numerous and, while this list is probably not exhaustive, paid amounts will likely vary according to: diagnosis; time since the onset of disability; size of the daily maximum; whether inflation is included; whether the claimant has incentive to



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preserve some of his lifetime maximum for the future; sex; type of care provider; region; age; whether a spouse is alive and is healthy; and the reason the claim qualified for benefits.

The actuaries depend upon accurate reporting of the listed items. Some of the listed items are identified in the in-force policyholder file, yet others change through the course of time. From the list above, the items that may change are the type of provider, the region and whether the spouse is healthy. Accuracy in recording of these items in the claim file may have a material impact on the size of the reserve.

INCURRED BUT NOT REPORTED (IBNR) RESERVES

Just as claim reserves for known claims depend on how the information is reported, so IBNR estimates may depend on how claims are counted and reported. For background, some actuaries include pending claims (open claims without any payments) in the IBNR while others apply continuance tables to the pending claims along with a probability that they will be eligible claims. The latter develop a pure IBNR.

Some actuaries identify IBNR counts using completion factors. If they are seeking a pure IBNR, they derive the IBNR counts from claim triangles using counts by incurred dates and report dates. If they are including pending claims in IBNR, they derive them from claim triangles using counts by incurred dates and first payment dates. In either case, consistency of counting claims is important. If the administrators alter their

procedure for entering a claim on the system, or if they alter the rules for closing pending claims, the counts in the triangles can be inconsistent and the completion counts can be distorted.

The nature of the exposure should help to identify the expected claim incidence as a reasonableness test for the calculated IBNR. If the exposure has reached a steady state, the new claim counts (including IBNR) ought to remain fairly level relative to the exposure. If the exposure has an increasing percentage of new business, the new claim counts will normally be declining relative to the exposure, and if the exposure has a declining percentage of new business, the new claim counts will normally be increasing relative to the exposure. This concept can be fine-tuned by segmenting the exposure and the new claim counts by factors such as, but not limited to, policy duration, age and sex.

Seasonality may also be a factor in completing claim counts, so the actuaries need to account for it in calculating the IBNR count.

Usually, more judgment is needed to estimate IBNR than to derive reserves for known claims. The estimate of the IBNR reserve usually depends upon recent developments in the exposed population. Therefore, the range of values will likely be relatively wide compared to the reserve on known claims. Yet the relatively large range for IBNR will usually be relatively small for the entire reserve. Assume the IBNR ranges from 9 percent to 11 percent of the total claim reserve. The 20 percent range on an expected IBNR of 10 percent is only a 2 percent range on the total claim reserve. ■

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SESSION 73 | Tuesday, October 21 | 10:30 a.m. – Noon

Preparing for PBA and Stochastic Modeling

SPONSORED BY THE LONG-TERM CARE INSURANCE SECTION

Stochastic long-term care insurance models being developed for principle-based reserve purposes incorporate complex stochastic approaches. This session will discuss those approaches including how interaction effects of mortality, lapse and claim incidence are handled.

SESSION 52 | Tuesday, October 21 | 8:30 – 10:00 a.m.

LTC Claims Management of the Future

SPONSORED BY THE LONG-TERM CARE INSURANCE SECTION

Learn more about the emerging trends in claims intervention and how future changes in the delivery of care and services for LTC claimants will alter claims management.

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Care for the Caregivers

MEMORY CARE HOME SOLUTIONS TEAMS WITH WASHINGTON UNIVERSITY TO EVALUATE UNIQUE CAREGIVER INTERVENTION PROGRAM

by Lisa Baron

Lisa Baron, JD, is the executive director of Memory Care Home Solutions. She can be reached at lbaron@memorycarehs.org.

[Editor's Note: This article is reprinted with permission from the St. Louis Metropolitan Medicine magazine, Volume 29, Number 5, September/October 2007. Many thanks to the publishers and to Lisa Baron, JD, the executive director of Memory Care Home Solutions and author of this article.]

A day does not go by when I'm not forced to advise a family about the difficult decision of placing a patient in a skilled care community. Daily, I make rounds and counsel children who don't know where to turn in an effort to effectively care for their parents at home. My staff is inundated with questions from overwhelmed caregivers about the disease of Alzheimer's and what assistance can they turn to in the community. As the caregiver experiences the impact of the stress on their system, often caregivers become my patient as well.

I've often wondered: Is there a social service out there to help these families at home deal with the 24/7 challenges of dementia care? There is. Memory Care Home Solutions (Memory Care) exists to extend and improve time at home for families who are caring for a loved one with dementia. Their in-home caregiver training and geriatric phone service assistance can help our patients, our staff and the individual struggling to retain abilities. Mostly, though, Memory Care helps stressed out and overwhelmed caregivers. There is no charge for families in need.

UNIQUE INTERVENTION

Family members who care for people with dementia need a wide range of support services to help them do the important work of caregiving at home. Memory Care, a St. Louis-based non-profit organization, provides comprehensive, in-home dementia caregiver training. Through the Customized Caregiver Training & In-home Consultation Program, a 12-month intervention combining personalized caregiver trainings and family conferences, Memory Care teaches families behavioral and environmental strategies

to increase quality of life at home. A strategy report sent to each family caregiver trained identifies all community resources available to assist the family. Washington University, Department of Psychology, is working in association with Memory Care tracking all outcomes related to reduction of caregiver stress and reduction of health care costs as a result of the Customized Caregiver Training & In-home Consultation Program.

"We want to keep the patients in a home environment as long as possible. The idea that an organization like Memory Care Home Solutions can expedite effective services for a patient with Alzheimer's disease and their caregiver is most exciting. It will provide a better environment for patients and also will save money because hospitalization and skilled nursing facilities are expensive and facilities are taxed in terms of the increasing number of patients. Lisa Baron [executive director] is an amazing young woman and she has organized this and is moving it along very nicely. It's a terrific organization," says Memory Care Advisory Council member Dr. William Peck, director of the Center for Health Policy at Washington University and former dean, Washington University, School of Medicine.

DEMOGRAPHICS

Alzheimer's disease and related dementias are progressive conditions that affect an estimated 4.5 million Americans (Alzheimer's Association, 2006). As these conditions advance, people afflicted with them need more and more direct supervision and care, as cognitive impairments worsen. The majority of care for people with dementia is provided by family members. Indeed, of 150,000 Missouri residents with Alzheimer's disease, 75 percent remain at home with family caregivers. Research suggests that the home will continue to be the primary site of dementia caregiving for years to come.

Most caregivers want to keep their family member with dementia at home for as long as

**I've often wondered:
Is there a social service out there to help these families at home deal with the 24/7 challenges of dementia care?**

possible.¹ Home-based care has numerous advantages, including the ready accessibility of caregivers who are familiar to the care recipient and a familiar physical environment. Moreover, from a health policy perspective, delaying institutionalization reduces overall medical costs.²

Unfortunately, while home-based care may be beneficial, it is associated with added responsibility and stress for untrained caregivers (usually family members).

CASE STUDY

When her husband Ed was diagnosed with Alzheimer's disease, Fern was immediately overwhelmed by feelings of shock, confusion and, above all, helplessness.

"My heart was pounding, and it was difficult to breathe," she remembers. "We left [the doctor's] office and sat in the waiting room, thinking that someone would come to tell us what to do next. But no one came."

Fern eventually sought help from Memory Care Home Solutions. Memory Care conducted an extensive evaluation of Fern and Ed's home environment and offered a comprehensive strategy for improving communication between the couple, reducing physical risks to Ed and improving Fern's confidence as a caregiver.

As Memory Care's executive director, Lisa Baron, explains, "The condition of the caregiver is often overlooked in cases of Alzheimer's or dementia. But as the population of the memory impaired grows, more and more people are left feeling overwhelmed and unprepared for the enormous demands of caring for their loved ones with dementia."

INTERVENTION

The active phase of the 12-month intervention begins with an initial home visit in month one, conducted by a Memory Care program coordinator. This visit lasts approximately two hours.

With a semi-structured interview, self-report questionnaires and a walk-through of the home, the program coordinator gathers extensive information about the caregiver and care recipient in their home environment. After the initial home visit, the program coordinator reviews the assessment information and develops an individualized, comprehensive strategy report that identifies the caregiver's strengths, outlines recommendations and strategies to address difficult issues and recommends appropriate community resources. This comprehensive, written report is mailed to the caregiver, and the program coordinator contacts social service agencies recommended to facilitate referrals. The program coordinator then follows up by phone with the caregiver to discuss the results of the assessment and the strategy report.

The overarching goals of the home visit and phone contacts are to:

1. provide education about dementia and cognitive impairments;
2. teach an environmental approach to managing behavioral problems;
3. assess the home environment and suggest modifications to optimize functioning;
4. practice effective communication skills;
5. instruct and implement ways to involve the person with dementia in self-care and other activities of daily living;
6. instruct the caregiver about how to employ assistive devices and where and how to purchase medical equipment; and
7. reduce caregiver stress.

Throughout this phase, the program coordinator is available by phone and e-mail if the caregiver has additional questions.

CONTINUED ON PAGE 14



Numerous studies have documented negative physical and psychosocial consequences of caregiving, including depression, reduced well-being and life-satisfaction, poor physical health and fatigue.

The maintenance phase of the intervention begins with a family care call placed by a Memory Care care coordinator in month three (three months after the initial home visit). In month six, the program coordinator conducts a follow-up home visit with all caregivers to gather comparison data to the baseline data originally collected. Family conference calls occur in three-month intervals after the second home visit through month 12 of the program tracking the following variables: caregiver self-efficacy, usage of health care services and costs they incur, caregiver and care recipient's medication usage and costs incurred and home environment impairments.

WASHINGTON UNIVERSITY ASSOCIATION

Seeking an objective and clinically viable evaluation of its services to caregivers like Fern, Memory Care is currently collaborating with a research team from Washington University's Department of Psychology. Headed by Assistant Professor of Psychology Dr. Brian Carpenter, the team is in the process of collecting and analyzing a wide range of data pertaining to caregivers' financial expenses, emotional and psychological well-being and overall success in putting Memory Care's home-centered strategies into practice. Dr. Carpenter's team will publish the findings from its IRB-approved research in a study to be released in 2008.

"We're enthusiastic about handling these aspects of the research," says Dr. Carpenter. "The medical community stands to gain from an objective, empirically verified study on these specific services to caregivers. It's not just Memory Care that will benefit from the study, but the increasing population of lay and professional caregivers as well."

Along with the hoped-for endorsement of the medical and academic establishments will be the testimonials of caregivers like Fern. "I am now a

more confident caregiver and feel less stressed on a daily basis," she shares. "It is comforting to know Memory Care cares for me, the caregiver, at this time of great need. This is simply priceless."

Numerous studies have documented negative physical and psychosocial consequences of caregiving, including depression, reduced well-being and life-satisfaction, poor physical health and fatigue.^{3,4} Furthermore, caregivers who are overwhelmed and under-supported are likely to turn to nursing home placement at higher rates and earlier in the course of dementia.⁵

Your knowledge and referral to this program will assist your staff, your patients and the efficiency of health care systems in general. The society is supportive of cutting edge community resources for important health care issues including the burgeoning population of overwhelmed caregivers of those with dementia. Memory Care offers a cutting edge program which serves as a national model and one the society is proud to support. ■

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LTC Newsletter Publication Schedule

Publications Month: December
Articles Due: September 24

Long-Term Care Claimants

TELL THEIR STORIES

by Joan Welch with Jan McFarland

When people think about needing long-term care, they often see a life without any possibilities. Fortunately, in many cases, that assumption could not be further from the truth. One thing that I've learned as a care coordinator is that long-term care situations can be successfully managed.

The claimants I speak with every day lead very full lives, thanks, in part, to the group long-term care insurance offered by their employers. Three in particular come to mind as examples of individuals who have made the most of their coverage in terms of using it through intelligent and conservative benefit utilization.

Kathy is 44 years old and needs long-term care as the result of an automobile accident. Having long-term care insurance has enabled Kathy to receive the level of care she needs at home to protect her family members from the potential burden of caregiving, since she does not need to depend on them to assist her with some of her more personal tasks.

Bill is also 44 years old, having become quadriplegic following a diving accident. Aside from the obvious financial advantages of having insurance to pay his long-term care expenses, Bill has been pleased with the support he receives from the care coordination program. It has been able to assist him in finding the help he needs so that he can continue to work full time, without unnecessary distractions.

Diane has been a long-time claimant and acknowledges that the insurance has made "a profound difference" in her life. She has managed her benefits conservatively, using them to supplement help received from friends and family. As a result, Diane's five-year lifetime maximum benefit, which is a pool of money, rather than a fixed time period, has lasted 14 years.

Looking to the future, all three individuals maintain a very positive outlook. Kathy is still working at the company that first offered the long-term care insurance. Her focus is to continue the exercise program she has undertaken so that she can stay as healthy as possible and even works out on a special bicycle for an hour a day, five days a

week. She describes the coverage as a "real blessing." She hopes that there may come a time when she can decrease the long-term care services she uses and maybe not need them at all.

Bill is also working full-time and lives in his own home, with the help of caregivers that help him prepare for work in the morning and lend him a hand getting ready for bed in the evening. He sees the quality of his life being much better than it would have been if circumstances had forced him into applying for Social Security disability. Long-term care insurance has supported his desire to remain a "contributing member of society" by helping him avoid dependence on the government program. One of Bill's goals is to make his benefits last as long as possible, so he is taking advantage of the discounted provider rates that he can access through the coverage.

Today, Diane is the busy mother of two young children. Her long-term care insurance has even enabled her to take family vacations, by paying for an aide to help with her care on trips to Wisconsin, Florida and even the Virgin Islands. She anticipates that her benefits will run out at some point next year. Even so, she retains her optimism and has already made contingent plans for her care, once the coverage is exhausted. When asked what she would say to employees considering the coverage, she says, "Young people don't think about long term care at all—until they need it" and thinks that more employers should offer the benefit.

The individuals who shared their stories are truly remarkable. Each one has overcome the challenges of living with long-term care and all three appreciate the access they had to long-term care insurance. All three are upbeat people who have refused to let their circumstances define them.

Kathy, Bill and Diane have used their group long-term care insurance benefits to help them continue to lead productive lives. The coverage has lifted much of the financial burden from their shoulders and decreased their dependence on loved ones. Anyone who questions the value of long-term care insurance should spend time with a claimant—it is the best way I know to see the difference this coverage can make in a person's life. ■

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Independent Providers

A CHALLENGE IN LONG-TERM CARE CLAIMS MANAGEMENT

by Angie Forsell

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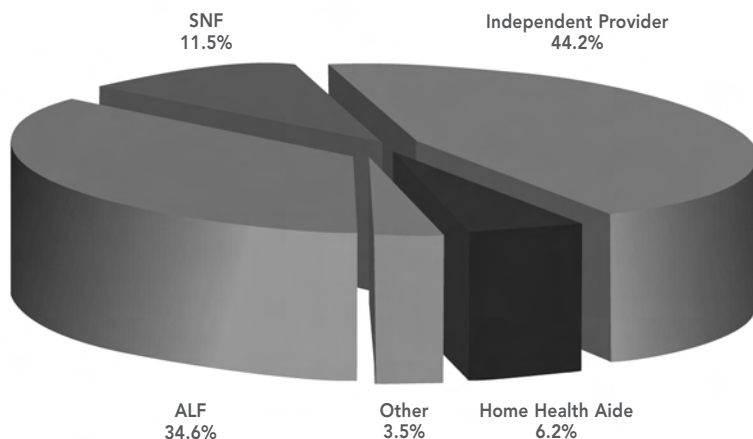
Growing in popularity, coverage of Independent Provider services under long-term care insurance plans providing home health care benefits presents unique challenges—from product design to claims practices. For claimants in remote areas for whom home health care agencies are not available, for those with unique needs for whom continuity of care by a single individual is important, for others with limited benefits and a need to carefully control out-of-pocket expenses, the ability to receive eligible care from an Independent Provider can mean the difference between remaining at home or transitioning to a nursing home setting.

An Independent Provider, or an IP, is a person hired directly by the claimant or family to provide home care services. The IP is typically not licensed or certified, often has no formal training to provide personal care services and is employed by the claimant, not the insurance company. Because they are employed directly by claimants and their families, their hourly rates are usually lower than those charged by agencies providing primarily custodial care services. A cost-effective IP can save

claimants considerable money, through minimizing out-of-pocket expenses or by helping to extend limited LTCI benefits. If claimants' needs are such that they do not incur expenses that meet or exceed their maximum daily benefits, the use of an IP may be cost-effective for the carrier, as well.

Long-term care insurance plans that cover the services of IPs have usually placed a wide range of conditions on that coverage. Some cover IPs only under Alternate Plans of Care provisions, subject to the carrier's approval. Others, some because of state mandate, impose no requirements on the IP's training or experience. Still others will cover the services of an IP, but only if they are reasonably satisfied that the individual has been adequately trained and/or has sufficient related experience to ensure that safe and effective care can be provided. Most, but not all, exclude coverage of services by family members, whether as IPs or otherwise. All plans providing benefits on an expense-incurred basis, however, have in common a requirement that claimants provide documentation to substantiate that services have been provided and expenses incurred and paid for the care by an IP.

Paid Claim Months



IP COVERAGE IS EXTREMELY POPULAR

Under comprehensive long-term care plans that provide IP coverage, as many as 45 percent of all claims and as much as 60 to 80 percent of home health care benefits can be for IP care. The following information comes from Long Term Care Group's claims database for one of its largest administrative clients, and illustrates how paid claims were distributed during an average month in 2007. This comprehensive LTCI plan provides IP coverage under its Alternate Plan of Care provision.

The reasons for the popularity of IPs are clear:

- Hourly rates may be as much as 30 to 50 percent lower than for agencies.
- Daily or monthly benefit amounts go further.
- Claimants can choose friends or neighbors to provide care.¹

CONFIRMING PROOF OF LOSS CAN BE DIFFICULT

When benefits are provided on an expense incurred basis, the claimant must present documentation to confirm that the expense has been incurred and paid or, in the case of an assigned benefit, that a charge has been made and assignment has been accepted by the caregiver.

- In the absence of an assignment of benefits, requiring that claimants provide carriers with cancelled checks or other bank-produced proof that a caregiver has been paid for his services is an effective means of ensuring that care has not been provided in trade (e.g., room and board in exchange for care) and that the expense has not been inflated by the claimant beyond the amount actually paid to the caregiver.
- Assignment of benefits has a powerful sentinel effect. The understanding by both claimants and their caregivers that directly paid caregivers will receive a 1099 tax form at year's end has proven to minimize problems with inaccurate reporting of time/expense by claimants and families and helps to ensure that caregivers understand their role in accurately documenting the care they provide and the charges they make for that care. Since the use of an IP puts a claimant into the role of employer, using assignment simplifies the process considerably.

THE INCIDENCE OF FRAUD AND ABUSE IS HIGHER THAN FOR CARE BY LICENSED CAREGIVERS

Unfortunately, fraud may be committed by claimants, by the providers or by the family members overseeing the care and managing the claim. Fraudulent activity may be occurring with or without the claimant's knowledge. Carriers must be alert to signs of fraud when evaluating all long-term care claims, but there is an increased potential for fraud and abuse when care is provided by IPs. Consider the following reported scenarios, some commonly occurring:

- Caregiver is living with claimant, reporting 24-hour care. Claimant submits invoice for 24-hour care, but is actually receiving a portion of his compensation from the caregiver in the form of room and board.
- Claimant's family asks caregiver to sign timesheets in advance, and then uses pre-signed timesheets to submit invoices for care when the caregiver was actually on vacation or after caregiver's services had permanently ended.
- Caregiver is asked to sign blank timesheets, so is unaware that claimant is submitting charges for reimbursement well in excess of what the caregiver has actually been paid.
- Claimants, not caregivers, report services provided, often inflating or completely misrepresenting the actual services—for example, reporting total ADL care when actually receiving only homemaker services from the IP.
- Claimants submits charges for care that is actually provided to other family members (who do not have coverage or whose benefits are inadequate to cover all the expenses), but submitting invoices under his own name.
- The caregiver is actually disabled (discovered via Social Security Disability Income search), yet claims to be providing physical assistance to the claimant.

Since the use of an IP puts a claimant into the role of employer, using assignment simplifies the process considerably.

¹ Plan design will dictate terms and conditions of IP coverage. Not all plans will allow unlicensed or uncertified caregivers; others will place few or no restrictions, other than to exclude family members as caregivers. State law often bears on this provision.

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Carriers must work hard to communicate their concern for claimant safety and vulnerability by encouraging caregiver relationships that are best suited to individuals' needs. ...

MONITOR TO ENSURE ELIGIBLE CARE IS IN PLACE

Once a claimant has been approved for benefits, carriers must employ methods for monitoring care until formal reassessment to ensure that eligible care, i.e. the care for which benefits were approved, remains in place. When such care is provided by licensed home health care agencies, record keeping is more reliable and reasonably standard. While some may need clarification as to a carrier's specific requirements, home care agencies will generally comply with a need for regular documentation of services provided. IPs, who are independent contractors, usually have no license or certification at risk when performing their duties as caregivers.

The carrier must establish a means by which the caregiver and claimant can report care, hours and expenses. Daily notes are critically important in order to ensure that care provided is consistent with the approved Plan of Care, so carriers must do all they can, in conjunction with offering coverage of IP care, to create a reporting process that provides reliable data. Carriers may consider providing claimants with preprinted forms on which to submit an itemization of services, hours and cost and provide written instructions for proper completion. By including a preprinted date range on the forms, carriers minimize the potential that claimants will create a single timesheet, and then submit copies week after week.

COVERING IP CARE WARRANTS UNIQUE CLAIM MANAGEMENT PROTOCOLS

The typical long-term care claimant is elderly, often with some form of dementing illness or severe functional impairment. Consider the following:

- By definition, a person who has been deemed cognitively impaired such that he/she must be supervised for safety is not competent to manage the employer/employee relationship when an IP has been hired to provide care.
- Does the cognitively or significantly functionally impaired claimant's vulnerability present an increased risk of victimization? Is the family actively involved in the care and in monitoring the IP caregiver?
- Because they are not licensed or certified and are not employed by a licensed entity, IPs operate without any regulatory oversight,

so the burden of managing quality of care and record keeping falls to claimants and families. Is there an able family member available and close at hand that is willing to assume this responsibility?

- Does plan language give the carrier the option to limit coverage to licensed agencies or to licensed individuals if it determines that an IP is not appropriate and to revoke previous approval of an IP if the claimant proves unable to adequately manage the plan's requirements or if fraud is suspected?
- A conflict of interest exists when a claimant's legal representative wishes to act as a paid IP caregiver. That individual then acts as both employee and employer, paying him/herself, and then claiming reimbursement. There is no objective reporting in such a scenario and represents an inherent conflict of interest. To the extent plan language permits it, consider not approving coverage of an IP who is also the claimant's legal representative.

CLAIMANT SAFETY IS A COMMON GOAL FOR THE CARRIER AND FAMILIES

Carriers must work hard to communicate their concern for claimant safety and vulnerability by encouraging caregiver relationships that are best suited to individuals' needs and which consider their support systems (able spouses, willing children, etc.). Claimants and families must understand their role as employer, and not just the freedom, but also the responsibility that role brings.

- Care by IPs is attractive to claimants and increasingly demanded in the long-term care insurance market. In addition, the market strongly demands this benefit; to remain competitive, LTCI carriers must continue to offer it. But they must do so with an understanding of both the benefits and risks of this popular benefit, and they must spend the time and effort to plan for and manage this special benefit effectively and efficiently. Being cognizant of their ethical obligations to the unique and vulnerable population they serve, LTCI carriers can design products and develop administrative practices that meet all the challenges of offering IP coverage. ■

Provide Peace of Mind

FOR YOUR FAMILY

by Dr. Patricia A. Bomba

What will happen if you experience a sudden illness that prevents you from making your own medical decisions? Will your family or loved ones know enough about what you value and believe to feel comfortable about making decisions about your care?

Everyone 18 years of age or older should express their health care preferences and end-of-life wishes to family members and their physician and put them in writing in a legal document called an *advance directive*. This discussion and documentation process is known as *Advance Care Planning*, and it will spare your loved ones the emotional burden and turmoil that come with trying to guess what your wishes might have been, particularly during a medical crisis when you can't speak for yourself.

In 2002, *Means to a Better End*, the first national end-of-life report card, reported that just 15 to 20 percent of Americans had an advance directive. Unfortunately, the completion rate had not increased since Americans were given a right to do so with the 1991 Patient Self-Determination Act. That's probably because many people believe this is an issue solely for the elderly or the seriously ill. In November 2005, the Pew Center reported that 29 percent of Americans have an advance directive. Experts speculate that this increase likely represents a silver lining to the tragic case of Terri Schiavo that prompted these questions to be openly and thoughtfully discussed.

The reality is that these conversations should begin when individuals are young, healthy and independent, and they should continue as our life experiences transform our views of what is important, and what we are willing to undergo in terms of medical treatments and interventions.

Advance Care Planning is a process that asks individuals to explore, clarify and put in writing their values, beliefs, goals of care and expectations. It requires them to name a legal spokesperson, and an alternate, who will work best with physicians and health care providers to carry out patient wishes. And it also requires them

to complete the necessary legal documents, keep them up-to-date and make them accessible to their spokesperson, provider and others.

If one begins to view Advance Care Planning as part of health and wellness, then review can be integrated with periodic health evaluation, such as the annual gynecologic exam. By reviewing advance directives along with nutrition, exercise, smoking, injury prevention, stress management, etc., the importance is clarified and the fear of discussion is demystified.

Copies of a step-by-step booklet on Advance Care Planning can be obtained free of charge by visiting www.compassionandsupport.org, a community Web site dedicated to helping individuals "Know Your Choices. Share Your Wishes." A new video on traditional advance directives called *Community Conversations on Compassionate Care* along with Five Easy Steps for completing an advance directive can be viewed on-line at www.compassionandsupport.org.

An advance directive may be called a Health Care Proxy, Living Will, Durable Power of Attorney for Health Care or Advance Directive for Health Care, depending on the state in which you reside. Forms may vary but the process remains the same. State-specific forms can be obtained at www.caringinfo.org.

For more information on Advance Care Planning, Medical Orders for Life-Sustaining Treatment (MOLST), palliative care and other end-of-life resources for patients, families, health care and other professionals created by the Community-Wide End-of-life/Palliative Care Initiative, view www.compassionandsupport.org. ■



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Is the Compression of Morbidity a Universal Phenomenon?

by Jean-Marie Robine, Siu Lan K. Cheung, Shiro Horiuchi and A. Roger Thatcher

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Acknowledgment: This study of the compression of morbidity is part of a wider project called the M-project, led by the four authors, which aims to explore the demographic factors leading to an increase in the adult longevity, investigate the phenomenon called the compression of mortality and develop a new methodological approach to longevity analysis with focus on the modal age at death (M).

ABSTRACT:

Recent reviews of national health trends show conflicting results. It is clear today that the various health dimensions follow different trends over time. For instance, an expansion of morbidity may accompany a compression of disability. What do we measure when we observe a decline in disability? Is the elderly population intrinsically healthier or are individuals more independent and less helped by children, using more technical devices in a more favorable environment? The recent OECD study, reviewing trends in ADL disability at age 65 and over in 12 OECD countries during the 1990s, demonstrates that there is clear evidence of a decline in disability among elderly people in only five of the 12 countries studied: Denmark, Finland, Italy, the

Netherlands and the United States. Three countries (Belgium, Japan and Sweden) report an increasing rate and two countries (Australia, Canada) a stable rate. In France and the United Kingdom, different surveys show different trends in ADL disability (OECD, 2007). These results suggest that a decline in ADL disability may be less universal than expected. More importantly, the OECD study shows that ADL disability at age 65 and over ranges widely from a low 7.1 percent in the Netherlands (HIS) to a high of 18 percent in the United Kingdom (GHS survey). This paper reviews available evidence about the compression of morbidity and the disability decline and discusses the context in which they occur: initial level of disability, initial value of life expectancy and trend in life expectancy. ■



Estimates of Incidence, PREVALENCE, DURATION, INTENSITY AND COST OF CHRONIC DISABILITY AMONG THE U.S. ELDERLY*

by Eric Stallard

[Editor's Note: This is an abstract of the presentation made at the Society of Actuaries' Living to 100: Survival to Advanced Ages International Symposium held on Jan. 7–9, 2008 in Orlando, Fla. Readers should be alerted to the Living to 100 conferences held by the Society of Actuaries as they contain very pertinent discussions and information on long-term-care-related topics. As well, readers may wish to contact Eric Stallard for a fuller report on this particular presentation.]

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View Stallard's paper and other papers presented at the Living to 100 Symposium at <http://www.soa.org/livingto100monographs>.

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ABSTRACT:

OBJECTIVES: To estimate the burden of chronic disability on the U.S. elderly population, using sex-specific measures of long-term care (LTC) service use, intensity, and costs.

METHODS: Multistate life-table analysis of adjacent rounds of the National Long-Term Care Survey (NLTC) from 1984, 1989 and 1994, using criteria introduced in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to stratify the disabled population according to level of disability based on ADL and cognitive impairment criteria. Rates of transition to/from non-disabled to disabled states and from all states to death were computed and analyzed for differences by age and sex. Rates of service use, intensity and costs were computed conditional on age and sex.

RESULTS: Approximately 20 percent of the residual life expectancy at age 65 for males and 30 percent for females was spent in a state of chronic disability. For both sexes, the years of chronic disability above age 65 were split evenly between mild/moderate and severe disability. The expected costs of purchased LTC services were \$59,000 (includes home/community care and institutional care, in constant 2000 dollars), with substantial sex differences—\$29,000 for males versus \$82,000 for females.

For both sexes, the overwhelming majority (92 percent) of the LTC costs were incurred during episodes of severe disability, with the remaining 8 percent incurred during episodes of mild/moderate disability. Residual lifetime unpaid home/community care averaged 3,200 hours for males and 4,000 hours for females, with approximately one-third of those hours incurred during episodes of mild/moderate disability.

Differences in the costs of acute health care were substantial for the different levels of disability and associated differences in survival.

CONCLUSIONS: The criteria for identifying severely disabled persons introduced by HIPAA effectively targeted the high-cost disabled subpopulation. This group accounted for the overwhelming majority of purchased LTC services, and a large majority of unpaid LTC services, over age 65. Sex differences in expected per capita lifetime LTC costs were substantial, with females outspending males 2.8 to 1. ■

SOA 2008 Annual Meeting & Exhibit

LTC SECTION-SPONSORED SESSIONS AND DESCRIPTIONS

by Amy Pahl

This year the Annual Meeting will be held on October 19–22 in Orlando, Fla. Participants can look forward to the following sessions.

SESSION TITLE: LTC CLAIMS MANAGEMENT OF THE FUTURE

Join us to learn more about the emerging trends in claims intervention and how the landscape is changing in the delivery of care and services for LTC claimants. Also find out more about the best practices in LTC claims management. Attendees will learn more about where the LTC industry is relative to claim management today, where we need to be tomorrow and what tools are available to get us there.

SESSION TITLE: LITIGATION & PUBLIC RELATIONS MANAGEMENT—LTC SECTION HOT BREAKFAST

This session provides an opportunity for LTC actuaries and interested parties to get together and network on an informal basis. A brief update of the activities of the LTC Section will be followed by a presentation on managing litigation and public relations issues in this post-*NY Times* article age. In attending this session, you'll get a glimpse at what is happening at the company and regulatory level in dealing with image and litigation issues relating to the LTC insurance market.

This breakfast session is open to all meeting attendees. It is free for LTC Section members to attend. There is a modest fee for non-members.

SESSION TITLE: WILL STATE LTC PARTNERSHIP PROGRAMS GENERATE MEDICAID SAVINGS?

The passage of the Deficit Reduction Act of 2006 authorized the expansion of public-private Partnership LTC programs. Purchasers of

private LTC policies would be able to qualify for Medicaid LTC benefits without exhausting all their assets. For each dollar of benefits received from a Partnership LTC policy, a dollar in assets would be disregarded for purposes of Medicaid eligibility. Many states view the asset protection as a significant incentive for the purchase of private LTC insurance and are moving aggressively toward implementation of these programs. However, there does not appear to be a broad consensus that they will ultimately reduce Medicaid LTC expenditures.

This session will explore the potential for Partnership Medicaid savings from various perspectives, including the states that have had Partnership programs for many years, the Department of Health and Human Services, the Government Accountability Office (which published a recent report on potential Medicaid savings from Partnership), the insurance industry and the academic community. The session will include discussion of demographic, morbidity and cost of care projections.

Attendees will gain a better understanding of how Partnership programs operate, the trends that are generating public policy concern over how aging baby boomers will fund their long-term care needs and the potential for this public-private Partnership to address those concerns.

SESSION TITLE: PREPARING FOR PBA & STOCHASTIC MODELING

Long-Term Care insurance models being developed for principle-based reserve purposes incorporate complex stochastic approaches to many of the key variables. This session will discuss those approaches including how interaction effects of mortality, lapse and claim incidence are handled. Attendees will gain an understanding of the processes and calculations of a prototype Excel-based model that incorporates that key principles and concepts of the principle-based reserves stochastic model.



SESSION TITLE: LTCI PRICING: PROFITABILITY MEASURES AND THEIR BEHAVIOR

This session will help improve the actuary's understanding of the various profit measures that could be applied during LTCI new product pricing and the unique characteristics of each profit measure. The actuary will have a better understanding of which measure is most appropriate for the company's goals and how to discuss and present profit measure analyses to management.

Profit measures to be discussed will include return on GAAP equity, internal rate of return, economic value added and loss ratio measures. For each measure, the session will provide a definition, compare pricing results using a target, compare anticipated annual profit streams, discuss unusual results or idiosyncratic behavior, consider the impact of scenario variations and discuss how "moderately adverse" experience might be defined. We will also consider how a stochastic approach to pricing might interact with these measures or if new measures might need to be defined. How stochastic pricing impacts "moderately adverse" could also be discussed.

SESSION TITLE: LTC SECTION-SPONSORED RESEARCH STUDY RESULTS

This session will provide the attendee an update of the findings of three research projects sponsored by the LTCI Section of the SOA.

"A Study on Transition Rates Between Claim Stages"—This study will analyze experience transition rates between claim settings. The primary transitions that will be analyzed are those between facilities and home care. Transitions between other care settings, such as assisted living facilities, will also be examined to the extent that credible data is available.

"Cognitive and Functional Disability Trends in Assisted Living Facility Residents"—The purpose of this research is to better understand

the functional and cognitive trends among assisted living facility residents. Specific questions to be addressed include: What are the ADL, cognitive and medical profiles of assisted living residents and how has this changed over time?; How does the ADL and cognitive profile of assisted living residents differ from service users in nursing home settings and in home health care settings?; and, What are the most prevalent dependencies among individuals in assisted living?

"A Study on Underwriting Selection Wear-Off"—This study proposes to develop an ultimate table of morbidity incidence rates and claim costs, develop related select-and-ultimate factors by issue age, gender and marital status and perform various analyses to test the appropriateness and significance and variability of the results. Also considered will be the impact of underwriting requirements, marital status, underwriting classification, product design and distribution, and a review of how the select period has changed over time.

SESSION TITLE: SECURITIZATIONS AND REINSURANCE — HOW THEY APPLY TO LTC

LTC writers are looking for ways to release trapped capital in their LTC insurance business. Securitizations offer a possible solution. This session will discuss the fundamentals of insurance risk securitizations, recent trends in securitizations for health and LTC business, and the outlook for the future.

The reinsurance market for LTC has been expanding over the last several months. Attendees of this session will learn more about what is driving this trend, the opportunity for reinsurers and the benefits of reinsurance for direct writers. ■



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