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Managing Cognitive Claims: What's Next?

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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.

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

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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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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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