



Long Term Care International Forum Newsletter

Your key for entry into the 21st Century

July, 2000

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PRESIDENT'S MESSAGE

By Norm Kono

The passing of the gavel from PMSI to LTCIF at our 1st Annual Conference in Toronto on April 26th marked the end of 7 years of parental care by the then PMS Company. It also commemorated the end of a year of organizational effort by a committee-at-large of as many as 20 persons resulting in a new, independent, non-profit corporation.

Betty Bennion and Swiss Re deserve a special thanks. Shortly after Betty took on the task of negotiating and arranging our conference at the Sheraton Centre, Swiss Re decided they would not enter the LTC market in North America. Despite the fact that Swiss Re no longer had any commercial interest in LTC, Betty continued her tireless efforts and the Swiss Re backed her as she assisted in the securing of our site for next year. Gillian Fleming, also of Swiss Re, Betty, and Beth Hostvedt, AIG were ready with registration packets, directions, and friendly smiles.

Pat Orford, Pyramid Life is elected Vice President. He will continue to direct the Membership Committee.

Geralyn Barbato, AIG, is Treasurer. The

report for 2000 will be presented at the Palm Springs conference.

Steve Rowley, General & Cologne is Secretary. He has headed the Program Committee for the last two years and is putting the program together for 2001.

In the last ten years, LTC insurance has undergone tremendous change. Lifetime benefits, home health care, and assisted living benefits were introduced. The number of carriers writing LTC went beyond 100. By 2010, the number could increase by 50% as new carriers find new niches and group LTC insurance begins to take hold.

The tax deductibility of LTC insurance premiums will give individual sales a boost.

Business is being consolidated at the top. John Hancock purchased Time/Fortis LTC; GE bought the Travelers LTC; and CNA LTC is available as part of the individual business being sold off. Conseco, a leader in LTC insurance, saw its stock tumble to record lows.

When all is said and done, the LTC insurance industry will be poised for record growth in the first decade of the 21st century. The members of the LTCIF will be there to lead the revolutionary changes taking place for the good of the insureds.

California...here we come!

The LTCIF 2nd Annual Conference will be held in Palm Springs, California, April, 2001.

If you weren't in Toronto for our 1st Annual Conference, read the comments from the evaluation forms and see what you missed –

- “All speakers were excellent!”
- Regarding David Solie, “excellent speaker”
- “Brilliant content and presentation”
- “Great session”
- “Very informative”
- “Useful and practical”
- “Motivating speaker”
- “Inspiring”
- “Very good panel. Good balance”

Membership dues and renewal

A membership form and renewal invoice is attached to this newsletter. Please clip and forward to Gerry Barbato with your dues.

Become a member of LTCIF and be part of the future!

Disease Management Comes to Long Term Care

By Pat Pannone, RN, BSN, MPH. AUL/RMS

Disease Management (DM) is emerging in the Long Term Care Insurance (LTCI) industry as an important strategy to prevent claims and control costs for insureds already on a claim. The common ground between Medical and LTC DM is chronic disease, which drives costs across the care continuum. Although managed care has sometimes been a painful catalyst for change, one of the benefits we now reap from it is the establishment of “best practices” among health practitioners that form the basis of DM.

Why Long Term Care DM?

To promote both quality of life and cost controls, LTCI professionals work toward preventing or delaying institutionalization. We also provide services and resources for those on claim, to support the informal caregivers who provide billions of dollars worth of

services for family members. For the chronically ill, we work to restore function, whenever possible – a natural segue into DM. Intervention aims to prevent acute episodes of chronic illness, which often lead to functional decline, with all its associated human and financial costs.

Of course, the demographic imperative of aging “baby boomers” mandates action now. DM is a clinical strategy based upon evidence of success, primarily with MCOs. Recognizing the complexities of chronic illness helps DM companies plan new holistic approaches, bringing into play the psychosocial factors that affect an individual's functional abilities.

What characteristics of the LTCI population support this as a viable strategy? It is an active group, aware of the impact of chronic illness. They have a long term relationship with the insurer, in contrast to medical plan members who may be here today and gone tomorrow.

They are becoming connected via technology, accessing information on chronic disease, prevention and management. Additionally, they have already shared demographics and health data through applications to help the insurer identify needs as the insured faces the fragmented acute and long term health care systems.

Integrating DM into LTC

The first step is to understand the health characteristics of the insured population, from actual data (underwriting or claims), and national data resources for groups with similar demographics and known diagnoses.

The second step is to involve clinical experts to design a short term DM plan with existing resources, testing concepts for claims that involve Care Coordination, where we have on-site comprehensive assessments, physician reports, and billing data from community and institutional care.

Establishing a relationship with the insured is essential, beginning with empathetic professionals prescreening all potential claims. Claim analysts and care coordinators then partner to assist the insured. Care coordinators have the expertise to assess risk, establish baseline data, stratify by need, and offer DM. As a pioneering effort, there are few DM clinical pathways that fit LTC, so Care Models of Care Coordination may differ, but basic concepts and practice standards are shared across the continuum. What better place to start Disease Management? (*Continued on p. 3 . Disease Management*)

(Disease Management)

The third step is to develop a long term strategy for the next five, ten, and 15 years. This might include redesigning or expanding databases for the newly insured, benchmarking to report outcomes, and shifting with changes in technology, research, and health systems.

The LTCI industry will assess and adapt methods to help our insured population stay as independent as possible. From the date of issue, there will be opportunities to intervene and expand the time between the “surely well” to “surely ill,” in AUL RMS Executive Vice President Gary Corlise’s words.

LTCI can learn from Medicare MCO approaches, which begin DM from the time of enrollment confirmation. Insureds surveys usually include questions about chronic illnesses, function, history of acute episodes, self-evaluation, support system, and more, to predict probability of repeated hospital admissions – the primary cost focus of MCOs. The new member population is then stratified into “layers” of low, medium, and high risk. DM programs are targeted across the health continuum from the very well to the very ill. This model, adapted to LTCI, is a viable approach. Clinical and actuarial expertise can be combined to lead to positive outcomes.

In addition to surveys for early baseline data, national health data is easily available via the Internet: information on risk factors is available for the chronic conditions that most affect LTC claims. National associations are disseminating evidence-based best practices to reduce risk for the chronically ill. Clinicians can use this information to develop protocols based upon medical risk factors and contributing factors: cognition/memory deficits, behavior, emotions, support systems, or environmental and financial concerns.

What Barriers Do We Face?

The question is always “Who will pay?” Currently, few LTCI policies address wellness behaviors or managing chronic illness prior to a claim. Just as LTCI policies have evolved from nursing home-only coverage to comprehensive plans, current LTCI policies will most likely move from claim-only involvement to intervention at other points on the health continuum. The temptation is to spend money for the short term fix – for those already on claim. LTC insurers’ sustained relationship with the insureds provides the opportunity to intervene proactively and to reap positive outcomes.

Currently, there are no DM programs tailored to the specific needs of LTC insurance and its Care Coordination model. Developing protocols raises issues of time and cost. In addition, we lack the needed connections and incentives to physicians. The primary contact and recipient of DM is the insured, in LTC.

Nonetheless, DM is an essential strategy to prevent or control claim costs. It helps the insured achieve the highest possible level of independence and stability. While data and outcomes over time will help refine the approach, we have the facts and expertise to move forward actively managing chronic disease. By the end of 2000, step one and step two toward Disease Management will be well under way at AUL RMS’s Long Term Care division.

Can You Justify the Co\$ of Care Coordination?

By Sharon Reed, RN. CHCS, Inc.

Friend or Foe? Benefit or Gatekeeper? Look out claims department. If you have not yet been asked to justify the cost of Care Coordination, you soon will be!!

Actuaries and administrators alike are asking the tough questions just months into the year 2000. Long term care insurance companies (LTCI) are realizing the impact of Care Coordination fees and are scrambling to explain related cost savings and customer service functions. What is the impact of Care Coordination? How does it impact the claims dollar? What diagnosis groups generate the most benefit from Care Coordination intervention? Does everyone need Care Coordination? Forever?

Care Coordination services were introduced in the 1990’s when the varying level of services available in a LTCI policy became more complex. Definitions of covered services and access to appropriate levels of care confused many policyholders. Retrospective review of claims was difficult due to varying levels of accuracy in daily progress notes and documentation of actual delivered services. Many carriers were faced with dissatisfied customers and negative image perception as a result of this practice.

The early phases of LTC Care Coordination incorporated limited utilization of the Care Coordinator, who was used primarily for onsite assessments for verification of benefit
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(Care Coordination)

eligibility only. The actual observation by an impartial party allows for documentation of the policyholder's functional abilities, cognitive status, required level of care, medical and health history and living environment. Benefit eligibility decisions are made promptly with this information, avoiding many of the denied claims, misunderstandings and huge down payments for services. Care Coordinators could use the assessment to develop an appropriate and cost effective plan of care, based on the policyholder's individual needs.

LTC Care Coordination has evolved from this basic evaluation and advocacy process to meet the needs of the changing environment and aging risk pool. The services of the Care Coordinator can also include linking qualified claimants with cost effective services. When directed to appropriate cost effective services, the impact of Care Coordination is realized throughout the length of the claim. It is much better to steer a policyholder to appropriate services, than it is to remove or deny those that are inappropriate.

LTCI remains in its early stages. Market penetration remains below 10% and companies must be highly competitive in marketing their products. Care Coordination type benefits have become a selling component for many companies, but is it just a perk? Can you expect savings on claims above and beyond the actual costs of Care Coordination?

The answer is a resounding YES, but you may need to do some work to gather the necessary information for savings documentation. Data collection is essential in answering the questions. There must be a good interface between your LTCI company system and the Care Coordinator's data. Distinctions in policy type, benefit maximum, covered services, etc. greatly affect the type of Care Coordination you will want to use. All policies are not created equal and all policies do not require the same program of Care Coordination. A clear dialogue and related plan with your Care Coordination company and internal staff is essential to maximize the impact of Care Coordination. Let's look at a few of the items you will want to address:

Intake and Triage

The most important part of the process is at the beginning. Policyholders are looking for direction in the confusing maze of services offered to meet their needs. Benefit eligibility is determined in a consistent, professional manner. Those not eligible are offered

alternative services to meet their needs. Those that are benefit eligible are offered services from a cost effective provider. Network savings, or negotiations at the time of referral translate into tremendous savings for the LTC insurer, which continue for the length of the claim.

The claimant can be triaged to an alternate payor, usually their primary medical coverage. The Care Coordinator acts as liaison with the medical doctor in coordinating a higher level of covered services while protecting the exposure on the LTC policy. This is particularly important in the event the claimant needs more intensive rehabilitative services in a facility or home setting. Additionally, the Care Coordinator is an expert at identifying local community services available to meet the claimant's needs.

Customer service satisfaction is high when professional Care Coordinators interact with the policyholder at this confusing juncture.

Ongoing Care Coordination

Does the care continue to be appropriate? Is the policyholder still benefit eligible? When does the claimant need to decrease hours of care? Is he/she progressing in a rehab setting? Care Coordinators assist the claimant to reach their highest level of function and even discharging from benefit completely. Evaluating the effectiveness and appropriateness of the plan may require some ongoing Care Coordination until a final care projection can be made.

Claim risk and the resulting exposure are not equal on all policies. The result is varying cost savings. It is essential that the company devise a strategic plan with multiple departments to determine its Care Coordination philosophy. Identifying the purpose of the Care Coordination is primary and must be demonstrated in the marketing and regulatory material. Tough questions need to be answered regarding the purpose and intensity of the services that will be provided:

- Is it a care advisory program or will managed care principles be used to decrease care when the policyholder shows improvement?
- Will the company use its own nurses or utilize the services of an external vendor?
- How will the costs for the program be applied; as a claims or as an administrative expense?
- Are the costs deducted from the policyholder's bucket of benefits?

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(Care Coordination)

There is value and savings clearly associated with principles of Care Coordination. Companies must strategically plan their program and customize their departments to maximize the savings from their activities. Long term, chronic claimants may simply need basic advocacy and unit cost savings to show dollar impact. However, short term, rehabilitation type claimants may benefit by more aggressive management services to impact claims dollars.

Care Coordination can be a friendly advocacy benefit designed to impact the bottom line - but it must be strategically planned that way and implemented with the primary goal of cost savings!

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We would like to establish an "Ask the Expert" page. We need volunteers to read and answer questions on a daily basis, for 30 days.

**WE WELCOME YOUR SUGGESTIONS
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If you are interested in volunteering or if you have any suggestions for the webpage, please contact Sandy Mandell:

Phone: 973-882-3512. Fax: 973-808-0353
E-mail: smandell@dimensionsinmanagedcare.com

-CALL FOR ARTICLES-

Is there something you want to share with the rest of us? Call, fax or e-mail Sandy Mandell with your ideas and/or articles.

MISSION STATEMENT

The Long Term Care International Forum is a voluntary, not-for-profit organization whose purpose is: to promote efficiency, effectiveness and high standards of performance in long term care insurance; to provide a forum for research, education, personal development and the exchange of ideas relating to various aspects of long term care administration. Discussion or actions in restraint of free trade or in violation of federal antitrust laws are forbidden.

Membership shall be open to all persons, corporations or organizations dedicated to the purpose of the association.

**POLICY STATEMENT OF ANTI-TRUST
COMPLIANCE**

The LTCI Forum is open to any and all companies or persons interested in the advancement of administration, claims and underwriting knowledge of long term care insurance. Under no circumstances shall any meeting, formal or informal, of any conference participants or attendees be used as a forum for representatives of competing companies to reach any understanding whatsoever about the pricing of specific products, whether particular products should be marketed to the public, or term on which products are marketed. By your membership, you agree to follow both the letter and spirit of anti-trust laws which prohibit any activities that might lessen or tend to lessen desirable competition among insurance companies.

Did you know.....

..... A serum vitamin B12 level below 400 pg/mL can contribute to increased confusion or memory loss.

.....Maryland passed a law giving first time buyers of LTC insurance a one-time \$500 state income tax credit, provided they purchased the policy after July 1, 2000.

.....Group LTC sales increased 121% in 1999.

.....Only 38% of American's over the age of 50 have a Will and Power of Attorney.



Annual Dues Invoice - 6/1/2000 through 5/31/2001

Amount Due Per Company \$250.00 U.S.

Please make check payable to:
LTCI Forum, Inc. (Federal Tax ID 75-287 4444)
and mail to:
Geralyn Barbato
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Third Floor, Suite 305
Trevose, PA 19053

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JUST FOR FUN

Did you ever wonder why.....

It's called "face-to-face" assessment for underwriting, but "onsite" assessment for claims????



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