

Understanding How Long-Term Care Benefit Triggers Are Implemented in the Private Insurance Setting

By Marc A. Cohen, Jocelyn Gordon, and Jessica Miller

The Community Living Assistance Services and Supports (CLASS) Plan – a groundbreaking component of the Affordable Care Act – creates a voluntary federally-administered insurance program to help individuals pay for needed assistance in a place they call home if they become functionally limited. Implementation will require knowledge translation from various sectors, including research and existing public and private programs. This Technical Assistance Brief Series seeks to answer questions pertinent to developing and implementing the program.

This brief provides information about how long-term care insurers implement benefit eligibility triggers in the private insurance market both from a contractual and process perspective. The way in which companies have operationalized benefit eligibility triggers can inform the development of regulations for the CLASS Plan.

Introduction and Overview of Insurance Contract Language

In order to better understand in a more concrete way how insurers apply benefit eligibility triggers¹ LifePlans conducted a structured survey with key individuals involved in the claims management process from 13 major long-term care insurance carriers representing the vast majority of policies sold in the market. We also examined a set of long-term care (LTC) insurance contracts from several of the largest insurance companies selling in the market today to understand if and how these contracts are similar to or different from regulations governing LTC insurance contracts and each other. The key regulations have been developed by the National Association of Insurance Commissioners (NAIC) and adopted by a majority of the states where private LTC insurance is sold. The regulation governing private LTC

insurance is the NAIC Model Regulation, which was adopted in 1986 and updated over the years.²

One of the strongest tools that insurers have to manage the underlying risk associated with the insurance policy is the contract language itself. In essence, the insurance policy represents a contract between the individual policyholder and the insurance company. As such, it is enforceable in a court of law. Thus, it is not surprising that LTC insurance contract language related to benefit eligibility triggers generally mirrors the NAIC Model Regulation and HIPAA definitions found in the IRS code. Given the fact that policies must be filed in all 50 states, the NAIC Model regulation and HIPAA requirements made it easier for insurers to make very minimal adjustments to their contracts based upon state requirements, but have a uniform way – from a contract standpoint – of expressing the standards for benefit triggers. In essence, to assure the tax qualification status of the insurance, the

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contracts needed to contain language that defined all the component requirements of the IRS code.

Upon review of seven different policy contracts filed with the Florida Insurance Department from four of the major long-term care insurance companies accounting for more than 60% of all sales, we found that the wording for the ADL definitions was exactly the same as that found in the NAIC Model Regulation. That is, all of the LTC contracts reviewed used the same definitions for the six basic ADLs. Furthermore, the wording for the other terms detailed in the IRS code (Chronic Illness, Severe Cognitive Impairment, Substantial Assistance, and Substantial Supervision) were all similar enough that while it may have differed slightly across contracts, there did not appear to be any discernable implication for how benefits would be adjudicated.

Implementation of Benefit Eligibility Triggers in Practice

Definitions and Measurement of ADLs

While the high level definitions contained in the insurance contract language are virtually identical across the industry, there is latitude in the way that a company can define and measure the performance of each ADL and the existence of cognitive impairment. How this is done in practice is particularly important to companies because it affects how the underlying risk that is being insured for is actually defined, and this has implications

for the underlying financial solvency of the products they are selling. In essence, the precise definitions and measurements employed by a company are a key to both predicting and managing the risk that the insurance is designed to ameliorate.

Interviews with long-term care insurance company claims experts showed a great deal of variation across the industry in terms of how HIPAA triggers are actually applied and administered in practice – specifically the way that insurance companies define and measure the performance of each ADL and the existence of cognitive impairment. The activities or sub-components that comprise an ADL often differ as do the ways in which the performance of these activities may be evaluated in terms of determining whether or not “dependence” exists.

For instance, bathing as an ADL is defined by the NAIC Long-Term Care Insurance Model Regulation Act #641 as “washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.”³ In practice, the act of “washing oneself” is comprised of many components. The table on page 3 illustrates that of ten possible bathing-related tasks, there is absolute consensus among the surveyed companies on only the three tasks which are listed in the definitions contained in the NAIC Model Regulation (shown in the shaded cells).

TABLE Distribution of Companies by Use of Component Parts of Bathing ADL Definition

Components of Definition	Included in Definition of Independence	Not included in Definition
Washing oneself by sponge bath; or in either a tub or shower	100%	0%
The task of getting to or from the tub, shower or sink	23%	77%
Getting into or out of the tub or shower	100%	0%
Obtaining/disposing of water for sponge bath	38%	62%
Turning on/off water or controlling water temperature	54%	46%
Washing the body	100%	0%
Towelng dry all parts of the body	77%	23%
Washing the back	58%	42%
Washing the hair	58%	42%
Washing the feet	58%	42%
Additional items considered	8%	92%

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As the table shows, some companies are explicit about the parts of the body that one must be able to wash (e.g., the back, hair, or feet) whereas others leave the definition more open ended. This is true for all of the ADLs; they contain the required NAIC component definitions, but then additional components may be added to the definition.

There are two ways that a licensed health care practitioner can make a

judgment about an individual’s ability to perform their activities of daily living: (1) through self-report, whereby the individual is asked if and how they perform the activities, and (2) through the use of ADL demonstrations. In the latter case, the assessor asks the individual to actually perform the ADL (e.g., transfer between a bed and a chair) or simulate the performance of the ADL (e.g., show how they might dress themselves). Our research indicates that

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almost all companies (93%) require ADL demonstrations during the assessment process in order to determine benefit eligibility based on ADL functioning.

We also uncovered the alternative ways that companies conceptualize a “substantial need” for assistance with a specific ADL. The IRS language around the definition of substantial assistance (i.e., hands-on or stand-by) is perhaps one of the most difficult to define and implement in the assessment process. There are two concepts that confound a straight interpretation of this standard. The first concept is the question of performance adequacy of a specific ADL. Some companies fully take this into account whereas others do not. For example, if an individual can perform an ADL without assistance, regardless of how well they do it, they may be considered independent in that ADL. An alternative viewpoint is that if an individual performs the ADL, but not all elements adequately, then perhaps they have a “need” for assistance. The presence of this need suggests that they are not independent in the ADL, but in fact may require substantial assistance.

The second concept that confounds a straightforward interpretation relates to the issue of “safety” in assessing ADL performance. That is, even if an insured can perform an ADL, if the evaluation is that they cannot do so safely – that is, they may be at risk for adverse consequences when they perform the ADL – the individual may be evaluated as having a need for substantial assistance in this ADL.

Responses from the long-term care insurance companies on these issues varied. Slightly more than two thirds of companies take into account safety as well as adequacy in performance of the ADL in making judgments about whether an individual is dependent or independent for the purposes of benefit eligibility. The other one-third evaluates performance exclusively on the basis of whether the individual can or cannot perform the ADL.

Given the fact that all of the ADLs consist of various definitional sub-components, an additional question arises: Do insurers take into account the scope of assistance required? Put another way, if an individual can perform 3 of 4 sub-components of an ADL, are they considered independent or dependent? Figure 1 shows that three-quarters of the companies surveyed stated that the inability to perform even a single sub-component of the activity is enough for the individual to be evaluated as dependent in that ADL.

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FIGURE 1 How Scope is Accounted for in ADL Evaluation

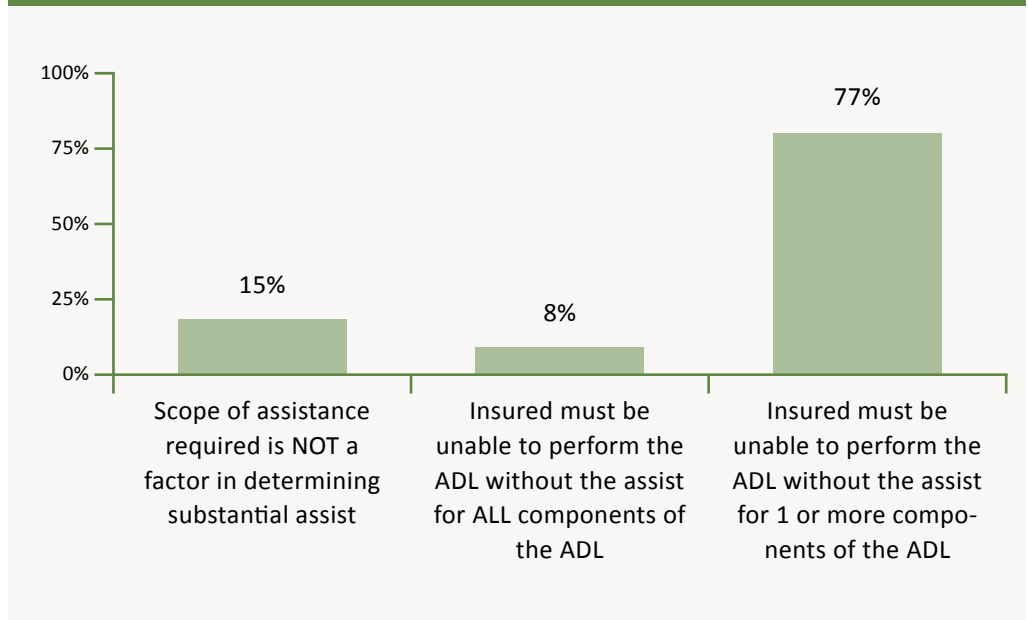
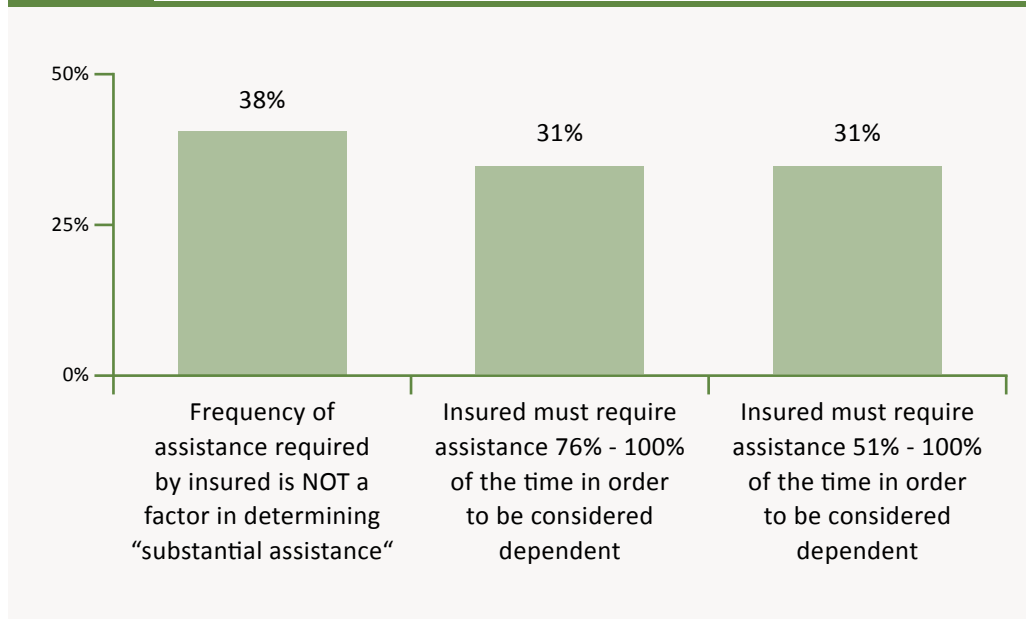


FIGURE 2 How Frequency is Accounted for in ADL Evaluation



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There is much less consensus on how the frequency of performance – how much of the time an individual requires assistance – should be addressed in the ADL assessment process. Figure 2 shows that roughly two-in-five companies do not even relate to this issue whereas about one-third define “assistance” in part to mean that the individual requires help at least 75% of the time when they are performing the ADL. The other one-third have a somewhat less stringent definition in which an individual who requires assistance at least 50% of the time establishes an ADL dependency.

Cognitive Impairment and the Interplay with ADLs

While cognitive impairment is treated as a separate benefit eligibility trigger in HIPAA as well as the CLASS Plan, there is clearly interplay between having a cognitive impairment and ADL dependencies. An individual can be certified as Chronically Ill if they have a certain level of ADL loss or they require substantial supervision to protect themselves from threats to health and safety due to severe cognitive impairment. When asked whether cognitive impairment is always considered a separate pathway to benefit eligibility or whether it is also taken into account when reporting ADL status, roughly half of the companies reported that they do not focus on the impact of cognition on the performance of ADLs, but rather focus on this as a separate and distinct pathway to benefits. Other long-term care insurers reported that they judge an individual as unable to perform ADLs without stand-by or hands-on assistance if they require cueing, prompting, or directing due to a cognitive impairment.

This distinction may have little practical implication in terms of benefit eligibility status because even if an individual who needs cueing to perform the ADLs may be assessed as ADL independent, he/she would likely be assessed as severely cognitively impaired and consequently benefit eligible in any case. However, there may be financial implications for the CLASS Plan if it ties benefit amounts to varying levels of disability.

There are a variety of standardized tests for cognitive impairment that are available to insurers. All companies surveyed use the Mini Mental Status Exam (MMSE), also known as the Folstein test, to identify whether an individual has severe cognitive impairment. Many companies also use elements of other tests (e.g., Short Portable Mental Status Questionnaire, Neuropsychology exams, and behavioral evaluations) to corroborate certain test results. Companies do vary greatly in their approach to the “cut-off” score that they use to classify an individual as impaired. While there is agreement about the base test that should be used to measure the presence of cognitive impairment, there is not a high degree of consensus regarding the interpretation of results and whether and how these results should be combined with other tests.

It is noteworthy that these tests have been developed with elderly populations in mind and that their validity has not been well established in specialized population groups such as those suffering mental health issues or the developmentally disabled. If such individuals are in the

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work force, they may qualify for the CLASS Plan and thus there is a need to find more sophisticated ways to measure their cognitive status.

Chronic Illness Certification

The third component of the benefit eligibility trigger is that the underlying need for assistance must be expected to last at least 90 days. There is no specific test for this, but rather, the licensed healthcare practitioner – typically a nurse – is expected to render a clinical judgment. The only issue on which companies may vary in their approach relates to the starting date of the 90-day certification. Roughly 25% of the companies surveyed view the assessment date as the time when the 90-day certification begins and the others use another date, most often the date that the disability began as reported by the individual or as documented in a medical record or nursing notes.

be developed to determine whether benefits are payable, the degree of impairment that exists, and the amount of benefit that will be paid. The experience of private insurers in applying the HIPAA eligibility criteria in long-term care contracts is clearly instructive for policymakers charged with implementing the CLASS Plan. Information provided in this report can assist policymakers to develop strategies and approaches that support the underlying financial viability of the CLASS Plan, as well as maximize opportunities for the public and private sectors to work together to address the nation’s LTC financing challenge.ⁱ

Considerations for CLASS Plan Design and Implementation

The Community Living Assistance Services and Supports (CLASS) provision in the Affordable Care Act requires that an assessment process

ⁱAdditional considerations for implementing benefit eligibility triggers under the CLASS Plan Design and Implementation are presented in The SCAN Foundation’s CLASS Technical Assistance Series Brief #4: (“The Independent In-Person Assessment Process”).

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