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CLAIMS EXPERIENCE: AN ANALYSIS OF CONNECTICUT PARTNERSHIP POLICYHOLDER CLAIMANTS

Laurie Kyzivat
Patricia H. Kelleher

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The Partnership

The **Connecticut Partnership For Long-Term Care** is a joint public - private program, which encourages individuals to plan for their long-term care needs by purchasing insurance protection in an amount commensurate with assets, or more precisely, the amount of assets he or she wishes to protect. If and when an individual exhausts insurance benefits, he or she can apply for Medicaid in Connecticut and each dollar that the insurance policy has paid in benefits will be subtracted from the assets the individual still has so that those assets would not be recognized or considered in determining the individual's eligibility for Medicaid in Connecticut.

The Project

The **Connecticut Partnership For Long-Term Care** is a program of the State of Connecticut. It was launched in August 1989 with a three-year grant of nearly $1.8 million from the **Robert Wood Johnson Foundation**. The Foundation extended the grant and increased the award to $2.5 million. Connecticut was the first state to implement such an ambitious initiative to make long-term care insurance benefits available to many of its residents by combining private insurance with state Medicaid funds. The Connecticut Partnership program became a permanent state program in June 1994. The research component of the project includes special studies ranging from surveys of individuals denied insurance or dropping coverage, to the collection of baseline information on those newly insured.

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David Guttchen, Director
Connecticut Partnership For Long-Term Care
State of Connecticut, Office of Policy and Management
450 Capitol Avenue, MS#52LTC, Hartford, CT 06106-1379
(860) 418-6318, e-mail: david.guttchen@ct.gov

Website: www.CTpartnership.org (select "Researcher")

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I. Introduction and Data Collection Methods:

The Connecticut Partnership for Long-Term Care (Partnership) is a unique alliance between State government and the private insurance industry developed to: 1) provide individuals with a way to plan for their long-term care needs without the risk of impoverishment; 2) enhance the standards of private long-term care insurance; 3) provide public education about long-term care; and 4) conserve State Medicaid funds. Connecticut was the first state in the country to implement a Partnership program. The program has been in operation since April, 1992.

The Uniform Data Set (UDS) is the data reporting requirements and documentation developed collaboratively among the four original Partnership states (Connecticut, New York, California, Indiana), the National Partnership Program Office at George Mason University, and the Program Evaluator, Laguna Research Associates. The UDS was specifically designed to provide a single reporting format for use by all of the long-term care insurance providers participating in each of the four Partnership states.

As part of the UDS, each participating company is required to send to the Office of Policy and Management (OPM – the State agency that administers the Connecticut Partnership) detailed information on each Partnership claim that is filed, including assessment information and service utilization, on a quarterly basis. This includes information such as: date and outcome of assessment, functional and behavioral status, cognitive test scores, services utilization, and amounts billed, paid, and protected.

In addition to the collection of the UDS data, each quarter the Partnership conducts a Survey of Persons Purchasing Partnership Insurance, also known as the Baseline Survey. In the past, this survey was sent to every Partnership policy purchaser. However, due to a substantial increase in the number of purchasers each quarter, the survey is now sent to a 50% random sample of purchasers in alternate reporting quarters. It is important to remember that the Baseline Survey is completed at time of purchase, and what may be true at time of purchase, such as marital status and living arrangements, may not necessarily be true at time of claim. For purposes of this paper, the Baseline Survey data was linked with the UDS data for 341 of the 612 claimants who reported service utilization to obtain more comprehensive demographic information about claimants who responded to the survey.

II. Claimant Profile:

This paper focuses on claims data received through June 30, 2007. As of that date, 44,806 Connecticut Partnership policies had been purchased and 726 policyholders had filed claims since the inception of the Connecticut Partnership in April, 1992. Of these 726 policyholders, 699 (96%) were determined eligible for benefits under their Partnership policy. Subsequently, services/payment data was received for 612 of the 699 eligible claimants, leaving 87 claimants for whom no services/payment activity was reported. Using data provided by the participating insurers, Partnership staff were able to determine that, of these 87 claimants, 46 died before receiving services under their Partnership policies, 3 let their policies lapse and an additional 17 were recently eligible, meaning they had not yet, or only very recently, satisfied their elimination period. In an effort to determine why no payment activity was reported for the remaining 21 claimants, the Partnership office informally surveyed their participating insurance companies, yielding the following information: 9 claimants recovered during their elimination period; 4 claims were withdrawn; 3 claimants never completed their claims forms or submitted any bills; 2 claimants died during their elimination period and after the close of the latest reporting quarter; 1 claimant was terminally ill and receiving services paid by Medicare; 1 claimant chose to receive care from a non-covered provider; 1 claimant had begun receiving payments under their Partnership policy after the close of the reporting period covered in this study. The focus of this paper will be the 612 claimants for whom service utilization and payment data was reported through June 30, 2007.

Table 1
UDS Data for Claimants Who Have Had Service Utilization Reported
N=612

Male **Female**	37% 63%
Average Age at Purchase **Range** **Standard Deviation**	70 30 – 88 9
Average Age at Time of Assessment **Range** **Standard Deviation**	76 31 – 96 9.4
Married **Not Married** **Unknown***	43% 27% 30%
Died **Dropped ** **	238 13

* The Partnership program was implemented using a state-specific data set that predated the development of the UDS. This earlier data set did not include marital status among its variables, resulting in missing marital status information on the earliest policy purchasers, who make up the majority of claimants to date. This accounts for the high percentage of unknown marital status.

** There is no way of knowing with any degree of certainty why these individuals chose to drop their policies. It is possible that some or all of them actually died, but were incorrectly reported as having dropped.

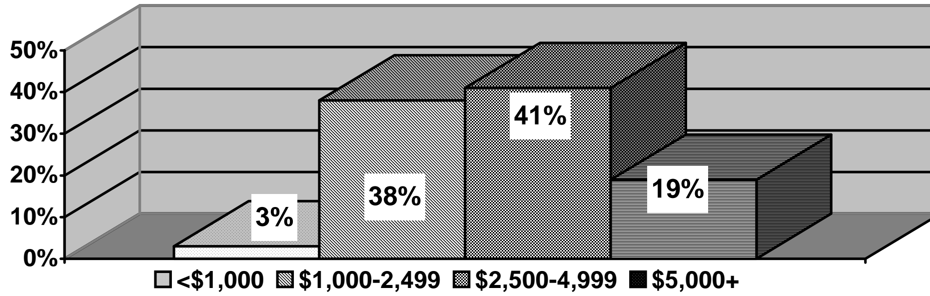
Table 2
UDS Data for Claimants Who Had Service Utilization Reported and Who Responded to Baseline Survey
(Survey filled out at time of purchase)
N=341

Male **Female**	37% 63%
Average Age at Purchase **Range** **Standard Distribution**	70 39-88 7
Married* **Widowed** **Divorced** **Single, never married**	56% 25% 5% 14%
Live Alone **Live With Spouse** **Live With Unmarried Partner** **Live With Relatives** **Live With Non-relatives** **Live With Children** **Children Live with Me** **(categories not mutually exclusive)**	35% 54% 2% 8% 2% 2% 1%
Number of People Living in Household **1** **2** **3 or more**	 35% 58% 7%
Number of Adult Children Living Within a 1 Hour Drive **0** **1** **2** **3 or more**	 21% 39% 23% 17%

* More information on marital status is available when linking with the Baseline Survey data because the Baseline Survey has collected marital status information since the inception of the Partnership.

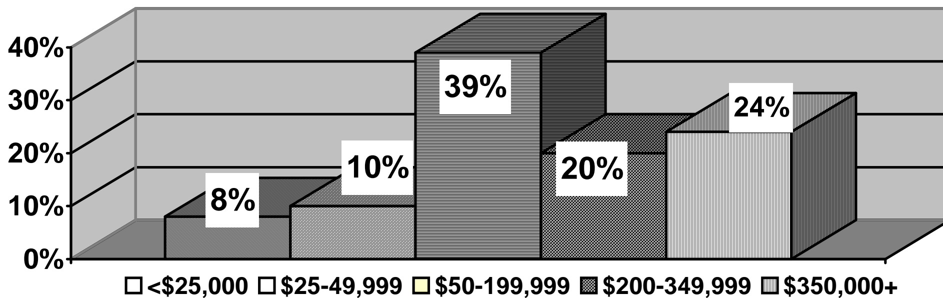
Respondents were asked to report their monthly household income and total household assets based on the ranges specified in the Baseline Survey. It is important to note that, for the purposes of the Baseline Survey, assets are defined as including: bank accounts, stocks, bonds, investment or business property and the cash value of any life insurance. Respondents are instructed **not** to include their house or car as an asset. However, there is no way to verify that respondents are adhering to these instructions when self-reporting income and assets.

Chart 1
UDS Data Linked with Baseline Survey Data
Partnership Claimants Monthly Household Income
N=316*



* Only 316 of those claimants who had responded to the Baseline Survey provided information on their Monthly Household Income.
Totals may not add up to 100% due to rounding.

Chart 2
UDS Data Linked with Baseline Survey Data
Partnership Claimants Total Household Assets
N=293**



** Only 293 of those claimants who had responded to the Baseline Survey provided information on their Total Household Assets.
Totals may not add up to 100% due to rounding.

It is interesting to note that the majority of claimants who responded to the Baseline Survey report income and assets falling in the middle income and asset ranges. These responses differ noticeably from those of the total Baseline Survey population where the majority of respondents have reported income and assets at the highest levels. One reason for this difference

could be that the claimants purchased their polices and, therefore filled out the Baseline Survey, at an older age than the average age for all Baseline Survey respondents. As a result, they would be less likely to be working and accumulating and growing their assets.

By looking at the data collected on the 341 claimants who filled out the Baseline Survey, a profile of the average claimant begins to emerge. The average claimant, based on information provided when completing the Baseline Survey, is a married female, 70 years old, with at least one child living nearby (within an hour's drive), with more than $2,500 per month in income and having less than $200,000 in assets. Sixty-three percent of the claimants were female, 56% were married and 25% were widowed when they purchased their policy. Thirty-five percent indicated that they lived alone and over three-quarters (79%) reported they had at least one adult child living within one hour's travel time at time of purchase. Forty-one percent have between $2,500 and $4,999 per month in income. Fifty-seven percent had less than $200,000 in assets.

The average policyholder who responded to the Baseline Survey has a very different profile. The average purchaser is a 62-year old married female with at least one adult child living nearby, earning over $5,000 per month and having more than $350,000 in assets. Fifty-five percent of the claimants were female, 77% were married when they purchased their policy and 10% were widowed. Sixteen percent indicated that they lived alone and sixty-one percent reported that they had at least one adult child living within one hour's travel time. Forty-five percent earned more than $5,000 per month in income and forty-two percent had more than $350,000 in assets.

When comparing claimants who responded to the Baseline Survey with all policyholders who responded to the Baseline Survey, there are significant differences in their responses. There are proportionately more female claimants (63% vs. 56%). Fewer claimants were married at time of policy purchase (56%) when compared to all policyholders (77%) and more were widowed (25% vs. 10%). Thirty-five percent of claimants lived alone compared to 16% of all policyholders. Claimants also reported lower incomes and fewer assets, and accordingly, purchased lower policy benefit amounts. Forty-one percent of claimants who responded to the Baseline Survey reported income between $2,500 and $4,999 per month, while 37% of all survey respondents reported that level of monthly income. However, only 19% of claimants reported income over $5,000 per month, while 45% of all survey respondents indicated that level of income. Fifty-seven percent of claimants had less than $200,000 in assets, while 36% of all survey respondents reported assets at that level. Only 24% of claimants reported assets over $350,000, while 63% of all respondents indicated that level of assets.

III. Policy Profile:

Looking at policy information, 7% of claimants purchased nursing home only policies, while 93% purchased policies with both nursing home and home care benefits. Eighty-six percent of the claimants are new (first time) purchasers, while 7% are upgrades (converted from a non-Partnership policy to a Partnership policy within the same company), and 7% replaced their current Partnership or non-Partnership policy with a new Partnership policy from a different company. The table below shows policy elimination periods for claimants.

Table 3
Elimination Periods

Elimination Periods	Nursing Home (N=612)	Home Care (N=569)
0 days	1%	15%
5 days	--	1%
14 days	--	8%
20 days	8%	8%
30 days	13%	12%
50 days	1%	--
60 days	6%	6%
90 days	37%	30%
100 days	35%	20%

Almost three-quarters (72%) of claimants have 90 or 100 day nursing home elimination periods, while 50% have 90 or 100 day home care elimination periods.

The total policy benefit amounts at time of purchase for claimants ranged from $31,025 to $1,000,000. The average benefit amount purchased was $173,364. The average benefit amount at time of claim was $215,182. These averages do not include the 38 claimants who purchased an unlimited (lifetime) policy benefit.

It is interesting to compare the types of policies purchased by claimants with the types of policies purchased by all purchasers. When looking at claimants, 90% purchased comprehensive policies (both nursing home and home care coverage), 86% were first time purchasers, 7% were upgrades (converted from a non-Partnership policy to a Partnership policy within the same company), and 7% replaced their current Partnership or non-Partnership policy with a new Partnership policy from a different company. The total policy benefit amounts at time of purchase for claimants ranged from $31,025 to $1,000,000, with an average of $173,364. When looking at all purchasers, 99% purchased comprehensive policies, 93% were first time purchasers, 7% were upgrades or replacements and their total policy benefits ranged from $34,675 to $2,160,800, with an average of $233,221.

IV. Health Conditions - Functional, Behavioral and Cognitive Status

As noted earlier, insurance companies participating in the Partnership are required to submit quarterly information on all claims, including functional, cognitive and behavioral test results. Functional status is measured by looking at six Activities of Daily Living (ADLs) and determining if the claimant can perform these activities independently. There are several ways to qualify for benefits based on ADL deficiencies, cognitive impairment or a combination of cognitive impairment and behavioral problems. The six ADLs are: bathing, dressing, eating, toileting, transferring from bed to chair, and continence. Bathing (92%) and dressing (91%) were the most commonly reported ADL deficiencies among claimants. In fact, 87% of the assessments indicated that assistance was needed with both bathing and dressing. Transferring was the next most frequently reported ADL deficiency (68%), followed by continence (47%) and eating (28%).

The assessment also examines four behavioral problems: wandering, abusive or assaultive behavior, poor judgment and bizarre personal hygiene. The most frequently reported behavioral problem was poor judgment (41%). This was followed by wandering (14%), bizarre personal hygiene (7%) and abusive or assaultive behavior (6%). One-half (50%) of the assessments reported some level of cognitive impairment. There are two standard cognitive tests administered as part of the assessment: the Short Portable Mental Status Questionnaire (MSQ) and the Folstein Mini-Mental State Examination (Folstein). The MSQ is composed of 10 questions and the Folstein has a maximum score of 30. Benefits can be accessed under a Partnership policy if the claimant fails to answer 7 questions correctly on the MSQ or, in combination with identified behavioral problems, such as those listed above, fails to answer 4 questions correctly on the MSQ or scores 23 or lower on the Folstein.

Of the 393 claimants who were reported as having taken the MSQ, over one-quarter (27%) answered all 10 questions correctly. Fifty-two percent answered 4-9 questions correctly and 21% answered less than four of the questions correctly. There were 439 claimants reported as having taken the Folstein test. Twelve percent answered all of the questions correctly, 41% scored between 24 and 29, and almost one-half (47%) scored 23 or lower.

The Baseline Survey includes questions pertaining to self-reported health status and comparative health. The first question asked the Baseline Survey respondent to rate their health compared to others their age. When looking at the Baseline Survey population as a whole, 56% reported excellent health, 42% reported their health was good, 3% reported fair and .01% reported poor health. When looking at the Baseline Survey responses for claimants, only 36% reported excellent health, 55% reported good health, 8% reported fair and 1% reported poor health.

The Baseline Survey lists a series of specific health conditions and asks the respondent to indicate which of these conditions they have had in the past. The following chart compares the

prevalence of these health conditions in the entire Baseline Survey population with the claimants who responded to the Baseline Survey.

Table 4
Health Conditions

Health Conditions	Baseline Survey Respondents (purchased through 12/31/06) N=11,707	Claimants who Responded to the Baseline Survey N=341
Hypertension	18%	22%
Arthritis	12%	19%
Cancer	7%	13%
Diabetes	8%	11%
Stomach Disorder	11%	16%
Heart Condition	6%	8%

V. Service Utilization:

There were 612 claimants who were reported as having received service payments under their Partnership policies. The average amount of time elapsed between the date the claimant purchased the policy and the date they were first determined to be eligible under their policy was 5.9 years. Forty-one percent of claimants spent some time in a nursing home. Forty-five percent received some type of home health care services (not including personal support services such as: homemaker, chore and companion services). Nursing home use ranged from 1 day to 1,155 days (3.2 years), with an average of 292 days. Home care use ranged from 1 day to 985 days (2.7 years), with an average of 142 days. The chart below examines service use, as well as the percentage of the total amount billed that was paid. Ninety-two percent of the amount of claimants' bills submitted was reported as paid by their Partnership policy. (It is important to note that, while the UDS requires that the insurers report the amount billed for each service, there is no guarantee that each insurer is reporting every service that is billed, or is aware of every service that is billed in cases where bills are sent directly to the claimant and then submitted by the claimant to the insurance company. In addition, payments from a Partnership policy may not cover 100% of the amount billed due to several reasons, such as, expenses incurred during the policy's elimination period and expenses in excess of the policy's daily/monthly benefit maximum.)

Table 5
Service Utilization

Service Used	Percent of Population Who Used Service (N=612)	Percent of Total Amount Billed That Was Paid For By The Partnership Policy
Nursing Home	41%	78%
Assisted Living Facility	21%	92%
Home Health Skilled Services and Skilled Nursing Services	10%	91%
Home Health Aide	43%	92%
Adult Day Care	7%	93%
Companion	3%	100%
Homemaker	5%	98%
Personal Care/ Chore/Laundry Services	14%	97%
Personal Emergency Response System	5%	96%
Respite Services	2%	93%
Hospice	3%	87%
Housing Improvement	3%	99.7%
Durable Medical Equipment	7%	99%
Case Management Services	59%	96%

A total of $37,596,245 was paid out in benefits for the 612 claimants. One hundred fourteen of these claimants have exhausted their policy benefits, with forty of them having accessed the Connecticut Medicaid program.

VI. Conclusion:

The differences evident when comparing the overall policyholder population with the subset of policyholders who have filed claims will continue to be monitored over time by Partnership staff as additional UDS and Baseline Survey data is collected. While it is relatively early to paint a comprehensive picture of Partnership policyholder service utilization, the analysis provided here shows that the majority of bills submitted for a wide variety of long-term care services are being paid under Partnership policies.

It is also important to note that 699 (96%) of the 726 policyholders who were assessed for eligibility under their Partnership policy were approved for benefits. While still early in the Partnership's claims experience, this data suggests that long-term care insurance benefits can be an accessible, valuable resource for those in need of long-term care.

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