1999 HEALTH CARE CONFERENCE
REPORT ON SESSION ON LONG TERM CARE
ALTERNATIVE BENEFIT TRIGGERS

Consideration of various claims under LTC policies where care needs appeared to exist but sufficient activities of daily living (ADLs) had not been failed provided the impetus to set up a working party to consider this aspect. The aim of the working party was to investigate how good ADLs really are as triggers for the provision of care under LTC policies and whether there are any alternatives from the UK perspective.

Payments under long term care policies in the United Kingdom are provided when a claimant fails 1,2 or 3 out of, usually, 6 ADLs. These are measures of physical impairment. Mental impairment would also be considered; tests of this usually require medical proof, the outcome of various substandardised tests or considering the impact on physical functioning. Other bodies with interests in provision of care also look at various aspects of physical, mental and social functioning. Physical impairment may be measured through failure of ADLs or IADLs, self-rating, psychological indicators or presence of disease. mEntal functioning was usually measured by mental status examinations, self-completed questionnaires, formal psychological tests. Social functioning, the ability to cope despite functional limitations, is a rather subjective concept and is not included in LTC policies.

In considering the suitability of measures used for determining when provision would be made under long term care policies, objective criteria need to be established for the policyholder, the insurance company, for claims assessment. The measures also need to be relevant to the elderly. They need to be clear to the policyholder and be capable of allowing substandard lives to be accepted. Insurance companies need adequate data and aim to reduce the risk of anti-selection. Different benefits may be payable for different levels of disability. The boundary for accepting or declining claims should be capable of definition. Measures need to be reliable and valid.

Under benchmarks proposed by the ABI, ADLs in the UK cover washing, mobility, dressing, toileting, transferring and feeding. Failure is defined as:

'being unable to perform the task, even with the use of special equipment. Constant physical assistance throughout the entire activity would always be required'

A list of objective criteria against which benefit measures could be assessed were drawn up by the working party. In general, ADLs scored well against most of these criteria, although some less well than others. However, the definition of failure of an ADL is often stricter than is actually used in practice so that borderline claims become subjective and it is difficult to explain where the trigger actually lies. This may allow the office to meet care needs without exposure to care wants, but is this fair to the policyholder?

Looking at the USA, there is no standardisation of ADLs there. Although superficially similar to the UK, US definitions are usually stricter than UK definitions. For example, mobility and feeding (the latter would not be failed in the US if the claimant were capable of taking intravenous feeding). The UK has a greater emphasis on home care. Comparable US

products are often cheaper. In general, UK definitions and practice are targeting lower levels of disability than the US. The implications of this include:

- US insured data are no use for pricing UK products
- Industry standards should not be too weak (ADLs may be better suited to more severe levels of disability), and
- There may be a generation of cheaper more restricted products waiting to be developed in the UK (eg benefits payable only in care homes).

The use of IADLs was also considered by the working part. These include such things as being unable to shop or make financial arrangements. However it was felt that IADLs failed many of the suitability criteria; in particular they are not reliable and objective.

The Royal Commission of Long Term care gave its backing to the use of ADLs in assessing care needs, although replacing always requiring attention with regularly requiring attention. The Commission also favoured using failure of one ADL only rather than two of three to require care provision.

The working party also looked at the use of systems for identifying needs and preparing care packages used by other bodies with interests in care provision. There would be considerable benefits in using a standardised assessment. In particular, a system developed in the US, known as the Minimum Data Set/Resident Assessment Instrument (MDS/RAI), was investigated. This has been tested in several countries and shown to give reliable results when assessments made by two independent assessors. The results for assessing ADLs were very good in nearly all the countries. The system has also been trialled in the UK and is being taken up by various users, including some local authorities and health trusts. The use of MDS also appears to reduce the decline in ADL functioning and cognitive status. Examples of the assessment forms were available to delegates.

The database held at the University of Michigan now has 7 million longitudinal assessments, which might prove valuable to the insurance industry for research into ADLs or the setting up of a points scale for triggering payments under policies.

The overall conclusions of the working party were

- ADLs are not so bad, but may be unfair
- Weaker ‘simple’ triggers would not work
- ADLs could be developed
- Next advance would probably involve close links with the state