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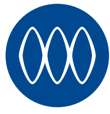

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FALL 2004

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Patient Safety First

by Sherrie Dulworth

Around 400 B.C., Hippocrates wrote, "As to disease, make a habit of two things—to help—or at least to do no harm." Since that time, medical and lay personnel have studied issues of healthcare patient safety. But the catalyst that kindled attention in recent years was the 2000 Institute of Medicine report, *To Err is Human*, which estimated that up to 98,000 deaths per year may occur in hospitals due to medical errors. The report launched a full-court press into the topic of patient safety and ways improve the healthcare delivery system.

For employers that sponsor health benefit plans, the issue of patient safety carries additional concerns, including healthcare quality and costs. This article explores ways plan sponsors may assess their health plan providers and positively influence the outcomes of medical care for employees.

Safety in the Healthcare System

Safety is a subset of larger quality issues. It can be viewed as the avoidance or prevention of an adverse event that might arise from the process of healthcare delivery. In other words, patients should not find themselves harmed as a result of having sought medical care, and patient safety activities should lead to better quality outcomes. While much of the recent emphasis on patient safety has been directed at the hospital setting, safety concerns and responsibilities are not restricted to a given site or personnel. Instead, they run through the continuum of care including ambulatory, hospital, recovery facility, home care, and nursing home, and among the breadth of personnel who work within those settings.

Employers, especially those in the small- to medium-size range, have historically abdicated safety/quality oversight to health plans or medical management vendors. It was not an issue that employers had the time or resources to tackle, or one they believed they could strongly influence. After all, with the exception of healthcare institutions, employers are not the hands-on caregivers nor do they typically provide the direct medical management oversight. But that laize-fare approach to safety is changing.

Your Money or Your Life

Employers have learned that the additional burden of adverse medical events contributes heavily to the increasing healthcare price tag. Studies have shown the increased costs associated with some common, and often preventable, complications of medical care. The increased costs come in various forms, including excess hospital lengths of stay, excess charges, and excess mortality. For example, one study showed that post-operative blood clots added an average burden of about $22,000 in additional charges and an increased mortality of almost 7%. These statistics do not include the indirect costs of disability, lost work time, and lost productivity to employers.

In a recent webcast on patient safety that was co-sponsored by Milliman, 75% of the attendees responding to a survey ranked safety as "very important" to their customers. But those safety concerns appear misaligned when vendors are asked to focus on quality, given that most of the decisions an employer makes, in fact, are based on cost. A 2004 survey by the Society for Human Resource Management revealed that cost is the number one factor (93%) that employers use to evaluate health plans; quality ranks as number two (44%).

Vendors, including those in healthcare, match their priorities with their customers'. Cost is important, but when weighed without the context of quality, healthcare is reduced to a commodity. Is it any wonder that most healthcare network contracting goals focus on reimbursement rates and ensuring that care givers meet "minimally acceptable" credentials or accreditation standards rather than "best practice" providers? Adding quality to the healthcare formula offers balance and allows for a value-based equation and assessment.

Employers' Sphere of Influence

Employers can assess the "safety quotient" of medical management vendors (health plans, utilization/case/disease management companies, pharmacy benefit managers) in various ways.

The LeapFrog Group for Patient Safety, which boasts a sizeable employer membership, has developed well-publicized patient safety initiatives based on scientific evidence. The LeapFrog Group also recommends the following purchasing strategies to enhance patient safety:

- Informing and educating employees about patient safety and their healthcare choices;
- Rating and comparing major healthcare providers' safety efforts;
- Using substantial incentives to reward outstanding efforts to improve patient safety;
- Focusing on discrete advances in patient safety, highlighting a common set of delivery system improvements likely to yield the largest safety gains;
- Holding health plans accountable for their role in reducing medical errors; and
- Enlisting the support of benefits consultants, brokers, and purchasing coalitions to promote patient safety.

Reducing Infections

Infections are expensive in both monetary cost and the added burden of human suffering. The Centers for Disease Control and Prevention estimates that 2 million patients develop hospital-acquired infections (HAIs) annually and as many as 88,000 die as a result, adding an estimated $5 billion to the annual national healthcare costs. While not all healthcare associated infections are avoidable, many are. Research published this year in the *American Journal of Medical Quality* indicates there is a link between longer stays and higher incidents of infections. To further evaluate the efficiency and quality components of care, several organizations, including Milliman, can provide severity-adjusted discharge data that can be used by employers when considering overall hospital quality and safety performance. Employers and third-party payers can then use this hospital profile information in making contracting decisions.

Because of the number of individuals at risk, the area of HAIs is an important one in which small improvements can make a major difference in safety outcomes.

Not Just a Hospital Issue

Much attention has focused on the need for safety improvements in the hospital. While these are valid concerns, the ambulatory office or clinic setting is also rife with opportunity for error, although for multiple reasons, it is more dificult to determine the magnitude within this venue. For a physician to read all of the new pertinent medical literature on a monthly basis, some have speculated, there would be no time left for patient care. The information overload is real and accelerating. But various resources exist to help physicians manage patients according to best practices. While the good news is that physicians appear more willing to use practice guidelines, the adoption and integration of such guidelines into patient care has been slow.

Hospital medication errors are often caused by misinterpretation of physician handwriting or medical "shorthand," or multiple caregivers prescribing drugs. The safety initiatives being put into place in many hospitals are helping to reduce these errors. In the ambulatory setting, a patient may obtain prescriptions from multiple physicians, or physicians may neglect to note contraindications to medications that match the patient's conditions. For example, gentamicin may be the ideal drug of choice for a serious respiratory or urinary tract infection, but prescribing it for a patient with underlying renal dysfunction can also lead to irreversible deafness. Among the appropriate management steps in prescribing this common antibiotic are that the physicians determine if a less toxic drug could be used as a first-line agent, ascertain if the infectious organism is susceptible to gentamicin, evaluate the patient for potential underlying renal dysfunction, educate the patient for early adverse effects, and monitor patient blood levels for gentamicin toxicity.

Employers can advocate for the use of best practices and clinical care guidelines in the ambulatory setting. The National Committee for Quality Assurance, an independent nonprofit organization that accredits health plans, has 22 HEDIS® "Effectiveness of Care" measures for assessing the quality of care delivery in the outpatient setting for areas such as hypertension control, comprehensive diabetes care, and antidepressant medication management. These measures can provide insight into omissions or delays in care that can lead to patient safety concerns. Despite demographic and plan design differences, employers can find appropriate ways to evaluate key quality outcome measurements for their covered population. (Some "Questions for Vendor Assesment" are available at www.milliman.com.) Employers should evaluate methods of rewarding desired outcomes through contracting incentives with health plans, administrators, and providers.

Rewarding Employees

Educating employees is a good thing but providing financial incentives might go further in driving changes toward improved patient safety. Health plan participants often select providers based upon geographic

convenience and word of mouth referral but know little about safety and quality issues. Most employees spend more time contemplating the safety record when purchasing a new car than when selecting a hospital, physician, or other healthcare provider. Some do so due to the lack of available and credible data or because of ingrained cultural patterns that reflect an inherent trust of the medical system.

But in some cases, it is due to the plan design—specifically the financial incentives or penalties—that strongly influence employee decisions. A typical plan offered by employers imposes penalties, in the form of higher co-pays, which are designed to discourage participants from seeking healthcare out of the network. And most networks are developed with cost concerns foremost in mind, along with providing the greatest geographic coverage for a given employee population. Increasingly, employers are offering financial incentives to providers who follow defined quality/safety measures or meet outcome targets. But employers or their vendors could also use profiling data to define a select subset of providers with the best safety/quality records in various categories (providers of excellence) and provide employee incentives (e.g., waived deductibles or co-pays) that would help steer members to the best providers.

Interest or Commitment?

Healthcare organizations are making changes to improve patient safety but it is a complex problem that requires complex solutions. Advances can be seen in systemwide adoption of policies designed to reduce the opportunity for miscommunication and errors, such as those designed to mitigate the chances of wrong-site surgeries. But there remain opportunities for improvement and ways in which employers can help shape the safety movement.

Employers have become increasingly empowered with the knowledge that they can act to positively influence safety and the need to do so. As with most things that result in lasting change, interest and commitment should not be confused. The commitment to safety from the employer-purchaser market, and the collective influence employers have, can continue to be a powerful force—driving change and improving care.

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The Retirement Equity Act: Still Crazy After All These Years

by Dawilla Madsen

Twenty years ago the Retirement Equity Act (REA) was born. At this age, REA should be all grown up, and abiding by the rules and regulations should be second nature for retirement plan sponsors. However, because guidance in many key areas is still missing, not only are plan sponsors still struggling with the interpretation of the original act, but also the rules and regulations are being disregarded in many cases. Except for a growth spurt now and then in the form of additional guidance, plan sponsors are back where they started in 1984 when REA was in its infancy.

What Did REA Do?

Although REA contains several provisions, it is probably most noted for its changes in survivor benefits. These provisions are also the most troubling and least understood and, yes, a little crazy.

In general, REA requires that retirement benefits from a qualified defined benefit (DB) plan, and money purchase and target benefit defined contribution (DC) plans with a value of greater than $5,000 be paid in the form of a qualified joint-and-survivor annuity (QJSA); and if the participant dies prior to the date benefits commence (i.e., the annuity starting date or ASD), preretirement death benefits must be paid in the form of a qualified preretirement survivor annuity (QPSA). The QJSA must be available to the participant on the earliest date that the plan permits distributions of any other optional form (e.g., if a lump-sum distribution is payable immediately upon termination of employment prior to early retirement, the QJSA must also be payable immediately). Under certain circumstances, the QJSA or QPSA can be waived, but only if the plan provides for the waiver and the participant is given a timely written explanation of the terms and conditions of the QJSA or QPSA before any waiver. If the participant is married, the written acknowledgement and consent to the waiver must be obtained from the spouse.

Most 401(k) and profit-sharing DC plans are exempt from the majority of the waiver and consent requirements unless they offer life annuities as an optional form of benefit. Church and governmental plans are not subject to the provisions of REA regardless of the type of plan (i.e., DB or DC).

REA Consent Requirements

The one thing that is consistent throughout the REA provisions is

that nothing is what it seems and there are always exceptions to the general rule.

Who Is the Spouse?

A spouse is a spouse is a spouse, right? Well not always, according to REA. Usually, the spouse is the person to whom a plan participant is married on the ASD or the date of the participant's death. However, the plan can provide that the spouse will not be eligible for the QPSA unless the participant and spouse have been married for at least one year. Although this seems like a straightforward concept, for purposes of the QJSA, it is not. Instead, a spouse will be considered the spouse on the ASD regardless of how long the participant and spouse have been married. If the marriage ends before one year or if the participant dies before the end of the one-year period, a plan may provide that the former spouse loses the right to the QJSA.

Divorce adds another layer of complexity. If as a result of a divorce a qualified domestic relations order (QDRO) has been issued naming the former spouse as the spouse for purposes of the QJSA or QPSA, the former spouse is eligible for the survivor rights under the QJSA or QPSA as if he or she were married to the participant. In such a scenario, the current spouse would not be eligible for survivor benefits.

The definition of marriage can also be confusing. Marriage is determined under the local state laws and includes common-law marriages if recognized by the state. Recently, there has been controversy over same-sex marriages. For the time being, however, the 1996 federal Defense of Marriage Act takes precedence over state law and does not require same-sex marriages to be recognized for purposes of QJSA and QPSA rights. However, this is a rapidly changing issue that bears watching in the courts and in legislation.

What Is Consent?

Plans have the option of permitting participants to opt out of providing survivor benefits to the spouse. However, the participant's spouse must consent in writing to any waiver of the QPSA or QJSA. This consent must acknowledge the consequences of the waiver and be witnessed by a representative of the plan or a notary public. Most plans require the consent to be irrevocable; however, a revocable consent is permitted. Regardless of the spouse's ability to revoke, a participant must be allowed to change the form or beneficiary at any time prior to the ASD.

Consents can be either specific or general. In a specific consent, the spouse must agree to the specific form and beneficiary that the participant has elected. In a general consent, the spouse simply agrees to the waiver of spousal rights under a QJSA or QPSA and must acknowledge that he or she has the right to a specific consent and is relinquishing such right. Under a general consent, a participant may change the form or beneficiary without any further consent of the spouse.

If a plan provides that the QPSA can be waived before the participant attains age 35, any waiver and associated consent becomes void at age 35 and a new waiver and consent must be obtained or else the spouse will automatically receive the QPSA benefit.

There are circumstances when spousal consent is not required. If the spouse cannot be located, spousal consent is not required. If the spouse is legally incompetent, a legally appointed guardian is permitted to give consent. Finally, if the participant is legally separated or has been abandoned and has a court order to such effect, spousal consent is not required unless a QDRO requires it.

REA Consent and Disclosure Requirements

What is Required to Waive the QJSA or QPSA?

For any waiver or consent to be valid, the participant (and spouse, if applicable) must attest to understanding the consequences of the waiver. REA requires that before any waiver or consent is made, the plan administrator must give a written explanation of the QJSA or QPSA in a form that can be understood by the average participant. This "QJSA Notice" must be given at least 30 days, but no more than 90 days, before the ASD to all participants regardless of marital status. A plan may permit a participant to waive the 30-day requirement if distribution does not occur prior to the eighth day after the participant receives the QJSA Notice.

In general, the "QPSA Notice" must be given upon commencement of employment. However, if the participant is younger than age 32 when hired, the QPSA Notice must generally be given within the period between ages 32 and 35.

Both the QPSA and QJSA Notices must be provided in writing via first class mail to the participant's last known address or by hand delivery. Posting the notice in a common location or via electronic means is not permitted.

What Information Must the QPSA and QJSA Notices Contain?

The QPSA and QJSA Notices can either be specific or general in nature.

Specific Notices

A specific QJSA Notice must contain a description of all of the plan's optional forms of benefit, including eligibility requirements and other material features; and the amount payable under each form (i.e., the financial effect). For DB plans, the relative value of each form compared to the QJSA must be detailed.

A specific QPSA Notice must contain a general description of the QPSA, and if the plan requires the participant to pay for QPSA coverage, the amount by which the participant's benefit is reduced.

General Notices
A general explanation contains the same information as the specific notices, except it uses an example of a "typical" participant and spouse to illustrate the financial effect and relative value of each optional form. If a general notice is given, however, the participant has the right to request specific information.

Grown-up at Last?

The latest adolescent spurt for REA came in the form of two sets of final regulations from the IRS. The first set explains the procedures for the implementation of a relatively new exception to the timing of the QJSA Notice. Briefly, if the QJSA Notice is issued after the ASD, a "retroactive annuity starting date" (RASD) occurs. For example, a participant gives notice of his retirement within 30 days of the date he wishes to retire; thus, the 30-day requirement for the QJSA Notice cannot be met. In this case, the participant would have to elect a RASD to receive the retroactive payment. To utilize a RASD, the plan must provide for it (or be so amended) and the participant must affirmatively elect it. If the participant does not want retroactive payments, he must be given an actuarially increased benefit to compensate for the later commencement date.

A RASD is not to be confused with an administrative delay. For example, if the QJSA Notice was given timely and the participant just delayed getting her paperwork competed until after the ASD, payments retroactive to the ASD would most likely not be considered as a result of a RASD.

Although required by the original REA regulations, there had been no clear guidance on how to disclose the financial effect and relative value of optional forms. Thus, plan sponsors ignored these requirements or only disclosed the financial effect and relative values in a general manner. The second set of regulations provides detailed instructions on how to present these concepts.

While the pair of new regulations finally provided some long awaited answers, the excitement over the relative value provisions soon waned. There were enough questions and controversy that the IRS postponed the effective date of the changes to many QJSA Notices until 2006 at the earliest. However, the new regulations' effective date for the QJSA Notice requirements is not postponed for plans that offer optional forms with payments that decrease over the life of the participant (e.g., lump-sum distributions, installment options, or level-income options) if the value of such optional form is less than the value of the QJSA. Notices reflecting the new regulations for these optional forms were required beginning October 1, 2004.

The best example of this situation is when a plan provides a subsidized early retirement QJSA and a lump-sum option that is based on the present value of the deferred normal retirement benefit determined without the subsidy. In this case, the relative value of the lump sum, determined under the methodology of the final regulations, would most likely be less than the relative value of the QJSA.

In addition, the effective date for all QPSA notices was not postponed. Regardless of the postponement for many plans, plan sponsors and administrators are charged with operating their plans in good-faith compliance, which means that the requirements cannot be ignored without risk.

The Next Crazy Steps

In light of the new regulations and renewed emphasis on proper disclosure so that participants and spouses have the tools to make proper decisions, now is the time to review those old procedures that have been in place for 20 years and probably forgotten. In reviewing procedures, the following questions should be considered:

- Do you have a QJSA Notice or, if applicable, a QPSA Notice?
- Do you provide the Notices within the proper timeframes?
- Does your plan permit the waiver of the 30-day requirement?
- Do you utilize a RASD provision and has the plan been amended to provide for it?
- What kind of spousal consent does the plan require and do your administrative forms accurately reflect the consent provisions of the plan?
- Do you provide the participant with the amount and relative value of each optional form before an election is made?

Once the review is complete, action should be taken to correct any deficiencies. In addition, the new RASD, financial effect, and relative value issues should be discussed with your plan's actuary or other similar professional advisor to develop a game plan for implementation.

Conclusion

How will REA develop in the future? There will probably be more exceptions to the rules and there will still be uncertainty in what and how to disclose the required information. REA will remain crazy after all these years.

Dawilla Madsen is a compliance consultant in Milliman's New York office. This article was peer reviewed by Gerald Kranson, a benefits consultant in the New York office.

True Group Long-Term Care Coverage: The Final Piece in a Comprehensive Safety Net

by Jon Shreve and Jill Van Den Bos

In the coming decades, many Americans will not have a way to pay for long-term care services. As people live longer due to better medicine and healthier lifestyles, there will be a growing need for long-term care services. However, as the need for services increases, government funding will not be able to keep up, undermining the financial health of a critical component of the nation's healthcare delivery system.

This article presents an overview of long-term care, discusses the problems associated with long-term care coverage, and explores how true group long-term care coverage might offer a means for employers to expand their benefit program safety net for their employees.

Demographics and the Demand for Long-term Care

Today, Medicaid covers roughly two-thirds of nursing home residents, but this payment system is already stressed and is getting more precarious. Viewed from another angle, about 10% of state budgets are spent on long-term care. Medicaid reimbursement rates are low, typically only 72% of the amount paid by private sources and commercial insurance. These rates are often inadequate to cover the expenses incurred by the facilities. As a result, long-term care providers are struggling financially. Since 1999, six of the top 15 nursing facility chains have filed for bankruptcy. Four have since emerged from bankruptcy, but the industry still subsists on extremely weak profit margins. Low Medicaid reimbursement rates have left nursing homes financially compromised and raised issues regarding access, discrimination, and quality of care for Medicaid recipients compared with private paying residents. Thus, Medicaid is struggling to provide enough coverage under today's circumstances and the baby boom generation has yet to need these services.

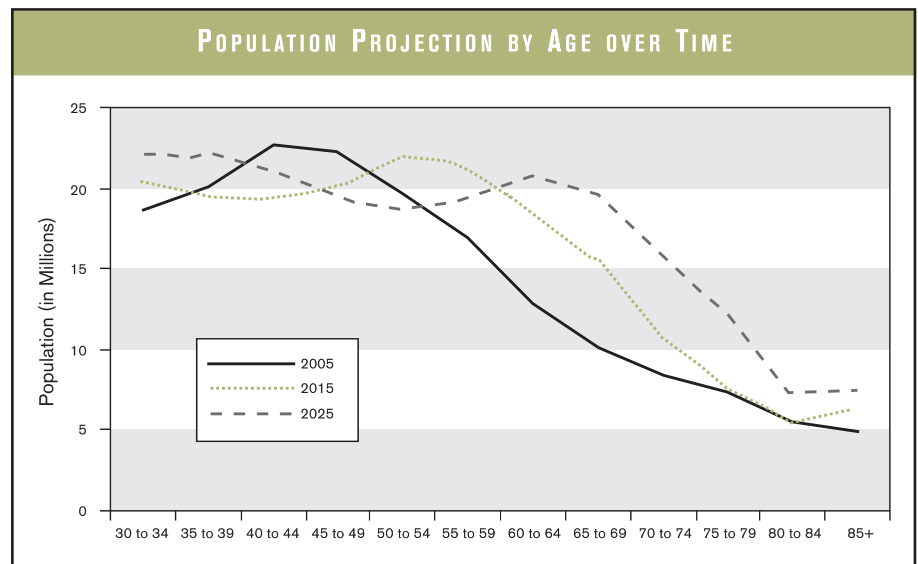
The inability of Medicaid to pay for long-term care services threatens to become worse. As America's baby boomers grow older (as shown by the US Census Bureau's population projections for 2005, 2015, and 2025, in Figure 1), the over-burdened Medicaid system will face greater demand for services without a concurrent increase in funding. The peak in each of the three lines in the figure shows the baby boomer population in each of the years presented.

The effect of the growth in the over-65 population is expected to be felt beginning around the year 2010, when the baby boomers begin to turn age 65. Some experts believe that without extensive systematic changes, Medicaid cannot subsist much beyond 2010 and cannot survive the impact of the boomers. Using US Census projections and the Milliman *Long-Term Care Guidelines*, the demand for nursing home services is estimated to increase by 48% from 2000 to 2020. This increase reflects utilization only and does not account for any increases in the cost of providing the services.

Current and Projected Costs

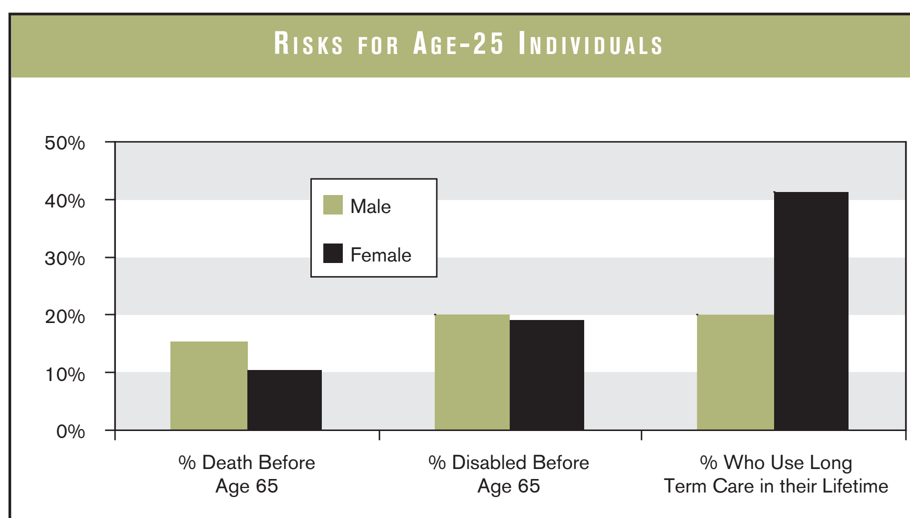
Many Americans mistakenly assume that Medicare or private health insurance will cover the cost of long-term care. Because they believe that nursing home costs are covered by other sources, they fail to plan for their future long-term care needs. Only about 3% of people are estimated to have long-term care insurance, yet about 43% of individuals turning 65 are expected to eventually enter a nursing home.

FIGURE 1



The average annual cost of a semi-private room in a nursing home now approaches $60,000. This is more than most Americans can afford to pay out of pocket. Medicaid requires that families exhaust their assets before a family member is eligible for nursing home coverage, and the majority of nursing home residents have had to do this. This sequence of events is catastrophic for a spouse who is left at home with limited assets. However, as the need for services outpaces the available funding and as the government starts reimbursing at lower rates and tightening qualification requirements, even this option may disappear.

FIGURE 2



It is estimated that 25% of all households have one adult providing care for an elderly person. This number is expected to increase substantially over the next 10 years. Caregiving for a dependent adult in the home can be stressful physically, financially, and emotionally. In fact, there are studies showing that caregivers are less healthy and more likely to die early than non-caregivers. Providing assistance with activities of daily living (ADLs) can require full-time effort and constant supervision. It can also put increased financial hardship on families for expenses that are not covered by medical insurance. For this reason, baby boomers are often referred to as the "sandwich generation," caught between caring for children and parents at the same time.

When the Caregiver is Your Employee

For working caregivers, the strain of balancing work plus caregiving can hurt job performance and productivity. Working adults caring for an elderly relative at home have more unscheduled absences and unexpected emergencies that interrupt their work during the day or require them to adjust their schedules. In addition, many individuals providing such care are forced to reduce their work hours or turn down additional job responsibilities.

The outlook for long-term care protection is gloomy. There is, however, a safety net to protect families from the financial adversity of long-term care. This safety net system has protected American families against catastrophic financial events such as sickness, death, disability, and retirement. Many US employers provide this safety net. Employers have protected their employees and families against financial destitution through traditionally designed benefit programs: medical coverage protects employees against catastrophic medical bills; life insurance protects against the loss of income due to death; disability insurance protects against financial hardship in the event of loss of income; and pension plans protect against the loss of income after retirement.

Long-term care is a notable remaining potential financial catastrophe against which most employees have no protection. The probability that an employee will one day face a nursing home stay is greater than either the probability of disability or premature death while employed, yet the financial fallout from those events is protected with employer-provided group benefits. Figure 2 summarizes these various risks.

"Convenience" vs. "True" Group Long-term Care

The long-term care financial crisis has been slowly advancing for years. But only in 1996, with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), did a definition arise to spell out how long-term care coverage could be offered as a tax-preferred employee benefit. Consequently, more employers, including the federal government, are making long-term care insurance available through payroll deduction as an employee-paid voluntary coverage. But these "convenience" benefits are not consistent with the employer's safety net goals: participation rates among eligible employees are, at best, 15%. Low participation undermines the reasons for providing benefits in the first place and offers little in the way of a safety net for the employee population. To provide a meaningful safety net benefit in this neglected area, employers need to offer long-term care coverage in a way that encourages employee participation while keeping employer costs reasonably low.

Many in the long-term care insurance industry call a contract between the insurer and the employer—with certificates of coverage for employees—"true group" coverage. But more features are

necessary to achieve this status. These features are summarized in Table 1.

The two biggest advantages of true group long-term care coverage, in contrast to typical employer long-term care coverage, are: vesting and waiting period requirements target the more valuable longer term employees for the benefit; and employer contributions will encourage greater employee participation. Employers that implement true group long-term care plans will be fulfilling a valuable role in the protection of employees from a glaring hole in the current safety net.

Self-insured approaches in offering true group long-term care should be considered. A self-insured approach uses a stand-alone fund to accumulate the contributions, generate investment income, and pay claims and expenses. A self-insured plan has advantages of potentially lower cost and greater control of the plan by the employer. On the other hand, a self-funded plan exposes the employer to more administrative burdens and risk.

TABLE 1

CONTRAST BETWEEN "TRUE GROUP" AND "CONVENIENCE" LONG-TERM CARE PLANS

True Group Long-Term Care	Convenience Long-Term Care
Employer Contribution	No Employer Contribution
Targeted at long-term employees by using waiting periods and/or vesting	Participation available to all employees immediately
Plan offered to dependents, if doing so meets employers' objectives	Plan offered to spouses, parents, retirees, and others to maximize insurance company prospecting
Benefit design set by employer and may be changed	Benefit design set by insurer and immutable
Possibly self-funded or alternate financing	Always fully insured
Commissions always removed	Commissions may be removed
High participation expected, providing meaningful safety net	Participation typically 6% to 15%

Conclusion

The market for true group long-term care coverage does not yet exist. But employers have a stake in influencing the market and can be the driving force to develop a viable product. In collaboration with government, insurers, and the nursing home industry, employers can help to avoid the impending crisis and ensure quality care for elder Americans. By designing a plan that uses appropriate vesting and waiting periods, and possibly self-funding, employers can reduce the cost of group long-term care coverage to less than the per-employee cost of a group dental plan.

Jon Shreve is a consulting actuary and Jill Van Den Bos is a consultant in the Denver office of Milliman. They are the authors of a book, ***True Group Long-Term Care****, published earlier this year by the International Foundation of Employee Benefit Plans. This article was peer reviewed by Steve Melek, a consulting actuary, also of the Denver office.*

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