



The Effect of Proactive Care Management on Long-Term Care Insurance Claimants: A 2.5-Year Longitudinal Analysis

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2. Abstract

Long-term care insurance (LTCI) members who completed a comprehensive needs assessment through The Helper Bees (THB) Care Concierge program, a proactive care coordination program, experienced an 82% lower annual facility transition rate than members who never engaged (2% vs. 12%) and remained at home an estimated 65 additional days by year two.

In addition to experiencing higher facility prevention rates, engaged members were projected to incur approximately \$150,000 less in cumulative costs over 10 years, incurring approximately \$681 less in costs per month, with savings concentrated in home-based care (\$430 per month). At the point of transition to institutional care, they drew on a smaller share of their available facility benefit, suggesting that moderately higher facility costs reflect care intensity rather than disproportionate benefit use. Long-term savings are driven primarily by delaying or preventing facility placement rather than by reducing facility care costs.

These results are drawn from 2.5 years of longitudinal claims data covering 925 plan members referred to THB. This analysis compared outcomes across increasing levels of program engagement, ranging from members who never engaged to those who completed a comprehensive needs assessment.

Greater engagement was consistently associated with more time at home, lower overall costs, and substantially different long-term claims trajectories. Care coordination should be evaluated by its effect on long-term claims trajectories, not simply by near-term utilization.

2.5 years

of longitudinal
claims data analyzed

925

plan members studied

82%

lower facility transition rates
at 12 months for fully engaged
members who completed
assessment ($p = .007$)

65

more days at home
at 24 months for fully
engaged members ($p = .007$)

19%

lower average monthly
claims costs for engaged
members ($p < .001$)

3. Introduction

Older adults overwhelmingly prefer to age in place, with an estimated 75% preferring this outcome (Binnette & Fanni, 2024).

Aging in place also offers several benefits beyond accommodating personal preference: It preserves autonomy, maintains social connection, and is associated with better quality-of-life outcomes than institutional alternatives (Wiles et al., 2012). Yet, for many older adults, this preference goes unrealized. Health crises such as a fall, hospitalization, or change in caregiver capacity can lead to an unplanned shift to a facility — a transition of care that is hard to reverse.

The financial impact of facility placement is substantial. For members, nursing home care can cost more than \$100,000 per year, and assisted living over \$70,000. This recurring cost can quickly exhaust even substantial personal savings (CareScout, 2025).

For long-term care insurance (LTCI) carriers, the challenge is structural: Facility placements cost more per month not just at the outset but through the remainder of the claim. A member who transitions to a nursing home at 78 instead of 83 does not incur only five extra years of facility costs — they generally exit the home-based care trajectory permanently, compounding the cost difference over time. Facility transition is the largest driver of long-term claims costs for carriers (Society of Actuaries, 2020).

Care coordination has shown promise in supporting aging in place and reducing avoidable care transitions in older adult populations. Structured interventions that proactively assess needs, coordinate services, and connect patients with appropriate support have demonstrated reductions in hospitalizations and acute care utilization across several well-designed studies (Counsell et al., 2007; Naylor et al., 2004). Many adverse transitions result from unmet needs that, if identified early, could be addressed through better-coordinated home-based care. But most of this evidence base comes from Medicare and Medicaid contexts, where the outcome of interest is hospital readmission. The care coordination literature offers little evidence on facility transitions in LTCI populations, where distinct needs, benefit structures, and risk profiles make direct extrapolation from Medicare and Medicaid studies unreliable.

The Helper Bees (THB) Care Concierge program was designed to test that proposition. The program offers LTCI claimants a structured engagement pathway: Members are referred by their plan, initially opting in for contact, and then invited to complete a comprehensive needs assessment that informs a personalized care plan. The premise is that identifying needs early may be associated with members remaining safely at home for longer.

This paper presents findings from 2.5 years of longitudinal claims data covering 925 LTCI plan members, examining whether engaged members spend more time at home compared to non-engaged members, how costs differ by care setting and engagement level, and whether investment in home-based care translates to lower long-term claims expenditure.

These findings carry direct implications for how carriers should evaluate care management programs as both near-term cost management tools and drivers of long-term claim performance.

4. Methods

4.1 Study Design and Population

This analysis is a retrospective cohort study of 925 LTCI plan members referred to the THB Care Concierge program between September 2023 and September 2025, with claims data tracked through February 2026. The analytic cohort includes 600 members (374 engaged members and 226 never-engaged members).

Members were required to undergo at least six months of observation from their program entry date for inclusion in the analyses. Because this is an observational study, members were not randomly assigned to engagement levels, and self-selection (i.e., where members who choose to engage may differ systematically from those who do not) cannot be fully eliminated. The six-month observation requirement helps mitigate this by ensuring that outcomes reflect sustained patterns rather than short-term differences in when members entered the program.

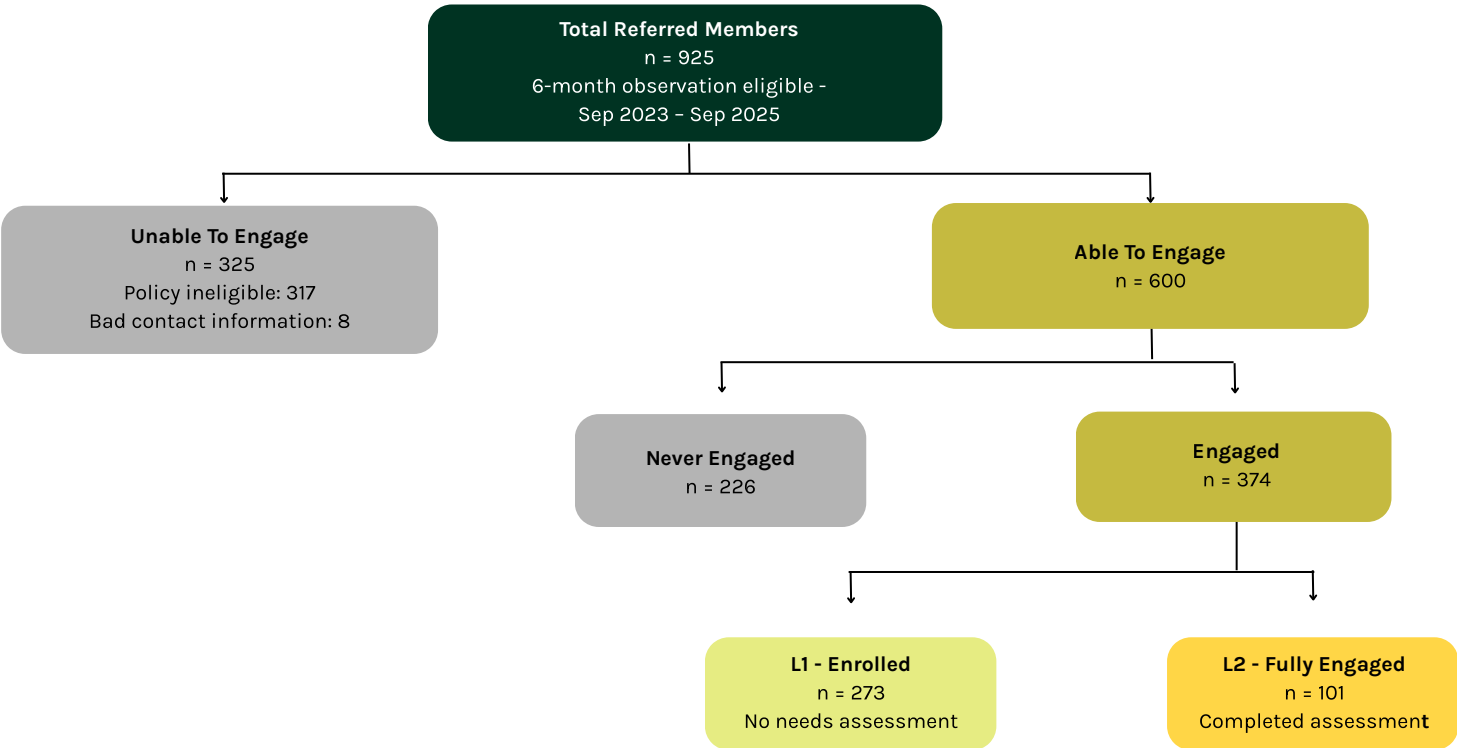
For facility transition analyses, the cohort is restricted to 573 members who were receiving home-based care at program entry. For cost analyses, the per-setting monthly cost cohort is restricted to 595 members who have at least one month of spend data at program entry, and the benefit utilization cohort is restricted to 543 members with at least one month of home-care spend data in the first six months after program entry.

4.2 Engagement Classification

Engagement levels are classified as Level 1 (L1) or Level 2 (L2). L1 (Enrolled) includes members who opted in to the Care Concierge program after being referred but have yet to complete a needs assessment. L2 (Fully Engaged) includes members who completed a full needs assessment after opting in to the Care Concierge program. Never-engaged members were referred to the program but did not opt in or complete an assessment. For engaged members, the program entry date is the earliest between their opt-in date or assessment date. For never-engaged members, it is their referral date.

Of the 925 referred members, 374 engaged with the program (L1: 273, L2: 101) and 551 never engaged. Among the never-engaged group, 325 members were not able to be engaged; 317 had ineligible policy statuses (i.e., policies that had been terminated due to death, benefit exhaustion, or lapse) and eight had no valid contact information on file. These members were structurally unreachable regardless of outreach effort and are excluded from the analyses. The remaining 226 never-engaged members were able to be engaged (i.e., they had valid contact information and eligible policies) but either could not be reached or declined participation. Figure 1 illustrates the full cohort structure and the composition of each analytic outcome's sub-cohort.

Figure 1. Study cohort flow



Outcome Analyses

Facility Transition Analysis	
Home-based care at program entry	
Engaged	Never Engaged
n = 357	n = 216

Cost Analyses	
Per-Setting Monthly Costs	
= 1 month of spend after program entry	
Engaged	Never Engaged
n = 369	n = 226
Benefit Utilization	
= 1 home-based month with valid benefit data in first 6 months	
Engaged	Never Engaged
n = 337	n = 206

4.3 Outcomes and Measures

Key Definitions

Term	Definition
Facility transition	The first observed move from a home-based care setting at program entry to assisted living or nursing home care at any point afterward.
Facility transition rate	The estimated probability of transitioning to facility care within a year, calculated using a statistical method that accounts for members being observed for different lengths of time.
Expected months at home	How long a typical member in each group is projected to remain in a home-based setting over one- and two-year periods, derived from the same statistical method.
Home care cost / facility cost	Average monthly reimbursement during months spent in each respective care setting.
Benefit utilization	The share of a member's maximum daily benefit (MDB) actually used, expressed as a percentage of their maximum allowable reimbursement.
Pre-program benefit utilization	The share of a member's MDB used in the period prior to program entry (months -6 to 0 relative to program start), restricted to members with at least one home-based month and valid MDB data during that window. Used to compare baseline utilization levels across groups before program contact. A fixed six-month window is used rather than all available history to standardize the observation period across members with varying policy tenures.
Utilization trajectory	Cumulative home care MDB utilization after program entry, expressed as the percentage-point change from each group's pre-program baseline, used to assess whether utilization patterns diverge over time.

Analyses conducted: facility transition rates and expected months at home; per-setting monthly costs; benefit utilization; pre-program benefit utilization; utilization trajectory; and long-term cost projections.

4.4 Long-Term Projections

To project how costs and outcomes might unfold over time, we use a simple two-stage model: At any point, a member is either living at home or in a facility. Once a member moves to a facility, they are assumed to stay there. The model uses each group's observed transition rate and average monthly costs as inputs, estimating total costs and the share of members in facility care at the three-, five-, and 10-year marks.

These projections assume that transition rates and costs hold steady over time. If anything, this understates the long-term advantage of engagement. Over our 2.5-year follow-up window, the gap between engaged and never-engaged members widens instead of holding steady (see Section 5.4).

4.5 Statistical Analysis

All outcome differences reported in this paper were tested for statistical significance.

Facility transition rates were compared using a method that accounts for the fact that members were followed for different lengths of time. Cost comparisons were based on each member's average monthly spending, using an approach designed for insurance claims data, where a small number of very high-cost cases can otherwise distort simple averages. Benefit utilization differences were tested by comparing the average share of daily care setting (i.e., home care and facility) benefits used between groups. Pre-program utilization differences and post-program cumulative trajectories were assessed using the same group-comparison approach applied to benefit utilization.

5. Results

5.1 Facility Transitions and Time at Home

Facility transition represents a major cost inflection point for LTCI claims. The national median cost of assisted living exceeds \$6,200 per month (CareScout, 2025) and is typically irreversible. The data from the THB Care Concierge program shows a consistent pattern in how to prevent facility transition: **Engaged members stay home longer, and the association is strongly dose-dependent.**

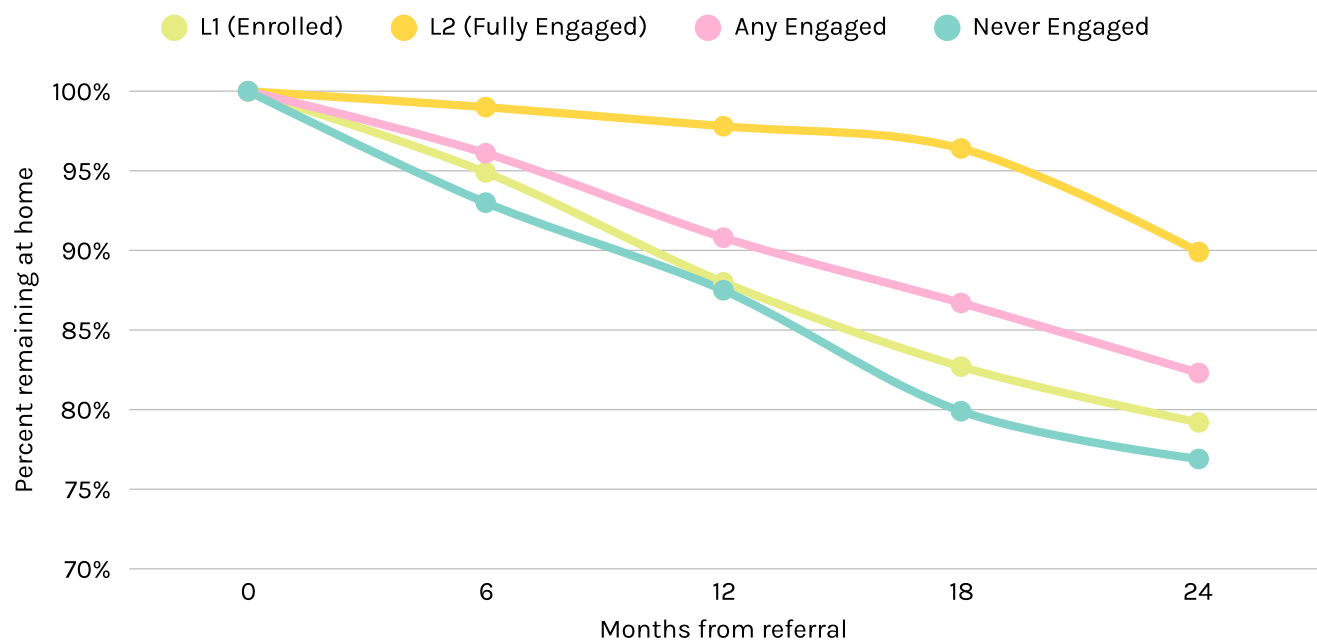
Two metrics capture the program's impact on aging in place: expected months at home (how long, on average, a member remains in a home-based setting over one- and two-year periods) and facility transition rate at 12 months. This analysis is restricted to members who were in a home-based care setting at program start, as only members starting at home can meaningfully “transition” to facility care.

Table 1. Facility transition rate and expected months at home by engagement level

Metric	L1 (Enrolled) n = 259	L2 (Fully Engaged) n = 98	Any Engaged n = 357	Never Engaged (NE) n = 216
Months at home (Year 1)	11.39	11.80	11.52	11.19
Difference vs. NE	+8 days	+21 days	+12 days	—
Months at home (Year 2)	21.37	23.09	21.90	20.95
Difference vs. NE	+13 days	+65 days	+29 days	—
Facility transition rate at 12 months	12%	2%	9%	12%
Difference vs. NE	2% reduction	82% reduction	25% reduction	—

Note: Facility transition rate at 12 months is significant for L2 vs. never-engaged (HR = .334, p = .007).

Figure 2. Facility transition rates



Only 2% of L2 members transition to facility care in the first year, compared to 12% of never-engaged members. That gap in outcomes compounds over time – by the end of year one, L2 members have spent 21 more days at home than never-engaged members. By year two, that advantage grows to 65 additional days.

Key Takeaways

Deeper engagement is associated with lower facility transition rates and more time spent at home.

L2

82% lower facility transition rate and 65 additional days at home by Year 2, compared to never-engaged members.

L1

2% lower facility transition rate and 13 additional days at home by Year 2, compared to never-engaged members.

Any

25% lower facility transition rate and 29 additional days at home by Year 2, compared to never-engaged members.

Outcomes are systematically associated with engagement depth. Getting more members to complete a full needs assessment is the most important lever for strengthening program results.

5.2 Cost Mechanism

Staying home longer is meaningful for program success only if it does not come at a higher cost. On average, engaged members show lower monthly costs than members who were never engaged, and the difference is concentrated in home-based care. When members enter facility care, costs are similar regardless of engagement level.

This pattern is consistent with engagement being associated with more efficient use of home-based services. **Engaged members cost less at home, and they end up costing the same as never-engaged members once in a facility.**

Costs are broken out into three components:

- Average monthly cost across all care settings
- Monthly home care cost (home-based months only)
- Monthly facility cost (facility months only)

Sample sizes differ across rows because each row counts members with at least one month in that care setting — most members have home care months, and a subset also have facility months. The average monthly cost (top row) reflects each member's total paid claims averaged across all months regardless of setting. It is not a simple weighted average of the home and facility rows because members contribute different numbers of months to each setting.

Table 2. Monthly costs by engagement level and care setting

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Average monthly cost	\$2,950 (n = 271)	\$3,000 (n = 98)	\$2,963 (n = 369)	\$3,644 (n = 226)
Difference vs. NE	-\$694	-\$644	-\$681	—
Average monthly home care cost	\$2,732 (n = 271)	\$2,878 (n = 97)	\$2,771 (n = 368)	\$3,201 (n = 222)
Difference vs. NE	-\$469	-\$323	-\$430	—
Average monthly facility cost	\$6,568 (n = 47)	\$6,337 (n = 7)	\$6,538 (n = 54)	\$6,097 (n = 54)
Difference vs. NE	+\$471	+\$240	+\$441	—

Note: Average monthly cost difference is significant for L1 vs. never-engaged ($r = .232, p < .001$), L2 vs. never-engaged ($r = .205, p = .003$) and any-engaged vs. never-engaged ($r = .225, p < .001$). Home care cost differences are significant for L1 vs. never-engaged ($r = .151, p = .004$) and any-engaged vs. never-engaged ($r = .135, p = .006$). Facility care cost differences are not significant at any level.

Figure 3. Monthly costs by engagement level and care setting



Note: Horizontal line marks the never-engaged level within each cost category. *p < .05 vs. never-engaged

Engaged members cost less per month, and those savings are concentrated in home-based services. Engaged members spend \$430 less per month on home care than never-engaged members on average, and L2 members spend \$323 less. When members enter facility care, engaged members trend higher in monthly costs than never-engaged members, though the difference is not statistically significant. The cost gap reflects lower home-based spending among engaged members, while facility costs, by contrast, trend modestly higher for engaged members.

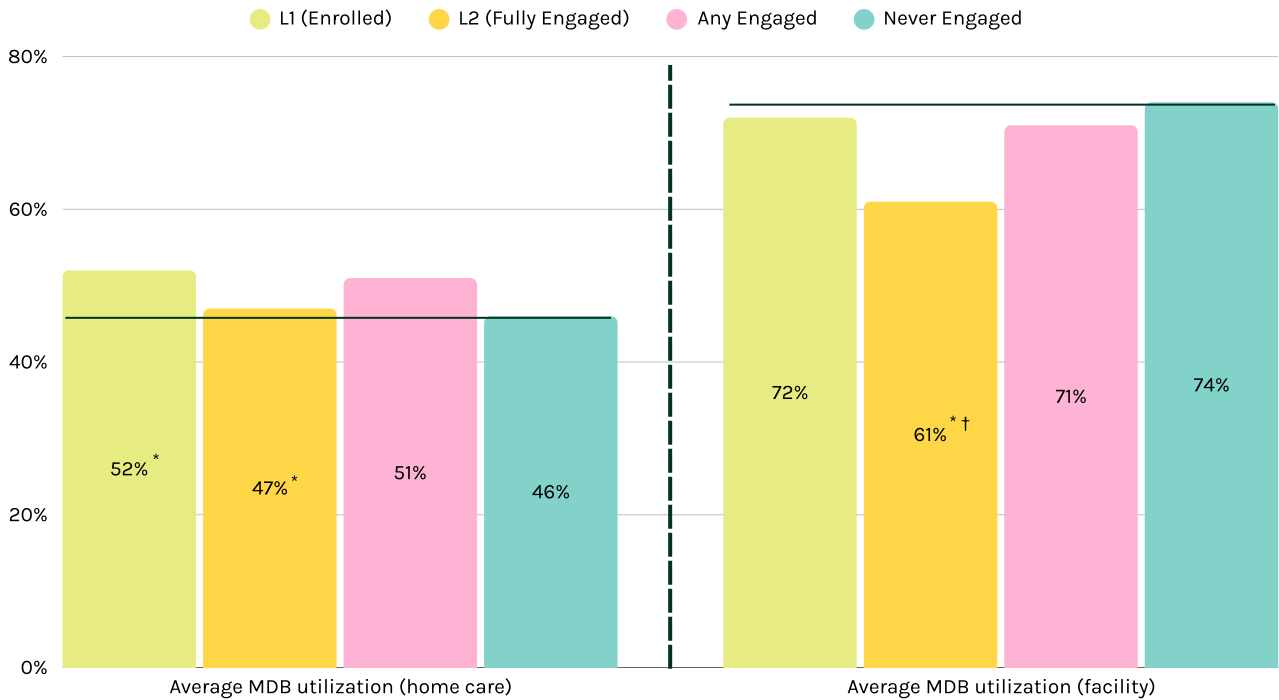
The cost data shows what members spend but not how fully they use their available benefits. MDB utilization fills in that picture by measuring the share of the available monthly benefit that members actually draw on. Higher utilization indicates that members are accessing more of the care they are entitled to, which is consistent with the program's goal of connecting members with appropriate services. For home care utilization, this analysis is restricted to home-based months in the first six months after program start for members with valid MDB data. For facility utilization, no restrictions were applied because of the small number of facility-based months among members.

Table 3. MDB utilization by engagement level

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Average MDB utilization (home care)	52% (n = 242)	47% (n = 95)	51% (n = 337)	46% (n = 212)
Difference vs. NE	+6.7 pp	+1.3 pp	+5.1 pp	—
Average MDB utilization (facility)	72% (n = 45)	61% (n = 7)	71% (n = 52)	74% (n = 54)
Difference vs. NE	-1.9 pp	-12.6 pp	-2.9 pp	—

Note: Average home MDB utilization is significant for L1 vs. never-engaged ($d = .166, p < .001$) and any-engaged vs. never-engaged ($d = .126, p = .005$). Facility MDB utilization is significant for L2 vs. never-engaged ($d = -.337, p = .017$), though this finding should be interpreted cautiously given the small sample.

Figure 4. MDB utilization by engagement level



Note: Horizontal line marks the never-engaged level within each utilization category. * $p < .05$ vs. never-engaged. † Facility L2 finding should be interpreted with caution given small sample size ($n = 7$)

Engaged members as a group draw on a larger share of their home care benefit than never-engaged members, but the pattern differs by engagement level. L1 members account for the full difference, and L2 members show no significant difference relative to members who never engaged. This is consistent with opt-in members accessing home-based services they were not previously using, while L2 members, who complete a full needs assessment, may already be receiving appropriately matched care. In facility care, the pattern reverses:

Despite trending higher in monthly facility costs, engaged members draw on a smaller share of their available facility benefit than never-engaged members, with L2 members showing the largest gap. The higher facility costs among engaged members reflect the price of care, not disproportionate benefit use. Together, the cost and utilization patterns point toward a consistent picture: **Engaged members are spending less on home-based care overall, and those at L2 are doing so in a way associated with substantially lower rates of facility transition.**

Key Takeaways

Engaged members spend less on home-based care and draw on a smaller share of their available facility benefit than never-engaged members.

L2

L2: \$323 less per month on home care than never-engaged members; no significant difference in home care MDB utilization.

L1

L1: \$469 less per month on home care; significantly higher home care MDB utilization than never-engaged members.

Any

Any: Facility costs trend modestly higher than never-engaged members, though not significantly; engaged members draw on a smaller share of their available facility benefit when they do transition.

Cost savings are concentrated in home-based care; when members do transition to facility care, engaged members draw on a proportionally smaller share of their available benefit than never-engaged members.

5.3 Utilization Trends Over Time

A key consideration in interpreting the home care utilization finding is whether engaged members entered the program with higher utilization to begin with. If so, the observed differences could reflect preexisting tendencies rather than a program-associated change. Pre-program home care MDB utilization was examined across engagement groups to test this directly.

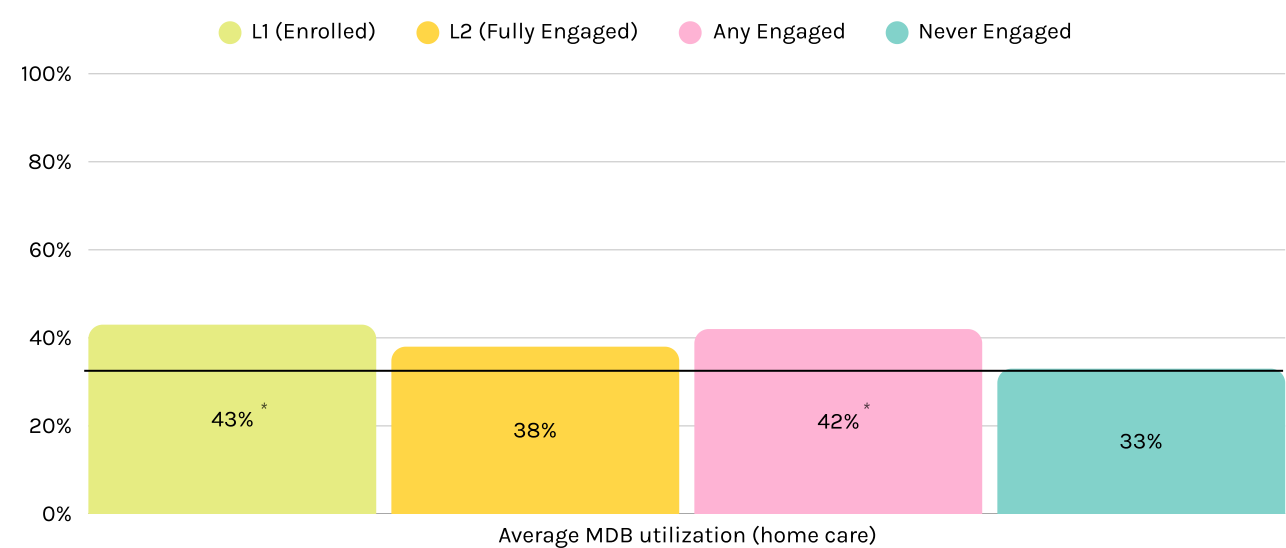
Engaged members do enter with higher utilization than never-engaged members, which is consistent with some degree of self-selection – however, rate of change analyses find that the groups diverge further after program start, showing a pattern that self-selection alone does not explain.

Table 4. Pre-program home care MDB utilization by engagement level

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Average MDB utilization (home care)	43% (n = 136)	38% (n = 54)	42% (n = 190)	33% (n = 150)
Difference vs. NE	+10.2 pp	+5.3 pp	+8.9 pp	—

Note: Pre-program home care MDB utilization covers months -6 to 0 relative to the program start date (home-based months only). The program start date is the engagement date for engaged members and the referral date for never-engaged members. Average home care MDB utilization is significant for L1 vs. never-engaged ($d = .283, p = .017$) and any-engaged vs. never-engaged ($d = .244, p = .027$).

Figure 5. Pre-program home care MDB utilization by engagement level



Note: Pre-program window spans months -6 to 0 relative to program start. Horizontal line marks the never-engaged level.
* $p < .05$ vs. never-engaged.

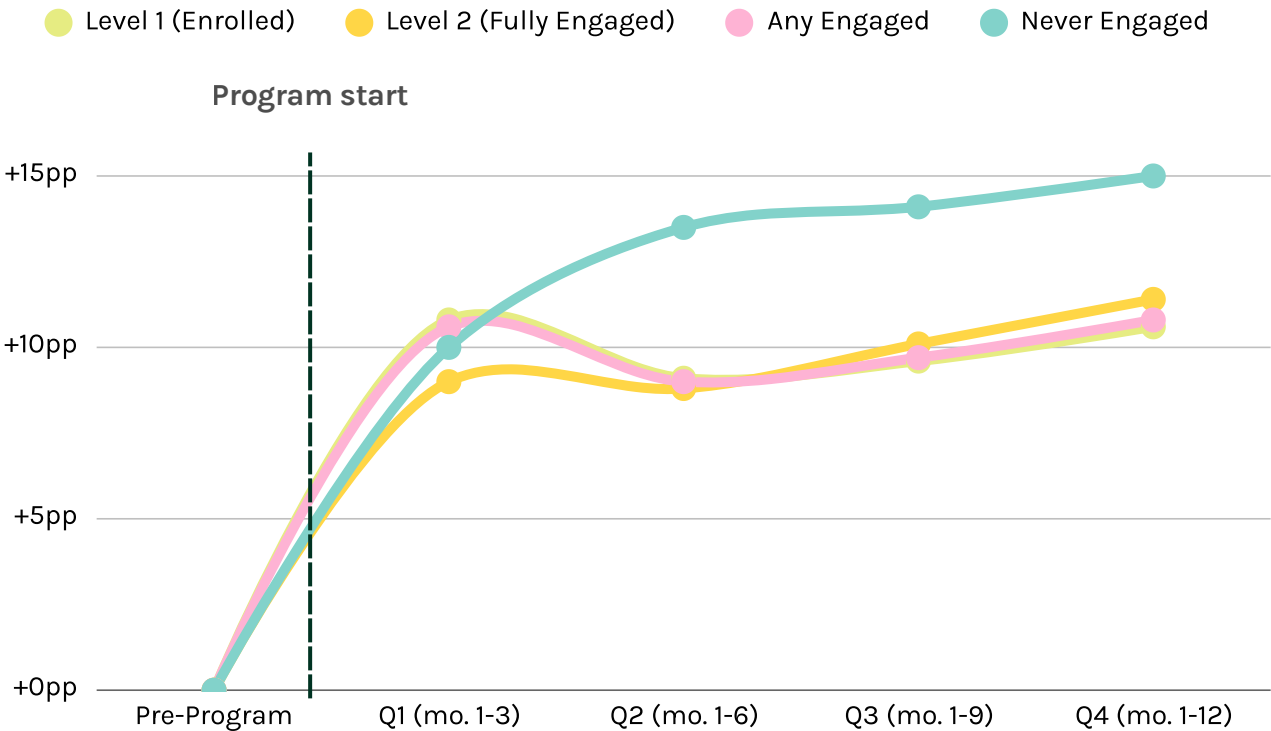
Engaged members draw on a meaningfully larger share of their home care benefit before the program starts as well. L1 members account for the full difference, averaging 43% and outpacing never-engaged members by 10.3 percentage points. L2 members, on the other hand, show a 5.3 percentage point gap that does not reach significance. These patterns suggest that engaged members are not a random subset of the member pool – they enter the program as relatively higher utilizers of their home care benefit.

Because the two groups differ at the baseline, a direct comparison of post-program utilization levels cannot isolate a program-associated effect. The more targeted analysis examines whether engagement is associated with a change in utilization trajectory over time, above and beyond where members start. A cumulative change analysis addresses this directly, comparing how each group’s average utilization evolves from the pre-program baseline through progressively longer post-program windows.

Table 5. Home care MDB utilization trajectory by engagement level (cumulative post-program windows)

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Pre-program	43%	38%	42%	33%
Q1 (mo. 1-3)	54%	48%	53%	43%
Q2 (mo. 1-6)	52%	47%	51%	46%
Q3 (mo. 1-9)	53%	49%	52%	47%
Q4 (mo. 1-12)	54%	50%	53%	48%
Δ (pre→Q4)	+10.6 pp	+11.4 pp	+10.8 pp	+14.8 pp

Figure 6. Change in home care MDB utilization from pre-program baseline by engagement level



Note: Values show change in percentage points from each group’s pre-program baseline. Pre-program = months -6 to 0; Q1-Q4 reflect cumulative post-program windows.

Engaged and never-engaged members follow distinct utilization trajectories over the post-program period – a pattern inconsistent with self-selection alone. In the first three months, all groups show a similar initial increase from the baseline.

From that point, the groups diverge: Never-engaged members’ cumulative utilization climbs steadily to +13.2 pp by Q2 and +14.8 pp by Q4, while engaged groups remain stable in the +9.0 to +11.4 pp range throughout the post-program period. This progressive divergence – rather than a difference in starting point – suggests that engagement is associated with a meaningfully different pattern of benefit use over time.

Key Takeaways

Engaged members enter with higher pre-program utilization; their post-program trajectories diverge in ways self-selection cannot fully explain.

L2	38% pre-program home care MDB utilization, 5.3 percentage points above never-engaged members; this gap does not reach statistical significance.
L1	43% pre-program home care MDB utilization, outpacing never-engaged members by 10.2 percentage points; a statistically significant gap.
Any	Post-program trajectories diverge from never-engaged members starting after three months and steadily grow.

The difference in trajectory shape, above and beyond starting-point differences, suggests engagement is associated with a meaningfully different pattern of benefit use over time.

5.4 Long-Term Cost Projections

The prior analyses establish that engaged members spend less on home-based care and follow a distinct utilization trajectory. A projection model applied to each engagement group estimates how those patterns compound over a 10-year horizon.

Members at all engagement levels are projected to cost less than members who never engaged at every time horizon.

For L2 members, the effect is particularly pronounced: Cumulative savings reach approximately \$25,000 at three years, \$54,000 at five years, and \$149,000 at 10 years — reductions consistent with a sustained lower rate of facility placement.

Table 6. Markov model projection at three years

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Cumulative cost	\$121,136	\$107,561	\$117,142	\$132,841
% in facility	32%	7%	25%	33%
Difference vs. NE	-\$11,705 2% facility reduction	-\$25,280 80% facility reduction	-\$15,698 23% facility reduction	—

Table 7. Markov model projection at five years

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Cumulative cost	\$223,112	\$183,624	\$212,254	\$237,709
% in facility	47%	11%	38%	48%
Difference vs. NE	-\$14,597 2% facility reduction	-\$54,085 78% facility reduction	-\$25,455 20% facility reduction	—

Table 8. Markov model projection at 10 years

Metric	L1 (Enrolled)	L2 (Fully Engaged)	Any Engaged	Never Engaged
Cumulative cost	\$526,966	\$387,942	\$493,419	\$537,065
% in facility	72%	20%	62%	73%
Difference vs. NE	-\$10,099 1% facility reduction	-\$149,123 73% facility reduction	-\$43,646 15% facility reduction	—

Key Takeaways

Across all engagement levels, lower facility transition rates are associated with lower cumulative costs over time.

L2

Cumulative costs are approximately \$25,000 lower than never-engaged members at three years, growing to approximately \$149,000 lower by year 10, consistent with 73-80% fewer L2 members in facility care.

L1

Costs are approximately \$10,000 to \$15,000 lower than never-engaged members across the projection window, consistent with a 1-2% difference in facility transition rates.

Any

At the any-engaged level, costs are approximately \$16,000 to \$44,000 lower than never-engaged members across the projection window, with 15-23% fewer members in facility care.

The 10-year advantage grows most substantially for L2. Increasing the share of members who complete a full needs assessment remains the lever most associated with long-term cost reduction.

Across all engagement levels, projected costs fall below those of never-engaged members at every time horizon, with L2 members showing savings that grow from approximately \$25,000 at three years to \$149,000 at 10 years. L1 members show savings that range from approximately \$10,000 to \$15,000 across the projection window, which is consistent with a 1-2% difference in facility transition rates relative to never-engaged members. Each year, a larger share of never-engaged members transitions into facility care, and the cost gap between groups accumulates over time.

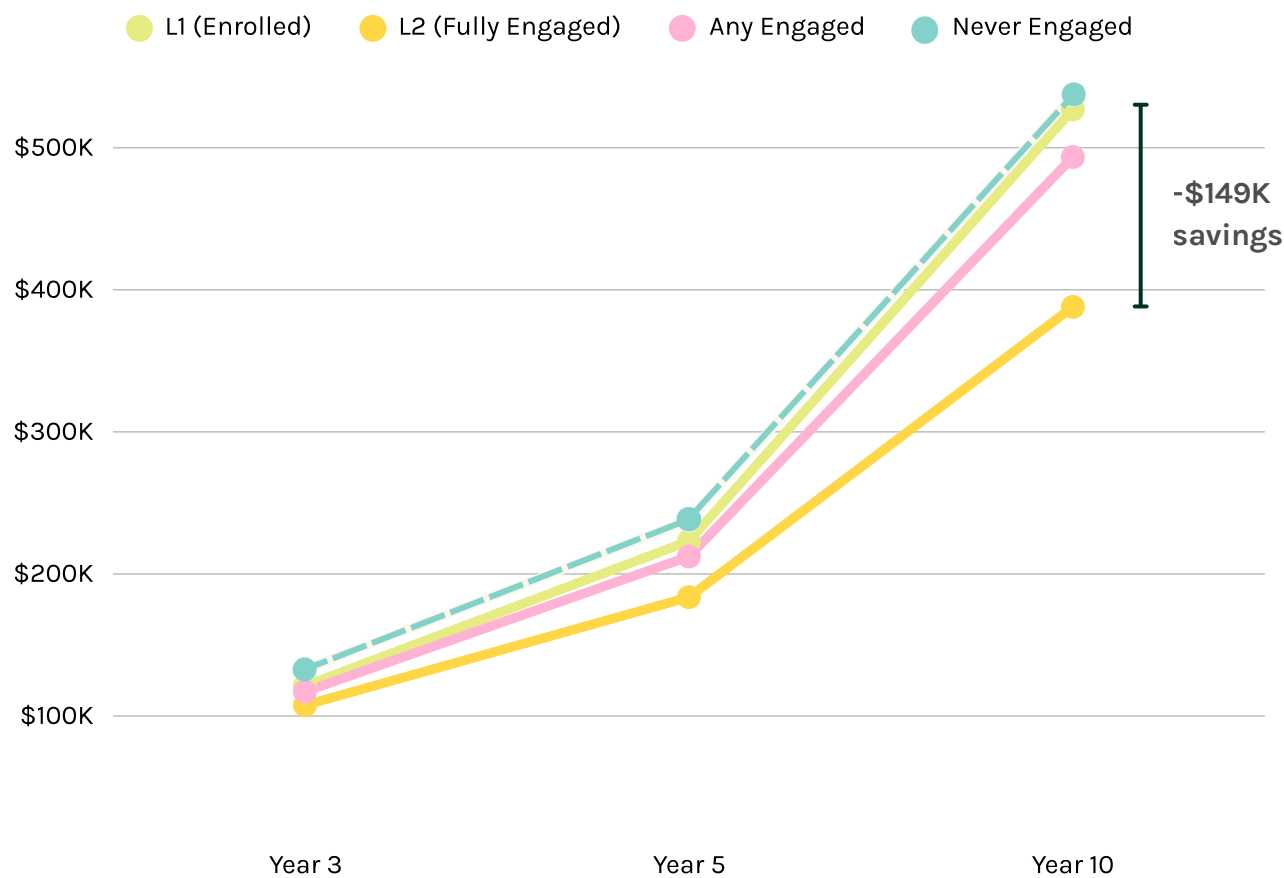
The degree to which savings compound is consistent with each group's rate of facility prevention: L2 members' 73-80% lower facility placement rate produces savings that grow substantially over time.

The results converge on a single figure: an annual facility transition rate of 2% for L2 members, compared to 12% for those who never engaged. By year 10, that difference compounds into nearly \$150,000 in cumulative savings per L2 member, with roughly 20% of L2 in facility care compared to nearly 73% of never-engaged members. The home-based savings are immediate, and the facility prevention advantage is durable.

6. Discussion

Across all outcomes, engaged members spent less on home-based care and transitioned to facilities at lower rates. For the most deeply engaged members, those two effects work together and compound over time. Figure 7 shows how the cost trajectories diverge across engagement levels over a 10-year horizon.

Figure 7. Cumulative projected costs by engagement level



Never-engaged members track toward higher costs and higher rates of facility placement with each passing year. Engaged members, and L2 members in particular, follow a meaningfully different path. For older adults managing care on fixed or limited incomes, that difference is not abstract. Lower monthly home care costs mean more financial stability in the near term, while a lower rate of facility transition corresponds to avoiding a shift that is both expensive and, for most members, permanent. The THB Care Concierge program is associated with outcomes that serve members on both dimensions simultaneously.

The cost and utilization findings add context to that picture. The pattern differs by engagement level in a way that is worth understanding. L1 members draw on a larger share of their available benefit and are more likely to access services they were not previously using. L2 members draw on a similar share to never-engaged members, but they spend less on home care and transition to facilities at dramatically lower rates. That contrast points toward two distinct ways the program may be working: For L1 members, engagement appears to be associated with connecting members to services they had available but were not using. For L2 members, completing a full needs assessment appears to be associated with using home-based care in a way that better supports long-term independence. Facility costs trend modestly higher for engaged members, but not significantly so – the meaningful difference shows up in how many members reach a facility at all.

A key interpretive consideration is whether engaged members were simply more active benefit users to begin with. The data confirms that they were: Engaged members entered with higher pre-program home care utilization than never-engaged members, showing consistency with some degree of self-selection. That starting-point difference, however, strengthens rather than qualifies the findings. The trajectory of utilization after program contact diverges in a way that pre-existing differences cannot fully explain – all groups showed a similar initial increase in the first three months, but never-engaged members' utilization continued to climb steadily throughout the observation period while engaged members' utilization remained stable. The progressive divergence, in other words, is not an artifact of who enrolled.

The case for proactive care coordination in LTCI is strongest where the evidence is most precise: among members who complete a full needs assessment. The approximately \$150,000 in cumulative savings per L2 member by year 10 reflects an 82% lower annual facility transition rate compounded over the projection horizon. These results are observed in a population that entered the program as relatively higher utilizers of home care benefits, a characteristic that strengthens rather than qualifies the finding. **For carriers, the implication is direct: Increasing the share of referred members who complete a full needs assessment is the highest-leverage point in the engagement pathway.**

7. References

Binette, Joanne and Fanni Farago. (2024). Home & Community Preferences Among Adults 18 and Older. Washington, DC: AARP Research, December 2024. <https://doi.org/10.26419/res.00831.001>

Counsell, S. R.; Callahan, C. M.; Clark, D. O.; Tu, W.; Buttar, A. B.; Stump, T. E. & Hendrie, H. C. (2007). Geriatric care management for low-income seniors: A randomized controlled trial. JAMA, 298(22), 2623-2633.

CareScout. (2025). Cost of care survey. <https://www.carescout.com/cost-of-care>

Naylor, M. D.; Brooten, D. A.; Campbell, R. L.; Maislin, G.; McCauley, K. M. & Schwartz, J. S. (2004). Transitional care of older adults hospitalized with heart failure: A randomized controlled trial. Journal of the American Geriatrics Society, 52(5), 675-684.

Society of Actuaries. (2020). 2000-2016 long-term care aggregated databases. SOA Research Institute. <https://www.soa.org/resources/experience-studies/2020/2000-2016-ltc-aggregate-database/>

Wiles, J. L.; Leibing, A.; Guberman, N.; Reeve, J. & Allen, R. E. S. (2012). The meaning of "aging in place" to older people. The Gerontologist, 52(3), 357-366.



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