Legal, Compliance, & Regulatory

Watch Out! Protect Your Company From LTCI Fraud

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ILTCI

Investigations

Chuck Angiolillo – CLAIMS BUREAU USA

Common Methods of Investigation

- Pharmacy & Hospital Canvass
- Record retrieval – police, fire, MVA
- Agency/Facility Visit
- Home Visit
- Background Investigation
- Surveillance

Claim Facts

- Female; 60s; on claim for over 5 years
- Brain injury; short-term memory loss; unable to process information; as well as back issues resulting from an MVA
- Private caregiver; is insured's live in partner; insured requires constant, hands on assistance and cannot be left alone

Challenges Found Within Claim

- Caregiver resides with the insured
- MVA occurred so long ago making it difficult to verify the specifics of the loss vs. the information provided by the insured

Red Flags Discovered

- Inconsistencies on behalf of the insured regarding the details of the MVA and the injuries she allegedly received
- Insured's described activity level within medical records was greater than what the insured had indicated to the carrier
- Reluctance by the insured to be assessed by any RN other than the RN that conducted the initial assessment

Investigative Findings

- Investigation into the insured's MVA
  - Police/Scene Investigation
  - Adverse Operator
  - Insurance Company
- Background investigation
  - Insured
  - Caregiver

Surveillance Findings

- Summary of activity
  - Very active insured
  - Insured and caregiver not always observed together
  - No hands on assistance observed outside of the home
  - Sporadic/varied use of a cane
  - Intelligently conversing and contributing at support group meetings

Legal Perspective – Case Studies

Michael Gugig – Saul Ewing LLP

FACT PATTERN #1

- Joan, who is 40 years old, applies for an LTC policy with an unlimited benefit period and $300 daily benefit.
- Joan answered “no” to all medical questions, including:
  - Have you been treated for, diagnosed with, etc.: muscular dystrophy?
  - Have you fallen within the last 5 years?
  - Do you use or have you used in the past 5 years adaptive devices to assist you in walking?

FACT PATTERN #1

- Joan identified only two doctors on her application – her GP and OB/GYN. As part of the application, Joan authorized the carrier to obtain her medical records.
  - Given Joan's age and negative answers to all medical questions, the carrier did not request medical records before issuing the policy.
- The policy is issued as applied for.

FACT PATTERN #1

- **Contestability**: Policy states that any misstatements in the application can result in rescission within the first 2 years, but only fraudulent (*i.e.,* intentionally false and material) statements can result in rescission after 2 years.
- **Claim**: Joan submits a claim 2 years and 2 months after the policy is issued.

FACT PATTERN #1

- In reviewing the claim, the carrier receives medical records from the GP and OB/GYN who were identified on the application.
  - Those records indicate that prior to application, Joan had been misdiagnosed with muscular dystrophy ("MD"). She in fact had a genetic disease with symptoms almost identical to MD.
  - Even though the MD diagnosis was ultimately found to be wrong, Joan had been treated at an MD clinic for many years and the records of many specialists included a diagnosis of MD.

FACT PATTERN #1

- **Question 1**: Did Joan fraudulently state on her application that she had never been diagnosed or treated for MD?
  - What was Joan's position?
  - What was the carrier's position?

FACT PATTERN #1

- **Additional Facts:**
  - Joan's brother, who was 3 years older than Joan, also had the same genetic disease. By the time he was 44, he was wheelchair-bound and needed full-time home-based assistance with ADLs.
  - At the time of application, Joan wore splints on both legs to assist her in walking – but, she did not wear the splints on the night that the agent came to take the application and did not wear the splints at the time of policy delivery.

FACT PATTERN #1

- **Question 2**: Did Joan make a fraudulent statement on her application when she answered “no” to the question about whether she used “adaptive devices” to assist her in walking?
  - What was Joan’s position?
  - What was carrier’s position?

FACT PATTERN #1

- **Additional facts**: One year before completing the application, Joan fell in a store and was injured. The fall apparently wasn't not caused by her illness – she seems to have tripped over a rack that was left in an aisle.
  - Joan sued the store and the case was settled with Joan receiving $20,000.

FACT PATTERN #1

- **Question 3**: Did Joan make a fraudulent statement when she answered “no” to the question about whether she had fallen in the 5 years before completing the application?
  - What was Joan’s position?
  - What was the carrier’s position?

FACT PATTERN #1

- Legal Issues: Because the carrier didn't request Joan's medical records during underwriting, did it engage in impermissible "post-claim underwriting?"
  - *The answer depends on the state.*
    - *In NY, the carrier can rely on statements in an application without obtaining medical records if the application informed the applicant that the carrier was relying on the applicant's statements.*
    - *But, in CA, if the carrier was authorized to obtain medical records during underwriting, it cannot rely on medical records it could have requested to prove a misrepresentation once the policy is issued.*

FACT PATTERN #2

- Tom, a 54 year-old, applies for an LTC policy with an unlimited benefit period. The application asked:
  - "Within the last 10 years, *have you had*, been diagnosed with or been treated for any of the following conditions: *** any chronic or progressive neurological disorder?"
  - Tom answered "no," and the policy was issued as applied for.

FACT PATTERN #2

- Because Tom filed a claim within 2 years, the carrier was permitted to rescind the policy if any answer in the application was "incorrect or untrue for any reason."
  - Tom files a claim approximately 1 year after policy issuance, claiming to need assistance with multiple ADLs because of difficulties with mobility and balance.
  - Carrier begins an investigation upon receipt of Tom's claim.

FACT PATTERN #2

- As part of its investigation, the carrier requested medical records and discovered that Tom had difficulties with his balance for some 5 years before applying and had sought treatment for this problem.
  - Tom says in a letter to his doctor: "I still have the balance problem and have to hold on to anything I can grab to move about. If I don't hold on to something I feel like I will lose my balance completely."

FACT PATTERN #2

- Tom then goes to several other doctors (all prior to applying for LTC coverage). These doctors all note Tom's symptoms, but none actually makes a diagnosis – tests are providing conflicting results, including a brain MRI showing no abnormalities.
  - Doctors noted that the condition was "very puzzling."
  - 3 separate brain MRIs showed no abnormalities.

FACT PATTERN #2

- Carrier rescinds policy because the pre-application medical records showed that Tom had symptoms "consistent with a progressive neurological disorder."
  - Thus, the question of whether Tom ever "had" any "chronic or progressive neurological disorder" is the critical issue.
    - What is Tom's position?
    - What is the carrier's position?

FACT PATTERN #2

- **Additional Facts**: the trial court made two findings: a) that Tom did not make a misrepresentation when he answered "no" to the question at issue; but, b) that Tom had a duty to inform the carrier of his "general health condition" when applying for the policy, and that his failure to do so justified the rescission.

FACT PATTERN #2

- On appeal, the court agreed with the trial court that Tom had not made a misrepresentation by answering “no” to the progressive neurological disorder question, and then went on to discuss whether Tom had a duty to disclose his “general health condition” on the application.
  - What was Tom’s position?
  - What was the carrier’s position?

FACT PATTERN #2

- **Result**: The appellate court reversed on the "general health condition" finding, holding that under federal common law (the policy was issued to a federal employee under a federal benefit program):
  - "A party applying for insurance . . . generally has no duty to volunteer information where no question plainly and directly requires it to be furnished."

FACT PATTERN #2

- **Legal Issues**:
  - As was true with the issues raised in fact pattern no. 1, the question of whether an insured has a duty to disclose health information that he or she knew would be material to the carrier, even if a specific application question was not asked about that condition, can vary by state.
    - Example: Although NY's general rule is consistent with the appellate court's holding, there are several cases finding that if a reasonable person would know that a particular health condition would be manifestly material to an insurer, s/he would have a duty to disclose. So, it may come down to a factual inquiry about what a reasonable person would understand to be manifestly material to a carrier.

FACT PATTERN #3

- Joe, who owns an LTC policy with an unlimited benefit period, files a claim with his carrier.
  - The claim form states that Joe needs assistance with at least 3 ADLs: bathing, toileting and transferring.
  - Joe represented that he was a retired nurse at the time he submitted the claim.
  - A physician's statement accompanying the claim form stated that Joe in fact needed assistance with bathing, toileting and transferring. The physician's diagnosis was fibromyalgia.

FACT PATTERN #3

- The carrier began to review the claim upon receipt:
  - An independent health examination was conducted by an RN. Although the RN's report indicated that Joe "appeared" to need assistance with the ADLs, she was unable to actually confirm that need. She reported that "something just wasn't right."
  - Medical records received from the physician did not indicate that Joe had seen other physicians. However, those records suggested that the doctor had seen Joe a few times over several years because Joe was complaining of generalized pain, joint pain and headaches. Testing did not result in a diagnosis, except that on the final visit before the claim was filed, the doctor indicated a diagnosis of fibromyalgia.

FACT PATTERN #3

- The carrier approved Joe's claim. Approximately 6 months later, the carrier required another independent medical examination ("IME") – this one with a physician.
  - Prior to the IME, the carrier retained an investigator, who documented that Joe was outside mowing his lawn (including changing the bag when it was full), appeared to be walking normally, and was able to bend down to pick up something from the ground without any apparent difficulty.

FACT PATTERN #3

- The IME doctor could not make a diagnosis because Joe's self-described symptoms could not be confirmed or rejected (again, generalized pain, joint pain and headaches).
- The investigator found through a records search that Joe had been a nurse as he represented on his claim form and application, but that he also owned a majority interest in the home health company that was providing services to him and to which the carrier was paying benefits.
  - Joe's interest in the home health agency was undisclosed.

FACT PATTERN #3

- The carrier then rejected the claim and demanded that Joe/his home health company return the benefits paid until that time.
  - What was the carrier's position?
  - What was Joe's position?

FACT PATTERN #3

- **Result**
  - Joe and his company refused to return the benefits paid, claiming that he was truthful on his claim form and that he had no duty to disclose his ownership interest in the home health agency.
  - The carrier filed suit to force Joe and his company to return the benefits paid to date and also referred the matter to the state's insurance fraud prosecutorial agency.
  - The litigation was stayed pending the resolution of the criminal issues – insurance fraud charges were filed against Joe and his company. Those charges remain pending.

Company SIU Perspective

Harry Markland -- Genworth

LTC Underwriting and Claim Review

Keep in mind:

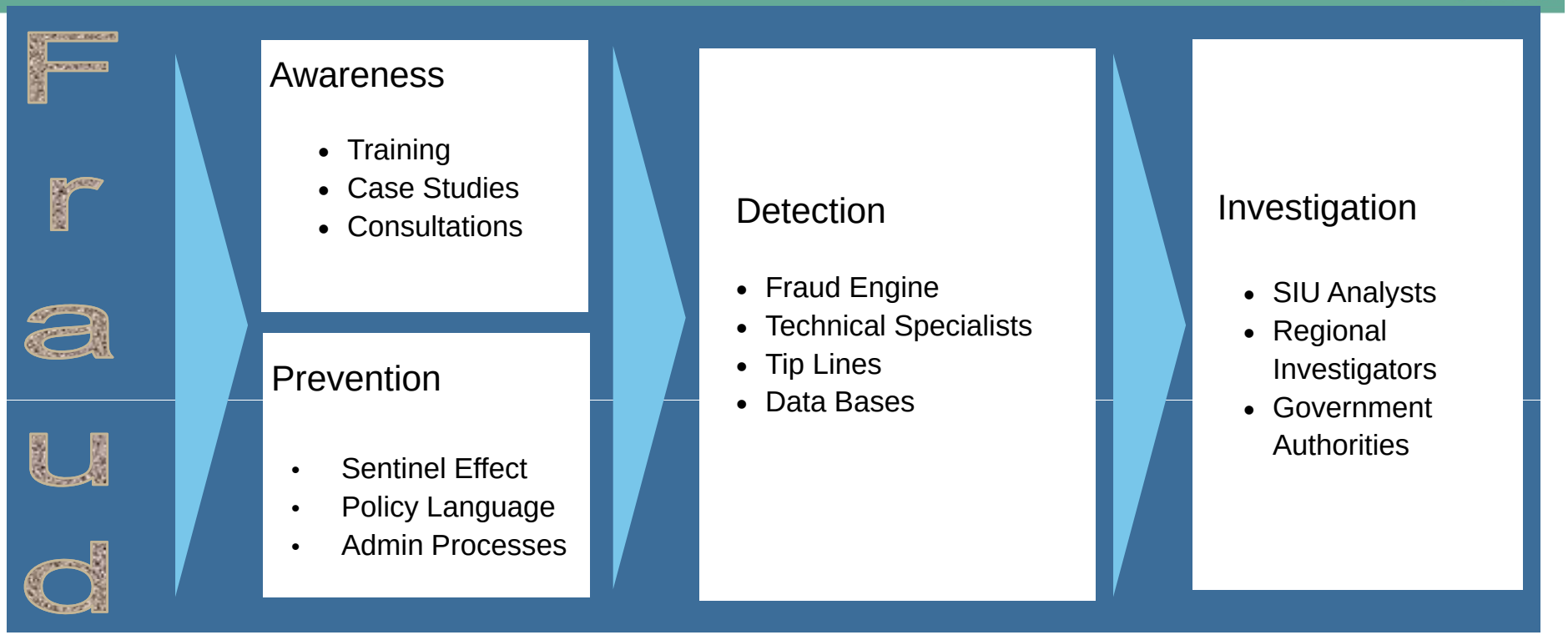
- ✓ Hindsight is 20/20
- ✓ If the applicant would have disclosed THAT…
- ✓ If we'd only known…
- ✓ It makes sense now…

And:

- ✓ The number of policies issued each week
- ✓ The number of claims filed each week

The following are meant to be Ahhh examples

Fraud Framework – What We Are Doing



Red Flag Discipline

Technology		Processes		People	
Business Continuity & Incident Response	Information Security	Access Management -Physical -Logical	Identity Management	Regulatory Compliance	Special Investigations & Suspect Activity

External | Internal | Third Party

Example of Sentinel Effect

FRAUD AFFECTS ALL OF US!

Insurance fraud is a growing concern in our society. It affects each of us by raising the cost of insurance. Help us combat this problem. If you know of or suspect fraud regarding this long term care insurance policy, please contact us:

By phone: 800-876-4582

By letter: Genworth Financial–SIU
6620 W. Broad
Bldg. 4, 2nd Floor
Richmond, VA 23230

Examples of fraud may include:

- submitting invoices for services that were not provided
- submitting invoices for expenses that were not incurred

GS1090 (01/07)

We treat fraud seriously!

Certain Medical Conditions

- ✓ Fibromyalgia, Chronic Fatigue Syndrome, musculoskeletal conditions and subjective conditions
- ✓ Back conditions, spinal stenosis, osteoarthritis and osteoporosis
- ✓ Depression, anxiety, “mental/nervous” disorders
- ✓ “Legal” Blindness

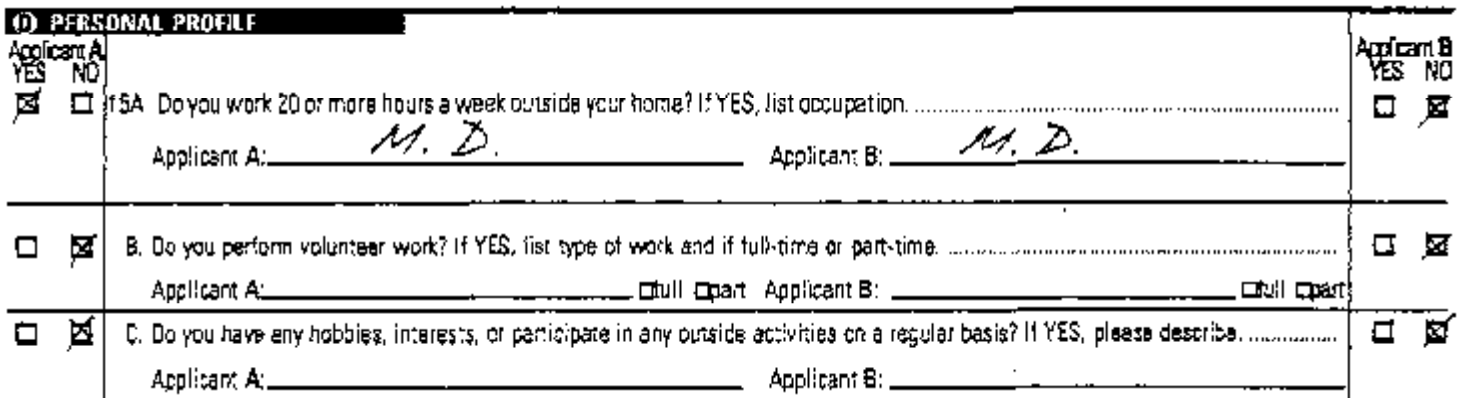
Fibromyalgia, musculoskeletal and depression are typical conditions in suspect claims.

Occupation Doctor – Not Working?

✓Effective=12/15/04
✓DOL=6/6/06
✓Current age=48
✓Claim Dx=Head injury

<u>Underwriting Red flags</u>

- Insured is a 44 y/o MD and is not working, doesn't volunteer and has no hobbies
- Unlimited, compound BIO
- At claim time, the insured tells us she is an anesthesiologist, but has not worked since 4/03 due to depression & "work experience"



(I) PERSONAL PROFILE

Applicant A YES	Applicant A NO		Applicant B YES	Applicant B NO
☒	☐	15A Do you work 20 or more hours a week outside your home? If YES, list occupation. Applicant A: M. D. Applicant B: M. D.	☐	☒
☐	☒	B. Do you perform volunteer work? If YES, list type of work and if full-time or part-time. Applicant A: ☐full ☐part Applicant B: ☐full ☐part	☐	☒
☐	☒	C. Do you have any hobbies, interests, or participate in any outside activities on a regular basis? If YES, please describe. Applicant A: Applicant B:	☐	☒

Occupation Caregiver

JUDI GRATE SENTENCED TO 6 YEARS & 5 MONTHS TO 15 YEARS IN STATE PRISON; BUCANO FAMILY FOUND GUILTY IN MILLION DOLLAR DISABILITY FRAUD SCHEME

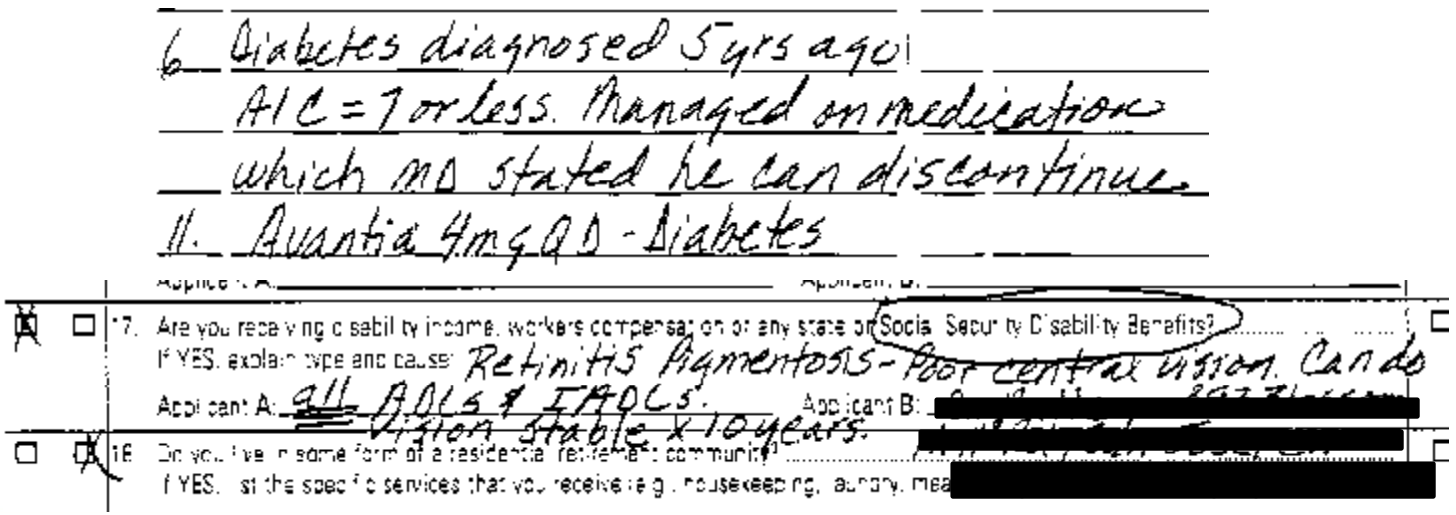
All defendants in the case were charged with 16 counts of forgery, 13 counts of insurance fraud, four counts of theft by deception, three counts of criminal attempt theft by deception, two counts of corrupt organizations and one count each of theft by failure to make required disposition of funds, dealing in proceeds of unlawful activity and criminal conspiracy.
According to The Pocono Record, seven of those people pled guilty to the charges on July 5th in Monroe County Court.

Coverage Increase Example

- ✓ Effective date= 07/25/06
- ✓ DOL= 09/20/08
- ✓ Current age= 58
- ✓ Claim Dx= Blindness due to disease

Underwriting Red flags

- ✓ On disability
- ✓ Unlimited, compound
- ✓ Originally applied for $100. CCR submitted on 8/23/06 (after issue) changing the DB to $400.


6 Diabetes diagnosed 5yrs ago
A1C = 7 or less. Managed on medication
which MD stated he can discontinue.
11. Avantia 4mg QD - Diabetes

17. Are you receiving disability income, workers compensation or any state or Social Security Disability Benefits?
If YES, explain type and cause: Retinitis Pigmentosis - Poor central vision. Can do
Applicant A: all ADLs & IADLs. Vision stable x 10 years. Applicant B: [redacted]
18. Do you live in some form of a residential retirement community?
If YES, list the specific services that you receive (e.g., housekeeping, laundry, mea[redacted]

Financial Suitability Example

- ✓ Effective=2/10/07
- ✓ DOL=3/2/09
- ✓ Current age=43
- ✓ Claim Dx=Parkinson's
- ✓ Only app admission is annual physical

<u>Underwriting Red Flags</u>

- ✓ Age
- ✓ Income (Per suitability form the premium is at least 5% of his $50,000 or less annual income)
- ✓ Unlimited, compound BIO
- ✓ Married, but spouse did not apply
- ✓ Medical record information documents family history of Parkinson's and insured participating in a Parkinson's study

Behavioral Change Red Flags

LTC NB, Underwriting, and Claims

- Insured has another Long Term Care policy
- Insured/family presents barriers to conducting phone or in-person interviews (language, availability, etc.)
- Family member or Caregiver is driving the claim
- The insured or their representative is overly aggressive and demanding

Document Red Flags

LTC NB, Underwriting, and Claims

- Whiteout or alterations to time sheets, APS, or medical records
- Same caregiver without any days off in the past 90 days
- Incomplete time sheets
- Inconsistent signatures between various forms

Mail/Return Red Flags

LTC NB, Underwriting, and Claims

- Address has been updated in the past 60 days
- EFT request – has been updated in the past 60 days
- Our correspondence to the insured is returned
- Unable to reach the insured by mail or phone
- Family doesn't want any mail going to the insured
- The applicant/insured receives our correspondence and writes/calls and states she has no knowledge of an application or a claim

Payments, Deposits, Withdrawals Red Flags

LTC NB, Underwriting, and Claims

- Mailing proceeds to a foreign address
- Excessive hourly rate for un-skilled care
- Difficulty providing proof of payment, ignores request for proof of payment, pays in cash and/or cash receipts submitted as proof
- Applicant is not financially suitable
- Premium is paid by a third party (not the insured or spouse)

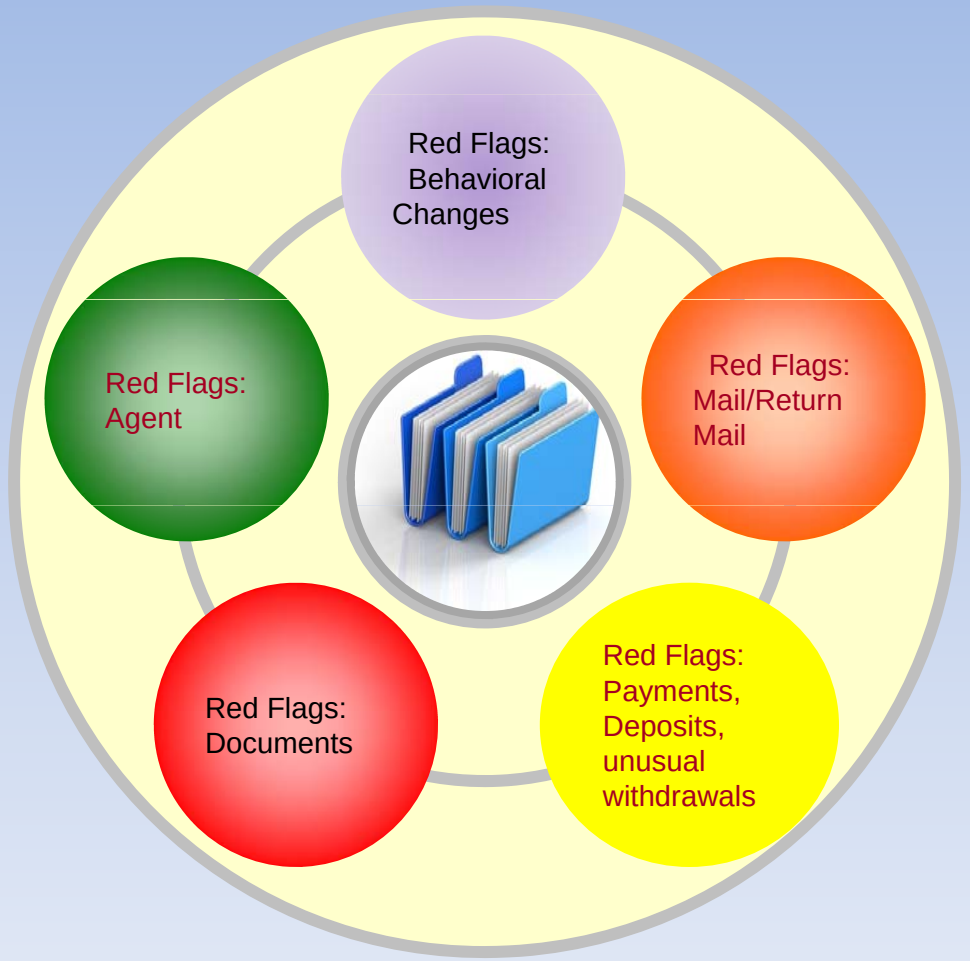
Agent Red Flags

LTC NB, Underwriting, and Claims

- Agent suddenly submits an unusual amount of business
- Agent is a family member or has same last name
- Agent is the caregiver
- Benefit checks mailed to the agent's address of record

Fighting Insurance Fraud

- Be aware of current trends
- Train your associates on “Red Flags”
- Document “Red Flags”
- Escalate suspected insurance fraud appropriately to SIU
- Update your SOPs and Written Procedures and then follow same



Underwriting Clues – Precursors to Claim

- Periodic, mutual sharing of data between Claims and Underwriting
- Review data fields currently tracked and reported in Claims and Underwriting – are we capturing everything?
- Continued refinement of Claim and Underwriting red flags
- Continued refinement of Claim and Underwriting guidelines based on experience, trends, and red flags

How can Claims, SIU and Underwriting work together to minimize potentially "bad" risks?