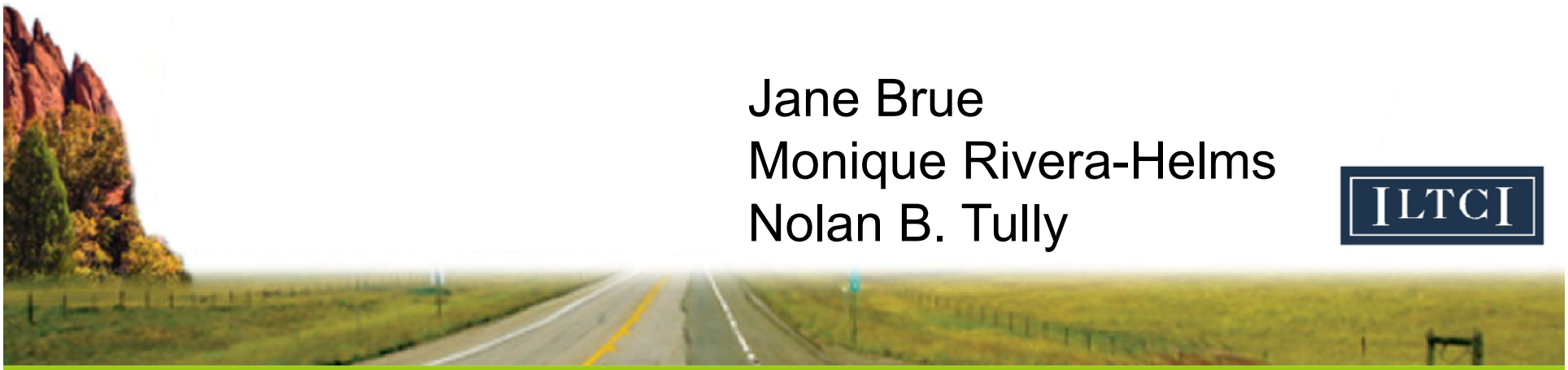
Legal, Compliance & Regulatory

POLICYHOLDER COMMUNICATIONS

Communicating Effectively with Policyholders Over the Life Cycle of the Policy



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ILTCI

15th Annual Intercompany Long Term Care Insurance Conference

Policyholder Communications Roadmap

- Best practices for policyholder communications with case studies and examples
- Enhanced letter writing to policyholders
- Reputational harm from social media
- Ineffective communication giving rise to litigation

Educate, Support and Comply

- Marketing
- Underwriting
- Policy Issuance
- Policy Owner Services
- Care Management
- Claims

More Than One Way to Do Something Right

Considerations for the Best Approach

- **The message…** good news, bad news or business as usual
- **The delivery method…** written, verbal or media
- **The audience…** co-worker insured, regulator or litigator
- **Changing perspectives**

Perspectives

Offer Content - Approved by DOI

Take advantage of this offer by August 1, 2014

The *Optional Inflation Increase* benefit provides you with the opportunity to purchase additional coverage on every third anniversary of the [redacted] without medical underwriting. This means you are pre-approved, and will not have to answer any health questions or provide any health history. If you accept the offer, your Daily Benefit Amount will increase to $177 and your Lifetime Benefit Amount will increase to $354,000.00[2] for a premium increase of just $174.74/Monthly.[3] Your additional coverage will become effective October 1, 2014.

2014 Optional Inflation Increase Offer for [redacted]

	Current Coverage	Additional Coverage Offer	New Coverage Total (As of 10/01/14)
Daily Benefit Amount	$152.00	$25.00	$177.00
Lifetime Benefit Amount	$304,000.00	$50,000.00	$354,000.00
Monthly Premium	$269.65	$174.74	$444.39

Here's how to accept your offer...

1 800. [redacted]

OR

Complete the Acceptance Form

Accept this offer using our automated telephone election system – 24 hours a day, 7 days a week.

Use the enclosed, pre-paid envelope to mail the completed form to:

[redacted]

For additional questions about your offer, contact customer service at [redacted], Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern Time.

P.S. This is a limited time offer, so take a few minutes to make your election by ***August 1, 2014****. If you accept the offer, you will receive a letter of confirmation and a new Schedule of Benefits reflecting your additional coverage. If you choose not to accept the offer, your coverage will continue according to its terms.*

Response Form - Approved by DOI

Inflation Increase Offer Acceptance Form

Prepared for [redacted] *for Coverage ID Number* [redacted] JUL 31 2014

To accept this Optional Inflation Increase offer, please sign, date and return this page in the postage-paid envelope provided. This is a limited-time offer. To take advantage of the increased benefits, you must respond by August 1, 2014.

Increased Benefit Levels: *New coverage totals as of October 1, 2014*

Daily Benefit Amount $177.00 Lifetime Benefit Amount $354,000.00 *Monthly Premium $444.39*

Election to Accept Optional Inflation Increase Offer

I, [redacted], Accept the Optional Inflation Increase offer from [redacted]. I have Reviewed and understand the Optional Inflation Increase offer as presented, including the effect on my coverage and premium Amounts. My signature below affirms my acceptance of the optional Inflation Increase offer described above. If I am currently paying my premium through Payroll Deduction, Pension Deduction or Electronic Funds Transfer (EFT), I authorize the automatic deduction of the new premium I understand that the increase in benefits and premium will be effective on October 1, 2014. The premium for my increase in benefits will be based on my attained age as of October 1, 2014.

[redacted] July 24 2014

Insured's Perspective

I am 88 yrs old & I have a hard time making ends meet.

I made a terrible mistake by enrolling in this new ~~_____~~ in August & Sept 2014. I thought all I had to pay was $25.00 a month, not $174.74 I called & the Girl said, it would

Can you please help me to get a Nov-2014 Check for $174.74 I really need it -

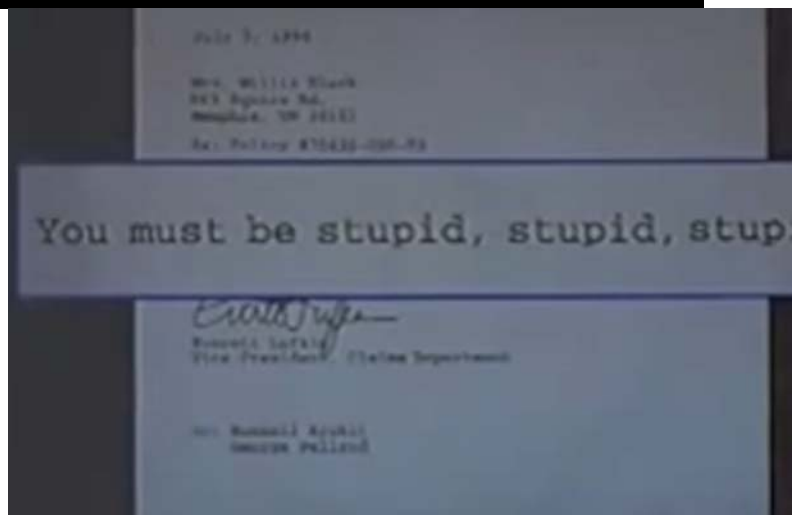
Example of a Bad Way to Deny a Claim

Dear Mrs. Black,

On seven prior occasions this company has denied your claim in writing. We now deny it for the eighth and final time. You must be stupid stupid stupid.

Sincerely,
Evert Luftkin
Vice President, Claims Department

www.youtube.com/Rainmaker



Why Does Letter Writing Matter?

Your Company's Reputation

- Customer Service
- Litigation
- Regulatory Agencies – Departments of Insurance, Department of Labor

Key Components of a Letter

What is the Goal?: To explain (in words that can be understood by a lay person) the reasons for your claim decision (i.e., that they are not eligible or no longer eligible for benefits) and provide an explanation as to what can be submitted to potentially change our minds on appeal.

- Cite the relevant plan/policy language
- Outline the key facts/evidence including a summary of the medical information
- Address contrary evidence
- Provide analysis – explain **WHY** you are denying/terminating benefits by connecting the policy terms to the facts of the claim and the evidence
- Perfection language (ERISA requirement)
- State specific language
- Required appeal language (Use specific ERISA language when appropriate)

Cite to Key Policy/Plan Provisions

- ERISA regulations state that a denial letter must cite to the specific plan provision(s) on which the determination is based
- Many state insurance laws include a similar requirement: Where an insurer's denial of a first party claim, in whole or in part, is based upon a specific statute, applicable law or policy provision, condition or exclusion, the written denial **shall include reference thereto and shall provide an explanation of the application** of the statute, the applicable law or provision, condition or exclusion to the claim.
- Regulators have cautioned against letters that are overly vague, non-specific and fail to provide an explanation of how the policy provision applies to the facts of the claim

ADULT DAY CARE BENEFIT

Eligibility: To be eligible to receive adult day care benefits, your care must meet fully all of the conditions listed below.

(1) It must be prescribed by a physician for a covered condition.

(2) It must consist of services performed routinely by a qualified adult day care center.

Clear Summary of Medical Information

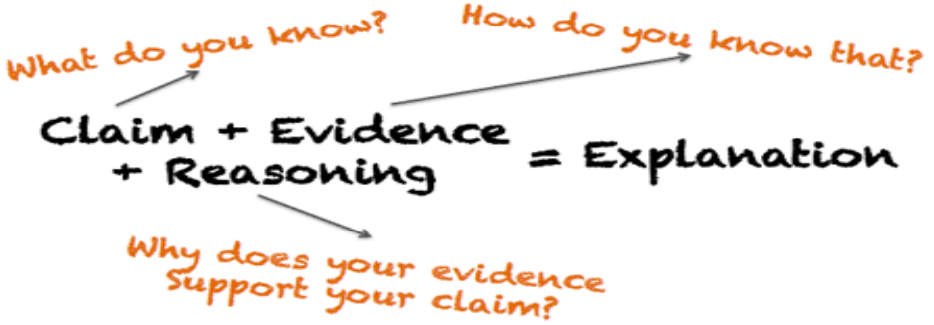
- When summarizing the medical information, avoid cutting and pasting the exact paragraphs from the medical records and physician consultant reports.
- When summarizing the medical information, communicate only what is essential to the claim determination. There is no need to include every detail.

Avoid:

- Using terms or acronyms that only someone familiar with the LTC business would understand.
- Cherry-picking, i.e., presenting only medical information supporting the decision to deny or terminate benefits and ignoring information favorable to the claimant.

Acknowledge AND Address Contrary Evidence

- Acknowledging receipt of information does not constitute addressing any issues raised in a letter.
- Address ALL the issues raised by the claimant, and or their representative.
- Find the right resources to assist you in responding to issues you don't know how to address.



Enhanced Letter Writing to Policyholders Cont.

What should be included in the analysis?

- the facts that support the decision
- the facts that the claimant would think supports eligibility
- An explanation of why the facts supporting the decision carry greater weight

Avoid:

- Templates or checklist
- A simple summary of the plan/policy terms, and the medical information; and no explanation of what lead to the conclusion that the claimant is not entitled to benefits.

Enhanced Letter Writing to Policyholders Cont.

Example:

- To make a benefit eligibility determination, we requested a copy of medical records from your primary care physician, Dr. X, as well as records from your treating rheumatologist. We also requested medical records from XXX Assisted Living facility. Furthermore, we arranged for you to undergo an on-site assessment at the assisted living facility with an independent registered nurse on August 1, xxxx. Following our review of this information, we do not find that you currently meet the benefit eligibility criteria as defined by your policy. Consequently, we find no basis for payment of benefits under the policy.

- This example does not explain the basis or the why.

Communication on Social Media

- The increasing use of social media presents a whole new paradigm for communicating with customers
  - Insureds and policyholders are increasingly using social media to do many of the things that they used to do via telephone, mail or even email
  - Benefits to contacting company via social media
    - Becomes a PR issue for company
    - May get direct, personalized response more rapidly

Reputational Harm From Social Media Case Study

- Matt Fisher vs. Progressive
  - Began with Tumblr post titled: “My Sister Paid Progressive Insurance to Defend Her Killer In Court.”
  - “Progressive didn't handle the social media replies well … the company responded to its detractors with stiff-sounding statements like: ‘We fully investigated this claim and relevant background, and feel we properly handled the claim within our contractual obligations’.” CNN Money, Aug. 17, 2012.

Ineffective Communication Giving Rise to Litigation

- Ineffective Communications at Point of Sale
- Terms and Conditions Outside the Base Policy
- Poorly Written and Administered Policy Forms

Ineffective Communications at Point of Sale: (Mis)Representations by Agents

Example of Immediate Family Exclusion:

We will NOT pay benefits for:

(1) loss that occurs while this policy is not in force;
(2) intentional, self-inflicted injury or attempted suicide (in Missouri, while sane);
(3) mental or nervous disorders without demonstrable organic disease **(however, subject to the other policy provisions, we will cover mental or nervous disorders that have a demonstrable organic cause, such as Alzheimer's and related dementias);**
(4) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a physician;
(5) care provided by a member of your immediate family;

Immediate Family: You, your spouse and respective parents, children, grandchildren or siblings.

Terms and Conditions Outside the Base Policy: Example of In-Home Caregivers

In addition to all of the requirements outlined above, once you have been determined to be eligible for the payment of benefits, in order to receive prompt processing of available benefits for the services rendered, all of the following conditions for payment must be adhered to and agreed to by you, and submitted on a monthly basis for the period of approval:

a) Completion of the Insurance Company's Monthly Statement of Care form; and

b) Completion of the Insurance Company's Monthly Caregiver Logs to outline dates and hours worked, as well as the type of care provided; and

c) Proof of payment to the caregiver as referenced in Section #4 above. Please clearly write the dates of care which the check is meant to cover for each month (cash payments and bonus payments cannot be accepted); and

d) Benefits cannot be considered for non-monetary compensation such as subsidizing for room and board, food, gas or other types of agreements you may have made with your caregivers; and

e) Benefits cannot be paid without the proper monthly documentation described above and clear reconciliation between the Monthly Statement of Care Form(s), Monthly Caregiver Log(s) and the proof of payment in the form of cancelled check(s) made payable to the caregiver.

Monthly Statement of Care form and *Caregiver Log*. In order to be accepted as proof of payment, the cancelled checks must be written and cashed/cancelled within 30 days of the end of the month in which the care was provided.

Poorly Written and Administered Policy Forms:

Benefits for Alternative Care: When you are eligible for alternative care covered by the policy, we have the option to pay a benefit. That benefit will be the actual charges for alternative care or services to which we have agreed. Benefits will be subject to the dollar value of the policy's maximum benefit day limit for nursing facility care. To determine that dollar value, multiply the Daily Benefit by the maximum benefit days, both of which are shown in the Policy Schedule. If the benefit days are shown as "Unlimited," we will use 3650 days (10 years) to determine the maximum amount we can pay as an alternative care benefit. It is understood that: (a) payment under this provision will not prevent you from making further claim for other unused and available policy benefits; but, (b) if you have not selected the "Lifetime/Unlimited" benefit plan, the payment of benefits for alternative care will be limited so as to assure that 12 months of nursing facility care benefits will remain.

To what must the carrier agree? The "actual charges" or the "alternative care or services?"

Litigation Case Study Cont.

Appeal letter from policyholder's POA:

The policy is clear and explicit on the quantitative amount of benefit provided when Alternative Care is approved. In Part I, the section covering Alternative Care, on page 7 of policy [redacted] it states (emphasis added to highlight the key information), "Benefits for Alternative Care: When you are eligible for alternative care covered by the policy, we have the option to pay a benefit. That benefit will be the actual charges for alternative care of services to which we have agreed. Benefits will be subject to the dollar value of the policy's maximum benefit day limit for nursing facility care." The alternative care plan was agreed upon by all parties, including you, and so you opted to pay a benefit. The amount of the benefit should therefore be, as stated in this policy, *the actual charges for alternative care, subject to the policy's maximum day benefit*, which is $120/day. There is no ambiguity in this coverage statement, and it is in direct contradiction to the decision that benefits for alternative care are paid at 1/2 the daily benefit. Therefore I request that the benefit for Claim [redacted] be paid, per the policy, at $120/day.

Litigation Case Study Cont.

Appeal letter cont.

I am writing to formally appeal the decision on [redacted] to provide only half the daily benefit stated in the policy. I spoke on the phone with [redacted] who escalated it further, but no one was able to provide an explanation for this decision without quoting business policies that are not documented in, and are contradictory to, [redacted] The claim for Alternative Care provided by [redacted] was approved, and a $60/day benefit was paid, but the daily benefit for the policy is $120/day. Nowhere in the policy does it state that Alternative Care will be covered at only half the daily benefit. The explanation I have been given is that Alternative Care benefits are only paid at half the daily benefit unless an Alternative Care Rider is purchased, in which case the full daily benefit would be paid. While this would certainly be a reasonable way to write an insurance policy, it was not written in policy [redacted] The insurance policies described to me verbally and used to make the claim decision are not part of the insurance policy that my parents purchased, and are therefore irrelevant and not legally valid.

For Further Questions

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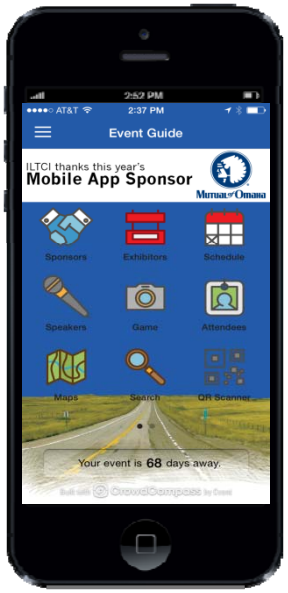
Don’t forget to fill out the survey

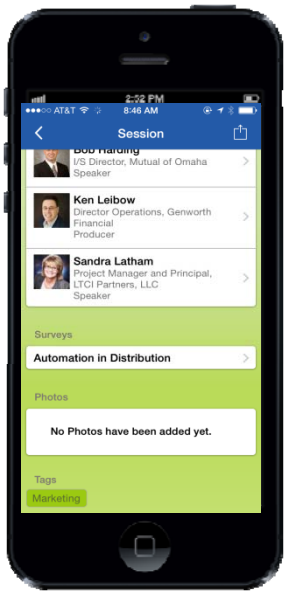


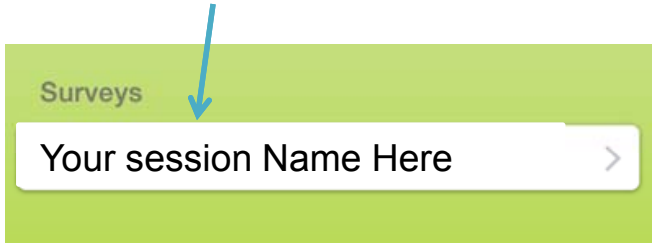
1st you must have download the ILTCI Mobile App
- Go to your app store; search ILTCI. It’s free.

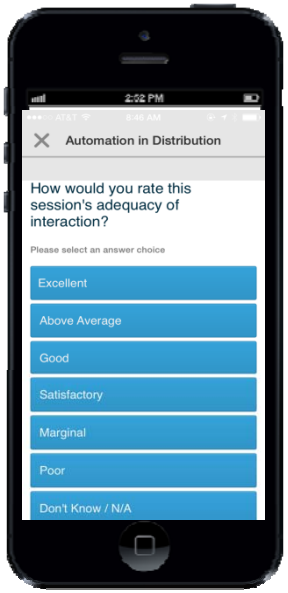
ANDROID APP ON Google play

Available on the App Store

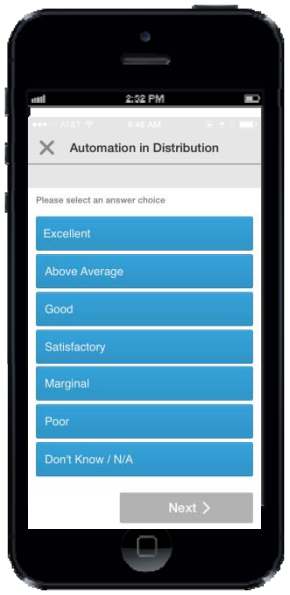
1. **Find the session**
2. **Scroll to the bottom**
3. **Tap on the session name below the survey**







Tap on the answer you wish to submit



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