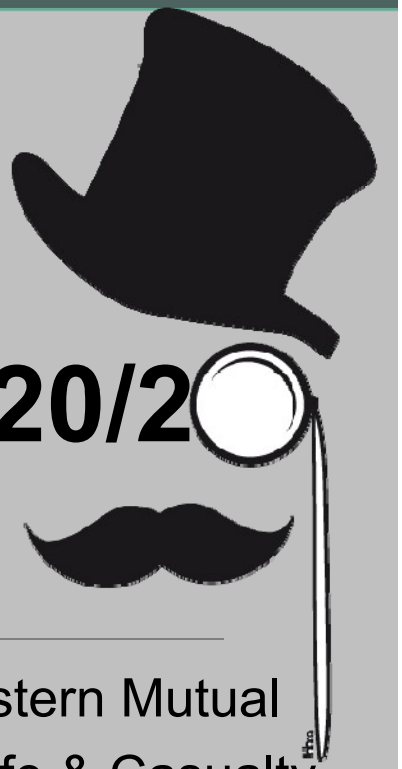
Claims & Underwriting

LTC Claims Fraud:

Hindsight is 20/2



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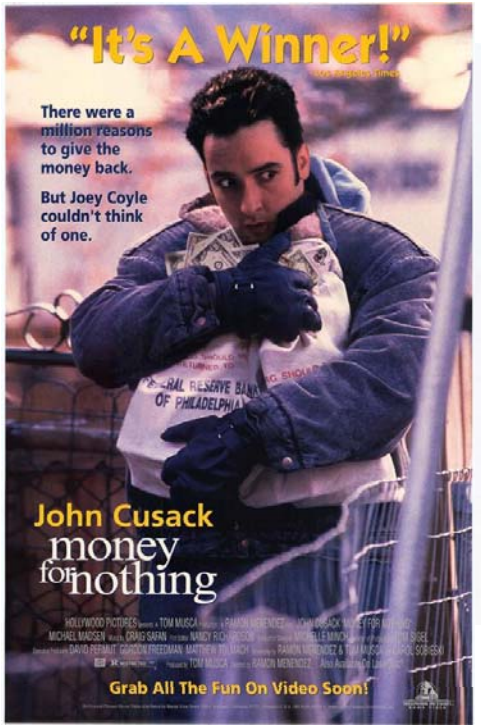
Session Overview – Key Concepts

- Undiscovered claims fraud costs the industry millions each year.
- Claims organizations necessarily need to drive efficiency – which means you can't get every piece of information on every claimant, over-review every different type of document, medical record, visit or care notes, surveil every claimant 24x7, etc.
- Each organization needs to make choices about what tools & techniques are in place to meet the often conflicting goals of processing efficiency vs. identification of policy abuse or fraud.
- This session will discuss and review three different case studies which each resulted in substantial losses for the LTC carrier.
- With "20/20 Hindsight", we have analyzed these cases and will suggest things we could have done earlier in the claims process to identify the fraud **before** it caused a big loss to the company.

Case Study Scenarios

- "The Accidental Claimant"
  - Claimant accessing policy benefits after a motor vehicle accident

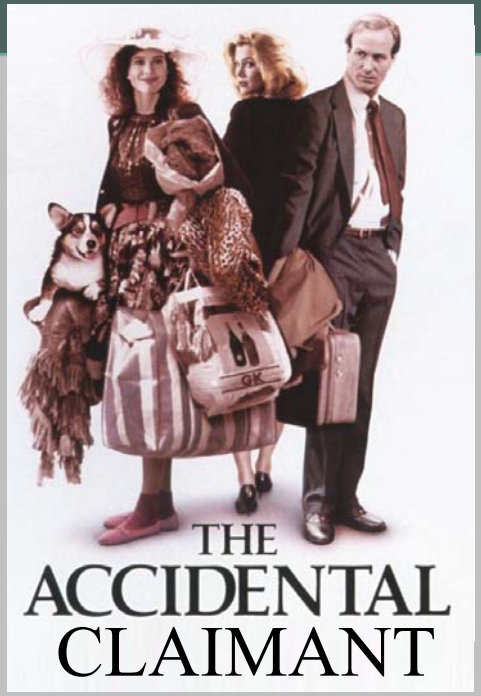


- "My Husband's Double Life"
  - Claimant's spouse was agent for policy, primary caregiver and owns "agency"

- "Money for Nothing"
  - Claimant accessing benefits for 5+ years while likely not receiving any care

Claims & Underwriting

The Accidental Claimant



LTCI Claims Case Study

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Facts of Case

- August 2008: Policy issued at Insured age 54
  - Lifetime benefit
  - High daily limit
  - Indexing
- October 2008: Motor vehicle accident
- January 2009: Notice for LTC benefits
  - Left sided trauma, pain and dysfunction
  - Unable to brush teeth, toilet, bathe and dress
- All functional assessments suggested ADL dependency; as well as frequently changing medical conditions
- Weekly timesheets indicate insured receiving assistance with all ADLs and cognitive supervision

Facts of Case, cont'd

- The Independent Provider is a friend (no relation)
- IP provided care 18 to 20 hours a day, 7 days a week, for 5 years
- Daily IP charge increases immediately after the maximum daily limit indexes
- Questionable proof of payment
- Reimbursement demanded every Thursday

Investigative Approach

- Performed thorough claim and medical review
- Database research
  - Revealed several MVAs
  - Bankruptcy
  - Active driver's license

- Conducted in-home interview
  - Insured represented significant decline in health and functional ability
  - Insured signed "confirmation of interview" statement
- Observed activity
  - Inconsistencies with statements from in-home interview
  - Care not observed when represented on service invoices

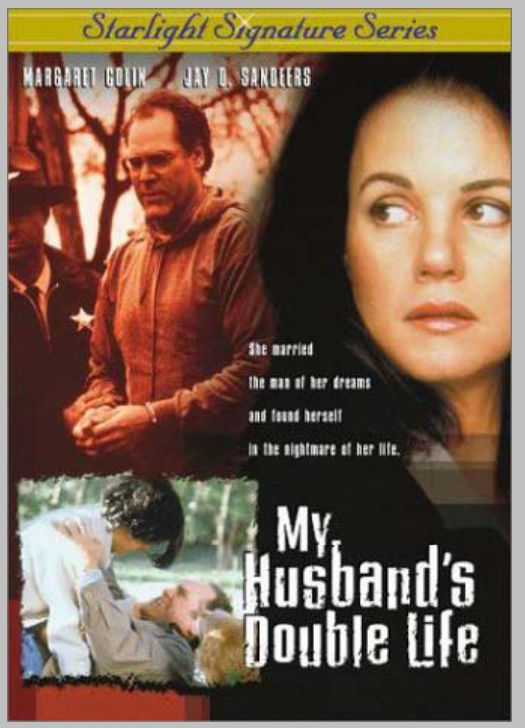
Outcome

- Closed claim
- Demanded return of benefits paid
- Insured obtained attorney representation
- State fraud reporting
  - State DOI referred case to State investigator and prosecutor for further investigation
  - State conducted evaluation of what steps to ensure restitution (i.e., freezing accounts pending prosecution)
- State's investigation:
  - Multiple MVAs: Received thousands of dollars in claims - - pattern?
  - Spoke with driver of the MVA that led to this claim
- Current status: Case being staged for prosecution

Hindsight is 20/20

- Should the policy have been issued (knowing about the multiple MVA history)?
  - Likely still yes
- Obtain medical records at time of claim directly from providers
- If MVA is triggering event to cause loss of functional status:
  - Obtain police report for MVA
  - Perform database research for MVA history
- More thorough claim analysis and medical review
- Verification of hours worked and care provided
- Recognize and listen to the red flags
  - Ask questions!
  - Care >12 hours/day, 7 days/wk from one provider with no breaks

My Husband's Double Life



LTCI Claims Case Study

ILTCI

Facts of Case

- 2 policies issued:
  - July 2009 (Contracted by agent/spouse)
    - Policyholder age 29-years old
  - November 2010 (Contracted by an agent sought out by agent/spouse)
  - Both policies had lifetime benefits with high daily benefit limits ($130k/yr)

- January 2013: Filed initial claim
  - 33-year-old at time of initial claim
  - Spouse/former agent providing care. Spouse claimed he worked for a home care agency (Title "Manager on Duty")
  - Initial billed hours 8:00 a.m. to 8:00 p.m.
  - Billed hours changed to 8:00 p.m. to 9:00 a.m.
  - Indicated friends provide informal care

- Conducted three on-site Benefit Eligibility Assessments (March and June 2013 and July 2014)
  - Assessments suggested significant ADL dependencies; Led to approval of claim

- Frequent reimbursement demands and threats to go to DOI and media made by spouse

- Refused LTC Carrier's telephony verification services

Investigative Approach and Outcome

- Referred case to SIU
  - Underwriting Review
    - ✓ Fraudulent misrepresentation identified on 1st application based on how questions were answered on 2nd policy application.
    - ✓ Underwriting missed opportunity to reject 2nd application (SSI benefits disclosed)
  - Investigated the HHC Agency
    - ✓ Spouse listed as only officer, executive, business contact and resident's address used as business address

- Conducted surveillance in 2013
  - Claimant walking outside home with a female companion – unassisted
  - When questioned claimant's ability to move around outside unassisted, claimant stated she has "good days"

- Medical Records
  - Identified that claimant represented a "disabled" status since 2006

Outcome - Result

- Could not prove claimant wasn't benefit eligible
- August, 2014, denied claim due to the policy's "Immediate Family" exclusion
  - Spouse was the owner and sole employee of agency
- Recommended seven (7) eligible providers
- Insurance carrier filed fraud report with DOI and opened up an investigation

Facts of Case, the Sequel

- October 2014, received claims for new HHC provider
  - HHC provider selected was not from the list of seven (7) eligible providers
  - New HHC provider had business license that was approved 10 days ***after*** claim denied
  - Spouse is listed as formal caregiver and employee under new HHC agency

Investigative Approach and Outcome

- Second referral to SIU
- Additional surveillance conducted on Claimant
  - Was observed moving into new home – unassisted
  - Showed no signs of disability
- Conducted interview with owner of new agency
  - Referred carrier back to the spouse/managing the business
- Ordered proof of payment including bank statements
  - Documentation was incomplete
  - Records did not reflect payment in full of invoiced amounts
  - Spouse confirmed that he was a 1099 independent contractor of the agency (not an employee)

Outcome - Result

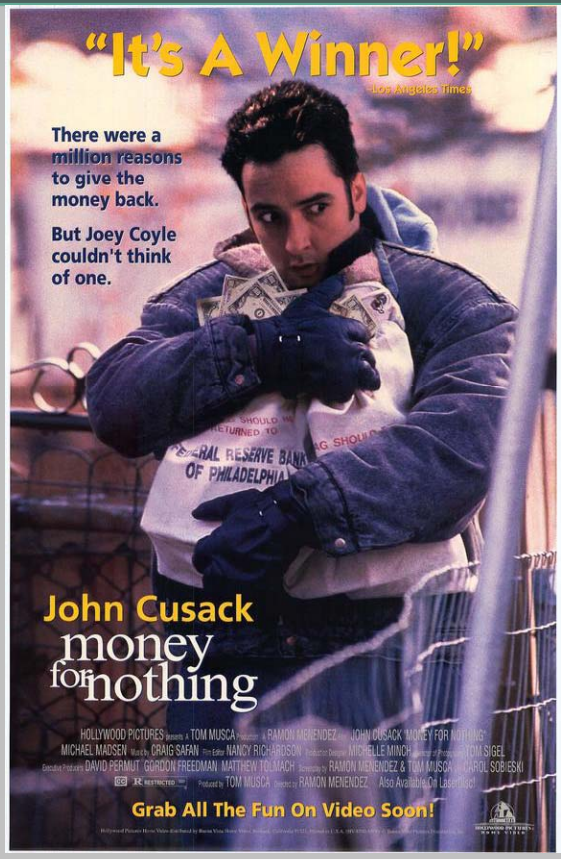
- Denied claim again due to the policy's "Immediate Family" exclusion
- Sent letter offering to forego litigation in exchange for the policy
- Claimant responded with DOI complaint
- Carrier responded to the DOI complaint to Department's satisfaction
- Carrier notified Claimant and spouse of possible litigation
  - Attempting to recover benefits paid to date ($269k)
- Claimant recently submitted new bills from an eligible HHC agency
  - Currently under investigation

Hindsight is 20/2

- Recognize and listen to the red flags
- Follow appropriate procedures at time of Underwriting
  - Thoroughly underwrite family members of agents
- Validate agencies and its employees
  - Especially when a family member acting as employee of an agency and is providing care
- Perform appropriate/adequate amount of surveillance
- Take advantage of the extra time provided by states for claim payment when potential fraud is identified

Money for Nothing

LTCI Claims
Case Study



Facts of Case

- Initial claim payment date June 2005
  - 52-yr-old at time of initial claim
- $320/day MDB, Unlimited lifetime maximum, 5% compound inflation protection
  - $116,000 per year when case received
- 6 BEA's performed from 2005-2012, all approved BE
  - Primary diagnosis: MS
- APOC approved which allowed Private Caregiver
- Same Private Caregiver from 2008-Jan 2012
  - Invoiced 16 hrs / 7 dys for 5+ yrs
  - Simple math:16 hrs x $20/hr = 100% of MDB

Initial Warning Signs

- AssuriCare / LTCfastpay received the case in December 2011
  - Began using telephonic timecard system Feb 2012
- Claimant initially gave substantial resistance to using timecard system
  - Claimant stated no home phone line, wanted to use cell phone
- Changed caregiver prior to start of timecard system use (after years of using the same caregiver)
- Care documented after use of timecard system began much different than self-reported hours prior to timecard system use
- Telephonic timecard system entries did not match log sheets submitted

Investigative Approach and Strategy

- Placed claimant in elevated initial risk tier
- AssuriCare gathered data for initial 2-week timecard use period
  - Many missing and inconsistent timecard entries
  - Multiple verification calls: waited for caregiver to check in, then placed phone calls to claimant cell
    - Caregiver and claimant were never together
    - Many instances where caregiver did not answer when called while checked in
  - Service hours varied wildly compared to previously reported consistent 16-hrs per day
- Performed Internet search
  - Identified that caregiver had second job while supposedly providing 16 hr/day care
- Good cop / bad cop with LTCI carrier led to AssuriCare (good cop) receiving info from claimant/providers
  - Provider(s) disclosed financial side deal with claimant
- Coordinated surveillance activities with carrier
  - Surveillance confirmed no care was being received
  - Specific care check-in and check-out times from timecard system provided for days surveillance was conducted
- Re-conducted additional on-site assessment
  - Claimant demonstrated functional dependence

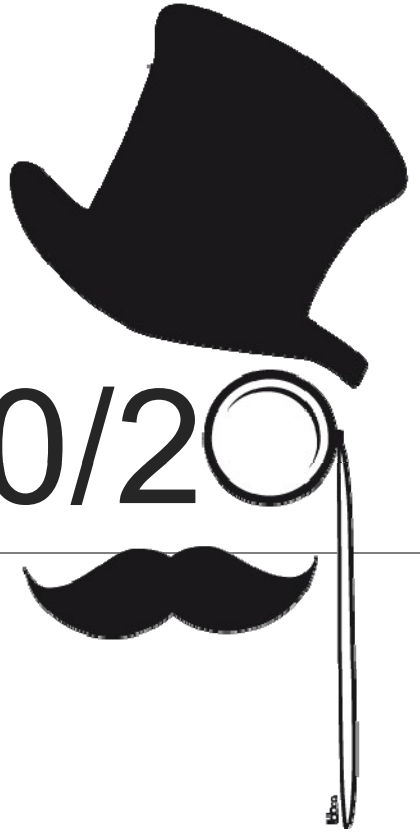
Outcome

- Exposed fraudulent agreement between claimant and provider(s) to split policy benefits
  - Claimant was providing caregiver with $500 per week payment for no care provided
  - Claimant was pocketing the remainder of the benefit payments ($1740/week)
  - Using the LTC policy as a revenue stream
  - Two of the newer caregivers ended up writing letters confirming relationship
- This carrier has never rescinded a policy for fraud, however:
  - Carrier denied all shifts submitted through AssuriCare based on AssuriCare data and surveillance
  - Carrier revoked APOC; must use a home care agency
    - Claimant subsequently went through 5-10 agencies who refused “service”
- Carrier referred claim to state DOI in Q2 2012
  - No known action taken by state DOI
- Claimant deceased (2015)
- Claim financials:
  - More than $600,000 in total claims paid
  - Over $350,000 in avoided claims after Feb 2002 (on unlimited lifetime benefit policy)

Hindsight is 20/20

- Earlier use of telephonic timecard system with identity and service verification could have reduced claim loss due to fraud
- Evaluate weight put on primary diagnosis of MS vs. evaluation of actual functional status
- Spot check proof of payment to verify benefits actually being paid to provider
- Recognize and listen to the red flags
  - Care >12 hours/day, 7 days/wk from one provider with no breaks

Hindsight is 20/20



COMMON THEMES AND LESSONS LEARNED

Commonalities between 3 case studies

- Claimants < 55 years old at time of claim
- Unlimited lifetime max benefit
- Maximum daily benefit > $300/day
- Presented as home care claims with friend/family caregivers
- Short time period between policy issue and notification of claim
- Multiple onsite assessments suggested functional dependence

Recognize and listen to the red flags!

- Care >12 hours/day, 7 days/wk from one provider with no breaks
- Claimants or providers “demanding” payment weekly
- Questionable or missing proof of payment
- Pushback / refusal to use enabling technology / timecard system
- Spouse/relative providing services as employee/contractor of an agency
- “Revolving door” of caregivers / agencies
- Only receiving ADL care at night

Parting Thoughts / Actions

- Claims evaluation process needs to be thorough AND efficient
  - Analyze claims thoroughly and ask questions – don't take claims at face value
  - Size up the risk and take commensurate actions

- Early / consistent use of timecard system with hours and identity verification
  - Coordinate surveillance times/dates with actual hours from timecard system

- Spot checking proof of payment is useful
  - Helps identify side deals between claimants and providers

- It's ok to be curious: Trust but Verify

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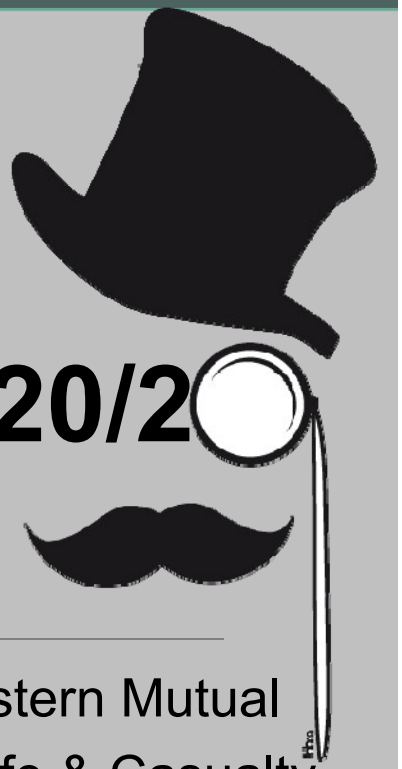

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