Claims & Underwriting

Grey Areas and Borderline Decisions

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Moderator: Michael Gilbert, President, AssuriCare

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Session Purpose:

- Explore how LTC Insurance carriers could (or should) handle claims decisions in a variety of controversial situations

Session Format:

- Audience polling
- Point → Counterpoint debate format
- Further discussion requested

A few notes about this session

- Polling questions deal in absolutes
- “More information needed?” Not today!
- Please answer every question

IMPORTANT:
Content presented during the Point → Counterpoint debate portion of the presentation is NOT representative of any specific individual’s or any specific insurance company’s point of view, processes or business practices

Question #1: Borderline ADL Dependence

Question:

Results of onsite assessment by an RN determines Claimant is independent for all aspects of dressing aside from the donning of socks and shoes that tie. Is the Claimant:

1. Dependent with Dressing
2. Independent with Dressing

Q #2: Frequency/threshold of ADL assistance

Question:

Results of onsite assessment by an RN determines Claimant requires assistance with managing incontinence of bladder, but is only incontinent of bladder once per week. Is the claimant:

1. Dependent with Continence
2. Independent with Continence

Q #3: Licensing vs. Location of Care

Question:

Onsite assessment determines that claimant requires assistance with 2 ADLs, but they are living in an independent living wing of a CCRC that does not provide ADL assistance and are not receiving home care services. The CCRC charges are:

1. Reimbursable
2. Not reimbursable

Q #4: Restoration of Benefits

Question:

Claimant with primary diagnosis of MS and ROB provision in their policy exhausted 98% of their benefits and went off claim 6.5 months ago. You just received a "Notice of New Claim." Claimant represents that they received no paid care during the 6.5 months. Do you:

1. Restore the benefit
2. Deny the restoration of benefits

Q #5: Bundled Facility Charges

Question:

The insured goes into a facility that refuses to break out the charges on the invoice for the costs of care, and only lists a bundled monthly fee which can include room, board, cable & utilities, grooming, maintenance fee and other charges. Do you:

1. Consider the entire fee reimbursable
2. Deny the charge if the facility will not break out specific charges

Q #6: Proof of Payment Unavailable

Question:

Claimant submits service invoices for care provided from an Independent Provider. Upon request from the insurer, claimant is unable to come up with any proof of payment. Do you:

1. Deny any dates of service for which the claimant was unable to provide proof of payment
2. Pay all dates of service, regardless of whether proof of payment is available

Q #7: Alternate Plan of Care

Question:

Insurer has used APOC language to approve Independent Providers for certain claimants whose policies only allow for care from licensed home care agencies. The insurer decides in the case of Mrs. Jones that this particular request for the same APOC agreement is not in the best interest of the company. Do you:

1. Approve the claim under APOC
2. Deny the claim under APOC

Post-Debate Discussion

- Did the Point → Counterpoint debate change your mind on any of these “Grey Areas?”
- Which question had the most “Grey Area?”
- Which question was the most “Black and White?”

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