Claims & Underwriting

Time to Care About Continuing Care:
Addressing Long-Term Care Insurance Claim Challenges Arising from the Proliferation of Continuing Care Retirement Communities

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18th Annual Intercompany Long Term Care Insurance Conference

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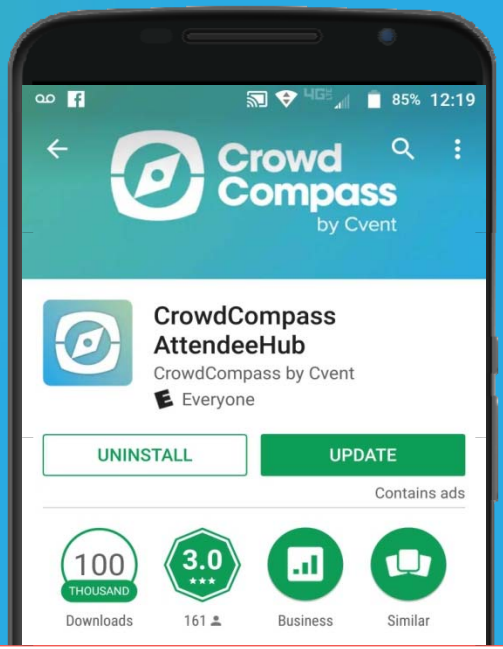

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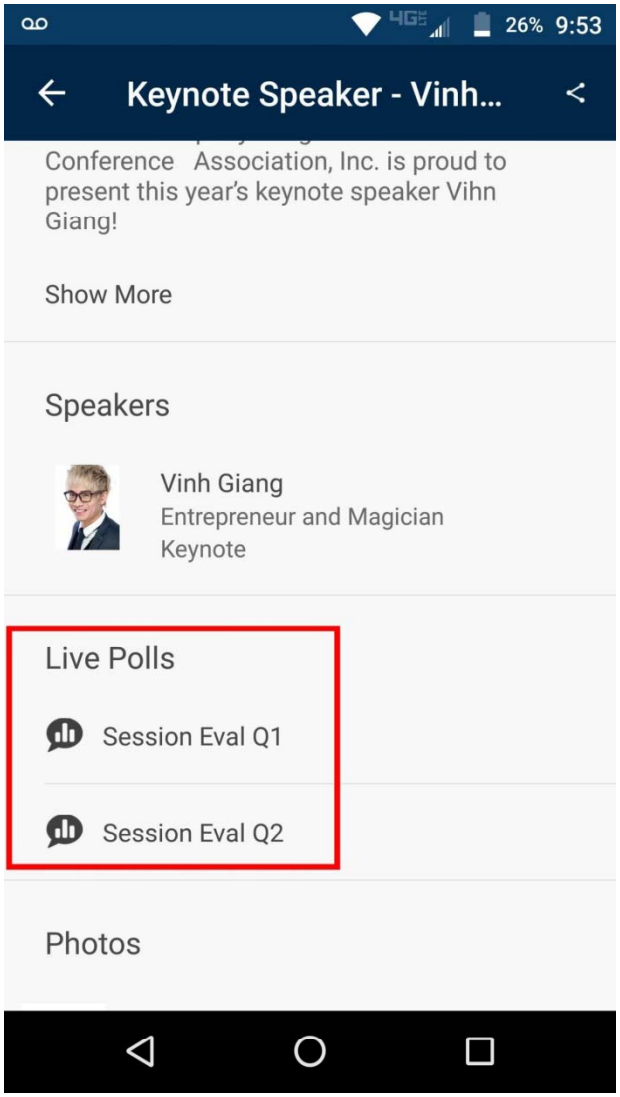
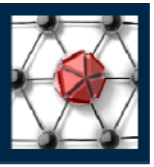


Once you are in the app go to the schedule and the session you are in.

Scroll to the bottom to find the Live Polling questions.

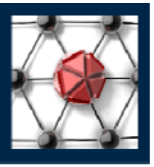
This year the session survey questions can be found in this section and will take just a couple seconds to complete.

INTRODUCTION



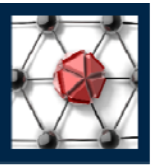
- The lay of the land
- Why are we here?
- Why are CCRC claims challenging?
- What do we hope to accomplish?
- What steps are you taking?

FACULTY



- Three perspectives on CCRC claim challenges:
  - Gina Besz (Claims Evaluation and Processing):
  - Matt Capell (Provider Solutions); and
  - Mike Rafalko (Outside Legal Counsel)
- In the trenches

SESSION FORMAT

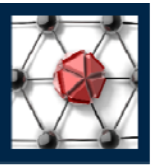


- Interactive session; audience participation
- Four “real life” case studies
  - Fact Pattern
  - Gina: Claims question, answer and takeaways
  - Matt: Provider question, answer and takeaways
  - Mike: Legal question, answer and takeaways
- We’re here to learn too – and to have some fun

Case Study #1

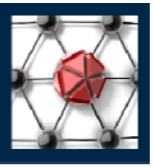
Matt Capell

FACTS



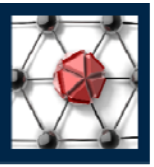
- Couple purchased condo in CCRC
- Couple had deed to condo, right to sell
- All units eligible to receive services from staff
- Limited number of “Assisted Living” units
- If AL units full, CCRC would find outside ALF and would cover cost up to amount it would have charged for on-campus AL
- Wife receives ADL supports in condo

FACTS (continued)



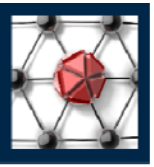
- Wife required more supervision and took the last unit in the on-campus AL unit, while husband stayed in the condo
- Then, the CCRC had another resident who needed an AL unit, so they offered to move wife back into the condo
- CCRC offered to rebate $2K/month, but provide invoice indicating AL-level care.

QUESTION – CASE STUDY #1 (GINA)



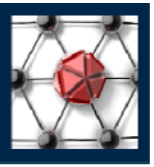
If the claim is processed as home care, how do you pay/prorate the $2000.00 monthly 'level of care' fee?

ANSWER – CASE STUDY #1



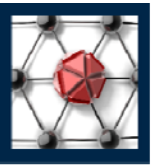
- Home care benefits are only payable on days the services were received
  - If the resident was out of the facility or did not receive any additional services on a specific day, that day should not be reimbursed

TAKEAWAYS – CASE STUDY #1



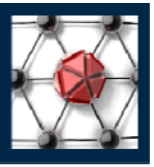
- Figuring out what benefits are payable can be difficult when a facility bills a 'level of care' fee in lieu of the traditional home care itemized hourly/daily billing
  - Request schedule of services from CCRC
    - Resident assessment will usually identify how often ADL services are needed (2x/day, weekly, etc)
  - Identify method to verify that services were rendered each day
    - Only pay for dates services were rendered
    - Ask facility if they keep daily care logs

Q&A: CASE STUDY #1 (MATT)



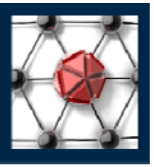
- How would you handle bills for wife before she moved into on-campus AL unit?
  - Actual Result: Paid as homecare claim
- How would you treat bills for wife while in the on-campus AL unit?
  - Actual Result: Paid as facility claim
- How would you handle bills for wife after returning to the condo?
  - Actual Result: Originally paid as facility claim then calculated R&B overpayment and paid as homecare

TAKEAWAYS – CASE STUDY #1



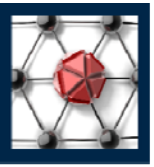
- Read the fine print on bills for indications of a change in care or setting
- Provider eligibility process should ask/encourage CCRC to notify of care or setting changes
- Train intake staff to forewarn claimants about these issues

LEGAL QUESTION (MIKE)



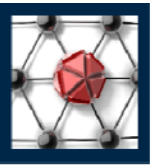
How might the insured's ownership of a condo in the CCRC affect the level at which benefits are paid?

LEGAL ANSWER



Many LTCI policies exclude facility-level benefits for care received in the “home” or “primary residence” (or other analogous term).

TAKEAWAYS

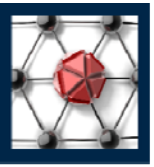


- Many CCRCs blur the lines of what constitutes the insured's "home"
  - The question "what is a home" has been litigated before in the LTCI context
  - Expect that it will be litigated again
- Highlights the difficulty of a "one size fits all" approach when dealing with a CCRC claim
- Policies and procedures
- Training claim professionals and call center professionals
- Field force bulletin?
- Consistent administration

Case Study #2

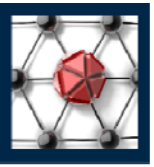
Gina Besz

FACTS



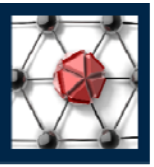
- Facility licensed as RCFE-Continuing Care Retirement Community
- All beds are licensed as RCFE
- Insured filed claim for private caregiver charges
- Residence Agreement received
  - $449,500 Entrance Fee
  - $4900/month
  - Levels of Care available
    - Independent
    - Assistance in Living
    - Assisted Living
    - No skilled or memory care available
- CCRC bills reflect:
  - '$4720.00 Rent- IL',
  - Care Fees Assisted Living- $0.00
  - Care Fees $400-$800/month

QUESTION – CASE STUDY #2 (GINA)



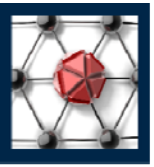
Is the insured receiving home care services or is this an assisted living claim?

ANSWER – CASE STUDY #2



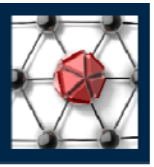
- Claim was paid as home health care until such time the insured began receiving assistance directly from facility.
- Benefits were provided for only the private caregiver charges under home health care
- When insured began receiving assistance from the facility, a level of care charge was added; the IL rent of $4720.00 and the level of care fee were then eligible facility charges
  - Private caregiver charges were denied once ALF benefits were approved

TAKEAWAYS – CASE STUDY #2



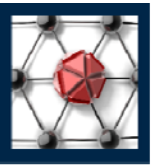
- Clarify all levels of care offered in the CCRC
  - Always review website and marketing information regarding levels of care
    - Often terms such as ‘Independent’ or ‘Assisted’ are purely marketing terms and are not indicative of the care provided
  - Question facility on the difference between all levels
    - Does the resident move to a new unit or is the care delivered in the current residence?
    - Does billing change?
- All beds are licensed as RCFE
  - If the Residence Agreement does not define when a resident is considered ‘assisted’, it is important to ask the facility

Q&A (MATT)



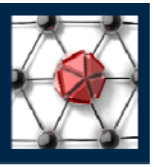
- Clarification Questions:
  - Would the $4,900/mo ordinarily include some level of ADL supports? If so, can care $ vs. R&B $ split be quantified?
  - Could CCRC have provided required supports?
  - Why $4,720 vs. $4,900?
- How would you treat bills for the $400-800/mo in outside care?
- How would you handle $4,720 in rent?

TAKEAWAYS – CASE STUDY #2



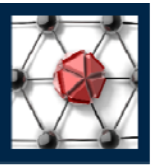
- Examine line items of bill closely
- Compare to:
  - Levels of care advertised
  - Levels of care licensed
  - Resident documentation

LEGAL QUESTION (MIKE)



What do you do if an insured wants care, needs care and is receiving care, but, for one reason or another, does not strictly meet the provider eligibility requirements of his/her policy?

LEGAL ANSWER



No “one size fits all” solution:

(1) Deny claim under strict reading of Policy?

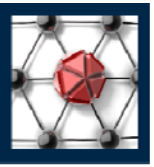
(2) Approve claim under “spirit” of the Policy?

(3) Alternate Plan of Care?

(4) Administrative exception?

(5) Other?

TAKEAWAYS

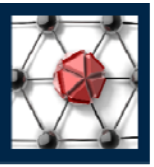


- CCRC claims not specifically contemplated in product design
- Possibility exists that insured will not rigidly meet terms of policy
  - Insured in an ALF, but is not receiving ALF-level care
  - Insured receiving home care level of care, but is not in the home
- I personally favor APOC **if** company deviates from a strict reading of the policy; but consider:
  - Agreement in writing
  - Agreement clear on what is and is not covered
  - Agreement for finite, specified period of time
  - Agreement clear about right of company to withdraw on a non-renew agreement (non-waiver)
  - Agreement is signed
- Sub-Consideration: What duty does insurer have to inform insured that modification of claim practice will result in greater claim payment?

Case Study #3

Mike Rafalko

FACTS

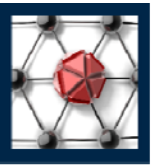


(1) Insured pays $250,000 to enter CCRC. She later characterizes this as a “prepayment” for care she expects to receive at a later time.

– CCRC has independent living, ALF and nursing home tiers.

(2) In addition to $250,000 up-front payment, insured pays $4,500 monthly, regardless of level of care (if any) that she receives. She also characterizes this monthly payment as “prepayment” for care she expects to receive at a later time.

FACTS (continued)



(3) Insured ultimately needs to receive dependent (ALF-level) care:

a. CCRC "charges" $280/day for that care ($8,500/month).

b. However, $8500/month charge is not actually billed to the insured.

c. Instead:

i. Insured is presented with an invoice that reflects $8,500 in services received; but

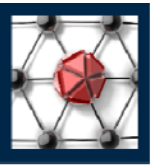
ii. Insured's actual, out-of-pocket expense is limited to the $4,500 amount she "prepays" each month.

iii. The remaining $4000 (i.e., the difference between the $8,500 invoice amount and the $4500 monthly prepayment) is not passed through to the insured.

(4) Insured claims for benefits, seeking to recover the entire $8,500 amount that is invoiced each month.

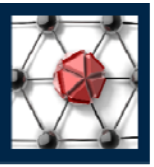
a. Insured claims entitlement to entire $8,500 amount on the basis that she prepaid the $4,000 delta between the $4,500 actual monthly charge and the $8,500 monthly invoice amount in the form of her $250,000 entrance fee and $4,500 monthly fees prior to needing care

QUESTION – CASE STUDY #3 (GINA)



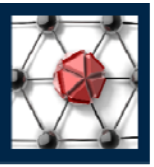
The monthly billing came in with a $280/day, $8500 monthly charge.
How do you verify the charge the resident is actually responsible to pay?

ANSWER – CASE STUDY #3



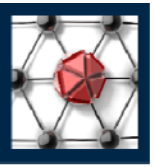
- The Resident Agreement should provide all information related to financial responsibility when levels of care are charged.
  - Decision makers should have focused training on understanding CCRC agreements

TAKEAWAYS – CASE STUDY #3



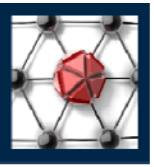
- It is important to identify that the facility is a CCRC and request the entire resident agreement
  - Some CCRCs merely add addendums when the resident increases level of care and this is what they will submit. Be sure to request the entire contract.
- Compare the initial bill with the increased level of care to the previous 'independent' bill
  - Are there any changes in the 'monthly' fee?
  - Are there any credits?
    - Often a CCRC will give a certain number of 'free' days per year

Q&A (MATT)



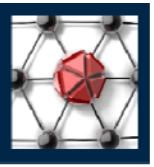
- Clarification Questions:
  - Would the $4,500/mo ordinarily include some level of ADL supports? If so, can care $ vs. R&B $ split be quantified?
- How would you handle the $8,500 invoice?
- How do you view the $250K and $4,500/mo?
- Would you request any proof of loss (e.g. canceled checks for amount claimant paid)?

TAKEAWAYS – CASE STUDY #3



- Develop practice standards for treatment of move-in and flat monthly payments
- Request DVNs, care plans and other proof of care delivery to substantiate what is indicated on invoice
- Develop consistent practices for level of care charges

LEGAL QUESTION (MIKE)



How much, if anything, did insurer reimburse the insured on a monthly basis:

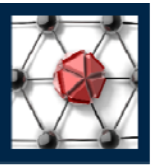
(1) $0.00 (because the insured would have gone out-of-pocket) $250,000 up front and paid $4,500/month no matter what, and no additional care charge would have been made but for the coverage);

(2) $4,500 (because that is the insureds ongoing monthly care cost);

(3) $8,500 (because that is the value of the care received and the insured's $250,000 enhance fee and monthly $4,500 payments contemplated that some or all of that money would be directed to future care costs); or

(4) Another amount?

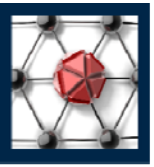
LEGAL ANSWER



$4,500

(the insured's ongoing monthly care cost)

TAKEAWAYS

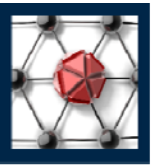


- To my knowledge, still only CCRC action to have been filed (putative class action)
  - Insurer moved to dismiss
  - Several amended complaints
  - Case settled before final decision on the merits
- CCRC claims can upend traditional claim economics
  - **How much** is an insured actually out of pocket for his or her care?
  - **When** is the insured out of pocket for care?
  - Is the insured's out-of-pocket expenditure properly **reimbursable** under the terms of the policy?
  - Would charges have been made absent the coverage?
  - Has the insured given adequate **proof of loss**?
- Appropriate to scrutinize the economics of the claim before approving

Case Study #4

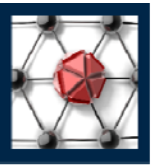
Matt Capell

FACTS



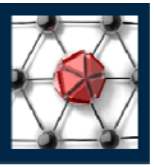
- Healthy woman without ADL or cognitive deficits moves into CCRC “cottages”
- Resident Admission Agreement allowed “aging in place” as long as care needs could be met in the “cottages”
- CCRC had separate section for skilled care but no designated area for AL

FACTS (continued)



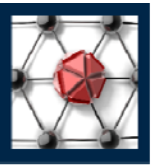
- A stroke led to ADL dependency
- Remained in “cottage”
- CCRC classified her as AL resident and provided ADL assistance
- Bills indicated AL care

QUESTION – CASE STUDY #4 (GINA)



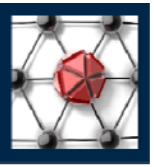
Depending on the CCRC agreement, there may not be any actual level of care charge reflected on the bills for the assisted living charges. Since the resident does not have to move to receive care, how can we verify that the resident continues to be an assisted living level of care?

ANSWER – CASE STUDY #4



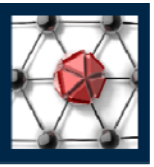
- When there is no actual charge on the bill, and the insured does not move to receive the care, the claims processor must be diligent in following up with the facility on a scheduled basis to ensure the resident is still consisted an assisted living level of care.
  - Request any and all care plans (these will reflect ongoing care or discharge date)

TAKEAWAYS – CASE STUDY #4



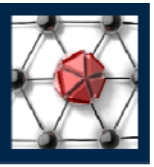
- CCRCs offer a wide array of care options and verifying current level of care can be difficult
  - Billing does not always reflect actual level of care
  - Never assume the resident will remain at the current level of care
    - Levels of care can be very fluid and difficult to identify increases/decreases
    - Chronic, high needs residents have options for care settings in CCRC and can transition to lower level of care with no change in billing

Q&A (MATT)



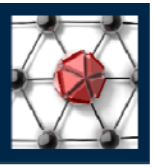
- How would you treat bills for care?
  - Actual Result: Paid as facility claim

TAKEAWAYS – CASE STUDY #4



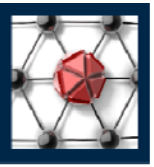
- Recognize “age in place” communities during claim intake / decisions
- Be sure to clearly understand distinctions between levels of care
- Ensure appropriate licensure exists for each available level of care

LEGAL QUESTION (MIKE)



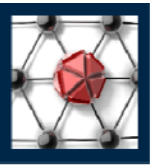
What level of benefits should be paid, and why, if an insured's care arrangement could be characterized as either home care or facility care?

LEGAL ANSWER



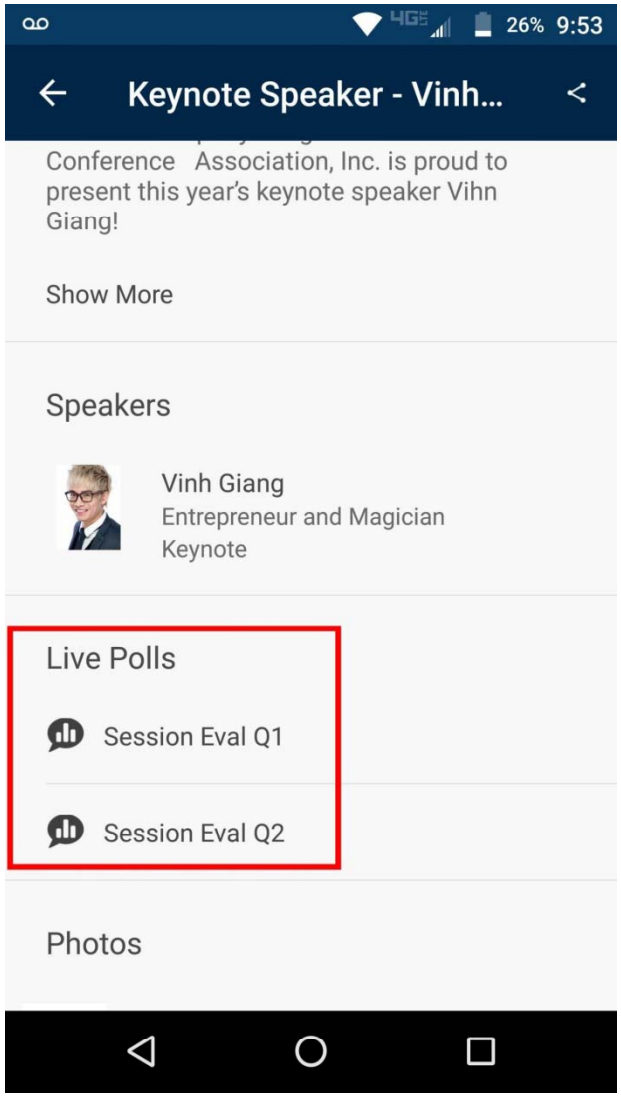
Subject to limited exceptions, care costs should generally be reimbursed at the higher (facility) level

TAKEAWAYS



- CCRC claims can blur the lines between what is a homecare claim and what is a facility claim
- Potential claims of ambiguity on illusory benefit?
- Diligent initial claim investigation is paramount
  - Residential agreement
  - Care notes
  - Understanding the facility
  - Understanding care needed and provided
  - Understanding care costs
- “Aging in place” is not a concept that fits neatly with most coverages
- Facilities aren’t dumb

Session Survey Instructions



Once you are in the app go to the schedule and the session you are in.

Scroll to the bottom to find the Live Polling questions.

This year the session survey questions can be found in this section and will take just a couple seconds to complete.

QUESTIONS