Claims & Underwriting

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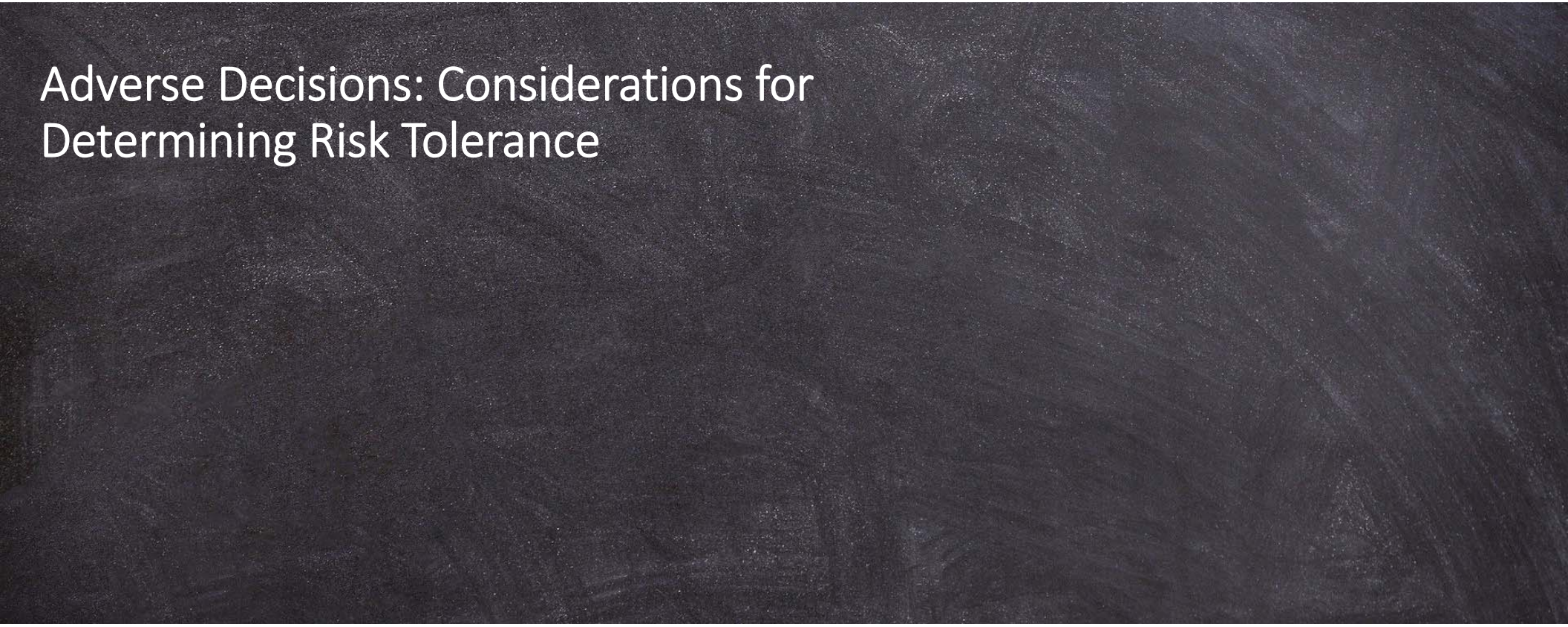


Adverse Decisions: Considerations for Determining Risk Tolerance

Agenda

- Decisions Process Risks
- Medical Necessity Determinations
- Certification of Chronic Illness
- Conflicting Information

Decisions Process Risks

Continuously changing rules

- New rules and regulations around appeal and denial handling
- Fixed contract language while care is evolving

Complaints

- Department of Insurance complaints
- Litigation

Other company impacts

- Claim assumptions
- Future rate increase need

Decisions Process Risk Mitigations

Prepare to make decisions

- Stay up to date with changes in regulatory environment
- Regularly review policies and procedures for consistency with regulations
- Educate and communicate with insureds regarding the claims process

Make decisions

- Consider some type of Claims Committee to review high risk claims
- Consider the support for an approval and denial prior to making final decision
- Document decision and reasoning

Internal Communications

- Decision processes can have impacts outside of claims
- Communication with other departments is important

Outside of the claims department, who should be members of a Claims Committee**?**

Polling Question

A. Compliance?
B. Legal?
C. Marketing?
D. Actuarial?
E. Medical Director?
F. Quality Assurance Team?
G. No one. (Claims only)?

Polling Response

Case Study – Alternate Plan of Care

The Event

Company LTC R Us recently denied a claim request for care received from a licensed memory care unit on the basis that the policy did not explicitly cover memory care facilities.

The insured did not specifically ask for the claim to be considered under the Alternate Plan of Care provision of the policy.

The Company received an appeal requesting that the claim request be reconsidered under Alternate Plan of Care. Claim was approved based on the originally provided claim documentation.

This is the way it has always been done.

Risks

- Care setting was not in existence at the time the policy was issued.
- Claim decision overturned based on no new eligibility or provider documentation. Only new piece is that the benefit requested is Alternate Plan of Care.
- Implication that policy procedures are not being regularly reviewed.

Fast Forward

Claim is approved, but the claimant is unhappy that it took an extra month for the claim to be approved and that the only thing that changed was asking for Alternate Plan of Care be considered.

Upset with LTC R Us, the insured writes a letter to the CEO of the Company expressing frustration.

Polling Question

The CEO has asked you to address this complaint. As the leader of the Claims department for LTC R Us, what is your next step?

A. Respond with the facts of the case and that the policy did not cover Memory Care Unit as an available care setting.

B. Revisit your team's handling of Alternate Plan of Care.

C. A and B.

D. Something different.

Polling Response

The Many Definitions of Medical Necessity

All Medical services and supplies Are:

(1) Provided in accordance with accepted standards of medical practice;
(2) Provided as needed by the patient's condition; and
(3) Not provided solely for the patient's or Doctor's convenience.

Required due to: *sickness*, *illness*, *disease* or *accidental injury*.

Requiring covered care due to *sickness* or *injury*. The care prescribed must be consistent with accepted medical standards for treating the diagnosed condition and could not have been omitted without adversely affecting your condition.

Medically prescribed services that are consistent with the diagnosed condition and which could not be omitted without adversely affecting your condition.

Care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental, investigative or randomized.

For medical reasons, you are necessarily confined due to *sickness* or *injury*, as certified by your doctor.

Treatment, care or services which are:

- Provided for acute or chronic conditions; and
- Consistent with accepted medical standards for a covered person's condition; and
- Not designed primarily for the convenience of a covered person's family; and
- Recommended by a physician

Required Because of *sickness* or *injury*.

A covered health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice.

Medical Necessity: Polling Question

What is your greatest challenge with Medical Necessity?

A. Applying a set of guidelines/rules not defined by the Policy

B. Validity of a Physician's recommendations

C. Conducting independent research related to the presenting condition

D. Detecting "medically *unnecessary*" claims

Polling Response

Different Philosophies for Determining Medical Necessity

Internal Rules Only

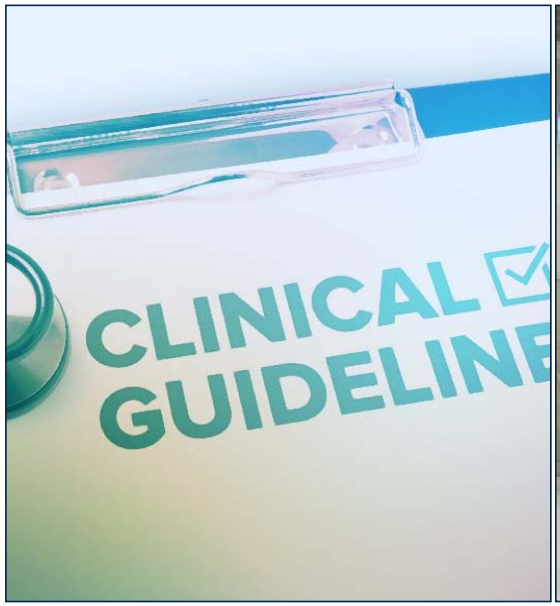
Internal Guidelines with Internal LHCP Consultation as needed

Internal Guidelines with External MD Consultation as needed

External MD Only

Difficulties Associated with Medical Necessity Decisions in Long-Term Care

- Can or should guidelines be one size fits all?
- Are there measures to ensuring validity with Physician recommendations?
- What tools exist to independently research reasonable care for a presenting condition?
- Can we determine a claim is medically unnecessary?



Case Study - Pain

The Event

89 y/o Female Living Alone

- Primary Diagnoses: Osteoporosis and Arthritis
- Fell at home and "broke her back"
- Treatment with surgical intervention
- Rehab stay s/p surgery with therapy
- Unable to continue living alone due to ongoing and unrelieved pain from the surgery and from other fractures that cannot be treated through surgery.

The Care Plan

Non-Medical Home Care Services:

- Fall Risk
- Assistance with IADLs in the home
- Cannot stand for any length of time – not even to prep small meals – mobility issues related to pain
- May need assist with getting into/out of the tub/shower
- May need assist with dressing lower extremities
- May need assist with incontinence and/or getting to the bathroom

Frequency, Intensity and Duration:

- Caregivers 2 hours per day / 5 days per week

The Policy

Benefits are payable when *treatment, care or services are*:

- Provided for acute or chronic conditions;
- Consistent with accepted medical standards for a covered person's condition;
- Not designed primarily for the convenience of a covered person's family; and
- Recommended by a Physician

MN Case Study #1 Polling Question

Benefits are payable when *treatment, care or services are*:

- Provided for acute or chronic conditions;
- Consistent with accepted medical standards for a covered person's condition;
- Not designed primarily for the convenience of a covered person's family; and
- Recommended by a Physician

Could the PH be eligible under Medical Necessity?

A. No, because assistance with IADLs is not a treatment, preventative or mitigating plan that would be "consistent with accepted medical standards for a covered person's condition"

B. No, because the PH needs infrequent assist with ADLs

C. Yes, because her pain limits her mobility, she is a fall risk and requires assistance as needed for safety

D. Yes, because all four elements of the Medical Necessity definition have been met

Polling Response

Case Study – Prevention

The Event

93 y/o male

living alone

- Primary Diagnoses: Diabetes w/peripheral neuropathy
- Fell at home once, without injury
- Fear of falling due to pain and weakness in lower extremities
- Utilizes pain medication as needed
- Wants to do as much for himself as he can, but also remain safe in his home.
- Physician recommended he obtain assistance with IADLs for safety

The Care Plan

Non-Medical Home Care Services:

- Fall Risk
- Be in the home when client is showering
- Assistance with IADLs in the home to include vacuuming, cleaning bathroom and kitchen

Frequency, Intensity and Duration:

- Caregiver 4 hours / 2 x per week

The Policy

Benefits are payable when receiving:

Care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental, investigative or randomized.

MN Case Study #2 Polling Question

Medical Necessity: Care that is appropriate to the diagnosis, widely accepted by the practicing peer group based upon scientific criteria, and not experimental, investigative or randomized.

Can Preventative Services be deemed Medically Necessary?

A. No, because the PH doesn't require any assistance with ADLs

B. No, because there is no evidence that assistance with IADLs is widely accepted by the practicing peer group as necessary for prevention of injury based on the PH condition

C. Yes, for safety reasons to prevent further injury, assistance with IADLs is reasonable

D. Yes, because all elements of the Medical Necessity definition have been met

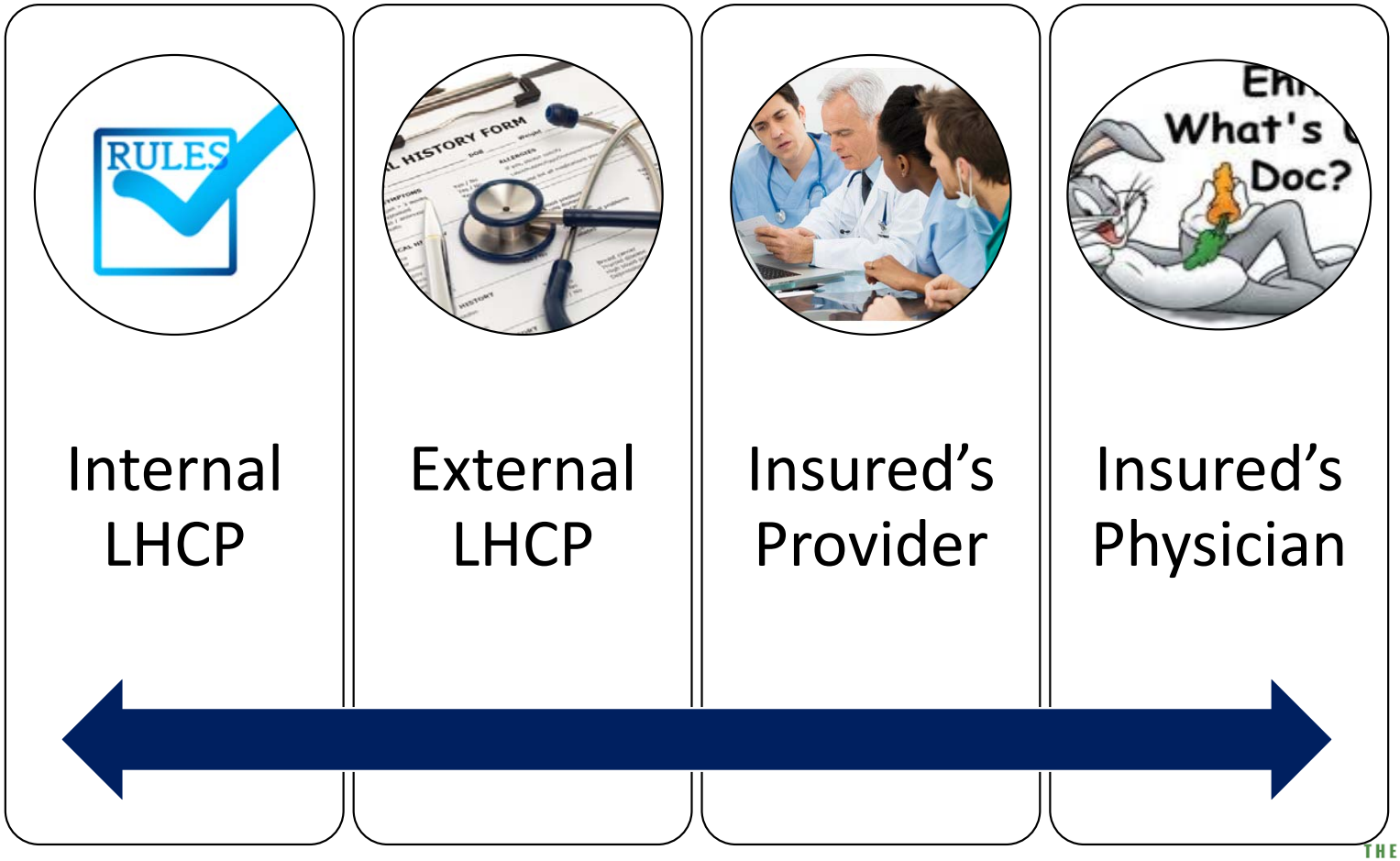
Polling Response

Considerations for Avoiding Risk

- Assessing the individual patient needs to avoid the appearance of an arbitrary decision
- Having clear internal guidelines to assist all Decision Makers on how to evaluate Medical Necessity
- Allowing flexibility with Medical Necessity guidelines to account for the needs of the Long-Term Care Patient
- Consultation with LHCP/Medical Director when clarity is needed for the presenting condition
- Consulting compliance for direction regarding undefined terms
- Regular Communication about claim experience to avoid inconsistencies in claim decisions
- COVID-19 Considerations:
  - Not being able to see the Physician and/or the quality of Telehealth Visits

Tax-Qualified Benefit Triggers

Different Philosophies for Chronic Illness Certifications



Polling Question

Who typically completes the initial Chronic Illness Certification for your organization?

A. Internal LHCP?
B. External LHCP?
C. Insured's LTC provider?
D. Insured's physician?

Polling Response

Case Study—Certifications

The Event

40 y/o male

- Primary Diagnoses: Fall and disc protrusion
- Fell from ladder aggravated previous back condition caused by MVA two years prior
- Claim filed two years and several months after policy issued. Back pain was disclosed on application and treatment was resolved

The Care Plan

Non-Medical Home Care Services:

- RN noted insured required assistance with 4/6 ADLs and IADLs (including driving) at time of claim approval due to pain, limited range-of-motion and side-effects from pain medication which made completing ADLs difficult.

Frequency, Intensity and Duration:

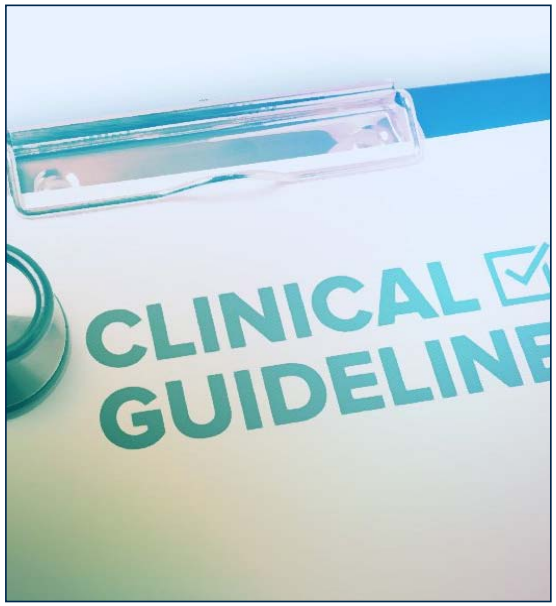
- Receives 12 hours of care per day. Cannot bend, lift, stand longer than 15 minutes. RN observed the following equipment while completing BEA: of cane, walker, raised, toilet seat, urinal, hand held shower

Ongoing Certifications:

- Claimant continued to qualify and receive home health care for two years
- At time for chronically ill certification for 3rd year, claimant noted nominal improvement – still requiring care with 4/6 ADLs
- Chronically Ill Certification and Plan of Care completed by CA nurse assessor noted he still required assistance with bathing, dressing, toileting and transferring due to chronic low back pain, gout, prostate cancer and sleep apnea.

Difficulties Associated with Tax Qualified Claim Decisions in Long-Term Care

- TQ decisions driven by policy language…there are varying interpretations to policy language.
- Does claimant “require” or “receive” qualifying long-term care services? What about the need for continuous vs continual supervision?
- How do you interpret substantial assistance to perform ADLs? “Hands on assistance” is fairly clear. What about “stand-by assistance”?



Case Study – Cognitive Impairment

- 84-year-old male residing at home (alone); still driving to church and appointments.
- HHC began April 1, 2019 and remains ongoing.
- Tax-qualified policy.
- Primary Diagnosis: Short-term memory loss, generalized anxiety.
- HHC Plan of Care – Assist with IADLs, Independent with all ADLs (5 days/4 hours).
- DVNs – IADLs only; family reports informal supervision at night and weekends starting in April.
- Medical records requested – provides only limited information.
  - Family complains of STM loss beginning 3/2019 during routine check-up.
  - August 2019 – Family reports worsening memory loss. Physician diagnoses mild impairment MMSE performed: 25/30.
- Claim filed December 2019.
- January On-site Assessment indicates:
  - Standby Assistance: Bathing; independent with all other ADLs.
  - MMSE: 21/30.

Case Study—Functional Impairment

- 71-year-old female residing at her mother's home due to being her mother's caregiver.
- Plan of care: 24/7 supervision with as-needed ADL assistance.
- Insured suffers from debilitating tremors for a period of approximately 15 minutes at a time.
- Tremors occur irregularly, but generally occur 3-4 times per week.
- During tremors, insured is more than 2 of 6 ADL dependent. Insured is independent otherwise.
- Tax-qualified policy.
- What frequency is needed in order to qualify as Chronically Ill?

What frequency of substantial assistance is needed in order to qualify as Chronically Ill?

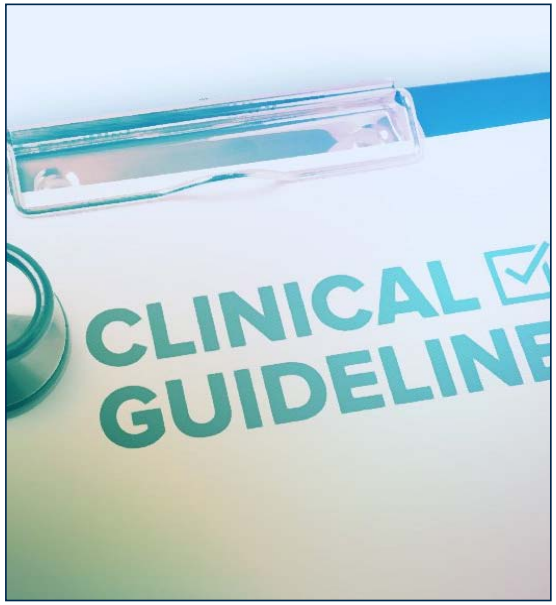
A. 1. Only
B. 1. or 2.
C. 1., 2. or 3.
D. D. or above

1. The insured needs substantial assistance for every time the ADL is performed;
2. The insured needs substantial assistance the majority of the time the ADL is performed;
3. The insured needs substantial assistance if the insured cannot perform the activity intermittently;
4. The insured needs substantial assistance rarely to perform the ADL.

Polling Response

Difficulties associated with adjudicating claims with conflicting information

- The role of clinical judgment
- Required v. receives—the struggle to remain independent
- Unresolved questions / lack of information
- Informal Caregiver Network




Questions?