

## **Independent Review for LTCi: Great Step or Too Little, Too Late?**

Independent Review for long-term care insurance (LTCi) claims is the best thing to happen to the LTCi industry in a long time. Is it “too little”? In some respects perhaps, but that could be fixed. In other ways, it may be “too much”; if so, that characteristic may be less likely to be fixed.

Is it “too late”? Probably not, but it would have been better if the LTCi industry had adopted this practice long ago, before the media spotlighted claims issues, arousing state regulators and federal politicians. With the NAIC and states acting and Congress having held hearings on the industry’s claims practices, the industry has less flexibility than if it had taken the initiative earlier.

This article expresses opinions about the value of IR for LTCi, describes precedents, and ends by out-lining likely future issues.

The most critical need for the LTCi industry is to earn/retain the trust of the distribution system, non-distributor financial advisors, media and the public. The LTCi industry has no business being in business if coverage is not in effect when the insured needs LTC or the coverage does not accomplish the insured’s reasonable expectations at that time. Clearly, a key aspect of fulfilling expectations is: will the claim be paid?

More than 25 years ago, I saw Larry Miller, president of Leisure Werden and Terry (Los Angeles, CA) turn to the person in front of me in a buffet line and heard him say “Claims? That’s easy! You talk to the cadaver. If the cadaver talks back, you don’t pay the claim.”

Of course, life insurance claims are not really that easy. For example, they can be contestable or involve accidental death considerations. However, I remembered Larry’s words 15 years later when I got involved with LTCi. LTCi triggers (cognitive impairment or inability to perform 2 of 6 ADLs) are not as clear-cut as death.

Beyond the triggers, there are other uncertainties in LTCi claims. Does my LTC provider meet the definitions of the contract? When did my incapacity begin? What is causing my need for LTC (is it excluded)? Do other exclusions apply to my situation? According to a report by the Government Accounting Office (GAO)<sup>1</sup>, “Determining whether a consumer has met the benefit triggers to begin receiving claimed benefits can be complex”.

To try to evaluate a carrier’s reliability in paying claims, many people have asked what percentage of LTCi claims are denied (number of denials divided by the number of claims). Relying upon claims payment percentages is hampered because:

- 1) There are various definitions of a “claim” (the denominator of the ratio) – the per initial contact method (used by California), the per claimant method, and the per claim submitted method (used by the NAIC). Imagine that my brother

and I have LTCi policies with 90-day elimination periods and are in an accident together. We each contact our carriers promptly. Later, after I have satisfied my elimination period, I receive 36 monthly benefit payments. My brother's claim is rejected. The "per initial contact" method reports a 100% claims denial rate based on this data<sup>2</sup>. The "per claimant" method reports a 50% claims denial rate<sup>3</sup>. The "per claim payment" method reports less than a 3% claims denial rate based on this data<sup>4</sup>. That's a huge variance!

- 2) There are also a variety of different definitions of a "denial" (the numerator of the ratio). If a claim is denied because a policy is not in force, should that be counted as a claim denial? What if the elimination period was not satisfied? What if there was a pre-existing condition? What if it was a home care claim and the policy was facility-only? Depending on answers to such questions, the claims denial rate can vary substantially. The NAIC method excludes claims made relative to policies that are not in force, denied due to the elimination period not having been satisfied, and denied due to a pre-existing condition, but counts all other denials.<sup>5</sup>
- 3) A low decline ratio could signify that an insurer is paying invalid claims. Such an insurer might not be a good choice for someone seeking LTCi because payment of invalid claims could lead to price increases that increase his cost in the future.

Standardization of definitions could reduce the problems cited above. The NAIC Senior Issues (B) Task Force has concluded that insurers are not using consistent definitions when reporting claims denial data to the NAIC. It is working on developing standard definitions so that such data will be more meaningful.

**But what people really want to know is that 100% of valid claims are paid.**

"Independent Review" (IR) provides an outstanding litmus test for this issue! With IR, meaningful statistics can be developed such as the percentage of claim denials which were overturned by subsequent independent review.

Some insurers have felt that IR is not necessary because they pay claims properly, thanks partly to strong internal appeals procedures. They cite a study done by LifePlans for the U.S. Department of Health and Human Services which documented that 94% of claimants either had no disagreement with their insurance company or had a disagreement that was resolved satisfactorily.<sup>6</sup> Furthermore, the GAO reported that four insurers' internal appeals processes resulted in paying 20% of appealed denials.<sup>7</sup>

Despite such encouraging findings, I believe:

- If any insurer does not pay all claims properly, bad publicity and word of mouth can harm the whole industry.
- In any process of this type, some mistakes must occur, if only a small percentage. A mechanism to fix such mistakes is of value to all parties.

- IR provides an effective defense if media or citizens inaccurately criticize the industry or regulators regarding claims payment practices.
- Even if a perception that LTCi companies deny a significant number of valid claims is inaccurate, it can cause financial advisors and media not to recommend, insurance brokers not to sell, and consumers not to buy LTCi policies.

One precedent for LTCi IR comes from the medical insurance industry. At least 44 U.S. jurisdictions permit insureds to invoke IR to challenge medical insurance claim denials based on medical necessity or experimental procedures/drugs. IR procedures became prevalent during the Clinton administration, possibly in response to federal discussion of Patient Bill of Rights legislation. In 1999 and 2000, the industry averaged one IR appeal each year for every 14,000 insureds. Slightly more than half of the appeals resulted in supporting the insurers' denial.<sup>8</sup> I am not aware of data which indicates how many of the decisions that were overturned relied on information that had not previously been provided to the insurer. If new information is presented, an overturned denial would not suggest that the insurer was wrong to decline the claim initially.

There are at least three external review precedents in the LTCi industry: the Federal LTCi program, the NY Partnership for LTC, and a block of Transamerica Occidental LTCi business.

The Federal LTCi program was an early adopter of independent review.<sup>9</sup> It permits IR relative to disagreements about whether a claimant has satisfied the triggers (ability to perform Activities of Daily Living or cognitive impairment) after an internal appeal has upheld the denial. The IR decision is binding on the insurer, but the claimant retains the right to take his case to court.

The Federal LTCi program has more than 220,000 insureds<sup>10</sup>. As of year-end 2008, only 3 claims had gone to independent review and in all 3 cases, the insurer's decision was upheld. After independent review, none of the three claimants chose to take their claim to judicial review.

The NY Partnership for LTC assumes the role of advocate in the claims denial process, linking claimants to an Independent Assessment in cases where a denial of a claim is based on lack of cognitive impairment or lack of an impaired ability to perform at least two ADLs. The Independent Assessment functions only to determine whether the insured has a sufficient level of impairment to trigger the benefit. The NY State Insurance Department may also intervene at this juncture to help resolve disputes regarding contractual issues (i.e. Is the provider of care licensed? Is the specific service for which the claim has been filed covered under the contract?)

Following an Independent Assessment, if there is no agreement between the insurer and the insured, the case may be referred to the Joint Technical Review Board (JTRB), comprised of Participating Insurers and representation from the NY Partnership state agencies. If a resolution is still not reached at the JTRB level, the case may move to the arbitration level, where the decision is binding on both parties.

According to Bill Koester, Director of the New York State Partnership for Long Term Care, "From inception through the second quarter of 2008, there have been 2,781 benefit authorization requests. Of these, 180 were denied, for a denial rate of 6.4%. One-hundred one of those 180 were denied for failure to satisfy the triggers, the other 79 having been denied for contractual reasons. To the best of my knowledge, none of the 101 trigger-based denials has gone into arbitration. Claims processing is a complex procedure; what is most critical is that the process be open and satisfy the expectations of consumers without compromising the terms of the policy (i.e. paying invalid claims). Compromising can lead to higher premiums, even on existing policies."

In policies issued during the latter half of the 1990s, Transamerica Occidental offered clients the unilateral right to demand binding arbitration relative to "Any controversy or claim arising out of or relating to this policy."<sup>11</sup> As of early 2007, no policyholder had acted on their right to demand binding arbitration.<sup>12</sup>

Therein lies the great advantage for the LTCi industry (and the whole country). With IR provisions, advisors, media, distributors and clients will be more confident in LTCi products. When insurers can publish data demonstrating that challenged claims are properly handled, the confidence will burn even brighter. If the IR decisions all support the insurer, the conclusion is that the insurer is paying claims properly right away. To the degree that IR decisions overturn the insurer's internal decision, the conclusion may be that the insurer did not pay all valid claims initially (perhaps due to lack of information), but the process successfully results in valid claims being paid.

As a result of media attention on LTCi claims payment, regulators have begun to press for independent review of LTCi claims. Iowa's IR process should be in effect by the time this article is published. Several other states have been interested and the NAIC Senior Issues (B) Task Force is working on a model regulation.

Anticipating IR requirements, the insurance industry is preparing.

John Hancock was the first insurer to develop IR standards voluntarily. It provided IR rights to purchasers of its Custom Care II Enhanced product which it introduced in the second quarter of 2008.

"Industry reports to the NAIC, States and the Congress reflect very low claim denial rates. While we don't believe there is a widespread industry problem in paying valid long-term care insurance claims, we believe that our Independent Review process will go a long way towards giving consumers and producers additional assurance that valid claims will indeed be paid," says David Plumb, Vice President of John Hancock LTC Product Development & Risk Management. "We were applauded for our leadership on this subject in a Congressional hearing in July, 2008 and we hope the rest of the industry will follow our lead."

Barbara Rothermel, Regulatory Manager for Prudential, agrees. “IR is positive for both the consumer and the industry. It will validate numerous studies that have shown that eligibility denial rates are fairly low and will build confidence in the product and the valuable protection it can provide.”

David Acselrod, head of MetLife's LTCi division says "MetLife is supportive of Independent Review for LTCi and we have been exploring how to implement this for our LTCi insureds. We believe that Independent Review can help to strengthen confidence in the LTCi product and the overall LTCi industry."

The John Hancock product includes the following wording (wording may vary slightly from one state to another, but the concepts have not been rejected by any jurisdiction):

**Independent Third Party Review**

You have the right to request an Independent Third Party Review if the Claim Appeals Review Board upholds a denial of Your claim (author note: in other words, if an internal appeal concludes that denial is appropriate) based upon a determination that You do not need:

- Substantial Assistance to perform at least two Activities of Daily Living; or
- Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

We will provide You with written instructions on Your right to request an Independent Third Party Review when we notify you of the Claim Appeals Review Board's decision. You must make a request for an Independent Third Party Review in writing no later than 60-days after the date of Our notice informing You of the Claim Appeals Review Board's decision. The role of the Independent Third Party is to review relevant material related to the denial of Your claim that We provide. You will not undergo an exam. The Independent Third Party will provide both You and Us with written notice of its final decision. The decision of the Independent Third Party is final and binding on Us. We will pay the costs associated with an Independent Third Party Review. The Independent Third Party must be either:

- mutually agreed to by You and Us; or
- state approved or certified to conduct such reviews if the state requires such approvals or certifications.

In addition, an Independent Third Party must:

- be, or have on staff or contract with a qualified and licensed health care professional in an appropriate field for determining an individual's ability to perform the Activities of Daily Living or an individual's Cognitive Impairment, whichever applies to Your claim;
- not be affiliated with nor in any manner related to an entity or individual that previously provided care or services to You;
- not employ a licensed health care professional who is associated with Us or related to You in any manner; and
- not be compensated in any manner that is dependent upon the outcome of the review.

Key characteristics of this IR provision include:

- The insurer's internal appeal process must be utilized before IR can be requested.
- It is limited to denials based on failing to meet the triggers.
- It is binding on the insurer, but not binding on the insured. That is, the insured can still pursue his interests through the judicial system.
- There is no cost for the insured (other than effort).
- The person doing IR must have appropriate competence and independence.

I suspect that the Iowa law and current drafts of the NAIC committee follow the above outline, but my efforts to obtain those drafts have been unsuccessful.

In my lead paragraph, I questioned whether the IR effort is “too late”. I believe that the IR effort will, over time, build increasing confidence in the LTCi industry. Such increased confidence will benefit everyone living in the USA. (Even uninsured people benefit to the degree that the LTCi industry helps to relieve pressure on Medicaid.) However, it would have been preferable for the LTCi industry to implement IR procedures before adverse publicity criticized industry claims practices. Past adverse publicity will negatively impact the LTCi industry for at least ten years and perhaps longer (things live forever on the internet), but IR processes will minimize new complaints and cause the negative impact to wither away eventually.

Is the above IR provision “too little”? I prefer allowing broader reasons for IR, such as was done in the Transamerica policy and in at least six jurisdictions relative to health insurance claims<sup>13</sup>. If there is a dispute as to whether a provider fits the policy's definition, why should a denial for that reason be exempt from IR? According to the Supreme Court decision in *Rush Prudential HMO v. Moran*, state IR requirements are not pre-empted by ERISA if the IR process involves contract interpretation.<sup>14</sup> So it seems that a broader IR process is permissible.

As noted above, I believe that IR provisions can generate appropriate trust. Hence the industry should promote and publicize IR. However, it is difficult to publicize a “sometimes” IR provision. Telling a prospect that an insurer has an IR process to handle disputed claims may be accurate but the prospect might think that the IR process would cover all claims disputes. Explaining that the IR process is restricted to questions involving the triggers is complicated and can inspire as many doubts as it resolves. Hence a broad IR provision is best for building confidence.

However, the above approach is also “too much”, particularly if it were to be expanded as suggested in the previous two paragraphs. The industry fears that every claim denial might be challenged through independent review, increasing insurer claims processing cost. Inefficiency is not in anyone's interest.

There are ways to minimize such fears. Some states' health insurance IR processes have some of the following protections<sup>15</sup>, as did the Transamerica policy form arbitration

wording (which was approved in all but one or two jurisdictions which concluded that arbitration could not be offered under any circumstances<sup>16</sup>).

Unfortunately, the momentum seems to be swinging in a direction that may make the following types of precautions unlikely to be included (I hope to be pleasantly surprised):

- 1) IR could be binding on both parties. If the claimant prefers to take her concern to court, she has that right. But why should she be able to go to IR, lose and then take it to court? The purpose of IR is to make it easier for the insured to challenge a claims denial, not to encourage a sequence of challenges to multiple independent entities.
- 2) A filing fee might discourage frivolous requests for IR and help pay for them. To avoid discouraging valid challenges, the fee could be reimbursed by the insurer if its denial is overturned and could be waived if justified by the claimant's financial hardship.
- 3) The department of insurance or independent reviewer could be required to screen a request for IR for appropriateness prior to involving the insurer.
- 4) IR could require that a minimum amount of money be at stake.

Several favorable developments lay the groundwork for future growth of the LTCi industry (Partnership programs, "Own Your Future" communication programs, greatly improved rate stability, tax breaks, HSAs, etc.), but Independent Review of LTCi claims may rival any of these favorable developments in terms of long run significance.

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<sup>1</sup> GAO-08-712, LONG-TERM CARE INSURANCE; Oversight of Rate Setting and Claims Settlement Practices, page 8

<sup>2</sup> This method evaluates the claim only at the time of first contact with the insurer. My brother's claim was denied. My claim was also "denied" when I first contacted the insurer because I had not yet completed my elimination period. This method generated in Charles Duhigg's statement: "In California alone, nearly one in every four long-term-care claims was denied in 2005, according to the state." The statement appeared in "Age, Frail and Denied Care by Their Insurers", New York Times, March 26, 2007.

<sup>3</sup> This method considers my claim to have been paid but my brother's claim to have been denied. Therefore 50% of the claims were paid.

<sup>4</sup> This method concludes that my brother failed one claim and was denied. I filed 36 claims, all of which were paid. Thus, in total, we submitted 37 claims, 36 of which were paid.

<sup>5</sup> See Appendix E of the Long-Term Care Insurance Model Regulation

<sup>6</sup> "Following an Admissions Cohort: Care Management, Claim Experience and Transitions among an Admissions Cohort of Privately Insured Disabled Elders over a 16 Month Period" by Marc A. Cohen, Ph.D., Jessica S. Miller, M.S., and Xiaomei Shi, M.A., LifePlans, Inc., May 2007, page 22 (paging may vary)

<sup>7</sup> GAO, op. cit., page 31.

<sup>8</sup> "Independent Medical Review Of Health Plan Coverage Decisions: Empowering Consumers With Solutions", American Association of Health Plans (now America's Health Insurance Plans), April 2001, page 1. Similar results for the same time period were published in "Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation", Prepared for the Kaiser Family Foundation by Karen Pollitz, Jeff Crowley, Kevin Lucia, Eliza Bangit, Georgetown University Institute for Health Care Research and Policy, revised May 2002.

<sup>9</sup> See the Benefit Booklet for the Federal Long-Term Care Insurance Program, page 11.

<sup>10</sup> GAO, op. cit. page 13

<sup>11</sup> Transamerica Occidental Life Insurance Company, TransCare Companion policy.

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<sup>12</sup> Telephone conversation with Carolyn Eickenberg in early 2007.

<sup>13</sup> America's Health Insurance Plans, "Independent Medical Review: Summary of State Laws and Selected 2007 Legislation (as of July 1, 2007)"

<sup>14</sup> "The Effect of Rush Prudential v. Moran: A Review of Three State External Review Laws", by Anthony F. Shelley & Lisa T. Murphy, Miller & Chevalier Chartered, Analysis & Perspective, Volume 11 Number 42, Thursday, October 24, 2002, page 1521

<sup>15</sup> Ibid.

<sup>16</sup> Author's memory. He was the senior officer of LTCi at Transamerica at the time and remembers trying to explain to a state DOI that mandating arbitration would be unacceptable but offering a client a unilateral right to demand arbitration was not counter to the state's principles.