

# THE IMPORTANCE OF CLAIM PRACTICES IN MANAGING CLOSED LTCI BLOCKS



By ANGELA FORSELL

*Vice President, Clinical Services, Univita Health*

STEPHEN K. HOLLAND, M.D.

*Chief Medical Officer and Chief Compliance  
and Privacy Officer, Univita Health*

and

EILEEN J. TELL, MPH

*Senior Vice President, Product Development and  
Analytic Services, Univita Health*

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“Because company resources may be redirected to more viable and growing product lines within a company, closed blocks often have more limited resources to devote to claims adjudication, customer service, system enhancements, and compliance.”

Here is the challenge: For a variety of reasons, many insurance companies have exited the long-term care market. These carriers are left with closed claims blocks that have huge liabilities associated with them, which may take decades to run off. At the end of 2012 approximately 45 percent of covered lives and approximately 37 percent of premium dollars in the LTCI market were held in closed blocks. These figures are magnified in the group market, where 70 percent of covered lives and 55 percent of premium dollars were held in closed blocks.<sup>1</sup>

Because company resources may be redirected to more viable and growing product lines within a company, closed blocks often have more limited resources to devote to claims adjudication, customer service, system enhancements, and compliance. Legacy administration, claims processing systems, compliance, and products tend to receive less attention and resources than do product lines that are the focus of a carrier's current business and growth strategy, so keeping up with best claims practices and regulatory requirements may not be a priority.

Specifically, closed blocks present the following challenges:

- Low profitability
- Reputation risk if claims, complaints, regulatory compliance issues, and customer service functions are not adequately addressed
- Reluctance or inability on the part of the company's leadership to invest in the personnel, training, and technology needed to serve insureds and properly manage policies and claims
- A low priority on maintaining expertise in the product and keeping up with industry trends, best practices, and regulatory changes
- Diversion of leading-edge staff resources to other more profitable business lines
- Negative regulatory exposure that may result from inconsistent and/or outdated claim practices and inefficiencies

- Increased financial strain from inadequately managed claim losses and increasing liabilities on balance sheets

Profitability losses with “runaway” claims as a primary driver are perhaps one of the most serious problems presented by closed blocks. While, to some extent, these issues likely contributed to the decision to close an LTCI block, the fact that new sales and improved rate-stabilized products are not entering the block exacerbates an already significant problem. Closed blocks tend to perform worse than open blocks do. Research has shown that the ratio of actual-to-expected incurred claims is 92 percent for companies with closed blocks, compared to 81 percent for those still selling LTCI.<sup>2</sup>

Given that closed blocks already present significantly greater challenges to profitability, it becomes more crucial to ensure that carriers utilize highly focused talent and strategies to mitigate losses and improve performance to the extent possible. Due to the complexity within these blocks, limited expertise, and resource constraints, claims in a closed block may not be optimally adjudicated and managed. Fraudulent claims, administrative inefficiencies, and complaints may increase, creating greater losses and further declines in profitability.

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Maintaining profitability and mitigating avoidable losses are major concerns for all carriers, but especially for those with closed blocks. This is even more apparent as it has become difficult to obtain rate increases even if a carrier can show a need for the increase based on claims experience. The risks to a closed block are significant:

- If adequate claim and care management practices are not followed, the company’s goal of paying all eligible claims in an equitable and timely manner and helping claimants obtain high-quality and cost-effective care may not be met.
- Deficient and outdated claims practices may impact future rate increase efforts as regulators cite them, rather than actuarial misses, as the basis of unexpected claims losses.
- If claims are not carefully screened, newly devised fraudulent schemes may go undetected.
- If regulatory changes are not tracked and adhered to, or if claims are not adjudicated correctly and good business practices not followed, regulatory actions and lawsuits can occur.
- If quality customer service is not maintained, a company’s reputation can be negatively affected.

Successfully managing LTCI is a challenge even under the best circumstances, but closed blocks pose additional challenges. They are often comprised of older policy forms with less specific policy language that is challenging to administer in the face of the long-term care delivery system and provider communities that have changed significantly over recent decades. Some of these blocks grew through acquisition of other companies’ LTCI business or the introduction of new product forms to replace those found to be performing poorly. Consequently, a closed block may be made up of a complex mixture of policy generations with wide variations in contract language — making it much more difficult to administer adequately and reliably, especially with respect to benefit eligibility, provider eligibility, and claims adjudication.

This article explores key claims practice areas and illustrates the importance of managing claims specifically to the unique challenges of a closed block.

**Table 1****Sample Closed Block — Paid Claims**

Top 10 claimed diagnoses*	Distribution within top 10 conditions
Pure dementia	33.7%
Cancer	16.0%
Stroke	11.4%
Fracture/injuries	10.8%
Respiratory disease	6.2%
Parkinson's	5.8%
Cardiomyopathy, congestive heart failure	5.8%
Arthritis and other rheumatic diseases	4.5%
Disorders of the spine	3.6%
Dementia with fall, fracture, or accidental injury	2.3%

\* Top 10 conditions account for more than 70 percent of all paid claims.

Source: Univita Health (2014)

## Claims and Care Management

Proper claims and care management protocols are critical to improving claims experience with respect to cost, legal risk, and customer service. A well-managed claims management process supports the primary goal of making accurate benefit eligibility decisions (so that all eligible claimants receive the benefits and services to which they are entitled), but in a way that ensures that benefits are not paid for individuals or providers not meeting eligibility requirements.

For both the carrier and its insureds, it is critical to manage claims in a cost-effective, clinically sensitive, and consistent way that meets claimants' needs while protecting the insurer's ability to provide the promised benefits. This minimizes the need for rate increases or, when rate hikes cannot be avoided, enables the block to function effectively within current rate constraints.

## Making the Correct Benefit Eligibility Decision

The clinical conditions presenting for benefits in closed LTCI blocks are similar to those seen in open LTCI blocks (Table 1), though claimants are generally older and their policies tend to have non-standardized and often vague benefit eligibility criteria. Making the correct benefit eligibility decision at the time of claim is critical to the effective management of a closed block, yet research has shown that many carriers still struggle. One study found that from 6 percent to 17 percent of claimants receiving benefits do not satisfy the benefit eligibility criteria. (The variation is based on service setting.)<sup>5</sup>

Benefit eligibility decisions based upon the criteria established under HIPAA for the administration of federally tax-qualified (TQ) long-term care plans, though straightforward for most presenting for claim, can be a challenge in response to a marginally disabled claimant. In contrast, determining eligibility without standardized clinical criteria — often the case with older non-tax qualified (NTQ) plan language that relies on the poorly defined concept of “medical necessity” — is more challenging and presents both profitability and litigation risks.

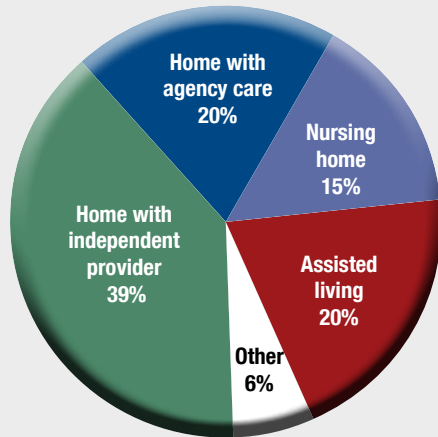
Also, experience has shown that reliance upon provider statements invariably produces inappropriate benefit eligibility determinations. This is due not only to the financial incentive providers have to report “qualifying” levels of impairment, but also because many custodial care providers (both facility- and home-based) lack the clinical expertise to accurately measure and report on clients' functional and cognitive deficits and care needs. The carrier's development and application of objective clinical benefit triggers are essential to effective benefit eligibility determination for all the various NTQ benefit eligibility definitions in the multitude of policy forms that make up much of a closed LTCI block.

## Controlling the Plan of Care

One way to avoid paying benefits for unneeded services is to make sure that the Plan of Care is clinically appropriate and consistent with verified deficits and need. Many carriers solicit Plans of Care from physicians or providers, either because they don't have the technical

Figure 1

**Percentage of Claims With Recovery, by Location of Care**



Source: Univita Health (2014)

ability to handle this internally or because they believe that relying on attending physicians minimizes disputes.

However, experience supports an alternative approach: using trained clinical professional staff employed by or under contract to the insurer to construct Plans of Care that are appropriate, consistent, and in compliance with both policy language and applicable law. An important part of this approach is the active collaboration among the carrier, claimants, and their families to reach consensus on a Plan of Care that is responsive to claimants’ verified needs, taking into account paid care, unpaid care by families and friends, and assistive devices or modifications that enable as much safe and independent function as possible. Plan of Care professionals must ensure that planned services are consistent with benefit limitations and policy constraints, at the appropriate intensity and frequency, and delivered in the most appropriate setting.

**Getting Cognitive Assessments Right**

Cognitive impairment can be difficult to identify and quantify, and inaccurate assessment of the degree of impairment is a leading cause of premature benefit eligibility approvals. However, a cognitive assessment

tool developed specifically for the LTCI industry — the Minnesota Cognitive Acuity Screen (MCAS) — has become a critical tool for assessing cognitive impairment. The MCAS can be administered over the telephone or in person and is highly sensitive and specific in detecting mild and early stages of cognitive impairment in underwriting, as well as moderate to severe dementia at time of claim. The MCAS has been performed over 1 million times since 1999 and has been consistently revalidated in university-based blinded trials.<sup>4</sup>

Since this tool provides insurers with accurate information on a claimant’s degree of cognitive impairment, it can reduce premature approvals. When combined with a careful investigation of current limitations and required supervision and services, the assessment and proper claims adjudication processes assure carriers that they will approve cognitive claims strictly in line with policy requirements and actuarial assumptions.

**Staying Engaged With Claimants to Monitor and Encourage Recovery**

Many believe that recovery is rare for someone who once met the eligibility threshold for long-term care benefits. But experience shows that significant recovery of functional ability is seen in as many as a third of cases, sometimes as late as two years after claim initiation. Even with some forms of cognitive loss, recovery — while less frequent — can occur. (For example, there are cases where an acute illness has exacerbated a mild or marginal cognitive condition or caused delirium of limited duration in an otherwise healthy older person.)

Recovery can reduce the level of care needed or even end claim eligibility. A recent Univita Health study of one large closed block of claims found a recovery rate of more than 31 percent of approved claims — and only about half of those who do recover subsequently reclaim. Where a benefit is provided also plays a role in the probability of recovery (Figure 1). By actively monitoring claimants’ health status, encouraging family and provider involvement in all stages of recovery and rehabilitation, and conducting thorough and timely reassessments, insurers can close claims for individuals who recover to non-qualifying levels of function and independence.

## Meeting Claimant and Carrier Goals Through Care Management

The goal of care management is to enhance claimants' health and quality of life by ensuring they receive the services that best meet their needs in the most suitable setting and from the most appropriate providers. Care management also can prevent unnecessary costs for both claimants and the insurer. For instance, a care manager may help develop a Plan of Care that will allow an individual to receive care at home so that the claimant doesn't have to move to a more intensive and expensive facility care setting.

One important tool for effective care management is the use of an in-home assessment. This involves a clinician's visit to a claimant's home and includes an assessment of function, cognition, home safety, caregiver competency, medication compliance, and independence, all designed to become the basis of a professional understanding of care needs and the social support network. Information collected during the assessment improves the accuracy of the benefit eligibility process and supports care planning based upon identified needs rather than benefit maximums. This visit also initiates the very important relationship between the claimant and the care management team and enables timely Plan of Care updates, including a reassessment of continued eligibility or potential for recovery.

## The Role of Claims Audits

It is also important for insurers to regularly obtain an objective review of their claim practices to understand deficits and areas of vulnerability. This is especially critical for assessing the ongoing effectiveness of how a closed LTCI block is being managed. Hiring an experienced independent entity or maintaining an independent LTCI audit team internally to perform structured audits of claims and care management process enables comparison with known "best practices" and can identify areas of risk and areas for improvement.

An independent claims audit can identify potential savings through modifying claim practices to include more accurate eligibility decisions, clinically sound Plans of Care, and careful monitoring of ongoing claims to

ensure claim closure on recovery. An audit can address administrative issues such as claims intake, assessment, reassessment, documentation, and timeliness of claim payment that may have become inefficient and ineffective as the closed block and claims practices have aged. Even if a practice doesn't result in incorrect payment, it may not be efficient or changes could result in additional administrative and claims savings.

In addition, a properly conducted audit can flag claims with possible legal or regulatory concerns or indications of fraud. An independent claims audit examines payments and practices for a representative sample of claims to determine which claims and how many of them would have been approved under model claims practice, compared to actual practice. The audit then can estimate the number of claims unnecessarily paid or overpaid, as well as the amount of potential overpayment. The audit also can identify reasons for errors in claim adjudication and payment.

Past audits have identified opportunities for improved claims-handling protocols in the following categories: financial (45 percent of audited claims), regulatory (15 percent), and procedural (15 percent). Other audits have produced improvements that have enhanced recovery efforts, mitigated the risk of fraud through changes in claims practices, and provided a more effective means to investigate and resolve known fraud and abuse.

It is important to note that these improvements were not achieved by denying eligible claims. They were achieved by ensuring that only benefit-eligible claimants were paid under clinically appropriate Plans of Care and by closing claims in a timely manner for those who have recovered and are no longer eligible for benefits. Claims in these types of audits are selected randomly, and if the sample is selected correctly, findings can be projected across the entire block of claims to estimate potential claims savings. Several recent Univita audits of closed claims blocks have found that identified changes in practice projected across the entire claim block using best practice protocols potentially could result in a 20 percent to 27 percent reduction in annual incurred claim payments.

## In Conclusion

It is critical that carriers continue to invest in claims practices, personnel, systems, and compliance efforts to ensure that their closed LTCI blocks are performing as effectively and efficiently as possible. To that end, carriers must have highly focused talent to mitigate losses and improve performance to every extent possible.

Because of complexity, limited expertise, and resource constraints, claims in a closed block may not be adjudicated and managed as efficiently and effectively as possible. Fraudulent claims, administrative inefficiencies, complaints, and negative regulatory exposure may increase as the block ages. It is important to focus on key risk management areas, including conducting accurate and timely assessments of cognitive loss and benefit eligibility, aggressively reassessing and encouraging the potential for recovery, monitoring for fraud and abuse, and maximizing use of care in less restrictive and less costly settings. Additional economies are possible from periodic claim practice audits to identify existing protocols that are not consistent with best practices.

Closed LTCI blocks that are managed well benefit both carriers and their insured populations by virtue of the positive impact on the need and scope of potential rate increases. However, the optimal management of these closed blocks takes the same effort and investment — if not more — than open LTCI blocks require, which is often contrary to how carriers approach and manage their closed LTCI blocks today. 🌐

- 1 Source: LIMRA's *Group and Individual Long-Term Care Insurance Annual Review*, ongoing.
- 2 Cohen, MA, "Long-Term Care Insurance: A Product and Industry in Transition," presented at the National Association of Insurance Commissioners (NAIC) Senior Issues Task Force, November 2012.
- 3 Miller, J., "Enabling Claimants to Maximize Independence," presented at the Eleventh Annual Intercompany Long-Term Care Conference, March 2012.
- 4 Knopman, D., Knudson, D., Yoes, M., Weiss, D., "Development and Standardization of a New Telephonic Cognitive Screening Test: The Minnesota Cognitive Acuity Screen (MCAS)," *Neuropsychiatry Neuropsychol Behav Neurol Journal*, 2000: 13(4); 286-296, and Tremont, G., et al., "Use of Telephone-Administered Minnesota Cognitive Ability Screen to Detect Mild Cognitive Impairment," *American Journal of Alzheimer's Disease & Other Dementias*, 2011.

**Angela Forsell** is Vice President, Clinical Services, for Univita Health. She has more than 35 years of experience in claims and care management, the last 14 exclusively in long-term care. In her current capacity, Forsell is responsible for the implementation of all clinical and technical protocols that guide the administration of Univita's clients' long-term care claims. She also provides consultative services to carriers throughout the United States for which Univita currently does not provide administrative services. Forsell is a graduate of Kent State University. She can be reached at [AForsell@univitahealth.com](mailto:AForsell@univitahealth.com).



**Stephen K. Holland, M.D.** serves as Chief Medical Officer and Chief Compliance and Privacy Officer for Univita Health. He contributes more than 25 years of long-term care and managed care leadership experience. Dr. Holland formerly served as Senior Vice President and Medical Director for the Long Term Care Group, which became part of Univita in 2008, and has played an integral role in building the company. In addition to his responsibilities for demonstrating Univita's value proposition through outcomes research and all compliance and privacy issues, Dr. Holland leads Univita's efforts to understand and improve care, recovery rates, and independence for those with functional and cognitive deficits and dependencies. He holds an M.D. from the Case Western Reserve University School of Medicine and completed postgraduate training in internal medicine at the University of Washington. Dr. Holland can be reached at [SHolland@univitahealth.com](mailto:SHolland@univitahealth.com).



**Eileen J. Tell, MPH** is Senior Vice President, Product Development and Analytic Services, for Univita Health. She has nearly 30 years of experience as an industry leader in long-term care policy, research, and consumer education. Tell is responsible for policy analysis, product design, compliance, market trends, and competitive and regulatory analysis. She has conducted extensive research on various aspects of long-term care finance and delivery. Tell graduated *magna cum laude* from Tufts University and earned a master's degree in public health from the University of Michigan. She can be reached at [ETell@univitahealth.com](mailto:ETell@univitahealth.com).