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Partnering Business Operations With Clinical Expertise in Long-Term Care Insurance Claims

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As the life expectancy of Americans continues to increase from advances in medicine, the average age of a Long-Term Care Insurance (LTCI) carrier's block also continues to age. With increasing life expectancy comes increased incidence of cognitive conditions such as dementia, stroke and Parkinson's. The World Health Organization estimates the total number of new cases of dementia each year worldwide is nearly 9.9 million, implying one new case every three seconds. The number of people with dementia is expected to increase to 82 million in 2030 and 152 million in 2050.[1,2]

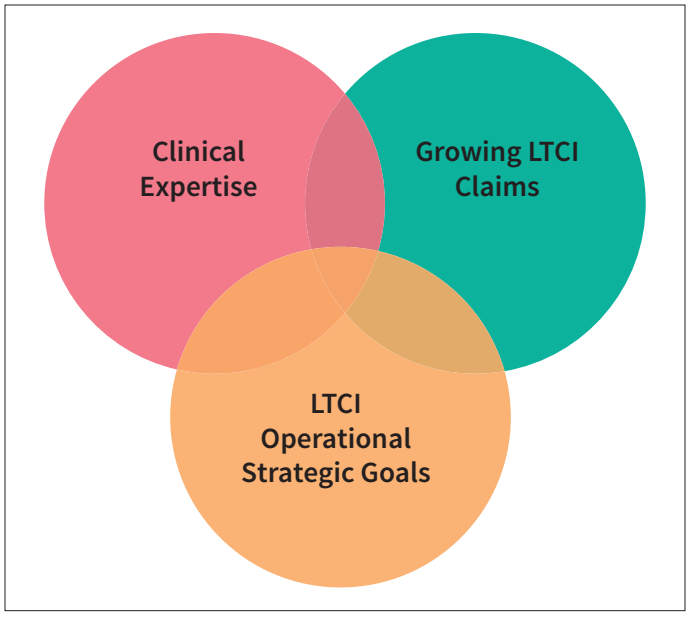
Today, at least 50 percent of all LTCI claims are for cognitive conditions such as dementia.[3] Original policy language does not provide methods to assess "severe" cognitive impairment in a standardized manner and claims operations teams will face additional pressure to capture relevant, timely and accurate neurological data and to employ guidelines to make appropriate claims adjudication decisions on cognitive claims.

OPPORTUNITIES FOR CARE OPTIMIZATION AND BEST PRACTICES

Care optimization is a concept very applicable to LTCI. In health insurance and managed care, quality metrics and evidence-based guidelines exists to bridge physicians with the business operations of insurance companies. These joint business units bring together clinical and operational teams to assess the medical necessity, appropriateness and efficiency of health care services, procedures and benefits, and ensure these issues are reflected under policy language.

An example of a typical quality guideline may ask a patient to complete an X-ray for knee pain before ordering a more expensive test such as a magnetic resonance image (MRI). This practice leverages evidence-based protocols and allows the insurance company to "rule out" any obvious knee trauma before approving payment for a more expensive test, in this case the MRI.

Figure 1
The Partnership Between Clinical Expertise and Business Operations in LTCI Allows for Care Optimization and Best Practices During Claims Processing



STANDARDIZING CLAIMS PROCESSING WITH ESTABLISHED GUIDELINES

To aid in the diagnosis of dementia as well as to help doctors understand how to rule out other issues, the American Academy of Neurology, Centers for Medicare and Medicaid, and the American Psychiatric Association have established quality guidelines

and best practices to help clinicians accurately assess a patient for severe cognitive impairment.

These guidelines also show the importance of being able to "rule out" treatable conditions. A multitude of conditions present as dementia, but are actually conditions arising from metabolic or infectious causes. For instance, it is common to see patients with urinary catheters develop urinary tract infections that may make mild cognitive impairment appear severe. This type of temporary exacerbation of a cognitive problem is known as delirium.

Clinical research has shown that these guidelines are seldom followed and only 15 percent of physicians employ these established guidelines and protocols, fueling a large gap in care.[4,5] One of the contributing factors is that clinicians are time-constrained in a fee-for-service model and don't have the training nor the expertise to operationalize dementia best practices in their clinic. Furthermore, neurology is an elective during medical school and there is a systemwide shortage of neurologists across the United States that makes accessing a guideline-based diagnostic approach uniquely challenging and especially relevant to the LTCI market.

Many carriers and TPAs turn to medical records to obtain relevant information, but often describe this experience as "finding a needle in a haystack."

Several LTCI carriers and third-party administrators (TPAs) say these types of guidelines and protocols are extremely useful when adopted for claims processing both at the carrier and TPA level. The LTCI industry's use of these clinical guidelines represents an opportunity to reduce cost, leverage data insights and improve quality standards for claims processing.

By embracing this approach to care optimization, carriers can positively impact the quality of care for insureds and, at the same time, improve their bottom line—truly a win-win between business and clinical care. For LTCI carriers who say they are not allowed to "practice medicine," this affords them an opportunity to advocate for the insured, especially because many insureds and their family members seldom know about these guidelines. Often, a diagnosis of a reversible condition can be found by asking whether an appropriate medical workup has been done and whether the insured truly has "irreversible" dementia (per policy language) before approving the claim.

CLAIMS AUDIT FINDINGS

In 2019, Neurocern, a predictive analytics and neuroinformatics company, audited the claims process for multiple carriers who collectively represent over 25 percent of the market and greater than 1 million covered lives. In addition, the audit included clinical chart review and auditing claims process practices of three TPAs.

The following trends demonstrate a need for an independent, clinically based process that uses established evidence-based guidelines and embraces care optimization.

1. RELEVANT, ACCURATE INFORMATION AT THE RIGHT TIME IMPROVES THE CLAIMS PROCESS

Many carriers and TPAs turn to medical records to obtain relevant information, but often describe this experience as "finding a needle in a haystack." In 2019, the Alzheimer's Association reported that only 16 percent of seniors are screened for cognitive concerns during Medicare annual wellness visits and, of those diagnosed, only half are told the diagnosis by their physician. This clinical gap directly complicates the claims workflow process as carriers and TPAs are tasked with gathering years' worth of medical records.

Furthermore, obtaining relevant and accurate information during claims review is important. For instance, patients who have been recently discharged from the hospital require very specific (and varying) consult and rehabilitation records during claims processing as opposed to claims originating from the home or assisted living facilities. During a TPA audit and complex case review, Neurocern found that over 51 percent of claims seen (and adjudicated for) by the TPA did not gather the right information at the right time. Obtaining relevant information based on quality standards allows insurance carriers to find substantial evidence that a claim might be too early for benefits or in some cases may be recoverable.

2. EMPLOYING BEST PRACTICES CAN CHANGE OUTCOMES

Carriers rely on independent nurses to help assess the cognitive status of an insured during the claims process. Nurses who perform face-to-face assessments are not provided clinical context on the insured's case and are generally "blinded" to the case; as a result, during an audit, a wide range of inconsistencies in the quality of cognitive assessment testing was found across all assessment vendors.

As a neurologist, we ask our patients to come to our clinic during the "best time of the day" for standardized cognitive testing to obtain their abilities at their best. In the review and audit of claims, it was found that:

- Insureds who met clinical criteria for possible alcoholism (who were concurrently applying for severe cognitive impairment claims) did not have a blood alcohol level test before administering a cognitive assessment as part of the Benefit Eligibility Assessment (BEA).

- Insureds with Parkinson's disease who are known to have "on" and "off" states of cognition and physical performance were not told to take their medications before cognitive testing.
- Insureds with dementia-related psychosis and urinary incontinence were not tested for infection prior to cognitive testing.

These simple examples represent opportunities for claims teams to improve the quality and standards during BEA testing and implement care optimization principles earlier in the BEA process.

As many carriers look to digitize their existing BEA form, there is a need for clinical standards to be put in place. In addition, advanced communication with the nurse about best practices to improve the BEA can ensure that insureds are being accurately tested during the right time in the right setting.

3. PREDICTIVE ANALYTICS CAN FIND AND TRIAGE QUESTIONABLE CLAIMS

In partnership with carriers, the Neurocern analytics engine was introduced during claims processing. It identified at least 20 percent of claims (approved by either a TPA or carrier) that could have gone into a separate workflow for further testing based on evidence-based guidelines and best practices in care. These claims represented cases that could have been delayed as the information provided at intake did not support "irreversible and severe cognitive impairment."

ACCURATE CLAIMS DATA CARRIES POSITIVE IMPLICATIONS FOR ACTUARIES

As principle-based reserving becomes more widely adopted across the industry, there will also be an increasing demand to characterize, risk stratify and predict the morbidity, mortality and claim duration of insureds in a particular block. Actuarial practices have generally been retrospective in review. Predictive analytics, on the other hand, can help actuaries capture prospective risk and better characterize and predict the needs of insureds to set active and disabled life reserves accurately.

The relative risk for morbidity and associated liability across carriers varies significantly, as seen in Neurocern's datalake. So, reinsurers, private equity, and actuaries must consider the heterogeneity of these relative risks when assuming risk and liabilities ahead.

BRIDGING CLINICAL EXPERTISE WITH BUSINESS OPERATIONS A WIN-WIN FOR ALL

We are taught in medicine that all patients should not be treated the same. Each patient requires a careful history in order to understand their unique symptoms to help formulate a plan of care. As a neurologist, some of my most fulfilling consults include identifying patients with treatable conditions that were misdiagnosed as irreversible dementia.

Polypharmacy (too many medications), normal pressure hydrocephalus (extra fluid around the brain) and toxic metabolic encephalopathy represent just some of the cases I've seen clinically that were managed into recovery. From my patients' perspective, these accurate diagnoses allowed them to regain their livelihood, which in some cases meant retirement could wait and aging in place with family and friends became a reality.

It is rewarding for me to work with insurance carriers and help align the interests between the claims operations teams and medical community. And, it is a powerful win-win for carriers and their insureds to utilize technology that enables more accurate assessment of dementia along with leveraging data insights for aging in place. ■

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ENDNOTES

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