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LONG-TERM-CARE (LTC) CLAIMS MANAGEMENT

Moderator: DONALD M. CHARSKY
Panelists: ROGER E. DESJARDINS*
BARBARA PRESCOTT†
Recorder: DONALD M. CHARSKY

Panelists will discuss issues associated with handling claims based on different insurable events—activities of daily living (ADLs), cognitive, medical necessity.

MR. DONALD M. CHARSKY: Our two panel members bring much claims management experience to this discussion. Barbara Prescott is the assistant vice president of claims for the Duncanson & Holt (D&H) group in Avon, Connecticut. She manages the provision of LTC claims management services to D&H's reinsurance customers. Roger Desjardins is the director of LTC claims at AMEX Life Assurance Company, the largest writer of individual LTC in the U.S.

MS. BARBARA PRESCOTT: There's a lot of consumer distrust about LTC claims management. Some people look at claims management as a means for an insurer to save money and deny them immediate services that they feel they need to maintain their independence. But case management in the LTC area is more than precertification, utilization review, or preferred provider organization (PPO) networks, although it does contain these elements. For LTC insurance, case management is now perceived as the most effective mechanism to avoid costly institutionalization for people who could otherwise live independently at home provided appropriate support services were available.

Early generation policies base their benefit trigger on the medical model. Insurers did this because they felt very comfortable with this. Their claims staff and their agents understood it. They felt it was a proven approach and therefore it was logical that they use it. However, any claims person will tell you, medical necessity based on physician certification can be easily manipulated by the insured and his or her family because a doctor will usually recommend whatever an insured or the family really wants. It's very difficult to refute doctor's orders. A doctor, however, is not the best assessor of ADLs. Doctors, for the most part, also lack knowledge about what services are available, what is appropriate and what the costs are. That's why a well-trained case assessor or case management person is very valuable.

The ADLs benefit trigger was developed as a means to measure individual LTC needs. The index of independent ADLs is one of the most widely used measures. It was developed by Dr. Sidney Katz and it was developed to determine a person's ability to function. Under the Katz model, all people who could perform an ADL without human help are rated as independent, based on the usual performance and not ability. A person who refuses to perform a function, although physically capable of doing it,

*Mr. Desjardins, not a member of the sponsoring organizations, is Director of LTC Claims at AMEX Life Assurance Company in San Rafael, California.

†Ms. Prescott, not a member of the sponsoring organizations, is an Assistant Vice President of Claims at The Duncanson & Holt Group in Avon, Connecticut.

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would be considered independent. The ADL model is a more reliable and objective approach and research also supports this approach. There's a strong correlation between ADL dependence and the need for LTC services. Again, ADLs are activities that people normally and habitually perform.

Early policies do not include cognitive impairment as a benefit trigger. Insurers were very nervous about using it. They felt it would be abused. It does add further complexity to the claims administration process because it's difficult to measure the degree of cognitive impairment and predict what the level and intensity of service needs would be over time. Usually some form of dementia rating is used and a care manager will typically conduct a minimal status exam. Sometimes this is done during underwriting to screen out people with cognitive deficits. It is used to measure orientation, recall, and visual abilities. It should be given by a trained assessor and rated accordingly. This is supplemented by clinical data and structured interviews with family members, who are in the best position to really know how a person functions. I include instrumental ADLs because I don't believe they really belong as a benefit trigger. They are very gender specific, they are less reliable, and culturally biased. They involve such activities as managing money, doing laundry, and shopping for groceries. Many men don't know how to shop for groceries or prepare meals, so how can you say they're really impaired in that area?

To determine the insurable event is the fun part of my job. Under the medical model, claims examiners are relying on doctor's reports and claims forms. For the most part, doctor's reports are very incomplete. You really don't get a good picture of the claimant. You're relying upon little blocks that are checked off on a form. You really don't get into the meat of it. You don't get a complete picture of the whole person. We underwrite and look at our claims from the perspective of the whole person. What I usually see when we have a medical necessity trigger is that the doctor will say that person needs help at home. It doesn't say what kind of help or the required amount, or if it can be rendered by trained, semiskilled people. Usually the claimant and the family are left to their own devices in arranging for help. Sometimes, on their own, they'll get a nurse or a certified nursing aide, and that could be very expensive. This is another area where care management really is of value in determining the insurable event under a mandatory care management policy. This provides the claimant, and I'm talking here from an advocacy standpoint more than cost control, and the family with a very knowledgeable and experienced care manager who will visit the claimant and assess his or her unique situation.

Usually there is a telephonic prescreening when the claim is first reported so you get an idea of the person's status, what the condition is and what activities the individual needs help with. Then I recommend that the claims department work very closely with the assessor, who is usually an RN, before he or she goes out. It's important that you talk to the assessor so you can set the expectations as to what you really want. If this is a contestable claim, for example, you might want to have the assessor focus on past medical history and try to elicit more data like the referring physicians. It's also a good idea before the assessor goes out to inform the patient and the family that the assessor is coming to visit them and explain why. It's also a good opportunity to reiterate what the terms of the policy are, and what you have to do to collect benefits, because what you have to do in order to be eligible for benefits may be very different than what the insured believes. We have an instance right now under a home health

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care plan where the policyholders have been led to believe by the agent that it is a medical policy, and they're looking for maid service. This one lady called on our toll free line and said that her husband was out of town and she needed help. She had a high temperature. We said, "Shouldn't you call your doctor?" She said, "Oh, I called my doctor, and he said I probably have the flu. He told me to drink fluids and go to bed, but I need help. I want somebody to come over."

You will spend much time on the phone with insureds and their families explaining what the coverage is all about. It's a very labor-intensive, customer-service-oriented product. It's not like medical, and what I found among my self-administered clients, is that they still have their medical claims staff handling these claims, and that is a big mistake. You really need to develop some expertise with your claim people so they know what this is all about and that it's different from medical. The care assessor visits the client and makes the assessment, develops a care plan and then helps implement that plan by facilitating access to various services. Care assessors also will do monitoring and reassessment.

Let's talk about what's involved with this on-site assessment, at least let's talk about what I want to get out of it. It's a first-hand account. I have somebody out there who's telling me, "This is how I see the claimant in his or her own environment." We get a physical and mental health description, past medical history, again especially helpful if it's during the contestable period, but look out if you rescind on these policies. You don't stand a chance. It's required to do your underwriting upfront so there are no surprises, but you still have that clause and you have to really rule that out if it is an early claim situation.

You're looking at the use of appliances, such as canes and walkers. What kind of home setting is it? Are there architectural barriers? For example, the bathroom is on the second floor and there's nothing on the first floor. That's going to have an impact on being able to perform two ADLs, toileting and, incontinence.

Support systems is number one. What support systems are in use right now? Are they family members and formal caregivers? This is critical to know because the care manager will be able to identify strengths and weaknesses in the care network and the extent of the family support. What you usually find is that if there is a spouse involved, you have an elderly couple where one spouse is trying to provide care to the claimant and that the spouse is in as much need of care in many instances as the claimant.

You also want to determine right away if there is a power of attorney situation, because this is the person who will be making decisions about the services and the level of care. You also want to find out about the financial situation. You don't have to get into the real nitty-gritty. Find out if there is other insurance. Is there health insurance that can pay for much of the acute costs? Also, has Medicare come into play? Although I understand the new Medicare regulations are such that they will be secondary. I haven't seen the final guidelines on that, but the policy may offset with Medicare, so it's important that you find out what other coverages are in force. Also, if the person might be entitled to, because of their income level, any state, federal or local coverages.

Behavior, emotional outlook, and motivation are important. Some people get very depressed—they've had a stroke or they're in the early stages of Alzheimer's. Alzheimer's is progressive, but with a stroke or diabetes, it's possible that you can help them return to independence, so it's important that you know what their outlook is upfront.

Functionality is where we really get into the insurable event's determination. What we usually use is a scale of zero to three—zero being independent, three being totally dependent. Here the care manager assesses each ADL based on that scale. Independent would mean that the person can perform the activity by one's self with or without the aid of equipment or without the assistance of another person. Minimal assistance required might be a 1. That means the person must have verbal guidance, or partial or intermittent hands-on assistance from another person. Moderate assistance would be a two. This means assistance from another person with all or most of the activity. Dependent is a three, which means the person does not participate in the activity and must be totally and continuously cared for by another person. Claims people really appreciate having contracts that are very tightly worded. Please have a precise definition of what you mean by inability to perform an ADL. Any ambiguity will be resolved in favor of the insured.

Don't say cannot perform an activity. You've got to be more specific. For example, say assistance is needing help from another human being every time the activity is performed. But human assistance may be in the form of physically helping the person perform the function or giving directions to those physically capable of performing the activity, but mentally unaware of how to do it. The assessor will also rate the cognitive abilities and that's where the minimal status exam comes into play.

Another area that I find helpful is the assessor observations. The assessor has already talked to the family, talked to the claimant and gotten a feel for just how the family feels the person performs each ADL and how the claimant feels. The claimant will say he can perform more ADLs than what the family says. The family will say the claimant is totally helpless, because it wants help. Whereas the care manager will be able to observe how the claimant is performing the ADLs. I also feel after the assessor has made his report that the claim examiner call the assessor and expand upon what's in that report, because there are some difficult issues such as family dynamics. That is what you will see at claim time. You're dealing more with a family than you are dealing with a person who is going to be on claim.

The care manager should be a person who has very good interviewing skills, can empathize, has knowledge of human behavior, has an awareness of what services are available in the community, and has knowledge of cost. That way you're directing people to providers that are cost-effective. You're not saying where they have to go for services, unless you have a network, but typically giving the person choices.

That applied to determining the insurable event. For controlling utilization costs, care management plans encourage early notification and intervention. This can be handled by a phone call and it simplifies the claims-filing process tremendously. An 800 number through which the claimant can either call your claim department or the care manager directly also allows for early intervention. You will be hearing a lot more

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about early intervention with disability insurance as well. It is really critical that the right choices are made upfront before it's too late. If they're off on one course of treatment, it's very difficult to steer them into another track. It also provides options to the insured and to the family that they might not be aware of at the time of claim. Believe me, it's a very upsetting time and LTC services are fragmented. People do not know what is out there and a care manager can bring that altogether and at least provide them with some solace and some direction as to the best course.

Also, a care manager will direct them to the right level of service providers. For a lower needs case you can have a trained, semiskilled person providing the care. Most of the care will be personal care needs: feeding the person, preparing meals, and skin care. These are usually services that are provided by home health care aides. Then you have home care aides. This is kind of a step down. They might help with ambulation and exercise, but they don't always provide the hands-on treatment that a home health care aide would. Then on the lowest rung you have your homemakers. You will see a lot of these type services coming into play. This is light housekeeping, grocery shopping, meal preparation, mopping, vacuuming, and things of that nature. Those costs run about 40% lower than what you see for your home health care aides. A care manager also will be able to recommend less costly alternatives to nursing home institutionalization. I strongly recommend that you be flexible in administering the claims because it makes sense sometimes to cover a person who is in a residential facility or congregate living or even an assisted living situation. However, you have to be careful with assisted living that you're not paying room and board. What you want to pay is the home health care-type services that are provided. There are all kinds of arrangements that you can work out, but what you want to do is to come up with a less costly alternative than what a normal nursing home stay would be.

Under mandatory care management, in order to collect benefits, the services have to be in the care plan. In that care plan, the care manager outlines what the frequency and duration is and the level of care. Then the insured's claim department reviews and approves that with input from the family physician. But it is approved by both the insured and the insurer. Also, a care manager assures too that your benefits are not used up right away. You're stretching out benefits, especially on plans that go on a service basis. If it's on a calendar-year basis where the clock starts ticking the minute they go on claim, then forget it, but if it's on a service basis, you want to ensure that there will be money until the end as the claimant's condition deteriorates.

Care management is a means to substitute public for private dollars whenever possible. (That's not very politically correct right now as we're facing budget constraints.) There are many local, free-entitlement-type services that people might be eligible for, and a care manager should know what is available. I feel it's very important that you maintain a clear separation between the person who is doing the assessing and the person who is providing services. You want to maintain that objectivity and you should have a claim department making the decision as to whether or not the claimant meets the eligibility criteria. It's not the care manager. The care manager is doing the assessment and making the recommendation on the care plan, but he is not an expert in insurance or in determining whether a person is eligible for benefits.

One other thing I wanted to mention is the fact that there has been some concern from insurers that mandatory care management is not the best way to go. They're afraid of

litigation, for one thing, if there is a disagreement with the care plan. I have been involved with over 100–150 care plans over the last two years and we have not had any conflicts at all. We've worked them out. Also, they don't want to invest the resources. They do not have a nationwide network of case assessors, but there are companies that do provide that service well. The cost is not inexpensive, and I can't tell you that there is a definite savings at this point. You're spending money upfront and, in many instances, you're avoiding many claims because of it, but it's really too soon to say what the eventual savings are going to be. The on-site assessment will normally run about \$300–400 and that includes the development of the care plan. Then monitoring and reassessment services are usually paid on an hourly rate, and include travel.

I believe care management ensures quality of care and claimant satisfaction. I like happy claimants. I like feeling that I've done something good, and I know cost containment is very important. We don't want to spend dollars unwisely, but care management is more of an advocacy approach. It assists the claimant and family in identifying options which best meet that particular person's needs. Then the family and the claimant can select from those options. It also coordinates and facilitates access to those services that are geared to improving the quality of life and to maximizing claimant independence. It identifies alternate care options that may be less costly and more appropriate. As I said before, insurers should be willing to go beyond the normal limits of the contract and agree to extend coverage for services not normally covered, if it is practical. I will point out that there can be room for abuse here with an alternate care provision in your contract. Claims people have to be very, very careful in how they manage this because sometimes it is misunderstood.

I've already pointed out that monitoring is very important. You do not set up regular monitoring points. It's not automatic that once a person qualifies for a claim you're going to review it every month or every two weeks. You do it on a basis of the claimant's situation, and on the basis of the care plan. And, as every claim is different, it's considered on its own merits. No two claims are alike, so the care manager and the claim department must work hand-in-hand. You can save some money by having your claims people do some of the legwork like requesting medical reports and nurses' notes and have it supplemented by the care manager. But, monitoring provides a good opportunity to really evaluate the appropriateness, quality and level of services being provided and to make changes or recommend changes. There might be changes with the informal support systems, too. An elderly spouse's health has deteriorated and so the individual needs more services. Or, the individual may need less services; for example, Aunt Millie has moved back to town and will provide some care for the person.

Insurers require that a comprehensive and standardized assessment be scheduled based on clinical judgment of the likelihood of changes in the claimant's functional or cognitive capacity or personal situation. Reassessments determine the claimant's continued need and preferences for services. It can lead to reduction, or an increase in the services authorized in the care plan. One thing you will come across with your monitoring and reassessment is that there might be problems with personalities of the providers who are coming into the home. It might be a language barrier or perhaps just a personality conflict. These are conflict situations in which a care manager can talk to the home health care agency to bring in a different provider, or in some situations a different agency altogether. Many people do not want what they call

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“strangers” coming into their home. A care manager can be a very valuable tool in explaining or allaying that fear. I hope that I’ve given you at least a basic understanding of just how the process works and what its value is. I think it is a way of saving money and also insuring happy policyholders.

MS. LORETTA J. JACOBS: You were talking about a care plan. If somebody wants some type of care, like say, a homemaker, to do a chore that’s not part of the actual care plan, are you suggesting that you tell a person that this service would not be covered if it’s not in the care plan?

MS. PRESCOTT: Yes. It has to be in the care plan. If, for convenience sake, the person wants more assistance, then you really have to be firm and explain, because of the person’s particular needs, it’s really not necessary. The fact is you don’t want the individual to use up these benefits; you want to extend the benefits. We’ve had many claims where we’ve spent the money upfront sending somebody out to do the assessment and then the insured decided not to file a claim. The claimant wanted to save his benefits.

MR. BRUCE A. STAHL: Does the answer change when you’re working with an elapsed time benefit provision as opposed to a service product?

MS. PRESCOTT: Yes.

MR. STAHL: Some contracts are based on calendar days rather than days of service.

MS. PRESCOTT: That’s right. That’s when the clock starts ticking, when they’re eligible for claim. We had a situation in which the lady had Alzheimer’s and the husband, a contractor, who was in business for himself, was the sole caregiver and he was just worn out. He needed assistance. As a result, we had a home health care aide come in three days a week and two days a week; she went to adult day care. The husband took care of her on weekends, but then her condition steadily deteriorated. She became very combative and adult day care wouldn’t take care of her any longer. Then she was moved into an Alzheimer’s treatment facility about 50 miles from where the couple lived. The facility was located through the help of the care manager. It wasn’t a nursing home; it was 60% of the cost of the nursing home, which was the benefit of the policy. It was a win-win situation for us because the husband could have put her in a nursing home in the area and we would have been paying the full benefit. Instead we paid 60% of that benefit. We continued to review this special arrangement, called it an individual case management (ICM) arrangement, to make sure it was still appropriate. It has worked out quite well.

MR. STAHL: Many benefit eligibility criteria use ADLs. Are you looking at just those ADLs that are in the criteria?

MS. PRESCOTT: No, you’ve got to look at the whole picture. Usually your selection criteria is two out of five and when someone is dependent, usually bathing and dressing are the first two that go. So if the person is a three in bathing and a two in dressing, he or she would certainly qualify. We would have an assessor go out, even though the tele-phonc interview indicates that the individuals are fine, and there is no impairment.

We want to be absolutely sure before we deny a claim that we're doing it appropriately and of those, I would say, at least 5% of the time I have wound up paying that claim.

MS. JACOBS: How much of the time, if you just listened to what they said on the phone would there be an on-site assessment where you would find that the individual doesn't qualify.

MS. PRESCOTT: Very rarely have we found that they have not qualified.

MR. ROGER E. DESJARDINS: It's great to have interest in LTC claims finally surface in different venues. I'm an associate of life and health claims with the International Claim Association and I'm director of LTC claims at AMEX. I, like Barbara, consider myself a claims person. I want to present a macroview of how my company's claims department has gone through a very rapid series of changes. I'll tell where some of you, if you are in the LTC business right now, could find yourselves in the near future. Bear in mind that at AMEX we have approximately 270,000 policyholders and our claim block consists of about 3,000 open claims at any given time. We get approximately 45-60 new claims a week. We have a large claim block. Our staff consists of two managers. I have an operations manager and a technical manager. We have 15 claims representatives who are completely dedicated to LTC claims, and we have a support unit of about ten people who assist in various administrative functions.

To the extent that Barbara and I do the same types of things every day, we will touch on some of the similar things, so I'll minimize the redundancy. What I really want to cover is my perspective from the industry side of what we expected in the early days of product development and what some of our actual early experience was. I want to go through some of the lessons we learned and surprises we encountered as opposed to what we expected. I want to tell you what I think are challenges and successes in managing a large claims block. I want to talk about the outlook for the future and some recommendations I have as you go back to your organizations and work with your claims managers.

One of the assumptions with early LTC claims was that they would be pretty easy to administer. We would have a few "claims adjusters" that could handle large volumes of claims at low costs. We assumed that most claims would be payable. I think many of us thought, "How much can you really do with a nursing home claim?" Most claimants would be confined until death. This is a quote from another claims professional that goes back to about 1987, when we started talking about LTC, "We won't have to worry about fraud in LTC claims; that's one good thing. We won't have the same issues that we have with other disability products."

Slowly our business began to grow. We were dealing with fairly simple products early on, for example, nursing home only, indemnity model, meaning once you hit the triggers you received a certain amount of money every day or every month, and prior hospitalization and doctor certification is required. What we call at AMEX, the "dreaded event," served as the gatekeeper. In other words, there is no incentive to use benefits. Nobody wants to go to a nursing home so when you get a claim in, it's got to be payable.

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Concurrent to this, the long-term health care provider industry was fairly stable and predictable. A nursing home, by one person's definition, was a nursing home by another person's definition. There weren't many alternatives at that time. All this added up to a claims philosophy for most departments that was really one of processing. When you gear a department towards processing, you try to get as much information as you can on the claim form upfront. The idea is to get the check out the door as quickly as you can, to put your resources into making sure you don't overpay people who may have died during the prior months, or you do confinement calls to nursing homes to make sure people are still there. The whole idea is to minimize handling costs. Once you process the claim and get it into pay status, you move it to an automatic payment system. It all pointed to minimal communication. We started out with claim representatives who found themselves not being able to speak to their claimants by and large, as opposed to the disability lines where you have your claimant at a younger age and available. We set up this environment of just mechanical processing.

LTC surprised many people. It just sort of exploded from a competition standpoint. One carrier's bell and whistle became another carrier's one-up—everyone had to do a better bell and whistle. Products became very unique, and in that process you may have sold a few policies of one type, or a few hundred policies of one series to some consumers, but then moved rapidly to another product and retired it. Nonetheless, you still have those consumers who have a contract that, at some point in time, someone will have to administer.

What happened from a claims standpoint as claims started coming in? You had claims representatives that were getting claims on many varied products. Again, simultaneously the LTC providers as an industry began to evolve extremely rapidly, so we began seeing this blending of facilities. It was difficult to tell if a facility was a nursing home. You looked at your contract which defined nursing homes as having x number of beds and y staffing ratios. The business of home care sort of took off. We knew consumers wanted to stay home as long as possible, the home care industry recognized it and started delivering services in that venue. The third bullet to this was LTC became demedicalized. You found fewer and fewer acute care skilled nursing beds. You found fewer and fewer physicians involved in the process, but far more allied health care professionals as care managers got into the business of LTC.

Lo and behold, one day, we asked the questions. We have this claim block and what's in it? Do we really know what compromises our claim block? When we asked this question at AMEX, we realized that we needed to do some analysis and some studying and to that extent, we engaged the services of an independent company, LifePlans, that came in and helped us do some analytical work. The findings were pretty surprising. We found that in general, 10% of our claimants didn't meet the functional or cognitive benefit triggers.

Many of them didn't even satisfy objective injury sickness requirements. They may have at one point in time, but they didn't at the time they were rechecked for the audit. We found daily indemnities were exceeding daily charges. People were making money on their LTC claims. Many were no longer in skilled beds. They'd moved to lower levels of care. As Barbara said, we began to rethink the role of the physician. We found that doctors, by and large, don't understand the LTC needs of their patients.

Certainly, doctors are critical in determining diagnoses and clinical treatment plans, but if you ask the doctor, "What kind of care needs does your patient have?" Doctors would say, "I don't know. I see them in my office once every two weeks, or once a month for ten minutes and by the time I see them, they're on an examination table and I don't see them move around and do the sorts of things that you're asking me to respond to." The claim forms didn't cut it anymore. When you have a claim form and you try to figure out the whole story, the pieces just weren't there.

As the experience began to grow and we started taking a closer look at it, one of the biggest surprises to us was that we did have opportunities to proactively manage the risk. Through venues like care management, we got better at measuring loss and disability for LTC so that we could help make better decisions as to whether people qualified under this myriad of benefit triggers that we had put out over a very short period of time. We found that setting expectations, the early intervention that Barbara talked about, was extraordinarily important. If you had somebody who was filing a LTC claim, but who really had a short-term disability, like a broken hip, something that you would expect recovery from, it's very important to communicate upfront to that claimant, "The good news is, Mrs. Smith, we don't expect this to be a LTC claim. Most people with a broken hip will be out of a nursing home in 10-12 weeks." This way you develop relationships and establish expectations upfront so you don't end up having Mrs. Smith's home being sold and having her move in with her family for the long haul.

Something very new that we're finding at AMEX with our block is that we have opportunities for extra contractual arrangements that make sense for both parties. Sometimes it makes sense to go outside of the contract, especially with some of the earlier products where we didn't have the scope of covered service options that we have in the newer products. We can work something out that makes sense to the claimant, the family, the doctor and the company; so a win-win situation is really achievable.

As we look at the claims block at AMEX, I'm seeing some new risks. One we call the moral hazard risk, and that's the indemnity versus reimbursement model where the cash to the claimant is greater than the cost of services. We find that with reimbursement products we're able to control that to a much larger degree so you're only paying out the benefits that were incurred costs by the claimant.

The next two are sort of interesting and fairly recent. We have something that I like to call a social hazard risk and these are the more social needs or companionship needs that people have. We find claimants who have more psychiatric/psychological disorders than they actually have ADL loss and they're trying to use their LTC policies to meet that need as well.

Third, the domestic hazard risk is an interesting one where we find people want to use homemaker and choremaker services. Shouldn't everyone have a maid and have it paid by their LTC policy?

What are some of the welcome surprises? Given everything I've said, we had to move away from a processing philosophy. We've moved to a claims adjudication philosophy, which means developing complete information on the claimant and really

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understanding the details of what's happening with that individual's clinical event. The next welcome surprise is a movement toward accurate administration of contracts. If any of you have claims departments with more than one claim representative, or if you're sharing a claim representative with other lines of business, they may not be accurately administering the contract language for that particular policy.

If you had a series that said "standby supervision" or one that said "continual one-to-one assistance," you need to make sure that your claims departments are in fact administering those triggers differently because they were priced differently. Part of the reason for a larger staff is balancing this philosophy. It takes more time and, given our volume, it means we have moved to a segmentation strategy, where you break down your claim block by similar type claims, maybe by product. We have contestable claims handled by one or two representatives that are really good at investigation and understanding the issues of contestability. We have home care claims handled by other representatives and then we have the claims that you just have no opportunity with, which is the majority, handled by lower level representatives. The point is you get tremendous value out of those claims you can manage early on and not have them turn into long-term loss situations.

At AMEX we monitor experience very closely and we act accordingly. We have a very strong relationship between claims and underwriting. We jointly look at claims on a weekly basis. It's extremely important to introduce the concept of risk management, if you don't have it in your companies today. It's not just an underwriting component. It's not just a claims component, but both have to come together. If you don't have it now, think about developing the diversity and expertise of your claims staff. Again, because of our segmentation strategy, we have technical experts, we have clinicians, we have claims professionals who came from long-term disability, disability income and short-term disability. We get a very good mix of perspectives in looking at the claims block from that group of people.

Now for some recommendations and outlooks. I think LTC is the new generation of disability claims. We're finding at AMEX that contestability and rescission are things at which we need to look very closely. We, in fact, believe that if you do have a policy that was issued under material misrepresentation that you need to go through the steps to rescind that policy. When they are black and white, we've been successful at doing that when they come up. I think we owe it to the industry to do that. It's extremely important to understand the difference between postclaims underwriting and rescission and misrepresentation. They're entirely different concepts, legally. They're mutually exclusive. If you underwrite your business upfront, you cannot be practicing postclaims underwriting.

Develop a claims environment concurrently with new products. In other words, include claims people in your product development task forces. If you are not included in your product development areas, insist on participating. As benefits get proposed and as bells and whistles get developed, ask How, when and where will we administer this benefit? How is this going to work in real life? I think the environment will continue to grow more varied. It's still very competitive. LTC as an industry is changing. Our products will respond accordingly and we need to keep an eye on the regulatory scene as well.

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Finally, don't minimize or overlook those opportunities for managing claims and influencing the outcomes. They really do exist and they can be extraordinarily valuable financially. If you look at the reserve of one claim that you can take down, you've legitimized a tremendous amount of work to that end.

MR. STAHL: I'm curious about the extra contractual agreements. Have you ever run into any disputes later on?

MR. DESJARDINS: We never have. Again, it's a fairly new territory. The concept came mainly from its successes in other disability lines where you can work out a win-win situation. Most of the current ones involve moving people to levels of care that their contracts don't cover so, by and large, the payout is a little bit less, which works out for the company. The insured, or the claimant, gets what he would like which is to move out of a nursing home (which is the only level their policy will cover) to an alternate care facility. The understanding is, if it doesn't work out, you go back to your nursing home and everything resumes as normal. It's got to be a win-win situation and you really have to get everybody involved. It has to work out with the doctor and the family. If they have legal concerns, we encourage them to consult an attorney. They're usually written up as very simple, extracontractual agreements. They're working very well. We're having a lot of success with them.

MR. DOUGLAS M. PRICE: I'm curious whether you think that one of the key elements of early intervention is shortened elimination periods? Do you think that probably long elimination periods will create problems in this area?

MR. DESJARDINS: Certainly what happens with many longer elimination periods is people wait to file their claim. In fact, if you could get people, despite the elimination period (EP), to file the claim early on, you can still track them through the elimination period to find out when it's over, have they recovered, are they still eligible, so you know when to start doing your assessments and when to start care management, if you need to. If there's any down side to longer EPs, it's that it delays your ability to proactively get in there and do some early intervention.

MR. STAHL: Is there anything stopping you from putting the requirement of care management in your contracts?

MR. DESJARDINS: Absolutely not. As a matter of fact, it's in many of the newer policy series and you will see it much more in home care-type liberal contracts, which is where we run into the other risks with people. As you loosen the triggers, people at home are, for the most part, less in need and there's more incentive to use the product, especially for homemaker-, choremaker-type services. One of the things I didn't mention, and part of the difficulty for the care manager, is to assess the needs versus the wants and communicate that to the carrier. What does the claimant really need from a functional standpoint to stay home safely and independently? Then you have to carve out the wants. That's the type of risks that are developing right now.

MS. JACOBS: Do you ever perform assessments and care management under products that do not require it?

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MR. DESJARDINS: Yes, we do. As a matter of fact, we've taken the concept of doing assessments and care management, again extracontractually, to products that don't really have it built in. So, in our effort to understand someone's disability at the time of claim with his level of impairment, we just go ahead and send out a care manager to do a face-to-face assessment, even though the contract doesn't necessarily specify that that's going to happen. We take a multidimensional approach. One of the risks I run into is people assuming that I'm saying don't involve the doctor. You need to involve information from the doctor obviously, to understand that piece of it, but all the pieces of the puzzle need to fit together. The doctor's diagnosis should match with what the care manager is telling you the needs are. Then the other component of care management that works so well is to try to get as much informal support and care as you can from qualified family members. One of our newer products is something called, "a caregiver training benefit," where if a family member needs some training to do some care service, we'll pay for that under the contract as well.

MR. DAVID M. WALKER: Has anyone had much experience with respite care benefits?

MR. DESJARDINS: Very limited. We have had it in our contracts for a while. It's perceived, I think, by the consumer as a valued benefit. The volume of claims that we have you'd think would precipitate some of these respite claims, but we're actually seeing very few.

MR. WALKER: Would it typically be used for a temporary institutional stay or as a substitute caregiver at home?

MR. DESJARDINS: We find both. We find people who are by and large primary caregivers or informal caregivers at home who want to go on vacation and they move mom or dad to the LTC facility for a short period of time, or increase the amount of professional home care to allow them to get out of the scene. We had one interesting claim a while back where somebody wanted, respite care on a weekly basis, and we worked it out so the person could get out and play bridge once a night. A valuable benefit for people who need it.

