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Claims – The Final Frontier?

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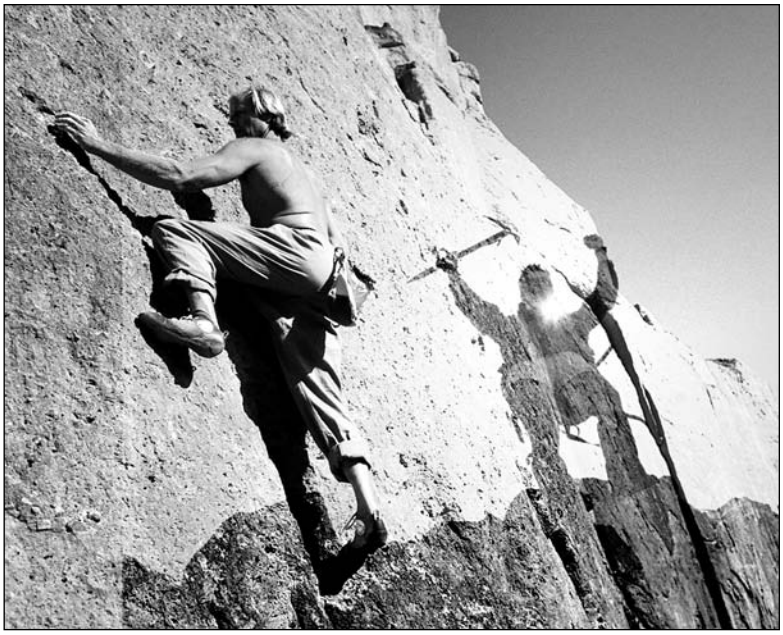

Some of the pioneers did not make it to their California destination. That thought crossed my mind recently as I (Phil) was skiing just a few miles from Donner Pass, named after a group of emigrants who became trapped in the Sierra Nevada mountains during the winter of 1846-47. Nearly half of the party died. That experience has become legendary as one of the most tragic in the record of Western migration. The Sierras were the final hurdle for the Conestoga wagons, which crossed our great continent long before interstate highways and four-wheel drive. The Donner party had come 2,500 miles in seven months only to lose their race with the weather by just one day, and then only 150 miles from their destination of Sutter's Fort (Sacramento), California. It's a sobering thought that making it most of the way wasn't good enough after having already overcome many setbacks.

Were the Sierras to the pioneers what claims may become to the LTC industry? Having weathered (for better or worse) challenges related to marketing, underwriting, persistency, interest rates and regulation; is *claims* the final frontier for the LTC industry?

Can any business be considered anything but a pioneer that does not know the actual cost of its product? Starting with the obvious, the benefit cost is not fully known at the policy level until any claims are fully incurred and paid. The last transaction for many policies will be a claim check. Developing a robust understanding of LTC ultimate claim costs is going to be a very long-term endeavor, given today's young issue ages, the fact that claims increase with attained age, and the extremely high persistency of the business. A further complication is that much of the claims experience to date is not based on today's plan designs or underwriting.

Therefore, and somewhat understandably, it is morbidity assumptions, not actual paid experience, that currently color much of what we perceive as LTC claim reality—for actuaries and non-actuaries alike. Actuaries at least have the technical ability to understand just how little actual claims experience has been paid in relation to what will be paid on today's inforce. However, after morbidity assumptions are chosen they tend to take on a life of their own, and like other perceptions of reality, become resistant to change.

Academically, claims must be the "final frontier" for any insurance product. But for most products, that frontier has already been crossed. The viability of current product designs has already been demonstrated.

Okay, so why the fuss about claims now? In the last couple of years, there has been a developing focus on claims in the LTC industry. One used to hear, "We'll worry about claim issues later. We have more immediate challenges." Now, one is more likely to hear, "Claims are growing, and we have some concerns about what we're seeing."

Financial results may be relatively unaffected by emerging problems with claims experience during the first years of a new program. Those results are more sensitive to valuation methods and assumptions than actual experience. Unfortunately, some insurers view financial results as the primary indicator of the health of their business, and somewhat understandably, because their constituents do. However, financial results are actually more of a trailing indicator for LTC. To determine how LTC is really performing, monitoring activities should include routine claim incidence and continuance experience

continued on page 12

analysis, in addition to actual-to-expected loss ratio analysis, and gross premium valuations.

Reflect on the fact that once a claim has been incurred, only the *continuance* assumption is relevant, *incidence* is thereafter history. Claim cost assumptions used in pricing may prove to be adequate in the long run, but the underlying *continuance* assumptions may not prove to be adequate, leading to understated claim reserves. This can occur when actual *incidence* is more favorable than anticipated, but actual continuance is less favorable. The best time to fully develop *incidence* and *continuance* assumptions is when a product is initially priced, so that experience analysis and valuation is not handicapped by only partially understanding what pricing anticipated.

Although industry morbidity experience in total appears to be on track in looking at NAIC Experience Report summaries, the possibility of weak claim reserves for some insurers may color those results. We've seen several instances where claim reserve strengthening has been needed, because the actual *continuance* is proving to be longer than originally assumed, especially for claims that persist beyond just a few months. Weak claim reserve is a multi-edged sword in that it not only defers losses by understating *actual* incurred claims, but also understates *actual-to-expected* incurred loss ratios, therefore masking or understating the need for a rate increase.

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The Schedule H test may uncover a claim reserve problem, but sheds little light on its nature and magnitude. For long-tail business, the amount of inadequacy generated during one year says little about the ultimate shortfall. The Schedule H test is necessary by regulation, but not necessarily sufficient for understanding the amount of (in)adequacy.

One of the most important types of LTC claim analysis involves developing and reviewing actual-to-expected claim termination rates. Actual length of claims is interesting, but any such measure is biased on the short side, whether looking at closed or open claims.

Claim termination rates decrease dramatically over the first several months of a claim. Therefore, claim duration is a key variable in such analysis. Cause of termination shifts from a high portion of recoveries over the first several months to mortality as the primary cause, thereafter. "Slicing variables" are needed, which reflect the characteristics insured and coverage, including underwriting class and plan options that may affect the experience. Primary cause of claim may also be a useful parameter in major diagnostic groupings, bearing in mind that the initial cause is not necessarily the current cause. At a minimum, separate analysis of claims that involve cognitive impairment versus those that do not is recommended, because of CI's longer continuance.

Unavoidably, credibility becomes an issue when looking at thin slices of experience. Credibility improves upon aggregating the experience, but comparisons to expected may suffer from variances in the underlying mix of business, unless the expected continuance assumptions are developed in sufficient detail. Was that pricing adjustment for incidence, continuance or both?

Beyond the first 12 months or so of claim duration, it may make sense to base continuance on a modified mortality table, rather than a confinement-based assumption that was developed a couple of decades ago. Individuals are living longer today, and the growth of home care and assisted living facilities may also make such older sources obsolete. (We've seen stand-alone home care claims for which this approach was the only one that reasonably fit the experience.)

Actuaries tend to be rational and quantitative in their outlook. That's a great strength, but it can also lead to a potential blind spot in developing models and choosing assumptions. In economic modeling, there's a tendency to downplay the significance of input factors that cannot be (or simply have not been) measured. For example, every actuarial pricing model assumes that underwriting classifies risks into the appropriate "buckets." Underwriting is somewhat of a mystery to many, because it does not easily lend itself to mathematical modeling nor can it be reduced to tight rule-based logic—where actuaries like to play. Just as LTC actuaries have needed to learn more about underwriting, the time has come to learn more about the claim process. Claim experience reports are not the full story. Please pardon the insistence that you really need to see how basic human behavior impacts LTC claims, both on the part of claimants, and also those who are managing the claims.

For example: contrary to ideal modeling assumptions, insureds do not have digital displays on their foreheads which indicate how many ADLs they fail or their level of cognitive impairment. For an underwriting assessment, one can (in theory) ask the applicant to demonstrate ADLs and cognitive ability, and they have an incentive to cooperate. For claim assessments, however, there is no incentive for an insured to demonstrate any lack of impairment that might disqualify them from receiving a desirable benefit. Unfortunately, benefit triggers require honest cooperation on the part of the insured, and are more easily gamed for claims than for underwriting. Also, assessors that tend to give the subject the benefit of the doubt in underwriting are even

more pressured to do so when claim dollars are involved. In developing assumptions and plan designs, benefit triggers have been generally considered to be objective and readily determinable. The fact that they are definitely not is a growing challenge facing the LTC insurance industry as *actual* claims increasingly affect financial results.

To a large extent, national long-term care studies use telephonic interviews in the assessment process. Participants' self-reporting may be relatively unbiased given the lack of any financial interest in the outcome. There may even be some bias toward under-reporting severity of impairment. Denial is a coping mechanism, and most individuals like to put their best foot forward when interacting with strangers. General population studies may still be our best source of "objective" data on ADLs or CI. The question then becomes one of how much to adjust such studies for the impact of human behavior when given a financial stake in the assessment outcome.

A major heads-up for a "trust without verification" approach to claims appeared in the *American Journal of Bioethics*, "Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public".[1] This study reported that 26 percent of prospective jurors believe that it's okay for a physician to lie to an insurance company to help a patient to receive an insurance benefit, and no less than 11 percent of physicians, also.

An interesting claim caught my attention recently. A person age 50 has "profited" from their indemnity LTC policy in the amount of $60,000 per year for the last two years. The current daily benefit is $180 of which only $15 per day is spent for one hour of home care. The maximum benefit is unlimited, and inflation protection is included. The coverage was issued in one of the states that are known to be more reluctant to approve LTC rate increases. Rationally, one might comment that if the person met the benefit trigger, then why all the fuss? For starters, how many reimbursement-type claims have you seen for which the insured receives only one hour of unskilled care per day? This claim is suspect, perhaps involving fraud or simply loose management. Some LTC insurers do not have well-defined criteria for flagging suspect claims for further investigation.

Even under the reimbursement model, a claimant may "profit" in non-monetary ways from their claim. A couple of examples include receiving companionship and the convenience/status of having, in effect, a maid and chauffer. If the insurer is not actively managing the claim, then someone else is—the insured, the insured's family or the care provider. Claims do not go unmanaged! But, why would the insurer *not* actively manage an LTC claim?

- Lack of experience and preparation – little or no experience with other lines that require active claim management (such as disability) and therefore the insurer is ill-equipped to do so.
- Lack of adaptation – initial policies covered only nursing home confinement, which required little management. The claim operation evolved as more of a claim processing (check cutting) operation than a claim managing operation.
- Lack of anticipation – failure to think through the necessary claim processes and to identify what could go wrong is especially punishing to "pioneers." Management by reaction to disappointing financial results may suffice for other established lines of insurance, but not LTC. Coverage cancellation is not an option and rate increases are difficult to come by.
- Lack of alignment – a claim management administrator that was not given sufficient marching orders (from the administrator's perspective), failed to provide the anticipated services (from the insurer's perspective), or had cross-incentives in the fee structure.
- Lack of business perspective – claim management involves saying "no" when it is appropriate. This is part of the fiduciary responsibility of only paying the appropriate claims. There is always a potential legal risk and cost for saying "no" to an insured. Consider whether the threat of a lawsuit drives claim management decisions. Claims managers may be uninformed of the likely greater cost of frequently paying claims that do not meet the benefit triggers, or that involve a level of services that is excessive in relation to the actual care need.

What to do?

As claim management issues become more evident, I expect that many insurers will first strengthen claim management in an attempt to make current policies work as originally anticipated. More "manageable" policy design and wording may ultimately be necessary, which would represent a rational retreat from the liberal benefits and options that have naturally evolved in a challenging market. However, because sales are also a challenge, insurers are not falling over themselves to be first to market

continued on page 14

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with such a product. (Perhaps if it were called LTC-Lite?)

Meanwhile, in a new operation it would be helpful to hold regular meetings to review the details of all new claims. In a larger more established operation, be aware of silo-centric perspectives, political realities, and the fact that any changes to existing operations are costly, impact budgets, and affect those that are held accountable for them. Pilot projects supported by senior management, and focused on no more than a small part of the claim process at one time, will probably be more effective for achieving headway in such situations. Remember to put yourself in the shoes of others and try to anticipate and address their legitimate concerns.

In reviewing many LTC claims across many insurers, here are some fairly common opportunities for improvement to claim management:

Self-reported impairment with no objective substantiation. Objective substantiation includes obtaining documentation from multiple sources whenever possible, in addition to the face-to-face assessment, such as assessments performed by a registered nurse. Although sometimes overlooked, therapist notes and hospital discharge summaries often provide valuable information. In the home setting, substantiation should not rely on simply checking off boxes based on a kitchen table conversation or phone interview. Substantiation should include observing and documenting how the insured performs various ADLs, and developing a good understanding of how they managed before, and why they cannot now. For example, simply by requesting the claimant to show the bathroom allows the assessor to note whether any assistive devices are present or lacking, facilitates observation of the insured's gait, ability to transfer, as well as to understand and retain simple commands. Currently, nurses infrequently use these techniques in performing face-to-face assessments. If benefit triggers are gatekeepers to desirable benefits, then self-reporting, reporting by the family, and even reporting by the insured's physician cannot be taken at face value without objective substantiation.

Plan of Service (POS) versus Plan of Care (POC). Although this could be the subject of an entire article, a POC is more comprehensive and detailed than a POS. A POC should include not only what care-services are provided by whom, how and when, but also supportive community resources, restorative services and therapeutic goals. A typical POS identifies the needed services, including frequency and intensity, based on a limited snapshot of the insured at the time the claim was opened. Also, a POS does not typically address how such covered services integrate with other services, providers or payers. For example, a POS would not request the insured's physician to consider therapy to improve function when appropriate. However, a POC should routinely include that as well as assistive devices that foster independence when appropriate.

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Managing the benefit not the claim. Once the insured has been determined to meet the benefit triggers, the intensity of services is all too frequently managed by the insured, their family or the provider. Managing the claim involves a POC for which the type and intensity of services is consistent with the type and level of actual impairment. For example, if the insured needs assistance with bathing and dressing only, then a two-hour visit may be appropriate, but not a six- or eight-hour visit. Also, a POC should be reviewed frequently during the early weeks of a claim. The economic implications of allowing extra hours beyond what is needed due to infrequent POC updates or to satisfy the insured's or family's desires is not always well understood by the person developing the POC or approving the claim.

Absence of communication with critical medical and therapeutic professionals to determine degree of impairment and prognosis. Often there is little or no communication with hospital discharge planners, therapists, insured's primary and specialist physicians to determine the insured's prognosis and therapeutic goals. This is a missed opportunity to substantiate both initial and ongoing eligibility, and to develop an appropriate POC that optimizes a claimant's ability to regain partial or full functional independence.

Poor understanding of how to apply policy language. Sometimes this involves ADL definitions, such as whether or not someone who has the ability to sponge bathe is bathing impaired. Or, what "severe cognitive impairment" or "threat to safety" mean in terms of specific claim situations. What cognitive assessment score is used, either as a necessary or sufficient factor, in determining whether an insured meets the cognitive

benefit trigger? What additional factors, if any, go into that determination? If benefits are paid starting with mild cognitive impairment, then the length and cost of claims will significantly exceed expectations. Another example involves the problematic "stand-by" definition of ADL impairment. For example, if someone requires stand-by for transfers because of fear of falling, but there is no documented history or clinical rationale, then the LTC coverage becomes "fear of falling" insurance. Clearly, an attitude is not an insurable event.

Lack of critical thinking in document review to establish eligibility. This involves taking time to identify and fully research any inconsistencies in the information provided by the insured, the insured's physician, family and the assessing nurse or therapist. If such inconsistencies are ignored, then obviously administrative expenses are reduced, but so too are opportunities to identify fraud and prevent unwarranted claim payments. This is an area where lack of economic alignment between the administrator and the insurer may involve conflicting incentives.

Balancing honest policyholder advocacy with responsibility to pay the claim as stated in the policy. Nurses are caregivers, nurturing by personality, training and experience. Consequently, they tend to develop a policyholder advocacy perspective, which can supercede their ability to appropriately manage a claim. While nurses bring positive skills to LTC claim management, this dynamic needs to be acknowledged and managed, along with the need for any claim operation to treat policyholders fairly and consistently, but at the same time, not pay benefits beyond what has been promised in the policy.

Absence of policies and procedures to drive decision-making. Few businesses can operate effectively without written policies and procedures. Yet surprisingly, these are frequently lacking, especially in smaller or medium sized operations. Without them, an insured has a better shot at making a case for not having received fair treatment. Also, polices and procedures are necessary for effective training of new personnel, to promote consistency across the operation, and to assess existing staff's (or administrator's) performance. Consistency, of course, is an important element to avoiding unfair trade practice issues. Also, the observant agent is likely to advocate repeating that one-time exception or liberal decision for future claims.

Aversion to liability that results in inappropriate claim approvals and benefit payments. This results from an unbalanced perspective regarding the cost of legal liability versus the cost of paying excessive benefits. Hallmarks of this approach are weak or nonexistent contestability procedures, no fraud screening or claims investigation, paying based on any information that can substantiate eligibility while ignoring any counterindications, and paying when benefits are demanded even though supporting information is inadequate.

Missed opportunities to coordinate with Medicare covered services. By not proactively pursuing Medicare payment for eligible services, insurers are needlessly overpaying. Generally, Medicare does not pay for ongoing chronic conditions, but many LTC claims hold the potential for at least partial Medicare payment during the first 60 to 100 days. The POC should anticipate and coordinate transition from Medicare to LTC benefits, including the continuation of any therapy, which is proving to increase independence. Besides needlessly paying for benefits, another important reason to initially use a Medicare eligible provider is that typically non-Medicare eligible providers do not include occupational and physical therapy, which is of critical value for restoring the claimant to partial or full independence and earlier claim termination.

In summary, the LTC insurance business has not yet completed its journey. Claims may yet represent the greatest challenge. However, even though the Sierras presented an insurmountable obstacle to some pioneers, others were better prepared. Some even discovered gold there, which turned the obstacle into a great opportunity. Claims is the final frontier for LTC. It will not be easy, but it doesn't need to be the Donner Pass of the industry either. Don't let it happen to the insurer(s) you work with! ✵

Endnotes

1) Werner M, et al., Lying to Insurance Companies: The Desire to Deceive among Physicians and the Public, *American Journal of Bioethics*, Vol 4, No 4 / Fall 2004, pp 53-59.

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