SOCIETY OF ACTUARIES

Article from:

Long-Term Care News

May 2009 – Issue 23

A Kind of Quality Assurance

by Brad S. Linder

At this particular time in our global financial crisis, we're looking for ways to restore our collective faith in the underlying financial systems. The abuses uncovered so far have done much to shake our confidence in the systems of checks and balances as well as other protections that are currently in place. A short list of the abuses range from inappropriately underwriting mortgage debt on high-risk clients to the Ponzi investment schemes to paying out super-bonuses to executives whose companies receive TARP money. Even the deaths and sicknesses of the recent salmonella poisoning via the peanut processing demonstrate a pattern of behavior that harms our best interests and shakes our confidences in the food supply. When pundits ask how our collective confidences can be restored in systems that appear to be failing, the answer starts with improving on a kind of quality control. We seek significant improvements in quality controls. Fairness needs to be restored. Further abuses need to be ferreted out. Can we really be assured that a particular job has been done and that it has been done well? We expect a kind of quality assurance.

From the perspective of those of us who work with long-term care (LTC) insurances, I believe that there are a number of things that we can each do to help improve our collective confidences. Consider what happens on your own job. Examine all of your own job responsibilities—both those responsibilities that are stated as well as the unstated ones. Examine if you are actually able to accomplish all of the details of your own job in a timely fashion. That means placing tight controls on any financial numbers you are in contact with or responsible for. How do you know/prove they are right? Do the calculations rely on data that is considered faulty? Does it ever happen that someone gives you information and you are supposed to read and understand, but you don't happen to get to it? Or do you assume that others who get the same information are reading it to pick up and report any mistakes appearing in it? If you rely on others, there is a danger.

Remember that in this day, employers are cutting back on the number of jobs. If the same functions and responsibilities still need to be covered, that means that the surviving employees inherit the responsibilities of those voted off the island. If there is no inheritance of duties, then dangerous results can happen. Loss of experience and technical expertise is bad enough. Loss of monitoring duties is a serious mistake. My best piece of advice to those who are in this situation is to report these facts to your bosses. Document it. Keep a safe copy of that document backed up on your computer network. Report it appropriately.

This article is actually a compliance test with questions designed to generate further discussion on a range of issues. Please remember that there are a number of wonderful people who have a large amount of collective knowledge about LTC. I encourage the newer readers to ask questions of them too. Learn more by entering into discussions with the more knowledgeable people. Ask yourself if there are ways to improve the quality of the job responsibilities you perform.

To illustrate how job cutting affects our industry, consider a real life example of understaffing in an assisted living facility (ALF). The basic example is from an actual nursing home, but I am changing the setting to an ALF because I would like more focus on the consideration of imposed inability to perform activities of daily living (ADL) as a problem for claims adjudication. To proceed, the proper staffing ratio—the nurse to patient (N2P) ratio—is unique for each ALF. Indeed, that N2P ratio is unique to each wing of the ALF. Often, cognitively impaired patients are grouped together and they require different care levels and monitoring. Therefore, it's easy to see that the N2P ratio is made up of a number of different factors that the administration staff monitors. Those factors include the type of care at the time that care is needed by the ALF residents. They also include the type of care able to be provided in the ALF by the trained staff. Please remember that there is a distinct shortage of care providers in a number of areas in this country. And, it is important to note that the job burnout rate for the care providers in an ALF (and nursing homes) is rather high.

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It might be fair to say that there has already been a serious shortage of care providers in the LTC industry. That being said, we ask the question of what happens when that N2P ratio drops. As the ratio drops, the wait time for needed care services increases. Yet, those services still need to be provided. Let us focus on the resulting effects on toileting since that area appears to be one of the simplest ways to compensate for staffing cuts. Examine the effect on the aspect of being able to self-toilet. If the individual starts out with only the inability to walk to the toilet or that they have become a slower un-dresser, then the increased wait times would cause more toileting accidents to happen. To combat this extra work, the remaining nursing staff depends on absorbent undergarments. Certainly, there's a lot less time-critical work involved by having the residents wear these simple undergarments. Unfortunately, it forces a resident to rely on using the undergarments when they can actually maintain control over their bodily function. By virtue of the understaffing, the staff cannot help all of the residents needing to use the restroom on a timely basis. Despite the complaints of the resident, a resident is taught to rely on the new method of using the undergarments. A resident must wait to use the restroom. And, you would expect that for the resident their inability to perform an ADL count increases automatically by two. Neither the resident nor the nursing staff is at fault for this unfavorable result. Is this a true observation? If the resident didn't previously qualify for benefits in their LTC policy, they probably would appear to now. So, as an insurer of that LTC policy, do you pay benefits or deny benefits? Is the answer documented as a written procedure in the insurer's claims adjudication manual? Why or why not?

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USING THE COMPLIANCE DEPARTMENT AS A QUALITY ASSURANCE TOOL

It used to be that when someone uttered the word compliance in a crowd, there were a lot of different reactions. Imagine back in the 1990s, a world where the reaction was mostly negative. Compliance was viewed as impeding the ability to do business. When compliance found that there was a rule that needed to be followed, a procedure that needed to be changed, the correction was viewed as personal tarnish against the area-manager affected.

Compliance audits should be used as an ongoing tool to test for quality and provide assurance that procedures are followed as expected. Not just a financial audit nor just an internal audit, they are designed to also directly test elements of complying with each and every one of the state insurance laws and requirements that the insurer does business in. Most of the states contain a simple compliance certification that appears in the policy form filings documents. That certification process clearly states that the signatory is responsible for and has knowledge of the underlying state rules, regulations and statutes as they apply to the subject LTC insurance. It's interesting to note that there are a lot of different LTC requirements that do vary by state.

So, ask yourself what you would do if you found that the LTC policy language does not match the procedures you are following? What do you do?

Compliance audits should be routine. The time periods for the routine should be explicitly defined for everyone. If there are available resources, the compliance audits should be cycling through each of the states' requirements. They should positively confirm where procedures are being handled correctly. If they happen to find something wrong or incorrect, it is good to get it corrected. Understanding and correcting what went wrong is always an opportunity to improve the quality of the procedures. Improving quality assurances is a major strength possible for any compliance department.

WHERE CAN WE LOOK?

Since I have seen and reviewed a large number of LTC policy forms, rate filings, and actuarial memoranda, I have often been asked what are the most common areas of LTC for the language to mismatch actual practice and mismatch what has been priced. I know that my understanding of these (and all of the other) policy provisions are a great way to improve on the quality assurance of what I do. I encourage each of you to find out more about policy language and statutory requirements! My list of areas where I find the most problems are:

1. *The Inflation Protection Options.* OK, everyone should first understand the basic idea of the required offer of the 5 percent Compound Inflation Option. The intent is to have a meaningful increase to the underlying available LTC benefits. The benefits get increased by 5 percent each year. Sure, that means that you have to manage on-anniversary increases to benefits as well as the normal billing for premium. No,

billing for premium should not be changing for this inflation option. It is priced as a part of a levelized premium product package. I use the term levelized carefully because it is meant to describe the calculation method where the premium is intended to provide for the benefits over the life of the policy. It's possible to have the intended premium-paying period of the policy shorter than the life of the policy. By way of another common example, the idea is similar to a whole life insurance policy where there is a serious amount of prefunding that is set up for future benefits. The prohibited term level-premium policy is considered misleading to consumers because of the implication of never needing a rate increase.

If the contract has a pool of available benefits, make sure that the daily benefit maximums are not the only element to increase. If the policy has a pool of days available, make sure the value of those days increases. Mismatches in contract language versus company procedures versus the actuarial memorandum have occurred. Keep a very clear understanding of the financial elements that get incremented in your electronic census listings (master files). It is critical that the claim files are completely accurate to the policy language. Companies have chosen from two very distinctly different ways to keep track of these options when policy benefits are paid out. Method 1 is the bank account method, where the policy terminates when the bank account first hits a zero balance. Method 2 is the hit-the-limit method, where the policy terminates when the limit for the total benefits payable equals the total benefits actually paid. The correct method for a given policy is only the one that exactly matches the claimant policyholder's contractual language. Would you consider other language correct?

Other inflation options have additional concerns. Simple interest versus compound interest? Three percent versus 5 percent versus CPI indexed inflation offers? Inflation addition offers could be timed to a particular policy duration—which does not have to be consecutive policy years. Those offers could be offered up to a certain cutoff attained age, or offered up until a certain number of refusals of the offers. The offers of inflation additions usually come with an increased premium price tag. Therefore, there's a need to make sure the billing dates, the premium, the coverage issue dates are all monitored.

It's easy to see that the increased complexity adds to the possibility of errors, and hence the need for excellent quality assurance. If you have found an error in how inflation is handled, can you get it corrected easily?

2. *Return of Premium (RoP) Options.* These are complex options that are most often trigger-based upon the death of a named insured. However, some companies have designs that are based upon survival of the insured. RoP may have an offset based upon claims already paid under the contract. Also, the stated return of premium percentage may decrease as the policy duration increases. Be careful to spot that an RoP claim should be hitting a claim account and not reversing entries in any premium account! It can be surprisingly common for non-LTC savvy folks to misunderstand this particular point.

3. *Restoration of Benefits (RoB).* These provisions reset the available policy benefits. There needs to be clear guidelines in the claim administration procedures that include verifications. Be watchful of claimant apparent recoveries just before benefits run out. The RoB reset is a significant temptation.

4. *Benefit Eligibility.* Understanding of the benefit triggers is a source of confusion, particularly

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at the time of claim. And, if a care plan document is required, then the document had best be a part of the claim file. If requiring the document is waived for any reason, there had best be documented written reasons matching the claim administration written procedures that allow the waiver.

5. *Waiver of Premium (WoP).* The complexity of this provision comes from when the provision triggers on as well as when it shuts off. While some companies use only generic language like, "… waive premium on a monthly basis," the provision usually needs to describe how premiums are due to be paid when the provision turns off. If it's pro rata, those details need to be stated. If it's going to change the billing mode to a monthly billing, it needs to be stated. It is very important that the consumer know how much and when that premium is due to be paid—particularly when they have just recovered from a claim!

   If the contractual language waives the modal periodic premium as they fall due, it may be easier to administer, but it has anti-selective possibilities. Your claim management system needs to monitor claims as they approach what would be the next premium due dates. Temptations depend on mode, but they still increase the closer to due date it is.

6. *The 60-days Limit of Back Premium for Reinstatements on Levelized Premium Contracts.* When I first saw this as a provision in an LTC contract, I questioned why this was included in the sample contracts. It did not make financial sense. A reinstatement is supposed to return to policy to the point as if there was not a lapse. For a contract that has a serious pre-funding of benefits, the restriction makes no sense. I know of two regulatory provisions—one in Georgia and one in Pennsylvania—that are pointed to as part of the LTC policy form filing gauntlet that companies are tested on. The last time I researched these two states' requirements, they were both not applicable to LTC insurances designed as I've stated. And, it makes no sense to not collect that back premium.

   To correct this flaw, make sure that the written procedures clearly state that no reinstatements will be made beyond that 60 days window. Caution: please note that there is a separate provision appearing on some LTC contracts for a six-month automatic reinstatement window for those insureds who are demonstrably cognitively impaired. Do not confuse these two different provisions! Writing a procedure for just the former provision might accidentally cause a problem when complying with the latter provision.

7. *Rate Increases.* Are the increases made by state-of-issue or are they to be made according to the current state-of-residence of the policy holder? Some contracts have made this language very explicit as to which rule is followed. So have some states! If the LTC contract is not explicit, what is correct? If your company has filed for an LTC rate increase, did it explicitly detail which method to follow in the filing to the insurance department(s)? If the method is not stated, are the insurance departments expecting insurers to apply rate increases in a particular way? Why?

If your company has filed for an LTC rate increase, did it explicitly detail which method to follow in the filing to the insurance department(s)?

In summary, there are a number of areas where WE can impact quality assurances. Don't assume that there is nothing wrong in areas previously thought to be OK. Substantial back checking should be made in all areas. If you think that it is someone else's job to check on it, that's actually a point where errors happen. Remember the bottom line, the people whom we serve depend on us to get it all right! We can't do it all by ourselves, but we—all of us—can help. ■