SOCIETY OF ACTUARIES

Article from:

Long-Term Care News

September 2012 – Issue 32

Independent Providers: A Long-Term Care Insurance Conundrum

POLICY IDEAS FOR MANAGING RISK FROM IP CLAIMS

by Michael J. Gilbert

EXECUTIVE SUMMARY

Paying for Independent Providers (IPs) has been a significant development in the evolution of long-term care insurance (LTCI) as a product. Twenty years ago, few carriers would consider including non-licensed home care agencies as an appropriate provider, much less allowing unsupervised, uncertified or even family caregivers. Today, however, IP policy benefits constitute a "must have" for LTCI policy sales for competitive reasons—and this can be a great thing for the LTCI industry.

IPs can potentially offer a cost-effective opportunity for our claimants to receive quality care from people they know and trust, while costing less and providing similar care to a home health agency. Our obligation (and our desire) as an industry is to provide payment for good, quality care that our policyholders have paid for and want, and to pay those claims as quickly and as efficiently as possible. We want to be sure that an appropriate caregiver is in place, that the claimant is safe, and that the care and caregiver meet their needs.

The challenge for the LTCI industry is ensuring that all appropriate claims are paid quickly and efficiently, while having the information, tools and processes available to be able to feel comfortable that the appropriate care has been provided and to be able to determine what services were rendered without traditional care invoices. Fraud and improper and inflated IP claims can cause a significant increase in claims expense, which contributes to higher administration costs, higher reserves and, ultimately, the need for future rate increases.

Over the last two years, a new approach to IP claim management has been developed: third-party verification of IP claims. A third-party verification service can benefit both the claimant and the insurer. Utilizing a third-party verification service enables claimants to more easily manage their caregivers and to submit claims efficiently, and provides needed oversight to ensure the necessary care is actually being provided. For the insurers, third-party verification provides new tools to quickly pay proper and appropriate claims, while giving vital new information and evidence to filter out and cost-effectively deal with improper, inflated or fraudulent claims. Implementing third-party verification of IP claims for a small number of insurers has indentified fraud, overbilling and other behaviors leading to overall inflation of claims by as much as 25 percent. In as many as 40 percent of cases observed, there has been some inflation of invoices which would yield claims savings if known prior to claim payment. In one program where third-party verification was mandated almost 6 percent of affected claimants simply went off claim, perhaps due to the sentinel effect. And in approximately 10 percent of all cases, there has been direct, intentional fraud or abuses identified and escalated to the proper authorities.

Here are some suggestions for how we, as an industry, can begin to adapt policy language to the new reality of home care and IP claims; to help claimants receive the care they need while helping safeguard the benefit pool for current and future policyholders alike.

POLICY EVOLUTION; SELF-REPORTED EVIDENCE

As policy benefits have become more comprehensive over the last 20 plus years to include home health care and independent care providers, policy language has developed to encompass and attempt to encapsulate some of this risk. However, claims organizations across the industry still struggle to actively manage the claims from these providers, while remaining within the letter of the policy language for each appropriate policy generation.

Following the initial benefit eligibility assessment, there is still a significant disconnect between the policy language that governs how IP claims can currently be managed, and the inherent risks of paying for care from providers that have little to no oversight. With claims from facilities or licensed home

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health agencies, LTC insurers rely on the state or federal oversight necessary to maintain the license as a primary fraud-prevention method when accepting self-reported proof of loss documentation. However, with no federal or state licensing oversight of IP caregivers, very little evidence exists (or is accessible to the insurer) to show that services were actually delivered, and even less exists to show that the care received was appropriate and supported the plan of care.

PROOF OF SERVICES/PROOF OF PAYMENT

In almost all cases, the evidence that is required by LTC insurers of their claimants is self-reported. Although policy language varies throughout the industry, it is relatively common for LTC insurers to require that claimants show some proof that services were actually provided, and/or that claimants show proof of payment for the care prior to reimbursement.

In a survey of 15 LTC insurers representing more than 90 percent of the LTCI industry conducted prior to the 2012 ILTCI Conference, nearly all reported relying on at least one of three self-reported means of service verification: caregiver invoices, caregiver log sheets or detailed service notes. (See Figure 1 below).

In the same survey, over 60 percent of respondents reported requiring cancelled checks with each claim as proof that services had been paid for prior to reimbursement, while 30 percent of respondents reported requiring no proof of payment. Approximately 25 percent of respondents also reported that they allowed claimants to assign benefits to an IP. (See Figure 2 below).

Figure 1. Proof of Services

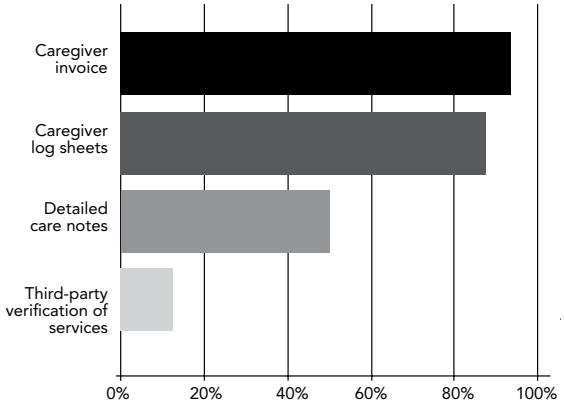
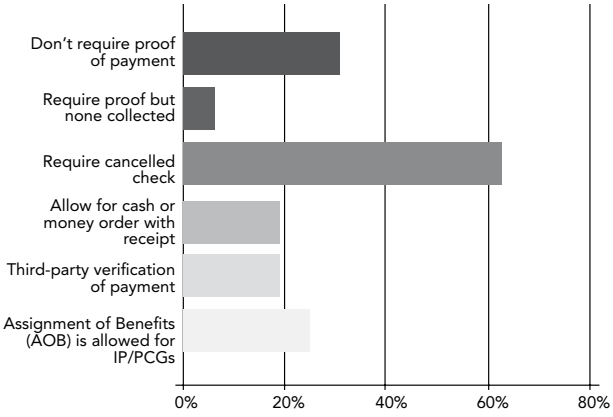


Figure 2. Proof of Payment



INFLATED CLAIMS AND FRAUD

Due largely to the lack of real, consistent oversight, the prevailing feeling amongst LTCI claims leadership is that there is an unquantified amount of overbilled, inflated or simply fraudulent claims within their IP claims block, which often frustrates claims organization due to the perceived inability to act. When asked about estimated fraud and abuse within the existing IP claims block, about 40 percent of respondents felt that amount was more than 5 percent of all IP claims paid, with half of those believing that fraud was more than 15 percent of all IP claims paid. Based on their current claims block(s) and policy language, only one-third of respondents felt they were currently managing IP claims effectively.

With self-reported claim forms and no additional oversight, there is the risk that IPs can inflate claims by adding hours to invoices sent to the insurer without the knowledge of the claimant in situations where assignment of benefits is used. On the flip side, given the relative ease of creating a service invoice, claimants may submit invoices including charges for IP care delivered on days when the IP was not present. There may also be situations where the claimants and IPs set up side agreements for delayed or partial payments, or sharing of claims proceeds. The detection of this behavior is very difficult for claims organization.

Much of this behavior could be considered "soft fraud." Claimants who are determined to be benefit-eligible often feel that they are "owed" their full benefit, and that they would lose some of that benefit if they do not use all of their daily maximum benefit every day of the claim. A claimant with a $120 maximum daily benefit who pays their caregiver $20 per hour and actually receives care five hours per day, four or five days per week, might invoice the insurance company for six hours per day, seven days per week, yielding a $120 daily charge which exactly matches the claimant's maximum daily benefit.

Other behavior can be somewhat more premeditated. With unemployment up across America, an insurance policy that will pay for care from a friend or family member can be an enticing revenue stream. This can lead in some cases to the employment of a friend or family member being "hired" by the claimant to provide care, although the actual number of hours spend providing the necessary activities of daily living (ADL) care or cognitive supervision may be substantially reduced from the claimant's plan of care and hours invoiced to the insurer.

Even when potentially fraudulent behavior is suspected, costly additional management activities (such as outbound calls), surveillance, reassessments or claim denials are often the only tools available for further investigation. Several insurers make random outbound calls to claimants' homes, trying to establish whether the claimant and caregivers are actually present, but these calls are infrequent and a missed phone call is easily explained away by the claimant/caregiver as "she was out at the pharmacy" or "she was out shopping for food." Surveillance is costly and potentially intrusive, and most insurers' fraud units require concrete evidence before authorizing its use. Reassessments offer an additional view into the home, but at a price of $350 to $500 per assessment it offers a view of the claimant's needs a single point in time, which is not necessarily indicative of the care that claimant is receiving. Recent legal activities and judgments suggest that claim denials may soon fall out of favor due to the perception of greater legal liability. Until recently, few other options were available for cost-effective oversight and management of IP claims.

THIRD-PARTY VERIFICATION

So what can we do? As stated above, our challenge is to ensure that all appropriate claims are paid quickly and efficiently, while having the information, tools and processes available to be able to determine that care invoiced was actually provided. It should also be recognized that the majority of claimants and care providers are honest, forthright and well-deserving of the policy benefits paid. We need to put in place a policy framework that enables us to cost-effectively sort out legitimate claims from illegitimate claims; we want to make sure we're paying the legitimate claims without making the legitimate claimants feel unduly burdened, but are able to put in place processes to minimize waste.

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In all, this program has benefited the policyholders and their families, while also being very useful in identifying previously undiscovered fraud and inflated claims.

Since 2010, HireFamily has been providing third-party verification services for IP claims to LTC insurers and claimants. These services include:

- Use of a telephonic timecard system for caregivers to check in and out at the beginning and end of each work shift;
- Verification of the identity of the caregiver and that they called in from the claimant's home;
- Verification of exact hours and services performed against the plan of care;
- Random and targeted calls into the claimant's home while the caregiver(s) are checked in to verify that they are providing appropriate services;
- Review of all claimant documentation and collection of proof of payment; and
- Standardized invoice generation and submission.

What we've seen during that time confirms that there is a need to have a mechanism to validate services that have been provided by IPs. As noted previously in the Executive Summary, inflation of submitted claims, claimants suddenly going "off claim" when third-party verification is mandated and out-right fraud (as delineated below) have been observed when third-party verification is implemented by a carrier.

Directly fraudulent cases identified through the third-party verification program include many examples of the following situations:

- Confirmed no care being provided despite claimants invoicing for services seven days/week;
- Identified recoveries despite claimants recently having been recertified as benefit-eligible;
- Unauthorized and ineligible caregivers being improperly invoiced/reimbursed; and
- Undue caregiver influence causing substantially increased hours not actually required by the claimant.

Several of these cases had been on claim for years prior to going on services with HireFamily, with one claim having already paid out over $600,000 in benefits. Within two weeks of working with HireFamily, this case was flagged as potentially fraudulent due to a potentially fraudulent pattern of timecard system usage. Subsequent surveillance/investigation identified that no care was actually taking place—this was a situation where the claimant was using LTCI benefits as a revenue stream.

In several of these situations, claimants had purchased policies with unlimited lifetime benefits, so any reduction in claims payments resulted in a reduction in claims/reserves. Even when lifetime benefits may be limited, paying only for care actually provided should extend the claimant's available benefits pool for a greater period of time. We are also educating claimants, helping people save their benefit for when they really need it.

In most situations, the timecard system and electronic claims submission process allowed claimants to more quickly and efficiently manage their caregivers, and to receive payment from the LTC insurer more quickly due to complete and correct claim information. Long-distance family caregivers benefited from the use of a telephonic timecard system, and appreciated the fact that someone was "checking in on Mom and Dad" to make sure that the caregiver was actually present in the home when they said they would be. In all, this program has benefited the policyholders and their families, while also being very useful in identifying previously undiscovered fraud and inflated claims.

SUMMARY

These early indicators show that we may just have scratched the surface, and that it's very likely that all LTC carriers paying for IP claims have some degree of inflated claims. Our early programs show that this inflated amount could potentially be as much as 25 percent or higher of all IP claims. However, undiscovered fraud is very difficult to quantify; the only way to understand the actual amount would be to place a statistically significant portion of the population of IP claims under verification. Ask yourself: Have you really factored in human behavior in the risk calculations? Or does the "human behavior" that we are seeing indicate that IP claims require better controls and oversight?

As mentioned above, IPs can potentially offer a cost-effective opportunity for our claimants to receive quality care from people they know and trust, while costing less and providing similar care to a home health agency. Our obligation as an industry is to provide payment for good, quality care, to be sure that an appropriate caregiver is in place, that the claimant is safe, that the care meets their needs, and that the caregiver is able to meet those needs.

Unfortunately, most claims organizations feel constrained by policy language from exercising enough control and oversight over these IP claims. As an industry, we should work together to ensure that future policies include language that allows proper oversight and management of IP claims, to help ensure the success and security of the LTCI products and insurers for all current and future policyholders.