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Independent Review of Long-Term Care Benefit Trigger Decisions

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For the first time in the history of the Long-Term Care Insurance (LTCI) product, benefit trigger decisions will be subject to review by an independent third party, in accordance with a National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Regulation provision that was adopted in late 2009. It's a process wherein, after the insured has exhausted all avenues of internal appeal, the insurer's benefit eligibility decision can be reviewed by an unbiased third party (an independent review organization, or IRO). The IRO would review the same file documentation that the insurer relied on to reach its decision that the benefit eligibility criteria (aka benefit trigger) wasn't met. The IRO would need to determine, for qualified LTCI contracts, whether the insured met the policy's benefit trigger and would review medical records, assessment documents, and other data to determine whether the insured requires substantial assistance with Activities of Daily Living (ADLs), has at least two or more ADL deficits, or has a severe cognitive impairment.

When I worked in a claim shop, I viewed denials as an educational opportunity. Most times, the person appealing the benefit eligibility denial was not involved in the policy purchase decision and was unfamiliar with LTCI, or didn't understand the policy's benefit trigger. We might hear something like, "But mom has diabetes and had a stroke last spring, and she now needs a walker to get around." Once we explained what an ADL is; how it's defined; how the benefit trigger works; and that if the insured is able to perform ADLs independently with use of a walker, the benefit eligibility criteria hasn't been met; the caller understood the explanation and the appeal usually dropped.

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One is not considered a chronically ill individual, as defined by federal law (HIPAA), simply because of the presence of a chronic illness, such as diabetes. But let's face it; LTCI is a more complex product than traditional medical reimbursement insurance. Given the often considerable period of time between completing the insurance application and submitting a claim form, the insured may not remember the explanation of the policy's benefit trigger given at solicitation. Each qualified LTCI contract has the same benefit trigger as established by federal law (to paraphrase HIPAA language): To be a chronically ill individual and eligible for benefits, one must be certified by a licensed health care practitioner as being unable to perform, without the substantial assistance of another person, at least two ADLs (e.g., bathing, continence, dressing, eating, toileting and transferring) for a period of at least 90 days due to loss of functional capacity; or require substantial supervision from another person to protect the individual from threats to health and safety due to severe cognitive impairment.

I believe there are more advantages to be gained from an independent review mechanism than disadvantages. Assuming that the IRO is a credible organization with the proper medical professionals to review cognitive and functional deficits, then LTC insurers should feel confident that the IRO will validate its decision. Having IROs confirm that the insurer's decision was correct can only mitigate the potential for misunderstanding, distrust and suspicion by a public that may be skeptical of the insurance industry. Perhaps having this avenue available will mitigate the potential for litigation. We can't anticipate the volume of individuals seeking appeals, and, of course, since the insurer pays the cost for the review and this is a price-sensitive product, we just don't know the pricing impact that independent review will have. Based on industry data available for medical external review, I expect the volume will be low.[1]

Having an NAIC LTCI Model provision for independent review may lessen the potential for state variations or state adoptions based on their medical external review law. In the medical external review world, the IRO is generally looking at the medical necessity or efficacy of a particular service or treatment, or whether it's experimental or investigational, while LTC insurers focus on the individual and deficits arising from functional limitations. A typical medical external review model will rely on the latest medical journals, clinical studies and data dealing with medical protocols to reach a determi-

nation as to medical necessity or the experimental/investigational nature of a service or treatment, but LTC benefit eligibility reviews need to focus on whether the insured has a condition that affects his ability to perform ADLs, or has a cognitive impairment that is so severe that he requires substantial supervision.

A LTC benefit eligibility review requires a familiarity with diagnoses, staging of the disease process, restorative potential, and the type of functional deficits that may be associated with a given medical condition (which a typical physician may not have). Medical protocols and journals won't be of much use in a LTCI benefit eligibility review, because the decision is generally one that is tied to the unique circumstances of the insured. LTC benefit eligibility reviews require a different type of reviewer and a different type of review than medical external review decisions and getting state regulators to understand that may be a challenge. I think education and awareness continue to be the key to the success of this product; education and awareness by the consumer, the regulator, and the public of both the product and the need for the product is an ongoing process.

As of this writing, only five states (Iowa, Vermont, Pennsylvania, South Dakota and West Virginia) have adopted an independent review mechanism for LTC benefit eligibility denials. Only one state (Iowa) has certified IROs to review benefit eligibility denials (Medical Review Institute of America; Clinix).

The potential disadvantages include significant state variations that make administration difficult and costly, or having IROs involved in the process that do not fully understand HIPAA's benefit trigger.

Independent review of benefit trigger decisions will show what most of us in the industry already know: that LTCI benefit eligibility decisions are being made appropriately and the product itself provides tremendous value to those in need. ■

ENDNOTE

[1] "An Update on State External Review Programs, 2006," America's Health Insurance Plans, July 2008, notes that "In all the states for which data were reported, on average, fewer than one out of every 10,000 eligible individuals submitted appeals for external review of coverage disputes." .