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Handling Long-Term Care Insurance Claims: Provider and Policyholder Eligibility Issues

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INTRODUCTION

Long-term care insurance claim handling practices have received increasing attention as a result of class action lawsuits and recent policyholder verdicts. As a result, at least some long-term care insurers have begun reviewing and improving their claims handling. These efforts are likely to improve the policyholder's claim handling experience and, hopefully, will reduce litigation.

However, there is always room for improvement. This article focuses on issues that arise when determining policyholder eligibility and provider eligibility under tax-qualified long-term care insurance policies and provides some suggestions and observations that should further improve claim handling and reduce litigation.

POLICYHOLDER ELIGIBILITY – IS THE POLICYHOLDER CHRONICALLY ILL?

The "Chronically Ill" Certification

The first step in analyzing a claim under a tax-qualified policy is to determine whether the policyholder is Chronically Ill. This should be a relatively straightforward analysis, since it requires nothing more than confirming that a Licensed Health Care Practitioner (LHCP) has certified that the policyholder is either "unable to perform (without substantial assistance from another individual) at least [two] Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity," or "requir[es] substantial supervision to protect … [the policyholder] from threats to health and safety due to Severe Cognitive Impairment."[1] As long as the LHCP provided the certification within the 12 months preceding the claim, and there are no indicia of fraud, the policyholder is Chronically Ill and eligible for policy benefits.

While this concept is relatively simple, claims analysts might unnecessarily (and improperly) complicate the task by looking to facts beyond the LHCP's certification to determine if a policyholder is, in the analyst's view, Chronically Ill. For instance, analysts may make Chronically Ill determinations by comparing the LHCP's certification with the services that the policyholder receives. If the LHCP's certification shows that a policyholder requires substantial assistance with three activities of daily living (ADLs) for a period of at least 90 days, but the care records show that the policyholder is receiving substantial assistance with only one ADL, then the analyst might decide to challenge the Chronically Ill certification. This approach is improper and is likely to antagonize policyholders and their families.

In other instances, long-term care insurers have discounted Chronically Ill certifications because they questioned the LHCP's objectivity. While physicians and other care professionals certainly are advocates for their patients and clients, insurers should not discount or ignore a LHCP's Chronically Ill certification based on a perceived lack of objectivity. Tax-qualified long-term care policies do not provide for this type of judgment call. If the policyholder's medical and care records call the Chronically Ill certification into question, the insurer may have a basis for seeking additional information or challenging the certification. However, the certification should not simply be discounted.

Claims analysts must remember that LHCPs are the only persons that can certify policyholders as Chronically Ill under a tax-qualified policy. If a LHCP makes that certification, and there is no indication that it is fraudulent or inaccurate, then the insurer must accept the certification and conclude that the policyholder is Chronically Ill and eligible to receive benefits. Moreover, if the analyst has reason to believe that the certification is inaccurate, a full investigation should be undertaken, including communicating directly with the LHCP and the policyholder, and employing other tools that the policy language may provide (such as an independent medical examination). The analyst

should not deny coverage based on suspicion that the policyholder may not be Chronically Ill alone, if an LHCP has provided a facially valid Chronically Ill certification.

What ADLs Are Relevant and When

When assessing a policyholder's eligibility, analysts must know both what ADLs are relevant to the claim and when they are relevant. Analysts who do not understand these issues may recommend approving uncovered claims and denying covered claims.

ADLs are often described as the "basic tasks of everyday life." However, for purposes of tax-qualified long-term care insurance, the federal government has limited them to eating, toileting, transferring, bathing, dressing and continence.[2] These six ADLs are the only ones that matter for tax-qualified long-term care insurance claims, and are the only ones that should be considered when assessing policyholder eligibility.

These six ADLs are identified (and usually defined) in tax-qualified long-term care policies. Accordingly, determining what ADLs are relevant should be relatively straightforward. Unfortunately, in the real world the ADL issue can be confusing. Several factors account for this. One important factor is that health care practitioners commonly define ADLs to include more than the six ADLs that are relevant to tax-qualified policies. Another is that long term care claim forms, which often are multi-purpose forms that are used in connection with claims under both tax-qualified and other types of long-term care policies, may identify more than the six ADLs.

Licensed or certified health care professionals like nurses and social workers commonly manage and staff long-term care insurance claims handling operations. Many of these professionals practiced in their respective fields before working for insurers and third-party administrators. Health care practitioners often think of activities that are known as "instrumental activities of daily living" (IADLs) as ADLs. IADLs are activities that reflect the ability to live independently, such as managing medications and personal finances, housekeeping, meal preparation, using transportation, operating a telephone and shopping. The federal government has not seen fit to include IADLs in determining eligibility for tax-qualified long term care insurance. Accordingly, conflating ADLs and IADLs can lead to improper eligibility determinations. For instance, a treating physician may certify a policyholder as Chronically Ill because he or she requires substantial assistance with toileting and medication management for a period of at least 90 days. Such a policyholder would not be Chronically Ill under a tax-qualified long term care policy because only toileting qualifies as an ADL for eligibility purposes. Nevertheless, claims analysts with prior health care experience may be inclined to rely on their past professional understanding of ADLs, rather than the policy requirements, and to accept otherwise invalid Chronically Ill certifications. Unless these errors are caught during a claim review, the insurer will end up paying for non-covered claims.

The failure to understand when ADLs are relevant to eligibility also can lead to the denial of covered claims. Simply put, ADLs are irrelevant to determining the eligibility of policyholders suffering from a Severe Cognitive Impairment. Both the Chronically Ill definition, and the Internal Revenue Service's interim guidance on tax-qualified long term care policies, make this clear.[3] This makes sense from a practical standpoint. Not to state the obvious, but Severe Cognitive Impairment entails cognitive limitations, not physical limitations (although a person may qualify under both parts of the Chronically Ill definition). Accordingly, for policyholder eligibility purposes, the focus with respect to Severe Cognitive Impairment is on whether the policyholder requires substantial supervision to protect against threats to health and safety. A person suffering from dementia may be physically capable of performing all six ADLs, but may forget to perform them or act in a way that threatens his health and safety, such as wandering from his home or leaving oven burners on. As a result, that person needs substantial supervision, not substantial assistance with ADLs. Analysts who uniformly assess policyholder eligibility based on ADLs will end up denying otherwise covered claims.

Insurers, many of whom have issued a variety of different long-term care policies with differing benefit triggers, can contribute to the confusion by providing policyholders with general purpose claims forms that comingle ADLs and IADLs. Policyholders may be given forms that contain a single list of "activities of daily living" that identifies the six statutorily required ADLs alongside IADLs that are irrelevant to tax-qualified long-term care claims. It is easy to see how this can confuse both the analyst and the policyholder. An analyst who is presented with a claim that is filed on com-

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pany-prepared forms may ignore his training and defer to the forms rather than the policy language, either because he is too embarrassed to seek clarification from a manager or because he assumes that the company's forms take precedence over his training. These forms can be equally confusing to a policyholder and her LHCP, since one or both may incorrectly conclude that a policyholder who needs substantial assistance with housekeeping and medication management is Chronically Ill. If your company's claim forms conflate ADLs and IADLs, we recommend refining the documents to either to create tax-qualified-specific forms that exclude IADLs or to specify that the ADLs are the only relevant activities for determining eligibility under tax-qualified policies.

PROVIDER ELIGIBILITY

Analyzing policyholder eligibility is (or at least should be) a relatively straightforward process. However, determining provider eligibility is anything but. Insurance policies are, at base, contracts between policyholders and their insurers. As a result, claim handlers and insurance professionals are taught that the policy language is paramount and governs the parties' rights and obligations. This generally is a valid conclusion, except when it comes to determining provider eligibility under a tax-qualified long term care policy.

Determining provider eligibility can be troublesome because the insurance policy intersects with state statutes and regulations governing long-term care insurance and the various service providers, including home health care agencies and home health care aides. Claims analysts must know how to apply the policy language within the context of the relevant state statutes and regulations.

While tax-qualified policies may contain variations on the definitions of Home Health Care Agency and Home Health Care Provider, a Home Health Care Agency generally is defined as:

> An entity which provides Home Health Care Services and:
>
> 1. Has an agreement as a provider of Home Health Care Services under the Medicare program; or
>
> 2. Is licensed by state law as a Home Health Care Agency.

A Home Health Care Agency also means a registered nurse, a licensed practical nurse, or a licensed vocational nurse operating within the scope of his or her license.

A Home Health Care Provider typically is defined as:

> An entity which provides home health care or Hospice Services and:
>
> 1. Has an agreement as a provider of home health care services or Hospice Services under the Medicare program; or
>
> 2. Is licensed or accredited by state law as a home health care agency or hospice, if such licensing or accreditation is required by the state in which the care is received; or
>
> 3. Is a licensed therapist, a registered nurse (R.N.), a licensed practical nurse (LP.N.), or a licensed vocational nurse (LV.N.) operating within the scope of his or her license.
>
> A Home Health Care Provider cannot be a member of your immediate family living with you.

At first blush, these definitions appear to be virtually identical. Both define eligible providers to include entities that are certified under Medicare and individuals who are licensed as registered nurses, practical nurses or vocational nurses. The definitions are not identical, however. The HHCA definition requires an eligible agency to be licensed. The HHCP definition, on the other hand, requires the agency to be licensed only if the state in which the care is provided requires a license.

Applying the plain meanings of these definitions to two identical claims from the same state could result in two very different outcomes. For instance, in a state like Missouri, which requires home health care agencies to be licensed only in certain situations, an unlicensed agency would not be an eligible provider under the HHCA definition because it requires the agency to be licensed, regardless of whether the state requires licensing. That same agency, however, would qualify as an approved agency under the plain meaning of the HHCP definition because Missouri does not require licensing for all agencies.

These conclusions should make sense to an analyst who was trained to apply the policy language as written. Unfortunately the analysis cannot stop there. The relevant state's statutory and regulatory scheme must also be taken into account. In the

context of this hypothetical, the problem is that the agency should qualify as an eligible provider under both definitions according to Missouri's statutory and regulatory scheme. Thus, analysts must be familiar with the applicable state laws and regulations if they are going to correctly determine provider eligibility.

To determine if an agency that is providing ADL assistance in Missouri is an eligible provider under the HHCA definition, the analyst should first look at Missouri's Long-Term Care Act. That act contains a section outlining the minimum standards for long-term care policies that provide home and community based care benefits.[4] That section reads, in relevant part:

> (10) Minimum standards for home health and community care benefits in long-term care insurance policies.
>
> (A) A long-term care insurance policy or certificate shall not, if it provides benefits for home health care or community care services, limit or exclude benefits:
>
> ***
>
> 6. By requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service.[5]

Since part two of the HHCA definition states that the agency must be "licensed by state law as a Home Health Care Agency," one must also look at Missouri's regulations governing home health care agencies to determine whether Missouri requires agencies to be licensed. If no license is required, then the insurer must deem the agency an eligible provider, despite the policy language, in order to comply with Missouri statute. The Missouri statute governing home health agencies defines a "home health agency" as "… an agency or organization that provides two or more home health services at the residence of a patient according to a physician's written and signed plan of treatment."[6] The statute then defines "home health services" as "any of the following items and services provided at the residence of the patient on a part-time or intermittent basis: nursing, physical therapy, speech therapy, occupational therapy, home health aid, or medical social services." [7] If an agency provides fewer than two "home health services," it is not a "home health agency" under Missouri law and is not required to be licensed.[8]

After considering all of the relevant information, including the statutory and regulatory context of the claim, the analyst considering our hypothetical should conclude that enforcing the HHCA definition's agency licensing requirement violates Missouri's statutory prohibition against requiring the provision of home health care services "at a level of certification or licensure greater than that required by the eligible service."[9] The agency therefore should be approved as an eligible provider.

Determining provider eligibility can be an involved and challenging process, but it is a necessary one. In an effort to facilitate this process, long-term care insurers should consider either preparing or commissioning the preparation of a 50-state survey summarizing each state's statutes and regulations governing long-term care insurance and provider licensing requirements. This will allow analysts and their supervisors to work more efficiently, while also helping to better ensure that the company reaches the correct result.

CONCLUSION

Incorporating the practices discussed in this article into existing claim handling procedures will improve the claim handling process. Claim handlers who understand how to properly determine policyholder and provider eligibility will handle claims more efficiently and will improve the accuracy of claim decisions. These improvements will benefit both the insurance companies and their policyholders. Insurance companies will see savings from both an operations and litigation standpoint, while policyholders will have their claims handled more efficiently and accurately. ■

ENDNOTES

1. Tax-qualified long-term care policies typically define Licensed Health Care Practitioners as "any physician and any registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of Treasury."
2. 26 USC § 7702B(c)(2)(B) (2013).
3. 28 USC § 7702B(c)(2)(A)(i)-(iii) (2013); IRS Notice 97-31, 1997-1 C.B. 417. As discussed earlier, most tax-qualified policies define a Chronically Ill individual as one who is either: (1) "unable to perform (without substantial assistance from another individual) at least [two] Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity; or (2) "requir[es] substantial supervision to protect such individual from threats to health and safety due to Severe Cognitive Impairment" (emphasis added).
4. See 20 C.S.R. § 400-4.100(10) (2013).
5. See 20 C.S.R. § 400-4.100(10)(A)6 (2013).
6. See § 197.400(3) R.S.Mo. (2013).
7. See § 197.400(4) R.S.Mo. (2013).
8. See § 197.405 R.S.Mo. (2013).
9. See 20 C.S.R. § 400-4.100(10)(A)6 (2013).