Claims Talking Points

Speakers:

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What % of Claims are Denied?

Audience participation:

Does anyone know?

Ed & Nan Brown have a car accident.

- Ed contacts his LTC insurer immediately.
  After the EP, they pay benefits until the policy expires in 3 years.
- Nan's insurer declines her claim.

What percentage of claims were denied?

Claim Denial Rates

- Most people 50% (Ed was paid; Nan not)
  - “Per claim” approach
- Sounds fair?
- Any problems with this approach?

Claim Denial Rates

- Most people 50% (Ed was paid; Nan not)
  - “Per claimant” approach
- Sounds fair?
- Any problems with this approach?
  - What if Ed’s carrier stops paying claims?
  - What if it did not pay claims initially?
  - What if it paid for fewer services than he expected?

Claim Denial Rates

- NAIC: Less than 3% denial in this example (1/37)
  - “Per claim payment” approach
- Addresses circumstances in which claims are not paid initially or stop being paid.
- Does not seem to address partial payments
- Makes it seem as though very few claims are denied. Not as intuitive as 50%.

Claim Denial Rates

- California: 100% (first contact determines)
  - “Per initial contact” approach
  - Done to avoid the problems of NAIC method
  - Like the 50% interpretation, it does not address initial denials, later denials or partial payments
  - Problematic with contacts during the EP

Claim Denial Rates

- NAIC: Less than 3% (1/37)
  - “Per claim payment” approach
- Most people 50% (Ed paid; Nan not)
  - “Per claimant” approach
- California: 100% (first contact determines)
  - “Per initial contact” approach

AHIP

- Some cos. use NAIC “per claim payment” method
- Others use the “per claimant” approach
- AHIP adds the numerators and denominators
  - Does ½ + 1/6 = 2/8???
  - Reports 3.3% but “per claimant” cos. report = 6.2%
  - Total “per claimant” is likely higher than 6.2%

AHIP July 23, 2007
Letter to Des Moines Register

"only 3.3% of LTCi claims are denied. We also found that claims were not paid for very understandable reasons, such as: particular health-care facilities were not part of networks, deductibles hadn't been met and a range of other very clear reasons"

HHS National LTC Claimant Study

- 94% of claimants either had no disagreement with their insurance company or had a disagreement that was resolved satisfactory
- Very positive findings!

AHIP Quoting
HHS National LTC Claimant Study

- "About 97% of claimants either had no disagreement with their insurance company or had a disagreement that was resolved satisfactory."
  - Applies only to those whose claims were APPROVED.

How much higher (%) would 2007 LTCi sales have been if we had avoided bad publicity regarding LTCi claims?

Audience participation: any thoughts?

Claude's thesis: We need to earn trust

- Proper claims payment
- Transparency
  - Logical statistics
  - Accurate statistics, well-explained
- Stick to principles
- Claims testimonials
- Ease of protesting claims

“We Pay 100% of Valid Claims”

- This is the litmus test
- It is a problem if carriers deny valid claims
- It can be a problem to pay invalid claims
  - Can lead to rate increases
  - “Tragedy of the Commons”
  - Regulators’ stance on rate increase filings
  - Maybe due to adding ALF coverage or stand-by

“We Pay 100% of Valid Claims”

- How can people know if carriers deny valid claims?
  - Rely on blind trust?
  - Your limited experience?
  - Rely on statistics?
  - Some type of public third-party appeal process
    - Such as Arbitration or Independent Review
    - Can produce public data on reviews & results
- How can you know if carriers pay invalid claims? That’s harder but less important.
  - Are there rate increases? Other ways?

Arbitration or Independent Review helps claimants

Compared to going to court, arbitration and independent review seem to be:

- Easier
- Faster
- Less expensive

IR is easier, faster and less expensive than arbitration

Precedents for Arbitration or IR in the financial services industry

- Acute Health care IR
  - Supported by AHIP; in at least 39 states and DC
  - Generally limited to “medical necessity” and “experimental”
  - 1 appeal/year per 14,000 enrollees
  - 50% of appeals end up getting paid
- Workmen’s Comp arbitration
- Securities Industry: NASD Manual Rule 10301(a) arbitration

Precedents for Third Party Review in the LTCi industry

- Federal LTCi Program
  - Appeals committee includes OPM person
  - If appeal fails, Independent Review
    - for ADL or cognitive issues
    - binding on insurers but claimant can still sue
- Transamerica Occidental optional arbitration
  - Binding on both parties
  - Each party responsible for own costs
- NY Partnership program
  - Appeal to Partnership; if unresolved, can choose binding arbitration instead of court

Independent Third Party Review will boost sales!

- Distributors will have more confidence in the claims process
- Prospects will have more confidence in the claims process
- Insurers will particularly benefit when they can quote statistics showing that their clients don’t feel a need to utilize such an alternative.

Distributor Survey: You place 50% of your business with Insurer A. Please indicate what percentage of your business Insurer A would get if it made the following changes.

% Increase in Sales if the following are instituted:		
Binding on both	Arbitration	11.8%
	Independent Review	11.4%
Non-Binding on each	Arbitration	4.0%
	Independent Review	7.0%

With Independent Third Party Review the industry can reduce bad PR!

IF there is an industry-supported approach…

When they hear claims complaints, the media will:

- ask whether the claimant utilized arbitration/IR
- ask if arbitration/IR supported the claimant
- report on the arbitration/IR process

If some carriers participate and others don't, the media will indicate which ones participate, shielding them from the "broad brush" problem.

Arbitration or Independent Review will come one way or another

If the industry does not act, the regulators will take charge:

- Iowa: $25 refundable claimant filing fee for IR, balance paid by insurer. IR is binding only on insurer.
- Acute Health as a model

The Claim Experience
“Delivering on a Promise”

Laurene A. Polignone
Assistant Vice President
Retail Claim Operations

February 25 , 2008

Agenda

- The Claim Experience
  - Claim Initiation
  - Benefit Determination
  - Care Coordination
  - Reimbursement
- Performance
- How Does JH Track Denials?

Intake Process

- Performed Live by calling into an exclusively dedicated Intake Unit
  - staffed by licensed nurses and social workers
- 25 minute call with policyholder or responsible party
- No claim forms
- Assess medical history, needs and services in place
- Review policy provisions
- Determine claim viability collaboratively
- Explain claim process
- Open Claim
- Initiate referral to discount provider program and care coordinator

Care Coordinator

- Face-to-face assessment in policyholder's home
- 1 ½ hour visit
- Registered Nurse or Licensed Social Worker
  - Active licensure
  - Background Checks
- Assess & review
    - Health and Medications
    - Cognition
    - Behavior & Emotions
    - Support Systems
    - Paid/Unpaid Caregivers
    - Environment
- Develop Plan of Care

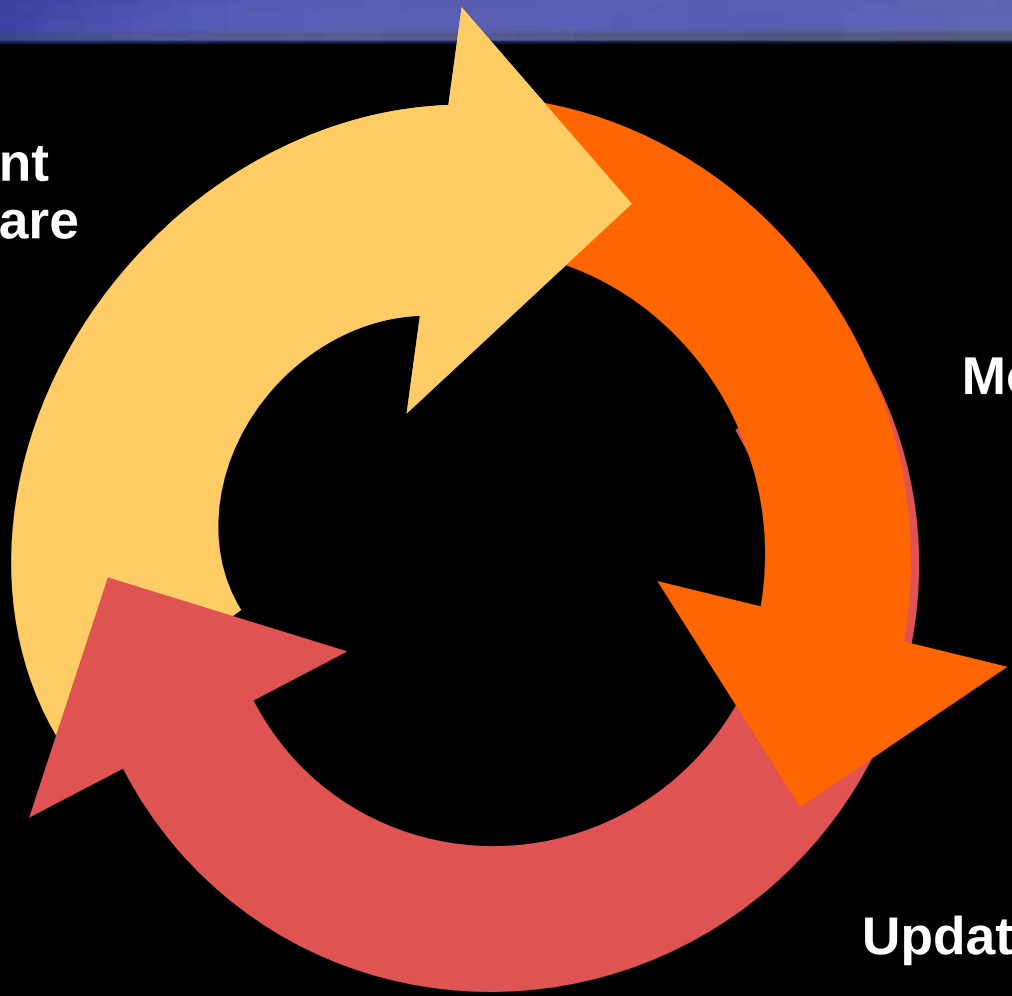
Benefit Determination

- Internal Clinician
  - Reviews Onsite Assessment & POC
  - Appropriateness & accuracy related to onsite
  - Perform TQ certification
  - BE Determination
- If Denied
  - Referred to Audit Unit for second decision
  - If auditor agrees with denial
  - PH contacted telephonically
  - Reason for denial discussed in detail
  - Determine if additional information is required
  - If no, denial letter forwarded
- If Approved
  - Approval letter forwarded
  - Care Coordination activated

Care Coordinator

- **Ongoing monitoring of needs**
- **Assistance with Medicare eligibility**
  - Typically during the EP
- **Provide community resource referrals**
- **Access to local & National support systems**
- **Facilitate coordination of services**
- **Education**
- **Continuously Assessing ADL & Cognitive Needs**

Care Coordination Benefit



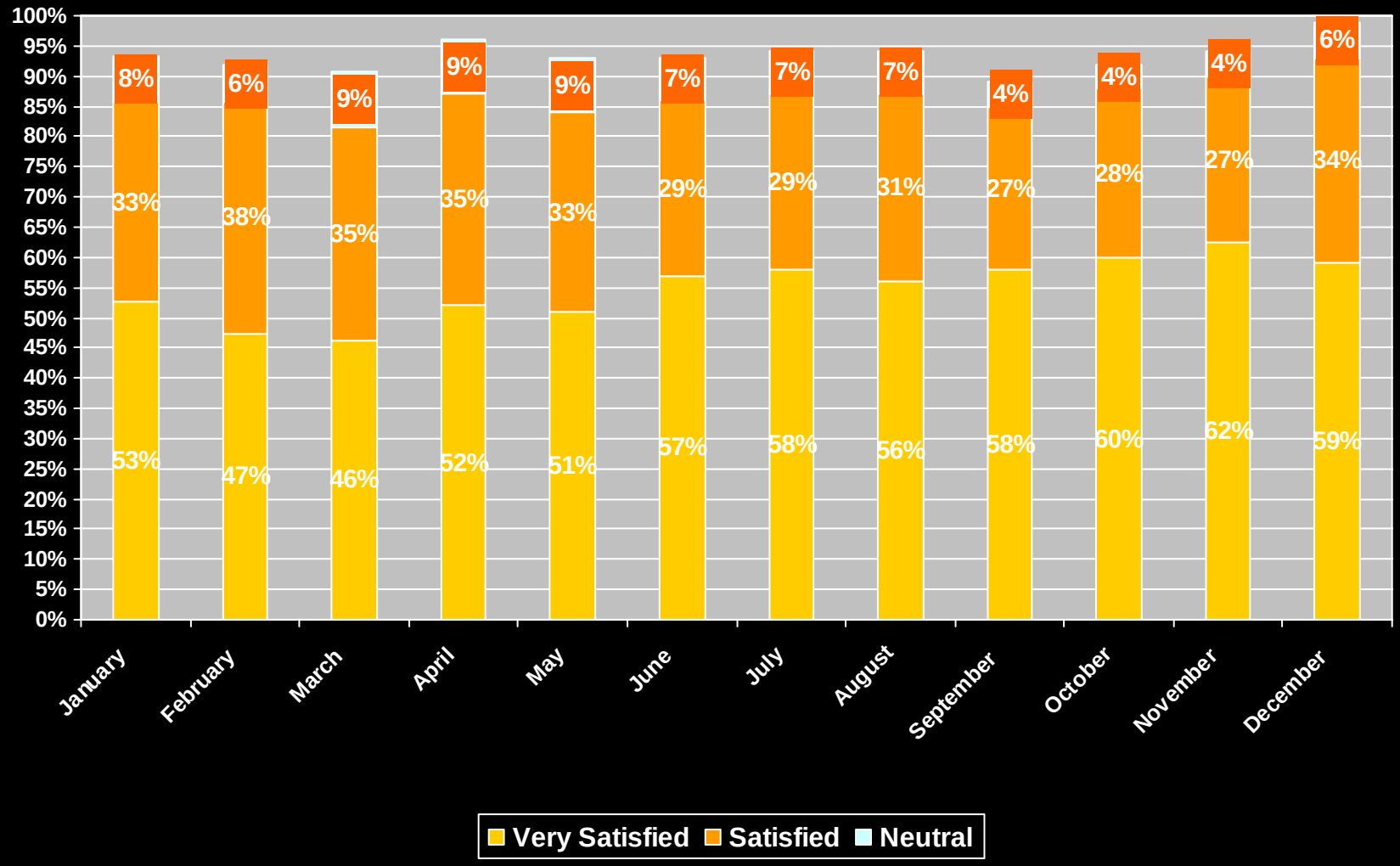
Reimbursement

- Review weekly/monthly invoices
- Review care coordination monitoring notes to determine ongoing benefit eligibility
- Reimburse within 15 days of receipt of invoice
  - 95% meet performance standard
  - 32 million in benefits paid monthly

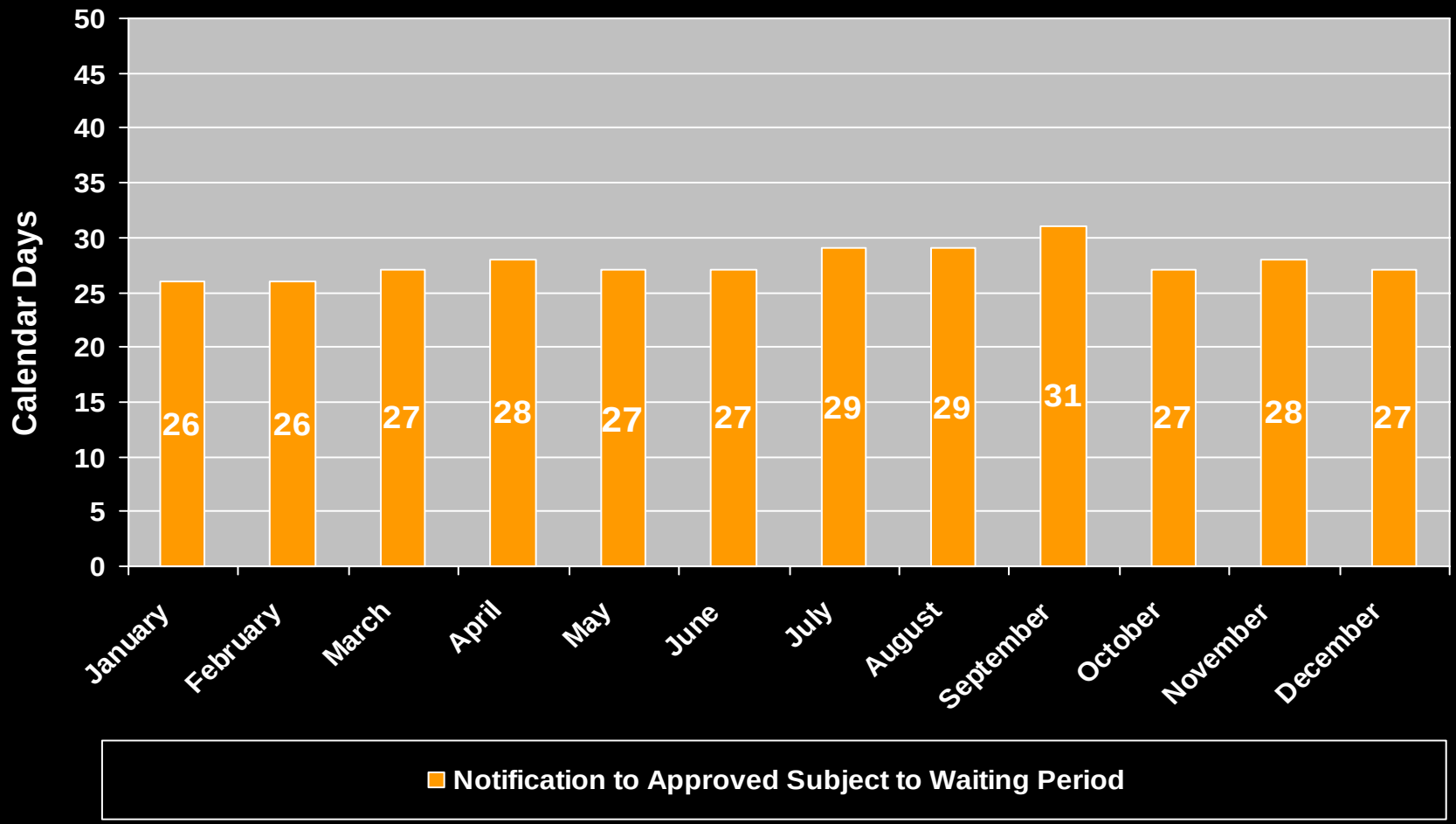
Quality Assurance

- End-to-End Auditing Program
- Dedicated Technical Unit Manages program
  - Call Monitoring
  - BE/PE Determinations
  - 100% denials
  - Payments
  - Vendor Performance
  - Customer Satisfaction
  - Appeals Reviewed by a Committee
- Department Held to a 98% accuracy standard

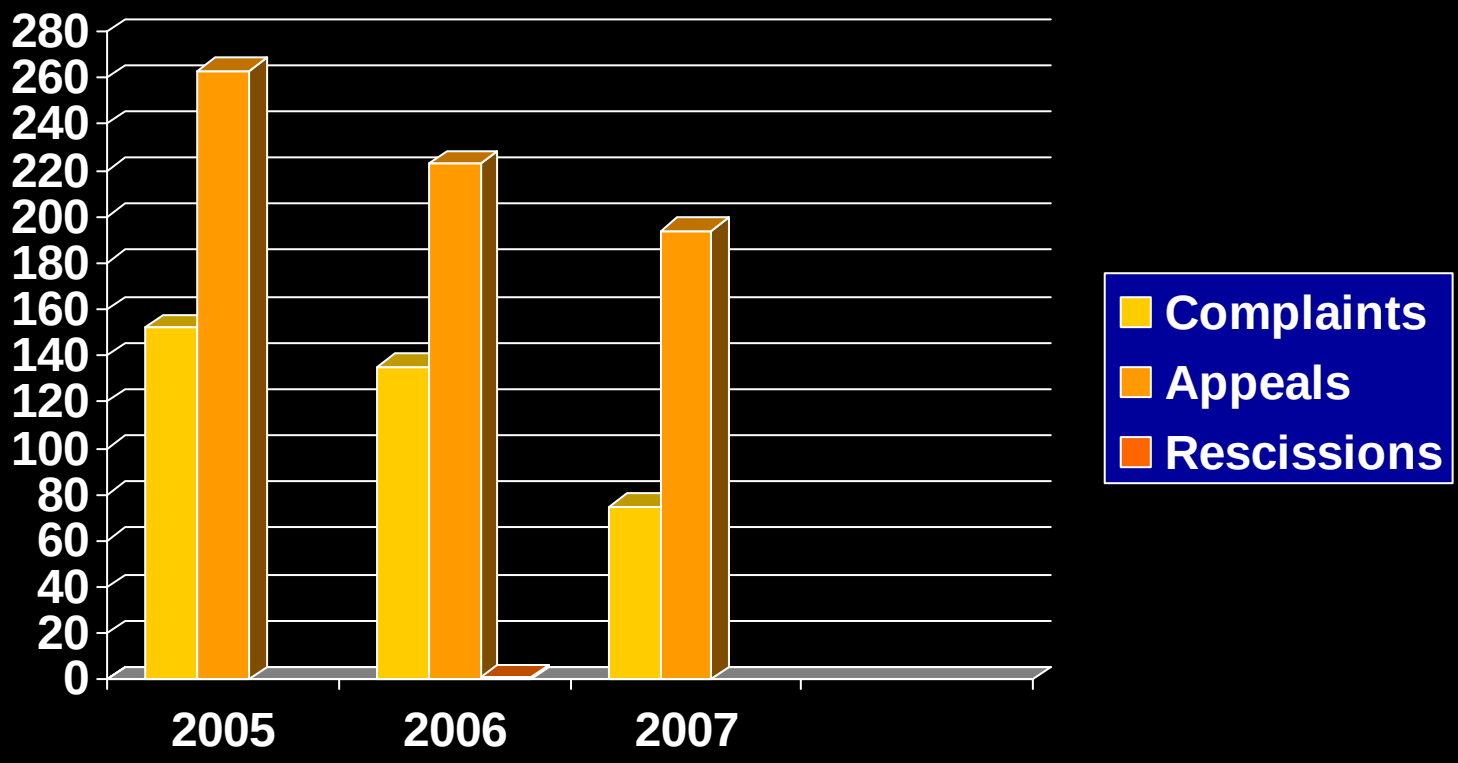
2007 Customer Satisfaction Survey Results



2007 Cycle Time



Complaint, Appeal & Rescission Activity



Base of 11,000 active claims and 750 new arising claims each month

How Does JH Claims Track Denials?

- Industry tracks denials - two methods
  - Person
  - Payment
- AHIP denial rate
- JH denial rate tracked by claimant based on BE determination
  - 4.7% (2006)
  - Intake Unit deems claim viable
    - Determination
      - Approval*
      - Denial*
      - Withdrawal

**Calculation is based on those claims in which a BE determination is rendered*

How Does JH Claims Track Denials?

- Denial Reasons

#1 PH Does Not Meet Benefit Eligible Trigger

- 1 ADL
- Early stages of a cognitive impairment – receiving medication management

#2 Provider Not Eligible

- Family member
- Does not meet TQ certification – hip replacement
- Rehabilitation Facility

John Hancock
LONG TERM CARE INSURANCE

Delivering on a Promise

Marketing the Claims Message

Laura Vail Wooster
AVP, Marketing & Communications
John Hancock Long Term Care

February 25 , 2008

Agenda

- Who is the message geared to?
- What is the message?
- When to deliver it?
- Why deliver the message?
- How to deliver the message?

Who & What is the message?

- Defining the Consumer Message
  - What do consumers want to know?
  - Only 2 out of 27 key consumer questions about LTCI are claims-related:

#1: "How many people are denied?"

#2: "Does my policy offer guidance and advice related to LTC planning?"

What is the message – at point of sale?

- *"How many people are denied?"*
  - Cite industry 3.3% denial rate
    - Explain difference between carriers with claim person process vs. claim per payment process
  - Explain why most claims are denied
    - Eligibility requirements not yet met
  - Sell a carrier that you can trust
    - Share history of carrier
    - Share experience of carrier
    - Show carrier ratings – S&P, AM Best, Moody's, etc.

What is the message – at point of sale?

- *"Does my policy offer guidance and advice related to LTC planning?"*
  - Explain all the benefits received from the policy (most are at time of claim)
    - Not just financial, also
    - Access to advice from experience staff and nurses
    - Access to ratings of providers
    - Claimant specific recommendations
    - Access to provider discounts
    - Supports family, too

What is the message – at policy delivery?

- *“How do I file a claim?”*
- *“What will my claims experience be like?”*
- *“What is my recourse if my claim is unjustly denied in my opinion?”*
  - Provide clear instructions on how to file a claim
  - Describe key steps in the process
  - Describe role of care coordinators, claims processors, etc.
  - Independent Third Party Review
    - New benefit being added to JH policies in spring
    - Entitles a policyholder to the right to appeal a decision using an independent third party

Why deliver the message?

- *NY Times article of March 2007*
- *LTCI is still uncharted territory*
- *Helps to set the record straight for the industry*
- *Eliminates objections up front*
- *Addresses lingering doubts*

How to deliver the message?

- *Testimonials*
  - *Video (Roll Tape!)*
  - *Brochures*
  - *Websites*
- *Third party reprint articles*
  - *Kiplinger's article and video*
- *Brochures*
  - *AHIP brochure speaks to industry experience*
  - *LTC overview brochures*
  - *Claims experience brochure*
  - *Advantage Provider Program brochure*
  - *5-step claims process*

Stop for Q&A

- Discuss Claude's additional issues if desired
  - Denial of claims attributed to inorganic mental and nervous disorders
  - Co-ordination of claim payments among carriers and between a carrier's own policies

Inorganic Conditions

- Schizophrenia; bi-polar; depression
- Chemical balances in brain differ
- Therefore they ARE organic
- Hence should NOT be declined based on “inorganic” or “not of organic” wording
- “Specified disease” exclusions do hold up
- But some carriers with “inorganic” wording are declining claims on that basis!

Claims Co-ordination of Benefits/ Non-Duplication

- Federal government requires non-duplication of Medicare
- CA & CT Partnerships require co-ordination of benefits between carriers
- 13 states have been rejecting co-ordination even among policies of a single company
- We should work to permit co-ordination