Claims Experience for Carriers with Large Inforce Blocks

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Antitrust Statement

The information reflected in these slides and shared verbally by all the carriers on this panel is not intended to endorse a process or be indicative of an experience that another carrier may encounter.

The information presented today is a reflection of general industry experience and possibly specific carrier's experience based on each carrier's specific policy provisions.

It is important that we refrain from discussing or exchanging information regarding any competitively sensitive information which would violate any state or federal antitrust law.

Actuarial Guidance

- ASOP 18 (original version - 1991) advised us to consider
  - Increased service utilization due to insurance
  - Reduced stigma and fear of confinement if more attractive facilities are available.
  - New LTC services may be developed.
- ASOP 18 (current version – 1999) added a number of considerations including
  - Assisted Living Facilities (separate claim costs)
  - Alternate Plan of Care
  - The possible substitution effect among the various benefits in the instances where more than one type is available

Medical Necessity Trigger

Long Term Care:

Care or services, including home and community based care or services, which are:

1. Medically Necessary; or
2. Due to the Inability to Perform Two or More Activities of Daily Living; or
3. Due to Cognitive Impairment.

Medically Necessary:

Care or services which are:

1. Provided for Acute or Chronic Conditions; and
2. Consistent with accepted medical standards for Your condition; and
3. Not designed primarily for the convenience of You or Your family; and
4. Recommended by a physician who has no ownership in the Long-Term Care Facility or Alternate Care Facility in which You are receiving care

Medical Necessity Trigger

- First product designs were consistent with medical necessity trigger
- Prior hospitalization and prior institutionalization requirements as per Medicare model
- Fell apart as the gatekeepers were removed and we went beyond the post-acute
- Huge cost impact for HHC and ALF

Medical Necessity

Challenges

- Broad trigger in older generation policies
- No TQ trigger – 90 day certification not required
- Qualification can be based on a "physician's plan"
  - Medical records do not typically assess functionality and cognitive deficits
  - Physician's plan is based on diagnosis and treatment
- "Medical assistance" in some policies defined as administration of medical interventions as required for an illness or an injury
  - Administering medications
  - Wound checks
  - PT/OT

Process Considerations

- Obtain physician's plan and geriatric assessment
- Collaboration between physician and clinician
- Is care setting appropriate?

Assisted Living Facilities

Sample Definition

A facility which

1. is licensed as an Assisted Living Facility.
2. provides 24 hours-a-day care with services sufficient to support inpatient's needs due to cognitive Impairment or the inability to perform Activities of Daily Living.
3. provides 3 meals a day.
4. has an awake employee on duty at all times who is trained in the appropriate procedures for handling and administering drugs and biologicals.
5. has formal arrangements for the services of a Doctor or Nurse to furnish medical care in case of an emergency.
6. has a minimum of 10 inpatients.

Assisted Living Facilities

- Assumed modest cost due to substitution effect and perhaps lower daily cost than NH
- Some policies attempted to exclude “rent”
- Failure to appreciate that these are places where people actually want to live (note “stigma” remark of first ASOP)
- Long continuance – move out only when too ill
- Added to ASOP 18 - recommends separate assumption tables for ALF

Assisted Living Facilities

Challenges

- Reimbursement model has changed - 100%
- Older policies - ALF treated as nursing home
- Various financial models
- Borderline benefit eligible at claim initiation – already move into facility, sold home
  - 1 ADL, med. Mgmt, supportive environment
- Charges represented differently and not itemized?
- Correlating service plan with Plan of Care
  - Difficult to determine level of care

Process considerations

- Obtain resident agreement to establish financial model – determine if fees are refundable
- Obtain entrance assessment and service plan to determine “care delivered”
- Request quarterly reassessments and updated resident agreements to determine ongoing benefit eligibility
- Assess care being delivered in accordance with policy triggers
- Room, board and services must be itemized

Informal/Independent Caregiving

Sample Definition

Nurse's aide, home health aide, personal care attendant or any other person qualified by training and/or experience to provide assistance in the home with ADLs, IADLs and/or supervision due to cognitive impairment. **Care provider does not need to be associated with an agency or provider organization.**

Informal/Independent Caregiving

- Pricing generally assumed care would be provided by appropriately licensed providers, e.g. Home Health Care Agency, RN, LPN, LVN
- Substitution effect and lower cost caregiver = cost neutral?

Informal Providers

Challenges

- **Caregiver Qualifications**
  - Not licensed or certified
  - Not willing to undergo training
  - No government ID
  - Unwilling to sign administrative forms
- **Level of Care**
  - Extensive hours
    - 24X7 care indicated – caregiver is on call
    - Reporting 24X7 is provided - based on geographic location not feasible
    - No break in services for 6+months
- **Cost of Care**
  - Rates higher than geographic average
  - Hourly rate inconsistent with credentials & experience
  - Hours invoiced inconsistent with POC
- **Adjudication**
  - Provider in place prior to claim initiation
  - Increased volume of forms to analyze
  - Caregiver turnover
  - Multiple providers per claimant

Process Considerations

- **Caregiver Qualifications**
  - Require formalized training, licenses and certifications
  - Government issued identification, Tax ID or social security #
  - Background checks
- **Level of Care**
  - Red Flag guidelines/systems to support identification of suspect claim activity
  - Background checks
  - Proof of Loss (creating baseline, managing to the POC, benchmarks)
- **Cost of Care**
  - Cost effective language
  - "Reasonable and customary" charges
  - Cancelled checks, bank statements
  - Is cost of care rising appropriately with geographic averages
- **Adjudication**
  - System functionality to support processing
  - Invoices compared to POC
  - Data analysis to monitor experience

Alternate Plan of Care

Sample Definition

If You would otherwise require a Long Term Care Facility stay under a Plan of Care, We may pay for alternate services, devices or types of care under a written Alternate Plan of Care, if such plan is medically acceptable. This Alternate Plan of Care:

1. Must be agreed to by You, Your Licensed Health Care Practitioner, and Us; and
2. Will be developed by or with Licensed Health Care Practitioners; and
3. Must be for Qualified Long Term Care.

Any plan, including the benefit levels to be payable, may be adopted, **as long as it is mutually agreeable to You, Your Licensed Health Care Practitioner and Us**. We are not obligated to provide benefits for services received prior to such agreement.

Agreement to participate in an Alternate Plan of Care will not waive any of Your or Our rights under the policy.

Any benefits payable under this provision will count against the Maximum Lifetime Benefit.

This plan may specify special treatments or different sites or levels of care. Some of the services You may receive may differ from those otherwise covered by Your policy. In this case, benefits will be paid at the levels specified and agreed to in the Alternate Plan of Care.

Alternate Plan of Care

- Pricing – commonly assumed cost neutral
- Requires agreement between insured, insurer and physician, potentially provides a way to cover lower-cost providers (if substitution), can limit payment to something less than full benefit
- In practice results vary
- Never anticipated paying things like major home modifications

Alternate Plan of Care

Challenges

- Broad language encompassing capital improvements, unlicensed facilities, DME & other settings
- No text requiring cost effective alternative
- How do you apply EP?
- Home modifications in multiple residences?
- Assessing the duration and effectiveness of home modification?
- Home modifications for claimants on hospice?
- Lifetime Benefit?

Process Considerations

- Coordinate with Medicare
- DME, Capital Improvement & Home Modification reviewed during clinical analysis for appropriateness and recovery
- PT/OC written evaluation as secondary source of data
- Policy language/Admin guidelines need to address a wide variety of situations i.e. clinical , geographical, cost effective, etc.
- Ongoing "proof of loss"
    - Ongoing Monitoring of the POC
    - Manage to benchmarks/recovery
    - Obtain clinical documentation
    - "Flow sheets", notes of care, assessments, Medical records
- Develop formula (cost and daily benefit) to determine EP days satisfied
    - Develop reimbursement model (lump sum vs. monthly)

Restoration of Benefits

- Service driven provision - “period of care” ends for X (e.g.180) days, pool restored

- Benefit eligibility driven provision – no longer benefit eligible for X (e.g.180) days, pool restored

Restoration of Benefits

- Expected modest additional cost
- Raw data theoretically may incorporate true restorations (recovery)
- Contracts should have been written more clearly to reflect the intent of true benefit eligibility restoration (recovery) rather than service break restoration
- May have been sold as substitute for unlimited LTM?
- Disconnect between contract, pricing, sales and claims practices

Restoration of Benefits

Challenges

- Enhanced claim adjudication
  - Ongoing Monitoring of the POC
  - Manage to benchmarks/recovery
  - Obtain clinical documentation
- Diagnosis and level of care critical to analyze if recovery occurred during 180 days
- "Red flag" activity
- Claim closure – family is providing care
  - **Does "discontinuing services" mean they have recovered from the illness?**
- Claim inactivity – claim closed due to non-receipt of invoices
  - **Does "non-receipt" of invoices mean they are no longer benefit eligible?**
- Provider "end of service" documentation - identifying the exact day "no longer BE"

Process Considerations

- Obtaining ongoing "proof of loss"
  - Ongoing Monitoring of the POC
  - Manage to benchmarks/recovery
  - Obtain clinical documentation
  - "Flow sheets", notes of care, assessments, Medical records
- Clinical evaluation critical at closure of claim to determine recovery
  - Diagnosis
  - ADL's
  - Cognition
- Monitoring of claim inactivity
- Systematic flags to manage provision
  - Triggers ROB reviews
  - Flags inactivity
  - Freezes future payments
  - Triggers communications

Claim Reserving Considerations

Claim Reserving Situations	Reserve Name	Likely Reserving Method
Claim is Known & Approved to begin Elimination Period and/or Benefit Period	"Open" Disabled Life Reserve	Seriatim valuation, considering specific benefits of the claimant
Claim is Known but Not Yet Approved to begin Elimination Period and/or Benefit Period	"Pending" or "Incomplete" or "Decision Pending" Disabled Life Reserve	Same as above times factor representing likelihood of approval and/or not being abandoned
Claim is Not Known About on Valuation Date	True New Claim Incurred but Not Reported ("True IBNR")	Various methods per Actuarial Judgment; often tied to standard lag studies but other methods such as expected loss ratio completion and/or triangular completion may be used as well
Claim was Known and Currently Closed but May Reopen (for a variety of reasons)	Closed Claim Incurred but Not Reported ("Closed IBNR" or "Reopen IBNR")	Various methods per Actuarial Judgment; often related to Claims Department protocols

Note that in the above, the "known" means known ***by Valuation Actuary*** , not known by Claims Department.

A valuation actuary must understand:

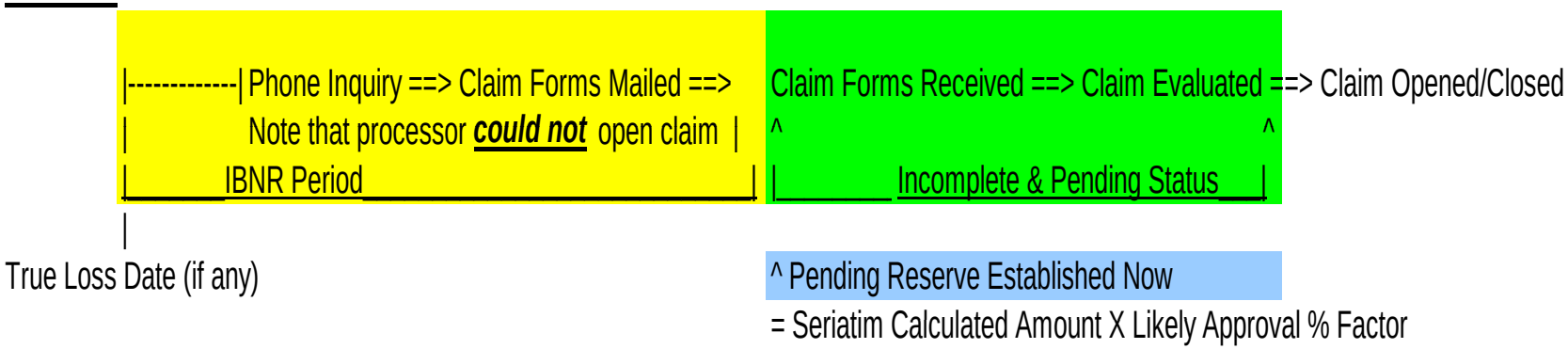
* When a new claim appears on the claim system
* When a new claim on the claim system will be fed to the Actuarial area for reserving purposes
* When information relating to claim status (such as death or recovery) is updated on claim system
* When information relating to claim status (such as death or recovery) will be fed to the Actuarial area for reserving purposes

Decision to Open a Claim

- At receipt of phone call
    - Services have already started
    - Services will start within 30 days
- At receipt of paper notification

Claim Opening By Phone Call vs. Receipt of Claim Forms

BEFORE:



Question: Did company track how many claim forms were mailed that were never returned?

Claim Opening By Phone Call vs. Receipt of Claim Forms, continued

AFTER:

|----------| Phone Inquiry ==> Claim Forms Mailed ==> Claim Forms Received ==> Claim Evaluated ===> Claim Opened/Closed
| ^ -- Processor ***chooses*** not to open claim -- ^ ^ ^
|_____IBNR Period_____| |_____Incomplete & Pending Status____|
|
True Loss Date (if any) ^ Pending Reserve Established Now
= Seriatim Calculated Amount X Likely Approval % Factor

Question 1: Is this approval factor the same as "old world"?
Question 2: What percent of these phone calls will ultimately send in claim forms anyway?
ISSUE: If approval % is lower, but actuary does not realize it, actuary has overstated reserves & tied up capital unnecessarily.

OR

|----------| Phone Inquiry ===> Claim Forms Mailed ==> Claim Forms Received ==> Claim Evaluated ==> Claim Opened/Closed
^ ---- Processor ***chooses*** to open claim ---- ^
| IBNR ^ <-- Extra Incomplete & Pending Status---> <----- Historical Incomplete & Pending -----> ^
| Period |_____ _____| |_____|
|
True Loss Date (if any)
^ Pending Reserve Established Now
= Seriatim Calculated Amount X Likely Approval % Factor X Likely Percentage that will return paperwork
Question 1: Is the approval factor the same as "old world"?
Question 2: Is the approval factor the same as "new world" where processor chooses not to open?
Question 3: What percent of claim opening phone callers will return their paperwork?
ISSUE 1: If approval % is higher, but actuary does not realize it, actuary has understated reserves.

OR "Phantom Claim"

|----------| Phone Inquiry ===>Claim Forms Mailed ==>Claim Forms NOT Received within **X** days==> Claim Closed
^ ---- Processor ***chooses*** to open claim ---- ^
| Extra ^<-- Extra Incomplete & Pending Status.This claim is NOT recorded in historical data. -->^
| IBNR |_____ _____ _____|
|
NO LOSS DATE ^ Pending Reserve Established Now
Question from above: What percent of claim opening phone callers will return their paperwork?
ISSUE 1: This is a pending reserve that was not required and chewed up capital while waiting X days.
ISSUE 2: This claim ends up generating additional IBNR in a lag calculation method if this still counts as a "received claim". IBNR needs to be recalculated to reduce claim receipt count or decrease the average IBNR claim amount.

Real World Considerations

What happens if claimant hurries around to submit claim forms after the "X days" allowable period?

% Closed for lack of forms by	Phone Call Claims Beginning in:									
	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Average
1 month-end later	13.6%	3.6%	12.8%	14.7%	6.8%	14.1%	9.5%	8.1%	10.6%	10.4%
2 months-end later	22.8%	20.6%	25.7%	25.3%	24.4%	28.2%	23.3%	20.4%		23.8%
3 months-end later	19.9%	17.8%	21.2%	24.7%	22.1%	28.5%	23.3%			22.5%
4 months-end later	16.9%	16.6%	18.1%	23.4%	20.1%	25.9%				20.2%
5 months-end later	15.2%	15.0%	15.0%	22.1%	17.5%					17.0%
6 months-end later	15.2%	15.0%	14.6%	21.8%						16.7%
7 months-end later	14.9%	14.2%	14.6%							14.6%
8 months-end later	14.2%	11.7%								13.0%
9 months-end later	13.9%									13.9%

Data is as of December 2010.

WARNING: If “late forms” are accepted, actuary needs to be sure they relate to the claim that was originally opened and not some later claim event. We should not be reserving for “future” loss dates on a given valuation date.

Real World Considerations, continued

What if Claim Dept becomes more (or less) likely to open claim by phone call?

Processing Month	Percentage of New Claims by Phone Call	Percentage of New Claims by Forms Received
Mar-10	47.2%	52.8%
Apr-10	42.7%	57.3%
May-10	45.1%	54.9%
Jun-10	48.1%	51.9%
Subtotal Mar-June 2010	***45.9%***	***54.1%***
Jul-10	58.8%	41.2%
Aug-10	66.6%	33.4%
Sep-10	65.7%	34.3%
Oct-10	56.7%	43.3%
Nov-10	63.6%	36.4%
Dec-10	64.3%	35.7%
First two weeks of Jan-11	64.2%	35.8%
Subtotal July-10 to mid-Jan 11	***62.8%***	***37.2%***

Claim Closures

- When do you close the claim?
  - Close claim due to death or max benefits after last payment has been made
  - Close claim at death even if last services have not been paid

- How does this affect Waiver of Premium?

Claim Closures, continued

Migration off claim

- Immediate closure of claim
- 30 day interim period prior to closure

- How long should you wait to close a claim due to lack of response to phone calls/correspondence?

Claim Re-Opens

- Criteria of Re-Open?
  - Re-Open with receipt of partial information
    - Tracking of claim
    - Follow up correspondence
  - Re-Open only after all information is received
    - No claim tracking
    - No follow up correspondence
- Re-Open vs. New Claim?
  - Re-Open if information is received within specified time frame
  - Re-Open if claim is for the same condition

Claims Experience for Carriers with Large Inforce Blocks

Model Office of a Claims Department for Closing Claims due to Death or Recovery

# Open Claims	20,000
# New Claims per Month	800
Annual Growth Rate in New Claims	5%
% Female of New Claims	70%
Average Age of New Claim	82
Daily Benefit	150
% of Claimants that will Recover	10%
3 months Benefits to pay on re-open after death	13,500
Annual Premium of a Claimant	3,600
Extra LTC benefits to pay for delayed migration	4,500

Claims Experience for Carriers with Large Inforce Blocks

Modeling of Claim Department decision to:

A. Close a Claim Immediately on Death and alert Actuarial of need for just an “accrued benefits through date of death” reserve.

OR

B. Keep claim open (not notifying Actuarial) until all accrued benefits are paid and the claim is then closed. Actuarial thus thinks claimant is alive during the interim period.

Claims Experience for Carriers with Large Inforce Blocks

Balance Sheet Comparison					
	YE	Reserves for Close Immediately on Death + Accrued Reopen	Reserves for 3 month delay before closing on death	Difference	% Difference
	2010	3,058,126,033	3,118,853,750	60,727,717	2.0%
	2011	4,036,726,364	4,116,876,136	80,149,773	2.0%
	2012	4,946,331,591	5,046,564,659	100,233,068	2.0%
	2013	5,799,701,136	5,920,292,614	120,591,477	2.1%
	2014	6,609,997,273	6,749,296,477	139,299,205	2.1%
	2015	7,379,723,182	7,538,830,568	159,107,386	2.2%
	2016	8,105,364,318	8,284,188,182	178,823,864	2.2%
	2017	8,790,487,727	8,987,102,273	196,614,545	2.2%
	2018	9,457,062,273	9,673,026,477	215,964,205	2.3%
	2019	10,106,805,682	10,340,560,568	233,754,886	2.3%
	2020	10,736,121,136	10,988,858,864	252,737,727	2.4%
	2021	11,367,057,955	11,637,219,545	270,161,591	2.4%
	2022	12,002,080,682	12,288,290,568	286,209,886	2.4%
	2023	12,648,626,818	12,951,526,932	302,900,114	2.4%
	2024	13,317,781,591	13,639,939,659	322,158,068	2.4%
	2025	14,010,933,182	14,351,615,568	340,682,386	2.4%

Claims Experience for Carriers with Large Inforce Blocks

Income Statement Comparison						
	Close Immediately & Hold Reopen Reserve		Close 3 months later after all bills are paid			
Year	Investment Income on Clm Res	Chg in Claim Reserve	Investment Income on Clm Res	Chg in Claim Reserve	Additional Pre-tax Loss	Additional After-tax Loss
2011	141,897,048	978,600,331	144,714,598	998,022,386	(16,604,506)	(10,792,929)
2012	179,661,159	909,605,227	183,268,816	929,688,523	(16,475,639)	(10,709,165)
2013	214,920,655	853,369,545	219,337,145	873,727,955	(15,941,918)	(10,362,247)
2014	248,193,968	810,296,136	253,391,782	829,003,864	(13,509,914)	(8,781,444)
2015	279,794,409	769,725,909	285,762,541	789,534,091	(13,840,050)	(8,996,032)
2016	309,701,750	725,641,136	316,460,375	745,357,614	(12,957,852)	(8,422,604)
2017	337,917,041	685,123,409	345,425,809	702,914,091	(10,281,914)	(6,683,244)
2018	364,951,000	666,574,545	373,202,575	685,924,205	(11,098,084)	(7,213,755)
2019	391,277,359	649,743,409	400,271,741	667,534,091	(8,796,300)	(5,717,595)
2020	416,858,536	629,315,455	426,588,389	648,298,295	(9,252,989)	(6,014,443)
2021	442,063,582	630,936,818	452,521,568	648,360,682	(6,965,877)	(4,527,820)
2022	467,382,773	635,022,727	478,510,202	651,071,023	(4,920,866)	(3,198,563)
2023	493,014,150	646,546,136	504,796,350	663,236,364	(4,908,027)	(3,190,218)
2024	519,328,168	669,154,773	531,829,332	688,412,727	(6,756,791)	(4,391,914)
2025	546,574,295	693,151,591	559,831,105	711,675,909	(5,267,509)	(3,423,881)

Claims Experience for Carriers with Large Inforce Blocks

Modeling of Claim Department decision to:

A. Close Claim Immediately Upon Recovery and re-start premium billing. Actuarial is notified via update to claim status on claim reserving feed.

OR

B. Provide one additional month of benefits as a “transition” period to a claimant who has recovered. Actuarial does not know claimant has recovered and is notified a month later after the transition period has been completed.

Claims Experience for Carriers with Large Inforce Blocks

Balance Sheet Comparison					
		Reserves for Close Immediately	Reserves for 1 month delay		
	YE	on Recovery	before closing on Recovery	Difference	% Difference
	2010	3,050,000,000	3,053,355,000	3,355,000	0.1%
	2011	4,026,000,000	4,030,436,364	4,436,364	0.1%
	2012	4,932,917,500	4,938,421,364	5,503,864	0.1%
	2013	5,783,562,500	5,790,078,409	6,515,909	0.1%
	2014	6,591,355,000	6,598,799,773	7,444,773	0.1%
	2015	7,358,430,000	7,367,011,591	8,581,591	0.1%
	2016	8,081,432,500	8,091,067,727	9,635,227	0.1%
	2017	8,764,175,000	8,774,794,545	10,619,545	0.1%
	2018	9,428,160,000	9,439,805,455	11,645,455	0.1%
	2019	10,075,522,500	10,088,124,545	12,602,045	0.1%
	2020	10,702,297,500	10,715,911,591	13,614,091	0.1%
	2021	11,330,902,500	11,345,487,045	14,584,545	0.1%
	2022	11,963,777,500	11,979,401,818	15,624,318	0.1%
	2023	12,608,090,000	12,624,754,091	16,664,091	0.1%
	2024	13,274,667,500	13,292,454,545	17,787,045	0.1%
	2025	13,965,340,000	13,984,388,636	19,048,636	0.1%

Claims Experience for Carriers with Large Inforce Blocks

Income Statement Comparison							
	Close Immediately on Recovery		Close 1 month after Recovery				
Year	Investment Income on Clm Res	Chg in Claim Reserve	Investment Income on Clm Res	Chg in Claim Reserve	Extra Benefits Paid (LTC + WOP)	Additional Pre-tax Loss	Additional After-tax Loss
2011	141,520,000	976,000,000	141,675,827	977,081,364	1,362,327	(2,287,864)	(1,487,111)
2012	179,178,350	906,917,500	179,377,155	907,985,000	1,769,891	(2,638,586)	(1,715,081)
2013	214,329,600	850,645,000	214,569,995	851,657,045	2,152,582	(2,924,232)	(1,900,751)
2014	247,498,350	807,792,500	247,777,564	808,721,364	2,508,218	(3,157,868)	(2,052,614)
2015	278,995,700	767,075,000	279,316,227	768,211,818	2,859,055	(3,675,345)	(2,388,975)
2016	308,797,250	723,002,500	309,161,586	724,056,136	3,244,364	(3,933,664)	(2,556,881)
2017	336,912,150	682,742,500	337,317,245	683,726,818	3,628,800	(4,208,023)	(2,735,215)
2018	363,846,700	663,985,000	364,292,000	665,010,909	3,963,927	(4,544,536)	(2,953,949)
2019	390,073,650	647,362,500	390,558,600	648,319,091	4,306,909	(4,778,550)	(3,106,057)
2020	415,556,400	626,775,000	416,080,723	627,787,045	4,673,018	(5,160,741)	(3,354,482)
2021	440,664,000	628,605,000	441,227,973	629,575,455	4,993,745	(5,400,227)	(3,510,148)
2022	465,893,600	632,875,000	466,497,777	633,914,773	5,324,945	(5,760,541)	(3,744,352)
2023	491,437,350	644,312,500	492,083,118	645,352,273	5,653,527	(6,047,532)	(3,930,896)
2024	517,655,150	666,577,500	518,344,173	667,700,455	5,964,218	(6,398,150)	(4,158,798)
2025	544,800,150	690,672,500	545,536,864	691,934,091	6,288,873	(6,813,750)	(4,428,937)

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