Long Term Care Insurance

Claims Processes

Presented by

South Dakota Division of Insurance

Long Term Care Insurance Benefit Standards

- Tax Qualified/Partnership
  - ADL triggers
  - Plan of Care
  - Chronically Ill Assessment
- Non tax Qualified
  - May or may not have ADL benefit triggers
  - Plan of Care and chronically ill assessment are typically not required
  - Maybe a level of care trigger and/or medical necessity

ADLs

- "Bathing," washing oneself by sponge bath or in a tub or shower, including the task of getting into or out of the tub or shower;
- "Dressing," putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs;
- "Eating," feeding oneself by getting food into the body from a receptacle such as a plate, cup, or table, by a feeding tube, or intravenously;
- "Continence," the ability to maintain control of bowel or bladder function or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene, including caring for a catheter or colostomy bag;

ADLs continued

- Toileting," getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
- "Transferring," moving into or out of a bed, chair, or wheelchair.

Benefit Triggers

- Inability to perform 2 of the ADLs

  1. May not be more restrictive than requiring the hands-on assistance of another person to perform the prescribed activities of daily living, **or**

  2. If the deficiency is due to the presence of a cognitive impairment, needing the supervision or verbal cueing by another person to protect the insured or others

  - "Hands-on assistance," the physical assistance, minimal, moderate, or maximal, without which the individual would not be able to perform the activities of daily living
  - "Cognitive impairment," a deficiency in a person's short- or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to awareness of safety

Benefit Triggers

- Medical necessity
  - Can be used as an additional trigger (an additional way to qualify for benefits)
    - Not a tax qualified trigger
  - Can not be used as an additional condition or hurdle to meet ADL benefit triggers
  - Must not be more restrictive than requiring the certification of a physician

Plan of Care

- Tax qualified long-term care insurance contract shall pay only for qualified long-term care services received by a chronically ill individual provided pursuant to a plan of care prescribed by a licensed health care practitioner
  - SD specifically allows for any licensed health care practitioner to develop plan of care, insurers cannot require it be done by their practitioner of choice

Chronically Ill Individual

"Chronically ill individual," any individual who has been certified by a licensed health care practitioner as:

- (a) Being 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 (b) Requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment.

The term, chronically ill individual, does not include an individual otherwise meeting these requirements unless within the preceding twelve-month period a licensed health care practitioner has certified that the individual meets these requirements;

Certification as to Chronically Ill

- Health care practitioner must certify that covered person expected to be unable to perform 2 ADLs for 90 days due to loss of functional capacity or severe cognitive impairment
  - Certifications must be done by practitioner who is a physician, registered professional nurse, licensed social worker, or other individual who meet requirements prescribed by the Secretary of the Treasury

Severe Cognitive Impairment

"Severe cognitive impairment," a loss or deterioration in intellectual capacity that is comparable to, and includes, Alzheimer's disease and similar forms of irreversible dementia, and is measured by clinical evidence and standardized tests that reliably measure impairment of an individual in the following areas:

(a) Short-term or long-term memory;

(b) Orientation as to people, places, or time; and

(c) Deductive or abstract reasoning;

Appeals

- If an insurer determines that the benefit trigger has not been met, the insurer shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:

(1) The reason that the insurer determined that the insured's benefit trigger has not been met;

(2) The insured's right to internal appeal and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and

(3) The insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process.

Internal Appeal

- Must be filed within 120 days of adverse determination by insurer
- Different personnel than those that made original determination must handle appeal
- 30 days to complete the internal appeal review

If internal appeal upholds denial, then notice must advise covered person of the right to an external appeal

External appeal

- Internal appeal process must be exhausted
- Must be filed within 120 days of date received notice of internal appeal decision (presumed received 5 days after mailing)
- Insurer must pay for the cost of the external review
- External appeals done by independent review organization
- Insured gets to choose IRO from list of IROs certified by Division of Insurance

External Review Process

- Within 5 days of notice of selection, IRO must notify insured, insurer and Division of Insurance of acceptance of review
- Additional information may be submitted to IRO within 7 days of notice of acceptance
- 30 days to complete IRO process
- Process solely for review of benefit trigger determinations

IRO certification

- Must establish that IRO non-biased and meet qualifications that include:

1. Use of qualified and licensed nonaffiliated health care professionals
2. Receive no compensation that is dependent upon the review outcome
3. Licensed health care practitioner must be qualified to certify individual is chronically ill

Clean Claims

"**Claim**," a request for payment of benefits under an in-force policy, regardless of whether the benefit claimed is covered under the policy or any terms or conditions of the policy have been met;

"**Clean claim**," a claim that has no defect or impropriety, including any lack of required substantiating documentation, such as satisfactory evidence of expenses incurred, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim.

Clean Claim requirements

- Clean claims must be paid within 30 days unless:

1. The insurer is declining to pay all or part of the claim and each specific reason for the denial; **or**
2. That additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary (when received triggers 30 day time frame)

Unpaid Clean Claims

- After 30 days has elapsed without payment or denial, then interest on claim at 1% per month beginning 45 days after receipt of clean claim
- No additional claim for the interest may be required (must be automatic)

Additional Recourse

- Anybody can file a complaint with or request assistance from South Dakota Division of Insurance including insured, insured's representative, or provider of long term care services
- Complaints can be filed at any stage of the claims process (DOI may await outcome of pending appeals before acting)
- Complaints may be filed whether or not internal or external appeals have been made

Division of Insurance

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