Long-term care insurance

Claims-handling practices used to deny claims can lead to staggeringly high punitive damages

By Terrence J. Coleman

For those who have practiced disability insurance litigation, the conduct of many long-term care insurance companies today is rather head scratching. Did insurers really learn *nothing* from all the multi-million-dollar punitive damage awards from juries across the country stemming from the wrongful termination of disability insurance claims? (See, e.g., *Chapman v. UnumProvident Corp.*, Marin County Superior Court, Jan. 23, 2003, Case No. CV012323 [$30 million punitive damage verdict]; *Ceimo v. General American Life Ins. Co.*, D. Ariz., Apr. 22, 2003, Case No. CV00-1386 PHX FJM [$79 million punitive damage verdict]; *Merrick v. Paul Revere Life Ins. Co.*, D. Nev., Case No. CV-S-00-0731-JCM-RJJ [$60 million punitive damage award]; *Ace v. Aetna Life Ins. Co.*, D. Alaska., Case No. J94-0018 CV [$16.5 million punitive damage award].)

In many ways, what is happening in the long-term care insurance arena mirrors what took place decades ago within the disability insurance industry, but on a grander scale. Like disability insurers in the late 1980s, who scrambled to sell high-benefit disability policies that were poorly underwritten, long-term care insurers did an even worse job in the late 1990s and early 2000s of underwriting their long-term care insurance products. As happened to disability insurers, the claims are finally coming home to roost, and long-term care insurers have adopted many of the same bad-faith claims handling tactics to stem the tide of staggeringly high claim payouts.

According to data published by the American Association of Long-Term Care Insurance, the sale of long-term care policies sharply declined in the early 2000s when carriers realized the unprofitability of the products they sold; and, predictably, claim payouts have steadily risen as the claims now pour in (See Figures 1 and 2).

Long-term care insurers forecast an exponential increase in claims over the coming years. A senior executive at Prudential Insurance Company, which stopped selling long-term care insurance policies in 2012, testified that Prudential anticipates that claims will steadily rise over the next 15 years. And as the number of claims is increasing, the number of claim *denials* is likewise increasing. As such, it is important to understand the key features of long-term care insurance policies, and the tactics that some insurers are adopting to avoid paying benefits.

Understanding the long-term care insurance product

In California, regulation of long-term care insurance is set forth at sections 10231 through 10237.6 of the Insurance Code.

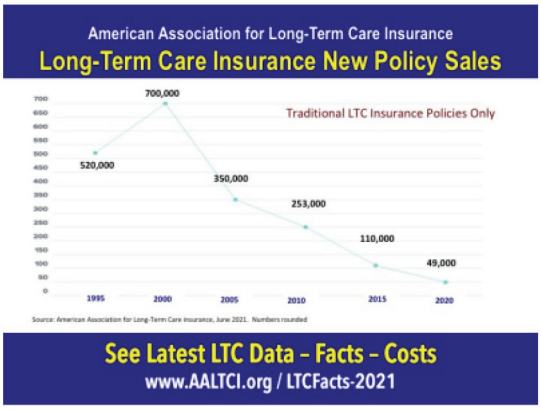

Figure 1: Annual Policies Sold

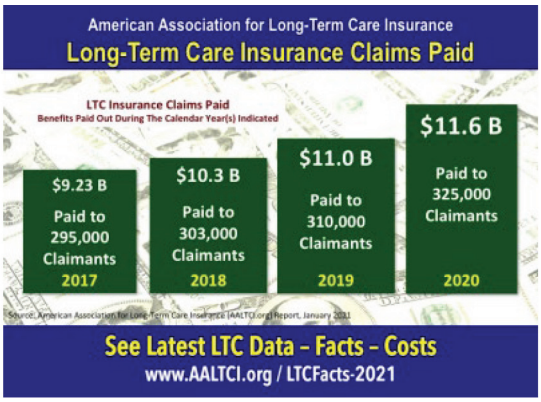

Figure 2: Claims Payments

Generally, long-term care insurance is designed to cover a host of services and expenses that are not covered by regular health insurance when the insured suffers from a chronic medical condition, disability or disorder, such as dementia. (See, § 10231.2 [defining long-term care insurance as providing coverage for "diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital"].)

Most policies will provide a set daily benefit for reimbursement of expenses incurred for the following types of care:

- **Nursing home care:** A facility that provides a full range of skilled health care, rehabilitation care, personal care and daily activities in a 24/7 setting.

• **Assisted living facilities:** A residence with apartment-style units that makes personal care and other individualized services (such as meal delivery) available when needed.
• **Home healthcare:** An agency or individual who performs in-home services, such as bathing, grooming or help with chores and housework.
• **Home modifications:** Adaptations, such as installing ramps or grab bars, to make the insured's home safer and more accessible.
• **Adult day care services:** Programs providing health, social and other support services in a supervised setting for adults who need some degree of help during the day.
• **Care coordination:** Assistance by a trained or licensed professional for determining needs, locating services and arranging for care. Policies may also cover the cost of training care providers.
Most long-term care policies trigger entitlement to benefits upon an insured suffering from cognitive impairment or being unable to perform two or more Activities of Daily Living ("ADLs") without assistance. ADLs refer to the following:
• Bathing, including the act of getting into or out of a tub or shower safely;
• Continence, including the ability to perform associated personal hygiene;
• Dressing;
• Eating, including being able to feed oneself;
• Toileting, including being able to get on or off of a toilet safely;
• Transferring, meaning the ability to move into or out of a bed, chair or wheelchair safely.

The typical LTC contract

A typical insuring agreement reads something like this:

We will pay a benefit for each day of Facility Confinement in a Nursing Facility or Residential Care Facility.

Payment will be the actual daily Facility Confinement charges you incur, up to the Daily Benefit shown on the Benefit Schedule. Benefits paid are subtracted from the Total Maximum Amount Payable.

Eligibility for Benefit Payment — You will be eligible for benefit payment for Qualified Long Term Care Services if:
• You are unable to perform, without Substantial Assistance, at least two Activities of Daily Living for an expected period of at least 90 days due to loss of Functional Capacity; or
• You have a Severe Cognitive Impairment.

The policy's benefit schedule will set forth the dollar amount of the daily benefit, the elimination period (the number of days that expenses must be incurred before benefits become payable), the maximum duration that benefits are payable including any maximum benefit caps, and the amount of inflation increases, if any.

Many policies, particularly those sold in the late 1990s, provide for *unlimited* lifetime benefits, with compound 5% annual COLA increases. For an insured suffering a chronic illness at a relatively young age, these policies can provide a significant amount of benefits. Further, the benefits provided are critically important and vital to the most vulnerable among us, typically the elderly who can no longer live independently. And for the adult children of such insureds, securing benefits under a parent's long-term care policy is critical to avoiding their own potential financial ruin. The cost of long-term care assistance is staggeringly high, particularly in California.

Some long-term care insurers have already implemented many of the same improper claims handling tactics that resulted in large punitive damage verdicts against disability insurers decades ago. We have seen the following:

Use of illegal policy provisions to deny claims

California law provides the minimum requirements for eligibility under long-term care insurance policies. Insurance companies are not permitted to contract around the statutorily required coverage. (*Mission National Ins. Co. v. Coachella Valley Water Dist.* (1989) 210 Cal.App.3d 484, 497 [The coverage provided by the Insurance Code sets the floor for coverage, but "[t]he insurance company, in drafting the insurance contract, had the right to enlarge coverage beyond the statutory language"].) Insurers can only contract to provide more or broader coverage, not less.

Insurance Code section 10232.8 sets forth various mandated provisions for long-term care insurance policies, including those that are intended to be "federally qualified" policies whereby premium payments are tax deductible and benefits, up to certain maximums, are tax free. Section 10232.8, subdivision (e) provides mandatory definitions of key terms and phrases found in such long-term care policies, by importing definitions found in guidance published by the Internal Revenue Service. Section 10232.8, subdivision (e) states:

> Until the time that these definitions may be superseded by federal law or regulation, the terms "substantial assistance," "hands-on assistance," "standby assistance," "severe cognitive impairment," and "substantial supervision" shall be defined according to the safe-harbor definitions contained in Internal Revenue Service Notice 97-31, issued May 6, 1997.

But some carriers try to skirt these mandatory definitions. "Severe cognitive impairment" is defined under the IRS Notice 97-31 as "loss or deterioration in intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia, and (b) measured by clinical evidence and standardized tests that reliably measure impairment in the individual's (i) short-term or long-term memory, (ii) orientation as to people, places, or time, and (iii) deductive or abstract reasoning." However, Prudential Insurance Company, for example, has issued long-term care policies in California requiring the presence of "severe cognitive impair-

ment" for benefit eligibility while purporting only to define the phrase "cognitive impairment" rather than the complete term "severe cognitive impairment." This would, in effect, serve to heighten the level of impairment necessary to trigger coverage by allowing the insurer to come up with its own definition of "severe." That is unlawful in California. The entire phrase, "severe cognitive impairment," has a statutorily mandated definition.

Sorry, the Insurance Commissioner approved it

Long-term care insurance policies issued in California must be reviewed and approved by the California Insurance Commissioner. (Ins. Code, § 10231.2.) Some insurers try to enforce otherwise illegal policy provisions by arguing that the Commissioner's prior approval of offending policy language makes them enforceable. Unfortunately, the Department of Insurance has an established track record of failing to actually review policy forms prior to permitting their use in California. (See, *Ellena v. Department of Insurance* (2014) 230 Cal.App.4th 198 at 208-209 [rejecting DOI's contention that it had no mandatory duty to review disability insurance policies prior to their use in California].)

In any event, approval by the Commissioner does not magically transform an illegal policy provision into a legal one. In *Frenzer v. Mutual Ben. Health & Acc. Assn.* (1938) 27 Cal.App.2d 406, the Court of Appeal long ago rejected an insurer's argument that its policy's limitation of benefits was enforceable because the policy had been approved by the DOI, even though the limitation conflicted with minimum requirements under the Insurance Code. The Court explained:

> Regardless of the fact that this particular provision and the policy itself was approved by the state insurance department does not prevent us from considering the matter, and stating that in our opinion the policy is misleading and does not conform to the requirements of the Insurance Act.

(27 Cal.App.2d at 414.)

The Court in *Frenzer* then reviewed the offending policy language, found it to be "violative" of various provisions of the Insurance Code, and declared that it "must therefore be held as invalid." (*Id.* at 415-416.) Simply put, slipping illegal policy provisions by the Department of Insurance doesn't make the provisions enforceable.

Use of deceptively worded claim forms to deny claims

The covenant of good faith and fair dealing requires insurers to thoroughly inquire into all possible bases to pay a claim before it is denied. (*Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 818-819.) The burden is on the insurer to seek out information relevant to a claim. (*Frommoethelydo v. Fire Ins. Exchange* (1986) 42 Cal.3d 208, 220; *Egan, supra*, 24 Cal.3d at 818-819; *Mariscal v. Old Republic Life Ins. Co.* (1996) 42 Cal.App.4th 1617, 1620; *Hughes v. Blue Cross of Northern California* (1989) 215 Cal.App.3d 832, 846.) This requires the insurer to communicate with the insured and her physicians in a "manner calculated to elicit an informed response." (*Hughes, supra*, 215 Cal.App.3d at 846.)

Despite this, some long-term care insurers have adopted deceptively worded claim forms in order to increase claim denials. One insurer has been found to send a "Cognitive Impairment Questionnaire" to assisted living facilities and treating physicians to complete. If the physician or facility does not check the box for "severe" cognitive impairment, and instead checks the box for "mild" or "moderate" cognitive impairment, then the claim is automatically denied without further investigation.

That is wrong, and this carrier knows that it is wrong. First, its own claims manual acknowledges that, "Labels such as 'severe cognitive impairment,' 'moderate cognitive impairment,' 'dementia,' etc. are not, in and of themselves, sufficient or reliable indicators of the degree of impairment." Second, its form *misstates* the standard for what constitutes a "severe" cognitive impairment. A "severe" cognitive impairment, according to the form, is where "24-hour supervision" is required. But that conflicts with the statutorily mandated definition of "severe cognitive impairment," which nowhere requires 24-hour supervision.

Abusive tactics designed to take advantage of vulnerable insureds

It is shocking to see the number of hurdles that vulnerable insureds must overcome in order to "perfect" a claim submitted to some long-term care insurers. Some carriers insist on monthly forms, signed by both the care provider and the insured or the insured's guardian, in addition to a care provider's certification of care, with a monthly invoice. Unless the forms are completed with 100% precision, the claim is automatically denied without further investigation. In one instance, a carrier denied benefits based on an obvious typo on the claim form.

In another instance, a carrier terminated benefits three years in a row, claiming that its 86-year-old insured, who had Alzheimer's disease and resided in an assisted living facility, no longer had "severe" cognitive impairment entitling her to benefits. Her son repeatedly called the insurance company to talk with someone in charge. But he could only talk to a carousel of call-center personnel, none of whom could speak meaningfully about the company's determination. He could never speak with anyone with substantive authority over his mother's claim, because the company's procedures do not allow claim representatives to speak with policyholders. Sharp tactics like this will inevitably lead to the imposition of punitive damages.

No doubt, many carriers are grappling with an onslaught of long-term care insurance claims. Some have beefed-up their claims departments in order to

appropriately manage claims and deliver on the promises that they made when selling their policies. Others have shipped off all claims-handling responsibilities to poorly trained and understaffed third-party administrators who are either unfamiliar with the covenant of good faith and fair dealing or, worse yet, disregard it.

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