Long Term Care Insurance: Policy Provisions in Dispute

by **Lisa S. Simmons** (Chicago)

Long term care ("LTC") insurance has been and will continue to be a focus of attention for the plaintiffs' bar and state and federal regulators. LTC insurance policies can be in effect for decades before claims are initiated. Policyholders, many of whom have paid premiums for years, only now are beginning to make claims. Increased claim activity inevitably leads to more disputes.

Commentators predict that litigation involving LTC insurance policies will increase dramatically as the population ages. In these cases, LTC insurers face potentially significant exposures, including class actions, statutory and bad faith claims seeking enhanced remedies, and regulatory inquiries. They also face unique challenges. Factually intensive claims decisions, as well as complex and varied benefit schemes involving a myriad of policy forms and regulatory environments, may require monitoring over time and can raise difficult coverage questions. In addition, LTC services have evolved. Changes in care options (such as the emergence of assisted living facilities and home health care, which may be more attractive to policyholders than traditional nursing homes) do not always fall within benefit parameters of LTC policies sold 15-20 years ago.

Compounding these challenges, plaintiffs' counsel have made inflammatory allegations that insurers prey on vulnerable senior citizens in marketing, premium-setting and rate increases, claims and coverage decisions, and lapsing policies for late premium payments. Claimants – elderly policyholders who planned for their futures and paid premiums for many years before filing claims – are especially sympathetic. Often, persons holding powers of attorney granted by policyholders ("POAs"), who were not involved in purchasing the policies, are the driving force behind the claims. Frequently, these POAs are emotional about the policyholders' entitlement to benefits, whether or not the claims are rationally based on policy terms.

This article surveys some LTC insurance policy provisions that have attracted recent litigation.

RATE INCREASES

Some of the earliest class actions filed against LTC insurance companies arose out of premium rate increases in the early 2000s. As LTC insurance companies began to implement these rate increases, policyholders filed class action complaints challenging them. Notwithstanding the insurers' clear right to request such premium increases and their approval by state regulators, plaintiffs alleged that insurers intentionally under-priced the policies to induce senior citizens to purchase the policies, while intending to increase the premiums later. Complaints in some of these earlier cases gained traction with the courts, resulting in settlements that provided class members with various insurance benefits. *See, e.g., Milkman v. American Travelers Life Ins. Co.*, 2002 Pa. Dist. & Cnty. Dec. LEXIS 94 (March 28, 2002); *Shaffer v. Continental Casualty Company*, 2010 U.S. App. LEXIS 726 (9th Cir. 2010).

In more recent cases, however, these complaints have not fared as well. Four U.S. federal circuit courts of appeal have affirmed dismissal of such complaints. *Flint v. MetLife Inc.*, 2011 U.S. App. LEXIS 26254 (6th Cir. Dec. 12, 2011); *Rakes v. Life Investors Ins. Co. of America*, 582 F.3d 886, 895 (8th Cir. 2009); *Crichton v. Golden Rule Ins. Co.*, 576 F.3d 392, 309 (7th Cir. 2009); *Alvarez. v. Insurance Co. of North America*, 2008 U.S. App. LEXIS 5182, *7-11 (3rd Cir. 2008). At least two courts have held that the filed rate doctrine compels dismissal of such complaints. *Flint*, 2011 U.S. App. LEXIS 26254, *7; *Armour v. Transamerica Life Ins. Co.*, 2012 U.S. Dist. LEXIS 8436 (D. Kan. Jan. 25, 2012). Indeed, in approving the class action settlement in *Shaffer*, the Ninth Circuit observed that the defendant insurer "had a strong defense to liability – the explicit language on the first page of [the] policies: 'We may change the premium rates.'" 2010 U.S. App. LEXIS 726, *5.

Nonetheless, policyholders continue to file lawsuits challenging premium rate increases. In April 2013, plaintiffs filed a class action complaint against Bankers Life, claiming it denied and delayed LTC insurance claims and breached its LTC policies by raising premium rates without improving benefits. *Bates v. Bankers Life and Casualty Co.*, Case No. 3:13-cv-00580 (D.C. Ore.). Defendant moved to dismiss the complaint on various grounds, including the filed rate doctrine and unambiguous policy language. That motion remains pending as of this writing.

In August 2013, following a rate increase, plaintiffs filed a class action against the California Public Employees' Retirement Fund ("CalPERS"), alleging it breached its contracts by misleading LTC insurance policyholders concerning the strength of its investment program.*Sanchez v. CalPERS*, Case No. BC517444 (California Superior Court, County of Los Angeles). Plaintiffs allege CalPERS "suddenly and unexpectedly" advised policyholders that its LTC insurance program was "grossly underfunded" and that it had stopped enrolling new members in 2009. [1]

MEDICAL ELIGIBILITY

Several recent complaints have involved standards for determining medical eligibility to receive benefits under LTC policies. See, *e.g., Lee v. Metropolitan Life Ins. Co.*, Case No 13-0203 (California Superior Court) (complaint alleging breach of contract, bad faith and statutory unfair competition, where defendant denied "cognitive impairment" claim made by policyholder with bipolar II disorder); *Lucchesi v. The Prudential Ins. Co. of America*, 9:13-cv-00486 (D. S.C.) (breach of contract, bad faith, and improper claims practices alleged, where defendant denied claim following a face-to-face assessment).

In another recent case, *Hull v. Ability Ins. Co.*, 2012 U.S. Dist. LEXIS 173487 (D. Mont. Dec. 6, 2012), plaintiff argued that to reduce claim payments and increase profits, defendant revised its definition of "continual supervision" to mean "that the insured requires and is provided continuous (round-the-clock) supervision from another person." Following trial, a jury returned a compensatory damage award of $250,000, damages under the Montana Unfair Trade Practices Act of $2 million and a punitive damages award of $32 million, which the district court later reduced to $10 million, in accordance with a state cap on such awards. *Id.*, *1-2. In otherwise upholding the punitive damages award, the court stated that "[d]efendants' wrongful and invalid termination of [plaintiff's] benefits to protect their profits by using 'more robust' claims handling practices establishes intent that is consistent with the purpose of punitive damages." *Id.*, *12.

While defendant based its definition of "continual supervision" on dictionary definitions for "continual" and "supervision," the judge allowed plaintiff's common law claims of bad faith and unfair trade practices to go the jury. The jury then heard argument that defendant had changed its claims standards for cost-saving reasons and treated "thousands of other" policyholders similarly. While some of this argument was patently inflammatory, *Hull* exemplifies the sympathy that may be felt by courts and juries in connection with such claim disputes. Medical eligibility questions present factually complex questions that may become problematic, particularly where treating physicians may be inclined to support their patients' claims.

LONG TERM CARE FACILITY COVERAGE

Many in-force LTC insurance policies sold in the 1980s and early 1990s were underwritten to provide coverage to insureds in skilled nursing facilities, i.e., traditional nursing homes. Since then, the focus of elder care has shifted to care at home or in residential assisted living facilities ("ALFs"). A variety of residential care facilities now exist to meet the demand for non-institutional elder care. Many are licensed and regulated, but some are not.

Such residential care facilities are an attractive alternative for persons needing limited assistance with daily living, but not yet in need of skilled nursing care. Policyholders sometimes submit claims for care at such facilities when the policies only cover confinement in skilled nursing facilities. Often such residential care facilities do not meet policy licensure or other requirements. In addition, these facilities may not provide, and in fact may be prohibited by state law from providing the level of nursing services that the policies require for coverage.

In yet another scenario, care facilities have developed in recent years that do not themselves meet the required level of care, but contract with outside entities to come in and provide "a la carte" services tailored to specific patient needs. The facility itself, however, does not meet policy requirements because it only provides basic services, such as room, meals, and possibly laundry or limited personal care services.

General provider definitions and coverage requirements, coupled with such expansions in care services beyond the drafters' original intentions, have generated policyholder disputes. Disputes have arisen, for example, over the meaning of "24-hour-a-day nursing services." Many courts have supported LTC insurer interpretations, requiring a nurse always to be present. *See, e.g., Milburn v. Life Investors Co.*, 511 F.3d 1285 (10th Cir. 2008); *McDermott v. Life Investors Ins. Co. of America*, 2007 U.S. Dist. LEXIS 84369 (W.D. Wash. Nov. 1, 2007).

However, some courts have parsed the words of policy provisions and related state regulations to give the insured a remedy or to find that factual questions preclude summary judgment. These courts did not seem sympathetic to the

reality that the insurers had drafted and priced their LTC policies under a commercial and regulatory environment that had changed substantially over time. Such cases demonstrate that with the emergence of new and alternative care choices, and of state regulations that did not exist at policy inception, coverage disputes can be expected.

HOME HEALTH CARE

Home health care ("HHC") is an expanding avenue of elder care, with a wide range of licensed and unlicensed providers. Some HHC policies track Medicare's restrictive home health care coverage requirements by, for example, reimbursing for custodial care only when provided in conjunction with skilled nursing care. Or, a policy might reimburse only for services provided by a Medicare-certified home health agency, or a state-licensed home health care agency.

These regulations may conflict directly with HHC care policy provisions, leading to coverage disputes. See, e.g., *Dunn v. Fortis Ins. Co.*, Case No. 04-09247 CA 31 (Florida) ("in light of the absence of a statutory entity known as a home health care agency and the lack of a definition in the policy of a home health care agency, the Court found the policy [to be] subject to different interpretations and . . . otherwise ambiguous).

See, *e.g., Fallow v. Bankers Life and Casualty Co.*, 2013 U.S. Dist. LEXIS 6347, *17 (D. Ore. Jan. 15, 2013) (where policy does not define "licensed or certified," court concludes phrase means "granted permission by any competent authority to provide home health care services").

A skilled nursing home policy may exclude or not otherwise provide coverage for ALFs, but may provide benefits for services provided in the insured's "home." Insureds have argued that the policy or statutory definition of "home" should prevail. In *Storfer v. Guarantee Trust Life Ins. Co.*, 2010 U.S. Dist. LEXIS 110282 (S.D. Fla. October 18, 2010), the district court granted summary judgment to plaintiff, stating "[t]here [was] no dispute . . . that [the ALF] is a licensed assisted living facility, legally operating in the state of Florida, and is providing 'custodial care' to [plaintiff] in his present 'home,' as defined in the Policy. [The ALF] meets the Policy definition of Home Health Care Agency because it is legally operated in the state of Florida, and is not an excluded [entity under the policy.]" *Id.*, *9-10.

In *Sherman v. Transamerica Life Ins. Co.*, 2012 U.S. App. LEXIS 10583 (11th Cir. May 25, 2012), plaintiff's HHC policy defined "Home" as where the insured resides, "other than" an ALF. The court held that the policy unambiguously excluded ALFs and therefore did not cover ALF expenses. *Id.*, *4. The court was not persuaded that ALF care is merely "home care" provided in a facility: "An ALF is a highly regulated environment with access to round-the-clock services, as necessary. . . . In her home, plaintiff's living arrangements are not regulated by the Department of Elder Affairs, and she had only part-time access to a home health aide on a pre-arranged schedule." *Id.*, *6-7, n.2; *see also Sawyer v. Transamerica Life Ins. Co.*, 2010 U.S. Dist. LEXIS 31210, *27-28 (S.D. Fla. 2010) ("[n]othing in [Florida regulation] declares that the policy issued by the Defendant is illegal, or that Florida law requires that insurers pay for their policyholders' decision to relocate to an assisted living facility").

Disputes have also arisen concerning the requirements for covered "independent" caregivers, or caregivers not affiliated with home care agencies. See, *e.g., Switzer v. Bankers Life*, Case No. 12 cv 2353 (N.D. Cal. Filed May 9, 2012); *see also Guerard v. Continental Casualty Co.*, 2009 U.S. Dist. LEXIS 88536 (N.D. Cal. 2009) (complaint dismissed where family member caregiver not covered unless employed by home care agency).

In light of evolving regulations, insurers should continue to be alert for conflicts between applicable regulations and policy provisions. Policyholders may seek to base HHC claims – particularly where older policies do not cover such care – under Alternate Plan of Care provisions. The carrier may also challenge a regulation's retroactive application. These issues are discussed below.

THE ALTERNATE PLAN OF CARE

Many LTC policies contain "Alternate Plan of Care" ("APC") provisions. An APC provision may provide that, if the policyholder would otherwise require confinement in an LTC facility, the carrier may in its discretion pay for services under an APC, even if the facility or benefits do not otherwise meet policy criteria. Because such benefits typically require that an APC be agreed to by the policyholder, the policyholder's physician, and the insurer, they are discretionary, i.e., not guaranteed. An insurer, for example, may agree to pay for special equipment in the home to enable a policyholder—who otherwise would need to be admitted to a nursing home—to remain at home. Or, the insurer may agree to pay for care in an ALF when no qualified nursing homes are available in a rural area.

For example, policyholders have claimed that facilities that are not otherwise covered under a policy be automatically covered as APCs, even where the carrier has not agreed to such coverage. Policyholders also have requested APC coverage for home health care where the policyholders elected not to purchase such benefits in the first place (and may not otherwise require confinement in an LTC facility). Finally, policyholders have requested APCs to obtain HHC services (in lieu of facility care) when the HHC benefit period has been exhausted.

To the extent such cases have resulted in published decisions, courts have enforced the mutuality requirements in APC provisions. *See Roland v. Transamerica Life Ins. Co.*, 337 Fed. Appx. 389 (5th Cir. 2008) (upholding denial of APC because policyholder, insurer, and medical provider failed to "mutually agree" upon APC terms); *Mansur v. PFL Life Ins. Co.*, 589 F.3d 1315 (10th Cir. 2009) (where policy required parties to agree on payment terms, no breach or bad-faith withdrawal of an offer, which had not been accepted); *Kneal v. Sentry Ins.*, 2009 WL 3283250 (D. Minn. Oct. 9, 2009) (no coverage because defendant must accept the alternative care plan before coverage is triggered).

Although not involving an APC provision, the Sixth Circuit enforced an analogous policy provision requiring an insured to request pre-certification to obtain coverage for an otherwise non-compliant nursing facility. *Crutchfield v. Transamerica Occidental Life Ins. Co.*, 2013 U.S. App. LEXIS 10566 (6th Cir. May 21, 2013) (where plaintiff's policy covered care in non-compliant nursing facility if insurers' "Personal Care Advisor pre-certifie[d] that the facility substantially complie[d]," district court did not err in concluding plaintiff failed to meet requirement where no evidence showed plaintiff requested pre-certification) .

In general, each APC request must be considered according to its own unique circumstances. Where it appears, for example, that an agent advised the policyholder that an APC might be agreed upon to obtain otherwise non-covered services, accommodations may be justified or difficult to refuse.

RETROACTIVE APPLICATION OF STATE LEGISLATION

As elder care has evolved, state laws and regulations governing long term care insurance have proliferated. Some of these laws and regulations require than LTC policies issued after their effective dates provide specific coverages or prohibit coverage limitations. Insureds and state regulators may seek to rely upon such laws and regulations, even though enacted long after a policy was priced, approved, and sold. In general, substantive laws operate prospectively unless the legislature expressly provides otherwise. Some courts, however, have held that renewal of a policy after a regulation's effective date constitutes a new agreement subject to regulations effective on that date.

In *Bushnell v. Medico Ins. Co.*, 246 P.3d 856 (Ct. App. Wash. 2011), for example, plaintiff brought an action for a declaration that the three-day-hospital-stay requirement in an LTC policy was invalid under a subsequently enacted Washington statute. In finding that this statute applied, the court concluded a new contract was formed "upon acceptance of each renewal premium." 246 P.2d at 862. According to the court, the "language of the policy [did] not indicate any intent that the original terms of the policy constitute one continuous contract or shall continue in force." *Id.* Notably, the policy at issue in this case was not a guaranteed renewable policy. The court said the result would be different where the policy stipulated the original agreement "continues in force." *Id.* The court also cited the policy's Conformity Clause, which read: "The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do not conform." *Id.* at 861.

Other courts have disagreed with this reasoning. In *Mann v. UNUM Life Ins. Co. of America*, Case No. 2012-CA-003133 (12th Judicial Circuit, Manatee County, Fla.), plaintiffs – who retired to and now reside in Florida – purchased their LTC policies in Connecticut. Connecticut approved premium rate increases on these policies, but Florida has not. In their class action, plaintiffs claimed the Connecticut rate increases implemented on their policies while they lived in Florida were illegal and sought refunds. Dismissing the complaint, the Florida court stated that each "renewal" was a "continuation" of the policy, not a re-issuance, because the policy was "guaranteed renewable" and contained "conditions for termination" (i.e., non-payment of premium). Plaintiff has appealed.

EXPANSIVE STATE REMEDIES

Finally, LTC insurers must be aware of expansive common law bad faith and state statutory remedies that exist outside insurance codes. For example, California has enacted an "elder abuse" statute. Cal. Welfare and Institutions Code §§15600 – 15657.7. This statute protects California residents age sixty-five and older from, among other things, "financial abuse." Financial abuse means taking an elder's property for a wrongful use, with intent to defraud, or through the exercise of undue influence. *Id.* at § 15610.30. Plaintiff's counsel bringing lawsuits concerning LTC insurance policies have been including purported claims under the "elder abuse" statute.

Notably, however, in a recent California case, a federal district court dismissed a policyholder's claim for "financial elder abuse" without leave to amend, finding that "neither the language of §15610.30 nor its accompanying legislative history indicate that basic denial of insurance coverage was ever contemplated as a form of 'financial elder abuse.'" *O'Brien v. Continental Casualty Co.*, 2013 U.S. Dist. LEXIS 114407, *17 (N.D. Cal. Aug. 13, 2013); *see also Temple v. Mutual of Omaha Ins. Co.*, 2013 U.S. Dist. LEXIS 10765 (D. S.C. Jan. 28, 2013) (granting summary judgment to defendant LTC insurer on bad faith claim where defendant complied with insurance code by paying claim within 40 days after all necessary information was received and never refused coverage); *Paulsen v. Ability Ins. Co.*, 906 F. Supp. 2d 909 (D. S.D. Oct. 27, 2012) (granting summary judgment to defendant on plaintiff's claim for emotional damages; "[w]hile [not paying benefits under an LTC insurance policy] is serious and allegedly committed against a particularly vulnerable member of society, none of defendant's acts arise to the level of atrocities").

As these cases suggest, insurance companies should consider legal challenges to bad faith and statutory claims providing for enhanced remedies, even in situations where the basic contract claim raises factual questions.

* * *

Within this challenging litigation environment, insurers issuing LTC policies continue to strive to react in ways that honor policy terms as written and priced, treat policyholders fairly and equally, and keep pace with commercial, statutory, and regulatory changes. As always, we continue to monitor developments in this area.