Long-Term Care
Insurance Update 2021

Jessica Loesing, Associate
John Moore, Associate

The information offered in this presentation does not constitute legal advice, and the specific advice of legal counsel is recommended before acting on any matter discussed in this presentation.
Overview

• Trends in Recent LTCi Litigation
  • Cognitive Impairment
  • Healing Ailments and Recert
  • Rate Increase
• Anti-fraud – Carriers Fight Back
• What’s Next in LTCi Litigation?
Part I

Recent Litigation Trends
PART I – Recent Litigation Trends

• The LTCi litigation landscape has continued to evolve
• During a positive economy, we saw declines in the number of LTCi lawsuits filed, and declines in class actions, even as the number of claims has risen
• COVID-19 has devastated the economy, and recovery has been slow
• Low interest rates have hurt reserve projections and LTCi block balance sheets, perhaps necessitating more or higher rate increase requests
• A bad economy, increased rate-increase activity and increased morbidity could create an environment ripe for a spike in litigation activity
Overview – Hot Topics in LTCi Litigation

• Cognitive Impairment Claims Litigation
• ADL Claims / Improvements / Healing Ailments and Litigation
• Rate Increase
Current Claims Litigation Issues – Summary

• General claims-based litigation risks continue to increase. Why?
  • Claims volume increases as insureds age
    ○ Claims become less commonplace and easy to decide – there are more “troublesome” or “gray area” claims
    ○ Increased opportunity for mistake
    ○ Lack of uniformity across claims determinations
  • Insureds who remain on claim for long periods of time need re-certification for benefit eligibility
    ○ Conundrum of what insureds are “receiving” for care versus what insureds “need” by way of plan of care
  • New facility types/facility changes as facilities trend towards being accommodating and “homes away from home”
Claims Litigation Dangers

- **Seemingly small issues become costly**
  - While only minimal benefits may be at issue, claims of bad faith, punitive damages, and elder abuse may create additional damages and risk
  - Different jurisdictions have different rules surrounding caps on damages. Some states have [no cap](#) on bad faith damages

*Insureds are generally sympathetic plaintiffs*
- For the most part, insureds are elderly and had respectable lives

- **Plaintiffs’ bar is becoming more sophisticated**
  - Plaintiffs’ attorneys are learning this product, and becoming intimately familiar with what to look for when selecting ideal candidates for litigation
Cognitive Impairment Claims

- Always more difficult to determine than ADL-based claims
- Just because they are more difficult to adjudicate does not mean that every cognitive claim should be automatically granted
- Difficult to administer when medical records are not abundantly clear and insureds do not reside in facilities where they are under constant supervision or on lockdown (i.e., in an intensive memory care unit)
- Cognitive claims may be mistaken for “one ADL” or “minimal” assistance type claims
- Uptick in litigation issues involving claims denials surrounding whether or not evidence of a cognitive impairment leads to benefit eligibility
What are the Potential Pitfalls?

• A diagnosis is not everything – insureds may not be able to get to a specialist to diagnose him/her
• Don’t rely on one or two pieces of evidence – need to consider the big picture
• Give family members’ concerns appropriate weight
• Doctors/facilities have not seen policy language
• **Claims examiners (especially those who have clinical backgrounds) and/or medical directors should review medical records closely**
  • Consider calling treating physician if records are inconsistent
  • Ask detailed questions of facility staff and those who know the insured
• MMSE scores are important, but should not be the sole basis for a decision
• Cognitive impairment usually (not always) worsens with time; delayed claims may result in a worsening condition by the time a claim is approved
The Healing Ailments and Recertifications

• Typically physiological claims based on need for assistance with ADLs
• Initial prognosis that insured will make some sort of recovery
• Claims are re-visited to determine whether the insured might have healed such that he/she is no longer benefit eligible
• Assistance with one ADL may be clear, but beyond that, assistance is not certain
• “Needs” assistance versus “Receives” assistance
• Medical records are just as important as facility records
What are the Pitfalls Here?

• The RN from the facility is an LHCP
• Is occasional assistance enough?
• What is “occasional?”
• Call the doctor – gather more information about the insured’s functional capacity; Has the insured really healed just because it was predicted that he would?
• Is “unable to perform” the same as “needs” or “requires” the assistance?
• How do you reconcile the doctor’s note with the RN’s information?
Rate Increases
Rate Increase Cases

- **Putative class actions challenging LTCi policy premium increases, starting in late 1990s and 2000s**
  - State/nationwide classes of thousands of policyholders
  - Sophisticated plaintiffs’ lawyers focused on this space
  - Potential for punitive damages
  - Cost of defense can be significant
  - Class action settlements (and losses) can be very expensive
Rate Increase Litigation – Common Plaintiffs’ Theories

• Insurers knowingly or “fraudulently” underpriced policies (low-ball theories or bait-and-switch)
• Insurers seeking rate increases should be responsible for their own alleged fraud/mistakes
• Policies were “experimental” / insurers held themselves out as experienced but did not know how to price products to shift risk of loss
• The “guaranteed renewable” language was rendered meaningless
• Policies will be “unaffordable” after an increase
• The purported “rate spiral” or “death spiral” leads to more frequent rate increases
Rate Increase Litigation – Common Defenses

• **Two central defenses to successfully obtain dismissal of these claims**
  • Policy’s express reservations of right to raise premiums
  • The Filed Rate Doctrine

• **Other defenses include**
  • Lack of reasonable reliance
  • Undisclosed plan to underprice for a long time, with the hope of future rate increases, is not plausible
  • Statute of limitations
The Filed Rate Doctrine

- A judicially created doctrine (federal and state courts)
- Limited case law in the LTC context, but generally accepted
- Prevents judicial attacks by policyholders on premium rate increases filed with or approved by regulators
- Generally applicable to claims predicated on both state statutory (i.e. consumer fraud, bad faith) and common law (i.e., fraud, breach of implied covenant) claims
- Often asserted at pleadings stage
Recent Developments
Newman – Relevant Facts

- Plaintiff elected Reduced-Pay at Age 65 option
- Higher premium before age 65; half the amount of pre-age 65 premium thereafter
- Policy warned Plaintiff that rates could increase in four places
In addition, you have selected the following flexible premium payment option: Reduced Pay at 65.

<table>
<thead>
<tr>
<th>Semi-Annual Premium Amount*</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Policy Anniversary at age 65</td>
<td>$ 3613.67</td>
</tr>
<tr>
<td>On and after Policy Anniversary at age 65</td>
<td>$ 3851.80</td>
</tr>
</tbody>
</table>
Newman – Relevant Facts

• Prior to age 65, 18% rate increase
• At age 65 policy anniversary, premium reduced by 50%
• When Plaintiff was 67 years old, premium increased 102% from the reduced rate
Newman – Plaintiff’s Claims

• Breach of Contract
  • Alleged policy precluded insurer from increasing premiums above her pre-65 level; claimed Option required locked-in premium after 65

• Fraud and Fraudulent Concealment
  • Alleged false statement in the option because insurer raised premium above pre-65 level

• Unfair and Deceptive Practices Under the Illinois Consumer Fraud Act
  • Alleged language of the Option amounted to a deceptive act or practice
Newman – Insurer’s Motion to Dismiss

• Breach of Contract
  • When read as a whole, the policy unambiguously and explicitly warned of the possibility of premium increase
  • Integrated contract

• Fraud and Fraudulent Concealment
  • Policy warned of increase
  • Insurer provided plaintiff with sufficient information to put her on notice and also provided opportunity to review and ask questions about materials she didn’t understand

• Unfair and Deceptive Practices Under the Illinois Consumer Fraud Act
  • Same argument as to fraud count
Newman – District Court Opinion

- Motion to Dismiss Granted; complaint dismissed March 9, 2017, without prejudice
- District Court enforced the unambiguous language permitting the rate increase; “[t]he Court will ‘not search for ambiguity where none exists’”
- Found no fraud or deceptive act as the policy alerted, in at least four places, that premiums could increase
Newman – 7th Circuit Opinion

• 7th Circuit reversed

• Held that the language used to describe the “Reduced Pay at 65 Option” payment option in the schedule page of the contract was ambiguous

• Court agreed that the Reduced-Pay excerpt in the Schedule Page could not be read alone, but found language reserving the carrier’s right to increase premium on a class-wide basis did not resolve the ambiguity

• The court also highlighted that class is not a defined term… “These passages do not resolve the ambiguity, because the word ‘class’ is undefined”
Carrier sought and obtained rate increases under group insurance policy
• Certain states granted larger premium increases than others

Policy contains language regarding rate increases
• “We cannot change the Insured’s premiums because of age or health. We can, however, change the Insured’s premiums based on his or her premium class, but only if We change the premiums for all other Insureds in the same premium class.”

Policy does not specifically define “premium class”
Plaintiff challenged the rate increases implemented by carrier

- Claims that the policy’s use of the phrase “premium class” means “the nationwide pool of insureds under the group insurance plan within a given age category”
- Claims that the carrier improperly increased his premiums because premium increases implemented varied on a state-by-state basis, based on regulatory approval or authorization
- Claims that carrier did not even seek the same rate increases in each state
- In short, claims that carrier was required to implement a uniform rate increase nationwide, or not at all

- Claims asserted for breach of contract, bad faith, violation of state consumer protection acts, fraud, fraudulent concealment, and declaratory and injunctive relief
Carrier moved to dismiss claim

- No breach of contract – insurer is required to seek state-by-state approval of rate increases and there is no contractual promise of uniform increases
- No fraud – didn’t represent that there would be no rate increases for insureds who bought inflation protection, didn’t represent that rate increase would be uniform, any failure to disclose the need to seek state-by-state approval of rate increases is not actionable
- Filed rate doctrine
- The plaintiff in *Gunn* relied heavily on the Seventh Circuit’s decision in *Newman* in support of his argument in opposition to a motion to dismiss filed by the carrier
• The district court rejected the plaintiff’s arguments and dismissed the complaint based on the filed rate doctrine.
• The plaintiff appealed the decision to the Seventh Circuit. *Gunn v. Cont’l Cas. Co.*, No. 19-2898 (7th Cir.).
• Following oral argument, the Seventh Circuit reversed the state court’s decision and remanded for further proceedings.
  • Whether the filed rate doctrine applies may depend on the applicable state law.
  • Directing the district court to determine the applicable state law, giving particular consideration to whether (1) law applicable to any insured is where that insured’s *certificate* is issued; or (2) whether all insureds governed by law governing the *group policy* at issue.
Part II

Carrier’s Combat Fraud, Waste and Abuse
Impact of Fraud, Waste, and Abuse

- **The cost of insurance fraud**
  - The FBI estimates that insurance fraud costs the insurance industry more than $40 billion per year – not even including health insurance
  - Average U.S. family pays between $400 and $700 per year in increased premiums as a result of fraud

- **Fraud can occur at every level of the process:**
  - Fraud in obtaining insurance
  - Provider fraud (false billing/over billing)
  - Claims fraud
Mitigating Fraud, Waste, and Abuse

- **Steps to detect and mitigate against claims fraud**
  - In addition to traditional tools such as surveillance, carriers have begun using more sophisticated, data-driven techniques to identify fraud in the claims process.
  - Data analytics allows carriers to identify historical “red flags” indicating the possible presence of fraud, and to identify incoming claims bearing those same markers.

- **What remedy when fraud is identified**
  - Stop ongoing claim payments (mitigation)
  - Repayment of payments already made as result of fraud (restitution)
  - These remedies have limits
Dallal – A New Remedy for Claims Fraud?

• Facts of Case (Lincoln Benefit Life v. Dallal, No. 16-cv-09307, C.D. Cal)
  • Joint comprehensive long-term care policy issued to the insureds, including coverage for home healthcare
  • Wife, as husband’s power of attorney, continued to pursue claims for LTC benefits under the policy despite being aware of husband’s cognitive impairment after surgery
• Fraud included:
  o Claim of cognitive impairments
  o Claim of required assistance with all ADLs
  o Wife filled out false provider documentation, impersonating caregiver approved by the carrier
    – Lied about care provided
    – Forged cash receipts
  o Husband feigned incapacity at his nurse assessments
  o Altered APS forms after signed by physician
Dallal – A New Remedy for Claims Fraud?

• Carrier filed lawsuit, seeking:
  • Declaratory Judgment that insured had not been entitled to benefits
  • To void the policy going forward as a result of claims fraud

• Court held that, under California law, carrier was entitled to void the policy going forward as a result of the fraud that had been committed
  • “It would be wholly inequitable to force Lincoln to continue insuring the Dallals, who have abused the claim process and Lincoln’s trust by submitting false claims under the policy.”
  • “Requiring a defrauded party to continue its contractual relations that are so immersed in fraud would be highly inequitable and unjust. The Dallals should not get a second chance to defraud Lincoln.”
Dallal – A New Remedy for Claims Fraud?

• **Significance**
  • Historically, rescission/voiding a policy was a potential remedy for *fraud in the inducement* (i.e., misrepresentations in an application for insurance)
  • Permitting a carrier to void policy for claims fraud:
    ○ Dissuades fraudulent conduct if insurance coverage may actually be required;
    ○ Allows insurer to avoid costs of additional monitoring for claims filed by known fraudsters;
    ○ Provides leverage for carriers attempting to recoup overpayments due to fraud
Part III

What’s Next?
Future of LTCi 2021-2025

- The impact of COVID-19 will be felt in the LTCi industry
- There will be immediate and measurable mortality and likely morbidity impacts
- Providers will be impacted forever
- Insured/family member behaviors will be altered
- Response from the regulatory community might provide opportunities
- Entire medical and health care industry will experience a new normal – telehealth, antiviral protocols, prevention processes, social distancing norms
Future of LTCi 2021-2025

• **Impact of COVID-19**
  • *Accelerated deterioration of an existing medical condition*, resulting from, for example, missed medical appointments, breaks in treatment, postponed operations, limited access to clinicians, and interruptions in medication schedules
  • *Prolonged hospitalization and respiratory rehabilitation* for those contracting COVID-19; Any muscle and functional loss due to hospitalization may be significant
  • *Functional deterioration* due to reduced mobility, being confined to their homes, and not being able to sustain their normal daily routines or recreational activities
Future of LTCi 2021-2025

• Impact of COVID-19
  • Psychological deterioration (e.g., fears, stress) due to imposed isolation, fear of being alone, the stress that comes from listening to the media, etc.; COVID-19 has created real isolation for many Americans, and particularly the elderly

• Interrupted caregiving is a natural outcome as both caregivers and care recipients are fearful of virus transmission; Home-care agencies report 30%–50% reduction in home-care client volume, across both paid and family caregivers; Without this vital support (e.g., food preparation and delivery, health checks, physical and mental stimulation and assessments, ADL and IADL help) deteriorating health status can come quickly; Moving to effective remote caregiving requires resources, a plan and expertise
Future of LTCi 2021-2025

• **What will be the impact on LTCi?**
  
  • **Fear of LTC facilities:** Nursing homes and assisted-living facilities might be perceived as places to avoid; The current crisis has heightened concerns about the health risks of living in a senior-housing facility; Many of these facilities are not accepting new residents; There has been extensive media coverage of the devastating impact of the virus on elder-care facilities
  
  • **Fear of home care:** Some seniors and their loved ones fear that bringing outside caregivers into their homes could increase their chances of contracting the disease; The home care industry is working hard to prepare and strengthen the trust in their caregivers and procedures, but this takes time; Some caregivers are also unwilling to go into homes at this time and are being asked to backfill positions in facilities
Future of LTCi 2021-2025

• **What will be the impact on LTCi?**
  • **Lack of action due to uncertainty:** In times of uncertainty, when there is no clear plan, people tend to delay decisions—even if they are critical decisions or if delaying them could have significant undesirable consequences
  • **Increased adaptability of the senior population with technology:** The current pandemic has forced many people to embrace newer technologies in order to maintain connection, whether it’s a videoconference with family members or a telehealth check-in with a primary care physician; We expect that increased acceptance of these technologies will lead to increased future utilization—in fact, we see a rise in requests for usage of Zoom videoconferences from insureds in their 80s
Lapse in a Post COVID-19 World

- Will things go back to normal, or will regulators have honed in on lapse issues coming out of COVID-19?
- When will folks have income coming in again such that they can afford premiums (let alone other things)?
- How forgiving should LTCi carriers be when policies lapse, generally?
- How lenient will insurers need to be when it comes to premium collection and lapse on a broad scale?
These hypotheticals are becoming more common, and lapse is becoming a “hot” litigation topic once more

**Hypothetical One**
- Insured is in a facility and currently has Alzheimer’s disease (diagnosed one month ago); Insured moved into facility one year ago
- Insured’s daughter just got around to cleaning Insured’s house and found the policy; Policy lapsed shortly after Insured moved into the facility; Lapse notices were sent to the TPD, who lives in a different state
- Daughter wants policy reinstated and benefits paid for the year that Insured has been in the facility; Daughter says that Proof of Loss requirement of policy allows for this
- Daughter says Insured was cognitively impaired for two years, but her impairment was not diagnosed until recently (i.e., no medical records showing impairment until one month ago); She says it is not fair to penalize her impaired mother
- What do you do?
Hypotheticals (continued)

- Hypothetical Two
  - Insured lived in a memory care unit of a facility for several years, but died this month
  - Insured’s daughter was cleaning out insured’s home and found the policy
  - Policy lapsed three months ago – it was on auto-pay from Insured’s account until Insured’s account ran out of money
  - Lapse notices were sent to the TPD, although unbeknownst to Insurer, the TPD (Insured’s brother) is also in a nursing facility and has Alzheimer’s disease
  - Daughter has medical records to show that her mother was cognitively impaired at the time of lapse
  - Do you make an exception?
Evolving Methods of Delivering LTC Continue to Pose Challenges

• The nature of LTCi and evolving nature of long-term care services can often lead to attempts to fit round pegs into square holes
  • Cutting edge facilities not contemplated by older policy language
  • Example: Insured receiving care in an ALF or a CCRC
    ○ If policy only covers nursing home care or home health care – is there coverage?
    ○ Is an ALF a “nursing home,” and does that vary from state to state?
    ○ Is an ALF or a CCRC the insured’s “home” for purposes of providing home health care
Contacts

Jessica E. Loesing  
Associate  
+1 215 988 2524  
jessica.loesing@faegredrinker.com

John M. Moore  
Associate  
+1 215 988 2750  
john.mooe@faegredrinker.com
Thank You