LITIGATION ISSUES IN LONG TERM CARE INSURANCE: REPRESENTING INSURANCE COMPANIES IN A COMPLEX AND DEVELOPING MARKET

By: Paul P. Bolus
Bradley Arant Boult Cummings, LLP
pbolus@babc.com
www.babc.com

I. INTRODUCTION

Long term care insurance ("LTCI") is an insurance product that allows consumers to insure against the risk of needing expensive nursing home care. As Americans are living longer and as medical costs increase, consumers have become increasingly motivated to seek LTCI. Simultaneously, Medicaid has applied more stringent restrictions on the ability of long term care patients with substantial assets to get government assistance, meaning that the average consumer will be unlikely to get Medicaid benefits as soon as long term care is needed. Consumers want to insure against these risks, and insurance companies are writing policies.

At the same time, however, serious uncertainties about the LTCI market exist. Because LTCI is a relatively new insurance product, underwriting criteria and claims patterns are hard to predict. It is difficult to price these policies effectively. Many early entrants to the field are now having to raise rates or restrict coverage. As a result, it should come as no surprise that long term care insurance issues are more frequently being litigated.

This paper will seek to address the primary issues relating to long term care insurance litigation from the perspective of the insurance company. After briefly examining the insurance product itself, this paper will proceed to examine the market forces that are creating uncertainty for insurers. The next section addresses common themes in LTCI litigation. Finally, this paper will conclude with a brief examination of emerging issues in LTCI litigation.

II. LONG TERM CARE INSURANCE

a. Traditional Health-Insurance Based LTCI

The traditional model of long term care insurance looks much like supplemental health insurance. The insurance covers certain expenses up to a maximum level in exchange for a premium. As always, the key to making these types of policies profitable is to set the premiums at a level that will suffice to cover the benefits that will have to be paid under the policies. As a general rule, early attempts at setting premiums resulted in serious underpricing.

This underpricing came from the fact that insurance companies miscalculated several different kinds of risks in pricing their policies. Initially, many companies thought that most consumers would allow their policies to lapse before ever claiming benefits. Actual claims far exceeded early estimates. Moreover, long term care costs increased faster than expected, meaning that more policies were paying out at higher rates than had been anticipated. In addition, some insurers priced their policies on the expectation that consumers would use LTCI as a “bridge” until the consumer qualified for Medicaid assistance; however, more insureds decided to keep paying premiums and making claims under the policies. In all of these areas, it could be said that insurance

companies failed to predict correctly the claims that would be made under their LTCI policies; however, some adverse effects have been caused by forces much more difficult to predict. For example, many early policies provided benefits for home health care. Even though these benefits were fairly narrowly defined, an entire home health care cottage industry has blossomed specifically to make claims under LTCI policies. Providers are tailoring their services to qualify as home health care providers and the value of the claims made by insureds in this area has far exceeded the insurance companies' initial estimates. While insurance companies have learned from these growing pains and are writing policies that may prove to be more profitable now, there is still a large number of policies in force that have very little likelihood of being profitable for insurance companies unless substantial price increases are allowed.

b. Asset-Based Long Term Care Insurance

Owing in large part to the lack of profitability from traditional LTCI products, some companies are looking at creating a form of long term care insurance that is asset-based. This new model is based on allowing a consumer to use the proceeds of a life insurance policy or annuity (the assets) to pay long term care expenses. The obvious advantage to an asset-based policy is that the consumer can still get the value of the money paid to the insurance company even if he or she never needs long term care.

An additional driving force behind the creation of asset-based policies is the Pension Protection Act of 2006, a law that allows holders of life insurance policies or annuities to withdraw money tax free to pay for long term care expenses. Because of this law, many insurance companies expect that consumers who want to protect their

assets will seek an asset-based policy. For a consumer with an existing annuity, adding a long term care benefit is a viable option.

It is unlikely, however, that asset-based LTCI will completely supplant traditional LTCI policies. Consumers that lack the means to purchase assets will not be able to take advantage of an asset-based policy. Moreover, many asset-based policies provide only limited benefits and are paired with a traditional policy that would pick up any amounts owed beyond the maximum benefit under the asset-based policy. The traditional model will continue to provide the paradigm for most consumers and providers of long term care insurance.

III. MARKET FORCES DRIVING UP LONG TERM CARE INSURANCE RATES

To understand the litigation issues facing providers of long-term care insurance, it is critical to appreciate that the cost of the insured risk – the cost of long term care – is increasing rapidly. The causes of this increase are myriad, but three are salient.

a. Demographic Shift

The baby boomers are beginning to face the onset of the diseases common to advanced age. Accordingly, the demand for long term care is almost certain to increase dramatically over the next decade or two. As baby boomers realize the likelihood of their need for long term care, they will increasingly look to purchase LTCI to offset the costs. The problem for insurers is that the benefits that are sufficient to meet a consumer's long term care needs today will be insufficient as inflation and demand-driven price increases take effect. Consumers are insuring today against risks that they will likely not face for another ten or twenty years, and insurance companies have to try

to price their policies with their best guess of what long term care insurance will cost when claims are made.

For many insurance companies, more LTCI policies means more losses. Many insurers have not found a way to make these policies profitable without drastic increases in premiums. However, some scholars expect an off-setting trend to emerge. For example, some see "propitious selection," a new theory that predicts that risk-averse people are both more likely to purchase insurance and less likely to make claims on their insurance, as a market force that will return LTCI policies to profitability. According to this theory, as long term care insurance becomes more common, the rise in the amount of premiums from policyholders will outstrip the growth of claims. *See* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE. L.J. 1223 (2003).

In conclusion, the demographic changes present insurers with a vast potential market for long term care insurance policies, but several insurers have not found dependable ways to make these policies profitable because they cannot accurately predict the costs of long term care in the future. While there may be some stabilizing market forces that cause LTCI policies to steer back towards profitability, there is nothing that currently suggests that the present policies, without significant premium increases, will be a good investment for insurers. As a result, policies are becoming more expensive.

b. Rise in Nursing Home Litigation Costs

Long-term care facilities face rapidly increasing litigation costs. Litigation expenses cause costs to rise in two ways. First, litigation costs, both in terms of paying

defense costs and satisfying adverse judgments, decrease profitability and drive many for-profit firms from the market. This point must not be understated, as a report in 2005 showed that every nursing home in Florida had, on average, five lawsuits pending against it and that Florida nursing homes paid over $1.1 billion in damages in 2001. Annual liability costs per bed nationally exceeded $2,500. Litigation costs are ubiquitous but not trivial, and companies are exiting the markets. Of special note is the rise of class actions in the long term care field, as plaintiffs have become more adept at pleading class-wide injuries stemming from understaffing or budgeting instead of bringing common negligence actions that are rarely suited for class-wide resolution. While nonprofit long term care providers are striving to meet the existing demand, the current supply of long term care beds is decreasing relative to demand. This relative decrease is causing prices to rise.

A second cause of rising prices is that litigation operates as a kind of *de facto* regulation of the long term care industry. If a provider is found liable for certain conduct, it must eliminate that conduct and prevent similar instances from recurring. Other providers will follow in an attempt to avoid liability. As a result, even those providers that survive potentially ruinous litigation face higher operating costs. Furthermore, the cost of liability insurance increases because insurers are rightly concerned about having to pay large judgments on behalf of their insureds. In Florida, for example, each long term care facility is required to carry at least $1 million of professional liability insurance, but some insurance companies are charging premiums near $1 million for coverage that complies with the state law. In some instances, the annual premiums *exceed* the maximum indemnified loss. All of these costs are passed along to consumers.

c. Regulation

Insurance regulation is almost exclusively handled at the state level, so there are few laws of general application that merit discussion. However, the National Association of Insurance Companies (NAIC) regularly propounds model rules and regulations that have a noted impact on state departments of insurance and legislatures.[1] A proposal from the NAIC is a bellwether for changes in state-level regulations.

In particular, the NAIC has recently considered changing Section 7 of the NAIC's Long Term Care Insurance Model Act, the section that address incontestability. The current version provides that an insurer cannot rescind a policy that has been in effect for two years or more without showing that the insured knowingly and intentionally misrepresented material facts relating to the insured's health. The proposed change would make the incontestability standard even more onerous for insurance companies, requiring them to prove by clear and convincing evidence that the insured committed intentional fraud that was material to the acceptance for coverage and that the fraud was related to the same preexisting condition for which the insured seeks benefits. California has adopted the new rule. *See* CAL. INS. CODE § 10232.3(d). Furthermore, even if amending Section 7 would have only a small effect on the majority of clams made under LTCI policies, the intent of the modification – making it more difficult for

[1] Every state has adopted some form of the NAIC's model rules or model act relating to LTCI, but each state tweaks the provisions to its liking. As a result, it is critical to consider the laws and regulations of each individual state and not to rely solely on the NAIC.

insurance companies to avoid paying benefits under LTCI policies – is clear and will lead to higher costs for insurance providers.[2]

Other regulations, such as NAIC Model Regulation No. 641, which established limitations on the ability of insurance companies to change LTCI rates and requires, in some instances, that the insurance company either lower its rates or increase its benefits if a rate increase is more profitable (*i.e.*, leads to greater "excess premiums") than expected. Florida adopted this rule and several insurance companies subsequently stopped writing new business in Florida as a result.

The net effect of new proposed and adopted regulations has been increasing the burden and cost of providing long term care insurance. While each regulation will usually have some provision that is favorable to insurance companies, and while it is true that the costs of providing long term care insurance were seriously underestimated in the last decades, most insurers find these changes detrimental to their business.

d. Conclusion

The high degree of volatility in the price of long term care creates corresponding challenges in providing insurance at profitable rates. There is also significant volatility in the price that an insurance company can charge for its long term care policies, volatility that stems both from market forces and from regulatory actions. As long as this two-headed volatility persists – and it will be around for a long time – there will be a ready supply of potential litigants. The next section of this paper will attempt to examine both the over-arching trends in long term care insurance litigation and highlight specific areas where rapid or interesting developments are occurring.

[2] A recent report by the State of Florida stated (perhaps "understated" would be more accurate) that "representatives of the [insurance] industry did not seem immediately receptive to [the idea of establishing a strict two-year incontestability cut off with no exceptions]."

IV. LITIGATION

Trying to analyze "litigation" is like trying to analyze "the economy" or "literature." In order to get a good grasp of what is happening in courtrooms across the country that is affecting long term care insurers, it is necessary to break litigation down into manageable categories. The broadest categorical distinction to be drawn is between private litigation – *i.e.*, litigation involving private parties, like individual insureds and insurers – and public litigation – *i.e.*, litigation brought by a governmental or regulatory body that affects parties beyond just the parties to the case.

a. Private Litigation

In the category of private litigation, it is most helpful to further subdivide the analysis into who is bringing the claims. The prototypical case is a suit by an insured (or putative insured) against an insurance company. Other areas to be considered are reinsurance litigation and class actions, with the latter existing on the blurry line between private and public litigation.

i. Insureds v. Insurers

1. Disputing Claims

Litigation by insureds against insurers is the most common type of litigation facing companies that provide long term care insurance. These types of suits usually arise when the insurer denies coverage or benefits to a claimant. Plaintiff insureds commonly allege breach of contract and bad faith. Because these suits arise out of individual transactions, there is little to distinguish them from bad faith or breach of contract suits arising out the denial of a claim under a supplemental or major health insurance policy. Liability hinges on specific facts relating to the merits of the insured's

claim and the manner in which the insurer investigated the claim and communicated its findings to the plaintiff. Another factor insureds must take into consideration is how state regulation may expand the coverage of a policy.

In many states, courts are less willing to find instances of bad faith than they used to be. Where the difference between breach of contract and bad faith may have been treated as a question of degree in the past, courts have increasingly separated the concepts of breach of contract and the tort of bad faith into clearly distinct claims. The standards for proving breach of contract are stable and not onerous, but plaintiffs bringing a bad faith claim must prove that an insurer had enough evidence to pay a claim and yet denied it. While a broadly-accepted test for what conduct rises to the level of bad faith has not gained acceptance, the conceptual shift toward viewing bad faith as a tort has created a recent trend away from findings of bad faith in insurance claim litigation, especially where the insurance company relies upon a reasonable interpretation of its policies. *See Shelter Mut. Ins. Co. v. Barton*, 822 So. 2d 1149 (Ala. 2001) (holding that an insurer is liable for bad faith only where it either had no basis to refuse a claim under the insurance contract or it intentionally failed to determine if such a basis existed); *White v. American Cas. Ins. Co.*, 756 N.E.2d 1208 (Mass. App. Ct. 2001) (holding that an insurance company that relied upon plausible interpretation of insurance contract cannot ordinarily be held liable for unfair claims settlement practice). In light of this emerging trend, the best practice is for insurance companies to focus on complying with their claims review procedures. Where these procedures are followed, it will be very difficult for a potential plaintiff to allege that the company acted in bad faith.

It should be noted, however, that a denial of benefits under an LTCI policy may expose the insurer to enhanced liability, including consequential damages. As is the case with health insurance policies, a denial of benefits under an LTCI could prevent a plaintiff from getting long term care. While, relative to the costs associated with treating cancer, long term care costs are low, insurers should be aware that their denial of benefits may result in a court ordering the insurance company to pay the reasonable costs of a successful plaintiff's long term care.

Also relevant in any discussion of damages is the fact that elderly plaintiffs can often both arouse great sympathy from a jury and be eligible to receive heightened damages because of their age. The elderly are a vulnerable demographic and the general public is sensitive to any perceived mistreatment. For example, the New York Times ran an article by Charles Duhigg on March 26, 2007 entitled "Aged, Frail, and Denied Care by Their Insurers" that highlighted the plight of people whose claims for long term care insurance benefits had been denied. As a result of this perception, and even though the compensatory damages flowing from a denial of benefits in the LTCI context may be low, the prospect of punitive damage awards can drastically increase an insurance company's exposure to potentially massive verdicts. In California, for example, senior citizens have a statutory right to seek treble damages for claims alleging unfair business practices in any context, including insurance. *See* CAL. CIV. CODE § 3345; *Hood v. Hartford Life & Accident Ins. Co.*, 567 F.Supp. 2d 1221 (E.D. Cal. 2008) (applying § 3345 against a provider of long term care insurance).

Finally, insurers must be aware that state regulations can often force a policy to provide more coverage than originally intended by the insurer, creating liability where

the insurer did not expect it ex ante. For instance, in Arizona, a "long term care" policy must provide coverage for at least twenty-four consecutive months. Ariz. Rev. Stat. § 20-1691.03(c). Even though an insurer provided for a maximum benefit under its policy, the court forced it to provide benefits, no matter the cost, for 24 months because the policy was considered a "long term care" policy by the court. *Rowe ex rel. Rowe v. Bankers Life and Cas. Co.*, 572 F.Supp. 2d 1138 (Sept. 17, 2008). The Court also ruled that a limitation on benefits was invalid because it did not comply with the requirements of the "long term care" policy regulations. The policy limited benefits to a maximum amount per "period," that reset after the insured did not require treatment for six months. Because the limiting term was not properly labeled per the "long term care" regulations, it was invalid.

Rowe and *Hood* are good examples of the increased risks associated with LTCI and particular state laws. It is likely that the insurer in *Rowe* did not value the policy based on the expanded coverage implemented by the court's decision. When drafting LTCI policies, insurers must carefully consider the applicable regulations and other regulations that courts might find applicable. If an insurer can comply with multiple regulations that may be deemed applicable, it decreases the risk of a judicial expansion of the scope of coverage. Because of the recent nature of LTCI policies and the extended time-frame in which claims can be made, insurers must carefully consider the terms of their policies. It is inevitable that insureds will sue when their claims are denied. However, through careful drafting of policies and implementation of procedures, insurers can limit their liability to denied claims.

2. Disputing Rates

Because of the high degree of volatility in the market for long term care insurance, insurers are increasing the rates they charge or are canceling policies. To the surprise of no one, these actions are leading to litigation. Unfortunately for insurers, these claims are similar for every policyholder. Accordingly, they are brought as class actions and will be discussed below.

3. Disputing a Duty to Insure

Another interesting area of law that is developing in the LTCI field is growing out of plaintiffs claiming that an insurance company wrongfully denied their applications for insurance. For example, in *Neily v. CALPERS*, 2004 WL 3030069 (N.D. Cal. Dec. 21, 2004), the court upheld summary judgment in favor of an insurance company that declined to insure a couple where the husband had diabetes and the wife suffered from polio. In the court's view, the potential insurer based its decision not to insure on medical data, actuarial principles, and actual experience. Because the insurer was able to show that its decision was based on "actual and reasonably anticipated experience," the court found that the plaintiffs' claims could not proceed to trial.

The *Neily* case highlights two important points. First, as the court specifically discussed, long term care insurers face a tough burden of showing that their underwriting criteria are satisfactory. Because LTCI is so new, the depth of statistical data that exists for other insurance products (automobile or life insurance, for example) simply do not exist. Without these historical data to provide a clear record of "actual experience," insurers have to rely upon what they think "reasonably anticipated experience" will show. While this different standard is not so difficult that insurers will

routinely be found liable violating it, it is a more difficult standard to meet than the "actual experience" standard.

The second lesson to learn from *Neily* is that providers of long term care insurance must keep very careful records to document all client interactions, from receipt of initial forms all the way through the claims process or termination. Because the insurer in *Neily* had records that could show what it reasonably anticipated the claim experience of the plaintiffs to be, it could meet the burden required by the court. Especially because the statistical data is relatively immature compared to other insurance products, long term care insurers must keep thorough records.

In conclusion, while most plaintiffs have been unsuccessful in holding a company liable for refusing to insure them, the fact that these types of claims are being brought shows the wide spectrum of litigation that long term care insurers are facing from individuals.

4. Disputing Definitions: "Nursing Home" vs. "Assisted Living"

The distinction between "nursing home" and "assisted living" facility must be carefully drafted if an insurer hopes to limit the type of facility its policies cover for the duration of the policy. Current litigation shows that insurers are relying on state regulations to define what type of facility is governed by their policy. Although the decisions to date have favored insurers, medical treatment will surely change during the life of these policies such that the distinctions drawn between "nursing home" care and "assisted living" care will become less clear. Inevitably, regulations will also vary. To

avoid costly litigation with individual policyholders, insurers need to carefully consider how they define the terms that govern what facilities are covered by their policies.

The potential ambiguity in these terms and reliance on malleable state regulations create a potential for litigation. In *Gillogly v. GE Capital Assurance Company*, the 10th Circuit relied exclusively on Oklahoma regulations to determine whether a facility was covered under a LTCI policy where the policy referred to state licensing regulations. 430 F.3d 1284 (10th Cir. 2005). The policy provided for care at a "Nursing Home" which was defined as a facility "licensed . . . to engage primarily in providing nursing care and related services to inpatients." The Court relied on the fact that in Oklahoma, the facility was registered as a "resident care home" rather than a "nursing facility." If Oklahoma were to change its licensing regulations, the coverage of this policy could be greatly expanded.

In *Geary v. Life Investors Insurance Company*, the court granted summary judgment in favor of the insurer where the plaintiff sought coverage for an "assisted living" facility and the policy only provided for "nursing home" care. 508 F.Supp. 2d 518 (N.D. Tex. 2007). The court, however, recognized that the policy was "dependent on" state licensing rules. By relying on state regulations to define the terms of the contract, the insurer creates the possibility that many more facilities will be covered under the policy than intended by the insurer.

Assisted living facilities, as they are known today, did not become widespread until the 1990's. If a LTCI policy was written prior to the emergence of the assisted living facility and did not properly exclude these facilities from its coverage, the insurer might find itself paying for care at facilities it never intended to cover. Similarly, if

today's LTCI policies are not carefully drafted; the next method of long-term care might unexpectedly be covered by a policy resulting in more harm to an already unprofitable policy. For example, as we discussed above, insurers did not anticipate the creation of a home health care industry. States can easily update their regulations to accommodate new methods of treatment, whereas, the policies will be fixed as of the time they are issued. In a subsequent opinion in the Tenth Circuit, Judge Henry noted that "predicting the kind of facility" where a policyholder will need services will become more difficult as medical technology improves. *Milburn v. Life Investors Ins. Co. of Am.*, 511 F.3d 1285 (10th Cir. 2008). Insurers need to carefully draft the definitions of facilities covered by LTCI policies to avoid litigation that attempts to expand the intended scope of the policies. With respect to existing policies, open-textured definitions are already forcing insurers to litigate the scope of coverage.

Against the backdrop of the rule of *contra proferentem*, insurance companies attempt to draft policies to avoid any ambiguity; however, because many policies make reference to underlying state regulations that are in flux, it is not always possible for even carefully drafted policies to escape a judicial finding of ambiguity.

5. Fraud for the Actions of Agents

A theory common to almost all types of insurance litigation is liability for the insurer based on fraudulent misrepresentations of agents. 4 Lee R. Russ & Thomas F. Segalla, Couch on Insurance, §56:11 n.77. LTCI insurers will not escape this theory of litigation. Especially in the light of premium increases that are and will be required to keep these policies profitable, insurers will face claims that policyholders were fraudulently induced to purchase the policy. Claims for fraudulent inducement are

common in the health insurance arena. *See e.g., Mehaffey v. Boston Mutual Life Ins. Co.*, 31 F. Supp. 2d 1329 (M.D. Ala. 1998) (remanding claim for fraudulent inducement to state court). These types of claims are of particular concern because of the availability of punitive damages. Finally, as this paper discusses below, these types of claims are starting to arise against LTCI insurers in the class action context which substantially increases the insurer's exposure to liability.

ii. Reinsurance Litigation

The next area of private litigation requires less explanation because the issues it presents are not unique to long term care insurance. Because insurers are uncomfortable with the degree of risk in their long term care insurance portfolios, they seek reinsurance. As recent events have shown, financial institutions are prone to underestimate the risk in their portfolios. Whenever reinsurers are forced to pay, litigation is likely to ensue.

iii. Class Actions

The most ominous development for insurance companies in the LTCI field is the prospect of class action litigation relating to increased premiums. As we have discussed, there is tremendous pressure to increase premiums on LTCI policies. As companies succumb to this pressure, litigants are bringing class actions alleging fraud and bad faith against insurance companies. Plaintiffs are arguing that the insurance company fraudulently induced the plaintiffs to purchase the policies. They allege that the policies were fraudulently underpriced to increase sales when the company had every intention of raising the premiums. Another claim is that representations by the insurer created an obligation to maintain premiums at the original price. For example, in

Carl v. North Carolina, the plaintiffs alleged that the insurer made representations that the LTCI premiums "would remain 'level'" and that increases in the premiums violated those representations. 665 S.E. 2d 787 (N.C. Ct. App. Sept. 2, 2008); *see also, Landau v. CAN Fin. Corp.*, 886 N.E. 2d 405 (Ill. App. Ct. 2008). Although there are not a lot of these actions pending around the country, they will only become more frequent as policyholders are squeezed between ever increasing premiums and a sluggish economy.

Indeed, in April 2009, American Heritage Life Insurance Company and Mutual of Omaha Insurance Company settled a Missouri class action of this type for an estimated potential value of $15,000,000. In that case, the plaintiffs alleged that the insurers used low premiums to entice customers while intending all along to implement steep rate increases. In another case, a putative class of 150,000 individuals claiming they were fraudulently induced to purchase a LTCI policy survived a motion to dismiss in Federal Court in Iowa. *Rakes v. Life Investors Insurance Company*, 2007 WL 2122195 (N.D. Iowa July 20, 2007). The plaintiff alleged that the insurer sold the LTCI policies with knowledge that the premiums would have to be increased. Over a period of four years, the insurer raised the premiums on the plaintiff's policies by thirty percent, forty percent, and thirty-five percent. For every dollar in original premium, the policyholders were paying $2.45 after the increases. The plaintiffs alleged that the insurer always intended to "pass the cost of the defective under pricing back to the plaintiffs." The plaintiffs' allegation focused on the underwriting procedures of the insurer. They claimed that the lapse rate was set too high, that the failure to conduct health evaluations created a risky premium class, and that the insurer failed to disclose the risk of "closing the block" to

the policyholders. As more companies are forced to increase premiums, close the block, and send books of business into a "death spiral," actions like *Rakes* will become more frequent.

These cases are instructive on two levels. First, the allegations of the plaintiffs are instructive as to what insurance companies might face in litigation. Second, they highlight the possibility that many of these class actions – like the Missouri action – will be litigated in state court. Because insurance policies vary from state to state, the putative class of plaintiffs will likely fall within a single state. Assuming plaintiffs' counsel can find a diversity-destroying defendant in the forum state, it will be difficult for the insurer to remove the case to federal court.

The removability of class actions involving LTCI policies will hinge on the district courts' application of the Class Action Fairness Act. Plaintiffs that limit their class to policies sold within a state will have a strong argument that federal courts should not exercise jurisdiction. The district courts cannot exercise jurisdiction over class actions where two-thirds of the plaintiffs reside in the same state and at least one defendant resides in the state that significant relief is sought from and whose conduct forms a significant basis of the claims. 28 U.S.C. § 1332(d)(4)(A). It is likely that insurance brokers in the state will have made representations that form the basis of the complaint. Of course, class actions based on nation-wide classes will be removable to federal court. *See e.g., Rakes*, 2007 WL 2122195.

If an insurer thinks that increased premiums will be the panacea to an unprofitable policy, it must consider the litigation risks. This form of litigation is not very

developed, but it is rapidly emerging as a large risk for insurers with under-priced policies.

b. Public Litigation

Apart from private litigation, insurance companies should be aware that states and other administrative bodies have the power to bring suits against companies in the long term care insurance field. While public litigation is not yet widespread, recent events have taught us to prepare for doomsday scenarios. It is not too far of a stretch to imagine that an insurer weakened by recent financial problems and suffering from an underperforming book of LTCI business could attract the attention of a crusading attorney general when it attempts to raise its premiums. Indeed, in 2001, the attorney general of Texas filed an action on behalf of 10,000 insureds against two major insurers alleging that the insurer failed to disclose the fact that premiums rates could increase. The attorney general of Iowa has an active fraud investigation pending against long term care insurers.

Attorneys general are most concerned with consumer protection issues, especially rate increases that make insurance unaffordable for existing policyholders. Unfortunately, rate increases are ongoing and are likely to continue, meaning that rate litigation will continue. Insurance companies must emphasize to their clients from the very beginning of the sales process that LTCI rates are subject to change and that rates have been rising. Clear and well-documented disclosures immunize a company against the most damaging public litigation and can do much to avoid private litigation as well.

One area where insurers have recently been seeking protection is the filed rate doctrine. Under the filed rate doctrine, entities required to charge a rate set by the

government are entitled to a presumption that the rate charged is unassailable by litigation. The issue to consider when raising the filed rate doctrine as a defense is that the industries to which the doctrine has historically applied – public utilities – are even more heavily regulated than the insurance industry. Only where an insurance company can show that it is heavily regulated will it get the benefit of the filed rate doctrine.

Every state requires insurers to notify the state's department of insurance of the premiums charged on its policies in force in that state. In states where the department of insurance requires nothing more than mere notification, the filed rate doctrine has not been employed as a successful defense. However, other states, including important LTCI jurisdictions like California and Florida, require that the department of insurance actually approve the premiums charged. In these "approval" jurisdictions, where insurers are already subject to public regulation of the rates they charge, the filed rate doctrine is an important defense that insurance companies have used successfully. In the insurance context, it is perhaps more accurate to call the filed rate doctrine the "approved rate" doctrine, as only those states that require public approval allow insurance companies to get the benefit of a presumption that the filed rate is acceptable.

V. Emerging Issues

As we have repeatedly emphasized, long term care insurance is new and filled with uncertainty. It could be argued that *all* issues in LTCI are emerging issues; however, some potential developments on the horizon stand out as particularly noteworthy.

a. Governmental Involvement

The political landscape in this country is changing. President Barack Obama has endorsed the expansion of the federal government's role in expanding seniors' access to long term care, and it appears that Congress is following his lead. In March of 2007, the House Committee on Energy and Commerce called Conseco and Penn Treaty, two important companies in the LTCI industry, to testify about why they were paying so few LTCI claims. The two insurers had to produce documents outlining their claims procedures and showing substantial justifications for denying claims. While there has been no Congressional action taken yet, it is reasonable to expect expansive federal regulation before long.

Even if Washington does not engage in regulation, the states are heading towards a Medicaid funding crisis arising from the likely increase in long term care costs. If current predictions hold true, seventy percent of Americans will require long term care before they die. Under the current system, it is unlikely that the states will be able to afford their current Medicaid obligations as more and more citizens need long term care. As a result, either the states or the Federal Government is likely to rework the current approach. The solution they reach will almost certainly lead to greater government involvement. To an even greater extent than is true now, consumers purchasing long term care insurance will be looking for a gap-filling solution, not insurance under which they plan to make claims for years on end.

The net result should be that long term care insurance will be increasingly regulated. Insurance companies will face fewer common law suits and more regulatory actions.

b. Tension in Equity Markets

The recent Wall Street problems have taken a heavy and very public toll on insurance companies. It is unclear to what extent the confidence of investors in the soundness of asset-based insurance has been shaken, but it is safe to assume that any lack of confidence will lessen the wide acceptance of asset-based long term care insurance and will keep most consumers focused on the traditional model. Asset-based insurance will fill a niche market, but will have a hard time gaining wide acceptance.

Moreover, because asset-based policies straddle the line between insurance and investments, it is possible that the investment side of these policies will prove insufficient to meet the costs of claims made under the policies. Ironically, the asset-based policies may turn out to be a greater liability to insurance companies because the policyholders did not appreciate that their insurance benefits could be affected by changes in equity markets. Raising rates on traditional plans has led to large amounts of litigation; certainly litigation will arise when an insured discovers that the expensive asset he purchased (assume an average annuity of $50,000) is insufficient to meet his needs. The extra volatility of the equity market will combine with the existing volatility in the long term care market and many insureds will not be willing to take on the extra risk.

c. Independent Trusts

One insurance company, Conseco Senior Health Insurance Company (Conseco Senior"), has taken an innovative approach to dealing with its existing unprofitable long term care policies. It created, after lengthy discussions with the Pennsylvania Department of Insurance, an independent trust into which it transferred roughly 144,000 long term care policies. The trust, capitalized with Conseco Senior reserves at the

outset, will receive the premium payments from the policyholders whose policies the trust holds. Part of the advantage of creating the trust for Conseco Senior is that it allows Conseco Senior to charge off the losses from its long term care insurance policies at once instead of having them hanging around in their financial statements. The other potential effect, and the one that has drawn much attention, is that the policies held by the trust are effectively cut off from the rest of the Conseco Senior risk pool.

Unsurprisingly, this idea has attracted a lot of attention. At least one prominent plaintiff's attorney organized a grassroots campaign in Pennsylvania to prevent the creation of the trust. Even though his efforts were unsuccessful and the Pennsylvania Department of Insurance allowed Conseco Senior to create the independent trust, the firestorm surrounding the creation of the trust is sure a signal that the trust has the attention of the state DOIs. And – because Conseco Senior was successful in creating the trust in Pennsylvania – it is reasonable to expect more insurers in more states to attempt to replicate the trust model. It is too early to tell, but this development could have far-reaching implications in the LTCI market.

VI. Conclusion

It is easy to understand why an insurance company would decide to get out of the long term care insurance business. Many policies have been historically under-priced and are now unprofitable. The push to move these policies out of the red has spawned individual, class-wide, and increasing public litigation. Potential ambiguities in policy language linger and cause uncertainty about how the policies will be interpreted by courts in the future. Regulation is ongoing and likely to continue. The underlying risk

the policies insure against – the cost of long term care – is rising quickly and shows no sign of slowing.

Insurance companies, however, are in the business of taking risks. Companies will find ways to serve their insureds and to make a profit. New policies are performing much better than older policies, both for the insured and the insurer. As insurers become more adept at pricing their policies and as underwriting criteria become more established and reliable, much of the uncertainty will dissipate. Until then, a major factor in the success of insurance companies in the long term care insurance industry will be the ability of insurers to get favorable decisions in the courtroom. Litigation provides a backdrop against which regulation and legislation occur. Through this period of instability in the industry, core issues will continue to be litigated across the country.