TORT TRIAL & INSURANCE PRACTICE

Committee News

Defending Liberty Pursuing Justice

Spring/Summer 2009

HEALTH AND DISABILTY INSURANCE LAW COMMITTEE

THE DEFENSE PERSPECTIVE: THE RISE OF LONG TERM CARE INSURANCE LITIGATION

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Long Term Care Insurance ("LTCI") issues are being more frequently litigated. Understanding the LTCI market and cases already filed can help insurers avoid and mange this litigation.

Few insurance markets are facing greater uncertainty than the LTCI sector. Because LTCI is a relatively new insurance product, underwriting criteria and claims patterns are hard to predict. Early efforts to price the policies missed the mark for a variety of reasons, including increases in nursing home care costs, increases in health care costs, an aging population, and other unforeseen pricing issues. This too low pricing has caused insurance companies to request rate increases. Some Departments of Insurance have not been willing to raise rates to the degree requested, which has caused the business not to be profitable for some carriers. At the same time, massive demographic changes are raising demand for long term care. State and Federal regulatory bodies are taking strong actions in the field and more regulation can be expected.

Two types of cases highlight some of the challenges facing long term care insurance providers. The first type addresses the high burden an insurer must meet to deny applications for long term care insurance. In *Neily v. CALPERS*, 2004 WL 3030069 (N.D. Cal. Dec. 21, 2004), for example, a federal court in California found that the insurers properly denied plaintiffs' applications for insurance because they relied upon "medical data, actuarial principles, and actual experience." While the court upheld the insurers' actions, the standard that the court imposed is a high one – especially in light of the fact that "actuarial data" and "actual experience" are both relatively thin data sources at present. Long term care insurance is a relatively new product and this relative novelty has led to uneven claims experience. It is important, therefore, for insurers to keep rigorous records of

Continued on page 12

IN THIS ISSUE:

The Defense Perspective: The Rise Of Long Term Care Insurance Litigation 1

Message From The Chair 3

The Plaintiff's Perspective: Recent Legislative And Regulatory Developments In Long Term Care Insurance. 3

An Organic Condition Is Required To Avoid Disability Plan's Mental Illnes Limitation 5

American Recovery And Reinvestment Act Of 2009 6

Fourth Circuit Upholds Dismissal Of Insurer's Claim For Rescission Even Though Insured Obtained Policy For Fraudulent Purpose . . 7

2009 TIPS Calendar 13

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MESSAGE FROM THE CHAIR

It was very nice to see many of you at the January 2009 35th Annual Mid-Winter CLE conference in Bonita Springs, Florida. Our committee presented seminar sessions regarding long-term care insurance coverage and tier-rating of health insurance policies. Both of these sessions were well-attended and very well received. Many thanks to the speakers at the conference: Mary Beth Senkewicz, Joseph Whatley, Paul Bolus, Ginger Busby, and Irma Solares. A special thank you goes to Hisham Amin, who served as a moderator for both panels. Next year, the conference will be at the same location, the Hyatt Regency Coconut Point Resort and Spa in January 2010.

After the Mid-Winter CLE conference, our committee received approval from ABA-TIPS to reprise the long-term care insurance coverage seminar at the ABA Annual Meeting in Chicago on August 1, 2009 titled: Long-Term Care Insurance-An Important Coverage Comes of Age in the New Millennium at the Hyatt Regency Chicago. We hope to see as many of you as possible in Chicago for what should prove to be another wonderful program. Paul Bolus, Joe Whatley, and Carol Mihalik will be the speakers. Please make every effort to attend the Annual Meeting and participate.

The Committee is now turning its attention to the recruitment and development of general members to become more involved in Committee leadership as Vice Chairs, Committee Chairs, and Program Chairs for the August, 2009-2010 year. We need to increase the ranks of active leadership so as to secure the future effectiveness of the Committee by bringing new and energetic leaders practicing in health and disability insurance law, whether they are in private practice, in-house, plaintiff or defense. Of equal importance for next year will be the recruitment of people interested in serving as subcommittee members and program chairs for future Mid-Winter and Annual Meetings. Service in such a position provides valuable experience for Committee members interested in consideration for a higher leadership position in the future with the Committee. Please contact Joe Hamilton, the current Membership Chair, at jhamilton@mirickoconnell.com if you are interested in becoming more involved with the Committee in leadership.

At the Annual Meeting in Chicago, my term will end and the leadership of this Committee will fall to the able hands of Josh Bachrach, the current Chair-Elect who has many good ideas for the Mid-Winter Meeting and beyond.

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THE PLAINTIFF'S PERSPECTIVE: RECENT LEGISLATIVE AND REGULATORY DEVELOPMENTS IN LONG TERM CARE INSURANCE

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The demand for long-term care services will surge in coming decades when the baby boomers reach their 80s. Declining family sizes, increasing childlessness, and rising divorce rates will limit the number of family caregivers. Rising female employment rates may further reduce the availability of family care, increasing the future need for paid home care. This study projects to 2040 the number of people ages 65 and older with disabilities and their use of long-term care services. The simulations show that even under the most optimistic scenario long-term care burdens on families and institutions will increase substantially.

R.W. Johnson, D. Toohey, J. Weiner, "Meeting the Long-Term Care Needs of the Baby Boomers," Urban Institute Discussion Paper 07-04 (September 17, 2008).

Under these circumstances, it is not surprising that Long Term Care Insurance ("LTCI") has garnered significant recent attention from the media, state departments of insurance, the federal government and various insurance organizations including the National Association of Insurance Commissioners ("NAIC"). However, because it is a relative newcomer to the insurance marketplace, we have only recently begun to see significant developments in case law. This paper defers a discussion of the limited judicial decisions and instead examines current LTCI issues being addressed by various state and federal legislative and regulatory bodies.

LTCI Introduction

The general purpose behind LTCI coverage is to help with costs associated with long term care services such as home health care, respite care, adult day care, nursing home care, and other assisted living care. In its short history, LTCI coverage has gone through various stages of product development, but most LTCI policies are currently structured around the same types of benefits and related options:

Most policies provide comprehensive coverage for care in nursing facilities as well as care in home and community settings; however, earlier policies covered only nursing facilities;

Benefits are typically paid on a daily basis (average benefits ranging from $30 to $100 a day) for a specific benefit period (ranging from one year to lifetime coverage);

An elimination period establishes the length of time the policyholder receiving long-term care and satisfying benefit "triggers" has to wait before the carrier will begin making payments (generally ranging from one to three months);

Inflation protection increases the maximum daily benefit and ensures the daily benefit remains consistent with the costs of care;

In addition to receiving long term-care, the insured must meet additional benefit "triggers" such as a specified degree of functional disability or cognitive impairment requiring supervision.

Many consumers who purchased LTCI in its infant stages are only now in a position of needing some form of long term care.

United States Government Accountability Office Report & Congressional Hearings

In July of 2008, the United States Government Accountability

Continued on page 8

AN ORGANIC CONDITION IS REQUIRED TO AVOID DISABILITY PLAN'S MENTAL ILLNESS LIMITATION

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In a recent ERISA decision, *Grace Miller v. The Prudential Ins. Co. of Am.*, No. 07-60882-CIV, 2008 WL 4540998 (S.D.Fla. Oct. 9, 2008), the United States District Court for the Southern District of Florida upheld the insurer's termination of benefits under the mental illness benefit limitation provision because the plaintiff was unable to demonstrate that her mental disorder was of organic or physical origin.

Prudential approved Miller's claims for short term and then long term disability benefits on the basis of "major recurrent and severe depression." The Plan limits benefits to 24 months for disabilities caused by mental illness. Citing this provision, Prudential terminated the plaintiff's benefits after 24 months. Following unsuccessful administrative appeals, Miller filed suit under ERISA. Prudential moved for summary judgment.

The court explained that based on the Supreme Court's ruling in *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109, 109 S.Ct. 948 (1989), the Eleventh Circuit had developed a six step analysis intended to guide district courts in their review of benefit claims under ERISA. *Williams v. BellSouth Telecomms., Inc.*, 373 F.3d 1132, 1138 (11th Cir. 2004). The six-step *Williams* analysis specifically provided for a conflict of interest inquiry, which in case of a conflict, required review under a heightened arbitrary and capricious standard of review. *Id.* Based on the interim ruling in *MetLife v. Glenn*, ___ U.S. ___, 128 S.Ct. 2343 (2008), the court acknowledged that the use of the heightened arbitrary and capricious standard had been overruled, and that the conflict was now "but one factor to consider in deciding whether the fiduciary abused its discretion."

With this backdrop, the court turned to the policy language in this case and found that the it conferred discretion upon Prudential pursuant to *Newell v. Prudential Ins. Co. of Am.*, 904 F.2d 644 (11th Cir. 1990). The court noted that the Plan also granted Prudential discretion in determining the applicability of the mental illness limitation provision. ("Disabilities, which, as determined by Prudential are due in whole or part to mental illness have a limited pay period during your lifetime.").

In its subsequent analysis of Prudential's termination, the court confirmed that Miller's initial claim had been submitted and approved solely due to severe depression. Miller had received continued treatment for depression and anxiety; yet had also provided some evidence suggesting that an organic illness may have contributed as a cause of her depression. As such, the court identified the "threshold question" as whether it was reasonable for Prudential to invoke the mental illness limitation at the end of the 24 month period despite the presence of some evidence suggesting the possibility of an organic injury which may have contributed, at least in part, as a cause of her depression.

Focusing on the specific language of the mental illness limitation provision, the court found that it limited coverage for disabilities attributable solely to a mental condition, as well as those where the disability was attributable in part to a physical condition, and in part to a disabling mental condition that spanned the entire 24 month period. As the Policy did not include a definition of "mental illness," however, the court found the provision to be ambiguous as to whether a condition was "mental" based on its symptoms or based on its etiology. *Miller*, 2008 WL 4540998, at *8. Applying the principle of contra proferentem to the provision based on *Billings v. UNUM Life Ins. Co. of Am.*, 459 F.3d 1088 (11th Cir. 2006), the court determined that an organic based illness, irrespective of its mental symptoms and/or manifestations, would always fall outside of the mental illness limitation.

Significantly, the court then applied the burden of proof rules articulated in the Policy to the question whether the medical evidence in this matter supported an organic based illness. As such, it required the claimant to show by objective evidence that a physically based or organic illness or condition prevented her from performing the duties of "any occupation." *Miller*, 2008 WL 4540998, at *8.

Based on the evidence in the administrative record, the court determined that it was not unreasonable for Prudential to find that Miller had not met this burden. Notably, the court focused on the

Continued on page 8

AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

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Prior to the enactment of the American Recovery and Reinvestment Act of 2009, employers with twenty or more employees offered continuation coverage to employees and dependents who lost coverage under the employer's group health plan due to a termination of employment, reduction in hours of service or other "qualifying event." COBRA coverage generally is available for eighteen months from the date coverage is lost, but is extended in certain circumstances and can terminate for, among other things, non-payment of premiums. Importantly, under COBRA, employers were not required to pay any portion of the COBRA premium and, thus, employees and dependents electing continuation coverage generally paid the entire COBRA premium to continue coverage.

The American Recovery and Reinvestment Act of 2009, signed into law by President Obama on February 17, 2009, contains significant changes with respect to COBRA coverage seemingly designed to alleviate some of the financial burden on employees. Notably, employees who were/are involuntarily terminated between September 1, 2008 and December 31, 2009 (and their qualified beneficiaries) may be entitled to a subsidy of 65 percent of the premium for a period of up to nine months. Thus, the eligible employees are only required to pay 35 percent of the premium under the plan. Employers would recover the 65 percent of the premium not as an upfront payment, but as a credit against their income tax withholding and FICA taxes. The IRS will have to provide additional guidance on how exactly this reimbursement process is to work.

The subsidy, however, is reduced if the individual's modified adjusted gross income exceeds $250,000 (for joint return filers) or $125,000 (for all other filers), and is otherwise eliminated if the individual's modified gross income exceeds $290,000 (for joint filers) and $145,000 (for all other filers) for the year in which they would receive such a subsidy.

Furthermore, among other things:

- there is an extended COBRA enrollment period beginning on the date of enactment of the Act and extending 60 days after the plan administrator provides proper notice of the extended election period;
- eligible employees are provided with a 90 day period to elect a benefit coverage option different than the one they were enrolled in as of the date of involuntary termination;
- subsidy payments begin March 1, 2009 and the maximum subsidy period ends 1. after nine months; 2. the individual becomes eligible for Medicare; or 3. the individual becomes eligible for another group insured medical plan (even if they do not enroll).
- new COBRA notices must include certain information delineated in the Act, including a statement advising the recipients of the availability of premium reductions.

If an individual's request for the subsidy is denied, he or she may generally appeal the decision to the Department of Labor. The Department of Labor must rule on the request within fifteen business days.

The Department of Labor has issued model COBRA notices to help employers explain to former employees how to take advantage of the premium subsidy. The new model notices may be found at: http://www.dol.gov/ebsa/COBRAmodelnotice.html

Lastly, a failure to comply with the notice requirements will be deemed a failure to provide adequate COBRA notification under the existing COBRA penalty provisions under ERISA and the Internal Revenue Code.

FOURTH CIRCUIT UPHOLDS DISMISSAL OF INSURER'S CLAIM FOR RESCISSION EVEN THOUGH INSURED OBTAINED POLICY FOR FRAUDULENT PURPOSE

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In the recent case of *First Penn-Pacific Life Insurance Co. v. Evans*, the Fourth Circuit Court of Appeals upheld the district court's dismissal of an insurer's rescission claim on summary judgment. No. 07-2020, 2009 WL 497394 (4th Cir. Feb. 26, 2009). In *Evans*, the insured engaged in a scheme whereby he obtained several life insurance policies and sold them to third-party viatical settlement brokers under the pretense that he was terminally ill. The insurer in this case, First Penn-Pacific Life ("First Penn-Pacific"), discovered the insured's scheme after the insured had transferred the policy to a third-party. First Penn-Pacific attempted to rescind the policy, on the basis that the insured had failed to disclose to First Penn-Pacific the existence of the policies he had previously obtained from other insurance companies, by sending a rescission letter to the third-party with a premium refund check. The third-party refused to cash the check and argued that First Penn-Pacific could not rescind the policy. In response, First Penn-Pacific filed a lawsuit seeking to rescind. After ensuing litigation in federal and state court and after filing a subsequent lawsuit in federal court, the United States District Court for the District of Maryland dismissed First Penn-Pacific's claim on summary judgment.

On appeal, First Penn Pacific argued that the district court improperly dismissed its claims because (1) the insured had no "insurable interest" (i.e., "an interest in having the insured life persist") in the policy at the time it was procured, and (2) the third-party who held the policy manifested its consent to rescind the policy when the third-party's representative (i.e., the "title holder" of the policy) endorsed the check over to it (i.e., the "beneficial owner" of the policy). The Life Insurance Settlement Association ("LISA"), the self-described "leading trade association promoting consumers' option to sell their life insurance policies on the secondary market," filed an amicus curiae brief supporting the district court's decision. LISA argued that a life insurance policyholder's right to assign his or her policy in exchange for market value would be "fundamentally diminished" if a life insurer was allowed to void such a policy on the basis of finding no "insurable interest" after assignment had occurred. It also argued that adopting First Penn-Pacific's position would "impose unjustified legal impediments upon the secondary market for life insurance," which would ultimately harm policyholders. Although LISA condemned the allegedly fraudulent conduct of the insured at issue in this case, it noted that First Penn-Pacific missed its two-year window, under the Arizona incontestability statute, to challenge the validity of the policy and that it should not be allowed to "bootstrap its fraud case on to the Arizona insurable interest statute based on its belief that such suits survive the incontestability period."

The Fourth Circuit rejected both of First Penn-Pacific's arguments, holding that the district court was correct in dismissing its claim. First, it found that the district court properly determined that the insured had an "insurable interest" in the policy when he obtained it. Notably, the court found that, despite the insured's "subjective" (and fraudulent) intent to transfer the policy at the time it was procured, the fact that no third-party was actually involved in obtaining the policy was significant. The court held that an "objective test" must be used to determine the existence of an "insurable interest," noting that using a "subjective test" – one based on the insured's actual intent – would "be unworkable and would inject uncertainty into the secondary market for insurance." Therefore, the court found, only where a third-party is involved in the insured procuring a policy will an "insurable interest" be eliminated. Second, the court found that the parties had not agreed to rescission solely, because the third-party's representative had endorsed the check over to First Penn-Pacific. In reaching its decision, the court again applied an "objective" test. It found that the fact that the third-party never cashed the check, and the fact that the third-party had always maintained rescission was improper were controlling.

The Fourth Circuit's decision in *Evans* is significant because the

court ignored the insured's underlying fraudulent conduct – both the scheme to transfer policies under false pretences and the failure to disclose the existence of other policies on policy application – in dismissing First Penn-Pacific's rescission claim. *Evans* certainly operates to protect third-party holders of insurance policies, such as LISA's members, and policyholders' right to negotiate the value of their policies on the secondary market. *Evans*, however, may place life insurers desiring to rescind policies (for valid reasons) in a catch-22 where the insureds have transferred the policies and the third-party holders of the policies refuse to assent to the rescission.

ORGANIC CONDITION...

Continued from page 5

plaintiff's own treating physicians' opinion that the plaintiff was left capable of sedentary activity with certain restrictions that would have permitted her to return to her regular occupation. *Miller*, 2008 WL 4540998, at *9. The court explained that it was further reasonable for Prudential to either extrapolate a physical ability to work in a sedentary occupation from the plaintiff's physicians' statements that she "objectively demonstrated the functional capacity to participate in her activities of daily living at a sedentary level", or to accord more weight to the contrary opinions of its own physicians regarding her functional capacities. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831, 123 S.Ct. 1965 (2003).

Finally, the court returned to *MetLife v. Glenn* in its analysis of the last factor of the *Williams* analysis — whether the insurer's conflict of interest tainted its decision, thereby rendering it unreasonable. The court evaluated the record for "malice, self dealing, parsimonious claims granting history, or other circumstances suggesting a higher likelihood that the structural conflict affected the benefits decision." *Miller*, 2008 WL 4540998, at *9. Being unable to find any evidence of that kind, relying on *Wakkinen v. UNUM Life Ins. Co. of Am.*, 531 F.3d 575 (8th Cir. 2008) and *Daic v. Hawaii Pacific Health Group Plan for Employees of Hawaii Pacific Health*, No. 06-17324, 2008 WL 3862074 (9th Cir. Aug. 13, 2008), the court assigned the conflict factor "a low importance rating." As it also did not locate any evidence of procedural irregularities or improprieties, the court did not find a close balance of factors for the conflict of interest to act as a tiebreaker in favor of a finding of an abuse of discretion. As such, it upheld Prudential's termination of Miller's claim.

PLAINTIFF'S PERSPECTIVE...

Continued from page 4

Office ("GAO") submitted its report to Congress regarding LTCI. The GAO report was completed at the request of a bi-partisan group of Senators and Representatives who wanted to examine the frequency with which LTCI customers were experiencing the denial of benefits and/or significant rate increases.

The GAO report concluded rate increases for LTCI policies fluctuated widely from state to state and plan to plan. For example, one company cited in the report repeatedly raised premiums, resulting in a cumulative increase of more than 70 percent since 1991, while another company had raised premiums only once since 1975. While the report recognized that rate stability standards had been adopted by some states, a large number of LTCI consumers remain unprotected from significant rate increases. The report also concluded state regulators need more time to analyze whether the enactment of rate stability standards will have a significant effect on moderating future premium increases

The GAO report also examined claims settled by LTCI insurers in ten states. The report found that standards for the timely payment of consumer claims varied significantly by state, with "timely" being defined as five days in one state, forty-five days in another, and one state did not have a timeliness requirement. The GAO also reported that some states are considering implementing an appeals process for adjudicating disputed claims.

In summarizing the GAO report, Representative John D. Dingell, Chairman of the House Committee on Energy and Commerce, stated:

The GAO's findings and our own Committee staff's investigation have identified troubling weaknesses in the states' ability to

Continued on page 10

SAVE THE DATE

Join TIPS at the ABA Annual Meeting
July 30-August 4, 2009 - Chicago, IL

Program on Issues Arising from Attorneys Suffering from Depression
Saturday, August 1, 2009 - 8:30am - 10:00am

This program will delve into the various aspects of the problems facing attorneys and law firms, arising from attorneys who suffer from depression.

Long-Term Care Insurance-
An Important Coverage Comes of Age in the New Millennium
Saturday, August 1, 2009 - 2:00pm - 3:30pm

This program will discuss Long-Term Care Insurance, which is becoming a more popular and important form of coverage as the population ages and lives longer. In addition, it will examine the growing costs of long-term care.

Register for the Annual Meeting & TIPS CLE Programs at:
http://new.abanet.org/annual/default.aspx

PLAINTIFF'S PERSPECTIVE...

Continued from page 8

protect consumers from abusive practices. If the insurance industry is not up to the task of correcting these problems swiftly and treating vulnerable policyholders and their families fairly then Congress will need to consider steps to ensure strong, uniform national standards. Our oversight hearing will lay the groundwork for urgently needed reforms in the industry and at the state and federal levels.

Senator Barack Obama echoed Representative Dingell's concerns:

> Many Americans are spending thousands of dollars on private long-term care insurance, and yet when they need help the most, they often face lengthy waiting periods and wrongful denials of claims. We must take steps to strengthen oversight of this industry, ensure claims processes are consistent and fair, and guarantee that benefit packages offer the financial protection promised.

Contemporaneously with the GAO report, the House Committee on Energy and Commerce held a hearing to address various practices associated with LTCI. The hearing witnesses included consumer and industry advocates, Commissioners of Insurance and officers of the largest LTCI insurers.

The Commissioners were consistent in their testimony that the principal LTCI complaints concerned claims-handling practices or rate increases. While each Commissioner recognized states' efforts to stabilize rates, New York Commissioner John Dinallo expressed his concern that LTCI rate projections remain "imprecise," thus, further analysis of industry-based data is necessary to determine the full effect of rate stabilization efforts.

The industry executives also recognized consumers' concerns with LTCI claims practices and rate increases. After pointing out that Conseco paid over 98 percent of submitted claims totaling over $750 million a year, John Wells, Conseco's Senior Vice President for long term care, testified that mistakes had occurred in the claims handling systems. Consequently, according to Mr. Wells, Conseco was committed to investing $27 million dollars between 2006 and 2009 to implement system and process improvements. With respect to rate increases, Cameron Waite, Executive Vice President, Penn Treaty American Cooperation, testified that Penn Treaty had been "challenged" by the fact that many of its older policies were underwritten based upon inaccurate claim expectations as a result of incorrect data relating to lapse, mortality and morbidity rates.

III. State Government Enforcement

In May 2008, state insurance regulators, working with the National Association of Insurance Commissioners (NAIC), entered into a regulatory settlement agreement between 40 jurisdictions and Conseco arising from a "pattern of consumer harm" in the Company's LTCI business. Under the settlement, Conseco will pay a $2.3 million penalty and at least $4 million in restitution and administrative costs to harmed policyholders. It will invest $26 million in system upgrades and improved claims administration. Conseco is also obligated to pay an additional $10 million in fines if problems are not corrected.

The settlement involved two Conseco subsidiaries — Conseco Senior Health Insurance Company and Bankers Life and Casualty Insurance Company — and covered claims filed from Jan. 1, 2005, through April 30, 2007. According to the terms of the settlement, Conseco Senior Health Insurance Company, which is not actively writing new policies, will automatically review 1,112 claims that were initially denied; will provide notices to another 18,000 policyholders covering 49,000 claims that may have been partially denied or subsequently denied after initial payment; and will set up a toll-free call center for all claimants who believe their claim settlement was not handled properly. The investigation found that the primary problems in most cases were delays in claim payments, rather than outright claim denials.

Commenting on the investigation and settlement, Pennsylvania Acting Insurance Commissioner Joel Ario stated "[i]t is vital that long-term care insurers make prompt and appropriate payment of claims to consumers who are older and whose life and well-being are dependent upon it. Conseco failed this test." The examination led by Mr. Ario concluded that claims investigations were not handled in a timely manner, claims files were not properly documented or maintained; and time frames for company responses to claimants did not adhere to applicable regulations. According to the press release announcing the settlement, Conseco self-reported issues in

complaint and claims handling, and blamed the problems on the challenge of integrating various computer systems. In the case of Bankers Life and Casualty Insurance Company, the investigation found inadequate marketing and sales compliance issues. The settlement requires Bankers Life to enhance its producer training program; eliminate producer complaint thresholds, so that a single complaint can result in disciplinary action; regularly review experience-period results for all producers; and supervise all producers and terminate them due to non-compliance with marketing standards.

Long Term Care Model Act & State Regulations

At its inception, LTCI was largely unregulated beyond general insurance statutory provisions applicable to health-related insurance products. In the early 1990's, the NAIC developed the LTCI Model Act and Regulation that has been adopted in some form in almost every state.[1] Although there are certain differences between the states, most LTCI statutes and regulations include provisions regarding font size of policy print, guaranteed renewal, limited waiting period and physician statement requirements if the applicant is over a certain age. Other statutory provisions or regulations prohibit: (a) the cancellation, nonrenewal, or termination of LTCI due to the insured's age or declining mental or physical health; (b) establishment of a new waiting period when a policy is converted or replaced; (c) limitation of coverage depending upon the level of care; (d) defining "preexisting condition" in a more restrictive manner than the statutory definition; (e) requiring prior hospitalization as a condition of eligibility, or requiring a higher level of institutional care as a condition for benefits; and (f) conditioning benefits after hospital discharge upon admission within less than 30 days and for the same or a related condition. In an attempt to address issues relating to questionable premium increases, some states have also adopted explicit provisions requiring actuarial proof of need prior to receiving a rate increase, as well as specific consumer disclosure requirements.

The NAIC recently adopted several revisions to the Long Term Care Model Act including a new section on producer training, which requires producers to complete a one-time, eight-hour training course before selling long-term care insurance products and an ongoing, four-hour training requirement from that point on. The amended NAIC model act and regulation seeks to ensure that long-term care insurance policies would pay for services in facilities in other states, even if the facilities are licensed or registered in a different way from those in the state in which the policy was sold. The adopted amendments also will provide consumers with more options when new services or providers become available in the market, and greater flexibility to reduce coverage in order to make premiums more affordable.

[1] More than forty states have enacted statutes or regulations similar to the NAIC Long-Term Care Insurance Model Act. **Alabama:** Ala. Admin. Code r. 482-1-091; **Alaska:** Alaska Stat. 21.53.010-21.53.200 (1990); **Arizona:** A.R.S. §§ 20-1691-20-1691.6 (1989); **Arkansas:** Ark. Stat. §§ 23-97-201-21- 97-213 (1990); **California:** West's Ann.Cal.Ins.Code §§ 10230-10232.8, 10235-10237.7 (1990); **Colorado:** West's C.R.S.A. §§ 10-19-101-10-19- 115 (1990); **Delaware:** 18 Del.Code §§ 7101-7107 (1990); **Florida:** West's F.S.A. §§ 627.9401-627.9408 (1989); **Georgia:** Official Code Ga.Ann. §§ 33- 42-1-33-42-7 (1989); **Hawaii:** Rev.Stat. §§ 431:10A-521-431:10A-531 (1990); **Idaho:** I.C. §§ 41-4601-41-4606 (1990); **Illinois:** 215 ILCS 5/351A-1-5/351A-11, formerly S.H.A. ch. 73, Art. XIXA ¶;¶963A-1-963A-11 (1990); **Indiana:** West's Ann.Ind.Code 27-8-12-1-27-8-12-16 (1990); **Iowa:** I.C.A. §§ 514G.1-514G.8 (1990); **Kansas:** K.S.A. 40-2225-40-2228 (1989); **Kentucky:** K.R.S. §§ 304.14-600 to 6304.14-625 (Michie/Bobbs-Merrill 1992); **Louisiana:** LSA-R.S. 22:1731-22:1737 (1989); **Maine:** M.R.S.A. tit. 24-A §§ 5051-5056 (West 1989 & Supp. 1994); **Maryland:** Md.Code Art. 48A, §§ 642-649 (1989); **Massachusetts:** M.G.L.A. c. 118E, § 16D; **Michigan:** M.C.L.A. §§ 500.2280-500.2290 (1990); **Minnesota:** Minn. Stat. Ann. §§ 62A.46-62A.56 (1990); **Mississippi:** Miss.Ins.Reg. 90-102 (1990); **Missouri:** V.A.M.S. §§ 376.951-376.958 (1990); **Montana:** Mont.Code Ann. 33-22-1101-33-22-1121 (1989); **Nebraska:** Neb.Rev.Stat. §§ 44-4501-44-4517 (1989); **Nevada:** Nev. Admin. Code §§ 687B.010-687B.135 (1988); **New Hampshire:** R.S.A. 415-D:1-415-D:11 (1990); **New Mexico:** NMSA §§ 59A-23A-1-59A-23A-8 (1989); **North Carolina:** G.S. §§ 58-55-1-58-55-35 (1990); **North Dakota:** NDCC 26.1-45-01-26.1-45- 10 (1989); **Ohio:** R.C. §§ 3923.41-3923.48 (Page's, 1988); **Oklahoma:** Okla. Stat. Ann. Tit. 36 §§ 4421-4427 (1989); **Oregon:** O.R.S. 743.650- 743.656 (1989); **Pennsylvania:** 40 P.S. § 991-1101 to 991.1114 (West 1992 & Supp. 1994); **Rhode Island:** Gen. Laws §§ 27-34.2-1-27-34.2-12 (1990); **South Carolina:** Code 1976, §§ 38-72-10-38-72-100 (1990); **South Dakota:** SDCL 58- 17B-1-58-17B-15 (1990); **Tennessee:** T.C.A. §§ 56-42-101-56-42-106 (1990); **Texas:** V.A.T.S. Insurance Code, art. 3.70-12; Tex. Admin. Code tit. 28, §§ 3.3801-3.3838 (1990); **Utah:** U.C.A. 1953 §§ 31A-22-1401 to 1410 (Michie 1991 & Supp. 1994); **Vermont:** V.S.A. tit. 8, §§ 8051-8063 (1989); **Virginia:** Va. Code §§ 38.2-5200-38.2-5208 (1990); **Washington:** West's RCWA 48.84.010- 48.84.910 (1988); **West Virginia:** Code 33-15A-1-33-15A-7 (1989); **Wisconsin:** W.S.A. 40.02(40m), 146.91, 600.03, 625.16, 632.82, 632.84 (1990); **Wyoming:** W.S.1977, §§ 26-38-101-26-38-106 (1990).

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THE DEFENSE PERSPECTIVE...

Continued from page 1

all claims information in order to avoid suits of this type.

The second line of cases relates to defining the scope of care that can be reimbursed as long term care expenses. These cases show the uncertainty that exists in this area. In *Geary v. Life Investors Ins. Co.*, 508 F. Supp. 2d 518 (N.D. Tex 2007), the court held that an insured receiving care from an assisted living facility was entitled to benefits under her long term care policy, because the policy did not provide for assisted living care. To distinguish between "assisted living" and "nursing home" care, the court looked to the policy, which it turn looked to how state law licensed and defined the two classes of facilities. The Tenth Circuit Court of Appeals, in *Gillogly v. Gen. Elec. Capital Assurance Co.*, 430 F.3d 1284 (10th Cir. 2005), also looked to state statutes to define the terms of a long term care insurance policy. The Court held that a "residential care home" was not a "nursing home" and that the insurer rightfully refused to pay for the plaintiff's claim. Obviously, state law definitions can vary state-to-state and can change over time, meaning that policies that make reference to state law are susceptible to changes in risk that come from differences in state laws. These cases highlight the necessity of an insurer's staying abreast of changes in state law that affects the scope of the coverage provided by a long term care policy.

In considering these two sets of cases together, the difficulties facing insurers are even greater. On the one hand, insurers face a high burden of proof when denying applications for insurance. On the other hand, regulatory actions and evolving state laws introduce uncertainty into the terms of every insurance contract that results from the application process. Insurers need a large amount of carefully considered data, but it is difficult to gather the needed data when the state law that defines coverage differs among states and is always changing. Everything is in flux.

On top of the uncertainty in litigation outcomes, regulatory changes are afoot that are limiting insurers' ability to adjust their rates. Many state departments of insurance, including Florida's, have adopted the National Association of Insurance Commissioners ("NAIC") Model Regulation 641, a rule that places significant burdens on long term care insurers who want to raise premiums. Insurers have to justify increases with detailed claims information and substantial disclosures about denials. Furthermore, NAIC Model Regulation 641 empowers states to force an insurer to lower rates or increase benefits if the insurer is benefiting from "excess premiums."

Wide-spread dissatisfaction about rate increases for LTCI products has also led to class-action litigation. Actions alleging breach of contract and fraud arising out of rate increases have sprung up in North Carolina, Illinois, Iowa, and other states.

Insurers have responded to these pressures in creative ways. Many insurers are looking into offering asset-based LTCI policies that are more akin to annuities than to traditional supplemental health insurance products like LTCI. While these asset-based policies may appeal to consumers because of certain tax advantages, the uncertainty in the equity markets makes them less attractive to most people seeking long term care insurance. Other insurers have sought significant rate increases to limited affect, and still others have found ways to leave the market altogether.

In conclusion, insurance companies offering LTCI face challenges on every side. Litigation poses additional risks and introduces more uncertainty into the industry. However, motivated insurers are finding ways to offer products that consumers want while taking intelligent risks in hopes of making a long term profit. The long term care industry is changing and will continue to present novel challenges. Insurance companies and their attorneys will have to learn to adapt.

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2009-2010 TIPS CALENDAR

June

23 **Using Technology to Present a Case** — **90-minute Webcast**
Contact: Debra Dotson – 312/988-5597 — **1:00 p.m. – 2:30 p.m. EDT**

24 **Lien On Me! Hot Topics in Settlement Negotiations** — **Multi-site Teleconference**
1:00 p.m. – 2:30 p.m. EDT
Contact: Debra Dotson – 312/988-5597

August

July 30-August 4
ABA Annual Meeting — **Marriott Hotel**
Contact: Felisha A. Stewart – 312/988-5672 — **Chicago, IL**
Speaker Contact: Donald Quarles - 312/988-5708

October

6-11 **TIPS Section Fall Meeting** — **Hotel Del Coronado**
Contact: Felisha A. Stewart – 312/988-5672 — **San Diego, CA**

22-23 **Aviation and Space Law Litigation** — **Ritz Carlton Hotel**
Contact: Donald Quarles – 312/988-5708 — **Washington, DC**

29-30 **FSLC Fall Program** — **Four Seasons Hotel**
Contact: Donald Quarles – 312/988-5708 — **Philadelphia, PA**

November

5-6 **Premises Liability National Program** — **Loews Don Cesar Beach & Resort**
St. Pete Beach, FL
Contact: Debra Dotson – 312/988-5597

2010

January

14-17 **Annual TIPS Midwinter Symposium on Insurance, Employment and Benefits** — **Hyatt Regency Coconut Point Resort and Spa**
Contact: Debra D. Dotson – 312/988-5597 — **Bonita Springs, FL**