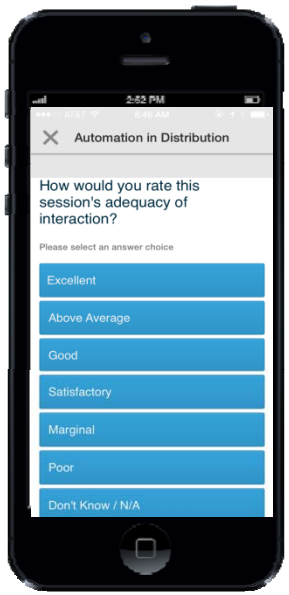
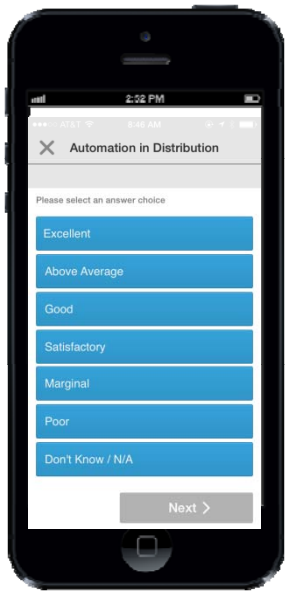
Don’t forget to fill out the survey!

1st you must download the ILTCI Mobile App - Go to your app store; search ILTCI. It’s free.

1. **Find your session using the Session or Schedule Icon**
2. **Scroll down until you see ‘Surveys’ and tap to begin answering.**



Tap on the answer you wish to submit



Click Next

Legal, Compliance & Regulatory

LTCi Litigation Update/Prevention

March 14, 2016

San Antonio, TX

Agenda

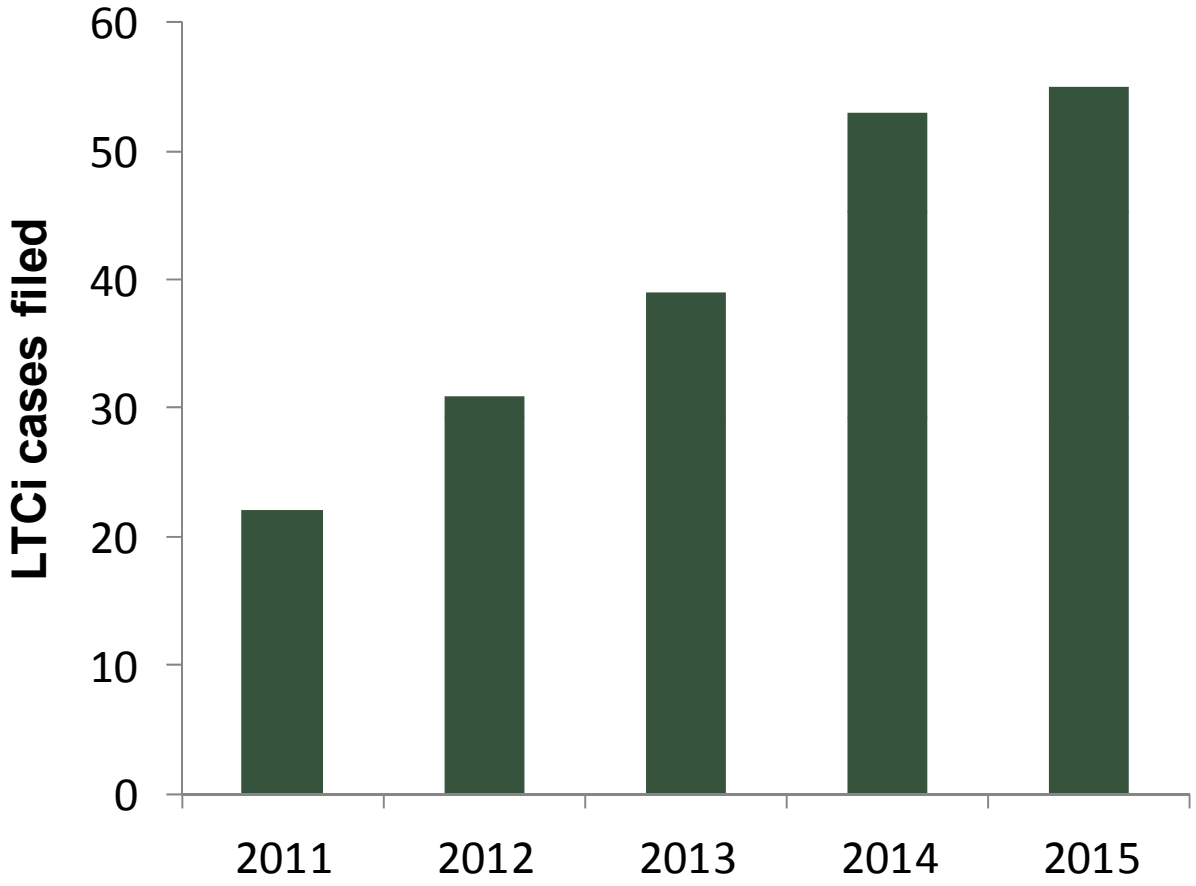
- Introduction and Trends
- Rate Increase Litigation
- Claims-Based LTCi Litigation
- Emerging Trends
- Conclusion

Litigation Risk

- Increased attention from plaintiffs' bar
- Increasing volume of claims
- Negative publicity
- Attention of regulators and consumer advocacy groups

Litigation Volume Continues to Increase

Number of LTCi complaints on the rise



Rate Increase LTCi Class Actions

What LTC Insurers Think About Rate Increases

"Rate increases are the only option carriers have to manage costs as claims experience emerges. . . . The potential for rate increases is clearly disclosed on the first page of most [] policies. No one likes rate increases, but they are necessary to ensure carriers' ability to pay claims in the future."

What Some Policyholders Think…

- "In my opinion, **older policyholders are being used as a cash cow** to make up for the company's bad management of the premium dollars invested."
- Insurers "sell these policies in hopes that you will pay on them for 20 years and then when you get about 70 years old, **they try to force you to decrease benefits or drop the policy so they will not have to pay**."
- **"I think it's a big scam**."

Rate Increase Litigation - Overview

- State/nationwide classes of thousands of policyholders
- Sophisticated plaintiffs' lawyers
- Potential for punitive damages
- Cost of defense can be significant
- Class action settlements (and losses) can be very expensive
- Recent cases have significantly curtailed the ability of plaintiffs' lawyers to bring these cases, although there continue to be new twists on old theories

Common Plaintiffs' Theories

- Insurers knowingly sold "defectively underpriced" policies at "low-ball prices"
- Policies were "experimental"
- The "guaranteed renewable" language was rendered meaningless
- Policies will be "unaffordable" after an increase
- Insurer targeted elderly consumers

Common Defendants' Defenses

- Unambiguous contract language and/or disclosures
- Lack of reasonable reliance
- Undisclosed plan to underprice for a long time, with the hope of future rate increases, is not plausible
- The "filed rate doctrine"
- Statute of limitations

Sanchez (pending, filed 2013)

- Insurer, a public entity, raised rates on a block of LTC policies in:
  - 2003 (30%)
  - 2007 (42%)
  - 2010-2013 (5%)
- In 2013, insurer announces 85% rate increase, beginning in 2015

Sanchez — Plaintiffs' allegations

- Class action filed against insurer, board members and actuary, asserting:
  - Breach of contract;
  - Breach of the implied covenant of good faith and fair dealing;
  - Breach of fiduciary duty;
  - Rescission;
  - Declaratory and injunctive relief; and
  - Professional negligence (as against actuary-defendant).

Sanchez — Plaintiffs' allegations (cont.)

- Plaintiffs' allegations pull out all the stops:
  - Insurer failed to properly underwrite
    - Insurer had hired an actuarial consultant to initially price the product and set premiums from 1995 to 2004
  - Insurer low-balled policyholders
    - Touted its financial stability and ability to offer low premiums as a self-funded, not-for-profit program
    - Targeted individuals that could not afford a rate increase
    - Knew that premiums would become unaffordable

Sanchez — Plaintiffs' allegations (cont.)

- Insurer failed to provide timely and accurate information to policyholders
- Insurer engaged in aggressive investment strategies that resulted in enormous losses
- Insurer knowingly caused a "death spiral" by closing blocks to new enrollees in 2009 (and failed to inform policyholders of its decision to stop accepting new enrollments)

Sanchez

- Despite weaknesses, **class certified** on breach of contract and fiduciary duty counts (as well as claims against actuary)
  - Breach of contract claims arguably barred by four-year statute of limitations (breach first occurred in 2003)
  - Breach of fiduciary duty claims troubled by governmental immunity defense under California Tort Claims Act
- Case ongoing

Toulon

- New twist on bait-and-switch arguments
- Following a 76.50% rate increase, Plaintiff argues that she was misled to believe that rate increases would be around 20%.
- Plaintiff alleges fraudulent misrepresentations and omissions, and related state-law claims
- She relies upon the Personal Worksheet that she was required to fill out at the time of sale

Toulon

- Worksheet explicitly stated that the insurer had a right to raise premiums, but….
- …other statements allegedly created "inferences" about the probability and magnitude of future rate increases. Specifically:
  - "Have you considered whether you could afford to keep this policy if the premiums were raised, for example, by 20%?"
  - Rates had not been previously raised on this form, and only by 15% on a similar form

Toulon

- Insurer allegedly "knew" that future increases would occur, and would far exceed 20%
- Why? Low lapse rates allegedly used to keep prices down.
- Accordingly, statement that premiums "may" change was allegedly misleading and false

Toulon (August 2015)

Holding: First Amended Complaint dismissed

- **Fraudulent Misrepresentation**
  - No "false lulling" -- "It would not be reasonable to infer that defendant was falsely promising to never raise premiums beyond 20%" since the content of the Worksheet was taken directly from a DOI regulation mandating its content
  - The Worksheet is "explicit" that the insurer "has a right to increase premiums in the future," which is stated "without any qualification" as the amount of such increase (*Rakes, Alvarez*)

Toulon (August 2015)

Fraudulent Omission

- No "duty to disclose" rate increase plans
  - No fiduciary/confidential relationship
  - No position of superiority/influence merely because the policyholder is elderly and unknowledgeable about LTCI
  - No misleading "half-truths"

Consumer Fraud Act

- No consumer fraud claim
  - the increase "will not said to be deceptive when the plaintiff is explicitly alerted to the complained of result"
- No unfair practice claim
  - Plaintiff did not allege that the insurer did "anything other than that which it was contractually entitled to do"

Toulon (February 2016)

The Second Amended Complaint:

- "the gist of Toulon's theory remains the same"
- Newly-alleged "misleading" statements include:
  - Notice to Applicant
  - Policy: "we may change the premium rates"
    - "Toulon argues extensively that by presenting to her the possibility of an increase in her premium, [the insurer] misled her as to both the probability and magnitude of such an increase."
    - Court: "unreasonable logical leap"

Holding: Dismissed with prejudice

Another Potent "Regulatory" Defense

- The "filed rate doctrine"
- State-law doctrine barring judicial challenges to rates which have been filed with a state regulator
- No "fraud exception"
- *Armour* (2012): all claims dismissed on MTD
- The defense has limits
    - *Gelfound* (2014): defense not applicable to claim that insurer incorrectly charged any premiums after ceasing to provide benefits under an inflation protection rider

The Emerging Battleground for Rate Increase "Litigation"

- New frontier will be administrative proceedings involving state insurance departments
- Process may look different from state to state, but generally it has the hallmarks of litigation in a court
- "Your filing has been disapproved…."
    - Minnesota (2014-2015)
- Policyholder challenges to approved rate increase
    - *Driscoll* (ongoing)
    - *Hatfield* (2009-2010)

Administrative Challenges—*Driscoll* (2015)

- 2011: 41% premium rate increase filed and approved by Washington OIC
- 2014: Driscoll challenges rate increase through an OIC administrative proceeding

Driscoll (2015)

- Summary of Driscoll's key administrative allegations:
  - Actuarial information provided to support rate increase was deficient under applicable regulations—entitling plaintiff to seek retroactive and prospective relief
  - Driscoll sought an administrative order to:
    - Direct the insurer to produce proprietary policy-related and actuarial information
    - Cease use of the revised policy schedule forms
    - Prospective relief from the approved rate increase

Driscoll (2015)

- Driscoll's case troubled by the SOL:
  - Under Washington law, a person aggrieved by a written order of the Commissioner has 90 days to demand a hearing
  - Driscoll's 2014 administrative challenge was clearly barred by the 90-day limitations period
  - Driscoll attempted to circumvent SOL by leveraging Washington regulations related to the rate approval process…but do not afford a private rate of action

Driscoll (2015)

- **Summary judgment granted** by Presiding Officer on the basis that the challenge was time-barred
- Driscoll files a petition for judicial review, appealing the administrative order

Driscoll (2015)

- **<u>Order upheld</u>**
  - Superior Court agreed that claims were time-barred…
  - But also applied the filed rate doctrine
    - A first for a Washington court (in the LTCi context)
    - The court applied *McCarthy v. Premera* (Wash. 2015), an *en banc* Washington Supreme Court decision recognizing the filed rate doctrine in the insurance context

Driscoll (2015)

- Driscoll's initial challenge may have played out differently if he had presented a timely challenge…
- Driscoll has filed a new demand for hearing with the OIC focusing on a July 2015 rate increase approval (22.69%)
- **Status**: In discovery; hearing set for June

Hatfield Administrative Hearing (2009-2010)

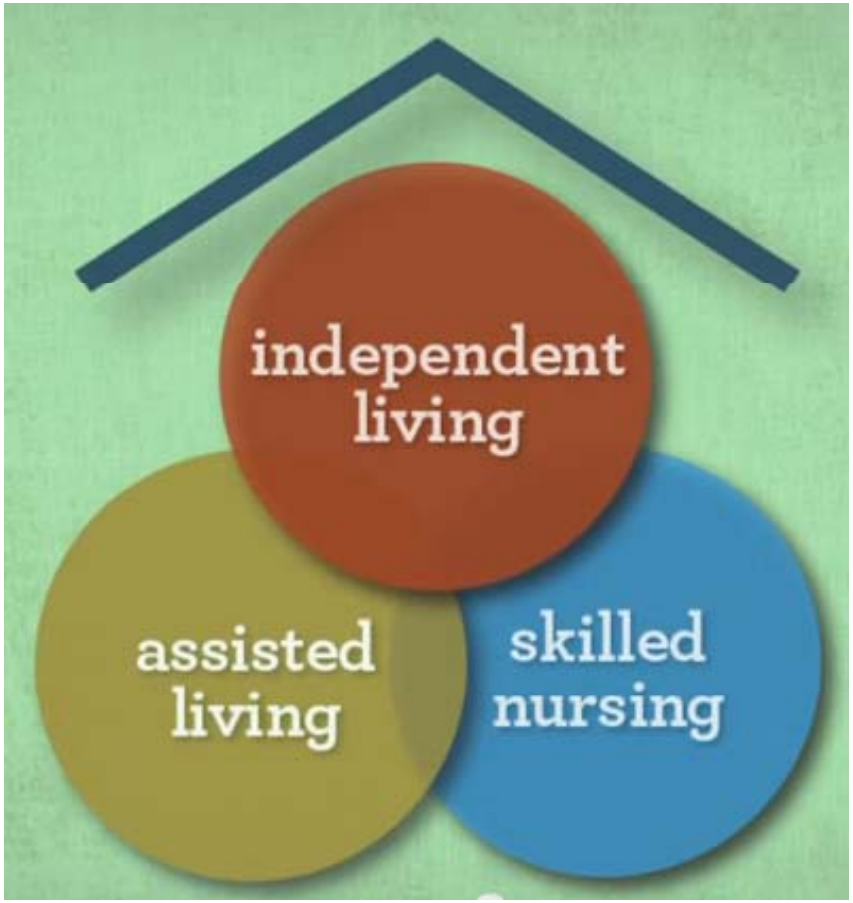
- Retired teachers association sought a hearing to challenge approved LTC rate increases
- Strange bedfellows: the insurer intervened to protect its interests and was aligned with the Department in presenting evidence to support the Department's work
- After discovery, pre-/post-trial briefing and a four-day trial with fact and expert witnesses, a 60-page decision upheld the rate increases

Hatfield Administrative Hearing (2009-2010)

- Issues at trial very different from a case brought in court:
  - What was the proper loss ratio test?
  - Were the benefits reasonable in relation to premiums?
  - Was the data provided by the insurer in support of its filing accurate, and were the future projections reasonable?
  - Did the Department consider all of the relevant statutory requirements?
  - Was there substantial evidence to support the Department's approval of the rate increases?

Claims-Based LTCi Litigation

Continuing Care Retirement Communities



- Tiered approach to retirement living
- Retirees enter CCRCs in independent living
- Transfer to assisted living or nursing care facilities, as necessary
- Three industry-standard contracts:
  - Extensive
  - Modified
  - Fee-For-Services

Entrance Fees

- Extensive Agreements:
  - Most common, allegedly accounting for 77% of CCRC contracts
  - Typically include an entrance fee, but fees **vary** both in size, ranging from $100k to $1M, and in treatment (some facilities offer fully refundable entrance fees)
  - Resident pays for accommodations and residential services at a set monthly fee for life of contract
  - Receives agreed upon dependent care, as needed, with only cost of living increases to set monthly fee

See http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html

McElwee—allegations (filed 2015)

- Plaintiff moved into a CCRC in 2012; in 2013 she moves from independent living to assisted living
- Plaintiff agreed to pay a set monthly fee ($4,521) to the facility (adjusted for inflation) regardless of whether she received dependent care

McElwee—allegations

- Plaintiff alleged $250,000 Entrance Fee to facility was a “pre-payment” for future care
  - The facility deducted $5,000 per month from the refundable value of the entrance fee while she resided in independent living
  - The facility deducted $7,500 and $10,000 for ALF and Nursing Home units, respectively

McElwee—allegations

- After Plaintiff moved to an assisted living unit, her monthly invoice reflected:
  - A $8,517 charge for dependent care ($280 per day)
  - An immediate program credit for the same amount
  - A room and board charge for the agreed upon set monthly fee (*i.e.*, $4,521)

McElwee—allegations

- Plaintiff's policy provides a $310 maximum daily benefit
- The insurer reimbursed Plaintiff for the $4,521 set monthly fee
- Plaintiff filed a putative class action, seeking recovery for the difference between the amount shown on her monthly invoice and the set monthly fee she was obligated to pay

The Policy

- We will pay the Assisted Care Living Facility Daily Benefit if . . . **You are a resident in an Assisted Care Living Facility** . . . .
- We will pay the **actual charges** for confinement in an Assisted Care Living Facility up to the Assisted Care Living Facility Daily Benefit as shown in the Policy Schedule.

McElwee

- The purpose of LTCi is to reimburse the policyholder for actual charges incurred
  - Plaintiff did not pay inflated $8517 monthly charge on her invoice—but sought to recover the delta as a "prepaid" expense…
  - But Plaintiff owed entrance fee regardless of whether she ever received covered care from a covered facility
- Status: Case voluntarily dismissed.

Gardner (pending)

- Claims arise out of alleged refusal to cover stays at Managed Residential Community ("MRC") or to cover the services provided through Assisted Living Services Agencies ("ALSA")
- Claims for named plaintiffs denied due to lack of licensure (MRC) and/or could not legally provide 24-hour/continuous nursing care
- Increasingly common claims issue: campuses that offer housing and basic services, with option to receive different levels of care in separately-licensed areas

Gardner (pending)

- Statewide class action alleging violations of Unfair Trade Practices Act, unjust enrichment, breach of contract, bad faith
- Insurer allegedly "concocted different ways to increase claim denials and terminations" following prior class action settlement involving an agreed "less restrictive" policy interpretation
- Plaintiffs allege and attack a policy of denying all claims for MRC/ALSAs

Gardner (pending)

- Insurer's alleged strategy included:
  - Refusing to open claims,
  - Refusing to send out claims forms, and
  - Refusing to issue timely written claims denials and/or only issuing verbal claim denials to elderly policyholders

Gardner (January 2016)

- In January 2016, the Court denied Plaintiff's application for a Preliminary Injunction to require written coverage decisions related to MRCs
  - o No irreparable harm:
    1) Plaintiffs already informed that MRCs in general not covered under their policy and specifically that their MRCs would not satisfy the policy, yet continued to reside at their MRCs,
    2) Plaintiffs had only minimal evidence that putative class members not receiving written claim denials.
- Motion denied <u>without prejudice</u> to renew if class certification is granted.

Gardner (March 2016)

- March 1, 2016: Class certification granted
- "the heart of these claims is a dispute over the proper interpretation of identically worded policies"
- "the overriding question to which this suit addresses itself is one that is capable of class resolution -- whether the policy (which Defendant admits to having) of denying all claims for coverage of MRC/ALSAs, demonstrates a breach of contract, unfair trade practice, or bad faith

Gardner (March 2016)

- 23(b)(2) injunctive relief class
  - Current (not former) CT residents who purchased in CT -- approx. 750
  - Injunctive relief sought by Plaintiffs: an end to the alleged policy of denying all claims for MRC/ALSAs across the board

Gardner (March 2016)

- 23(b)(3) damages sub-class for MRC/ALSA claim denials
- Even though small size (approx. 29) and "Plaintiffs have not put forth any evidence of financial barriers to filing individual claims":
  - "Many of the class members are likely to be elderly and of limited capacity, making it difficult for them to file individual suits."

Pistorese (2013)

This case had been on appeal to the 9th Circuit, but in late 2015 it was voluntarily dismissed, leaving the district court opinion from 2013 in place

Factual Background:

- Purchased a "Nursing Home Benefit" in 1993
- Declined optional Home Health Care coverage
- Declined to add Assisted Living Benefit in 2001
- Plaintiff moves into a licensed "boarding home" (now called an "assisted living facility")

Pistorese (2013)

- "Nursing Home" must be "engaged in providing . . . nursing care and related services on a continuing inpatient basis"
- Under state law, a boarding home is restricted to providing (but not required to provide) "intermittent nursing services" to "residents."
- *McDermott* (2007): same Court, same Policy language, different Judge
- A facility licensed as a boarding home can only provide "intermittent care" and is legally prohibited from providing nursing care on a "continuous inpatient basis," and is thus unable to satisfy the Policy language

Pistorese (2013)

- Policy "Nursing Home" requirement of providing "nursing care . . . on a continuing inpatient basis" is met if:

  provides "some" "nursing care to . . . continuing inpatients"

- Is that the same thing? What is a "continuing inpatient"?

  A "facility satisfies the second element if its residents receive some nursing care during an 'ongoing' or non-temporary stay at the facility."

- Result: *Pistorese* (WD Washington - Seattle) vs. *McDermott* (WD Washington - Tacoma)

Gutowitz (2015)

In 2015, Another Court Weighs In . . .

- Same policy language as in *Pistorese* and *McDermott*
- Result: (1) rejects *McDermott*, (2) same result in *Pistorese*, but (3) Court goes beyond, and "disagrees" in part with *Pistorese*
    - *e.g.*, rejects Policy construction of "continuing inpatients"
- Three different judges, from two different courts in different states, have now analyzed identical Policy language three different ways
- What impact does this have on claim decisions?

A Word of Caution About Splits of Authority

- Does a split in authority (*i.e.*, unsettled law) immunize against bad faith liability?

- Maybe not. Depends on applicable law, and the judge.

- *Gutowitz* refused to grant SJ on bad faith in light of the split in authority created by *McDermott* and *Pistorese*:

  [T]riable issues remain as to whether [the insurer's] interpretation of the policy was **reasonable**. A jury could find that, regardless of its investigation, [the insurer] **unreasonably ignored case law that more thoroughly analyzed the policy language than did *McDermott* to interpret the policy in a way that would permit it to deny coverage to Gutowitz**.

The *Milburn* Concurrence

- Judges are human = unpredictability
- Several years ago, two 10th Circuit judges in *Milburn* issued a strongly-worded concurring opinion expressing "serious concerns" about elderly policyholders having to wade through state regulatory schemes which change over time
  - "[S]ome corrective action is necessary to protect policyholders' reasonable expectations"
  - LTC insurers urged "to provide clearer definitions of the crucial terms"
  - Policymakers urged "to add simple clarity to this important area of law"

Emerging Theories of Liability

Emerging Theories of Liability

Securities Class Action Litigation

- Stock drop case against LTC insurer and its executives relating to disclosures about LTC business
- Statements by the LTC insurer in investor calls, press releases and/or SEC filings relating to the adequacy of the company's LTC reserves were allegedly false and misleading
- Case filed in 2014, and remains ongoing. The Court denied a Motion to Dismiss in May 2015.

Emerging Theories of Liability

Statutory "Elder Abuse" Claims

•Statutes vary from state to state, but generally they seek to protect the financial abuse of an elder or dependent adult

•Results have been mixed. Examples:

•*Haldiman* (2014): "This statute was not intended to include insurers administering claims."

•*Rosove* (2014): although "the California legislature enacted the statute to combat 'classic' financial fraud against elders," the language "sweeps far beyond 'unnecessary financial products,' and at least potentially reaches the denial of benefits at issue"

•*Bates* (2014): "[T]here is no elder abuse claim . . . arising out of defendants' alleged claims-handling practices." However, "[t]o the extent the claim is premised on fraud in the inducement, such conduct does appear to be cognizable as elder abuse."

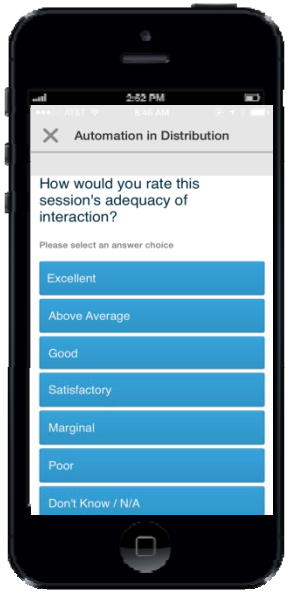
Conclusion

- Rising volume and magnitude of claims
- Significant rise in recent LTCi litigation
- Well-connected, sophisticated plaintiffs' attorneys
- Emerging theories of liability maintain pressure to ensure diligent claims practices and clear, accurate communications

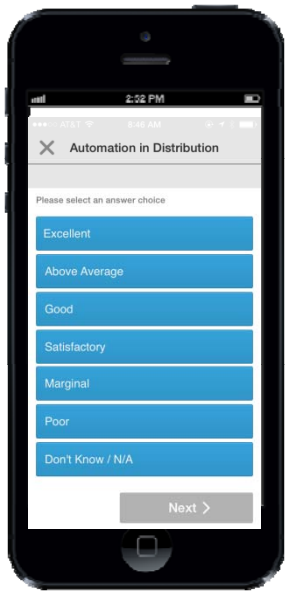
Don’t forget to fill out the survey!

1st you must download the ILTCI Mobile App - Go to your app store; search ILTCI. It’s free.

1. **Find your session using the Session or Schedule Icon**
2. **Scroll down until you see ‘Surveys’ and tap to begin answering.**



Tap on the answer you wish to submit



Click Next