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Long-Term Care Insurance Litigation Update

Agenda

- Litigation Risk: COVID-19 Pandemic
  - Effect on Insureds
  - Insurers' Responses
- Litigation Update
  - Litigation Trends
  - Rate Increase Litigation
  - Claims Litigation
  - General Litigation
- What would you do?

Litigation Risk: The COVID-19 Pandemic

- **Carriers responding to the pandemic based on regulatory directives, and:**
  - Recognizing difficult circumstances many insureds are facing
  - To adapt to a remote work environment
  - To adapt to an environment where some of the normal tools of LTCi administration must be done differently – benefit eligibility assessments, IMEs, reassessments, gathering of medical records, etc.
- **The elder care population is specifically at risk from COVID-19, both from a mortality and morbidity standpoint**

Impact of COVID-19 Pandemic on Insureds

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

Insurers' Responses to COVID-19 Pandemic

- Exceptions Typically Requested
  - Extension of cycle for lapse due to non-payment of premium
  - Waiver of premium continued where insured had been on WOP but discontinued home healthcare because of COVID-19 concerns
  - Elimination period satisfaction timing requirement waived/extended during the pandemic; In other words, if the EP is required to be satisfied within a set number of days, that number will be extended or the requirement eliminated based on the pandemic
  - Extension of a bed reservation benefit, beyond timeframe allowed in the contract and/or to provide the benefit where it is not expressly provided in the contract
  - Family member approved as caregiver where not precluded by the policy
  - Family member approved as caregiver despite policy exclusion

Insurers' Responses to COVID-19 Pandemic

- Exceptions That Have Resulted in Litigation/Pre-Litigation Threat
  - Requests for family members to serve as caregivers, where precluded by the policy
  - Requests for family members to serve as caregivers, where the policy is silent on that point

  - Requests for APOC concerning caregivers excluded under the policy, where the APOC language requires that the policyholder would otherwise require confinement in a nursing home and that is not the case
  - Extensions for payment of premium where none is required by state law or mandate

Insurers' Responses to COVID-19 Pandemic

- Premium Payment and Grace and Lapse Accommodations
  - Grace period extensions and restrictions on policy lapses have been imposed by regulators in some circumstances, and "urged" or "encouraged" in others
  - Therefore, carriers have more uniformly applied exceptions on these issues
  - Operational and phase out questions have arisen, however, and regulatory guidance on these issues is sparse
  - Restricting ability to lapse policies (*i.e.*, Alaska)

Insurers' Responses to COVID-19 Pandemic

- Premium Payment and Grace and Lapse Accommodations
  - Return to normal premium payment schedule
  - Avoidance of "shock" lapses
  - Payment plans – compare NY/NJ/DC with KY with "no-guidance" states
  - Lapse processes under payment plans – e.g., what if an insured is current on post-pandemic premium, but in default on a payment plan?
  - Retroactive approval and waiver of premium issues
  - Proof of loss requirements and lapse of time

Litigation Trends, Generally

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

Hot Topics in LTCi Litigation

The Usual Suspects:

- Cognitive Impairment Claims Litigation
- Recertification Issues
- Facility-based (Provider Eligibility) Claims and Litigation
- Lapse Issues and Litigation
- Rate Increase

Summary of Current Claims Litigation Issues

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

The Big Bad Faith

- Bad Faith Claims are on the Rise
  - Different jurisdictions have different rules surrounding caps on damages. Some states have no cap on bad faith damages.
  - Tiny claims issues come with bad faith claims, or other claims for punitive damages, making fast resolutions difficult
  - Ambiguities in policies always construed against Insurers
- Insureds are mostly sympathetic plaintiffs
  - For the most part, insureds are elderly and had respectable lives.
  - Deaths can play significant roles in pulling at jury heart strings
  - Plaintiffs' attorneys are learning this product, and becoming intimately familiar with what to look for when selecting ideal candidates for litigation.
    - Most recently, attorneys are looking at policies that exclude coverage (even if legitimate) as being improperly sold or administered improperly, which can result in class action exposure

Rate Increase Litigation Updates

Newman – last we met, the appeal was still pending

- United States District Court for the Northern District of Illinois
- March 2016 – Newman files a putative class action
  - In her application for the policy, Newman had selected a premium payment plan that required the insurer to reduce her premium in half when she turned 65 years old.
  - When Newman turned 65, the company fulfilled its obligation and reduced her premium by half.
  - The company subsequently filed for a class-wide premium rate increase, which was approved.
  - Newman contends that the payment plan required the Company to permanently freeze her premium at the reduced rate for the life of her policy.
- March 2017 – District Court grants Company's Motion to Dismiss
- Newman appealed to the U.S. Court of Appeals for the Seventh Circuit
  - February 2018 – The Seventh Circuit REVERSED the District Court's decision to dismiss Newman's complaint, holding that the "Reduced Pay" payment plan was ambiguous.
  - March 2018 – The Seventh Circuit issued an amended opinion and remanded the case to the District Court for further proceedings.
- November 2019 – Settlement Approved

Rate Increase Litigation

Gunn

- Carrier sought and obtained rate increases under group insurance policy
  - Certain states granted larger premium increases than others
- Policy contains language regarding rate increases
  - "We cannot change the Insured's premiums because of age or health. We can, however, change the Insured's premiums based on his or her premium class, but only if We change the premiums for all other Insureds in the same premium class."
- Policy does not specifically define "premium class"

Rate Increase Litigation

Gunn

- Plaintiff challenged the rate increases implemented by carrier
  - Claims that the policy's use of the phrase "premium class" means "the nationwide pool of insureds under the group insurance plan within a given age category"
  - Claims that the carrier improperly increased his premiums because premium increases implemented varied on a state-by-state basis, based on regulatory approval or authorization
  - Claims that carrier did not even seek the same rate increases in each state
  - In short, claims that carrier was required to implement a uniform rate increase nationwide, or not at all
- Claims asserted for breach of contract, bad faith, violation of state consumer protection acts, fraud, fraudulent concealment, and declaratory and injunctive relief

Rate Increase Litigation

Gunn

- The district court rejected the plaintiff's arguments and dismissed the complaint based on the filed rate doctrine
- The plaintiff appealed the decision to the Seventh Circuit, where the appeal is fully briefed and currently awaiting decision. *Gunn v. Cont'l Cas. Co.*, No. 19-2898 (7th Cir.)
- Following oral argument, the Seventh Circuit initially requested additional briefing on choice of law issues, but subsequently retracted the order for additional briefing and remanded the case to the district court
- Discovery is ongoing

Rate Increase Litigation

DiRito

- Policy purchased in 2004
- Policy stated (in three separate places) that rates are subject to increase
- 2009 rate increase of 18%
- 2015 rate increase of 102%
- Single plaintiff, but the action was framed as though it would be a precursor to a class action lawsuit.
- Plaintiff alleges that insurer defrauded him based on the 2015 rate increase, specifically that it is a "half truth" that premiums could increase.
  - In doing so, Plaintiff points to the policy "This is Guaranteed Renewable for Life"
  - Plaintiff also claims that the insurer had a duty to disclose information because of its "dominance, influence, and superiority" over him, with respect to coverage
- Insurer responds:
  - Plaintiff was on notice that the premium could change, also spelled out three times in the policy
  - Insurer had no legal duty to disclose the information plaintiff sought
  - Plaintiff's claims are barred by the Filed Rate Doctrine
  - Plaintiff was already on notice in 2009 when premium was first increased

Rate Increase Litigation

DiRito

- Complaint filed in Illinois state court
- Insurer's Motion to Dismiss was granted on August 11, 2017
- Plaintiff's Motion for Reconsideration was denied on December 15, 2017
- Plaintiff appealed to the Illinois Appellate Court
- In Plaintiff's appellate brief, he argued that the lower court got it wrong – that the Illinois courts were split, and the lower court was relying on *Federal* law, not state law
- Appellate arguments took place in late 2018, and the Appellate Court agreed with the insurer! The (unpublished) opinion is strong
- Illinois Supreme Court denied Plaintiff's petition for leave to appeal in March 2019

Claims/Fraud Litigation – Significant Update

- *Dallal*
  - Joint comprehensive long-term care policy issued to the insureds, including coverage for home healthcare
  - Wife, as husband's power of attorney, continued to pursue claims for LTC benefits under the policy despite being aware of husband's cognitive impairment after surgery
  - Fraud included:
    - Claim of cognitive impairments
    - Claim of required assistance with all ADLs
    - Wife filled out false provider documentation, impersonating caregiver approved by the carrier
      - Lied about care provided
      - Forged cash receipts
    - Husband feigned incapacity at his nurse assessments
    - Altered APS forms after signed by physician

Claims Litigation

- *Dallal*
  - Carrier filed lawsuit, seeking:
    - Declaratory Judgment that insured had not been entitled to benefits
    - To void the policy going forward as a result of claims fraud
  - At trial, the court held that, under California law, carrier was entitled to void the policy going forward as a result of the fraud that had been committed
    - *"It would be wholly inequitable to force Lincoln to continue insuring the Dallals, who have abused the claim process and Lincoln's trust by submitting false claims under the policy."*
    - *"Requiring a defrauded party to continue its contractual relations that are so immersed in fraud would be highly inequitable and unjust. The Dallals should not get a second chance to defraud Lincoln."*

Claims Litigation

- *Dallal*
  - Court later denied Dallal's motion for new trial but amended its conclusions of law
    - Original conclusions of law suggested the court's voiding of the policy was supported by California statutes applicable to general contracts and general insurance – provided roadmap for carriers to take down policies in other states with similar statutes
    - Amended conclusions of law suggests that trial is necessary for court to void policy
  - Pending appeal in the Ninth Circuit
- Significance
  - Historically, rescission/voiding a policy was a potential remedy for *fraud in the inducement* (i.e., misrepresentations in an application for insurance)
  - Permitting a carrier to void policy for claims fraud:
    - Dissuades fraudulent conduct if insurance coverage may actually be required;
    - Allows insurer to avoid costs of additional monitoring for claims filed by known fraudsters;
    - Provides leverage for carriers attempting to recoup overpayments due to fraud

Litigation Risk Scenarios

- The Recertification Issue
  - Insured is residing in covered ALF, age 88
  - Insured has back surgery, shows signs of recovery
  - Needs assistance with bathing and dressing post-surgery, claim approved
  - After 6 months of improvement, the facility states that they are providing her with hands-on assist for bathing, but only stand-by for occasional dressing with clasps, buttons.
  - At BDA, insured reports she no longer wears clothes with buttons, but says she needs occasional help putting on her lymphedema sleeve on her arm. She is now 89.
  - Doctor says she “cannot live independently anymore.”
  - Is Insured still Chronically Ill? Does she remain on claim?
  - What do you do?

Litigation Risk Scenarios

- The COVID Facility Issue
  - At the start of COVID, family pulls insured out of covered ALF. Insured is on claim. Policy provides ALF, SNF, and HHC benefits, with an APOC provision.
  - Insured was living home with family, but now that COVID is better controlled family finds new "facility" and moves insured in without checking with company.
  - New "facility" is licensed, but not as an ALF, SNF, or HHC, but as a "Group Family Home," which is explicitly not covered by the policy. Claim is preliminarily denied because the facility is not covered.
  - Family is irate: says the insured is only at the new facility because (i) there are less people there; (ii) no visitors are allowed unannounced; and (iii) insured is receiving an ideal level of care for him and is doing much better than in the ALF.
  - What do you do?

Litigation Risk Scenarios

- The COVID Family Issue
  - Insured and spouse was in ALF, covered, on claim.
  - Spouse contracts COVID, passes away.
  - Family moves Insured home before “she can contract COVID and die too.”
  - Family is very wary of strangers coming into home because of spread. Tried HHC, but nurse was too nonchalant and did not take enough safety precautions (accordingly to family).
  - Insured’s granddaughter has taken off from college to stay home and care for Insured. Family caregiver is excluded from the policy, and the claim is preliminarily denied. Insured’s son is a litigator, and threatens bad faith litigation.
  - What do you do?