LONG-TERM CARE INSURANCE: The Next Generation of Bad Faith Litigation

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I. INTRODUCTION

No doubt about it – Americans are getting older. More than 34 million people are over the age of 65. By the year 2010, this number will grow to 40 million. By 2020, it will exceed 53 million. And by 2030, one in every five people – almost 70 million – will be over the age of sixty-five. With our population's increasing longevity, it is no surprise that the largest growing segment of the population are individuals over age 85, with a 55% increase from 1982 to 1996. In 1996, there was an estimated 3.8 million people age 85 or older. This number is projected to reach 6 million by the year 2010, more than 8 million by the year 2030, and will grow to 18 million by the year 2050.

Along with the aging of Americans, comes an increasing awareness of the need for long-term care insurance. Statistics show that the risk of having a fire that will cause major damage to a person's home is one in 1200, the risk of having an accident that will totally destroy a car is one in 240, and the risk that a person will spend 2.5 years in a nursing home is one in three.[1] In addition, forty percent of working age adults will require long-term care services in their lifetimes.[2] And for most elderly people, a nursing home stay of more than one year represents a catastrophic expense, with the cost ranging from $35,000 to $75,000 annually.

According to the latest trends, a greater number of people will die of debilitating diseases, such as arthritis and hypertension, or mental diseases, such as senility, which suggests an even greater need for long-term care coverage. However, as more and more Americans turn to their long-term care insurers for assistance, the number of unreasonable denials is bound to increase as well. Accordingly, attorneys need to be well versed in all aspects of long-term care coverage, including policy features, statutory guidelines, and, of course, the insurers' ongoing duty of good faith and fair dealing in the handling of their insureds' long-term care claims.

II. THE EMERGING MARKET OF LONG-TERM CARE INSURANCE

Long-term care insurance is relatively new. When long-term care policies were first introduced 25 years ago, they were designed and marketed as nursing home insurance without providing coverage for alternative care. The language in most contracts relied on narrow definitions modeled after major medical policies. They generally required the insured to spend three days in

[1] J. Sadler & D. Newman, Journal of the Amer. Soc'y of CLU, CHFC, Making the Transition to Long Term Care, LAN, Nov. 1993, at 111.
[2] *Long Term Care Awareness Survey: A National Public Opinion Survey*, Harvard School of Public Health & Louis Harris and Assoc. (1996).

the hospital before benefits became payable, and illnesses causing loss of cognitive ability, including Alzheimer's, were excluded.

Long-term care policies have evolved to provide benefits for skilled, intermediate and/or custodial care. Generally, skilled care must be prescribed by a doctor, given by a registered nurse and available 24 hours a day. Intermediate care refers to occasional nursing and rehabilitative care under the supervision of skilled medical personnel. Custodial care involves assistance with activities of daily living (ADLs),[3] such as help in bathing or eating that can be provided by someone without professional medical skills. It is usually provided in residential care homes or to individuals in their own homes. The best policies pay for all three kinds of care, including care by non-professionals, such as family members or friends.

Benefits are paid on either an "indemnity" or "reimbursement" basis. A typical reimbursement policy will not pay more than the actual charge, regardless of the maximum daily benefit amount. However, any unused portion may be carried over from one period to the next. Whereas, under an indemnity policy, the insured is paid the daily or monthly benefit regardless of the actual charges.

Benefits are generally triggered by the loss of two ADLs or a cognitive impairment. However, the definition of ADLs used in the particular long-term care policy can make an enormous difference in whether or not benefits will be paid. For example, some policies count bathing and dressing as two separate ADLs, while other policies combine bathing and dressing into a single ADL. Since most insureds tend to lose bathing and dressing first, the effect of combining bathing and dressing into one ADL is significant – no benefits will be paid until the ability to perform a third ADL is lost, something which may or may not occur.

Reminiscent of disability insurance back in the 1980s, competition in the long-term care arena is intense as more and more carriers are moving into this market. Long-term care has become the fastest growing insurance product available. In 1986, there were only about 30 companies offering some type of long-term care product. Currently, however, there are 120 companies in the long-term care market. As such, one must have a good understanding of the benefits available with long-term care coverage.

Important features to look for in long-term care policies include:

- Coverage for skilled, intermediate and custodial care;
- Home care in same policy;
- Low activities of daily living ("ADL") requirements to qualify for benefits;
- No prior hospitalization requirement;
- Inflation protection features;
- Waiver of premium;

[3] ADLs include bathing, dressing, transferring, toileting, continence, and feeding. In some states (including California), mobility is considered a seventh ADL.

- Guaranteed renewability; and
- Coverage for Alzheimer's and other cognitive impairments.

Long-term care insurance can be sold on both an individual and a group basis, however, individual coverage predominates.[4] Thus, as most long-term care policies are purchased on an individual basis outside of the employment arena, ERISA is generally not an issue.

Long-term care insurance, however, is heavily regulated. In addition to the statutes and regulations applicable to all classes of insurance, most states have also enacted statutes specific to long-term care insurance that are based upon the Model Acts and Model Regulations developed by the National Association of Insurance Commissioners (NAIC).

III. STATUTORY GUIDELINES

Recognizing the potential for fraud, especially as long-term care products are marketed primarily to the elderly, the NAIC set forth model rules and regulations to help standardize long-term care insurance. In addition, most states have enacted statutes similar to the NAIC's Model Act, which regulate the sale and substance of long-term care insurance policies.[5] And these statutes, which are patterned after the Model Act, require certain policy features and practices that provide consumers with broad choices and expansive rights.

A. CALIFORNIA'S REGULATION OF LONG-TERM CARE INSURANCE

In California, long-term care insurance is regulated under Chapter 2.6 in Part 2 ("Life and Disability Insurance") of the Insurance Code, which provides for specific benefit provisions as

[4] According to A.M. Best Co., individual policies accounted for $2.1 billion of the $2.5 billion in total long-term care insurance premiums written by insurers in 1995.

[5] For example, see: Alabama (Ala. Ins. Dept. Reg. 91); Alaska (Alaska Stat. §§ 21.53.010 *et seq.*); Arizona (Ariz. Rev. Stat. Ann. §§ 20-1691 *et seq.*); California (Cal. Ins. Code §§ 10230 *et seq.*); Colorado (Colo. Rev. Stat. 10-19-101 *et seq.*); Delaware (Del. Code Ann. Tit. 18, §§ 7101 *et seq.*); Florida (Fla. Stat. §§ 627.9401 *et seq.*); Georgia (Ga. Code Ann. §§ 33-42-1 *et seq.*); Hawaii (Hawaii Rev. Stat. §§ 431:10A-521 *et seq.*); Idaho (Idaho Code §§ 41-4601 *et seq.*); Illinois (Ill. Rev. Stat. Ch 73 art. XIXA §§ 351A-1 *et seq.*); Indiana (Ind. Code §§ 27-8-12-1 *et seq.*); Iowa (Iowa Code §§ 514G.1 *et seq.*); Kansas (Kan. Stat. Ann §§ 40-2225 *et seq.*); Louisiana (La. Rev. Stat. Ann. §§ 22:1731 *et seq.*); Maryland (Md. Ann. Code art. 48A, §§ 642 *et seq.*); Michigan (Mich. Comp. Laws §§ 500.2280 *et seq.*); Minnesota (Minn. Stat. §§ 62A.46 *et seq.*); Mississippi (Miss. Ins. Reg. 90-102); Missouri (Mo. Ann. Stat. §§ 376.951 *et seq.*); Montana (Mont. Code Ann. §§ 33-22-1101 *et seq.*); Nebraska (Neb. Rev. Stat. §§ 44-4501 *et seq.*); Nevada (Nev. Admin. Code §§ 687B.010 *et seq.*); New Hampshire (N. H. Rev. Stat. Ann. §§ 415-D:1 *et seq.*); New Mexico (N. M. Stat. Ann. §§ 59A-23A-1 *et seq.*); New York (N. Y. Comp. Codes R. & Regs. tit. 11, §§ 52.12 – 52.13); North Carolina (N. C. Gen. Stat. §§ 58-55-1 *et seq.*); North Dakota (N. D. Cent. Code §§ 26.1-45-01 *et seq.*); Ohio (Ohio Rev. Code Ann. §§ 3923.41 *et seq.*); Oklahoma (Okla. Stat. tit. 36 §§ 4421 *et seq.*); Oregon (Or. Rev. Stat. §§ 743.650 *et seq.*); Rhode Island (R. I. Gen. Laws §§ 27-34.2-1 *et seq.*); South Carolina (S.C. Code Ann. §§ 38-72-10 *et seq.*); South Dakota (S. D. Codified Laws Ann. §§ 58-17B-1 *et seq.*); Tennessee (Tenn. Code Ann. §§ 56-42-101 *et seq.*); Texas (Tex. Admin. Code tit. 28, §§ 3.3801 *et seq.*); Vermont (Vt. Stat. Ann. tit. 8, §§ 8051 *et seq.*); Virginia (Va. Code §§ 38.2-5200 *et seq.*); West Virginia (W. Va. Code §§ 33-15A-1 *et seq.*); Wisconsin (Wis. Stat. § 146.91); and Wyoming (Wyo. Stat §§ 26-38-101 *et seq.*).

well as statutory duties aimed at protecting the consumer. The provisions begin with § 10230,[6] and define long-term care insurance as "any policy, certificate, or rider advertised, marketed, offered, solicited, or designed to provide coverage for diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services that are provided in a setting other than an acute care unit of a hospital."[7]

1. Benefit Provisions

Every long-term care insurance policy that purports to provide coverage for home care or community-based care must provide coverage for home health care, adult day care, personal care, homemaker services, hospice services, and respite care.[8] The threshold to establish eligibility for home care benefits may not be more restrictive than impairments in two out of seven ADLs (i.e., eating, bathing, dressing, ambulating, transferring, toileting, and continence) or impairment of cognitive ability.[9] The insurer may not limit coverage for home care such as requiring "medical necessity of care" as a prerequisite to benefits or requiring care in a nursing facility if home care is not provided.[10] In addition, the insurer may not limit the availability of home care or other benefits on prior hospitalization or institutionalization.[11]

Insurers cannot limit or exclude coverage by type of condition or treatment, unless the exclusion is based on: (a) pre-existing condition[12]; (b) mental disorder (excluding Alzheimer's disease or other degenerative and dementing illnesses); (c) drug or alcohol addiction; or (d) treatment arising out of war, participation in a felony, suicide or aviation.[13] Insurers cannot cancel or otherwise terminate long-term care insurance on the grounds of the age or deteriorating health of

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[6] The Health Insurance Portability and Accountability Act (HIPPA) added § 7702B to the Internal Revenue Code regarding the treatment and taxation of qualified long-term care insurance. Federally qualified long-term care policies are treated in the same manner as major medical insurance, i.e., benefits are generally not taxable and premium payments by individuals are deductible as an itemized medical expense or a percentage is deductible as an adjustment to AGI for self-employed taxpayers and employer paid premiums are deductible by the employer and excluded from the employee's income. The criteria for federally qualified policies, however, is more restrictive than California's criteria. For example, while there are only six ADLs under federally qualified policies, California includes seven ADLs (thereby providing for more expansive coverage). As a result, California's long-term care statutes were amended to provide for both types of policies – those meeting the more restrictive federal guidelines and those meeting California's more liberal guidelines. (*See* Cal. Ins. Code § 10232.25.) This syllabus will focus on California's criteria for "policies not intended to qualify for tax benefits" (i.e., policies that do not meet the federal guidelines).

[7] Cal. Ins. Code § 10231.2 (West 2004).

[8] Cal. Ins. Code § 10232.9 (West 2004).

[9] Cal. Ins. Code § 10232.8 (West 2004).

[10] Cal. Ins. Code § 10232.9 (West 2004).

[11] Cal. Ins. Code § 10232.5 (West 2004).

[12] The preexisting condition exclusion cannot be more restrictive than "a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage." In addition, the policy "shall cover preexisting conditions that are disclosed on the application no later than six months following the effective date of the coverage . . . regardless of the date the loss or confinement begins." (Cal. Ins. Code § 10232.4 (West 2004).)

[13] Cal. Ins. Code § 10235.8 (West 2004).

the insured.[14] And insureds must have the right to renew their long-term care policies – policies must contain an appropriately captioned renewability provision on the first page and be either "guaranteed renewable" (insurer can change premiums for all insureds in same class) or "noncancelable" (insurer cannot change premiums). As such, insurers must obtain the insured's written agreement before changing the terms of the policy and/or increasing the premium.[15]

2. Protection Against Unintentional Lapses

The statute also provides safeguards against unintentional lapses – a very real concern as many elderly insureds suffer from some sort of dementia or cognitive impairment. Before a long-term care policy is issued, the insurer must give the applicant the "right to designate at least one individual, in addition to the applicant, to receive notice of lapse or termination of a policy . . . for nonpayment of premium."[16]

The insurer cannot lapse a long-term care policy for nonpayment of premium unless the insurer gives proper notice (at least 30 days prior to the effective date of the lapse) to both the insured and his or her designee.[17] In addition, the required notice must advise the insured of his right to lower premiums by reducing coverage.[18] And the policy must provide for reinstatement of coverage if the insured has a cognitive impairment or loss of functional capacity sufficient to qualify for benefits under the policy, as long as the insured requests such reinstatement within five months of the date of lapse.[19]

3. Prohibition Against Postclaims Underwriting

The statute makes it very clear that postclaims underwriting is prohibited. Specifically, applications for long-term care "shall contain clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant." Questions cannot be compound and "shall require only a 'yes' or 'no' answer." While the application may request the "name of any prescribed medication and the name of a prescribing physician," if it does so, then "any mistake or omission shall not be used as a basis for the denial of a claim or the recision of a policy." Moreover, if an insurer "does not complete medical underwriting and resolve all reasonable questions arising from information submitted on or with an application before issuing the policy . . . then the insurer may only rescind the policy . . . or deny an otherwise valid claim, upon ***clear and convincing evidence of fraud or material misrepresentation*** of the risk by the applicant."[20]

4. Prohibition Against Unnecessary Replacement

Long-term care insurance policies may not be replaced "unnecessarily," with the presumption that any third or greater policy sold to an insured in any 12-month period is "unnecessary." In

[14] Cal. Ins. Code § 10233.2 (West 2004).
[15] Cal. Ins. Code §§ 10235.14, 10236 (West 2004).
[16] Cal. Ins. Code § 10235.40(a) (West 2004).
[17] Cal. Ins. Code § 10235.40(d) (West 2004).
[18] Cal. Ins. Code § 10235.50(d) (West 2004).
[19] Cal. Ins. Code § 10235.40(e) (West 2004).
[20] Cal. Ins. Code § 10232.3 (West 2004) (emphasis added).

addition, insurers and/or their agents are not allowed to replace coverage if it would "result in a decrease in benefits and an increase in premium."[21] And if a policy replaces existing long-term care coverage, then the replacing insurer must waive any applicable preexisting time periods to the extent that they were satisfied under the original policy.[22]

5. Outline of Coverage

Insurers (or their agents) must provide an Outline of Coverage to all prospective applicants at the time of the initial solicitation.[23] The outline of coverage must include the following:[24]

1. Purpose of Outline of Coverage – explaining that the outline is only a summary of coverage and, because the policy provisions control, the applicant should "READ YOUR POLICY CAREFULLY!"

2. Terms Under Which the Policy May be Returned and Premium Refunded – advising that the applicant has 30 days after the policy is delivered to return it (for any reason) for a full refund. (*See also* Cal. Ins. Code § 10232.7.)

3. Policy is Not Medicare Supplement Coverage

4. Long-Term Care Coverage and Benefits Provided by this Policy – providing a brief description of benefits.

5. Limitations and Exclusions – describing any policy provisions which limit, exclude, restrict, or reduce benefits under the policy, such that "THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITHY YOUR LONG-TERM CARE NEEDS."

6. Relationship of Cost of Care and Benefits – explaining that applicant should consider how the policy's benefits may be adjusted over time as long-term care costs continue to rise.

7. Terms Under which Policy may be Continued or Discontinued – discussing renewability provisions and any waiver of premium provisions contained in the policy.

8. Alzheimer's Disease, Organic Disorders, and Related Mental Diseases – stating that the policy provides coverage for insureds with Alzheimer's disease, organic disorders, or related degenerative and dementing illnesses.

9. Premium – stating the total annual premium and amount of annual premium corresponding to each benefit option.

[21] Cal. Ins. Code § 10234.85 (West 2004).
[22] Cal. Ins. Code § 10233.3 (West 2004).
[23] Cal. Ins. Code § 10233.5 (West 2004).
[24] Cal. Ins. Code § 10235.5 (West 2004).

10. Information and Counseling – advising applicants that they can obtain a Consumer Guide to Long-Term Care Insurance and that counseling for long-term care insurance is available.

6. Consumer Protection Provisions

In addition to guidelines regarding the specific benefit provisions to be contained in long-term care policies, California also imposes several statutory duties specifically aimed at protecting consumers, including suitability provisions, a duty of honesty and a duty of good faith and fair dealing.

a. Suitability Standards

Every insurer that markets long-term care insurance in California must "develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant." These standards must take into consideration the applicant's ability to pay for the proposed coverage, the applicant's goals with respect to long-term care, and the value, benefits, and costs of the applicant's existing insurance (if any) as compared to the value, benefits, and costs of the proposed long-term care coverage. [25]

In addition, insurers and their agents must make "reasonable efforts to obtain the [necessary] information" in order to determine if the applicant meets the suitability standards by asking applicants to complete a "Long Term Care Personal Worksheet." And if the insurer determines that the applicant does not meet its suitability standards (or if the applicant has refused to provide the information), the insurer "may reject the application."[26]

b. Duty of Honesty and Good Faith to Applicants and Insureds

California also imposes a statutory duty of honesty, and a duty of good faith and fair dealing. Specifically, with "regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe a policyholder or a prospective policyholder a duty of honesty, and a duty of good faith and fair dealing."[27] In addition, the statute separately provides that the conduct of an insurer, broker, or agent "during the offer and sale of a policy previous to the purchase is relevant to any action alleging a breach of the duty of honesty, and a duty of good faith and fair dealing."[28] Thus, the statutory duty of honesty and good faith and fair dealing is owed to *both* insureds and applicants and, unlike the common law duty of good faith and fair dealing implied in every insurance contract, is NOT dependent on the issuance of a policy.

Exactly how these statutory duties will play out remains to be seen. So far, there are no California cases that address either the statutory duty of honesty or the statutory duty of good faith and fair dealing. In fact, as of the writing of this syllabus there were only two California

[25] Cal. Ins. Code § 10234.95 (West 2004).
[26] Cal. Ins. Code § 10234.95 (West 2004).
[27] Cal. Ins. Code § 10234.8 (West 2004).
[28] Cal. Ins. Code § 10234.8 (West 2004).

cases regarding long-term care insurance (and they are unpublished at that).

In *Kagan v. Conseco Senior Health Insurance Co.*, 2006 WL 3039792 (E.D. Cal. Oct. 23, 2006), the insured made a claim for home health care benefits. The insurer denied the claim, and the insured sued for breach of contract and breach of the duty of good faith and fair dealing. The court granted the insurer's motion to dismiss because the insured had not complied with the insurer's proof of loss requirements, therefore her claim was not ripe for adjudication.

In *Kirsh v. Unum Life Insurance Co.*, 2002 WL 1293016 (Cal. App. 2 Dist. June 12, 2002), the insured sued his insurer for rescinding his long-term care policy, which the insured had purchased just prior to learning he had disabling colon cancer. The trial court granted the insurer's motion for summary judgment, and the court of appeal affirmed, reasoning that insured's breach of his continuing duty to disclose his diagnosis of colon cancer to the insurer overrode the insured's defenses to rescission. Unfortunately for plaintiffs' bar, this is a prime example of the classic truism that "bad facts make bad law" – the only good thing about this case is that it is unpublished.

Just as we saw with disability insurance, however, we can expect to see a surge of long-term care litigation in the near future.

IV. LONG TERM CARE CLAIMS

Although long-term care insurance is relatively new, the litigation has already begun. Following is a sampling of cases involving long-term care insurance.

- Numerous class action claims have been filed alleging fraud and other illegal conduct based on substantial increases in long-term care insurance premiums.[29]

- Courts have held that statutes regulating long-term care insurance are not retroactive.[30]

- Courts have upheld denial of long-term care benefits because the facility in which the insured resided was not a "nursing home" as defined in the policy.[31]

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[29] See *Rakes v. Life Investors Ins. Co. of America*, 2007 WL 2122195 (N.D. Iowa July 20, 2007); *Forest v. Penn Treaty American Corp*., 270 F. Supp. 2d 1357 (M.D. Fla. 2003); *Milkman v. American Travelers Life Ins. Co.*, 2001 WL 1807376 (Pa. Com. Pl.); *Rose v. United Equitable Ins. Co.*, 632 N.W.2d 429 (N.D. 2001); *Hanson v. Acceleration Life Ins. Co.*, 1999 WL 33283345 (D.N.D.).

[30] See *Yoder v. American Travelers Life Ins. Co.*, 814 A.2d 229 (Pa. Super 2002) (Pennsylvania statute, 40 P.S. § 991.1108, prohibiting prior institutionalization requirements in long-term care policies did not apply to policy renewals, and thus, did not apply to insured's policy which was issued prior to effective dates of statute, but renewed after such date.); *Haley v. AIG Life Ins. Co.*, 2002 WL 417419 (D.N.D.) (North Dakota statute, N.D. Cent. Code § 26.1-45-07, prohibiting prior institutionalization requirements in long-term care policies did not apply retroactively, such that the original terms of the policy remained in effect.).

[31] See *Geary v. Life Investors Ins. Co. of America*, --- F. Supp. 2d ---, 2007 WL 2325191 (N.D. Tex. Aug. 13, 2007) (facility specifically licensed as an assisted living facility under the regulations of Texas law

- Courts have held that rescission is improper where misrepresentation on application was innocent.[32]

- ERISA's savings clause protects claims brought under state statutes and regulations pertaining to long-term care insurance from ERISA preemption.[33]

And in addition to the typical breach of contract and bad faith causes of action[34], the nature of long-term care insurance naturally lends itself to claims of elder abuse.

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was not a "nursing home" ad defined under the long-term care policy); *Gillogly v. General Electric Capital Assur. Co.*, 430 F.3d 1284 (10th Cir. 2005) (licensed residential care home was not a "nursing home" as defined under long-term care policy); *Gregg v. IDS Life Ins. Co.*, 261 A.D.2d 799 (N.Y. App. Div. 1999) (denying benefits under a long-term care insurance policy because the facility in which the insured resided (apartment building offering a range of amenities and optional in-home care services) was not a nursing home as defined by the licensing requirement contained in the policy).

[32] See *Metropolitan Life Ins. Co. v. Conger*, 474 F.3d 258 (6th Cir. 2007) (Court held that (1) insurer abused its discretion by steadfastly adhering to its decision to rescind the insured's long-term care coverage while ignoring, without explanation, significant evidence contrary to its conclusion that the insured had a progressive neurological disorder when he applied for coverage; and (2) insured had no independent duty to disclose undiagnosed symptoms or medical history that was not specifically requested by insurer.); *Smith v. AF&L Ins. Co.*, 147 S.W.3d 767 (Mo. Ct. App. 2004) (Insurer's refusal to pay claims related to insured's admission to a long-term care facility for dementia and osteoarthritis was vexatious and without reasonable cause, subjecting insurer to damages under vexatious refusal to pay statutes, where insured provided truthful information on her application, acknowledged her memory problems at the application stage, submitted to a follow-up interview and successfully completed insurer's cognitive exam, and insurer did not adhere to protocol when replacing another policy.); *Derbidge v. Mutual Protective Ins. Co.*, 963 P.2d 788 (Utah Ct. App. 1998) (innocent misstatements made in application are not "misrepresentations" for purposes of rescission). But see, *Kirsh v. Unum Life Ins. Co.*, 2002 WL 1293016 (Cal. App. 2 Dist.). *Kirsh* involved an insured who sued his insurer for rescinding his long-term care policy, which insured had purchased just prior to learning he had disabling colon cancer. The trial court granted the insurer's motion for summary judgment, and the court of appeal affirmed, reasoning that insured's breach of his continuing duty to disclose his diagnosis of colon cancer to insurer overrode insured's defenses to rescission.

[33] See *Schneider v. Unum Life Ins. Co. of Am.*, 149 F. Supp. 2d 169 (E.D. Pa. 2001) (Pennsylvania statutes and regulations which addressed disclosure, underwriting, and language of long-term care policies regulated insurance within meaning of ERISA's savings clause, and thus employee's claims regarding LTC agreement under Pennsylvania statutes were not preempted by ERISA.)

[34] See *Oleson v. Physicians Mut. Ins. Co.*, 2003 WL 22038243 (Neb. App.) (Initial denial and delay in paying long-term care benefits was reasonable as insurer did not receive a timely plan of treatment from treating physician and insured failed to provide insurer with proper evidence of his home health care bills.); *Walker v. Conseco Services, LLC*, 252 F. Supp. 2d 524 (N.D. Ohio 2003) (Insured's motion for reconsideration was denied as trial court properly granted insurer's motion for summary judgment as insured's policy had lapsed for non-payment of premium prior to her entering the assisted living facility.); *Radcliffe v. Network America Life Ins. Co.*, 1999 WL 391380 (Wash. Ct. App.) (Trial court erred by granting insurer's motion for summary judgment on insured's breach of contract claim because insurer's requirement that home health care providers come from a licensed agency conflicted with Washington's Long-Term Care Insurance Act, RCW § 48.84, and applicable regulations, WAC § 284-54-030, as they existed in 1989, when long-term care insurance policy was obtained.); *Wickland v. American Travelers Life Ins. Co.*, 513 S.E.2d 657 (W. Va. 1998) (Insured did not have "preexisting condition" of falls and

V. ELDER ABUSE CLAIMS

In California, "fiduciary abuse of an elder" includes the acts of any "person who stands in a position of trust to an elder" and who "appropriates their money or property to any wrongful use, or for any purpose not in the due and lawful execution of his or her trust."[35] Conceivably, any applicant or policyholder who meets the statutory definition of an elder could use the elder abuse laws to pursue claims for, among other things, unnecessary replacement or sale of an unsuitable policy.

In addition, "abuse of an elder" includes "physical abuse, neglect, fiduciary abuse, abandonment, isolation, abduction or other treatment with resulting physical harm or pain or mental suffering."[36] Thus, given the appropriate facts, an elderly insured could state a claim for elder abuse based on the unreasonable denial of long-term care benefits, especially when the insured is without the resources to obtain the long-term care he so desperately needs.

VI. CONCLUSION

Long-term care insurance provides emotional well-being and peace of mind to the elderly and their families. Even though the fear of outliving one's income and becoming dependent may never be fully overcome, insureds' should be able to rest secure in the knowledge that their long-term care coverage is there to provide for them if the need arises. In short, having long-term care insurance means that growing old does not have to be equated with going broke or losing dignity, control, and autonomy. However, given insurers' past history of unreasonable denials in similar situations, it is more likely that long-term care insurance will become the next generation of bad faith litigation, rather than a security blanket for the elderly.

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vertigo, as defined by her long-term care insurance policy and pertinent statutory language, and thus, she was entitled to benefits even though insured twice complained of occasional or episodic dizziness during six-month period prior to effective date of coverage.).

[35] Cal. Welf. & Inst. Code § 15610.30 (West 2001).

[36] Cal. Welf. & Inst. Code § 15160.07 (West 2001).