As for damages, the results of substandard care for ALF residents may be less drastic medically than those of skilled nursing facility residents. Nonetheless, the losses ALF residents suffer can be every bit as substantial.

While a resident may survive an injury that heals, it could require an otherwise unnecessary move to a skilled nursing environment. This results in a loss of privacy (single rooms are uncommon in nursing homes), disruption of marital relationships (spouses frequently live together with their own furniture in ALFs), and an overall lifetime sentence to a more restrictive, institutional setting.

The resident bargained for adequate, consistent care to address his or her needs as determined by a knowledgeable and skilled caregiver. The laudable goals of dignity, a homelike environment, and individual autonomy must be secondary to health and safety.

Also, damages due to increased private payments or the accrual of governmental liens for Medicare/Medicaid payments can create "boardable" special damages that can be presented to the jury for repayment at the end of trial. Under the right set of facts, plaintiff lawyers should consider pressing for punitive damages against companies that focus on profits to residents' detriment.

The same corporate players often provide both skilled nursing and ALF levels of care, although they may do so under a different name or corporate guise. Since many of the major ALF players remain publicly traded,

A LONG-TERM CARE INSURANCE PRIMER

By Corinne Chandler and Glenn Kantor

Long-term care insurance policies theoretically provide valuable benefits. The product naturally appeals to senior citizens who want coverage for care they may need later in life. Consumers purchase these policies so that they will not be a burden on their families. But often, after paying premiums for 15 or 20 years, consumers discover that the policy does not provide the type of benefits they expected. At that point, they cannot switch coverage due to age or ill health, or the insurer's bureaucracy makes it difficult for elderly and infirm individuals to pursue their claims.

In contested claims, two themes often emerge: The insurer has changed the manner in which it interprets policies so as to deny benefits, or the policy the insured purchased is inadequate in today's market. The disputes rarely involve whether the insured is entitled to the care.

Most litigation centers around contract interpretation issues in ambiguous policies which must be resolved in favor of the insured. Frequent contract interpretation disputes may include the following.

Ineligible care provider. One of the most common grounds for claims denial is when the insurer determines that either the facility or the home health care provider is an "ineligible provider." This frequently occurs when the insured resides in an assisted living facility and receives caregiver services there. If a claim is presented under a home health care policy, the insurer may deny benefits because the insured is not receiving care in his or her "residence." However, "home" may not be defined in the policy or may be defined in such a manner that the facility should be considered the insured's home.

Alternatively, if the claim is presented under a nursing home or facility policy and the insured resides in an assisted living facility, the insurer may deny it because the facility is not "appropriately licensed." Older policies may require that a facility be specifically licensed as a "nursing home" to qualify as eligible. Benefits may be denied for the most common type of care being provided today—care in an assisted living facility. Many states now prohibit exclusion of assisted living facilities from policies that provide facility care.

There are several possible responses to an ineligible caregiver denial. For example, a nursing home policy may require only that the facility be "appropriately licensed." Under a literal interpretation, an appropriate license may include one for an assisted living facility, which may expand nursing home coverage to include an assisted living facility.

The same rationale may be used to rebut a denial under a home health care policy. The policy may contain language requiring that the caregiver be appropriately licensed in the applicable state. Some states, such as California, do not require caregivers to be licensed to provide unskilled services, such as companion or homemaker services.[1]

Unintentional policy lapse. Most insurers have protections in place to guard against an unintentional lapse of the policy. For example, the insured may designate third parties for the insurer to notify if the policy is about to lapse. The third party then can take steps to preserve the policy by ensuring a timely premium payment. If timely notification was not given to the third-party designee, the insured may contest the lapse.

Unfulfilled "gatekeeper" requirements. Older home health care policies usually contain gatekeeper requirements,

financial data can be obtained independent of discovery.

Senior citizens often must leave their homes for supervised care because of increasing physical or mental infirmities. If they receive careful attention and reasonable scrutiny by well-informed caregivers, an assisted living placement can raise the quality of life for the entire family. But assisted living residents' inevitably increasing fragility and vulnerability require constant vigilance by facility staff. When this vigilance is lacking and a resident is injured, plaintiff lawyers need to know how to hold the facility accountable.

Martin S. Kardon is a partner with Kanter Bernstein & Kardon in Philadelphia and can be reached at Kardon@kbklaw.com.

Notes

1. Sunrise Senior Living, Mission, Principles of Service, and Core Values, www.sunriseseniorliving.com/the-sunrise-difference/principles-and-values.aspx.
2. *See* AssistedLivingInfo, Paying for Care, www.assistedlivinginfo.com/Paying-for-Care/Overview.
3. For a complete list and description of the assisted living regulations in all states, see National Center for Assisted Living, Assisted Living Regulations, 2012 Assisted Living State Regulatory Review, www.ahcancal.org/ncal/resources/Pages/AssistedLivingRegulations.aspx.
4. For example, in Pennsylvania the regulations now separate "personal care homes" from "assisted living facilities," with the latter having greater service, documentation, and care requirements. *See* Pa. Code tit. 55, §§2600, 2800 (2010).
5. For example, Manor Care, Inc.'s policy of "negotiated risk agreements" (obtained in one client's case) states: "A negotiated risk agreement is completed by the executive director during move-in or during a resident's stay when a family's/resident's behavior or preferences puts the facility and/or the resident at risk. The form acknowledges that discussion of a particular risk(s) has taken place with the family/responsible party and that mutual understanding and agreement on the approach was reached."

which are now prohibited in many states. One of the most common requires the insured to be hospitalized for three days for the same condition that requires home health care. Many disabling conditions—such as Alzheimer's disease—do not require hospitalization, thus preventing the insured from using the policy as intended.

Litigation Tips

In many cases, the dispute involves a pure contract interpretation issue. If the policy language is not clear, other evidence may be helpful in ascertaining the parties' intent.

State departments of insurance may require insurers to submit advertising materials or outlines of coverage for approval before making them available to insureds.

Also, you may be able to gauge the insurer's intent by obtaining its communications with the department of insurance when it sought approval to sell the policy form or requested a premium increase. The insurer may have made representations regarding the scope of coverage that may be useful in your case.

Claims manuals, guidelines, and training materials are also relevant. Because many insurers have changed their approach to policy interpretation, it is helpful to obtain historical manuals and guidelines as well.

Discovery of other disputes involving the same issue may yield valuable evidence. For example, there has been extensive litigation involving premium increases imposed by long-term care insurers. There has also been litigation regarding the insurer's "alternate plan of care" provisions.[2]

Finally, you may be able to use a "conformity with state statutes" provision to bring the policy in line with current state statutes. Under this emerging theory, some courts have treated the annual insurance policy renewal as a new policy, which must conform to current state statutes that provide greater protection to insureds under long-term care contracts.[3]

Depending on the state, available remedies may include contract benefits and extracontractual remedies that are typically available in claims disputes. It may also be helpful to consult state statutes for enhanced remedies that may be available for the elderly.

Corinne Chandler and Glenn Kantor are partners in Kantor & Kantor in Northridge, Calif. They can be contacted at cchandler@kantorlaw.net and gkantor@kantorlaw.net, respectively.

Notes

1. Cal. Health & Safety Code, §1727(d) (1989).
2. *See Roland v. Transamerica Life Ins. Co.,* 570 F. Supp. 2d 871 (N.D. Tex. 2008) (court upheld an insurer's denial of benefits under an "alternate plan of care" provision on grounds that the alternate plan of care had not been mutually agreed on between the insurer and the insured).
3. *See Bushnell v. Medico Ins. Co.*, 246 P.3d 856 (Wash. App. Div. 1 2001) (policy that was renewed annually must conform with current state statute that prohibited three-day hospitalization "gatekeeper" provisions); *Bell Care Nurses Registry, Inc. v. Contl. Cas. Co.,* 25 So. 3d 13 (Fla. 3d Dist. App. 2009). *But see Haley v. AIG Life Ins. Co.,* 2002 WL 417419 (D.N.D. Jan. 24, 2002) (refused to apply current law to "guaranteed renewable" policy on grounds that the policy was a continuation of the original policy and was not required to conform with current state law); *Yoder v. Am. Travellers Life Ins. Co.,* 814 A.2d 229 (Pa. Super. 2002).