Article from

Long-Term Care News

April 2019
Issue 50

Tax-Qualified Language: Litigation Risks Stemming from Common Policy Language

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Many long-term-care (LTC) insurance policies in the market are "Tax-Qualified," or "TQ," meaning that they meet the federal standards for favorable tax treatment specified by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (or were grandfathered in to that definition). This is an attractive option for most insureds because under TQ policies, certain LTC insurance benefits qualify for favorable federal income tax treatment—if the policy pays only benefits that reimburse the insured for qualified LTC costs, the insured will not owe federal income tax on those benefits. Likewise, premiums are tax-deductible up to a maximum limit that increases with age. These benefits are not provided by policies that are "Non-Tax-Qualified," or "NTQ."

Congress included provisions concerning LTC insurance within HIPAA in an attempt to improve access to private LTC insurance. In doing so, however, Congress created some confusion for both insureds and insurers. For instance, in order to qualify as a TQ policy, the policy must contain a multitude of statutorily required provisions and language. Specifically, TQ policies must provide coverage for "qualified long-term care services," which "are required by a chronically ill individual, and are provided pursuant to a plan of care prescribed by a licensed health care practitioner." 26 U.S.C. § 7702B(c)(1). The term "chronically ill" is defined as "any individual who has been certified by a licensed health care practitioner as—

(i) being unable to perform (without substantial assistance from another individual) at least 2 activities of daily living for a period of at least 90 days due to a loss of functional capacity ... or

(iii) requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

26 U.S.C. § 7702B(c)(2)(A)(i)-(iii)" [emphasis added].

THE TWO "S" WORDS—"SUBSTANTIAL" AND "SEVERE"

The terms "substantial" and "severe" are not defined in § 7702B, HIPAA or the accompanying regulations. As a result, there is significant gray area that creates uncertainty as to whether individual claimants' conditions fall within the bounds of these terms. After all, an insurer's duty is to pay claims that are valid and covered and deny those that are not. Yet with a consistent increase in claims across the LTC insurance industry, there will organically be more risk associated with "close call" or "gray area" claims decisions. Likewise, as claims continue to increase, and more "gray area" claims are denied, there is a greater chance for dissatisfied insureds and thus a stronger likelihood of litigation. This article discusses hypothetical claims scenarios and identifies potential blind spots as a thought exercise on how insurers may approach "gray area" claims decisions with TQ policy language.

Scenario One—"Inconsistent Assistance" with Activities of Daily Living

The insured is a 70-year-old female, Jane Row, who lives alone in a two-story row home in an urban area. Ms. Row suffers from rheumatoid arthritis, which is progressively becoming worse. At her most recent rheumatology appointment, Ms. Row told her physician that she was struggling to care for herself more frequently, and the physician suggested that she begin receiving assistance at home.

At the first meeting, the home health-care provider chosen by Ms. Row discovers that Ms. Row's capabilities vary widely depending on whether she is having a "good" or "bad" day—all of which can change based on weather, amount of physical activity and sleep. On good days, Ms. Row primarily travels by taxi but walks to the grocery store, convenience store and pharmacy to run her errands, all of which are located within three blocks of her home. However, on "bad" days she struggles to climb the stairs to the second floor master bedroom and sometimes has to sleep on the first-floor couch instead. She no longer cooks because of the pain in her fingers, but she can microwave food that her family prepares for her. At times, however, she cannot hold her silverware, and on those days, she eats only hand-held fruits and vegetables. Ms. Row indicated that she only bathes on her "good" days, when she is able to grab the bar in the shower, lift her arms above her head to wash her hair and bend down to wash and dry her lower extremities. The clothing she wears depends on the type of day she is having, too. Sometimes, she can wear button-down

blouses and pants with zippers, but on most occasions, she needs pull-on types of clothing and will even stay in her pajamas all day. She is independent in toileting and continence. An on-site assessment likely occurred on a "good" day, because the nurse-assessor noted that Ms. Row shows some stiffness but is otherwise able to perform all of her activities of daily living with only minimal assistance.

Ms. Row would like to hire the home-health agency for one hour each morning to help her bathe and dress in regular clothing, and then for two hours each evening to cook and help her eat dinner, assist her to climb the stairs to her bedroom and to help her change into pajamas and prepare for bedtime. In her claim submission, however, Ms. Row acknowledges that on good days she would not require any of this assistance except for making her dinner. She does not deny leaving her home to walk to shops within her normal three-block radius. There are no other care or medical records available at this time.

Does Ms. Row require **substantial assistance** with two or more of her activities of daily living such that she would be eligible for benefits under her TQ LTC insurance policy? Her physician did not specifically find that she requires assistance—just that she would benefit from it. There is no documentation of what constitutes a "good" or a "bad" day for Ms. Row, but on "bad" days she arguably requires assistance with bathing, dressing and perhaps even eating. If she does not need any help on "good" days, then is the need for assistance substantial within the meaning of § 7702B and the applicable policy language?

When there is uncertainty like this in a claim file, claims professionals can gain information that might assist them in making the correct claims decision by conducting additional interviews with the insured's physician(s) and the insureds themselves. While a physician could exaggerate the facts to try and obtain coverage for his or her client, in most scenarios the physician will likely be able to provide a clear and complete picture of the type of care that is required. And in any event, a statement from the insured's own physician stating that the insured does or does not require substantial assistance with any activities of daily living is certainly one of the strongest pieces of evidence in determining the proper claim decision and having it withstand any external scrutiny. If more information is sought, however, the claims professional must be prepared to walk through the full scope of the insured's condition and the facts surrounding the claim, so as to gather as much relevant information as possible from the insured, the insured's physician or the insured's caretaker. Simply asking, "is the assistance this insured requires "substantial?" will not yield helpful data, as the response will simply be a judgment call based on that individual's definition of substantial. Obtaining this information will permit the insured to make a more informed decision

and, in the hopefully few but undoubtedly inevitable number of instances where the insured disagrees, it will help the insurer avoid extracontractual liability for bad faith, given that the insurer can show that they went above and beyond to obtain relevant data to make the proper claims determination. Finally, insurers should work within their existing guidelines to make sure that this additional information gathering takes place within the appropriate statutory and/or regulatory timelines.

Scenario Two—"Substantial Supervision" Required Due to "Severe" Cognitive Impairment

The insured is an 80-year-old male, Tom Doe, who lives alone. His daughter, however, believes that he needs to be in an assisted living facility because his mental health is declining. For example, Mr. Doe's daughter is focused on Mr. Doe's new and bizarre behavior. Mr. Doe recently went to the grocery store in his pajamas, and sometimes cannot remember the names of his grandchildren. Recently, Mr. Doe was hospitalized for dehydration, which his daughter attributes to his

failure to drink enough fluids. After the hospitalization, Mr. Doe's daughter decides that it is best for him not to live alone anymore, and so Mr. Doe moves in to an assisted living facility. He does not live in the memory care unit of the facility (even though it has one), and he receives "Level Two Care," which means that he receives assistance with one activity of daily living—bathing—and also receives administration of his medications. Mr. Doe's daughter instructs the facility that Mr. Doe needs assistance with dressing because otherwise he will forget to put on street-appropriate attire. She also believes that if he does not take his blood pressure medication, he will become very ill, and so the medication is given to Mr. Doe by the facility each day.

> A forward-thinking and risk-conscious claims operation is … aware of the pitfalls and gray areas … [in] TQ policy language.

Mr. Doe's daughter files a claim for benefits under Mr. Doe's TQ LTC insurance policy. In support of the claim, she submits a copy of the assisted living residency agreement, which is signed only by Mr. Doe and outlines that Mr. Doe will receive "Level Two Care," including reminders at mealtimes, cuing and prompting at bath time and assistance with dressing. Mr. Doe's daughter also submits a copy of the intake form, which was completed and signed by the head nurse at the assisted living facility, and states that Mr. Doe is "oriented x3, alert and appropriate, and exercises good judgment." The intake form states that one person is required to assist Plaintiff with dressing but provides no explanation of the exact care that will be provided or the need for the care. Recent care notes state that Mr. Doe is "doing well" but has been showing signs of "sundowning." Mr. Doe does not wander, but the facility is locked, and Mr. Doe could not leave the building without being noticed by security. An on-site assessment results in a Mini-Mental State Exam (MMSE) score of 26/30.

Finding a lack of support for a cognitive impairment claim, the carrier requests medical records from Mr. Doe's primary care provider. One month prior to Mr. Doe moving to the assisted-living facility, the primary care provider administered another MMSE, on which Mr. Doe obtained 28/30. During the appointment, Mr. Doe admitted he could not remember his grandchildren's names and could not remember the name of the street on which his new assisted-living facility was located. The provider noted that Mr. Doe was exhibiting "minor short-term memory issues" but made no reference to activities of daily living or other physical health problems. After the insurer informed Mr. Doe's daughter that the medical records received from the primary care provider were insufficient to support a finding of benefit eligibility, Mr. Doe's daughter took Mr. Doe to a neurologist a few weeks later. The neurologist found that Mr. Doe had "dementia, mild; things are at an early stage right now, but of course dementia is progressive, and Mr. Doe is not living independently right now. Mr. Doe should not drive or cook for himself." An MMSE administered by the neurologist resulted in a 22/30 score. The neurologist also prescribed Aricept, which the assisted living facility provides to Mr. Doe. Mr. Doe's daughter is very upset about her father's decline, and she is adamant that the claim is approved quickly because neither she nor her father have much money to pay for his care otherwise.

Claims Decision: Does Mr. Doe require 1) substantial supervision to protect him from threats to his health and safety 2) due to a severe cognitive impairment?

First, the claims adjuster must decide whether supervision provided by the facility is "substantial" in Mr. Doe's case. Although the scenario suggests that Mr. Doe could receive a higher level of care in the memory unit of the facility, it does not provide any information about the level of supervision that Mr. Doe receives in his current unit. "Substantial" supervision cannot, realistically, mean that a human being is watching Mr. Doe all day and all night since so few, if any, claims would satisfy that standard. This is particularly true given modern technology, which can obviate the need for physical human supervision. There is also a gray area as to what the triggers for "requiring" substantial supervision might be. For instance, just because an insured does not wander or self-harm does not mean that he or she does not require substantial supervision to ensure that future injury or harm does not occur. Therefore, claims examiners should ask appropriate questions to gauge whether or not supervision rises to the level of "substantial." For instance, even if a staff member or nurse does not physically watch an insured, does the facility monitor residents through the use of cameras? Can Mr. Doe come and go as he pleases or are the doors locked at all times? All of this information, if accurately received, would inform the decision as to whether or not Mr. Doe requires substantial supervision.

Next, if substantial supervision is required to protect Mr. Doe from threats to his health and safety, the claims administrator must determine whether any cognitive impairment is "severe." This is hard to do. All insureds are different, and individuals will respond to testing (like the MMSE, for instance) differently. Here, the neurologist's note that Mr. Doe suffers from "**mild** dementia" in an "**early** stage" seemingly suggests that

Mr. Doe does not suffer from a **severe** cognitive impairment. On the other hand, the remainder of the note (namely, that Mr. Doe should not cook or drive), coupled with other aspects of Mr. Doe's file (i.e., sundowning and the decreased MMSE score), could support a finding of severe cognitive impairment. To mitigate the risks associated with conflicting elements of a file, an insurer again could speak with the insured's neurologist to ask for clarification about the discrepancies in the record and to gain additional information about Mr. Doe's condition. Also, it should not be discounted that "early" dementia could be a "severe" cognitive impairment. Claims professionals should be careful not to focus on individual words and their plain meanings but to look at each claim holistically.

Another common mistake that arises is "claim segregation," or deciding preliminarily that an insured has only a claim based on his or her cognitive deficits as opposed to being an "ADL" based claim. Here, for instance, the claim examiner should note that Mr. Doe is receiving assistance with dressing and needs cuing to bathe and at mealtime. Regardless of Mr. Doe's cognitive status, the claims examiner should take note of Mr. Doe's functional capacity and evaluate whether these facts establish that he needs substantial assistance with two or more ADLs.

A forward-thinking and risk-conscious claims operation is one that is aware of the pitfalls and gray areas associated with TQ policy language and acts smartly and appropriately to avoid the consequences that can result from the lack of clear definitions for "substantial" and "severe" as those qualifying words are applied to everyday claims scenarios. Spotting potential "gray areas" and missing information will oftentimes lead to receipt of information needed to close those gaps and make the appropriate claims decision. Similarly, a heightened awareness of the need to clarify discrepancies in medical and care records will reduce the risk of litigation and/or negative regulatory scrutiny. ■

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