ANALYSIS: LONG TERM CARE INSURANCE COMPLAINTS

An analysis of complaints filed against long term care insurance companies to the Washington State Office of the Insurance Commissioner 2021 – 2023

April, 2024

SUMMARY OF FINDINGS

From July 2021 to June 2023, Washingtonians filed nearly 350 complaints against long term care insurance companies, according to publicly disclosed information from the Washington State Office of the Insurance Commissioner (OIC). These complaints dealt with issues such as spiking premiums, claim denials, and costly mistakes from insurance companies. These complaints show a distinct pattern: Washingtonians are facing unaffordable long term care insurance premiums, forced benefit reductions, difficulty accessing benefits that they have been paying for for years, policy denials based on preexisting conditions, claim denials based on complicated and unclear bureaucratic processes, and barriers to communicating with their insurance companies. While OIC was able to help resolve some complaints, these were typically the simple ones, such as updating addresses, and few reached the level of legal violations. Many complaints went unresolved due to jurisdiction, and unexpectedly high premium increases were mostly met with form letters that have been in use for years to explain that insurance companies can indeed raise premiums as much as they need. This report follows a similar analysis carried out in 2021, which examined complaints filed from 2015 to 2021.[1]

INTRODUCTION

70% of adults will need care at some point in their lives,[2] and many rely on long term care insurance to pay for that care when the time comes. Many long term care insurance policies are purchased as a rider to a life insurance policy, while others are standalone products. Regardless of the type of policy, however, long term care insurance companies require a separate underwriting process with different considerations regarding pre-existing conditions.

These policies are often used to cover in-home care, long term care facilities, or medical equipment. Long term care insurance policies typically require regular premiums (monthly, quarterly, or annually) until the policyholder needs to access their benefits. Additionally, most policies require an exclusion period, during which the policyholder needs care but does not qualify for benefits. Typical policies require 90 days, but exclusion periods can extend up to six months.

When Washingtonians face issues with insurance companies, many file complaints with the Washington State Office of the Insurance Commissioner (OIC). These complaints cover a broad range of insurance industries, including long term care insurance.

From July 2021 to July 2023, Washingtonians filed 344 complaints against long term care insurance companies regarding claim denials, premium spikes, difficulties contacting insurance companies, conflicting information from insurance representatives, policy denials, and many more issues over the

[1] Analysis of long term care insurance complaints to the WA Office of the Insurance Commissioner, 2015 – 2021
[2] Administration for Community Living, 2020

two-year period analyzed in this report. The complaints are detailed in the data section and expanded and excerpted in the analysis section, followed by a discussion of the trends seen from the data.

METHODOLOGY

A public disclosure request was submitted to the WA State Office of Insurance Commissioner on 7/14/23 for dates 7/1/2021 to present for all complaints to the OIC concerning long term care insurance, including their dates, categorization, violations, and summaries. The public disclosure request included full case files when possible, with personal information redacted to preserve complainant privacy and safety. Redacted information included medical diagnoses, financial account information, and personal identification numbers.

These cases were then analyzed by category, company, date, violations, and summary. Full case files provided additional information into OIC resolutions, process, and insurance company responses.

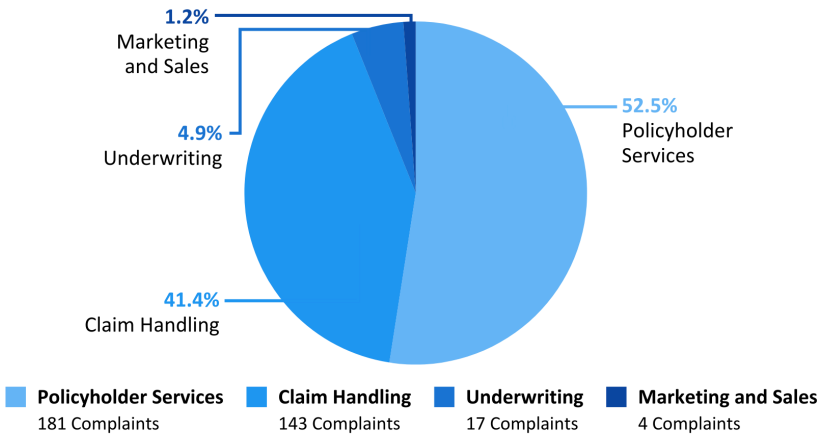
DATA

OIC received 344 complaints from Washingtonians against long term care insurance companies from July 2021 to July 2023.[3]

CATEGORIES

Complaints spread across five total groups as designated by OIC: Policyholder Services, Claim Handling, Underwriting, Marketing and Sales, and Uncategorized.[4] Chart 1 shows the breakdown of all complaints categorized by OIC.

Chart 1: Breakdown of Categorized Complaints



[3] Table 1: All Complaints contains the full list of complaints received by OIC from July 2021 to June 2023.
[4] While complaints can be assigned more than one category, only 11 of the 344 complaints fell into multiple categories. All 11 included Policyholder Services, paired with Claims Handling (7), Underwriting (3), and Marketing and Sales (1).

Policyholder Services

Complaints categorized by OIC as Policyholder Services complaints accounted for 181 of the 344 complaints received, or nearly 53%.[5] Policyholder Services complaints cover a broad spectrum of issues with long term care insurance companies, largely focused on rate increases, difficulty contacting or communicating with insurance companies, delayed refunds outside of the claims process, and other errors.

Claim Handling

Complaints categorized by OIC as Claim Handling complaints accounted for 143 of the 344 complaints received, or nearly 42%.[6] These complaints remain focused on issues regarding existing claims with long term care insurance companies, in areas such as claim denial, processing delays, complicated claim procedures, receiving false information regarding claims, and other claim-specific problems.

Underwriting

Complaints categorized by OIC as Underwriting complaints accounted for 17 of the 344 complaints, or nearly 5%.[7] These cases represent problems faced during the underwriting and approval process, such as policy denials without clear reasons, extended delays, conflicting policy information, and other underwriting errors, such as issuing the wrong policy or both approving and denying the same application.

Marketing and Sales

Complaints categorized by OIC as Marketing and Sales complaints accounted for four of the 344 complaints, or just over 1%.[8] These cases represent issues faced by consumers regarding false advertising, misleading statements, or difficulties accessing clear information and processes while shopping for long term care insurance policies.

Uncategorized

Complaints that were not categorized by OIC have been grouped into one “Uncategorized” group, which held 10 of the 344 complaints, or nearly 3%.[9] These complaints did not fall cleanly into a single category, instead representing issues such as general complaints about long term care insurance experiences, power of attorney approvals, or clerical errors.

VIOLATIONS

Of all complaints filed, 18, or just over 5%, were listed as long term care insurance companies violating Washington state law.[10] Two violations were noted: RCW 48.05.280,[11] regarding accurate record-keeping by insurers, and WAC 284-30-360,[12] regarding timely claims processing. Of the complaints ending in violations by long term care insurance companies, 17 violated RCW 48.05.280 with inadequate records, with one complaint violating Washington State’s claim laws.

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[5] Table 2: Policyholder Services Complaints contains the list of complaints in the Policyholder Complaints category.
[6] Table 3: Claim Handling Complaints contains the list of complaints in the Claim Handling category.
[7] Table 4: Underwriting Complaints contains the list of complaints in the Underwriting category.
[8] Table 5: Marketing and Sales Complaints contains the list of complaints in the Marketing and Sales category.
[9] Table 6: Uncategorized Complaints contains the list of complaints that were not placed in a category.
[10] Table 7: Violations contains the list of complaints that included a violation of Washington state law.
[11] RCW 48.05.280: Records and Accounts of insurers.
[12] WAC 284-30-360: Standards for the insurer to acknowledge pertinent communications.

ANALYSIS

While complaints spread across five total categories, three contained the most complaints: Policyholder Services, Claim Handling, and Underwriting. The breakdown of these complaints reveals the main issues Washingtonians face in regards to their long term care insurance policies: premium hikes, claim denials, and policy denials.

While some complaints were easily resolved by OIC, most of these complaints named issues resulting from human error within the insurance companies. More frequently, OIC was unable to find a resolution, and policyholders were either directed to contact a different agency or left without recourse.

POLICYHOLDER SERVICES

More than half (52.6%) of the complaints (181) filed with the OIC were categorized as policyholder services complaints. Most of these complaints dealt with unexpected premium hikes and forced benefit reduction. Others involved unexpected cancellations due to insurance company mistakes, lost premium payments, and inability to contact insurance companies after mergers or acquisitions.

Many policyholders faced surprise benefit increases that resulted in them needing to choose between paying unaffordable premiums or accepting a forced reduction in benefits. These reductions in benefits stretched across the entire policy, lowering the maximum benefit amount, lowering daily limits, reducing the types of coverage, and reducing the amount of time in which policyholders could use their benefits. Others saw even further losses, with reduced inflation adjustments added to the list.

Miscommunications or human error from the insurance companies also resulted in several complainants losing coverage. Lost payments, failure to update addresses or payment information, and other errors led to lapsed policies, often without warning, forcing the policyholder into a complex reinstatement process.

The following complaint excerpts provide examples of policyholder services complaints against long term care insurance companies:

> **Company nearly doubles premium for retiree on fixed income, forcing benefit reduction**
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> "For the same benefit I originally signed up for it increased from $257.94 to $427.29 a month. There were three other options that reduced the premium but also decreased the benefits and/or the time. I am single and own my own home so all expenses are on me alone. It's unfair to have to bear these increases when we are on fixed incomes in order to get the same benefits or have to choose a lower premium with less coverage. I had to choose less premium and benefits. This is approx an 85% increase."
>
> *Case #1657164*

> **Company requires $18k/year premium increase or significant benefit reduction**
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> In 1997, the policyholder amended a joint policy with her husband to add a long term care rider. They also selected a survivor benefit, meaning that after one dies, the premiums of the surviving spouse would be waived. Her husband died in 2012, after paying premiums for 25 years. Her company, facing court-ordered rehabilitation, informed her that this

policy was no longer possible, and she would need to either start paying more than $18k per year or choose significant benefit reductions to keep her survivor benefit.

However, she stated: “Recently I received a booklet in the mail along with some papers that state I must choose an option to change my policy or pay to keep my current policy. I’m currently living off my SS and my husband’s retirement, none of which can pay the total they are expecting me to pay. I am living paycheck to paycheck. I cannot afford to pay what they are requiring, also I am not able to live on my own with no help. This leaves me with a lot of stress and depression to be forced to make changes to a policy I originally signed into so many years ago knowing that I would be cared for for the rest of my life.”

Case #1668902

Policy lapsed due to payment error, company blocks reinstatement

After a payment failed to be processed, the policyholder’s long term care insurance policy was canceled without notice. When she reached out for reinstatement and completed the process, she was denied due to conditions that had already been disclosed and present when the policy was first issued.

“The denial of reinstatement, after paying this company close to $50,000 in the last 10-12 years (between my husband and I), is a mystery. It’s my understanding that they can't deny reinstatement for conditions that existed when the insurance was originally purchased.”

Case #1665590

Premiums rise more than 300% since policy began

“My wife and I each purchased a [company] Long-Term Care policy in 2004, understanding that our premiums could not increase except as a result of extraordinary circumstances over a whole class of policies. We continue to suffer significant premium increases about every three years on average, amounting to over 300% above originally-agreed-upon policy cost.”

Case #1650106

CLAIM HANDLING

Complaints categorized as “claim handling” made up 41.5% (143) of complaints filed during this 2-year period. These complaints involved long term care insurance companies refusing to provide benefits, denying claims, moving eligibility periods, and reimbursement or benefit payout delays.

Policyholders often submitted and resubmitted verification documents for months, involved care providers in submitting documents as well, and repeatedly followed up on necessary reimbursements of thousands of dollars with no success. Others were unable to access benefits at all, receiving conflicting information regarding exclusion periods and eligibility.

In these complaints, many policyholders described feeling as if long term care insurance companies were intentionally dragging out the claims process in an effort to not pay. Others detailed following the same process they had followed for years, only to stop receiving reimbursements. Many of the benefits denied were due to insurance company errors, while others were due to specific word choices in the insurance policies that had not been accurately explained to the policyholder.

The following complaint excerpts provide examples of claim delay and denial complaints against long term care insurance companies:

Company drags out claim approval process with multiple delays, resulting in loss of care

"I feel like we are being jerked around. I think [company] is delaying this over and over, hoping my mother will die before they pay out! As the result of this delay, we felt Mom could no longer afford to live at her assisted living facility, (not without the long term care support) so she had to move into my home. My mother deserves the chance to use her long term care policy. She qualifies and [company] is making this very difficult on my mother. She planned all her life to avoid living with one of her daughters and [company] has now shot that plan down, despite the THOUSANDS of dollars Mom has paid in premiums."

Case #1702451

Company delays claim approval, policyholder faces significant financial impact

"My client is in long-term care at an Adult Family Home, we made a claim for her to get the benefit of her Long Term Care Insurance but we cannot get them to say that they received the documents or that they will be paying the fees. This has been going on 2 months maybe 3 now and my client is getting kicked out of her home. We have called and emailed, faxed multiple times with no response or anyone able to help us. Each time we call we get a different answer. These seniors need assistance and I cannot imagine how they do this if they have any cognitive decline."

Case #1696893

Company delays exclusion period verification, failing to pay tens of thousands in benefits

"We cannot get the billing department to verify past claims to satisfy the Elimination Period so we can get paid for a current claim. We have sent the information needed, the agency who provided service has faxed the information twice further, and we still cannot get verification - it's been 2 months now. Mom has [a] new claim for $9,500k (monthly charge) that needs to be reimbursed, and without the Elimination period verified we cannot receive payment needed. My parents do not have the funds to wait this long for payment. It seems criminal to have paid this insurance for 25 YEARS plus to have to go through such a waiting game."

Case #1695568

Company delays claim reimbursement of nearly $10k due to processing issues

"Given the delay in processing my claims, I cannot avail myself of the level of support I need because I am on a fixed income. I cannot afford to be out the money for my long-term care with no clear idea when or if Genworth is going to reimburse me. I am running out of the ability to keep the care I depend on to live.

I live alone, am dependent on oxygen, am medically fragile, and immunocompromised. I need help with bathing, meal preparation, transportation to medical appointments, and

shopping. Knowing that I live alone and would be on a fixed income in my older years is why I purchased long-term care insurance through Genworth in the first place."

Case #1695098

UNDERWRITING

A total of 17 complaints (5%) involved long term care insurance companies denying policies, either for pre-existing conditions or unclear reasons.

Many long term care insurance companies deny policy applications due to pre-existing conditions. These complaints, however, largely focused on instances in which applicants were approved and that approval was revoked, or situations in which applicants were strung along through a long underwriting process only to be denied due to something that was disclosed in the initial stages.

The following complaint excerpts provide examples of policy cancellation or denial complaints against long term care insurance companies:

Company doubles underwriting, issues denial from one process after approving other

An insurance agent wrote regarding issues with a client's policy: "We were finally told my client was approved by the carrier - The client had sent in a check in the amount of $38,000 to the carrier prior to the cut off date. We were told the policy was approved, a policy # was generated. I was paid the commission from the carrier last week. Then we got a notice that the client was declined. The client does not know why he was suddenly declined."

After OIC reached out to the company, they reevaluated the denial and explained: "[Company] notes as part of the underwriting process, the applicant took two oral evaluations, and did not pass the first. As [company] does not permit applicants to take multiple interviews, they were not approved for the long-term care rider. [Company] reports their underwriters re-evaluated the applicant's risk and determined they could approve them for the long-term care rider."

Case #1663421

Company issues wrong policy to applicants

Applicants were issued and charged for the wrong policy type, and were not able to get the company to resolve the issue or refund their payments for this policy that they did not apply for or want. They contacted OIC to get the policies canceled with a full refund, but while the company admitted human error in processing the applications for the incorrect policy, they first fought to fix their error and keep the policies active rather than providing the requested cancellation and refund.

Case #1694011

Applicant denied due to minor sports injury

Applicant was denied for a long term care rider due to one recent physical therapy appointment after a minor sports injury. After OIC contacted the company with the complaint, the company reevaluated: "Typically, when we find a history of physical therapy

within the last six (6) months of applying, we deny LTC coverage. Originally, the LTC rider was going to be declined due to a recent physical therapy appointment; however, we made an exception and approved it." Though he did receive coverage, due to the physical therapy appointment, the policyholder is paying increased premiums until he can apply for a better rating in 12 months.

Case #1660784

COMPLAINT RESOLUTION

In some cases, the insurance companies responded quickly to OIC when the policyholders had been unable to reach them. For cases of delayed refund processing, lost premium payments, or address updates, a complaint filed against the company was often sufficient to immediately rectify the issue.

The following complaint excerpt provides an example:

OIC complaint necessary to update address

One complaint faced a lapsed policy after attempting multiple times to update his address and pay his premiums without receiving bills after he moved in 2021. He resorted to contacting OIC in 2022, and the insurance company responded: "Please allow me to provide clarification. Our records show that we processed [insured]'s address change incorrectly in April 2021. We have updated our records in accordance with his recent request… We have reinstated his coverage and notices regarding the premium due will be mailed to the current address on file. We regret any frustration [insured] may have experienced while attempting to maintain his coverage."

Case #1676374

In many instances, however, OIC was powerless to help the complainant, due to a variety of factors, such as jurisdiction or the fact that premium increases had been approved by the same office. For claims denied due to loopholes or misleading information from the insurance company, there was little OIC could do to help policyholders access the benefits they had paid for.

The following complaint excerpts provide examples of the lack of resolutions:

OIC acknowledges premiums continue to climb in a letter sent to several complainants

"Unfortunately, nothing that follows will be much comfort, I suspect, but here's what's going on: Long-term care insurance is a relatively new product, dating back to about the mid-1980s for a few companies, and the 1990s for many others. Unlike, say, life insurance, these companies had little or no claims experience with these new products. Insurance is inevitably about trying to predict the future, and in this case, they frankly didn't have much data and history to go on.

What has become apparent in the ensuing years is that these policies, by and large, were underpriced compared to the fast-growing cost of health care, particularly in recent years. In addition, the companies expected a lot more people to cancel their policies before ever using them – this happens very often with life insurance – but that didn't happen, meaning that their payouts will be significantly larger than they expected.

What's happening now – and what's causing anger and sticker shock among customers – is that companies have been boosting their rates to reflect the real costs of the medical care they've promised people. And that's meant steep and painful hikes for existing policyholders. We really wish there was something we could do, but we have our own staff actuaries who dig deep into the rate requests, and the medical trends and costs these companies are seeing are real. If we just denied the rate hikes arbitrarily in an effort to protect consumers, it would likely be a false and short-lived victory. The companies have the right to go to a hearing before an administrative judge, which they would almost certainly win, and the rate hikes would proceed anyway. We get them to reduce rates as much as we can, but even so, the resulting rate hikes in long term care insurance have been quite large."

Case #1650106

OIC explains premium hikes in a second letter sent to complainants:

"Insurers underestimated how long people would live. As it became apparent that the actuarial longevity estimates were wrong, the solution of choice seemed to be to raise rates… actuaries assumed many people would drop their coverage over time. This proved not to be the case, as dropping a policy meant the customer would receive nothing in return for premiums paid over time. An additional unknown was the extent of the incidence of cognitive memory disorders such as Alzheimer's disease. People can live for a long time with Alzheimer's disease and similar memory challenges.

LTC insurance companies have to adjust premiums to compensate for inaccurate pricing assumptions so there are enough reserves to pay long-term care claims under each plan. If rate increases didn't occur, the insurance carriers could run into financial trouble, leaving them unable to pay claims."

Case #1657164

DISCUSSION

Overall, these complaints reveal several shared difficulties among Washingtonians with long term care insurance companies: unexpected premium hikes; a significant lack of access to benefits; an inability to address errors, issues, or concerns with the companies; and difficulty receiving, understanding, and utilizing long term care insurance.

Many policyholders complained of surprise premium increases, in which their premiums doubled, tripled, or more. Some faced difficult decisions of paying significantly higher premiums in order to keep their current care and coverage, or reduce those benefits to keep premiums affordable. Often, those who complained were retirees, living on a fixed income with no choice but to accept lower benefits, and forcing them into an impossible choice regarding how much to cut from their own benefits simply to keep paying the same cost. Even after these difficult decisions, policyholders do not have any guarantee that their rates will remain steady.

In cases in which consumers were already utilizing their benefits and facing issues with claims, company errors resulted in reimbursement delays of thousands or tens of thousands of dollars - life altering amounts of money. Some policyholders could not continue their care while waiting for reimbursement,

losing their spaces in Adult Family Homes or long term care facilities. Many consumers reported feeling "strung along" by their long term care insurance company, in a difficult bureaucratic process that seemed designed to help the company avoid releasing benefits.

While some complaints detail major issues with insurance policies, other policyholders resorted to filing OIC complaints simply to get the phone number for their new insurance provider or update their address, because they could not reach anyone without state intervention. In cases across the spectrum of issues, policyholders who took the time to file an OIC complaint were simply directed elsewhere, to other states or systems based on jurisdiction.

With all of the issues faced by Washingtonians, only 5% of complaints rose to the level of a legal violation. Of those, most violations related to insurance company's failure to keep adequate records, often regarding policyholders' addresses and financial information. Only one of many claim denial and delay complaints, many of which resulted in significant financial jeopardy for policyholders, resulted in a violation for the company.

DISCLOSURE

This analysis was commissioned in July 2023 by We Care for WA Cares, a coalition of organizations supporting the state's Washington Cares Fund. We Care for WA Cares Coalition members include: Alzheimer's Association, Casa Latina, Connect Casino Road, Fuse Washington, Hand in Hand (Domestic Employers Network), LeadingAge Washington, Lupus Foundation of America, National Multiple Sclerosis Society, Northwest Law Health Associates, Puget Sound Advocates for Retirement Action, SEIU 775, UFCW 3000, Washington Association of Area Agencies on Aging, Washington Health Care Association, Washington Physicians for Social Responsibility, Washington State Budget and Policy Center, and Washington State Senior Citizens Lobby.