

Managing the risks of the long-term care insurance reinstatement process

by Loretta Jacobs, FSA, MAAA



As many long-term care (LTC) insurance blocks of business mature, new product management challenges are beginning to appear. One such emerging risk relates to the reinstatement process, which is the process by which a lapsed policy is reactivated and put back in the same position as it was before the lapse occurred. Since LTC insurance lapse rates have historically been low, insurers have not typically placed significant focus on the management and mitigation of the reinstatement risk exposure. However, a recent increase in litigation activity and regulatory scrutiny related to this process has led insurers to strengthen their risk management controls over it.

LTC insurance reinstatement requests primarily arise from one of three reasons, with only the first being specifically contemplated in LTC insurance regulation. First, a policy may be unintentionally lapsed because the policyholder is cognitively and/or functionally impaired at the time the premium billing notice is sent, and is not reasonably capable of paying the bill. Second, a policy may be unintentionally lapsed for a variety of other reasons, including the policyholder claiming not to have received a billing notice, the insurer claiming never to have received monies the policyholder sent, or the policyholder submitting the premium to the insurer sometime after the end of the grace period. Finally, a policyholder who has voluntarily lapsed coverage may simply have a change of heart and request to reinstate the policy.

Cognitive and functional impairment reinstatement situations

The NAIC Model LTC Regulation, and essentially every state with explicit LTC regulations, recognizes the need to protect LTC insureds from unintentional lapses of their LTC policies when they most need them (i.e., when they are eligible for LTC insurance benefits). The robust protection against unintended lapse typically includes requiring an initial billing statement and a 30-day overdue billing notice, to be mailed to the insured, plus a policyholder option to name at least one individual to receive a similar 30-day overdue billing notice alerting the named third party that the insured's premium is overdue and the policy is in danger of lapsing. Finally, termination of the policy cannot occur any earlier than at least 35 calendar days after the overdue notice(s) is (are) mailed.

Then, if the policyholder requests reinstatement of the policy within five months of termination, and can demonstrate that his or her condition would have qualified for LTC policy benefit eligibility on the termination date (i.e., that he or she was cognitively and/or functionally impaired in accordance with the definitions contained in the insured's policy), and pays all overdue premium, the policy is reinstated and treated as if it had never been out of force.

Examples of the cognitive reinstatement protection contained in the regulations of two states are below:

- ▶ Washington: <http://apps.leg.wa.gov/wac/default.aspx?cite=284-83-025>
- ▶ Florida: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0627/Sections/0627.94073.html

For purposes of this article, the reinstatement regulations of these two states will be analyzed and discussed. The reader may then

consider the similarities and differences of these regulations to those of the other states.

Washington's reinstatement regulation states, "A long-term care insurance policy or certificate must include a provision for reinstatement of coverage in the event of lapse if the issuer is provided proof that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity *before the grace period expired*. Reinstatement must be available to the insured if requested *within five months after lapse* and may allow for the collection of past due premium if appropriate. The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate."

Florida's reinstatement regulation states, "If a policy is canceled due to non-payment of premium, the policyholder is entitled to have the policy reinstated if, *within a period of not less than five months after the date of cancellation*, the policyholder or any secondary addressee designated... demonstrates that the failure to pay the premium when due was unintentional and due to the policyholder's cognitive impairment, loss of functional capacity *or continuous confinement in a hospital, skilled nursing facility, or assisted living facility for a period in excess of 60 days*." The Florida regulation also states, "Notice of possible lapse in coverage due to nonpayment of premium shall be given by *United States Postal Service proof of mailing or certified or registered mail to the policyholder and secondary designee* at the address shown in the policy or the last known address provided to the insurer. Notice may not be given until 30 days after a premium

is due and unpaid. Notice shall be deemed to have been given as of 5 days after the date of mailing."

Disputes arising from the five-month reinstatement request time period

An issue that has arisen recently surrounds the interpretation of the date on which the allowable five-month time frame to request reinstatement begins. The state of Washington suspended one insurer's license to sell LTC policies for six months in 2011 because it interpreted the five-month time frame as beginning on the date the (unpaid) premium was initially due, not the date on which the lapse transaction occurred, 65 days later. Not surprisingly, the dispute initially arose because the 65-day difference meant the difference between a Washington policyholder meeting and not meeting the five-month time frame to request reinstatement.

Washington's regulation defines the five-month time frame as beginning on the "lapse date." To an insurance carrier, the date of lapse may be the coverage termination date carried in its administrative records, which is typically the date the unpaid premium was due. However, to an insured, the date of lapse may be the date the grace period ends, since claims incurred during a grace period are covered, and thus insurance is "in force" throughout the grace period until the lapse transaction occurs.

Furthermore, the Washington state regulation references that the cognitive impairment or loss of functional ability must be demonstrated "before the grace period expires," and if the five-month clock were to start on the earlier premium billing due date, the insured whose cognitive or functional

impairment onset was at the end of the grace period would only have approximately three months to request reinstatement, not five.

To the extent that other jurisdictions follow the state of Washington's position, there are implications for insurers. Clearly, all insureds must be provided at least 7.13 months (equal to regulatory minimum of five months plus at least an additional 65 calendar days) after their termination effective dates to request reinstatement. Insurers who only carry termination effective dates on their administration systems may need to consider adding functionality to these systems because the relevant date for the reinstatement time clock is the date the lapse transaction occurs, not the date the termination is effective. This distinction is important, and not simply because of the presumed additional 65-day period of time allowed.

Indeed, if for some reason an insurer delays terminating a policy beyond the required minimum 65-day time frame from the original premium due date, the five-month time clock only starts on this latter date. For instance, if a carrier has a system outage and does not lapse any policies for a day, a week, a month, or some other time frame, this extra time the policy has remained in force does *not* count toward the five-month reinstatement request time period. Carriers need to capture the exact dates on which they terminate policies, and begin the five-month reinstatement request periods on those dates exactly.

Disputes arising from demonstration of cognitive or functional impairment

Another source of dispute in the cognitive and functional impairment reinstatement process is the requirement to prove that cognitive or functional impairment began before the grace period expired. As noted above, Washington

and most other states include language requiring that the evaluation standard of cognitive or functional impairment be no more stringent than that used to adjudicate claims under the policy. These standards usually involve a review of medical records and the results of formal cognitive testing performed on or before the lapse transaction date.

However, insureds may not have formal cognitive testing documented in their medical records. So even those insureds who truly have Alzheimer's, or another eligible cognitive impairment (as proven by cognitive testing performed at a later date), cannot clearly demonstrate such impairment in the medical records dated before the expiration of the policy's grace period. In these cases, reinstatement is not required by law. Alternatively, an individual may have had cognitive testing performed before the grace period ended, but the results of the testing do not indicate a *severe* cognitive impairment as required by the insured's LTC policy. While a modest cognitive impairment may have contributed in some way to the insured's alleged unintentional lapse of his or her policy, this level of impairment would not entitle the insured to have his or her policy reinstated.

Of course, state regulations are worded to permit insurers to utilize less stringent standards for evaluation of impairment for purposes of reinstatement of coverage than for benefit eligibility determination for claims submitted on in-force policies. Nevertheless, it is unlikely that carriers would employ such a procedure in practice due to the unpalatable prospect that a person whose policy was reinstated by virtue of meeting a less stringent cognitive (or functional) impairment standard could then possibly have his or her immediately following claim for insurance benefits under the reinstated

policy denied due to *not* being cognitively (or functionally) impaired, per the more stringent requirements in the policy. Denial of such a claim would likely lead to litigation, and if the policyholder's records were not documented clearly enough that a lesser standard had been applied for purposes of reinstatement *only*, the insurer would be exposed not only to an adverse legal judgment in the specific situation at hand, but also to the risk that the relaxed adjudication standard could be extended to the evaluation of other claims submitted on in-force LTC policies through follow-up class action litigation. Such a result would likely have broad implications for the overall book of business.

An interesting side note to this issue is the inclusion by the state of Florida of the phrase permitting reinstatement as long as the insured has been *continuously confined* in an assisted living facility for at least 60 consecutive days. This is problematic for insurers because simply being confined in an assisted living facility does not mean the insured is eligible for LTC insurance benefits. In fact, the term assisted living facility applies to a broad range of entities; many such facilities may actually be independent senior living apartments and serve as the primary residence of insureds who are neither functionally nor cognitively impaired. Indeed, recent legal actions in Florida have indicated that assisted living facilities qualify as private homes in the state of Florida and are eligible for benefits under *home health care only* policies. The inclusion of this phrase in the Florida law significantly broadens the reinstatement right for coverage that was allegedly terminated unintentionally.

Other reinstatement requests

Many situations arise in everyday policy administration where a policy is unintentionally terminated and the customer wants to put the policy back in force when the termination is discovered. These situations often arise in relation to alleged errors in the premium billing and collection process, such as:

1. Failure of the insurer to send the original premium billing notice, the overdue notice or the third-party designee notice
2. The insurer not receiving monies remitted by the insured

In addition, sometimes policyholders who intentionally lapsed coverage in response to premium rate increases or other reasons reconsider their decisions and request to reinstate their policies.

Allegations of premium billing and collection processing errors

Insurers typically research all complaints of alleged mistakes in the billing and collection process and if they find an error (for example, a request to change the address was not processed), they will reinstate coverage without underwriting. A common complaint is that the customer simply did not receive his or her billing notice or lapse warning or that a third party did not receive the lapse warning. It is unclear how often operational staff at insurance companies routinely reinstate coverage without an investigation or

management being involved when an insured maintains he or she simply did not receive his/her mail.

Insurers would be wise to keep a record of all such reinstatement activity, and may be surprised to find how often allegations of billing errors occur and how frequently certain individuals allege that they failed to receive their mail. To the extent that this activity is more frequent and exposes the insurer to more risk than it prefers, alternative management of the billing and collection process may be in order. For instance, an insurer who is reinstating a policyholder for a second or third time due to alleged lack of receipt of mail may wish to condition the reinstatement on future billing by automatic bank withdrawal.

Alternatively, an insurer may choose to investigate alleged billing errors in detail, rather than simply accepting the customer's word that an error occurred. If the insurer finds no evidence of any mishandling, it may deny automatic reinstatement, but as a good faith policyholder service, may offer these individuals the opportunity to reinstate coverage by providing satisfactory evidence of good health. With mature blocks of business, it is unlikely that more than half of the applicants will be able to satisfy the underwriting criteria, but offering some means by which an individual may reinstate coverage may be viewed more favorably by state regulators, or other outside third parties

who may end up reviewing these situations, than simply denying the request on the basis of not finding errors in the billing process.

Of course, offering reinstatement underwriting may be somewhat difficult for carriers no longer actively marketing LTC products, as such insurers likely do not maintain underwriting departments. Claims department clinicians may be able to successfully re-underwrite policies on a limited basis by referencing the underwriting manuals that were used to originally place the business, while certain third-party administrators and contract underwriters may also provide this service to carriers for a fixed fee, which may be directly charged to the reinstatement applicant.

As noted earlier, the Florida regulation requires that lapse warning notices to policyholders and third-party designees be mailed by United States Postal Service with proof of mailing, certified or registered mail. Presumably, the reason for this requirement is to reduce or eliminate the number of disputes arising from alleged failure of the United States Postal Service to deliver required notices. However, the additional costs of mailing these notices by certified or registered mail are likely not ideal for insurers with large blocks of business in Florida. While United States Postal Service proof of mailing is reasonably cost efficient, it does not provide evidence of *receipt* by the customer or third party, but rather simply provides



evidence that the insurer *mailed* the notice(s). Carriers may wish to consider the possibility of mailing lapse warnings via certified or registered mail for older and/or longer duration policyholders and the less expensive United States Postal Service proof of mailing for the remaining policyholders.

In addition, to the extent that the root cause of alleged non-receipt of billing notices is due to the notices being inadvertently discarded as “junk” mail by the recipients, insurers may wish to review their billing packages for effectiveness. For instance, adding a bolded “Important Insurance Information Enclosed” message on the envelope may be

an inexpensive, yet effective way to reduce the possibility that these important lapse warning notices will be discarded without being opened.

Litigation and Department of Insurance (DOI) complaints related to alleged failure of insurers to mail lapse warnings and/or third-party designee letters have increased as blocks of business mature, and the lapsed policyholders realize they cannot satisfy good health underwriting requirements and aggressively attempt to have their policies reinstated without underwriting. Carriers need to carefully consider their options and properly evaluate

the underlying elevated claim cost exposure before responding to such litigation or DOI complaints. In order to effectively respond to discovery requests for litigation or otherwise reconstruct what actually transpired on the policy, insurers should retain copies of all notices that are mailed to insureds and third-party designees and, as previously noted, maintain exact dates of transaction occurrences.

Premiums arrive late

A common problem that insurers face is whether to reinstate policies when premiums arrive shortly after the end of the grace period. Carriers may routinely provide an additional "internal grace period" of up to two days in the event that the 35th day following the mailing of a lapse warning falls on a Saturday, Sunday or holiday. But what happens if a premium is received on the 68th, 70th or 75th day after the original due date? What happens if the 35th day after a lapse warning was mailed falls on a regular business day and the premium arrives the following day? When is a premium finally "too late" to allow the policy to be automatically reinstated? These are questions LTC carriers have to answer for themselves.

Since providing any additional time over and above the statutory grace period likely sets a precedent for future treatment of similarly situated policyholders and may be discovered during litigation, it is important for insurers who choose to lengthen the grace periods by any amount of time to establish specific formal criteria for acceptance of "late" premiums and ensure their operations personnel follow the criteria without exception.

A separate emerging issue facing LTC insurers in the reinstatement management process relates to required health insurance policy reinstatement language that is inconsistent with the premium collection processes utilized by most LTC insurers. Since LTC is considered a type of health insurance, the health insurance reinstatement provisions are required to be included in LTC

policies, in addition to the cognitive and/or functional impairment reinstatement protections. The Florida provision, found at http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0600-0699/0627/Sections/0627.609.html contains the following language: "Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. *Later acceptance of the premium by the insurer, or by an agent authorized to accept payment without requiring an application for reinstatement, will reinstate this policy.*"

Recently, assertive plaintiff attorneys have seized upon this language to advise their clients wishing to reinstate their LTC policies, well after the allowable time frames for cognitive or functional reinstatement have elapsed, to go ahead and mail the premium to the insurer. These attorneys understand that LTC insurers typically process premiums through a bank "lock box" process. Directly billed LTC insurance premiums are mailed to a post office box that essentially is a banking facility. As soon as the premium is received at the lock box, it is deposited into the insurer's bank account. The insurer's accounting team subsequently reconciles the premium receipts to its active policyholder list and discovers that premiums have been received on a terminated policy. The insurer then refunds this premium to the lapsed policyholder by *issuing a new check*.

The attorneys claim the insurer has accepted the premium because it deposited the money in its bank account without issuing a conditional receipt and therefore the policy

has been reinstated even if the insurer issued a refund check within a short period of time, such as a week or two weeks. Case law on this issue is mixed, with some cases supporting the policyholder and others supporting the insurer with the individual facts and circumstances of the insurer's premium handling process often at the heart of the decision.

Although considered successful, this path to reinstatement exposes the insurer to significant adverse selection and should be managed by insurers. Furthermore, as more lapsed policyholders and their representatives learn of this path to reinstatement, insurers can expect the frequency of such activity to rise. At the minimum, insurers should explore ways to decrease the cycle time between receipt/deposit and refund of a late premium to reduce the likelihood of an adverse legal judgment. In addition, insurers may wish to research with their banking facility partner whether it is feasible to alter the process to eliminate certain checks from being directly deposited and instead held in abeyance for up to 24 hours while being researched. Such checks could be directly returned uncashed to the lapsed policyholders and the insurer will be less vulnerable to the argument that it had "accepted" the premium. Finally, regulatory and compliance areas may wish to explore with state regulators whether it would be possible to remove this required language from future LTC policies, since the LTC policies separately include the cognitive and functional reinstatement provisions.

Conclusion

A key component to successful management of an LTC insurance operation is development and implementation of a comprehensive risk management strategy. Procedures to address the risks of the reinstatement process should be incorporated into such a comprehensive risk management plan. Carriers may wish to consider establishing a senior management reinstatement review committee composed of underwriting, claims, actuarial, legal, compliance and policy administration personnel who would be charged with not only evaluating reinstatement requests, but also reviewing the various premium

billing and collection processes used by the company to determine if there are ways to alter them to mitigate the reinstatement risk exposure (without exposing the carrier to other risks). Such a committee should be able to maintain an appropriate balance between desiring to assist customers with unique specific circumstances and protecting the overall book of business. At the very least, participating in such a committee would enable senior management to become more cognizant of the many risk exposures inherent in the reinstatement process so that they may better provide leadership and oversight

to the process. Finally, as carriers begin to formulate risk management protocols to address reinstatement and other emerging LTC insurance business risks, it may be valuable to discuss the plans with internal or external risk management professionals and/or Sarbanes-Oxley compliance staff to gain additional perspectives and insights.

*For more information, contact
Loretta Jacobs at loretta.jacobs@ey.com
or +1 312 879 2631.*



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