Long Term Care Insurance: Trends and Challenges in Claim Presentation

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I. Introduction

As nursing homes became increasingly popular in the 1960s and 1970s, long-term care insurance (LTCI) hit the market to help seniors pay for care outside the home or hospital. Sales of LTCI policies steadily increased over the next several decades. At its peak in 2002, approximately 750,000 Americans purchased LTCI policies.

But despite its popularity, LTCI has never been profitable for insurance companies. The companies writing LTCI policies failed to accurately predict the cost of long-term care, which skyrocketed over the years. They significantly underpriced their LTCI products, causing huge losses.

In response, the industry significantly increased the price of LTCI policies after 2003 and became more selective as to whom they insured. Consequently, the LTCI market underwent a dramatic contraction, shrinking more than ninety percent from its peak. Whereas three quarters of a million people bought LTCI policies in 2002, only about 57,000 bought policies in 2018, even as the percentage of the American population in the prime purchasing demographic (age 60 to 69) expanded.

Much to the dismay of LTCI insurers, they still lost money even after raising prices and becoming more restrictive with underwriting criteria. The losses were less severe, but the majority of LTCI carriers ultimately gave up and exited the market. As a result, the number of companies issuing LTCI policies has shrunk from over 100 in 2005, to fewer than a dozen today.

This background provides important context for LTCI policyholders. Policyholders (and the attorneys who represent them) should understand that the insurance companies' massive losses on their LTCI products mean that they are in extreme "damage limitation" mode. This can translate into more aggressive claim denials and diminished customer service.

This paper will discuss the failure of the LTCI market and the implications for today's policyholders. It will also discuss some aspects of the applicable law in Georgia and a few of the most common issues we see when policyholders file claims.

II. What is Long-Term Care Insurance?

Long-term care insurance (LTCI) is an insurance product intended to help pay for "Custodial Care," meaning assistance with basic daily functions like eating, bathing, and dressing. LTCI policies promise to pay benefits, often at an agreed daily or monthly amount, to cover the costs of nursing home care, assisted living care, home healthcare, and/or adult daycare.

The most common type of LTCI policy is a reimbursement policy, which pays the actual costs incurred by policyholders up to a set daily or monthly limit. If the cost of covered services exceeds the daily or monthly maximum, the policyholder will have to pay the remainder out of pocket.

A less common form of LTCI policy is a flat-rate policy that will pay the insured a set daily or monthly benefit amount if they meet eligibility requirements. Flat-rate policies will pay the specified benefit amount regardless of the actual costs of covered services. If the policy provides for a $250 daily benefit, the insured will receive $250 per day, so long as they satisfy the conditions for payment. These policies are far rarer today than reimbursement policies, and they may even

allow a policyholder to recover more in benefits than they are spending on care.

Under either type of policy, the insured must meet medical/functional eligibility requirements to begin receiving benefits. Typically, the insured must require assistance with at least two of the following six Activities of Daily Living (ADLs):

- ***"Bathing"*** *means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower.*
- ***"Continence"*** *means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).*
- ***"Dressing"*** *means putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.*
- ***"Eating"*** *means feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.*
- ***"Toileting"*** *means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.*
- ***"Transferring"*** *means moving into or out of a bed, chair or wheelchair.*

Generally, there are two types of assistance one can require with respect to ADLs: physical assistance and cognitive assistance. These two types go by different names in different policies, but physical impairment is often called "Hands-on Assistance" or "Substantial Assistance," while cognitive assistance is often called "Stand-by Assistance" or "Substantial Supervision." The terms are generally defined something like:

> ***"Substantial Assistance"*** *means hands-on, physical assistance of another person without which an individual would be unable to perform the Activities of Daily Living.*
>
> ***"Substantial Supervision"*** *means that continual supervision by another person is necessary to protect the Insured from threats to his or her health or safety. Such supervision may include cueing by verbal prompting, gestures or other demonstrations.*

A need for physical assistance or supervision, alone, does not mean benefits become immediately payable. Almost all policies require policyholders to first satisfy an "Elimination Period," during which the insured must *receive and pay for* covered services before benefits become payable. Common Elimination Periods are 30 days, 60 days, 90 days, and 100 days. The cost to the insured of satisfying the Elimination Period can be significant.

There are also other technical requirements, discussed below, that may create traps for policyholders and technical defenses for insurers.

III. Georgia Regulatory Overlay

In 1989, the Georgia Insurance Commissioner's Office passed regulations applicable to "all long-term care insurance policies delivered or issued for delivery in this state . . . ." Ga. Long-

Term Care Regulations, Ga Comp. R. & Regs. § 120-2-16-.03. The regulations were subsequently amended in 2008, 2011, and 2020. Among other requirements, these regulations specify that:

- **Long term care services** must be defined in relation to level of skill required, nature of care and setting;
- **Providers of services** must be defined in relation to available services and facilities, licensure and certification;
- **Cognitive impairment** must be defined as "deficiency in a person's short or long-term memory, orientation as to person, place and time, deductive or abstract reasoning, or judgment as it relates to safety awareness";
- **Hands-on assistance** must be defined as "physical assistance (minimal, moderate or maximal) without which the individual would not be able to perform" an ADL; and
- **Home health care services** must be defined as medical and nonmedical services, provided to ill, disabled or infirm persons in their residences; may include homemaker services, assistance with ADLs and respite care services.[1]

Other subsections of § 12-2-16 contain requirements as to renewability and cancelation, prohibitions against exclusions and limitations (e.g., prohibiting preexisting condition or mental disorder exclusions or limitations) and prohibitions against "post-claims underwriting" (using omissions in the application for coverage as a basis for denying claims).

In addition, effective 2008, the regulations created standards relating to benefit triggers. Essentially, the regulations require that all LTCI policies issued in Georgia after April 1, 2008, provide for the payment of benefits if the insured requires assistance with 2 of 6 defined ADLs. Insurers may include additional benefit triggers in their policies, so long as they do not restrict or replace the regulatory ADL triggers.

IV. Market Failure: Actuarial Miscalculations Caused Huge Losses for Insurers, Leading to Contraction of the LTCI Market.

At its core, insurance is the business of quantifying and trading on risk. Insurance companies take on their customers' future risk in exchange for premium payments up front. It is crucial for insurance companies to accurately predict the risks of their customers so that they can set a profitable premium rate.

With LTCI, insurers miscalculated on several levels, industry wide. The companies writing LTCI policies in the '70s, '80s, and '90s significantly underestimated how many customers would keep their policies in force, the number that would file claims, and the degree to which the cost of long-term care would increase. By the early 2000's, it was clear that the industry had massively underpriced its LTCI products.

According to a July 2003 study, the LTCI segment's total pretax market income from 1997 through 2001, measured as a percentage of premium, was negative 2.9%. Notably, this was in a period where sales of new LTCI policies were nearing their peak. Despite booming sales, the losses

[1] Ga Comp. R. & Regs. § 12-2-16-.05.

on older issued policies were so great that they dragged the entire LTCI market into the red. It is estimated that Genworth, the single largest LTCI carrier, incurred approximately $3.6 Billion in losses by 2005 on its LTCI products.

Responding to their losses, LTCI insurers raised the premium rates for newly issued LTCI policies and simultaneously reduced coverage. In 2005, a buyer between the ages of 55 and 64 paid an average annual premium of about $1,900 for approximately $270,000 in coverage. By 2015, annual premiums had ballooned almost 40 percent to more than $2,600, while coverage had sagged to around $235,000 on average. Accounting for inflation, policies in 2015 provided almost 30% less coverage than they had in 2005, for almost 15% higher premiums (inflation adjusted).

LTCI insurers also became much more restrictive in issuing policies. According to recent estimates from the American Association for Long-Term Care Insurance, the industry's top trade group, somewhere between 44 percent and 51.5 percent of people over 70 who apply for a long-term care policy are now declined. Almost one-third of those between 60 and 65 are turned down. And, most strikingly, even 21 percent of people in their fifties have their applications rejected.

Despite increased prices, reduced coverage, and rejecting more applicants than ever before, LTCI carriers have continued to suffer losses even on newly issued blocks of policies. According to data from S&P Global Market Intelligence, as of 2020, the Direct Loss Ratio (DLR)[2] suffered by insurers on policies issued before 2003 was over 200%. In other words, LTCI insurers paid out more than twice as much, on average, for claims than they had received in premiums on policies issued before 2003. For policies issued between 2003 and 2010, the DLR was over 70%, and for policies issued after 2010, it was still over 10%.

As a result of continued losses, some of the biggest writers of LTCI policies stopped issuing new policies to customers. These include MetLife, which stopped issuing new policies in 2011, Unum (stopped issuing individual policies in 2009, group policies in 2012), Prudential (2012), Continental Casualty Company / CNA (February 2016), and John Hancock (November 2016). Many companies also sought to sell their blocks of in-force policies to other insurers, wiping their hands of the LTCI market entirely. In 2000, there were more than 100 companies selling LTCI policies; when John Hancock exited the market in November 2016, there were only 13 remaining. Today there are less than a dozen companies that sell traditional long-term care insurance.[3]

Meanwhile, long-term care costs continued to balloon. In 2015, the Department of Health and Human Services estimated that more than half of Americans turning 65 will need long-term care services, costing on average around $140,000 (roughly $175,000 today). According to National Health Expenditure projections, home healthcare spending will increase 83 percent from 2018 to 2027. Expenditures for nursing homes and other long-term care facilities are projected to increase 58 percent during that period. The Congressional Budget Office predicts that by 2050,

[2]Direct Loss Ratio (DLR) means the losses incurred by insurers directly due to the payment of claims, divided by the premiums earned. The DLR does not include adjustment expenses incurred by the insurer for investigating and settling claims.

[3] As an alternative to traditional LTCI, many companies have started offering hybrid policies, which generally take the form of life insurance policies with a rider for an accelerated benefits to pay for long-term care costs. However, these policies generally provide fewer long-term care benefits than traditional policies, and it is not clear yet whether they will be profitable for insurers.

when the youngest baby boomers will be well into their 80s, long-term elder care will consume approximately 3 percent of the entire U.S. economy.

Only a handful of states provide a public LTCI option and there is no federal public option for LTCI. The Affordable Care Act originally included a public long-term care option, but the program was widely criticized as unsustainable and was abandoned by the Obama administration in 2011. At the time of this writing, there does not appear to be any public LTCI program on the horizon. Other than state programs, the only public source of funds for long-term care is Medicaid, which requires that seniors meet strict means testing requirements before it will cover costs. As a result, many seniors must utterly exhaust their life savings before Medicaid kicks in to pick up the tab. This is exceedingly common, with Medicaid now covering approximately 60% of nursing home residents.

For those relatively few Americans who have purchased and maintained LTCI coverage, the treatment they will receive when they file claims for benefits may come as a surprise. As mentioned above, LTCI insurers have lost huge sums of money on LTCI policies. Their main objective today is damage limitation. Their strategies to limit losses from LTCI policies often comes at the expense of policyholders who have paid premiums to maintain their coverage for years, if not decades. Section V below will discuss some of the issues policyholders are likely to face when they present their claims.

V. Practical Considerations in Claim Presentation

Presenting a successful LTCI claim requires the insured or their representative to submit proof that the insured is physically or cognitively impaired in the performance of at least 2 Activities of Daily Living (ADLs).

One of the challenges is proving with existing evidence the policyholder's basic need for assistance. Typically, the need arises gradually, without a bright line medical event. In the face of this slow progression, the insured may not be seeing a doctor frequently enough to document the changes and emerging problems. Add to that - many doctors are not great about performing thorough examinations, ordering testing, and writing down what is happening in real time. As we frequently tell insurers, doctors are in the business of treating patients, not documenting insurance claims.

These problems can be compounded where the aging policyholder is unaware of their own limitations or is even in denial - wanting to believe they can still function independently. Any or all of these phenomena can cause a claim to be denied for lack of documentation, even where it is obvious to anyone who knows the situation that assistance is needed.

These holes in the proof are fairly easy to fix. Testing can be arranged to determine a claimant's physical (functional capacity evaluation) or cognitive functioning (neuropsychological evaluation). Medical records can be requested. Witness statements can be gathered along with statements from the insured themself. In-home evaluations can be performed by a licensed nurse / home care aide. When sufficient evidence has been gathered, the insured's treating physician(s) can weigh in on their need for assistance, "testifying" by interview or report to observations that may not have made it into the record.

An attorney can assist with the initial application to ensure the claim is accepted without controversy. However, most policyholders only seek representation after something has gone wrong in the claim process, and only rarely is it related to the proof discussed above. Instead, LTCI policyholders who call attorneys have typically had their claim derailed in one way or another by the insurer, by inadvertently vague or unhelpful statements from their doctors, by their own actions, or by some combination of the three. While the missteps that can be taken by the insured or their doctors are too numerous to meaningfully discuss in this paper, this section will discuss some of the tactics the insurer may use to derail the claim.

A. The Elimination Period: a trap for the unwary.

Almost all LTCI policies require the insured to satisfy an "Elimination Period" before benefits become payable. The Elimination Period is a period during which policyholders must be impaired in their ability to perform ADLs, while also receiving covered services (nursing care, home healthcare, etc.). Common Elimination Periods are 30, 60, 90, or 100 days. Many policies only require the insured to receive care a certain number of days per week or allow a certain number of calendar days during which the Elimination Period can be satisfied. Still, satisfying the Elimination Period almost always costs policyholders thousands of dollars out of pocket.

Many policyholders are unaware of the Elimination Period. They will often apply for benefits *before* they begin to receive care, hoping the insurer will approve their claim prospectively. Not without reason, they hope they will be fully reimbursed by their insurer when they begin to receive care. It can be a rude awakening for them to learn that they will need to spend a significant sum of money before their policy starts to pay out.

Even worse, when policyholders apply prematurely for benefits, it can make them vulnerable to abuse by a cost minded LTCI insurance company. Such an insurer may slow-play the benefit decision. The insurer might continuously request additional information, claim not to have received information submitted, or be generally unresponsive, without informing the policyholder that they must start receiving care to meet the elimination period.

By increasing the time before the insured begins to satisfy the Elimination Period, the insurer can effectively shorten the overall period during which benefits will be payable. This tactic can save the insurance company tens of thousands of dollars. The more they delay without the insured learning how the Elimination Period works, the more money they save. Meanwhile, the policyholder is being delayed in getting the assistance they need, usually with the brunt of the burden of care being borne by family. This, of course, defeats the very purposes of paying years or decades of LTCI premiums.

This is one of the most common complaints we get from potential LTCI clients. They report to us that they have filed their claim, but that their insurance company has not made a decision and is unresponsive to their attempts to communicate. When we dig deeper, we almost always find that the potential client has not yet started to receive care.

B. Hypertechnical denial rationales.

Delay is only one of the tactics insurers use to defeat policyholders' reasonable expectations. Insurers also employ more creative and technical tactics to try to save money on LTCI claims. One common tactic is to claim the policyholder is staying in the wrong type of

facility, or that the facility does not satisfy some technical policy requirement.

One of our recent cases presents a particularly egregious example. Our clients, a husband and wife, moved into an assisted living facility and immediately filed claims for reimbursement with their longstanding LTC insurer. They satisfied the Elimination Period. They had been evaluated by the facility, confirming they both needed assistance with ADLs. Their doctor was on board. Even the insurer agreed that they were both *medically* eligible for benefits under their twin policies.

Nevertheless, the insurer denied the claim, claiming that their facility was violating its technical state licensure requirements.

The insurer denied the claims based on a decades-old definition of "Long-Term Care Facility." Our clients' policies were so old they had been written before assisted living facilities had become popular, so the policy language no longer fit the nomenclature of modern institutions. This is common since the industry terminology has evolved a great deal in the last few decades. Here, Long-Term Care Facility was defined as a facility licensed as a "Skilled Nursing facility, an Intermediate Nursing facility, or a Custodial Care facility." Custodial Care was defined to mean assistance with ADLs.

A reasonable policyholder would expect an Assisted Living Facility to qualify as a Custodial Care facility. Assistance with ADLs is what they do. However, the insurer focused instead on a "fine print" policy requirement that a "Long-Term Care Facility" must provide "24-hour-a-day nursing services." The insurer claimed that the Georgia licensing statute applicable to Assisted Living Facilities prohibited those facilities from offering 24-hour nursing care. In fact, the insurer asserted that O.C.G.A. § 31-7-12.2(f), which states that an "assisted living community shall not admit or retain an individual who is in need of continuous medical or nursing care," prohibited assisted living facilities from "providing *any medical or nursing care*." (Emphasis supplied).

Read properly, the statute merely prohibits Assisted Living Facilities from caring for a patient who requires continuous medical attention. Such a patient would belong in a facility that provides a higher level of care, such as a skilled nursing facility, or even a hospital. Other regulations permit assisted living facilities in Georgia to provide "limited nursing services," and there is nothing in the law that would prevent an assisted living facility from making such nursing services available 24-hour-per-day for its overall population of residents, as this one did.

We gathered proof from the assisted living facility confirming that it did provide 24-hour-a-day nursing services and presented a demand for payment to the insurer analyzing the policy language in light of the facts and Georgia insurance and contract law. An effective demand in this situation will focus on favorable Georgia insurance and contract law:

> **[I]f a provision of an insurance contract is susceptible of two or more constructions**, even when the multiple constructions are all logical and reasonable, it is ambiguous (*Lakeshore Marine v. Hartford Accident, etc., Co.*, 164 Ga.App. 417(2)(a), 296 S.E.2d 418 (1982)), and the statutory rules of contract construction will be applied. Pursuant to the rule of construction set forth at OCGA § 13-2-2(5), **the contract will be construed strictly against the insurer/drafter and in favor of the insured.** *See American Southern Ins. Co. v. Golden*, supra, 188 Ga.App. at 586, 373 S.E.2d 652.

Hurst v. Grange Mut. Cas. Co., 266 Ga. 712, 716 (1996) (emphasis supplied).

Said differently, "[w]hen the language of an insurance contract is ambiguous and subject to more than one reasonable construction, the policy *must* be construed in the light most favorable to the insured, which provides him with coverage." *Western Pacific Mut. Ins. Co. v. Davies*, 267 Ga.App. 675, 680 (2004) (emphasis supplied). Moreover, insurance contracts are construed not based on "what the insurer intends its words to mean, but rather what a reasonable person in the insured's position would understand them to mean." *Id.*, quoting *Gulf Ins. Co. v. Mathis*, 183 Ga.App. 323, 324 (1987).

In a nutshell, these well-established rules mean that an LTC insurer may not take advantage of vague or ambiguous language to defeat the policyholder's expectations. The insurer's attempt to defeat coverage relying on now-outdated policy language is exactly the sort of self-serving interpretation these rules are designed to combat.

The company ultimately decided to pay our client's claims in full in response to our demand. Other policyholders have not been so fortunate. This same insurer has been the subject of multiple class action lawsuits, having repeatedly taken the position that to satisfy the over the 24-hour-a-day nursing requirement, a long-term care facility must have nurses <u>*on-site*</u> for 24 hours per day, 7 days per week.

While some courts have rejected this interpretation as a matter of law, *see Hoekenga v. Cont'l Cas. Co.*, Case No. 1:06-cv-458 (S.D. Ohio April 18, 2007), for the most part the company has also been able to settle the class action lawsuits for a fraction of stated policy benefits. In other words, despite its policy interpretation having never been upheld by a court, the insurer's strategy has saved it millions of dollars on claims, defeating policyholder expectations in the process.

C. Misuse of Alternative Plans of Care.

Another method an insurer may use to limit costs is combining a technical policy defense with an offer of an "Alternative Plan of Care" or APC. An APC is a separate agreement that modifies the terms of the policy, and must be agreed to and signed by both parties. It is usually used to allow for the payment of benefits that would not have been covered under the original policy, typically at a slightly lower benefit rate. A traditional APC can thus benefit both the policyholder and the insurer. The policyholder gets the care and support they need, and the insurer saves money. That is a win-win.

However, APC's can be abusive when offered in conjunction with an *unsupported* denial of benefits. Here, the insurer wrongly denies the claim and offers the policyholder an APC as a means of resolving the *manufactured* dispute. The danger to the insured is that the terms of the APC may be far less favorable than the coverage they had under their existing policy. In one such case, the insurer offered our client an APC that would pay only a fraction of the benefits promised under the policy. More problematic still, the APC would not have been "guaranteed renewable," meaning the insurer would have to re-approve it after a year. Worst of all, the fine print of the APC required the policyholder to agree in writing that the insurer's unsupported policy interpretation was *correct*.

Taken together, these changes could have been catastrophic. If the insured had signed it,

the insurer could pay benefits under the APC for one year at a reduced benefit rate and then decline to renew the APC. Having obtained the policyholder's agreement that they were not eligible for benefits under the policy, the insurer could deny further benefits and the policyholder would have no recourse. In our view a policyholder should never sign an APC agreement without having it reviewed by an attorney.

VI. Bad Faith Insurance Law in Georgia: A Paper Tiger?

Policyholders can pay LTC premiums for decades without ever filing a claim. When they finally do need personal assistance and care, they often feel deeply wronged if their insurer fails to deliver on its promises of protection.

In most disputed insurance claims, the policyholder is limited to breach of contract damages, i.e., the benefits owed under the policies, plus statutory interest. Most policyholders are looking for something more than that, raising the question of bad faith damages. Almost all states have some form of "Bad Faith" insurance law, allowing recovery of attorney's fees and/or other damages. Some even allow for the recovery of punitive or treble damages if the plaintiff can demonstrate that the claim for benefits was unreasonably denied. Many, including Georgia, provide for a statutory penalty – usually expressed as a proportion of the benefits owed.

The potency and efficacy of these Bad Faith laws varies widely between states. Georgia's Bad Faith statute, O.C.G.A. § 33-4-6, is arguably somewhat toothless due to judicial gloss. While the statute provides for attorney's fees and for penalties up to 50% of the benefits owed, Georgia courts have interpreted "bad faith" very narrowly.

Since at least 1946, the courts of Georgia have held that if there exists "any reasonable ground for contesting the claim, there is no bad faith." *Pearl Assur. Co. v. Nichols*, 73 Ga.App. 452, 455 (1946) (citing even older decisions) (emphasis supplied). Therefore, "[p]enalties for bad faith are not authorized where the insurance company has any reasonable ground to contest the claim and where there is a disputed question of fact." *Fortson v. Cotton States Mut. Ins. Co.*, 168 Ga.App. 155, 158 (1983) (emphasis supplied).

Making matters worse, the courts have held that the "test of bad faith within the meaning of the law in such cases is as of the time of trial, in the final analysis, and not at the time of refusal to pay upon demand. Whatever the facts are at the time of such refusal to pay if at the trial there was a reasonable ground for the insurer to contest the claim there can be no finding against the insurance company for bad faith and attorney's fees regardless of the outcome of the case." *Interstate Life & Acc. Ins. Co. v. Williamson*, 110 Ga.App. 557, 560 (1964) (emphasis supplied).

One might think the reasonableness of the insurer's grounds for denying the claim would be a question for the jury. Unfortunately, it often is not. Indeed, the courts have held that "if there is no evidence of such frivolous or unfounded refusal to pay, or if the question of liability is a close one, the court for the furtherance of justice should see to it that a verdict which illegally carries a penalty for bad faith is not allowed to stand." *Fortson*, *supra*, 168 Ga.App. at 158; *See also, King v. Atlanta Cas. Ins. Co.*, 279 Ga.App. 554, 556-57 (2006).

As a result, bad faith caselaw in Georgia is replete with decisions overturning jury awards and affirming trial courts' awards of summary judgment or directed verdicts in favor of insurance companies. *See Johnston v. Companion Prop. & Cas. Ins. Co.*, 318 F. App'x 861, 868 (11th Cir. 2009); *Scheinfeld v. LM General Ins. Co.*, 472 F.Supp.3d 1329, 1346 (N.D.Ga. 2020); *King*, *supra*,

279 Ga.App. at 557; *Southern Fire & Cas. Ins. Co. v. Northwest Georgia Bank*, 209 Ga.App. 867, 867 (1993); *Fortson v. Cotton States Mut. Ins. Co.*, 168 Ga.App. 155, 158 (1983).

It can be a daunting task to even get to a jury with a Georgia-based bad faith claim. Doing so typically involves defending a motion to dismiss or a motion for summary judgment. However, there are strategies for surviving these challenges.

While Georgia cases broadly pronounce that claims of bad faith are defeated if there existed "any reasonable grounds" for denying the claim, the courts have also long recognized that procedural shortcomings in claim investigation and decision-making can be sufficient to bring the question of bad faith in front of a jury. Indeed, "where an insurer denies the claim of its insured upon inadequate evidence or upon only a perfunctory investigation, the jury may properly infer that such refusal to pay was made in bad faith." *Atlanta Coca-Cola Bottling Co. v. Transamerica Ins. Co.*, 61 F.R.D. 120, 126 (1973), *citing Reserve Life Ins. Co. v. Ayers*, 217 Ga. 206, 212–214 (1961).

The core of a bad faith claim is the assertion that the insurance company's conduct in investigating and deciding the claim was unreasonable. Thus, the most important task is to establish that the insurer deviated from industry standards of good faith claim handling. These standards can be established using an industry expert, case law or statutory authority.

O.C.G.A. § 33-6-34 enumerates acts that constitute "improper claims settlement practices." While the statute does not create a private cause of action, it essentially codifies good faith standards of claims handling and can be used to rebut the insurance company's claims that its conduct was reasonable. Examples of improper claims settlement practices include "Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions," "Refusing to pay claims without conducting a reasonable investigation," "Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies" by making lowball offers, and delaying investigation or payment by requiring claimants to submit duplicative information, among others.

In a case where bad faith penalties are a legitimate possibility, the insurer is likely to have violated one or more of the industry standards listed in the statute. If not, an expert should be able to clearly articulate how and why the insurer's conduct was unreasonable. Given the amounts in dispute, the cost of such an expert is often justified.

Because the law permits dismissal of bad faith claims where there is "any reasonable grounds" for the claim decision, insurers challenge these claims aggressively. To survive these challenges, it is critical to establish the reasonable standards breached in the claim investigation and decision as well as to emphasize the facts demonstrating entitlement to benefits.

VII. Conclusion

Most Americans are unprepared for the costs of the long-term care they may need in old age. Long-term care insurance was created and marketed to help pay for it. However, the insurance industry has failed to make affordable long-term care insurance work. The few insurers who have remained in the LTCI market sometimes impose aggressive cost-saving strategies at the expense of reasonable policyholder expectations. As a result, policyholders seeking benefits today would greatly benefit from the advice of experienced counsel, preferably before a dispute arises.