



UP Director Amy Bach

BACH TALK...

Dear Friends:

United Policyholders has weighed in again before our country's highest court, this time in *Campbell v. State Farm*, a case that stems directly from our roots and is critically important to all policyholders. (See "UP to the Supreme Court" in this issue). The issue our Supreme Court will be deciding is whether to uphold the \$145 million verdict a Utah jury entered to punish State Farm for implementing a nationwide strategy to boost profits by rewarding adjusters for underpaying and denying claims. This very strategy sparked the founding of United Policyholders. *continued on page 2*

CA. ELECTS PRO-CONSUMER COMMISSIONER

John Garamendi won his bid to return to the job of California's top elected insurance industry watchdog. Garamendi worked closely with United Policyholders during his 1991-1995 term and was a very pro-active and pro-consumer regulator. He is a hero to many who lost their homes in the 1991 Oakland/Berkeley firestorm and is noted for the historic fine he levied against Allstate for claims handling violations. He boosted morale at the Department, implemented strong consumer protection regulations and stepped up enforcement activities against misbehaving insurers.

Many of Garamendi's improvements were dismantled by his successor, Chuck Quackenbush, but he showed that it can be done—California can elect an effective regulator who balances the needs of policyholders with the legitimate interests of insurers, and stands up for those who are victimized by unfair practices. Garamendi will have his work cut out for him thanks to the non-renewal plague that is sweeping the California homeowners insurance market. Congratulations John, we look forward to working with you!

AMICUS PROJECT UPDATE

The following are some of the recent activities of UP's Amicus Project:

Arizona

Liristis v. American Family Mutual Ins. Co. 1 CA-CV 00-0539. UP filed an amicus brief in this case on behalf of a family whose home became contaminated with mold from water used to suppress an accidental fire. Their insurer, American Family, cited a policy exclusion for mold and refused to cover the clean up claim. The family sued for breach of contract and bad faith. A trial court granted summary judgment in the insurer's favor and dismissed the family's case. The insurer filed a response to UP's amicus brief in which it accused UP of urging a "tortured interpretation" of their policy. In June 2002, the Arizona Court of Appeals found that coverage was a question of fact and reinstated the family's case. (See http://www.unitedpolicyholders.org/claimtips/tip_mold.html for related info). UP's brief was written *pro bono* by policyholder attorney **Gene Anderson** of **Anderson, Kill & Olick's** NYC offices, www.andersonkill.com, and **Richard Treon** of the Phoenix firm, **Treon, Strick, Lucia & Aguirre**.

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DISABILITY INS. GIANT FOUND GUILTY OF UNFAIR PRACTICES

Disability claimants all over the U.S. will benefit from a recent order by Federal Magistrate Judge James Larson finding The Paul Revere Life Insurance Company guilty of unfair business practices in Joan Hangarter v. Paul Revere. Judge Larson issued an order on November 14th, 2002 in which he held that the insurer committed "multiple acts of bad faith" in handling disability claims and that it forced insureds to litigate to obtain benefits. He ordered Paul Revere to obey the law and enjoined it from committing future violations, including but not limited to targeting categories of claimants, employing biased medical examiners, destroying medical reports, and failing to advise insureds of covered benefits. The order also upheld the unanimous jury award obtained for Ms. Hangarter by S.F. attorneys Bourhis & Wolfson. An entity comprised of former competitors Paul Revere/UNUM/Provident control the disability insurance market, and are in litigation all over the U.S. over the practices Judge Larson found illegal. (See page 11)

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BOARD FOCUS

UP is very pleased to welcome three new additions to our Board of Directors, bringing our total to seven members. Judith Hodgens, (See "Mayor/Fire Victim Joins UP Board" in this issue), Gerry Mannion, and Donald Pierce all have considerable prior experience serving on non-profit Boards. Gerry is a San Francisco policyholder attorney who brings a comprehensive knowledge of insurance issues, good humor and political savvy. Don is an Oakland firestorm survivor with extensive experience in communications as an executive with the Chevron Corporation. We will be profiling each Board member in future editions of What's UP.



UP Administrator and Board members (clockwise from L) Shirley Roberson, Judith Hodgens, Don Pierce, Bill Hedden, Gerry Mannion, Alice Wolfson, and Director Amy Bach at recent meeting.

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BACH TALK from page 1

Since our founding UP has filed more than one hundred pro-policyholder briefs, virtually all of which were written pro bono (free of charge), by experienced attorneys. Because the stakes in Campbell are so high, we hired an attorney who specializes in appearing before the U.S. Supreme Court. Thanks to the dedication of policyholder advocates across the United States, we were able to raise a substantial sum in a short period of time to cover his fee. We hope our brief will help convince the Court that punitive damages must be proportional to an insurer's actual profits if they are to serve as a true deterrent and remedy.

The claim tips and newsletter articles on our website continue to draw new supporters, and we routinely add information to the site in response to

reader requests. Your input allows us to keep your priorities our priorities, so please keep in touch with us. Our mold claim tips are currently our most popular publication because so many policyholders are being impacted by the hard line insurers are taking on mold claims. Our efforts to enact legislative reform this year on mold coverage in California were not a success, but we'll be trying again next year.

We are proud to welcome three new members to our Board of Directors, each of whom brings unique skills and perspective. (See "Board Focus" in this issue). The Board is looking forward to the challenge of shepherding UP's growth as we increase our staff to keep pace with the demand for our work. UP has always prided itself on being "lean and mean" by operating with a minimal infrastructure and tackling

only very select projects. Now we must grow internally so we can better meet the increasing demand for our services.

We sincerely appreciate the support of all who helped us raise funds for our Campbell brief and those who regularly support our ongoing work. Keep in mind it's easy and safe to make on-line donations to UP via credit card via our website. Our next issue will focus again on homeowner's issues, including boycotts consumers are facing in certain areas, mold coverage, and an update on earthquake insurance in California.

Amy Bach
Executive Director and Co-Founder

MAYOR/FIRE VICTIM JOINS UP BOARD



Recent addition Judith Hodgens brings a wealth of personal and professional experience to UP's Board of Directors. Judith is in her second term as Mayor of San Anselmo and serves as the development director of The Cedars, a non-profit organization. She has worked in non-profit management for 25 years. Judith and her husband lost their home in a fire two years ago. Executive Director Amy Bach interviewed Judith about her insurance claim and UP:

Q: What led you to contact UP?

A: I'd been searching the Internet trying to find insurance advice after our home burned down and we were having a tremendously difficult time dealing with State Farm and managing the process of our claim. Our home burned down June 18th, 2000 and I have not had a normal day since then. We were in shock initially, didn't have a copy of our policy, didn't know what our rights were. At first we relaxed and figured we'd be okay.

Q: What problems cropped up during the claim process?

A: Trying to reconstruct what we had and document every single item to State Farm's satisfaction was excruciating.

We were grossly underinsured for our personal property, yet we had to jump through all the hoops anyway.

The insurance company charged us \$10,000 for the services of a company called "Service Master." They hired them to salvage and clean our personal property but the items they picked were either obviously destroyed or not worth saving - lobster crackers is one item that comes to mind. We had no control over this expense - it simply got deducted from the precious insurance coverage we had.

We thought the riders we had for jewelry, etc. were extra coverage on top of our limits, it turns out they weren't. We were grossly underinsured yet my husband had spoken every year with our agent and the agent always assured him we were adequately covered.

Q: What problems came up in rebuilding your home?

A: Every contractor except State Farm's told us the remains of our house couldn't be saved and we needed to rebuild. We eventually convinced them but it took a long time. We needed an ACV payment to get started but State Farm offered us far less than our home was worth, so we demanded an appraisal and it came out way above our insurance limits. We had to fight

with them over appurtenant structures, fences, our garage, our foundation, and our roof...we're still fighting over coverage for code upgrades.

Q: Why didn't you use the contractor recommended by State Farm?

A: His company had never done a house in San Anselmo and had no experience with the home values in our area. I called the Builders Exchange, they'd never heard of the company and they weren't a member. My impression was the company was hired by State Farm to be their hired gun - not independent.

Q: What led you to join the Board of UP?

A: I want to work to make sure no person who has suffered a loss through fire will ever have to go through what we went through. Not just the fighting for every dollar you're owed but the humiliation... Even though we were so underinsured the adjuster insisted my husband inventory every single one of his extensive book collection, which he painstakingly did and it took him two months. The adjuster later told us she was too busy to look at the list and hadn't they paid us for a lot of books already.

WHAT KIND, AND HOW MUCH LIFE INSURANCE DO YOU NEED? PART 2

By Larry Ginsburg CFP and UP Board member

(See Part 1 at www.unitedpolicyholders.org)

What Type of Insurance Should You Buy?

The two types of insurance are "Permanent" and "Term." Permanent Insurance is just what it implies: you pay premiums sufficient to keep the insurance in force through the rest of your life. Permanent Insurance usually has some form of a savings or investment component. As a result, in the early years you may pay a little extra money that is invested so that in later years you do not have to experience a rise in your premiums. Permanent Insurance is excellent for people who can afford this coverage. Permanent Insurance may be acquired so that the investment portion can be allocated between different sub-accounts allowing you to own stocks or bonds. This type of insurance is usually referred to as "variable" life insurance. What is "variable" is the amount of return on the portion of the money paid in premiums that is invested in the sub accounts.

Permanent life insurance is generally obtained through a "universal" life insurance or a "variable universal" life insurance policy, where the premiums may be changed, or varied. This type of insurance policy is usually appropriate for those with greater disposable income. Permanent insurance policies also offer a tax advantage in that the tax deferred accumulation of the investment dollars can be received later as tax-free income in retirement should they be needed.

"Term" Insurance offers coverage for a specific period of time. Term Insurance can be purchased through the remainder of one's life (usually to age 95), with the premium rising each year. This type of insurance is called "annual renewable term". Term insurance can also be purchased

where the premium does not change for a specified period of time, such as 5, 10, 15, 20, 25, or 30 years. This type of insurance is called "Level Premium Term." At the end of the rate guarantee period in level premium term policies, the cost of insurance rises significantly. Term policyholders can then generally qualify for a lower rate than the guaranteed policy rates if their health allows them to qualify for such a discount.

Term Insurance is an excellent alternative for those with less disposable income who need to get the low cost of insurance in place for the immediate future.

Can Your Insurance Policy Be Changed?

Once an insurance contract (policy) has been issued, the insurance company is unable to make it more restrictive to the policyholder. After you have applied for a life insurance policy and the underwriting (evaluation of your health status) is completed, the company then issues you a life insurance policy. At this point, you have choices. You have a limited time to accept coverage by paying the premium due as long as your health status has not changed from the date of application. If you continue to pay premiums as scheduled in the policy, the right to keep the coverage in force is totally yours. Should your health status later deteriorate, the company cannot retroactively change your policy.

Choosing The Right Insurance For You

What is important is that you look seriously at what would happen in your family if you or your spouse were to die, or you were both to die together in an accident. What monies would need to be available? What would you want to happen if you could then make the

choice about life insurance? Those who are retired and have accumulated sizeable investment portfolios may find that they no longer need the type of life insurance they have owned for many years. Others may find that maintaining such insurance is a very wise decision. Those who are younger need to make certain that the protection your family will need is put in place before it is needed. Once you have given some thought to these issues, it may be helpful to review your concerns with an insurance professional who should be willing to give you proposals that include cost data. Please be sure to note that the cost of insurance is lower for those who are in excellent health as compared to those who are in poor health. Smokers can expect to pay substantially more for life insurance than non-smokers. Those who expect their health to deteriorate in the future are well served by making sure they have insurance in place now that they can maintain through the rest of their lives.

Larry Ginsburg, has been a member of the UP Board of Directors for many years. Larry is a Certified Financial Planner; his office is in the Montclair Village business district in Oakland, CA where he helps shape and secure the financial future for his clients through financial planning and investment management process. Larry is also Chairman of The Financial Planning Association (FPA) of the East Bay, and Chairman of the FPA Northern California Presidents' Council. He can be reached at (510) 339-3933, or by email at: lpjginsburg@aol.com.

IT'S UP TO THE U.S. SUPREME COURT

No amount of bad publicity will ever match the power of a punitive damage award to make insurers avoid the natural temptation to boost profits by arbitrarily cutting claim payments. Punitive damages are a uniquely critical consumer protection in the context of insurance. Insurance companies, like all businesses, naturally want to maximize profits. Unlike other businesses, insurers have the option of doing this by using claims as "profit centers", i.e. arbitrarily cutting claim payments to save money. UNUM/Provident's scheme of training doctors to deny disability claims is a classic example. (See Spring, 2002 edition of "What's UP" at <http://www.unitedpolicyholders.org/newsletters/summer02.html#UNUM>) State Farm's strategy to financially reward adjusters for lowballing claims as revealed in the case of *Campbell v. State Farm* is another example. Policyholders are devastated when they are victimized by such schemes. Because punitive damages offset the profits insurers gain through such schemes, they are a true deterrent and punishment. State insurance regulators and legislators are typically cozy with the industry and don't come anywhere close to being equally effective in protecting consumers.

When UP learned that our United States Supreme Court agreed to review a jury's \$145 million punitive damages verdict against State Farm in the *Campbell* case we swung into action preparing to file the strongest possible amicus brief. Eighteen amici, including the Ford Motor Company, U.S. Chamber of Commerce, and the National Conference of Insurance Legislators had already filed briefs supporting State Farm and opposing the verdict.

The evidence in *Campbell* showed that State Farm adopted a nationwide strategy to maximize profits by tying adjusters' salaries to the amounts they paid out on their assigned claims. This strategy was applied to Curtis *Campbell's* claim and it resulted in his financial ruin. The jury considered the evidence and testimony that State Farm's Board of Directors only pays attention to punitive damage awards that exceed \$100 million and entered a \$145 million dollar verdict after careful deliberations. An appeals court reduced that to \$25 plus million, but the Utah Supreme Court reinstated the entire jury verdict. The U.S. Supreme Court agreed to hear State Farm's appeal.

After months of hard work, and collaborative effort, UP filed its amicus brief in October and anxiously awaits the decision by the nation's highest court. Because punitive damages are the only truly effective deterrent against unfair claims practices, and because the U.S. Supreme Court has the last word, the outcome of the *Campbell* case is truly critical to policyholders and their advocates. We sincerely hope the Court reaches the right result and upholds the Utah Supreme Court's decision in its entirety.

UP's amicus brief was written by Washington, D.C. attorney **Tom Goldstein**, (www.goldsteinhowe.com) and Executive Director **Amy Bach**. Attorneys **Jeffrey Ehrlich**, **Tod Hindin**, **Cal Thur** and **Alice Wolfson** provided drafting assistance.

UP thanks the following firms for their generous recent contributions to support UP's Amicus Project:

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SUPERVISING YOUR OWN HEALTH INSURANCE CLAIMS

By Jacques Chambers, CLU

Dealing with health insurance and how it covers your medical bills can be a complicated and stressful issue. You may have an Indemnity or Preferred Provider Organization (PPO) Plan that pays medical bills after they are incurred. Or you may be covered under one of the many varieties of Health Maintenance Organization (HMO) Plans that "pre-authorize" certain treatments and disallow others. Either way, problems can arise in how the claims are handled, and unless caught early, they can grow into major financial and legal dilemmas.

It's tempting to ignore the whole medical payment process and assume that the insurance company and the doctors are handling everything satisfactorily. However, a rude awakening will usually occur when you receive a large bill for charges the insurance "denied or disallowed" or your HMO doctor finally admits that some of the treatments she recommended were not approved by the "HMO Committee."

Whether it is claims payments or treatment authorizations, most billing and precertification communication between a doctor and the insurance company is in codes, and one misplaced digit can make a substantial difference in the medical care paid for or allowed. It is important to catch those small errors early, and you, as the claimant, are the best person to do it.

You do not have to become an insurance expert to be able to oversee just how your insurance company is processing the medical bills you are incurring. At the least, you can get minor errors corrected quickly; at worst, you have built a solid file that will save the attorney or benefits counselor you hire a lot of billable time. It will take some time and

effort on your to understand how the process works and how you can affect it, but it will be well worth it.

The first step is, of course, "Know Your Coverage." Easy advice to give, but this is often the biggest problem in overseeing your coverage. Insurance contracts are scary; they're hard to read; they don't make a lot of sense if you're not a lawyer. You don't need to memorize your plan or know every single provision to understand how it works.

Get a copy of your coverage. It may be an insurance policy, a booklet of coverage, a Summary Plan Description, or a chapter in an employee benefits manual. The health plan description will cover twenty to thirty pages or more.

Don't try to sit down and read it all the way through. That would put anyone to sleep. But, look through it. Note the different parts. There will be parts that describe the benefits. There will be sections that tell when you become covered and when your coverage ends and what may be available after it ends. Don't try to memorize every provision of your plan so much as just get familiar with where things are so you can refer to them as you deal with the insurance company.

Things you should try to find are:

The Schedule of Benefits - This is often at the front of the plan. It's the part that tells what the insurance company pays and what you pay. It lists the deductibles, the insurance percentages they pay, the co-pays you are expected to pay at each doctor's visit, etc.

Covered Benefits - Often separate from the schedule of benefits, this will be a listing of what is covered. In some plans this will be a fairly long list; others will give a short list of a broad range of benefits covered.

Exclusions and Limitations - This lists the things that the plan will not cover

like experimental treatment, or cosmetic surgery. It also lists the things that it will cover but puts special limits on, such as mental health, or convalescent home care, or treatment for conditions that existed when your coverage started. You may want to paperclip this section, as you may need to refer to it more frequently.

Claims Procedures - This will be a couple of pages that talks about filing claims. The important section here is the part that tells you how to appeal denials. You may want to read that through, as there are usually some important time limits and other information there.

Mark it up. This is the rulebook that the insurance company must play by so don't hesitate to use paperclips, tabs, highlighting and underlining to make it easier for you to use.

The policy alone may not be that helpful, but you will find it valuable as you work with the insurance company and your medical provider when there are claims questions since it must contain the basis of their denials or cutbacks.

How you watch the medical claims depends on what type of plan you are under. If you have coverage through an Indemnity Plan or a Preferred Provider Organization (PPO) Plan, the insurance company will process the claims and pay their portion after you have received the treatment.

With these plans you will receive an Explanation of Benefits (EOB) every time they process a charge. Review each EOB carefully. Was everything "allowed" in full even if only a percentage was paid. If not, call and ask for an explanation. There will usually be a toll-free number on the EOB. Take notes as to whom you talk to and what they say. Don't be bashful about asking for more clarification.

LONG TERM CARE INSURANCE

by Gloria St. John

If you're looking ahead and considering buying long term care (LTC) insurance, careful shopping is in order. The decision over whether or not or when to buy a long-term care insurance policy should be made as part of your overall financial planning strategy. LTC policies offer a range of benefits and options, and prices vary considerably from company to company. The main variables in policies are the Daily Benefit Amount (DBA), the trigger for benefit eligibility, the mix of health care services covered, the waiting period, and the duration of benefits. As with all insurance, its best to buy from a reputable, established carrier. Following is some basic information about this fairly complex product:

Who needs LTC?

The main reason to buy a policy is to preserve your assets for your spouse or heirs and not spend them on end of life care. Generally those with assets of more than \$2 million should be able to pay for their own care, though many prefer to obtain LTC insurance to maximize their own estate planning. Those with less than \$100,000 will probably not be able to pay for their own long term care needs, but they may also not be able to afford LTC premiums either unless they make it a priority in their budgeting. Individual health and family tendency toward disease should also be taken into account in estimating need as should other care resources such as whether family members might be able to furnish assistance.

Long-term care insurance will only benefit those individuals who actually need home health care, or nursing home care in later life. Many people underestimate both their need for this care and the amount it may cost when they need it. A recent survey by the AARP revealed that only 15% of

those surveyed (all over 45 years old) were able to estimate the current costs of long-term care with 20% accuracy. Predictions for the cost of care in 2030 are mind-boggling. A visit from a Home Health Aid could cost \$260, compared to \$61 in 2000; adult day care could be \$220 per day compared to \$50 in 2000 and assisted living and nursing home care would start at \$109,300 and \$190,600 annually, respectively.

Those who buy long-term care insurance should plan to keep it forever. Lapses in premium payment usually result in the policy's cancellation, though relatives can be notified if policy lapses are due to inability of the insured to maintain payments. Premiums may rise on policies after purchase. Couples should determine whether they need two policies or one. If there is a disparity in age and or health, one policy may be sufficient to preserve assets during the first spouse's decline, though rarely can anyone accurately predict future need for benefits. Some policies allow couples to share benefits.

Benefits

Most LTC plans cover a mix of home health care, and nursing home care (skilled, intermediate or custodial levels of care). Some pool the benefits and allow you to use them any way you choose, subject to policy limits. Home health care is a popular benefit since few people like the idea of going to a nursing home. However, to qualify for home health care, one may need to meet the same conditions of disability as someone qualifying for nursing home benefits. If this is the case, 24/7 home care will be too expensive as compared to cost of nursing home care. Home health care is usually an option for people with spouses and families willing and able to pitch in on a daily basis.

How long does coverage last?

There are plans that cover care from one year to a lifetime of care. Lifetime care with maximum benefits ensures that your estate will be intact. However, the average length of stay in a nursing home for those between the ages of 65 and 94 is two and one half years, with 90% staying fewer than four years. Policy purchasers need to consider that some elderly people stay much longer in a nursing home, which may become their final residence.

ELIGIBILITY AND WAITING PERIOD

Determination of eligibility: disability and cognitive impairment

How disabled must the insured be before qualifying for LTC? The activities of daily living (ADLs) -bathing, eating, toileting, transferring, dressing, ambulating, etc.- are used to assess a person's need for care. There are six activities of daily living used to measure the ability to live independently. LTC policies require you to be unable to perform two ADLs before you would qualify to receive benefits. The other qualified category of impairment is cognitive impairment such as Alzheimer's. All LTC policies are required to cover needs based on cognitive impairment (such as senile dementia and Alzheimer's Disease). It is important to note whether your own doctor or the insurance company will be able to certify your eligibility.

Waiting period

Most LTC policies require the insured to pay for his/her own care for a period of time after being diagnosed with a severe cognitive impairment or being unable to perform two or more activities of daily living. Payments then continue until the benefits are exhausted, unless lifetime benefits are furnished in their policy. Obviously the longer the waiting period, the lower the premium, but

HEALTH INS CLAIMS from page 6

Follow the appeal procedures to challenge their decision, if you disagree. Ask for your doctor's help with supporting your appeal.

For Health Maintenance Organization (HMO) Plans, most of the claims work is done between your doctor and the HMO and consists of authorizing treatment before it is given, not paying the bill after. Learn about your medical condition. Know what alternatives to treatment are available.

Then you need to spend some time with your doctor (or your doctor's insurance clerk) to understand when and what has to be pre-authorized by the HMO. How successful are they in obtaining approvals? How often are they denied? Can you be notified of denials and participate in appeals?

Health insurance is not maintenance free. It can't be just "turned on and forgotten." Just as you must take an active role in your health care and treatment as a patient, you must also stay alert and active as an insured with how your medical care is authorized and paid for.

Jacques Chambers, CLU, spent twenty-five years in the health and life insurance industry. He received his Chartered Life Underwriter in 1976. Since 1990, Jacques and his company, Chambers Benefits Consulting, have worked with people dealing with disabilities, educating them about their rights and advocating on their behalf. In addition to regularly writing on benefits and disability Mr. Chambers maintains a private practice where he provides individual counseling on benefits issues. He can be reached at 1-888-739-2595 or at jacques@helpwithbenefits.com. His website is: <http://www.helpwithbenefits.com>.

LONG TERM CARE from page 8

beware and check the policy's wording carefully here! If the waiting period is 90 days and you become disabled and receive home care only three days a week, it could take seven months before your benefits begin. Look for wording that specifies a 90-day period rather than 90 actual days. Also be certain that the waiting period is not reset when you go from one type of care to another. If you have waited 90 days for home care benefits and then go to a nursing home, there should be no additional waiting period. There is also a caveat to the way you spend your benefit dollars. The danger here is that policies with fixed dollar or days of benefits may have all the benefits used to cover home care; for example, leaving nothing left for nursing home care if needed at a later time. Policies with lifetime benefits eliminate this concern.

What does LTC cost?

Premiums are based on the age of the insured when the policy is issued and the amount of potential benefits. Long-term care insurance costs more for older people (about \$7,000 a year for a seventy-five year old and \$3,000 for a sixty-five year old or more). Younger people benefit from lower premiums, since the insurance companies expect benefits to be utilized between age 80 and 84. Premiums anticipate the policyholder paying approximately the same cost to the time of anticipated benefits need. Similar thinking helps us understand the tax deduction now offered for premiums on Tax Qualified Policies. When premiums are low, tax liability is typically high and vice versa, so the tax deduction allowed for premium payment may not be very meaningful in later years, should policy owners then be in a lower tax bracket.

What are some things to look for in policies

Inflation protection helps guard against the expected rise in future service costs for a 25% to 45%

increased premium. This benefit is expected to be a better match for future costs, but there is no guarantee that it will cover all expenses. Non-forfeiture protection can also be purchased for a 10 to 100% increase in premium. This allows the insured to retain some benefits even if premium payments are suspended. There may also be a rider that covers inflationary increases in premiums without an additional out of pocket expense.

When to buy it

LTC policies have changed over the years, and newer policies offer some benefits not available in earlier policies. Assisted living, for example, is a fairly new option and would not have appeared as a benefit in a policy written ten years ago. It is better to buy a policy that has the benefits you think you will need than to try to have them added later. Sixty-five is considered a reasonable age to purchase a policy if one does not have any health conditions that might prevent them from qualifying for coverage. Those at least age 50 should consider obtaining coverage, when qualification is easier, and premiums are lower. Insurance companies will not approve or issue LTC insurance coverage for anyone who is likely to need benefits within six months of application. Those who buy individual policies (not group plans through their employers) will need to submit to health status assessments. Twenty percent of those who apply are denied.

Employer vs. private policies

There is a strong trend toward including LTC in health insurance benefits through employers. The employee usually pays 100% and has choices from a range of benefits. The employer selects the carrier. Spouses and parents can usually be included in the coverage for an employee. This can be an advantage since premiums are group rated; however a healthy couple might do better on their own

and get a more customized plan if they purchase it privately. Employees who get plans through work are guaranteed coverage; spouse may need to submit some health status data; parents submit to full under-writing.

Are users satisfied with it?

The main regret among policyholders who have made claims is that they did not buy enough coverage. Studies conducted by Life Care for the Robert Wood Johnson Foundation and the federal government found that, on average, nursing home beneficiaries were receiving \$2141 monthly in covered expenses and paid \$1144 out of pocket. Most had paid premiums for five years before filing their first claim.

Which other programs pay for long term care?

Medicaid is the government program that 'kicks' in for long-term care after a prescribed combination of assets has been spent down. If income is too high for guidelines, the spouse must contribute to monthly payments. Guide-lines vary by state with California, New York and Florida providing the most generous plans. When one spouse becomes ill and expected to need care, some elder care experts suggest transferring assets to the healthier spouse. This may, however, result in a waiting period before the patient is eligible for Medicaid. In any event, if Medicaid is paying the bill, the patient or elderly person must be in a facility that accepts Medicaid. These are not always the most desirable facilities.

Medicare does not pay for long term care; it pays only for a short term of skilled nursing care (not intermediate or custodial levels of care) - the care you need after surgery or to recover from an illness or accident. This is a main source of misunderstanding among the 'baby boomers' who

somehow think they will be covered by this health insurance plan.

Where to get it

Look for a company with top credit ratings from Standard and Poor's and A.M. Best. It should have at least \$1 billion in assets and five years experience in LTC policies. Track their history of rate increases through the State Insurance Agency. Be sure it is portable from state to state. Finally, do your homework before contacting an agent (or even better - a broker). Know what you want and what to look for so that you wont be unduly swayed by the so-called low premiums and high benefits that are touted by salespersons. Be especially aware of emphasis on 'fluff' benefits like holding your nursing home bed open while you go back into the hospital for a short stay rather than meaty benefits like short waiting periods, having your own doctor determine eligibility, and freedom to have a mix of services covered by your policy.

Resources

- Complete Guide to Health Services for Seniors, Consumer Reports, 2002

This is an excellent guide to understanding the complex components of long-term care and a number of other related topics.

- <http://www.insure.com/ltc/index.html>

This site offers detailed information on LTC policies.

Gloria St. John is a freelance writer on consumer and health topics and a consultant to United Policyholders.

WE WANT TO HEAR FROM YOU

Please complete the enclosed Reader's Survey and return it with or without a donation in the envelope provided.

UP SURVEYS OUR READERS

We periodically survey our readers to determine their priorities in connection with our work and update our records. We thank all those who took the time to complete and return our last survey for giving us feedback and supporting us through donations. Although we have not yet been able to cover the costs of producing a newsletter through the contributions made by readers, that is our goal. Change of address information helps keep our costs down.

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Your Priorities

Our readers' priorities are (most to least interested):

- 1 Homeowners insurance issues and information
- 2 Legislative developments
- 3 Earthquake insurance and information
- 4 Insurance litigation
- 5 Life/Disability insurance issues and information
- 6 HMO/Health insurance issues and information

AMICUS UPDATE from page 1

Pennsylvania

Pennsylvania Erie Ins. Exchange v. Jean Hollock, Docket No. 298 MDA. A trial court determined that Erie violated the state's Bad Faith Statute and was liable for punitive damages for mishandling its policyholders' Uninsured Motorist claim. Erie appealed the trial court's ruling, and obtained amicus support from a state and a national insurance trade association. (Insurance Federation of Pennsylvania and the National Association of Independent Insurers) UP submitted an amicus brief refuting the points raised by amici and supporting the trial court's determination that Erie acted in bad faith in handling Hollock's claim. **John Ellison** and **Timothy Law** from the Philadelphia office of **Anderson, Kill & Olick** wrote UP's brief *pro bono*.

California

Dart Industries v. Commercial Union Ins. Co. CA. Supreme Court Case No. S086518, August 19, 2002. The good guys scored a victory in this case on the issue of what a policyholder must prove to establish the terms of a lost insurance policy. A trial court found that Dart Industries, (a commercial insured), had introduced sufficient secondary evidence to establish coverage by proving the substance of a lost policy's material provisions. Dart lost in the Court of Appeal, which held instead that policyholders must prove the actual words of those provisions. The California Supreme Court reversed and reinstated the policyholder's case. UP submitted a pro-policyholder brief in this case along with the California Attorney General, the California Trustee's Association, and other commercial insureds. UP's brief was written *pro bono* by **John MacDonald** of **Anderson, Kill & Olick's** Philadelphia office.

E.M.M.I. Inc. v. Zurich Amer. Ins.Co. Ct. Appeal No. B152740. UP submitted a letter brief to the California Supreme Court urging them to depublish the Court of Appeal's decision in this theft insurance coverage dispute.

A jeweler's employee was transporting merchandise in his car. He pulled over and got out to examine his tail pipe to determine the source of a rattling noise. While he was bent over behind the car a box of merchandise was stolen from the front seat. The insurer adopted a strained, narrow interpretation of its policy and denied the claim as "excluded" by arguing that the insured had abandoned the car. In what UP contends was an erroneous decision, the Court of Appeal upheld the insurer's interpretation of its policy language. UP's letter brief was authored by San Francisco policyholder attorney **Lori Lee**.

Scottsdale v. Essex 98 Cal.App.4th 86, 119 Cal.Rptr.2d 62 (2002). The California Supreme Court declined UP's request via letter brief to depublish this decision. UP argued that the decision will adversely affect the ability of thousands of insureds in California to secure defense and indemnity against construction defect claims and in turn impair the ability of homeowners to recover for defective property. UP's letter brief was drafted *pro bono* by San Francisco attorney **Timothy Wilson of Aaron & Wilson, L.L.P.**

Mohammed Hameid v. Nat'l. Fire Ins. of Hartford -CA. Supreme Court, reviewing decision by Ct. Appeal, 4th A.D., Div. 3, Case No. G026525. The issue in this commercial coverage case is the scope of the duty to defend advertising injury claims. A small business was sued for allegedly misappropriating a customer list. National Fire Ins. refused to defend its policyholder against the allegations. UP argued in its amicus brief that the term "advertising" in CGL policies should be broadly defined to include the type of advertising activities engaged in by small businesses including but not limited to direct mailings, telephone solicitations, and in some cases, one-on-one solicitations. UP's brief was written *pro bono* by **David Gauntlett** and **Eric Little of Gauntlett & Associates**, a firm based in Irvine, California. www.gauntlettlaw.com.

California Consumer Health Care Council, Inc. v. California Dept. of Managed Health Care Ct. of Appeal, 3rd Dist., No. C041091. United Policyholders and the Congress of California Seniors weighed in for health care policyholders in this case. The case involves policyholders' rights to obtain documents from the CDMHC in connection with their appeal of an HMO's claim denial. **Gene Anderson** and **Steven Snyder of Anderson, Kill and Olick's** New York office drafted UP/CCS's brief *pro bono*.

Maine

UP is working through the efforts of Gene Anderson to obtain documents from the Maine Department of Insurance relating to disability insurance giant Provident's acquisition of UNUM. These documents include an unredacted copy of an accounting report by Arthur Anderson. (See related article "UNUM Disability Update" in this issue)

New Mexico

Allstate Ins. Co. v. Jose Pincheira and Olivia Pincheira, New Mexico Ct. of Appeals, Case No. 22,760. UP submitted an amicus brief in this case seeking to educate the Court on why it should allow discovery of documents pertaining to Allstate's Claims Core Process Redesign program. Allstate has used this program to effectuate large-scale claim denials in order to bolster its profits. (See related article "It's UP to the U.S. Supreme Court" in this issue) Policyholder attorneys **William ("Chip") Merlin** and **Mary Kestenbaum** prepared an excellent and detailed brief for UP *pro bono*, but unfortunately, the court declined to accept the submission. www.gunnmerlin.com.

New York

Medical Society of the State of New York v. Gregory Serio, Superintendent of Insurance for the State of New York NY Cty Index No. 116519/01, August 6, 2002. UP weighed in for

continued on page 9

insured drivers in this proceeding to challenge a regulation shortening the amount of time injured parties have in which to file insurance claims. UP's brief was written *pro bono* by **William Passanante** of **Anderson, Kill & Olick's** NYC offices.

Ohio

Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co., 95 Ohio St.3d 512, 2002-Ohio-2842. June 2002. The Supreme Court of Ohio adopted UP's argument in this commercial coverage case. The case involved the issue of whether an insured is entitled to secure coverage from a single policy of its choice that covers "all sums" incurred as damages "during the policy period," subject to that policy's limit of coverage when a continuous occurrence of environmental pollution triggers claims under multiple primary insurance policies. During oral argument in the case, the Honorable Judge Stratton, stated "Allocations sound like a good, reasonable, fair thing to do but I have to say I was quite impressed with the United Policyholders Amicus Brief which went through a parade of horrors that results from when you require the insured to do the allocation. Why shouldn't the insured get what they pay for and if it's damage outside the policy period, they don't get that. It's pure and simple." UP's brief was prepared *pro bono* by **Gene Anderson** and **Richard Lewis** of **Anderson, Kill & Olick's** New York office.

Donations to support UP's Amicus Project can be made online by credit card:

www.unitedpolicyholders.org

or sent to:

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110 Pacific Ave.
San Francisco, CA 94111**

The Value of Amicus Briefs

The purpose of UP's Amicus Project is to provide judges with a balanced perspective when they review cases involving insurance questions. Amicus briefs are the vehicles through which interested parties other than the parties in a case make points for reviewing judges to consider. Judicial decisions define insurance consumers' rights and insurance companies' obligations, so they are critically important and have long lasting impact.

Insurers and their trade associations routinely deluge courts with briefs arguing their views. In the majority of cases, judges get no briefs at all that advance the perspective of insureds/insurance consumers. Predictably, the results often favor the insurance industry. UP is striving to change this imbalance through our Amicus Project.

The Amicus Project Benefits Everyone

We are increasingly serving as the voice for policyholders in cases all over the country where the rights of insureds are at stake. Unlike insurance companies, however, we do not have unlimited resources to pay attorneys to submit our amicus briefs. We need your help. UP's Amicus Project is growing because of the generosity of a very small number of attorneys who are providing legal services free of charge. We need your help. We need to expand our base of pro bono counsel, and secure donations to cover our expenses. All policyholders benefit from this Project. All policyholders should support this Project.

Your Eyes and Ears can Help

Help us identify cases for UP's Amicus Project. If you know of a case on appeal involving important insurance principles where policyholder *amicus* support is needed, contact UP online at info@unitedpolicyholders.org or call Amy Bach at (415) 381-7627.

KING, KING & FISHLEDER SUPPORT AMICUS PROJECT

The Oakland, CA. firm of King, King & Fishleder recently donated \$10,000 to support UP's Amicus Project. The firm specializes in representing policyholders in property insurance disputes and ERISA litigation over health and disability benefits, and are long-time UP supporters.

MORE UNUM/PROVIDENT/PAUL REVERE INFO

UP is serving as a clearinghouse for documents evidencing UNUM/Provident/Paul Revere's strategy to boost profits by unfairly denying disability claims. Policyholder advocates recently provided UP with additional documents including the deposition testimony of whistleblower doctor Patrick McSharry and the jury instructions used to obtain a nearly \$7 million verdict in *Hangarter v. Paul Revere/UNUM/Provident*. If you are a policyholder or advocate and would like to obtain copies of these or other materials send an email to mpjaarsma@aol.com or leave a message at (510) 763-9740.

VISIT US ONLINE

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Insurance companies have armies of lobbyists and lawyers advancing their interests. Insurance consumers (policyholders) have United Policyholders. We are the only consumer organization that is 100% dedicated to educating the public, courts, and elected officials on insurance issues and consumer rights. We are working hard so you can truly have the peace of mind you think you're buying when you write that premium check to your insurance company. Don't let them sell you short - support us so we can support you.

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NAME: _____

MAILING ADDRESS (if you recently moved) or CORRECTIONS: _____

E-MAIL ADDRESS: _____

Has your homeowners insurance been recently non-renewed or cancelled? Yes No

If you answered "Yes", please identify the name of the insurance company that non-renewed or cancelled you:

Would you describe your agent/broker as proactive or pro-consumer, and if so, what is his or her name and location?

PLEASE CIRCLE ALL OF THE FOLLOWING THAT DESCRIBE YOU:

Homeowner/Renter Disaster survivor Legal Prof'l Insurance Prof'l Commercial Insured Other _____

ARE YOU A MEMBER OF A PROFESSIONAL OR TRADE ASSOCIATION that might have an interest in insurance issues?

(Please identify name of organization and contact phone number)

ARE YOU INTERESTED IN VOLUNTEERING WITH UP? Yes No

THANK YOU

FOR TAKING THE TIME TO COMPLETE AND RETURN THIS SURVEY.

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