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POHLS & ASSOCIATES
ATTORNEYS AT LAW

California Attorneys for the
Insurance and Financial Services Industries

12657 Alcosta Boulevard, Suite 150 ♦ San Ramon, California 94583-4698
Voice: (925) 973-0300 ♦ Fax: (925) 973-0330 ♦ www.califehealth.com

LONG TERM CARE INSURANCE

Selected Considerations for Insurers, Agents, Regulators, and Litigators

by Robert R. Pohls

(Based on materials presented at the 2001 Midwinter Meeting of the Life Insurance Law, Health and Disability Insurance Law, Public Regulation of Insurance Law, Employee Benefits, Financial Services Integration, Seniors' Law, Workers' Compensation and Employers' Liability Law Committees of the American Bar Association's Tort and Insurance Practice Section in Palm Beach, Florida on January 13, 2001)

1. INTRODUCTION

Long term care insurance protects against a particular class of financial losses caused by chronic illness or disability. Specifically, it enables policyholders to offset the substantial costs of home care, nursing care and other services that they will need for extended periods when they can no longer care for themselves.

Long term care insurance is heavily regulated. To be certain, it is subject to many of the same statutes and regulations applicable to all classes of insurance. However, most states also have enacted statutes specific to long term care insurance that are based upon Model Acts and Model Regulations developed by the National Association of Insurance Commissioners (NAIC). In addition, certain forms of long term care insurance are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Those statutes mandate a variety of policy features, marketing practices and other requirements that are unlike those imposed on other classes of insurance. Understanding those statutes is essential to any insurer who writes long term care insurance and any agent who markets their policies. Moreover, as the American population ages, the number of people who obtain insurance for their long term care needs will increase. Therefore, regulators and litigators will soon begin to confront these issues with increasing frequency.

Because it has more citizens over the age of 65 than any other state, California is a leader in regulating long term care insurance. For that reason, this article will focus on selected elements of the California statutes, while identifying some of the legal issues that distinguish long term care insurance from other insurance products. In the process, it will expose long term care insurance as a unique product that is virtually certain to produce extremely volatile disputes.

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2. THE ROLE OF LONG TERM CARE INSURANCE.

The need for long term care is not an issue encountered only by the elderly. Rather, it can be an issue for any young or middle-aged person who has been seriously injured in an accident or who has suffered a debilitating illness. Nevertheless, long term care services are most often provided to older people. The U.S. Department of Health and Human Services reports that people of age 65 face at least a 40 percent risk of entering a nursing home sometime during their lifetime. According to other estimates, nearly 7 million Americans over the age of 65 will need long term care in this year alone.

Statistically, the odds of entering a nursing home (and of staying for longer periods) increase with age. At the same time, the American population is rapidly aging. Thus, while the U.S. Bureau of the Census estimates that 34.1 million Americans were at least 65 years of age in 1997, it expects that figure to double to nearly 70 million by the year 2030. At that point, approximately 8.5 million Americans will be over the age of 85.

Most of those people will be cared for at home. In fact, family members and friends are the sole caregivers for approximately 70 percent of the elderly. However, many older Americans enter (or are placed in) nursing homes to meet their long term needs. Indeed, the U.S. Bureau of the Census reports that 22 percent of people over the age of 85 live in nursing homes and that 45 percent of them need help with daily activities.

On average, those Americans who enter a nursing home will stay for more than two years. However, between 10 and 20 percent will stay in the nursing home for five years or more. The projected annual cost of placement in a nursing facility is between $35,000 and $50,000, and those costs are substantially greater in more expensive parts of the country (like California). On average, then, half of all women and one-third of all men who reach the age of 65 can expect to spend at least $85,000 on long term care.

Few Americans are prepared to meet that financial obligation. In 1993, for example, the median net worth (assets minus liabilities) of households headed by a person over the age of 65 was just $86,300. At the same time, figures from 1997 indicate that the median annual income of persons over 65 years of age was just $13,049. Long term care insurance therefore can enable older Americans to avoid financial ruin by offsetting the substantial costs of the long term care that may be essential to their health and well-being.

3. GIVING CONSUMERS A CHOICE: The Differences Between Federally-Qualified and Non-Qualified Long Term Care Insurance

As a part of HIPAA, Congress enacted certain provisions to assure that the tax treatment of private long term care insurance is the same as that for major medical coverage. Pursuant to those provisions, individual consumers may apply the premiums paid for long term care insurance and any out-of-pocket expenses for long term care toward the 7.5 percent floor for medical expense deductions in the federal tax code.[1] In addition, employers may deduct the premiums paid for long term care insurance as a business expense.[2]

To qualify for that favorable tax treatment, a long term care policy sold after 1996 must meet certain standards. Among other things, those standards require that federally-qualified long term care insurance policies provide benefits only when an insured meets one of two

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eligibility criteria: 1) an impairment of cognitive ability,[3] or 2) an impairment of any two out of six activities of daily living.[4]

At the time HIPAA was enacted, California law mandated a similar set of eligibility criteria. Specifically, California Insurance Code Section 10232.8(c) required that:

> "In every long term care policy or certificate that provides home care benefits, the threshold establishing eligibility for home care benefits shall be at least as permissive as a provision that the insured will qualify if either one of two criteria are met:
>
> (1) Impairment of two activities of daily living.
> (2) Impairment of cognitive ability."

However, while HIPAA included *six* activities in its definition of "activities of daily living," California law defined that phrase to include *seven* activities.[5] As a result, insurers could not offer Californians a federally-qualified long term care insurance policy without violating California Insurance Code Section 10232.8(c)'s apparent mandate for more expansive coverage.

The California Department of Insurance initially addressed that problem through its Bulletin No. 96-11. In that Bulletin, the Insurance Commissioner explained that "many long-term care insurance products approved under current California law will not be `tax qualified' long-term products under [HIPAA]." Bulletin No. 96-11, p. 1. He also acknowledged that "Californians may benefit from the preferential tax treatment provided for in [HIPAA]." Bulletin No. 96-11, p. 1. Bulletin No. 96-11 therefore indicated that the California Department of Insurance would approve of new long term care insurance products "if it finds, after review, that they comply with California law except for changes necessary to meet federal standards for tax qualification." Bulletin No. 96-11, p. 1.

Bulletin No. 96-11 was later invalidated under California's Administrative Procedures Act.[6] Nevertheless, a portion of California Insurance Code Section 10232.8(c) gave the Insurance Commissioner discretion to approve of long term care insurance policies using "other criteria or combinations of criteria" upon a showing that "the interest of the insured is better served." The order by which the Court invalidated Bulletin No. 96-11 therefore suggested that, despite the eligibility criteria mandated by California Insurance Code Section 10232.8(c), the Department of Insurance could approve of federally-qualified long term care insurance policies – provided that it did so on a case-by-case basis.

The California statutes have since been amended. Under the current law, any insurer offering a long term care insurance policy that is intended to be federally-qualified must also "fairly and affirmatively concurrently offer and market long-term care insurance policies or certificates that are not intended to be federally qualified."[7] Stated differently, California law now requires that insurers either: 1) offer only long term care insurance policies which use the state's more expansive eligibility criteria, or 2) offer consumers a choice between a policy using the California criteria and one using the more restrictive federal criteria that qualifies for favorable tax treatment.

Toward that end, California Insurance Code Section 10232.1(a) requires that every long term care insurance policy prominently indicate on its application, the outline of coverage, and page one of the policy form whether it is "intended to be a federally qualified long-term care

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insurance contract." California Insurance Code Section 10232.25(a) further requires that any insurer offering federally-qualified long term care insurance policies provide a notice to the consumer at the time of solicitation which advises that the insurer offers two types of long term care insurance policies in California. Upon receiving that notice, consumers are free to choose whichever long term care insurance product they prefer.

Because of uncertainty about the tax treatment of long term care insurance policies that are not intended to be federally-qualified, California's lawmakers also provided a means for consumers to change their minds about which type of long-term care insurance they prefer. Specifically, California Insurance Code Section 10232.23(b) directs the Department of Insurance to adopt emergency regulations within 90 days of any federal law or Treasury Department decision that clarifies the tax treatment of benefits paid under policies that are not intended to be federally-qualified. Regardless of whether the federal government chooses to tax those benefits, the statute mandates that the regulations require insurers to notify consumers of a one-time right to exchange policies on a guaranteed-issue basis, without new underwriting, new probationary periods, new elimination periods or new contestability periods.[8]

4. CONSUMER PROTECTION REQUIREMENTS

Aside from the issue of whether it is intended to be federally-qualified, a long term care insurance policy must take one of three forms. Some cover only the provision of institutional care ("nursing facility only" policies). Some are limited to home care services and community-based services ("home care only" policies). Others cover both institutional care and home care ("comprehensive long-term care" policies). The application, outline of coverage and first page of the policy form must prominently identify which form the policy takes.[9]

No matter which form a long term care insurance policy takes, statutes patterned after the Model Act mandate certain policy features and practices that provide consumers with broad choices and uncommon rights. Those consumer protection features include the following:

A. Guaranteed Renewability or Noncancellability.[10] Every individual long term care insurance policy must contain a renewability provision that spells out the terms and conditions under which the policy may be renewed and whether the insurer has the right to change the premium.[11] However, the statutes separately provide that every individual long term care insurance policy must be either "guaranteed renewable" or "noncancelable."[12] Accordingly, an insurer must obtain the policyholder's written agreement before changing the terms of an individual policy in any way that increases premiums or that expands or reduces benefits.[13]

B. Prohibitions on Limitations and Exclusions.[14] Subject to certain enumerated exceptions, no long term care insurance policy can limit or exclude benefits by type of illness, treatment, medical condition or accident.[15] In California, the permissible exclusions and limitations based upon type of illness, treatment, medical condition or accident include only the following: (a) preexisting conditions or diseases; (b) mental or nervous disorders; (c) alcoholism and drug addiction; and (d) illness, treatment, or a medical condition arising out of war, participation in a felony, service in the armed forces, intentionally self-inflicted injury, or aviation.[16]

The scope of those permissible exclusions (as well as those that are not based upon the type of illness, treatment, medical condition or accident) is often limited by other statutes. Among other things, they cannot operate to make benefits dependent upon the policyholder's

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having had a prior hospitalization.[17] Similarly, they cannot operate to make eligibility for benefits provided in an institutional care setting dependent upon the receipt of a higher level of institutional care or to make the availability of benefits for community-based care, home health care or home care on a prior institutionalization.[18] In addition, they cannot make eligibility for noninstitutional benefits dependent upon a prior institutional stay of more than 30 days.[19]

Some of the key limitations on other exclusions are as follows:

(i) Preexisting Conditions.[20] As noted above, long term care insurance policies may exclude coverage for preexisting conditions.[21] However, the policy must define the phrase "preexisting condition" in a way that is no more restrictive than a condition for which medical advice or treatment was recommended by (or received from) a health care provider within six months preceding the effective date of coverage.[22] Likewise, the policy cannot exclude coverage for a loss which is the result of a preexisting condition unless the loss begins within six months of the effective date of coverage.[23] Once that six month waiting period expires, though, the insurer usually cannot exclude coverage or benefits for a preexisting condition.[24]

(ii) Mental and Nervous Disorders. Long term care insurance policies may exclude coverage for losses that are attributable to mental or nervous disorders. However, they cannot define the phrase "mental or nervous disorder" to include more than "neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder."[25] Policies also cannot use mental and nervous disorder exclusions to limit or deny benefits for losses on the basis of Alzheimer's disease or other "progressive, degenerative, and dementing illnesses."[26]

(iii) Medical Necessity. Before paying benefits under a long term care insurance policy, an insurer may require a written declaration that the services for which a claim has been presented are necessary. In that regard, it may obtain a written declaration from a physician, independent needs assessment agency or other source of independent judgment that the insurer deems suitable.[27]

(iv) Reasonable and Customary. Long term care insurance policies cannot limit benefits to those charges which are "usual and customary", "reasonable and customary", or otherwise subject benefits to a standard using words of similar import.[28]

C. Extension of Benefits.[29] Every policyholder must be given an opportunity to take advantage of any new benefits or criteria for benefit eligibility that the insurer may develop.[30] Specifically, the insurer must notify all policyholders of any new benefits or new criteria for benefit eligibility and offer to add a rider to the policy that includes the new terms (and for which a separate premium is charged).[31]

Alternatively, the insurer may offer to replace the existing policy with a new policy.[32] In either case, the insurer may require new underwriting.[33] However, the premiums for the replacement policy must be calculated either on the issue age of the policy being replaced or after granting premium credits equal to 5 percent for every year in which no claim was made under the policy being replaced.[34]

D. Continuation and Conversion Rights.[35] While an insurer is prohibited from changing the terms of a long term care insurance policy without the policyholder's written

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consent, policyholders must be afforded certain rights to change the terms of their coverage. Specifically, the policy must give them a right to lower their premiums by sacrificing certain benefits.[36] At least once a year, they also must be allowed to increase certain benefits for an extra premium.[37] In addition, every policyholder must be given an opportunity to take advantage of any new benefits or criteria for benefit eligibility that the insurer may develop.[38]

Every certificate of group long term care insurance also must provide its certificate holders with certain conversion rights. Specifically, the policy must give certificate holders the right to convert their coverage to an individual policy with at least substantially equivalent benefits – without any consideration of their insurability – so long as their group coverage was not replaced within 31 days or terminated for nonpayment of premium.[39]

E. Discontinuance and Replacement Policies.[40] Long term care insurance cannot be canceled, nonrenewed or otherwise terminated on the basis of the policyholder's age or deterioration in health.[41] In any event, the termination of coverage cannot prejudice any benefits that are payable for an institutionalization that began while the policy was in force and continues without interruption.[42]

Every application for long term care insurance must ask the applicant if the proposed insurance is intended to replace any other policy that is in force.[43] If the response to that question indicates that the sale involves a replacement, the insurer must furnish the applicant a notice.[44] Among other things, the prescribed notice explains that any preexisting conditions that the applicant has "may not be immediately or fully covered under the new coverage." It also suggests that the applicant "secure the advice of your present insurer or its agent" to review "all the relevant factors involved" in replacing existing coverage.

Long term care insurance policies may not be replaced "unnecessarily."[45] In California, it is presumed that any third or greater long term care insurance policy issued to a policyholder in a 12 month period is "unnecessary."[46] However, the statutes otherwise provide only that "the commissioner shall define inappropriate replacement of long-term care insurance in consultation with other interested parties."[47]

Despite the uncertainty about what constitutes an unnecessary replacement, the replacement of a long term care insurance policy is contingent upon the insurer's declaration that the replacement policy "materially improves the position of the insured."[48] In that regard, any insurer issuing a replacement policy must waive any time limitations in the new policy -- including those applicable to preexisting conditions and waiting periods – to the extent that similar provisions in the original policy were already satisfied.[49] In addition, any insurer issuing a policy to replace a different policy issued by the same insurer must recognize past insured status by granting premium credits.[50]

F. Protections Against Unintentional Lapse.[51] Before the policy is issued, the applicant must be given the right to designate at least one other person to receive premium notices, lapse notices and other communications about the policy's termination for non-payment of premiums.[52] If the applicant chooses not to exercise that right, the insurer must obtain a written waiver.[53]

No long term care insurance policy can lapse for non-payment of premiums unless the insurer gives proper notice to the policyholder and his or her designee.[54] The required notice must advise the policyholder of his or her right to lower premiums by reducing coverage.[55] In

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any event, the policy must provide for reinstatement upon proof that the insured had a cognitive impairment of loss of functional capacity that was sufficient to qualify for benefits under the policy.[56] However, the policyholder will lose that right if he or she fails to request reinstatement within five months of the date of lapse.[57]

HIPAA imposes one other requirement on federally-qualified long term care insurance policies. Specifically, it requires that such policies include nonforfeiture provisions which provide for at least one of the following forms of benefits in the event of lapse: reduced paid-up insurance, extended term insurance, or a shortened benefit period.[58] Under California law, insurers must offer each applicant an option to purchase a "nonforfeiture benefit" at the time of application, pursuant to which an insured who has paid 10 years of premiums may be eligible for three months of nursing facility benefits – even after the policy has lapsed.[59]

G. Disclosure Requirements.[60] At the time of the initial solicitation, each applicant must be given an outline of coverage.[61] If the applicant is solicited by an agent, the agent must deliver the outline of coverage before presenting the application or enrollment form.[62] If the applicant is solicited by direct response, the outline of coverage must be presented in conjunction with the application or enrollment form.[63]

The substance and sequence of the text in the outline of coverage is prescribed by statute.[64] Among other things, the outline of coverage must:[65]

(1) explain that the outline of coverage is only a summary of coverage and that, because the policy contains governing contractual provisions, the applicant should "READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!";

(2) advise that the applicant has thirty days[66] after the policy's delivery to examine the policy and return it, for any reason, for a full refund;

(3) caution applicants who are eligible for Medicare to review the Medicare Supplement Buyer's Guide available from the insurance company;

(4) describe, in general terms, the benefits provided by the policy and the criteria for benefit eligibility, including any need for certification of a policyholder's level of functional dependency or any use of activities of daily living to measure the insured's need for long term care;

(5) provide a brief specific description of any policy provisions which limit, exclude, restrict, reduce, delay, or in any other manner operate to qualify payment of benefits under the policy;

(6) explain that, because the costs of long term care services will likely increase over time, the applicant should consider whether and how the policy's benefits may be adjusted;

(7) identify the terms under which the policy may be continued in force or discontinued by describing the policy's renewability provisions and whether the policy has a waiver of premium provision;

(8) state that the policy provides coverage for insureds who are clinically diagnosed as having Alzheimer's Disease or related degenerative and dementing illnesses;

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(9) state the total annual premium for the policy and, if the premium varies with an applicant's choice among benefit options, the portion of annual premium which corresponds to each benefit option;

(10) describe any other important features of the policy, including at least a statement about whether medical underwriting is used; and

(11) advise applicants that the can obtain a Consumer Guide to Long-Term Care Insurance from the state department of insurance and that counseling may be available from the Health Insurance Counseling and Advocacy Program (HICAP) that is administered by other state agencies.[67]

The outline of coverage also must include a graphic comparison of the benefit levels of a policy that increases benefits at a compounded annual rate of at least 5 percent with one that does not increase benefits.[68] It also must reflect any expected premium increases or additional premiums needed to pay for automatic or optional benefit increases.[69]

H. Prohibitions on Post-Claim Underwriting.[70] The questions in an application for long term care insurance must contain "clear, unambiguous, short, simple questions designed to ascertain the health condition of the applicant." To that end, they cannot be compound. Moreover, unless it calls for the applicant to identify the name of any prescribed medications or prescribing physicians, each question must require only a "yes" or "no" answer.[71]

Theoretically, the simplified structure of a long term care insurance application could enable insurers to streamline their underwriting processes. However, no long term care insurance policy may be "field-issued."[72] In fact, long term care insurers are required to complete their medical underwriting and "resolve all reasonable questions arising from information submitted on or with the application before issuing the policy."[73]

Any insurer who fails to discharge that obligation will find its ability to deny benefits or rescind coverage on the basis of a misrepresentation in the application to be greatly complicated. Specifically, an insurer who does not fully underwrite the application before issuing a long term care insurance policy cannot rescind the policy or deny an otherwise valid claim without proof of fraud or proof of a misrepresentation that: (a) pertains to the condition for which benefits are sought; (b) involves a chronic condition, (c) involves dates of treatment before the date of application; or (d) is material to the acceptance for coverage.[74] In addition, the insurer is required to make that proof with "clear and convincing evidence."[75]

Proof of that type is not typically required in other contexts. In California, for example, even an innocent misrepresentation of material fact gives the insurer a right to rescind other types of insurance policies.[76] Likewise, California does not follow the loss-causation rule for other classes of insurance.[77] In addition, its statutory definition of materiality uses an objective standard and is broad enough to include all facts which might influence the insurer in forming its estimate of the disadvantages of the proposed contract, or in making its inquiries.[78] A long term care insurer who relies on post-claim underwriting therefore must be prepared to make a greater showing – under the more demanding "clear and convincing evidence" standard – when attempting to rescind a policy.

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I. Minimum Standards.[79] As noted above, a long term care insurance policy must take one of three forms.[80] Regardless of which form of policy is involved, the insurer must offer every applicant an option to purchase a policy that covers assisted living care in a licensed residential care facility, with a minimum benefit that is at least 50 percent of the maximum benefit for institutional care.[81] In addition, every long term care insurance policy must define the maximum lifetime benefit as a single dollar amount that may be used interchangeably for any home- and community-based services, assisted living benefits, or institutional care covered by the policy.[82]

Other statutes attempt to standardize the benefits provided by different forms of long term care insurance. For example, a policy that purports to cover home care or community-based services must provide benefits for home health care, adult day care, personal care, homemaker services, hospice services and respite care.[83] In addition, home care benefits cannot be limited or excluded by requiring a need for care in a nursing home, requiring that skilled nursing services be used before (or with) unskilled services, requiring the existence of an acute condition, or limiting benefits to services provided by Medicare-certified providers.[84] Further, policies covering home care or community-based services cannot make benefits contingent upon a showing of "medical necessity."[85]

Every long term care insurance policy that provides reimbursement for care in a nursing facility must cover and reimburse *per diem* expenses, as well as the costs of ancillary supplies and services, up to the maximum lifetime daily facility benefit set forth in the policy.[86] Likewise, every comprehensive long term care insurance policy that provides for both institutional care and home care must pay a benefit for home care that is at least 50 percent of the maximum benefit payment for institutional care.[87]

J. Inflation Protection.[88] Insurers must offer every applicant an option to purchase a policy with an inflation protection feature.[89] That inflation protection provision must increase benefit levels by at lease 5 percent annually.[90] If those benefit increases are intended to be automatic, the insurer must state in its offer a premium for that benefit which it expects to remain constant.[91]

When considering that offer, the applicant must be permitted to review the outline of coverage and a set of graphs which compare the benefits and premiums with and without the inflation protection feature. [92] If the applicant rejects the offer, he or she must do so by signing a document which confirms their receipt of those documents and their decision to reject inflation protection.[93]

5. STATUTORY DUTIES

The statutes that are patterned after the Model Act also impose several duties on insurers and their agents. In certain respects, those statutory duties are unique to the long term care industry. For a variety of reasons, they also are likely to form the basis for most of the litigation involving long term care insurance.

A. Suitability. The consumer protection requirements that are imposed on the sale of long term care insurance are designed to ensure that consumers make informed and knowledgeable choices about how to insure against their need for long term care. Among other things, each applicant must be given a comprehensive outline of coverage, information about optional coverage, and copies of information prepared by consumer groups before applying for

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a long term care insurance policy. They also must be permitted to modify the premiums for (and benefits under) for their policies to accommodate any change in their needs.

Under such circumstances, one might think that the concept of *caveat emptor* (or "let the buyer beware") applies to the sale of long term care insurance. However, that concept has little or no application to long term care insurance. Indeed, the concept of *caveat venditor* (or "let the seller beware") probably is more applicable.

Specifically, the statutes patterned after the Model Act require that every insurer or other entity marketing long term care insurance develop and use suitability standards to determine whether the purchase or replacement of long term care insurance is appropriate for the needs of the applicant.[94] Those suitability standards must consider a variety of factors,[95] including:

> (a) the applicant's ability to pay for the proposed coverage and other pertinent financial information;
>
> (b) the applicant's goals or needs with respect to long term care and the advantages and disadvantages of insurance to meet those goals or needs; and
>
> (c) the value, benefits and costs of the applicant's existing insurance (if any), in comparison to those of the proposed long term care insurance policy.

The statutes also charge long term care insurers with an affirmative duty to use those suitability standards to determine "whether issuing long-term care insurance coverage to an applicant is appropriate."[96]

Insurers and their agents therefore must make reasonable efforts to obtain the information necessary to make a suitability determination.[97] Toward that end, the statutes require that insurers ask applicants to complete a "Long Term Care Insurance Personal Worksheet" patterned after that described in the Model Regulations.[98] If, after reviewing that information, the insurer concludes that an applicant does not meet its suitability standards, it may reject the application.[99] In the alternative, it may send the applicant a form letter about its suitability determination and, upon receiving a signed copy of that letter from the applicant, proceed with issuance of the policy.[100]

B. Duty of Honesty. With regard to long-term care insurance, all insurers, brokers, agents, and others engaged in the business of insurance owe policyholders a duty of honesty.[101] However, the statutes separately provide that the conduct of an insurer, broker, or agent "during the offer of sale of a policy previous to the purchase is relevant to any action alleging a breach of the duty of honesty."[102] The statutory duty of honesty therefore is one owed to both policyholders and applicants. In other words, it is not dependent on the issuance of a policy or the formation of a contract.

Thus far, there are no reported California cases which address this statutory duty of honesty. However, other statutes regarding long term care insurance clarify that "twisting" (knowingly making misleading representations for the purpose of inducing a transaction involving insurance) is a prohibited unfair trade practice.[103] Similarly, high pressure tactics (marketing methods which induct the purchase of insurance through force, fright, threat or undue pressure) and cold lead advertising (marketing methods which do not disclose in a conspicuous manner that a purpose is solicitation of insurance) also constitute forms of

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prohibited unfair trade practices.[104] Arguably, then, evidence of such false, misleading and unfair sales tactics could establish a breach of the statutory duty of honesty.

C. Duty of Good Faith and Fair Dealing. In California, a covenant of good faith and fair dealing impliedly exists as a part of every contract.[105] To establish a breach of that implied covenant of good faith and fair dealing, an insured generally must show that the insurer withheld a benefit payable under the policy, unreasonably and without proper cause.[106] Upon making that proof, an insured typically can recover contract benefits and pursue claims for tort damages.[107]

Because the implied covenant of good faith and fair dealing arises out of a contract, the existence of a contractual relationship between the parties is a prerequisite to any bad faith claim.[108] For that reason, the implied covenant normally applies only to the post-contract formation conduct of parties to the contract.[109] However, the statutes regarding long term care insurance impose a statutory duty of good faith and fair dealing that applies to "insurers, brokers, agents and others engaged in the business of insurance."[110] As with the duty of honesty, the statutes also provide that the conduct of an insurer, broker, or agent "during the offer of sale of a policy previous to the purchase is relevant to any action alleging a breach of the duty of . . . good faith and fair dealing."[111] Unlike the implied covenant, then, the statutory duty of good faith and fair dealing is not dependent upon the existence of a contract, is not limited to parties who are in privity, and is broad enough to cover the parties' pre-contract actions.

There are no reported California decisions regarding that statutory duty of good faith and fair dealing. As a result, it is not yet clear what types of conduct would constitute a breach of that duty. In addition, whether a breach of the statutory duty gives rise to a claim for tort damages and other remedies is an issue that has yet to be decided.

6. LITIGATION ISSUES

A. Remedies for Statutory Violations. California Insurance Code Section 790.03 identifies several categories of conduct that are deemed "unfair methods of competition and unfair and deceptive acts or practices in the business of insurance." In *Royal Globe Ins. Co. v. Superior Court*[112], the California Supreme Court held that persons aggrieved by such conduct could pursue a private right of action for damages. Nine years later, though, the California Supreme Court reversed its decision in *Royal Globe*, holding instead that no private right of action exists under Insurance Code Section 790.03. *Moradi-Shalal v. Fireman's Fund Ins. Cos.*[113]

In reaching that conclusion, the California Supreme Court first explained that Insurance Code Section 790.03 was enacted as part of a bill "contemplating only *administrative* enforcement by the Insurance Commissioner" that made "no mention . . . of a possible private civil remedy."[114] It then noted that Insurance Code Section 790.03 is part of a statutory scheme that authorizes the Insurance Commissioner to impose "substantial administrative sanctions," including the issuance of cease and desist orders, fines and the suspension of an insurer's license.[115] The Court therefore concluded that:

> "Neither section 790.03 nor section 790.09 was intended to create a private civil cause of action against an insurer that commits one of the various acts listed in section 790.03, subdivision (h)."[116]

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The same analysis could lead to the conclusion that no private right of action exists for claims under the long term care statutes. Indeed, like the statutory scheme that includes Insurance Code Section 790.03, the long term care statutes (seemingly) contemplate only "administrative enforcement by the Insurance Commissioner" and (arguably) make "no mention . . . of a possible private civil remedy."[117] Like Insurance Code Section 790.03, those statutes also authorize the Insurance Commissioner to impose "substantial administrative sanctions,"[118] including penalties and the suspension (or revocation) of an insurer's license.[119]

However, the remedial provisions of the long term care statutes differ from the remedial provisions used to enforce Insurance Code Section 790.03 in at least one important respect. Specifically, the remedial provisions used to enforce Insurance Code Section 790.03 refer to the possibility of a civil lawsuit only when authorizing the insurance commissioner to petition the courts for an injunction against unfair practices which have persisted after a cease and desist order.[120] In contrast, the remedial provisions in California's long term care statutes state that:

> "Upon a showing of a violation of this chapter in any civil action, a court may also assess the penalties prescribed in this article."[121]

To be certain, nothing in that statute identifies the parties who might have standing to file "any civil action" under the long term care statutes. Nevertheless, it does direct the court to "award reasonable attorney's fees and costs to a prevailing *plaintiff* who establishes a violation of this chapter."[122]

Creative plaintiff's attorneys can be expected to seize upon that language to combat any suggestion that the long term care statutes authorize only administrative remedies. Should they prevail on that issue, their prize could be substantial: the chance to litigate a host of untested statutory duties, including a statutory duty of good faith and fair dealing for which they might recover tort damages and attorneys' fees from both the insurer *and* its agents.

B. Ancillary Claims. A company's status as an insurer does not make it a fiduciary.[123] Rather, as one court has explained:

> "The relationship between an insurer and an insured is *akin to* a fiduciary relationship. The insurer is bound to conduct itself with the utmost good faith for the benefit of its insured [citations]. However, the protection afforded by that relationship is *not* unlimited [citations], and the insurer has *no duty* to totally disregard its own interests when they conflict with the insured's interests [citations]."[124]

To establish that a long term care insurer is a fiduciary, a policyholder therefore must prove something more than a mere contractual relationship. More specifically, the policyholder must establish some form of "special relationship" with the insurer.[125]

In most cases, a policyholder's relationship with their long term care insurer exists solely by virtue of the policy. However, the relationship created by that policy often has certain other features that, under the appropriate facts, can give rise to a variety of other claims.

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(i) Elder Abuse Laws. In California, the elder abuse laws define the phrase "fiduciary abuse of an elder" to include the acts of any "person who stands in a position of trust to an elder" and who:

> ". . . takes, secretes, or appropriates their money or property to any wrongful use, or for any purpose not in the due and lawful execution of his or her trust."[126]

For obvious reasons, the sale of long term care insurance involves the transfer of money from an applicant or policyholder to an insurer. Often, that transaction is completed with the assistance of agents. Arguably, then, any applicant or policyholder who meets the statutory definition of an elder[127] could use the elder abuse laws to pursue claims for unnecessary replacement,[128] the sale of an unsuitable policy,[129] or breach of the statutory duties of honesty, good faith and fair dealing.[130] In fact, they could use the elder abuse laws to pursue any claim which charges that their premiums were applied for a "wrongful use, or for any purpose not in the due and lawful execution of" the trust they placed in the insurer and its agents.[131]

Given an appropriate set of facts, an elderly applicant or policyholder also could state a claim for "abuse of an elder" that involves the sale of long term care insurance. To that end, the elder abuse laws define the phrase "abuse of an elder" to include:

> ". . . physical abuse, neglect, fiduciary abuse, abandonment, isolation, abduction or other treatment with resulting physical harm or pain or mental suffering."[132]

At the same time, California's Elder Abuse and Dependent Adult Civil Protection Act defines the phrase "mental suffering" to mean "fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by threats, harassment, or other forms of intimidating behavior."[133] A claim that the sales agent engaged in the type of high pressure tactics proscribed by the long term care statutes therefore could give rise to a separate claim for abuse of an elder.[134]

The remedies available to plaintiffs who elect to pursue such claims can be significant. In California, for example, any plaintiff who prevails on a claim of elder abuse can recover both actual damages[135] and attorneys' fees.[136] It therefore is likely that litigation involving long term care insurance will frequently involve ancillary claims under the elder abuse laws.

(ii) Unfair Competition Claims. California's version of the Unfair Competition Act deems any "unlawful," "unfair" or "fraudulent" business act or practice to be "unfair competition."[137] In effect, it "borrows" violations of other laws and treats them as unlawful practices that are independently actionable.[138] Plaintiffs in long term care insurance litigation therefore may try to claim that the conduct of an insurer or its agent is actionable under the unfair competition laws because it violated certain of the long term care statutes.

Thus far, the efforts of plaintiffs to use violations of California Insurance Code Section 790.03 as a basis for unfair competition claims have failed. Indeed, numerous California cases establish that a plaintiff cannot avoid the bar of *Moradi-Shalal*[139] by re-labeling the theory when the material allegations assert nothing more than an insurer's violation of Section 790.03.[140] California courts therefore have had "no difficulty in deciding the Business and Professions Code provides no toehold for scaling the barrier of *Moradi-Shalal*."[141] Analogizing claims under

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the long term care statutes to claims under Insurance Code Section 790.03 therefore could enable insurers and agents to successfully resist unfair competition claims.

Should the plaintiffs' bar achieve a different result, the unfair competition laws will authorize a variety of equitable remedies.[142] However, damages should not available.[143]

7. CONCLUSION

An insurer who carefully complies with the many consumer protection requirements imposed by the long term care statutes may develop a false sense of security. To be certain, compliance with those requirements will produce a series of documents that will be useful in demonstrating that policyholders made conscious and informed choices about their long term care insurance needs. However, in this highly-regulated field, compliance with those requirements may not be enough.

Long term care insurers can expect to face an increasing number of lawsuits involving the sales practices of their agents, including claims for the unnecessary replacement of long term care insurance and claims for the sale of an unsuitable policy. Because they involve uncertain standards of liability and offer some hope for expansive remedies, the statutory duties of honesty, good faith and fair dealing also are likely to be the subject of most long term care insurance litigation. As demonstrated herein, policyholders also can be expected to pursue unfair competition claims, as well as the remedies afforded by laws on elder abuse.

Despite those risks, the market for long term care insurance is strong and virtually assured of substantial growth in the future. Insurers, agents, regulators and litigators therefore need to prepare now for the disputes that are certain to follow.

About the Author

Rob Pohls has been shaping California insurance law for more than 20 years. He is the principal of *Pohls & Associates*, a firm in the San Francisco Bay Area that he established in 1999 to represent life, health, disability and long term care insurance companies in bad faith, ERISA and other forms of complex litigation. As a member of the Association of Life Insurance Counsel and a former Chair of the American Bar Association's Health & Disability Insurance Law Committee, he is a prolific author and frequent speaker on issues of interest to the insurance and financial services industries. More information about Rob, his firm and his practice is available online at: *www.califehealth.com*. Contact him by e-mail at: *rpohls@califehealth.com*.

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Endnotes:

[1] 26 U.S.C. §7702B(a)(2).
[2] 26 U.S.C. §7702B(a)(4).
[3] See, 26 U.S.C. §7702B(c)(2)(A)(iii) [defining "chronically ill individual" to mean an individual who has been certified by a licensed health care provider as "requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment"]. California Insurance Code §10232.8(d) separately defines "impairment of cognitive ability" to mean that "the insured needs substantial supervision due to severe cognitive impairment."
[4] See, 26 U.S.C. §7702B(c)(2)(i)-(ii). For policies intended to be federally-qualified, California Insurance Code §10232.8(d) is consistent with HIPAA by defining "activities of daily living" to include "eating, bathing, dressing, transferring, toileting, and continence." See, 26 U.S.C. §7702B(c)(2)(B).
[5] That definition now appears in California Insurance Code Section 10232.8(a), which defines the phrase "activities of daily living" to include the same six activities included in HIPAA's definition (eating, bathing, dressing, transferring, toileting, and continence) *plus* "ambulating."
[6] See, *Congress of California Seniors v. Quackenbush*, Los Angeles County Superior Court Case No. BC 164481.
[7] California Insurance Code Section 10232.2(a).
[8] California Insurance Code Section 10232.23(c)(1).
[9] California Insurance Code Section 10232.1(b)-(d).
[10] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to guaranteed renewal or noncancellability. 26 U.S.C. §7702B(g)(2)(A)(i)(I).
[11] California Insurance Code Section 10235.14(a).
[12] California Insurance Code Section 10236.
[13] California Insurance Code Section 10235.14(b).
[14] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to prohibitions on limitations and exclusions. 26 U.S.C. §7702B(g)(2)(A)(i)(II).
[15] California Insurance Code Section 10235.8.
[16] California Insurance Code Section 10235.8(d)(1)-(5).
[17] California Insurance Code Section 10232.5(a).
[18] California Insurance Code Section 10232.5(b) and (c).
[19] California Insurance Code Section 10232.5(d).
[20] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Act's requirements relating to preexisting conditions. 26 U.S.C. §7702B(g)(2)(A)(ii)(I).
[21] California Insurance Code Section 10232.8(d)(1).
[22] California Insurance Code Section 10232.4(a).
[23] California Insurance Code Section 10232.4(b).
[24] California Insurance Code Section 10232.4(d).
[25] California Insurance Code Section 10235.2(b).
[26] California Insurance Code Sections 10235.8(b) and 10233.2.
[27] California Insurance Code Section 10233.
[28] California Insurance Code Section 10233.2(e).
[29] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to extension of benefits. 26 U.S.C. §7702B(g)(2)(A)(i)(III).
[30] California Insurance Code Section 10235.52.
[31] California Insurance Code Section 10235.52(a)(2)(A).
[32] California Insurance Code Section 10235.52(a)(2)(B)-(C).
[33] California Insurance Code Section 10235.52(b).
[34] California Insurance Code Section 10235.52(a)(2)(B)-(C).
[35] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to continuation and conversion of coverage. 26 U.S.C. §7702B(g)(2)(A)(i)(IV).
[36] California Insurance Code Section 10235.50(a).
[37] California Insurance Code Section 10235.51(a).

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[38] California Insurance Code Section 10235.52.
[39] California Insurance Code Section 10236.5.
[40] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to discontinuance and replacement of policies. 26 U.S.C. §7702B(g)(2)(A)(i)(V).
[41] California Insurance Code Section 10233.2(a).
[42] California Insurance Code Section 10235.10.
[43] California Insurance Code Section 10235.16(a).
[44] California Insurance Code Section 10235.16(b).
[45] California Insurance Code Section 10234.85. To dissuade agents from making unnecessary replacements, California Insurance Code Section 10234.97(a) limits the sales commission for a replacement policy by requiring that it be calculated on the basis of "the difference between the annual premium of the replacement coverage and that of the original coverage."
[46] California Insurance Code Section 10234.85.
[47] California Insurance Code Section 10235.17.
[48] California Insurance Code Section 10234.97(a).
[49] California Insurance Code Section 10233.3; See also, California Insurance Code Section 10236.8(e) [group policies].
[50] California Insurance Code Section 10234.87(a).
[51] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to unintentional lapse. 26 U.S.C. §7702B(g)(2)(A)(i)(VI).
[52] California Insurance Code Section 10235.40.
[53] California Insurance Code Section 10235.40(a)(2).
[54] California Insurance Code Section 10235.40(d).
[55] California Insurance Code Section 10235.50(d).
[56] California Insurance Code Section 10235.40(e).
[57] California Insurance Code Section 10235.40(e).
[58] 26 U.S.C. §7702B(4)(B).
[59] California Insurance Code Section 10235.30.
[60] HIPAA requires that federally-qualified long term care insurance policies satisfy all but section 9F of the Model Regulation's requirements relating to disclosures. 26 U.S.C. §7702B(g)(2)(A)(i)(VII).
[61] California Insurance Code Section 10233.5.
[62] California Insurance Code Section 10233.5(b).
[63] California Insurance Code Section 10233.5(c).
[64] California Insurance Code Section 10233.5(f).
[65] California Insurance Code Section 10233.5(h).
[66] The 30-day "free look" is mandated by California Insurance Code Section 10232.7.
[67] California Insurance Code Section 10234.93(a)(8) and (9) separately require that insurers provide applicants with a written notice that HICAP provides health insurance counseling to senior California residents, free of charge, and that insurers supply each applicant with a copy of the long-term care insurance shoppers guid developed by the California Department of Aging.
[68] California Insurance Code Section 10237.6(a)(1).
[69] California Insurance Code Section 10237.6(a)(2).
[70] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to prohibitions on post-claim underwriting. 26 U.S.C. §7702B(g)(2)(A)(i)(VIII).
[71] California Insurance Code Section 10232.3(a).
[72] California Insurance Code Section 10232.3(d).
[73] California Insurance Code Section 10232.3(c).
[74] California Insurance Code Section 10232.3(c).
[75] California Insurance Code Section 10232.3(c).
[76] Whether the representation was intentionally or unintentionally false does not alter the injured party's right to rescind the policy. *Telford v. New York Life Ins. Co.*, 9 Cal.2d 103, 105 (1937). "An insurer may rescind the contract of insurance *ab initio* for a material misrepresentation -- even though the insured's misstatements were the result of negligence, or, indeed, the product of innocence." *Barrera v. State*

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Farm Mutual Automobile Ins. Co., 71 Cal.2d 659, 666 (1969); See also, *Cummings v. Farmers Ins. Exchange*, 202 Cal.App.3d 1407 (1988).

[77] *Torbensen v. Family Life Ins. Co.,* 163 Cal.App.2d 401, 405 (1958)["It is not necessary that the misrepresentation have any causal connection with the death of the insured"]; *Cohen v. Penn Mut. Life Ins. Co.,* 48 Cal.2d 720, 726 (1957) [same].

[78] See, California Insurance Code Section 334. The full text of that statute reads as follows: "Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries."

[79] HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to minimum standards. 26 U.S.C. §7702B(g)(2)(A)(i)(IX).

[80] California Insurance Code Section 10232.1(b)-(d).

[81] California Insurance Code Section 10232.92.

[82] California Insurance Code Section 10232.93.

[83] California Insurance Code Section 10232.9(a).

[84] See, California Insurance Code Section 10232.9(c)(1)-(6).

[85] California Insurance Code Section 10232.9(c)(7).

[86] California Insurance Code Section 10232.95.

[87] California Insurance Code Section 10232.9(d).

[88] With one minor exception, HIPAA requires that federally-qualified long term care insurance policies satisfy the Model Regulation's requirements relating to inflation protection. 26 U.S.C. §7702B(g)(2)(A)(i)(X).

[89] California Insurance Code Section 10237.1.

[90] California Insurance Code Section 10237.5(a).

[91] California Insurance Code Section 10237.4(b).

[92] California Insurance Code Section 10237.5(b).

[93] California Insurance Code Section 10237.5(b).

[94] California Insurance Code Section 10234.95(a).

[95] California Insurance Code Section 10234.95(b)(1)-(3).

[96] California Insurance Code Section 10234.95(f). An earlier version of the California statute imposed this duty only on agents. See, Former California Insurance Code Section 10234.95 ["In recommending the purchase or replacement of any long-term care insurance, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement."]

[97] California Insurance Code Section 10234.95(c).

[98] California Insurance Code Section 10234.95(c).

[99] California Insurance Code Section 10234.95(h). If the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent. *Id.*

[100] California Insurance Code Section 10234.95(h).

[101] California Insurance Code Section 10234.8(a).

[102] California Insurance Code Section 10234.8(b).

[103] California Insurance Code Section 10234.93(b)(1).

[104] California Insurance Code Section 10234.93(b)(2)-(3).

[105] *Comunale v. Traders & General Ins. Co.*, 50 Cal.2d 654, 658 (1958) ["[There] is an implied covenant of good faith and fair dealing in every contract [including insurance policies] that neither party will do anything which will injure the right of the other to receive the benefits of the agreement."

[106] *California Shoppers, Inc. v. Royal Globe Ins. Co.* (1985) 175 Cal.App.3d 1, 15, 54; See also, *Opsal v. United Services Auto. Association* (1991) 2 Cal.App.4th 1197, 1205.

[107] In other contexts, compensation for a breach of the implied covenant of good faith and fair dealing has "almost always been limited to contract rather than tort remedies." *Foley v. Interactive Data Corp.*, 47 Cal.3d 654, 684(1988); See also, *Freeman & Mills, Inc. v. Belcher Oil Co.*, 11 Cal.4th 85 (1995).

[108] See, e.g., *Smith v. City and County of San Francisco* (1990) 225 Cal.App.3d 38, 49 [the prerequisite to any bad faith claim is "the existence of a contractual relationship between the parties, since the covenant is an implied term in the contract."].

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[109] *Gruenberg v. Aetna Insurance Co.*, 9 Cal.3d 566, 576 (1973) ["the non-insurer defendants were not parties to the agreements for insurance; therefore, they are not, as such, subject to an implied duty of good faith and fair dealing."].
[110] California Insurance Code Section 10234.8(a).
[111] California Insurance Code Section 10234.8(b).
[112] 23 Cal.3d 880, 891 (1979).
[113] 46 Cal.3d 287, 306 (1988).
[114] *Moradi-Shalal, supra,* 46 Cal.3d at 300; emphasis in original.
[115] *Id.*, at 304, citing California Insurance Code Sections 790.05-790.09.
[116] *Id.*, at 304; See also, *Id.*, at 305 [the Legislature has "not manifested an intent to create . . . a private cause of action" for alleged violations of the statute]; *Zephyr Park, Ltd. v. Superior Court* (1989) 213 Cal.App.3d 833 [applying same rule in first party context].
[117] *Moradi-Shalal, supra,* 46 Cal.3d at 300; emphasis deleted.
[118] Accord, *Moradi-Shalal, supra,* 46 Cal.3d at 304.
[119] California Insurance Code Sections 10234.3 and 10234.4.
[120] California Insurance Code Section 790.06(b).
[121] California Insurance Code Section 10234.2(b).
[122] California Insurance Code Section 10234.2(b); emphasis added.
[123] *Love v. Fire Insurance Exchange*, 221 Cal.App.3d 1136, 1148-1149 (1990).
[124] *State Farm and Marine Casualty Co. v. Superior Court*, 216 Cal.App.3d 1222, 1226-1227 (1989); emphasis added; citations omitted.
[125] *Henry v. Associated Indemnity Group*, 217 Cal.App.3d 1405, 1418-1419 (1990); See also, *General American Life Ins. Co. v. Rana*, 769 F.Supp. 1121, 1126 (N.D.Cal. 1991).
[126] California Welfare & Institutions Code Section 15610.30.
[127] In California, Welfare & Institutions Code Section 15610.27 defines "elder" to mean "any person residing in this state, 65 years of age or older."
[128] California Insurance Code Section 10234.85.
[129] California Insurance Code Section 10234.95(f).
[130] California Insurance Code Section 10234.8(a).
[131] California Welfare & Institutions Code Section 15610.30.
[132] California Welfare & Institutions Code Section 15610.07.
[133] California Welfare & Institutions Code Section 15610.53.
[134] California Insurance Code Section 10234.93(b)(2)-(3).
[135] California Welfare & Institutions Code Section 15657(b).
[136] California Welfare & Institutions Code Section 15657(a).
[137] California Business & Professions Code Section 17200.
[138] *Farmers Insurance Exchange v. Superior Court* , 2 Cal.4th 377, 383 (1992).
[139] See, footnote 113 and related text.
[140] See, e.g., *Lee v. Travelers Cos.*, 205 Cal.App.3d 691. 694-695 (1988); *Doctors' Co. Ins. Services v. Superior Court*, 225 Cal.App.3d 1284, 1289 (1990); *American Int'l Group, Inc. v. Superior Court*, 234 Cal.App.3d 749, 768 (1991).
[141] *Safeco Ins. Co. v. Superior Court* , 216 Cal.App.3d 1491, 1494 (1990); See also, *State Farm Fire and Casualty Co. v. Superior Court*, 45 Cal.App.4th 1093, 1103 (1996) [". . . the provisions of section 790.03 may not be `borrowed' to serve as a basis for an action under the UCA."].
[142] California Business & Professions Code Section 17203.
[143] *Bank of the West v. Superior Court*, 2 Cal.4th 1254, 1266 (1992).