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Grassley seeks information from long-term care insurance providers
Senator continues oversight of industry

WASHINGTON — Sen. Grassley is asking the nation's top providers of long-term care insurance to provide information about how claims are processed in order to learn more about how effectively the sector is meeting the needs of Americans who have purchased such policies, which has been encouraged through federal tax incentives.

"Preparing for long-term care needs can make a big difference in both the quality of life for individuals and the solvency of Medicaid," Grassley said. "Long-term care insurance products are fairly new to the marketplace, so it's important that policy makers continue to assess how they are working to meet needs and how their success is affecting public programs."

In April, Grassley asked the independent Government Accountability Office to conduct a review of the long-term care insurance industry following a New York Times story about rejected claims by policy holders. In August, the Des Moines Register ran a series of stories about whether long-term care insurance policies are providing the coverage purchasers expect. Grassley said he is asking providers for information today based in part on the response he received recently from the National Association of Insurance Commissioners to questions about trends in the industry.

Grassley is a long-time advocate for enhancing retirement security with incentives for long-term care coverage and has exercised oversight of the long-term care insurance industry on behalf of policy holders. As Chairman of the Senate Special Committee on Aging during the late 1990s, he first sponsored legislation to expand long-term care insurance opportunities for individuals and held hearings on a range of retirement security issues. He undertook several initiatives to improve the quality of long-term care services.

As Chairman of the Finance Committee for four and a-half years between 2000 and 2007, Sen. Grassley continued his efforts to promote awareness about long-term care insurance by working to create a long-term care information clearinghouse at the Department of Health and Human Services. He also expanded the partnership program, which is intended to encourage people who might otherwise rely on Medicaid to purchase long-term care insurance, in the Deficit Reduction Act of 2005.

The text of Grassley's letter to 11 insurance providers follows a list of those who received the letter.

September 27, 2007

Chairman, President and Chief Executive Officer
Genworth Financial, Inc.
6620 W. Broad St.

Richmond, VA 23230

Dominic D'Alessandro
President and Chief Executive Officer
Manulife Financial Corporation
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C. James Prieur
Chief Executive Officer
Conseco, Inc. / Bankers Life and Casualty
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Carmel, IN 46032

Stephen W. Lilienthal
Chairman and Chief Executive Officer
Continental Casualty Company
333 S. Wabash Ave
Chicago, IL 60604

Robert C. Henrikson
Chairman of the Board, President and Chief Executive Officer
MetLife, Inc.
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27-01 Queens Plaza North
Long Island City, NY 11101

William W Hunt, Jr.
President and Chief Executive Officer
Penn Treaty American Corporation
3440 Lehigh Street
Allentown, PA 18103

Thomas R. Watjen
President and Chief Executive Officer
Unum Group
1 Fountain Square
Chattanooga, TN 37402

Timothy Francis Kneeland
President
Life Investors Insurance
4333 Edgewood Rd NE
Cedar Rapids, IA 52499

Dan Neary

Chief Executive Officer
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Arthur Ryan
President and Chief Executive Officer
Prudential Financial, Inc.
751 Broad Street
Newark, NJ 07102

Sy Sternberg
Chairman of the Board and Chief Executive Officer
New York Life Insurance Company
51 Madison Avenue, Suite 3200
New York, NY 10010

Dear :

The United States Senate Committee on Finance ("Committee") has exclusive jurisdiction over the Medicare and Medicaid programs and, accordingly, the duty to ensure that these programs are fiscally sound. As a senior member of the United States Senate and Ranking Member of the Committee, I have a special responsibility to ensure that programs such as Medicare and Medicaid are not unnecessarily burdened. It is for this reason that I have been interested in learning more about long term care insurance ("LTCI").

As you know, LTCI is an invaluable tool to millions of Americans planning for their long term needs. Furthermore, the Federal Government has a significant interest in the LTCI industry's partnership with the Medicaid program. As part of the Deficit Reduction Act of 2005, Congress allowed for the expansion of the long term care insurance partnership program to all 50 states. The purpose of the partnership program is to encourage people who might otherwise rely on the Medicaid program to purchase LTCI to help meet their long term care needs. However, if more claims for long term care related expenses are denied, there could be a substantial and perhaps unnecessary financial burden placed on Medicaid.

As you are likely aware, earlier this year the New York Times NYT published an article critical of the long term care insurance industry. The article focused on reports that a growing number of LTCI policyholders are experiencing greater difficulty in recovering claims for long term care expenses. The article also suggested that some LTCI providers have made it more difficult for policyholders to be paid for legitimate claims.

In response to my growing concern over this matter, I asked the Government Accountability Office ("GAO") to perform an extensive review of the long term care insurance industry. I also contacted the National Association of Insurance Commissioners ("NAIC") to gather its insight on these matters.

While the GAO review is ongoing, I have received the NAIC's response and it contains some troubling data. In my letter to the NAIC, I asked a number of questions, including whether or not there were any notable trends in the industry. Specifically, I was concerned with reports of an increasing number of claim denials. In its response, the NAIC reported that there has been a 92% increase in the number of long term care complaints nationally from 2001 to 2006. The NAIC also conveyed that it had identified a steady increase in the number of complaints regarding claim denials, including a 74% increase in the number of claim denial related complaints between 2003 and 2006. While this may be explained by the increasing number of people purchasing LTCI, the relationship remains unclear. Furthermore, the NAIC reported that over 70% of claim denials are overturned in favor of the policyholder upon appeal. The NAIC noted that this is "a pattern of error not typically found in other lines of health-related insurance."

As part of the Committee's ongoing inquiry into these important matters, I am interested in learning how LTCI providers manage their policies and serve their beneficiaries. I am also interested in learning how providers decide which claims to approve and which to deny. Accordingly, I would appreciate your answers to the following questions regarding your company's policies and practices:

1. Please describe, in detail, the process Unum Group utilizes when receiving a claim for payment of a LTCI policy. Specifically, I am interested in learning:

a) How a claim is handled from the moment it is first received to when it is paid to the policyholder;
b) What requirements must be fulfilled in order for a claim to be paid, including any documents needed for submission;
c) The process by which it is determined that additional information is needed to complete a claim and the process for communicating this additional information to the policyholder (e.g., via telephone, postal mail, electronic transmission, etc);
d) The process by which a claim is denied and the process for communicating the denial to the policyholder (i.e., telephone, postal mail, electronic transmission, etc);
e) The process, if any, for a policyholder to appeal a claim denial;
f) The process by which policyholder inquiries are handled; and
g) The process by which persons responsible for claims processing are reviewed for performance. Please include a list of any and all performance incentives for which the aforementioned persons are eligible (e.g., bonuses, deferred compensation, etc). Also, please identify whether these employees have denial or approval targets and, if so, what those targets are.

2. Please provide a copy of the current Unum Group employee manual for persons responsible for claims processing and any documents related to mandatory training for these employees.

3. Please provide to the Committee the following information concerning LTCI claims at Unum Group:

a) The number of LTCI policies sold per year for calendar years 2001 - 2006;
b) The number of LTCI claims submitted per year for calendar years 2001 - 2006;
c) The number of LTCI claims that were denied in whole or in part by Unum Group per

year during calendar years 2001 - 2006, including a breakdown of the most common reasons for denial;

d) Of those denied, the number that were appealed per year from 2001 - 2006, and the number of appeals that were resolved in favor of the policyholder;

e) The average amount of time between a claim being filed and its payment or denial;

f) For claims that are appealed, the average amount of time between the filing of an appeal and its resolution.

Please provide the information and documents requested by October 19, 2007. In complying with this request, respond by repeating the enumerated request, followed by the accompanying response; attach and identify all relevant documents or data by title and the number(s) of the enumerated request(s) to which they are responsive. Secondly, in complying with this request, please refer to the attached definitions concerning the questions set forth in this letter. Finally, in cooperating with the Committee's review, no documents, records, data, or other information related to these matters, either directly or indirectly, shall be destroyed, modified, removed, or otherwise made inaccessible to the Committee.

Sincerely,
Chuck Grassley of Iowa
United States Senator
Ranking Member of the Committee on Finance

Here is the text of Sen. Grassley's request to GAO made earlier this year on allegations of overly burdensome obstacles that make it difficult to receive coverage for long-term insurance claims.

April 3, 2007

The Honorable David Walker
Comptroller General
U.S. Government Accountability Office
441 G St, NW
Washington, DC 20548

Dear Mr. Walker:

A recent article in *The New York Times* highlights what appears to be a growing and systemic problem with the long-term care insurance industry. [1] As you know, many of our nation's seniors rely on the prospect of a long-term care insurance policy to provide an adequate safety net for healthcare related expenses. However, it is reported that there are many overly burdensome obstacles that make it difficult to receive coverage for insurance claims. For instance, the article notes that many long-term care policyholders are confronted with draconian policies that deny claims for minute administrative errors such as failing to submit unimportant paperwork, filling out wrong forms after receiving them from the insurance company, and the company failing to recognize an approved facility.

Long-term care policies play an integral role in the fiscal integrity of federal health programs such as Medicaid. However, if insurance companies are making it more complicated to recoup claims, this may force seniors into an already financially burdened Medicaid program, thereby increasing program costs.

Additionally, I am concerned that these problems are not isolated to a small segment of the population; but rather that they are pervasive throughout the long-term care insurance industry.

Therefore, I request that the Government Accountability Office conduct an inquiry into the practices of the long-term care insurance industry. In doing so, please ensure that the following matters are examined: an analysis of industry policies and practices concerning both claim approvals and denials including but not limited to a comparative analysis of approval versus denial rates and the most common reasons for denying a claim; an analysis of whether or not companies are adhering to Health Insurance Portability and Accountability Act (HIPPA) standards relating to consumer protection for long-term care insurance and whether or not companies are adhering to HIPPA guidelines relating to their administrative and marketing practices; a review of whether state insurance enforcement agencies are properly and promptly investigating reports of long-term care insurance claim denials and the results of such reviews; and an estimate/analysis of the potential implications to the Medicaid program due to improper denial of long-term care insurance claims.

Thank you for your attention to this important matter.

Sincerely,
Charles E. Grassley
United States Senator
Ranking Member, Committee on Finance

[1] Charles Duhigg, *Aged, Frail and Denied Care by Their Insurers*, N.Y. Times, March 26, 2007

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Mary Rose Derks was a 65-year-old widow in 1990, when she began preparing for the day she could no longer care for herself. Every month, out of her grocery fund, she scrimped together about $100 for an insurance policy that promised to pay eventually for a room in an assisted living home.

On a May afternoon in 2002, after bouts of hypertension and diabetes had hospitalized her dozens of times, Mrs. Derks reluctantly agreed that it was time. She shed a few tears, watched her family pack her favorite blankets and rode to Beehive Homes, five blocks from her daughter's farm equipment dealership.

At least, Mrs. Derks said at the time, she would not be a financial burden on her family.

But when she filed a claim with her insurer, Conseco, it said she had waited too long. Then it said Beehive Homes was not an approved facility, despite its state license. Eventually, Conseco argued that Mrs. Derks was not sufficiently infirm, despite her early-stage dementia and the 37 pills she takes each day.

After more than four years, Mrs. Derks, now 81, has yet to receive a penny from Conseco, while her family has paid about $70,000. Her daughter has sent Conseco dozens of bulky envelopes and spent hours on the phone. Each time the answer is the same: Denied.

Tens of thousands of elderly Americans have received life-prolonging care as a result of their long-term-care policies. With more than eight million customers, such insurance is one of the many products that companies are pitching to older Americans reaching retirement.

Yet thousands of policyholders say they have received only excuses about why insurers will not pay. Interviews by The New York Times and confidential depositions indicate that some long-term-care insurers have developed procedures that make it difficult -- if not impossible -- for policyholders to get paid. A review of more than 400 of the thousands of grievances and lawsuits filed in recent years shows elderly policyholders confronting unnecessary delays and overwhelming bureaucracies. In California alone, nearly one in every four long-term-care claims was denied in 2005, according to the state.

"The bottom line is that insurance companies make money when they don't pay claims," said Mary Beth Senkewicz, who resigned last year as a senior executive at the National Association of Insurance Commissioners. "They'll do anything to avoid paying, because if they wait long enough, they know the policyholders will die."

In 2003, a subsidiary of Conseco, Bankers Life and Casualty, sent an 85-year-old woman suffering from dementia the wrong form to fill out, according to a lawsuit, then denied her claim because of improper paperwork. Last year, according to another pending suit, the insurer Penn Treaty American decided that a 92-year-old man had so improved that he should leave his nursing home despite his forgetfulness, anxiety and doctor's orders to seek continued care. Another suit contended that a company owned by the John Hancock Insurance Company had tried to rescind the coverage of a 72-year-old man when he was diagnosed with Alzheimer's disease four years after buying the policy.

In court filings, all three companies said the denials had been proper. They declined further comment on the cases, though Bankers Life and John Hancock eventually settled for unspecified amounts.

In general, insurers say criticisms of claims-handling are unfair because most policyholders are paid promptly and some denials are necessary to root out fraud.

In a statement, Conseco said the company "is committed to the highest standards for ethics, fairness and accountability, and strives to pay all claims in accordance with policy contracts." Penn Treaty said in a statement, "We strive to treat all policyholders fairly, and to deliver the best, most efficient evaluation of their claim as possible."

But policyholders have lodged thousands of complaints against the major long-term-care insurers. A disproportionate number have focused on Conseco, its affiliate, Bankers Life, and Penn Treaty. In 2005, Conseco received more than one complaint regarding long-term-care insurance for every 383 such policyholders, according to data from the insurance commissioners' association. Penn Treaty received one complaint for every 1,207 long-term-care policyholders. (The complaints touch on a variety of topics, including claims handling, price increases and advertising methods.)

By comparison, Genworth Financial, the largest long-term-care insurer, received only one complaint for every 12,434 policies.

Conseco is among the nation's largest insurers, collecting premiums worth more than $4.2 billion in 2006, of which long-term-care policies contributed 21 percent. Penn Treaty focuses primarily on long-term-care products and collected premiums of about $320 million in 2004, the last year the company filed an audited annual report.

In depositions and interviews, current and former employees at Conseco, Bankers Life and Penn Treaty described business practices that denied or delayed policyholders' claims for seemingly trivial reasons. Employees said they had been prohibited from making phone calls to policyholders and that claims had been abandoned without informing policyholders. Such tactics, advocates for the elderly say, are becoming common throughout the industry.

"These companies have essentially turned their bureaucracies into profit centers," said Glenn R. Kantor, a California lawyer who has represented policyholders.

Yet these concerns have been ignored by state regulators, advocates say, and have gone unnoticed by federal lawmakers who recently passed incentives intended to promote purchases of long-term-care policies, in the hopes of forestalling a Medicare funding crisis.

Conseco and Bankers Life "made it so hard to make a claim that people either died or gave up," said Betty J. Hobel, a former Bankers Life agent in Cedar Rapids, Iowa.

"When someone is 70 or 80 years old," she said, "how many times are they going to try before they just give up?"A Race to Sell Policies

When Mrs. Derks bought her long-term-care policy from a door-to-door salesman in 1990, she was unaware that she represented the insurance industry's newest gold mine.

Her husband had died eight years earlier of a stroke, leaving her to run a barley farm in northern Montana, where she lived with her three children and her aging mother. As she watched her own parent decline, Mrs. Derks became preoccupied with sparing her children the expense of her final years.

"She was terrified that she would bankrupt us or get sent to a public nursing home," said Ken E. Wheeler, her son-in-law.

At the time, long-term-care policies, which can cover the costs of assisted-living facilities, nursing homes and at-home care, were becoming one of the insurance industry's fastest-growing products. Companies like Conseco, Bankers Life and Penn Treaty were aggressively signing up clients who were not in the best health at rates far below their competitors' in order to win more business, former agents said. From 1991 to 1999, long-term-care sales helped drive total revenue gains of roughly 500 percent each at Penn Treaty and Conseco, including its affiliate Bankers Life.

Cracks in the business, however, soon started to appear. Insurance executives began warning they had underestimated how long policyholders would live after entering nursing homes. The costs of treating Alzheimer's, Parkinson's and diabetes ballooned.

As insurers began realizing their miscalculations, they persuaded insurance commissioners in California, Pennsylvania, Florida and other states to approve price increases of as much as 40 percent a year.

By 2002, Conseco's long-term-care payouts exceeded revenue. Those and other disappointing results prompted the company to file for bankruptcy, from which it emerged 10 months later.

That same year, Mrs. Derks entered Beehive Homes, a cheery, 12-bed center one block from the Prairie View elementary school. In the previous four years, she had been hospitalized more than two dozen times. She had once lain unconscious in her living room for a day and a half. Her physician ordered her into an assisted-living center.

Initially, Conseco told Mrs. Derks's daughter, Jackie Wheeler, that her claim would go through smoothly, Mrs. Wheeler said. The family began paying Beehive Homes's $1,900 monthly fee.

But three months after submitting her claim, Mrs. Derks received a letter from Conseco saying she had waited too long, and her earliest costs would not be reimbursed. Two months later, she received another letter denying her entire claim because she had not submitted proof of illness.

Yet a copy of Mrs. Derks's policy, sent to the Wheelers by Conseco in 2004 and reviewed by The Times, mentions no requirement for proof of illness. The policy requires only that the confinement be ordered by a physician, and it allows for a notice of claim to be sent "as soon as reasonably possible."

Mrs. Derks's daughter called Conseco and explained that her mother could not recall the date or people's names and had started multiple fires by forgetting to turn off the stove. She sent letters

stating that her mother needed assistance to dress, eat, go to the bathroom and inject insulin.

"This is medically necessary!!!" reads a form signed by Mrs. Derks's physician in 2004. "This has been filled out three times! This person needs assistance!"

Seven months later, Conseco sent another letter, this time denying Mrs. Derks's claim because her policy "requires a staffed registered nurse 24 hours per day." Her policy does not mention such a requirement.

Conseco also sent letters denying Mrs. Derks's claim because her policy had an "assisted living facility rider," and because Mrs. Derks "does not have an assisted living facility rider." In all, the family received more than a dozen letters from the company. Many contradict one another, and frequently cite requirements that are nowhere mentioned in Mrs. Derks's policy.

"There was always a new step in the runaround," Mrs. Wheeler said. "It felt like everything was designed to make me just go away."

Over two years, Mrs. Wheeler estimated, she called the company about 100 times. Twice a month, she sent envelopes stuffed with medical records. Some afternoons, she spent hours making calls. After one conversation, Mrs. Wheeler slammed down the phone and started to cry. Then she drove to Beehive Homes, where her mother was surrounded by faded photos of her childhood and boxes of adult diapers.

"I wouldn't tell her about the problems we were having with Conseco, because I knew it would cause her so much worry," Mrs. Wheeler said.

Eventually, the Wheelers sold part of their John Deere dealership to raise money to pay for her mother's care. In October 2006, they sued.

Conseco, asked by a reporter about the company's handling of the Derks claim, declined to answer, citing the pending litigation. In court documents, the company denied Mrs. Derks's allegations without specifying why her claim was denied.

"We did everything they asked," Mrs. Wheeler said. "And this company just treats us like dirt."Tales of Bureaucracy

Inside the large Conseco headquarters in Carmel, Ind., scores of employees receive the flood of documents and calls that arrive each day. At times, according to depositions and interviews, that deluge became so overwhelming that documents were lost, calls went unreturned and mistakes occurred.

Some employees describe vast mailrooms where documents appear and disappear. One call-center representative said he was afforded an average of only four minutes to handle each policyholder's call, no matter how complicated the questions. Employees said they were instructed not to say when the company was behind in processing paperwork, even when the backlog extended to 45 days. Workers were prohibited from contacting each other by phone,

although such calls might have quickly resolved obstacles, according to depositions.

Conseco, asked in detail about the company's policies, declined to respond.

Bureaucratic obstacles were pervasive, according to interviews with 10 former Conseco employees and depositions of more than a dozen others. Robert W. Ragle, a former Bankers Life branch manager, once contacted the claims department on behalf of a client, and "they just laughed us off the phone," he said. "Their mentality is to keep every dollar they can." Mr. Ragle was dismissed by Bankers Life in 2002. He sued for wrongful termination and settled out of court.

In lawsuits, complaints and interviews, policyholders contend that Conseco, Bankers Life or Penn Treaty denied claims because policyholders failed to submit unimportant paperwork; because daily nursing notes did not detail minute procedures; because policyholders filled out the wrong forms after receiving them from the insurance companies; and because facilities were deemed inappropriate even though they were licensed by state regulators.

In depositions conducted on behalf of angry policyholders, Conseco employees described bureaucratic obstacles that prevented payment of claims. Those depositions were sealed in settlement agreements but were obtained by The Times.

In a 2006 deposition, a Bankers Life and Conseco claims adjuster, Teresa Carbonel, testified that she denied claims because of missing records but was prohibited from calling nursing homes or physicians to request the documents. She also testified that when a claim was denied, she was forbidden to phone a policyholder, but instead used a time-consuming mailing system.

Ms. Carbonel's testimony, recorded during lawsuit on behalf of a 94-year-old policyholder, Rhodes K. Scherer, also disclosed that if policyholders did not mail requested documents within 21 days, Conseco might abandon their claim, sometimes without informing them.

In the case of Mr. Scherer, who was institutionalized after a bathroom fall, it was difficult to obtain a response, Ms. Carbonel said, because the company's requests were mailed to his home address, rather than the nursing center where the company had been notified that he had moved. Ms. Carbonel, who is no longer with the company, did not return calls. Conseco declined to comment on her testimony.

In another deposition, Conseco's then-senior manager for long-term- care claims, Jose S. Torres, testified that Conseco would sometimes withhold payments until it received documents not required by customers' policies. In Mr. Scherer's case, Mr. Torres said, the company refused to pay his nursing home costs unless he sent copies of the home's license, payment invoices and medical records, even though those documents had no bearing on approving his claim.

Mr. Scherer's claim "was handled not in the best way, but it was handled according to the processes and procedures placed at the time," Mr. Torres testified. "Mistakes are going to be made, you know."

Other executives testified that when Conseco appeared to have lost important documents in Mr. Scherer's claim, no investigation was initiated. Shawn Michael Schechter, a Conseco claims supervisor who left the company in 2005 on positive terms, according to the deposition, testified that the handling of Mr. Scherer's claim violated the principle of good faith, which requires insurance companies to treat customers fairly.

"The claim adjuster could have made that very easy and not have put the burden back onto the policyholder," he testified.

Mr. Torres did not return calls. Mr. Schechter declined to answer questions.

Mr. Scherer died in 2004 without receiving benefits from Conseco. His estate settled with the company in February for an undisclosed amount, according to a lawyer representing the estate.

Conseco declined to discuss its complaint history or individual cases, citing confidentiality agreements. In its statement, the company said that in 2006, Conseco paid nearly $2.3 billion on 9.8 million claims in all types of insurance sold by the company.

The company added: "Conseco, through training, education and process improvements in all of its insurance companies, is continuously focused on enhancing service and resolving any problems expeditiously. The Conseco Insurance Group's overall insurance department complaints decreased 20 percent from 2005 to 2006."

Depositions of executives at Penn Treaty also point to questionable practices. In a 2005 lawsuit, a Penn Treaty senior vice president, Stephen Robert LaPierre, testified that the company rejected one claim without informing the policyholder why, asked for information that was not required to process a claim, gave incomplete information about a claim's status and said the company was delaying payment because of an investigation while failing to take steps that might have resolved the inquiry.

Mr. LaPierre declined to discuss his testimony. Penn Treaty settled the lawsuit by paying the policyholder an unspecified amount, the policyholder's lawyer said.

Penn Treaty said in a statement that evaluating a company by measuring its complaints was flawed, and that since 2003, the company has denied an average of less than 1.7 percent of the up to 8,000 claims it received every year because of reasons related to policyholder eligibility. "From time to time, Penn Treaty is compelled to investigate fraud or questionable billing activities," the company added.Few Regulatory Inquiries

Few of the cases or complaints filed against Conseco, Bankers Life, Penn Treaty or other insurers have received much attention, in part because many lawsuits filed against long-term-care insurers have been settled with the requirement that depositions, documents and settlement terms be kept confidential. Frequently, say policyholders' lawyers, the companies have been willing to pay millions of dollars in exchange for confidentiality.

Furthermore, despite the complaints against long-term-care insurers, few states have conducted

meaningful investigations.

Ron Gallagher, a deputy commissioner with the Pennsylvania Insurance Department, said, "I don't know that we have a real problem with improper claim denials."

Yet data from the National Association of Insurance Commissioners show that from 2003 to 2005, Pennsylvania received more complaints regarding Conseco, Bankers Life and Penn Treaty than any other state. Mr. Gallagher said he might begin a new review of those companies.

Other states with large numbers of long-term-care complaints, including California, Missouri, Maryland, Indiana and Washington have not begun investigations, or have reviewed only small numbers of policies.

As a result, other seniors may end up like Mrs. Derks.

While she was waiting for her lawsuit to proceed, Medicaid began contributing to Ms. Derks's care. Taxpayers now pay Beehive Homes about $32 daily for her care.

"Long-term-care insurance is supposed to result in less pressure on Medicaid, not more," said Ms. Senkewicz, the former executive at the insurance commissioners' association.

For Mrs. Derks's family, things have already broken down.

"How many other people are out there who don't have a family to fight for them and have just given up?" asked Jackie Wheeler. "This company should be ashamed."