

Marshall Fritz Testimony at MIA Hearing on Genworth LTC Rate Increases May 2021

As a long-term LTC Genworth policy holder, I am testifying in 2021 as I had in 2016 and 2017 hearings. Much of the reasons for my concerns remained unresolved, as they go beyond the costs of claims that exceed premiums collected. However, my concerns are exacerbated that Genworth is providing arbitrary rate justification figures when they submit a notice in December 2020 that they are seeking a 160% premium increase, and then turn around this spring only weeks ago and then rescind it retroactively by a minimum 315% increase. There was nothing provided to customers to explain this exorbitant difference. Whether a clerical error or not, it suggests that Genworth's accounting is completely out of control. Worse, even the 160% increase is far and away exceedingly higher than the Genworth claims of 2016 and 2017 that they justified 48% and 75% increases, respectively. This is runaway scalping without any medical need reason why this is happening. Worse, even the 160% increase is far and away exceedingly higher than the Genworth claims of 2016 and 2017 that they justified 48% and 75% increases, respectively.

There is nothing in the hands of consumers to connect the dots as to why this acceleration is now occurring or whether it would/would not be expected to continue to accelerate further in future. There is little reason to trust any of the Genworth figures, perhaps at any time in the past to projecting the future, when they so flippantly can say that they really can be off by a factor of two in shortfall, just a factor of two, as if it were just a minor discrepancy. **Such a discrepancy is extraordinary and should be cause of MIA rejecting the application outright, especially coming from a history of unsupportable figures such as lapse rate projections. And, it raises questions as to how MIA has allowed such figures to be even considered as evidence of bona fide financial shortfalls by Genworth.**

In the submission accompanying the testimony, I have aggregated several sets of communications I have submitted or received earlier. I testified in 2016 and 2017. I submitted a complaint to MIA in 2017, but received a response from Genworth that overgeneralized responses pertaining to pool of policy holders and Genworth operations. Details sought such as asset growth, reserves, administrative expenses, and exactly how the increased premiums were calculated beyond claims experiences were totally lacking. I submitted comments about proposed 2017 regulations. I have checked off important paragraphs of these materials, indicating that many of the points I raised back then have yet to be fully explained or documented for consumers and remain as background concerns impacting all current and future rate increase reviews.

Thus, the acceleration of rate increases sought is so fast and furious that the implications for the future are extraordinary. And, annual increases of 15%, which will never catch up with these extraordinary Genworth rate increase claims, will in themselves lead long term to extraordinary premium levels or extraordinary converted policies that mean that almost no one could pay these premiums and almost no one will benefit much at all from the reduced values of the policies. Others may find that in future years they have paid so much in premiums that they could never recoup those amounts from future claims – that is not insurance and they might as well lapse their policies while increasing the rate of premium acceleration for everyone else.

And all this is happening without any clear substantiation to the consumer that MIA is in control over the true justification for these gigantic rate increase requests. There is more than mere claims payouts

and premiums collected that need to be evaluated to determine whether or not Genworth are cooking the books in other ways to make the picture favorable to them.

If I were to live to 100 as my mother did before needing LTC in a nursing home, about the age of her admission to a nursing home, my premium could be about \$400,000 a year if compounded 15% increases were approved every year. If exceptional premium rate increases were approved at the 315% justification rate for the current year, with acceleration into the future in like manner without any amelioration or flattening, my annual premium could well be in the millions of dollars. Perhaps even many millions of dollars. Such an acceleration is almost exponential, rising about 250% in 4 years, and will likely be worse with a shrinking non-institutionalized aging pool where administrative expenses will swamp claim benefits. And, I would have paid out millions of dollars in premiums, in all likelihood more than I could recoup through a claim.

In other words, there is nothing to stop the premium level from exceeding what the vast majority of my age cohorts could recoup in benefits, let alone the MILLIONS of dollars already spent on premiums to date. Under such an event not prohibited by current legislation or MIA purview, there would be NO consumer protection. Maryland does allow for extraordinary premium increases when the extraordinary need is justified under simplistic formulae that can belie true justification from behind-the-scenes insurer financial manipulations outside of claims benefits.

Testimony from MIA and Genworth in 2016 talked about the increases back then constituting rate stabilization'. I termed it in my testimony as RATE DESTABILIZATION. What we are seeing now makes that rate stabilization term a sick joke. My rates have more than doubled, with forecasts of upcoming tripling justified on the road to potential annual increases of 15%, OR HIGHER, forevermore into the 'future.

We all know that lapse rates were grossly underestimated in the 1990s by Genworth, basing them on different products with different consumer values for lifetime holdings. But, no thorough study has been reported to consumers that I am aware of, whether by independent actuaries, MIA, or national organizations that thoroughly examines other significant parameters as to whether policy holders have been wronged by unfair tabulations that ignore conditions of Genworth business outside of claims processing of benefits. Reading of the NAIC and Genworth publications over the years point to other critical aspects that should be fully reckoned with in rate increase justifications. These include:

- In 1997, NAIC reported underpricing of policies by 1/3-1/2. But, now going forward, premiums have more than doubled and Genworth is already seeking more than sextupling of the premiums in its latest notifications. Isn't something wrong here that premiums and pricing are already out of control, with forecast of further accelerated exponential premium requests, even before most baby boomers who took out such policies have any need to make LTC claims?
- Has Genworth already recouped from current premium levels the premium shortfall envisioned by NAIC in 1997?
- How Genworth overall assets have fared over a decade when equities have soared. Surely, Genworth corporation owns significant equities beyond fixed income holdings of premiums and reserves. These equity asset increases should be made to offset any claims losses. Note Bene: The Fidelity Investments Monitor & Insight analysis publication shows that over the last year the Select Insurance Portfolio increased in value by 57.5% and by 12.3% overall for the past 10

years. Did Genworth values not follow this trend, let alone its external investments they have which earn capital gains and dividends which might be booked separately?

- How Genworth spreads equity increases and reserves among the various insurance divisions, and whether funds have been moved away purposefully, and disproportionately, away from LTC to make it appear that LTC losses are intolerable to Genworth.
- Whether Genworth has provided distributions to shareholders that otherwise should have been used to bolster LTC insurance reserves or stave off excessive premium rate increases.
- The extent to which Genworth has followed normal business practices for covering losses in one Division by profits in another Division, and, if not, why not. Has Genworth engaged in contrary practices just because it knows that States will reward it for such non-customary business practices?
- Whether Genworth has reallocated its assets properly in a business model of supporting and shoring up Divisions that need additional support, drawing upon other Divisions doing well
- How administrative costs, staff, and resources have been allocated to LTC within the company. Have administrative cost centers been added to LTC unnecessarily from other Divisions to prime the pump of unacceptable Loss Ratios? Why have LTC admin costs gone up disproportionately over the years compared to claims? What MIA purview review procedure prevents excessive overpadding of administrative expenses to pump the prime of Loss Ratios in generating increasingly high 'justified' premium increases? There is no apparent regulation of administrative staffing and expenses that I can see from recent hearing experiences.
- Has Genworth made bad choices of mergers from other LTC insurance companies, to the detriment of those taking out Genworth policies decades ago? And, are the original Genworth customers suffering in their policy premiums and services from the financial impacts of even more poorly-managed merged policies coming into the Genworth fold? Is this a proper business practice to merge other policies in the pricings, even beyond claims benefits?
- How have the assets of lapsed policies been calculated into the cost projections, inasmuch as risk to Genworth on future claims can solely come from the value of premiums already paid and sitting in fixed income accounts earning interest?
- How have the significant future savings from policy conversions been factored into the projections, inasmuch as the customer loses premium-increase buying power compared to base policy increases every time customer converts? Genworth gains more than the customer does with these conversions, especially repeated downgrade conversions. This has been pointed out in hearings and the literature. Furthermore, isn't it possible under the Genworth policy conversion pricing policies of factoring in justified increased costs (even several hundred percent increases) for a customer to find that downgrading actually costs more than keeping the policy as is with limited annual 15% increases?
- There is no clear reporting as to what demographic and economic population statistics were used by Genworth over time and in projections into the future. Without being able to certify that official US statistics were used, it is impossible to validate their models.

After the 2017 Hearings, the Maryland Legislature showed their concern over the accelerating premiums by putting pressure on MIA to work with the insurance companies to lower their costs. Based on the current justification rates pursued by Genworth, supposedly-justifiable increases of over 300% in four years does not reflect any lowering of internal costs. In fact, being so much higher than claims could

have risen so fast, it likely reflects acceleration of administrative costs out of control or cooking of the books. Exactly what has MIA done to exert pressure to lower costs. If nothing, or inconsequential pressure on companies, then MIA has violated the spirit of the legislation and cannot be a fair arbiter of consumer protection in setting premium rates.

Medical costs and medical inflation have remained low in recent years; that cannot be the reason for accelerating cost benefit justification. This should well offset the low interest rates possible in fixed income accounts of premiums paid in.

Covid deaths in nursing homes removed many policy holders from active or future claims short of any projections. This, and the lowering of life expectancy, should have had a downward impact on last year claims or projections of 2020/21 cost tabulations for upcoming rate reviews. To what extent has the accelerated 315% premium rate justification incorporated such mortality, morbidity, and life expectancy already or will in the next year?

It is clear that MIA failed to properly review all the underlying assumptions in the rate structure. They, as well as Genworth, should be held accountable for the failures which are now costing consumers many thousands of dollars a year more than they could have expected in their wildest nightmares to encounter from the possibility of minor adjustments in rates down the road. Neither undertook due diligence in their actions, starting with initial premium rate setting. There is no evidence that an independent actuary thoroughly reviewed ALL of the cost, benefit, projections, and Genworth background financial status when premium rates were initially set. Nor was this evident at the 2016 and 2017 hearings. Both parties should be held accountable for their failures. MIA has a conflict of interest in reviewing any of these rates given their own consumer protection failures in the 1990s that left consumers holding the bag for either exorbitant cost increases or policies that need to be downgraded to the point where they no longer protect individuals from financial ruin upon need for extensive and expensive daily LTC.

CONCLUSION: GENWORTH'S AMBIGUOUS AND UNDERDOCUMENTED FINANCIAL STATUS INFORMATION AND JUSTIFICATIONS FOR EXTRAORDINARY PREMIUM INCREASES DO NOT MERIT CONTINUING AWARDS OF PREMIUM INCREASES BECAUSE THERE IS NO CERTAINTY FROM HIDDEN FIGURES THAT THESE PREMIUM INCREASES ARE ACTUALLY JUSTIFIED YEAR-AFTER-YEAR. MIA HAS NOT EXTENDED DUE DILIGENCE FROM THE 1990S FORWARD IN EXPOSING THESE AMBIGUITIES. CONSUMERS NEED MORE EFFECTIVE CONSUMER PROTECTION THAN MERE ALLOWANCE FOR CONVERSION DOWNGRADES THAT MAY NOT HELP FINANCIALLY-SCRAPPED CONSUMERS IN THE LONG RUN AND MAY ACTUALLY LEAD TO HIGHER PREMIUMS THAN NOT CONVERTING, BASED ON THE MANNER THAT GENWORTH HAS PRICED CONVERSIONS. CONTROL OVER THE ENTIRE PREMIUM RATE REVIEW PROCESS SHOULD BE TURNED OVER THE ATTORNEY GENERAL CONSUMER PROTECTION DIVISION. FURTHERMORE, INVESTIGATION OF ANY ETHICS VIOLATIONS FAVORING INSURANCE COMPANIES SHOULD BE EXAMINED BY THAT DIVISION AS TO HOW/WHY THIS IS ALL HAPPENING IN THE MANNER RECENTLY UNFOLDING, LET ALONE SINCE THE GROSSLY-FAULTY RATES WERE APPROVED DECADES AGO.

signature on original

Marshall Fritz
Wheaton, MD
Genworth LTC Policy Holder



Long Term Care Insurance

March 30, 2021

from Genworth Life Insurance Company

Genworth Life
P.O. Box 40005
Lynchburg, VA 24506

Insured
MR MARSHALL S FRITZ

Policy number

██████████

Customer service
800 456.7766
M-TH: 8:30 – 6PM ET
F: 9-6PM ET
Fax: 800 876.8220
genworth.com

MR MARSHALL S FRITZ
██████████ RAMPART WAY
WHEATON, MD 20902

Dear MR MARSHALL S FRITZ,

Thank you for choosing Genworth for your long term care insurance needs.

On 11/26/2020, we sent you a premium change notice informing you that your long term care insurance policy premiums would increase. We recently discovered an error in our notice.

The information we provided included, for example, your new premium, the percentage of the increase, and options for adjusting your coverage. This information was correct.

However, we also informed you about our plans to seek *future* rate increases in addition to the one we were implementing with our notice. We incorrectly informed you that, as of the date shown in the notice, we planned to seek at least 160% in additional rate increases on your policy.

We should have instead informed you that, as of the date shown in the notice, we planned to seek at least 315% in additional rate increases on your policy. Again, the actual increases we seek may differ, and planned rate increases will take effect only as permitted by the applicable state insurance department and state law.

We regret any confusion or inconvenience this may have caused. If you have any questions, or if this information causes you to reconsider your recent decision to adjust your coverage, please call our Customer Service Team at the above number within 60 days of this letter.

Sincerely,

Long Term Care Customer Service

4/25/16

Selected bulleted passages from Marshall Fritz's Complaint to MIA on Genworth and MIA premium rate increases.

- In the pamphlet from GE Financial that I received upon opening my policy, "Important Information About Long Term Care Insurance Premiums from GE Insurers", under the heading "How do insurers determine the premium rates they charge", is stated:
"Factors taken into account in determining price included: benefits expected to be paid, **percentage of policies expected to lapse, ..., investment returns on the insurer's general account assets,....**

(Therefore, in their own words, any rate increases MUST also focus on not just the low interest rates on reserves from premiums after the rates dropped 10 years ago, but ALSO whatever other investments the ENTIRE GE Capital/Genworth (general account assets of the insurer's entire) portfolio contained and how well they performed at times when the market was very hot for other types of investments.)

Indeed, GE Financial also states in "Important Information About Long Term Care Insurance Premiums from GE Insurers", under the heading "Can premiums increase over the life of my policy?":

"Our goal has been to price our long term care insurance policies so that premiums will remain at original levels for the duration of the policies...."

"The NAIC Long Term Care Insurance Model Regulation also includes a rigorous process for rate increase filings. **Actuaries must explain which pricing assumptions are not being realized and why, and cite any other actions being taken by the insurer.**

The only other actions taken by the insurer appear to be allowing customers to make certain downgradings in their policy benefits in order to lower premiums to stave off the increases in premiums. Doing so provides no onus against the carrier and just puts customer into a pricing strategy that may be inferior to those who took out such lower/downgraded benefits from the start, after paying premiums for greater benefits for years.

- Lack of acknowledged corrections by Genworth for improper modeling projections
 - What did Genworth know about parameters that it had not modeled accurately from the inception years decades ago, when it should have known at the latest that the models were not accurate on such critical aspects as lapse rates being in actuality below 1% instead of 5% annually, and
 - What did it do to timely correct for these inaccuracies in original policy pricings subsequently and need for premium increases in a timely manner – not just decades later with greater negative impacts on policy holders?

Of note is a Kiplinger January 2011 article entitled "Long-Term-Care Rate Hikes Loom", which may even underestimate the overall lapses because 5% annual lapse rates suggest that almost everyone would drop their policies within 20 years.

“Genworth says that it needs to boost rates because more people are keeping their policies in force than the company originally expected. “We priced these policies expecting to have a large number of them lapse,” says Beth Ludden, senior vice-president of product development for Genworth.”

- It would appear that MIA did not use due diligence in vetting out appropriate assumptions at each stage in time where detailed assumptions by Genworth were not appropriate or best industry practice? Factor (4) that is to be used in reviewing pricing is “Concentration of experience within early policy duration”. What was reported on lapse rates and what did MIA do when it learned about experience with early policy duration? It appears MIA did nothing when they should have known of the overly-aggressive lapse rate projection estimates, grossly overly-aggressive estimates.
- Consumers are not given information on their demographic assumptions and where the demographics no longer mesh with the original policy pricing models. It is not even clear if Genworth is using standard demographics and care usage such as published by CMS, Census, or BLS, or similar authoritative source in their analyses.
- The actual impact of low interest rates is conflated by the probable underpricing of the premiums from the start. Thus, the impact of low earnings from recent interest rates cannot be separated from any underpricing in initial premiums when interest rates were substantially higher and would have generated considerably more reserves for Genworth. Furthermore, low interest rates are balanced by the low inflation of recent years that would impact the costs of LTC services.
- The underpricing decades ago on totally-unrealistic and overly-aggressive lapse rates should be corporate responsibility, not consumer responsibility for bait and switch to higher premiums as a result. The past critical errors by Genworth should not be entirely shouldered decades later solely by policy holders who are mostly retired.
- The Genworth campaign for policy holders to downgrade their policies whenever there is an increase is probably not one in the interest of consumers as it unravels with endless 15% increases. Customer help with downgrading each year belies the likely fact that repeated downgradings on a cyclical basis may cost that consumer, or all Genworth policy holders, more in the long term than would be the case with a downgrade based on cumulative premium increases for this whole cycle of increases. All increases are modeled on the previous benefit levels two years or so earlier, not the costs to Genworth of benefits with the assumptions of consumer downgrading to lower premiums. Thus, Genworth may insidiously be reaping extra premiums for those who downgrade each year.
- Neither the consumer nor MIA has any way to judge the expectation for future increases because Genworth currently need not provide to either a complete, formal picture of what it sees as its justifiable needs for all increases. Therefore, neither the consumer nor MIA

can fully plan ahead the impact. Piecemeal increases in such a situation only serve to confuse the problem and wash out the impact of 15% increases in any given year. .

- Based on the Oct. 2016 hearing, it would appear that MIA does not typically receive all the assumptions that go into the company models, not just for the current year increase but whether there has been a cumulative problem aggravated by inaccurate assumptions in all past years since policies were issued. The impact of that inaccurate assumptions on lapse rates, for example, does not just stop in the first year of the policy, but cascades and accelerates in future years that cannot just be taken out of context for cost justification in the whole history of premium pricing.
- The sudden claims of need for premium increases starting earlier in this decade, after years of saying Genworth has never increased premiums, make the issue of the nature of the sudden increases one of monumental proportions. Why are all/most of the carriers seeking premium increases at the same time starting around 2011? They should have foreseen a problem long before solely based on lapse rate misassumptions, but failed to report timely. Is this collusion?
- At the October 2016 hearing, MIA termed the latest proposed increase of 15% 'premium rate stabilization'. This is actually rate 'destabilization.' It appears that Genworth expects to receive approval on the premium increases without much further ado than appearing for a few minutes in a hearing without hard numbers provided in evidence. Customers have no information that MIA has sought any details to support the claim of justifying 15% increase, or sought additional information after the hearing.
- If a current year balance sheet is all that is provided to MIA, it is woefully inadequate to justify why there were not adequate reserves from inception of the policies and the accuracy of the assumptions used to justify pricing all the way back to the present. I.e., how the unrealistic lapse rates at the time of policy inception impacts the balance sheets currently.
- What is needed is the complete history of GE Capital/Genworth general account investments for increases or movements internally, not just the history of recent low-rate guaranteed fixed-income assets for its LTC reserves, using the original consumer brochure's words. And, similarly, how the carrier has distributed resources, including profits, amongst its divisions. Has LTC been treated as an orphan product while funds were shifted into supporting other products of its choosing in order to make the LTC balance sheets look even worse?
- The 'Loss Ratio' issue looms large as to whether the premium rate increases are paying for claims benefit outlays – or something else. As a reward for underpricing policies and using grossly unrealistic lapse rates in its projections for years, Genworth can now continue to increase its administrative overhead/profit ratio each year in an accelerating manner, while claiming to return 60% to claimant benefits, and in a manner out of the purview of consumers and perhaps MIA, alike. It is doubtful that Genworth needs to have allowed administrative overhead twice or more over what it priced its policies at,

✓ when considered for the level of increases the premiums this decade are leading to, unless it was negligent with realistic pricing models from the start. There is no accounting for internal transfers of funds within Genworth so far. Genworth should not increase its overhead, general investment account profits, and shareholders dividends at a time when it failed to provide protection to its policy holders on matters such as lapse rates and proper pricing from the inception of the policies.

✓ To a great extent, these administrative costs have little to do with expediting payment of just claims and, in fact, may go towards greater expenditures in trying to extinguish claims or paying shareholders.

- The impact of policy downgradings on future cost projections and premium rate increases is uncertain. What happens to the funds that the carrier is saving from not paying on downgraded benefits? This is unknown to the consumer. The projection models may be insensitive to dynamics which would favor the consumer in future premium increases and are designed to increase profit rather than lower future premium increases.
- ✓ • At the Oct. 2015 hearing, Ms. Elana Edwards of Genworth testified that Genworth 'employed the best estimates at the time of pricing'. However, this is debatable, especially in terms of lapse rates, given the NAIC admission during the 1990s that the industry used overly aggressive lapse rates, combined with the Genworth CEO's 2016 published interview that 5% lapse rates were used when experience showed less than 1% lapse rates. Without proper, timely corrections immediately headed towards realistic lapse rates, her statement, and the whole history of premium rate increases, becomes dubious.
- The timing of the industry-wide requests for premium rate increases of such exorbitant proportions only over the last few years deserves attention not just to Genworth. All these carriers should be investigated to see if
 - they colluded in any manner to lead to the current situations on premiums,
 - ✓ ○ whether intentional underpricings in years past occurred,
 - ✓ ○ whether they were waiting out until recent years when policy holders can hardly begin to look again for carriers years later, or
 - ✓ ○ whether faulty parameters being used across carriers that would appear to justify their costs but which would suggest series of questionable models being proffered to State Regulators.

LONG-TERM CARE INSURANCE MODEL REGULATION

EXCERPTS Compiled by Marshall Fritz upon review of the entire NAIC Model Regulation 2014 package, including historical commentary from the NAIC regulatory review records included within the document posted on the MIA site.

Emphasis added by Marshall Fritz.

These passages were cut & pasted into a separate WORD document and, while the indexing numbering corresponds to the original index numbering/letting, the tabbing is imperfectly undertaken visually even though the excerpted content faithfully copies the cited paragraphs and subparagraphs.

Section 4. Definitions

B. (1) **“Exceptional increase” means only those increases filed by an insurer as exceptional for which the commissioner determines the need for the premium rate increase is justified:**

- (a) Due to changes in laws or regulations applicable to long-term care coverage in this state; or
- (b) Due to increased and unexpected utilization that affects the majority of insurers of similar products.

(2) Except as provided in Sections 20 and 20. 1, exceptional increases are subject to the same requirements as other premium rate schedule increases.

✓ (3) The commissioner may request a review by an independent actuary or a professional actuarial body of the basis for a request that an increase be considered an exceptional increase.

✓ (4) The commissioner, in determining that the necessary basis for an exceptional increase exists, shall also determine any potential offsets to higher claims costs.

Drafting Note: The commissioner may wish to review the request with other commissioners.

Section 10. Initial Filing Requirements

A. This section applies to any long-term care policy issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] except that Subsection B(2)(d) and Subsection B(3) apply to any long-term care policy issued in

this state on or after [insert date that is six (6) months after adoption of the amended regulation].

- B. An insurer shall provide the information listed in this subsection to the commissioner [30 days] prior to making a long-term care insurance form available for sale.

Drafting Note: States should consider whether a time period other than 30 days is desirable. An alternative time period would be the time period required for policy form approval in the applicable state regulation or law.

- (1) A copy of the disclosure documents required in Section 9; and
- (2) An actuarial certification consisting of at least the following:
 - (a) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;
 - (b) A statement that the policy design and coverage provided have been reviewed and taken into consideration;
 - (c) A statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;
 - (d) A statement that the premiums contain at least the minimum margin for moderately adverse experience defined in (i) or the specification of and justification for a lower margin as required by (ii).
 - (i) A composite margin shall not be less than 10% of lifetime claims.
 - (ii) A composite margin that is less than 10% may be justified in uncommon circumstances. The proposed amount, full justification of the proposed amount and methods to monitor developing experience that would be the basis for withdrawal of approval for such lower margins must be submitted.
 - (iii) A composite margin lower than otherwise considered appropriate for the stand-alone long-term care policy may be justified for long-term care benefits provided through a life policy or an annuity contract. Such lower composite margin, if utilized, shall be justified by appropriate actuarial demonstration addressing margins and volatility when considering the entirety of the product.

Drafting Note: For the justification required in (iii) above, examples of such considerations, if applicable to the product and company, might be found in Society of Actuaries research studies entitled "Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance" (2012) and "Understanding the Volatility of Experience and Pricing Assumptions in Long-Term Care Insurance Programs" (2014).

- (iv) A greater margin may be appropriate in circumstances where experience to support its ed to determine the premium rates.
- (e)
 - (i) A statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or
 - (ii) A comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

Drafting Note: In the event a series of increases is being applied to another policy form, intermediate premium levels are not to be used in this comparison.

Drafting Note: It is not expected that the insurer will need to provide a comparison of every age and set of benefits, period of payment or elimination period. A broad range of expected combinations is to be provided in a manner designed to provide a fair presentation for review by the commissioner.

- (f) A statement that reserve requirements have been reviewed and considered. Support for this statement shall include:
 - (i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held; and
 - (ii) A statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or if such a statement cannot be made, a complete description of the situations where this does not occur. An aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship.
- (3) An actuarial memorandum prepared, dated and signed by a member of the Academy of Actuaries shall be included and shall address and support each specific item required as part of the actuarial certification and provide at least the following information:
 - a. An explanation of the review performed by the actuary prior to making the statements in Paragraph (2)(b) and (c),
 - b. A complete description of pricing assumptions; and
 - c. Sources and levels of margins incorporated into the gross premiums that are the basis for the statement in Paragraph (2)(a) of the actuarial certification and an explanation of the analysis and testing performed in determining the sufficiency of the margins. Deviations in margins between ages, sexes, plans or states shall be clearly described. Deviations in margins required to be described are other than those produced utilizing generally accepted actuarial methods for smoothing and interpolating gross premium scales.

C. In any review of the actuarial certification and actuarial memorandum, the commissioner may request review by an actuary with experience in long-term care pricing who is independent of the company. In the event the commissioner asks for additional information as a result of any review, the period in Subsection B does not include the period during which the insurer is preparing the requested information.

Drafting Note: The commissioner may accept a review done for another state or states if such review is for the same policy form or where any differences in benefits and premiums are not material within eighteen months of the date of the actuarial certification in Subsection B(2) above.

Section 19. Loss Ratio

- A. **This section shall apply to all long-term care insurance policies or certificates except those covered under Sections 10, 20 and 20. 1.**
- B. **Benefits under long-term care insurance policies shall be deemed reasonable in relation to premiums provided the expected loss ratio is at least sixty percent (60%), calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:**
- (1) Statistical credibility of incurred claims experience and earned premiums;**
 - (2) The period for which rates are computed to provide coverage;**
 - (3) Experienced and projected trends;**
 - (4) Concentration of experience within early policy duration;**
 - (5) Expected claim fluctuation;**
 - (6) Experience refunds, adjustments or dividends;**
 - (7) Renewability features;**
 - (8) All appropriate expense factors;**
 - (9) Interest;**
 - (10) Experimental nature of the coverage;**
 - (11) Policy reserves;**
 - (12) Mix of business by risk classification; and**
 - (13) Product features such as long elimination periods, high deductibles and high maximum limits.**

Section 20. Premium Rate Schedule Increases

Drafting Note: Section 20 applies to policies issued for effective dates prior to the date that is six (6) months after adoption of the amended regulation incorporating Section 20. 1 (as adopted by the NAIC in 2014). Policies issued on or

after that date should adhere to the requirements of Section 20. 1 instead of Section 20. Section 20 and Section 20. 1 are identical with the exceptions of Subsections A, C and G.

A. This section shall apply as follows:

- (1) Except as provided in Paragraph (2), this section applies to any long-term care policy or certificate issued in this state on or after [insert date that is 6 months after adoption of the amended regulation] and prior to [insert date that is six (6) months after adoption of the amended regulation incorporating Section 20. 1].
- (2) For certificates issued on or after the effective date of this amended regulation under a group long-term care insurance policy as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act], which policy was in force at the time this amended regulation became effective, the provisions of this section shall apply on the policy anniversary following [insert date that is 12 months after adoption of the amended regulation].

B. An insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least [30] days prior to the notice to the policyholders and shall include:

Drafting Note: In states where the commissioner is required to approve premium rate schedule increases, "shall provide notice" may be changed to "shall request approval." States should consider whether a time period other than 30 days is desirable. An alternate time period would be the time period required for policy form approval in the applicable state regulation or law.

(1) Information required by Section 9;

(2) Certification by a qualified actuary that:

- (a) If the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated;
- (b) The premium rate filing is in compliance with the provisions of this section;
- (c) The insurer may request a premium rate schedule increase less than what is required under this section and the commissioner may approve such premium rate schedule increase, without submission of the certification in Subparagraph (a) of this paragraph, if the actuarial memorandum discloses the premium rate schedule increase necessary to make the certification required under Subparagraph (a) of this paragraph, the premium rate schedule increase filing satisfies all other requirements of this section, and is, in the opinion of the commissioner, in the best interest of policyholders.

Drafting Note: In any comparison of premiums under Section 10. B(2)(e) or Section 20. B(4), such lower premium or any subsequent higher premium based on a series of increases should not be used.

(3) An actuarial memorandum justifying the rate schedule change request that includes:

- (a) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase; and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale;
- (i) Annual values for the five (5) years preceding and the three (3) years following the valuation date shall be provided separately;
 - (ii) The projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;
 - (iii) The projections shall demonstrate compliance with Subsection C; and
 - (iv) For exceptional increases,
 - (I) The projected experience should be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase; and
 - (II) In the event the commissioner determines as provided in Section 4A(4) that offsets may exist, the insurer shall use appropriate net projected experience;
- (b) Disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;
- (c) Disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;
- (d) A statement that policy design, underwriting and claims adjudication practices have been taken into consideration;
- (e) In the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, the insurer will need to file composite rates reflecting projections of new certificates; and
- (f) A demonstration that actual and projected costs exceed costs anticipated at the time of initial pricing under moderately adverse experience and that the composite margin specified in Section 10B(2)(d) is projected to be exhausted.
- (4) A statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

- (5) Sufficient information for review [and approval] of the premium rate schedule increase by the commissioner.

C. All premium rate schedule increases shall be determined in accordance with the following requirements:

- (1) Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits;
- (2) Premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:
 - (a) The accumulated value of the initial earned premium times fifty-eight percent (58%);
 - (b) Eighty-five percent (85%) of the accumulated value of prior premium rate schedule increases on an earned basis;
 - (c) The present value of future projected initial earned premiums times fifty-eight percent (58%); and
 - (d) Eighty-five percent (85%) of the present value of future projected premiums not in Subparagraph (c) on an earned basis;
- (3) In the event that a policy form has both exceptional and other increases, the values in Paragraph (2)(b) and (d) will also include seventy percent (70%) for exceptional rate increase amounts; and
- (4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in the [insert reference to state equivalent to the Health Insurance Reserves Model Regulation Appendix A, Section IIA]. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

✓ D. For each rate increase that is implemented, the insurer shall file for review [approval] by the commissioner updated projections, as defined in Subsection B(3)(a), annually for the next three (3) years and include a comparison of actual results to projected values. The commissioner may extend the period to greater than three (3) years if actual results are not consistent with projected values from prior projections. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

✓ E. If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in Subsection B(3)(a), shall be filed for review [approval] by the commissioner every five (5) years following the end of the required period in Subsection D. For group insurance policies that meet the conditions in Subsection K, the projections required by this subsection shall be provided to the policyholder in lieu of filing with the commissioner.

F. (1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in Subsection C, the commissioner may require the insurer to implement any of the following:

- (a) Premium rate schedule adjustments; or
- (b) Other measures to reduce the difference between the projected and actual experience.

Drafting Note: The terms "adequately match the projected experience" include more than a comparison between actual and projected incurred claims. Other assumptions should also be taken into consideration, including lapse rates (including mortality), interest rates, margins for moderately adverse conditions, or any other assumptions used in the pricing of the product. It is to be expected that the actual experience will not exactly match the insurer's projections. During the period that projections are monitored as described in Subsections D and E, the commissioner should determine that there is not an adequate match if the differences in earned premiums and incurred claims are not in the same direction (both actual values higher or lower than projections) or the difference as a percentage of the projected is not of the same order.

(2) In determining whether the actual experience adequately matches the projected experience, consideration should be given to Subsection B(3)(e), if applicable.

G. If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the

commissioner may impose the condition in Subsection H of this section; and

(2) The original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to Subsection C had the greater of the original anticipated lifetime loss ratio or fifty-eight percent (58%) been used in the calculations described in Subsection C(2)(a) and (c).

H. (1) For a rate increase filing that meets the following criteria, the commissioner shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the twelve (12) months following each increase to determine if significant adverse lapsation has occurred or is anticipated:

- (a) The rate increase is not the first rate increase requested for the specific policy form or forms;
- (b) The rate increase is not an exceptional increase; and
- (c) The majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse

(2) In the event significant adverse lapsation has occurred, is anticipated in the filing or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, the commissioner may determine that a rate spiral exists. Following the determination that a rate spiral exists, the commissioner may require the insurer to offer, without underwriting, to all in force insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

a. The offer shall:

i. Be subject to the approval of the commissioner;

ii. Be based on actuarially sound principles, but not be based on attained age; and

iii. Provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

b. The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

i. The maximum rate increase determined based on the combined experience; and

ii. The maximum rate increase determined based only on the experience of the insureds originally issued the form plus ten percent (10%).

I. If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the commissioner may, in addition to the provisions of Subsection H of this section, prohibit the insurer from either of the following:

Drafting Note: States may want to consider examining their statutes to determine whether a persistent practice of filing inadequate initial premium rates would be considered a violation of the state's unfair trade practice act and subject to the penalties under that act.

(1) Filing and marketing comparable coverage for a period of up to five (5) years; or

(2) Offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

J. Subsections A through I shall not apply to policies for which the long-term care benefits provided by the policy are incidental, as defined in Section 4C, if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, are guaranteed not to

be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy;

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirements as applicable in any of the following:

(a) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Life Insurance];

(b) [Cite state's standard nonforfeiture law similar to the NAIC's Standard Nonforfeiture Law for Individual Deferred Annuities], and

(c) [Cite state's section of the variable annuity regulation similar to Section 7 of the NAIC's Model Variable Annuity Regulation];

(3) The policy meets the disclosure requirements of [cite appropriate sections in the state's long-term care insurance law similar to Section 6L, 6J, and 6K of the NAIC's Long-Term Care Insurance Model Act];

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements as applicable in the following:

(a) Policy illustrations as required by [cite state's life insurance illustrations regulation similar to the NAIC's Life Insurance Illustrations Model Regulation];

(b) Disclosure requirements in [cite state's annuity disclosure regulation similar to the NAIC's Annuity Disclosure Model Regulation]; and

(c) Disclosure requirements in [cite state's variable annuity regulation similar to the NAIC's Model Variable Annuity Regulation].

(5) An actuarial memorandum is filed with the insurance department that includes:

a. A description of the basis on which the long-term care rates were determined;

b. A description of the basis for the reserves;

c. A summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

d. A description and a table of each actuarial assumption used. For expenses, an insurer must include percent of premium dollars per policy and dollars per unit of benefits, if any;

- e. A description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;
- f. The estimated average annual premium per policy and the average issue age;
- g. A statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used and, if used, the statement shall include a description of the type or types of underwriting used, such as medical underwriting or functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting occurs; and
- h. A description of the effect of the long-term care policy provision on the required premiums, nonforfeiture values and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

K. Subsections F and H shall not apply to group insurance policies as defined in Section [insert reference to Section 4E(1) of the NAIC Long-Term Care Insurance Model Act] where:

- (1) The policies insure 250 or more persons and the policyholder has 5,000 or more eligible employees of a single employer; or
- (2) The policyholder, and not the certificateholders, pays a material portion of the premium, which shall not be less than twenty percent (20%) of the total premium for the group in the calendar year prior to the year a rate increase is filed.

Section 20. 1 Premium Rate Schedule Increases for Policies Subject to Loss Ratio Limits Related to Original Filings.

Drafting Note: Section 20. 1 applies to policies issued for effective dates on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20. 1 (as adopted by the NAIC in 2014. Policies issued prior to the adoption of the amended regulation incorporating Section 20. 1 shall continue to adhere to the requirements of Section 20. 1 as amended in 2014. Policies issued on or after the date that is six (6) months after adoption of the amended regulation incorporating Section 20. 1 are identical with the exception of Subsections A, C and G.

Section 28. Nonforfeiture Benefit Requirement

- A. This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.
- B. To comply with the requirement to offer a nonforfeiture benefit pursuant to the provisions of [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act]:
 - 1. A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers and benefit length that are the same as

coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefit described in subsection E; and

2. The offer shall be in writing if the nonforfeiture benefit is not otherwise described in the Outline of Coverage or other materials given to the prospective policyholder.

C. If the offer required to be made under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act] is rejected, the insurer shall provide the contingent benefit upon lapse described in this section. Even if this offer is accepted for a policy with a fixed or limited premium paying period, the contingent benefit on lapse in Subsection D(4) shall still apply.

D.

(1) After rejection of the offer required under [insert reference to Section 8 of the NAIC Long-Term Care Insurance Model Act], for individual and group policies without nonforfeiture benefits issued after the effective date of this section, the insurer shall provide a contingent benefit upon lapse.

(2)

In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificateholder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(3) A contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age / Percent Increase Over
Initial Premium

29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%

68 44%

Triggers for a Substantial Premium Increase

<u>Issue Age /</u>	<u>Percent Increase Over</u> <u>Initial Premium</u>
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69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

- (4) A contingent benefit on lapse shall also be triggered for policies with a fixed or limited premium paying period every time an insurer increases the premium rates to a level that results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, the policy or certificate lapses within 120 days of the due date of the premium so increased, and the ratio in Paragraph (6)(b) is forty percent (40%) or more. Unless otherwise required, policyholders shall be notified at least thirty (30) days prior to the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

<u>Issue Age /</u>	<u>Percent Increase</u> <u>Over Initial Premium</u>
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Under 65	50%
65-80	30%
Over 80	10%

This provision shall be in addition to the contingent benefit provided by Paragraph (3) above and where both are triggered, the benefit provided shall be at the option of the insured.

- (5) On or before the effective date of a substantial premium increase as defined in Paragraph (3) above, the insurer shall:
- a. Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 27 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

- b. Offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of Subsection E. This option may be elected at any time during the 120-day period referenced in Subsection D(3); and
 - c. Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(3) shall be deemed to be the election of the offer to convert in Subparagraph (b) above unless the automatic option in Paragraph (6)(c) applies.
- (6) On or before the effective date of a substantial premium increase as defined in Paragraph (4) above, the insurer shall:

- a. Offer to reduce policy benefits provided by the current coverage consistent with the requirements of Section 27 so that required premium payments are not increased;

Drafting Note: The insured's right to reduce policy benefits in the event of the premium increase does not affect any other right to elect a reduction in benefits provided under the policy.

- b. Offer to convert the coverage to a paid-up status where the amount payable for each benefit is ninety percent (90%) of the amount payable in effect immediately prior to lapse times the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period. This option may be elected at any time during the 120-day period referenced in Subsection D(4); and
 - (c) Notify the policyholder or certificateholder that a default or lapse at any time during the 120-day period referenced in Subsection D(4) shall be deemed to be the election of the offer to convert in Subparagraph (b) above if the ratio is forth percent (40%) or more.
- (7) For any long-term care policy issued in this state on or after [insert date that is six (6) months after adoption of the amended regulation].

- a. In the event the policy or certificate was issued at least twenty (20) years prior to the effective date of the increase, a value of 0% shall be used in place of all values in the above table; and
- b. Values above 100% in the table in Paragraph (3) above shall be reduced to 100%.

LONG-TERM CARE INSURANCE MODEL REGULATION

(8) Cited Citations

(9) Cited ngs of the NAIC

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Section 6D

F. The task force first considered proposals which would place a cap on the amount of increase in rates allowed in 1991. They were concerned that low prices would be charged for younger ages with dramatic increases later; and also concerned, on the other hand, with solvency issues. **1992 Proc. IB 986.**

The task force decided the issue of rate caps was tied to the nonforfeiture issue. However, the task force could discuss prohibiting attained age rating and adopted such a provision in 1991. **1992 Proc. IB 983.** The proposal adopted is now Section 6F(1). **1992 Proc. IB 970-971.**

When reviewing the draft of the new paragraph, one individual inquired whether age 65 was an absolute cut-off or whether those who continue to work until a later age should be excluded. After some discussion the task force concluded the cap should be set at 65. **1992 Proc. IB 960.**

One industry attendee at the task force meeting stated that the draft implies that rate adjustments for policies issued to individuals beyond age 65 are not allowed. An NAIC staff member responded ake sure the rate structure does not actually display increases based on either age or duration. **1992 Proc. IB 961.**

Section 6F

Section 6F (cont.)

After adoption of the amendment on attained age and durational rating, the task force continued to consider rate stabilization a high priority. **1992 Proc. IIB 688.**

The task force agreed to consider the concept of an annual and lifetime rate cap. A consumer representative stated that rate stabilization was of considerable public policy importance. One regulator commented that the task force should consider the long tail of these policies and the budget consequences. Another consumer representative emphasized that currently the risk is being placed entirely on the consumer who is unable to evaluate it. **1992 Proc. IIB 695.**

The working group members considered several discussion drafts distributed by interested parties. One was the development of a "dynamic" grid, which would contain basic assumptions regulators could use in reviewing long-term care insurance rate filings. A regulator suggested the approach of rate caps for certain ages and proposed a 50% lifetime cap and a 5% per year cap for policyholders over the age of 70. The working group agreed to consider other approaches to rate stabilization also. **1993 Proc. IB 851-852.**

A consumer representative listed several concerns he thought should receive consideration by the task force: (1) "low balling" (setting an artificially low initial rate and then increasing the premium significantly), (2) rate shock and the effect of lapses at all ages, (3) the predictability of rates, and (4) solvency due to the long tail of claims. Several attendees at the meeting urged the task force to undertake a full discussion of the principles and not rush into anything. Others told of rate increases r individuals over 80 years of age and urged the task force to address the issue immediately. **1993 Proc. IB 841.**

The preliminary recommendation of the task force was to limit annual and lifetime increases to specified maximums. Several possible caps were mentioned, but it was suggested that any combination of annual and lifetime limits between 5/50% and 10/100% should give insurers sufficient latitude. If absolute caps are needed at the older ages, attained age 75 may be a reasonable compromise. In addition, the task force recommended that the prohibition against attained age rating in Section 6F(2)(d) be lowered from age 65 to age 50. **1993 Proc. 2nd Quarter 757.**

When they were ready to draft the language, the members expressed a preference for the following rate stabilization measures: (1) initial rate guarantees of three years, (2) rate increases thereafter are limited to 10% per year and subsequent increases will be limited to two-year increments, (3) aggregate rate increases are limited to 100% of the initial rate, (4) the commissioner may waive the rate restrictions upon the insurer's demonstration of imminent financial insolvency, and (5) premiums may not be increased once the policyholder reaches age 78 (issue age 75). **1993 3rd Quarter 466.**

In the discussions related to nonforfeiture and to rate stabilization, regulators and interested parties repeatedly emphasized the close relationship between these two concepts. **1993 Proc. 3rd Quarter 482.**

One regulator asked whether the intent of rate stabilization was to impose responsibility on the companies up front in pricing their policies, and the chair responded that certainly was one intent. Another regulator said the goal of rating restrictions was to force accountability for poor underwriting decisions and initial under-pricing of the product. In another listing of goals, the chair said a fundamental issue was protection of older policyholders from large increases when they can least afford them. **1993 Proc. 3rd Quarter 481.**

In considering whether or not to add a provision making the policy non-cancelable at a certain age, a representative of a trade association emphasized the industry's concern about cost shifting.

Consumer representatives spoke in favor of making a policy non-cancelable at age 80. The chair responded that a 10% cap on rate increases once the insured attains age 80 is a significant protection. One of the consumerists suggested adding a drafting note stating that the ultimate goal move toward a non-cancelable approach for all long-term care policies. **1993 Proc. 4th**

Quarter 711.

After discussion of options related to differing caps for group and individual policies, caps varying by age, as well as other variations, the working group decided to expose a draft with a five-year limit on rate increases, 25% for those under age 65, 15% for those age 65 through 79, and 10% for those policyholders age 80 and above, and removal of the lifetime cap on rate increases. The reasons for removing the lifetime cap were because the draft as proposed provided policyholders with sufficient protection and a lifetime cap would only serve to limit purchasing long-term care policies. **1993 Proc 4th Quarter 709.**

The actuary referred to the level payment principle and explained that a significant reserve is created during the early years of the policy, which is used to supplement the policy in later years when the annual premium is insufficient to fund the claims for that year. The theory behind lapse-supported pricing is that the fund amount is used so that premiums are lower for all policy years. He added that, if nonforfeiture is added to a policy, then more premium needs to be collected in order to pay off the nonforfeiture benefit upon lapse by the policyholder. **1997 Proc. 3rd Quarter 1351.**

A representative from an insurer described the rating problem from an insurance company's point of view. He said the key drivers of the premium rate increases were untested assumptions, using an inadequate rating structure such as the one used for Medicare supplement insurance, inadequate long-term care insurance experience, and using quinquennial age rate bands. These practices resulted in underpricing of policies by one third to one half. Also the first generation of long-term care insurance policies had higher utilization than expected. He said that underwriting practices have evolved substantially and he opined that now companies have better data and use less aggressive termination assumptions. **1997 Proc. 3rd Quarter 1351.**

An insurer representative said part of the solution to the rate stabilization problem was better upfront pricing. He said this is a fine line, because insurers do not want to price potential insureds out of the market, but the initial rates needed to be adequate to provide sufficient reserves for future benefits. A consumer representative expressed concern that consumers were buying the cheapest policy they could find, and then facing large rate increases later in the life of the policy. She also expressed concern that the insurers that do price adequately upfront are being squeezed out of the market because the premiums for their policies are more expensive. **1997 Proc. 3rd Quarter 1351.**

A regulator opined that unless the insurer is really motivated to keep rates stable through proper underwriting, using adequate assumptions and agent training, nothing will change. An interested party asked what could be used as a tool to motivate the company to set initial rates that are adequate. A trade association representative opined the idea of contingent nonforfeiture will change or tinkering with rates but discourage the large rate increases that rate stability is designed to prevent. **1997 Proc. 3rd Quarter 1353.**

A regulator stated there needed to be a distinction between the concepts of rate caps and rate stabilization. He said that the issue of rate stabilization could be defined as a collection of activities that will maximize the probability that premium rates will be unchanged for the life of the contract, provide maximum economic value to the insured, and encourage economic value and stability for insurers. **1997 Proc. 3rd Quarter 1342.**

The task force identified several different approaches that could be used separately or collectively to satisfy the need for rate stabilization. These methods could be directed at appropriate product design, product pricing, underwriting, claim adjudication, policy reserve levels and methodology, and consumer education. If, despite all reasonable efforts, rate increases became unmanageable for insureds, then those insureds should be given useable options for maintaining some level of long-term care insurance coverage. Another consequence of insured options and rate stabilization would be to encourage insurers to make every effort to prevent unmanageable premium increases. **1997 Proc. 3rd Quarter 1342.**

One regulator noted that a rate filing he had received referred to multiple rate increases that would be necessary in the future. Another regulator opined that initial premiums were being set too low it was a bait and switch tactic, which resulted in harm to consumers. **1997 Proc. 4th Quarter**

937.

Section 19. Loss Ratio

A. This subsection was included in the 2000 amendments. **2000 Proc. 1st Quarter 1109.**

The 2000 amendments eliminated the use of loss ratios for most policies. A regulator explained that currently companies use a fixed loss ratio, which is the ratio of claims to premiums, as a basis to calculate rates for long-term care insurance products. This fixed loss ratio method effectively establishes a cap on premiums that a company can charge and artificially limits initial premiums; however, by increasing claims, a company can increase expenses. The fixed loss ratio method creates an incentive for insurers to increase claims so they can receive higher expenses. This leads to rate increases in the future. **2000 Proc. 1st Quarter 335-336.**

Under the amendments adopted in 2000, there would not be a fixed loss ratio requirement on initial filings as is the current practice. However, penalties would be imposed in the future if there are rate increases. **2000 Proc. 1st Quarter 336.**

A regulator explained that, for an initial rate filing, the proposed change would apply to new policy forms filed after the effective date. For individuals the new rating system would apply only to new policies issued after the effective date of the amendments, which would include a new policy issued under the existing policy form. For groups, the proposal would apply to new policies issued after the

uld apply to new certificates issued under an
certain point in time. **2000 Proc. 1st Quarter 336.**

Eliminating the initial loss ratio in long-term care insurance rate filings was a major departure from current regulatory practice. Regulators believed that the current regulatory structure did not address the issue of inadequate initial pricing. With the package of amendments adopted in 2000, the incentives to price adequately are materially enhanced. **2000 Proc. 2nd Quarter 162.**

B. When the regulation was presented for adoption, the chair of the Long-Term Care Insurance Subgroup made special comments on the loss ratio provisions of the model regulation. **1988 Proc. I 652.**

The 60% loss ratio was of concern to the advisory committee, which felt it was high. They urged the addition of a drafting note and submission of the provision to the Life and Health Actuarial Task Force for review. **1988 Proc. I 711.**

The loss ratio section was originally conceived as an optional rating provision to serve as a benchmark for those states deciding to use loss ratios to determine reasonableness of benefits in n to premiums. However, that was changed before the regulation was adopted. **1988 Proc. I 0-661.**

Section 20. Premium Rate Schedule Increases

[See discussion of rate stabilization at the beginning of Section 9 for background information.]

✓ (10) A consumer advocate asked what is meant by “lifetime” as used in Paragraph (3) of this subsection. The chair responded that lifetime refers to the life of the policy form as opposed to the life of a single individual, and that it was common for carriers to use thirty to thirty-five years in the projections that they filed with the states. **2000 Proc. 2nd Quarter 1113.**

(11) While reviewing a first draft of the new Section 20, one regulator commented that the components of the ratios needed to be defined. **1999 Proc. 1st Quarter 801.**

The chair explained the new proposal: if an increase in rates was needed, 58% of the initial premium and 85% of the increased portion of the premiums must be available to cover claims on a lifetime present value basis. A regulator asked if this penalty structure would lead to all policies being noncancellable. The chair responded this would be ideal, but no insurer could issue noncancellable policies in today's marketplace because there is so much uncertainty. Another regulator asked about states that do not have actuaries on staff and the chair responded that it should be easier for those use the 58%—85% formula. 2000 Proc. 1st Quarter 336.

The derivation for the 58% loss ratio minimum was the traditional 60% loss ratio reduced by a 2% allowance for policy fee expenses. 2000 Proc. 2nd Quarter 1113.

G. A regulator noted that the approach in Section 20 seems to cap the number of rate increases instead of the initial premium filings. There was discussion about whether this might put an insurer out of business. An industry spokesperson disagreed, saying an insurer would go out s only if it filed inadequate initial rates on a continuous basis. 2000 Proc. 1st Quarter 336.

**MARYLAND INSURANCE ADMINISTRATION
COMPLAINT FORM**

Complaint Against Insurance Professionals or Authorized Insurance Assistance Personnel

This form is to be used by any person or entity that wishes to file a complaint against any licensed insurance professional or authorized insurance assistance personnel.

One of the primary roles of the Maryland Insurance Administration (MIA) is to protect consumers from illegal insurance practices by ensuring that insurance companies and insurance professionals that operate in Maryland act in accordance with State insurance laws.

The MIA:

- Provides consumer information and investigates consumer complaints against insurance companies and insurance professionals for most types of insurance.
- Works to respond promptly and completely to consumers' insurance-related questions and complaints, assist consumers in resolving those complaints whenever possible, and help consumers understand their options in handling insurance-related matters.

Submit the completed form via mail, fax, or email to:

Maryland Insurance Administration
Attn: **Consumer Complaint Investigation**
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Fax : (410) 468-2245
Email: enforcement.mia@maryland.gov

INFORMATION ABOUT YOU (Complainant)

First Name: Marshall Middle Initial: S Last Name: Fritz
 Address Line 1: [REDACTED] Rampart Way
 Address Line 2: _____
 City: Wheaton State: MD Zip: 20902
 Home Phone: 301 933-1621 Business Phone: _____
 Cell Phone: 240 472-3050 Email Address: marshfritz@att.net

INSURANCE PROFESSIONAL LICENSE TYPE -or- AUTHORIZED INSURANCE ASSISTANCE PERSONNEL AUTHORIZATION/CERTIFICATION TYPE (if known)

Insurance Professional License Type		or	Authorized Insurance Assistance Personnel Authorization/ Certification Type	
<input type="checkbox"/> Insurance Adviser	<input type="checkbox"/> Public Adjuster		<input type="checkbox"/> Individual Navigator	<input type="checkbox"/> SHOP Navigator
<input type="checkbox"/> Insurance Producer (Life/Health/Property/Casualty/ Title/Bail Bonds)		<input type="checkbox"/> Maryland Health Connection Call Center Employee		
<input type="checkbox"/> Third Party Administrator	<input type="checkbox"/> Viatical Settlement Broker	<input type="checkbox"/> Connector Entity	<input type="checkbox"/> Application Counselor Entity	
<input type="checkbox"/> Surplus Lines Broker	<input type="checkbox"/> Viatical Settlement Provider		<input type="checkbox"/> Application Counselor	

Name: _____ Phone: _____
 Email Address: _____ License Number: _____
 Agency / Entity the individual represents: _____
 Address Line 1: _____
 Address Line 2: _____
 City: _____ State: _____ Zip: _____

EXPLAIN YOUR PROBLEM/COMPLAINT

Have you filed a complaint with anyone else? Yes No If yes, with whom? _____

Please complete providing as much detail as possible (attach additional sheets if necessary).

Date of incident: 2017, 2016, 2015, 2014 and all the way back

Location of incident: Maryland to 2002 & 2003

Explain:
see attached complaint material regarding
Genworth and MIA LTC policy in
question is Genworth LTC [redacted]

Are you submitting supporting documents? Yes No If yes, please **DO NOT** send original documents, copies only please.

- A copy of the complaint form and any or all of the enclosed information that you provide to us may be sent to the party the complaint is directed against.
- A licensed insurance professional or other authorized insurance assistance personnel may not retaliate against a consumer or use the fact that a complaint has been filed as a sole reason for cancelling or refusing to renew or issue a policy.

Complainant Signature: [redacted] Today's Date: 1/23/17

To: Maryland Insurance Administration
Consumer Complaint Investigation
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Enforcement.mia@maryland.gov

This is a complaint from Marshall S. Fritz, Policy Number [REDACTED] on the premium increase notification from Genworth which arrived in December 2016 for application to the premium payment due in February 2017. While the complaint addresses the current increased premium, it equally addresses the whole history of the initial premium rate with the other two premium increases before the current one. And, this is occurring while Genworth has applied for an additional increase for which a hearing was held in October 2016.

Background of Complainant

I am a retired resident of Wheaton, Maryland, in Montgomery County, who originally purchased a Long Term Care Policy in Maryland in 2003 with GE Capital, now Genworth. At the time, I was a Survey Statistician for the U.S. Dept. of Health & Human Services.

I purchased my GE Capital/Genworth policy at a time when the Federal Government, my employer, was encouraging employees to buy such policies. It was also a time when the press also began emphasizing the purchase of such policies as prudent and responsible. The brunt of the focus on who should immediately purchase such a policy was on the baby-boomer generation as well as their parents. For the baby boomers, there was considerable discussion of the need to cover many years of potential long term care as lives were getting longer without bankrupting family finances, as well as the costs of private pay long-term care services in or out of an institution. Baby boomers, such as myself, sought to protect ourselves from the potential of becoming wards of the State by insuring ourselves at reasonable costs while still young. I understood that GE Capital was a company that was well-capitalized and did not have a history of raising rates for Long Term care policies.

In the pamphlet from GE Financial that I received upon opening my policy, "Important Information About Long Term Care Insurance Premiums from GE Insurers", under the heading "How do insurers determine the premium rates they charge", is stated:

✓ "Factors taken into account in determining price included: benefits expected to be paid, percentage of policies expected to lapse, marketing and sales costs, costs of administering policies, investment returns on the insurer's general account assets, mortality, morbidity, plan, option and demographic mis assumptions, as well as other factors.

"The National Association of Insurance Commissioners Long Term Care Insurance Model Regulation includes a rigorous process for rate filings...."

“Currently, in all but a few states, insurers must demonstrate at least 60% of premiums paid will be returned to policyholders in benefit payments over the lifetime of their policies.”

Note also that the discussion mentions ‘the insurer’s general account assets’, not merely returns on reserves from premiums invested in guaranteed short-term and fixed income securities. Therefore, in their own words, any rate increases MUST also focus on not just the low interest rates on reserves from premiums after the rates dropped 10 years ago, but ALSO whatever other investments the ENTIRE GE Capital/Genworth (general account assets of the insurer’s entire) portfolio contained and how well they performed at times when the market was very hot for other types of investments.

Indeed, GE Financial also states in “Important Information About Long Term Care Insurance Premiums from GE Insurers”, under the heading “Can premiums increase over the life of my policy?”:

“ Our goal has been to price our long term care insurance policies so that premiums will remain at original levels for the duration of the policies....

✓
✓
“The NAIC Long Term Care Insurance Model Regulation also includes a rigorous process for rate increase filings. Actuaries must explain which pricing assumptions are not being realized and why, and cite any other actions being taken by the insurer. It requires significantly higher loss ratio assumptions for the increased premiums than for the original premiums and reporting of actual to projected results for three years. Based on these reports, a regulator could direct rate adjustments, special replacement offers or other indicated remedies.

✓
Based on this information, combined with the arguments below, I do not believe that Genworth is entitled to this 15% increase, as part of the string of past 15% increases and the potentially endless string of 15% in the future without a showing that it was harmless to any negligence for projections modeling mistakes/inaccuracies in the past which have led to these exorbitant, continual increases. that it timely raised these issues of financial concern to customers and regulators, and that it is not unduly profiting from these mistakes going forward into the future under the guise of benefit cost increases supposedly needed.

Maryland has offered no ‘remedy’ to date, as their actions do not result in rate stabilization but rate instability into the future. Active policy holders have no remedy to date from MIA that they could not get from Genworth by seeking independently to downgrade their policies. Indeed, endless 15% increases may, in the long run, cost long-term, active policy holders additional monies based on the way pricing and projection of costs are handled by Genworth and MIA. It is debatable whether any relief is offered to these active long-term policy holders that is a concession for these consumers. Rather, it appears that what has been termed relief (such 15% increase jumps and required options to downgrade) are just another way of grandfathering the cost increases that have been built-in to the policies by having been underpriced originally. Indeed, as I demonstrate, such underpricing is likely to have been not so much from population and provider industry dynamics as by the vast impact of policy holders not lapsing their policies at unrealistically high levels Genworth projected, and, instead, consumers holding onto their

policies at rates that should have been expected to do from inception by the nature of the instrument.

Introduction to the Issues of the Complaint

The issues of the complaint are numerous. While the policy is with Genworth (originally GE Capital), this complaint applies to both Genworth and MIA for their failures of the past that have led to these premium increases which are incessant in recent years and appear to be based on errors and miscalculations that go well beyond the pricing of LTC in various venues and longevity. It is impossible to completely separate Genworth from MIA involvement in this complaint because there is an inference from available information that the oversight from MIA may not have caught questionable assumptions and practices from years back forward that have led to all of these recent increases, as well as future increases.

But, Genworth must respond in detail to show the policy holder that, despite due diligence on its part, the increases are necessary and justified. Indeed, in the GE Financial pamphlet, "Important Information About Long Term Care Insurance Premiums from GE Insurers" (Attachment 1), under the heading "Can premiums increase over the life of my policy?" is stated:

"Our goal has been to price our long term care insurance policies so that premiums will remain at original levels for the duration of the policies....

✓ "The NAIC Long Term Care Insurance Model Regulation also includes a rigorous process for rate increase filings. Actuaries must explain which pricing assumptions are not being realized and why, and cite any other actions being taken by the insurer. It requires significantly higher loss ratio assumptions for the increased premiums than for the original premiums and reporting of actual to projected results for three years. Based on these reports, a regulator could direct rate adjustments, special replacement offers or other indicated remedies.

In the spirit of these very noteworthy statements, I have a right to expect to obtain, and/or ensure that MIA receives, all the information pursuant to the GE Capital/Genworth promises and terms of its operations. These include, by GE Capital/Genworth's own words:

- Specific pricing assumptions not being realized,
- Any and all other actions being taken by the insurer to eliminate the need for rate increase filings,
- Reportings of actual to projected results for three years, and
- The justification for any increase with definitively 'significantly higher' loss ratio assumptions for the increased premiums. And, exactly what are the 'significantly higher' loss ratio assumptions.

If these terms from the carrier itself are not met, Genworth should not, and cannot, be granted the increases – based on their own filings with customers for the minimum they themselves offer to show to justify a premium increase. Indeed, Genworth testified at the October 2016 hearing of no 'significantly higher' loss ratio threshold assumption for the increased premiums than had been in place since the NAIC regulations that Maryland adopted two decades ago.

The increases are not even ceasing from the patterns of the last few years, but are based on questionable assumptions that are likely to lead on to further increases year-after-year, perhaps without end. Indeed, in October 2016, Genworth testified that future increases are needed by them.

The major points of complaint being raised here are summarized below, with further discussion throughout this complaint.

- What did Genworth know about parameters that it had not modeled accurately from the inception years decades ago, when it should have known at the latest that the models were not accurate, and
- What did it do to timely correct for these inaccuracies in original policy pricings subsequently and need for premium increases in a timely manner – not just decades later with greater negative impacts on policy holders?

If the answer puts the blame on Genworth, the policy holder should not be the one being penalized in all recent years of much/all of these premium increases since 2011. This is the heart of the underpricing, bait and switch, aspects for which policy holders are now penalized by exorbitant premium increases.

Of note is a Kiplinger January 2011 article entitled “Long-Term-Care Rate Hikes Loom”, there was general trends discussion as well as focus on Genworth. Policy specialist expert Bonnie Burns was quoted on the likely reactions of State Regulators receiving increase requests this decade, “They want the companies to prove that things are as bad as they say they are **and to explain why they didn’t know this sooner.**”

✓ “Genworth says that it needs to boost rates because more people are keeping their policies in force than the company originally expected. “We priced these policies expecting to have a large number of them lapse,” says Beth Ludden, senior vice-president of product development for Genworth.”..

“In the past, the large long-term-care insurers didn’t have much trouble getting their rate hikes approved because regulators were convinced that the increases were necessary to ensure that insurers had enough money to pay claims.

“But it might be tough to get approval for the rate hikes this time. “I think a lot of regulators are suspicious of this,” says Bonnie Burns, a policy specialist with California Health Advocates.

✓ “They want the companies to prove that things are as bad as they say they are **and to explain why they didn’t know this sooner.**”

Consequently, Genworth has to provide data that it has not made this situation worse by delaying years to report funding concerns to the point where the impact is far worse than had they raised issues with the States earlier regarding adequacy of rates and

administrative overhead component increases that can be as high as 40% of any rate increase.

Likewise, what did MIA know about Genworth's assumptions regarding each of the policy year issuance prices, as well as post-2011 price increases, and did MIA not use due diligence in vetting out appropriate assumptions at each stage in time where detailed assumptions by Genworth were not appropriate or best industry practice? Factor (4) that is to be used in reviewing pricing is "Concentration of experience within early policy duration". Was this done with due diligence by both Genworth and MIA in reviewing the premiums?

The following considerations need to be fleshed out quantitatively, not just in generalities, in order to fully justify these increases by Genworth:

- Demographic assumptions and mis-assumptions. Consumers are not given information on their demographic assumptions and where the demographics no longer mesh with the original policy pricing models. It is not even clear if Genworth is using standard demographics and care usage such as published by CMS, Census, or BLS, or similar authoritative source in their analyses.
- The actual impact of low interest rates is conflated by the probably underpricing of the premiums from the start. Thus, the impact of low earnings from recent interest rates cannot be separated from any underpricing in initial premiums when interest rates were substantially higher and would have generated considerably more reserves for Genworth. Furthermore, low interest rates are balanced by the low inflation of recent years that would impact the costs of LTC services.
- The historical, overly-aggressive estimates of lapse rates by Genworth and others have most likely been the driver for seeking cost increases. It is irrelevant whether they are currently using more realistic lapse rates – the premiums were originally priced on the assumptions that almost everyone drops their policy before coming of age for LTC utilization. The underpricing decades ago should be corporate responsibility, not consumer responsibility for bait and switch to higher premiums as a result. The past critical errors by Genworth should not be entirely shouldered decades later solely by policy holders who are mostly retired.
- The Genworth campaign for policy holders to downgrade their policies whenever there is an increase is probably not one in the interest of consumers as it unravels with endless 15% increases. Customer help with downgrading each year belies the likely fact that repeated downgradings on a cyclical basis may cost that consumer, or all Genworth policy holders, more in the long term than would be the case with a downgrade based on cumulative premium increases for this whole cycle of increases. The more the consumer is modeled as being at a higher tier, the higher the expected claim benefits are modeled. It would appear that continual, encouraged downgrading to keep premiums level may not be optimum for the average policy holder but advantageous to Genworth, both for its profit structures and for leading to additional future increases.

- Neither the consumer nor MIA has any way to judge the expectation for future increases because Genworth currently need not provide to either a complete, formal picture of what it sees as its justifiable needs for all increases. Therefore, neither the consumer nor MIA can fully plan ahead the impact. Piecemeal increases in such a situation only serve to confuse the problem and wash out the impact of 15% increases in any given year. Any statements of total additional premiums needed by Genworth are not formal statements and do not tie Genworth's hands for finality, long term or short term going forward. This makes a mockery of rational actions by the policy holder to downgrade the policy because of the confusion and uncertainty it breeds rather than settles.
- Based on the Oct. 2016 hearing, it would appear that MIA does not typically receive all the assumptions that go into the company models, not just for the current year increase but whether there has been a cumulative problem aggravated by inaccurate assumptions in all past years since policies were issued. So, if the data is not being clearly enumerated for model checking by MIA, MIA may not be able to truly approve the need for the increases. We know that lapse rates were grossly modeled by Genworth, and the impact of that inaccurate assumption does not just stop in the first year of the policy, but cascades and accelerates in future years that cannot just be taken out of context for cost justification in the whole history of premium pricing.
- The sudden claims of need for premium increases starting earlier in this decade, after years of saying Genworth has never increased premiums, make the issue of the nature of the sudden increases one of monumental proportions. It is doubtful that this would not have been foreseen before 2011 or so when the applications for increases were first submitted. It raises question whether it was held out partly for a bait and switch practice, as older policy holders would have little alternative to open policies elsewhere. Given what appears to be a sequence of increases by Genworth leading to at least a 100% premium increase over an 8-10 year period in 15% increase installments, this sounds mighty fishy. Costs didn't just increase out of nowhere in 2010-2011, and since then, and the (perhaps significantly) underpricing of policies should have been known long before but not revealed to customers or MIA heretofore this period.
- At the October 2016 hearing, MIA termed the latest proposed increase of 15% 'premium rate stabilization'. If Genworth has used this term in its postings, this would probably in itself violate Federal or State protocols for misleading anti-consumer practices because this is NOT premium rate stabilization – nothing is stabilized by this increase as it only eggs on the carrier to apply for more increases in the future (as it already has). Worse, it appears that Genworth expects to receive approval on the premium increases without much further ado than appearing for a few minutes in a hearing without hard numbers provided in evidence.
- If Genworth has not provided MIA with all data to support its assumptions and projections and needs for increases over the years since ALL policies were generated, then Genworth has not provided data to justify its assumptions on costs. What is

happening in the current years cannot be taken out of context because insurance is not like a bank account where the balance between income and outlays in a given year are the major source of cost needs/profit; to the contrary, insurance companies base their projections on the history of the policies as well as future expectations. If a current year balance sheet is all that is provided, it is woefully inadequate to justify why there were not adequate reserves from inception of the policies and the accuracy of the assumptions used to justify pricing all the way back to the present.

- The complete history of GE Capital/Genworth general account investments for increases or movements internally, not just the history of recent low-rate guaranteed fixed-income assets for its LTC reserves, using the original consumer brochure's words.
- The 'Loss Ratio' issue looms large as to whether the premium rate increases are paying for claims benefit outlays – or something else. It appears that the Loss Ratio that is acceptable is around 60%, not 85% or 100% required to be returned to claimants as benefits. That leaves accelerating amounts of administrative overhead from each and every increase that is unaccounted for, certainly to policy holders if not MIA. The policy holder has no insight into what it means that it has been held to significantly higher loss ratios for its premium increases than original premium rates. As a reward for underpricing policies and using grossly unrealistic lapse rates in its projections for years, Genworth can now continue to increase its administrative overhead/profit ratio each year in an accelerating manner and in a manner out of the purview of consumers and perhaps MIA, alike. It is doubtful that Genworth needs to have allowed administrative overhead twice or more over what it priced its policies at, when considered for the level of increases the premiums this decade are leading to, unless it was negligent with realistic pricing models from the start. There is no accounting for internal transfers of funds within Genworth so far. Genworth should not increase its overhead, general investment account profits, and shareholders dividends at a time when it failed to provide protection to its policy holders on matters such as lapse rates and proper pricing from the inception of the policies.

Even if Genworth were to receive annual 15% premium rate increase approvals for years/decades into the future, would it ever reach the 60% Loss Ratio? If the answer is not clear that back-to-back annual rate increases would have it reach 60% in short order, then it can also be seen the extent to which these rate increases are a means to raise administrative overhead paybacks from policy holders to incredibly larger extents as time goes on. To a great extent, these administrative costs have little to do with expediting payment of just claims and, in fact, may go towards greater expenditures in trying to extinguish claims.

- When policy holders downgrade their policies or use nonforfeiture terminations, there is no information provided to customers as to what impact this has on projections and future cost needs. No information was provided at the Oct. 2016 hearing on this aspect. If there

is little or no difference in the justifiable cost levels resulting from/after downgrades in the upcoming year, it would appear that the projection models are insensitive to dynamics which would favor the consumer in future premium increases and are designed to increase profit rather than lower future premium increases; hence would be a sham for consumers.

- At the Oct. 2015 hearing, Ms. Elana Edwards of Genworth testified that Genworth 'employed the best estimates at the time of pricing'. However, this is debatable, especially in terms of lapse rates, given the NAIC admission during the 1990s that the industry used overly aggressive lapse rates, combined with the Genworth CEO's 2016 published interview that 5% lapse rates were used when experience showed less than 1% lapse rates. In fact, it says nothing about when or whether corrections were made subsequently in cost estimates if the original estimates proved to be inadequate/inaccurate. Consequently, ALL estimates/parameters SINCE THE INCEPTION OF MY POLICY/CLASS YEAR GROUP PRICING needs to be released in order to determination whether the increases are historically justified. Neither MIA nor the policy holder nor any other review body can review the validity of this complaint and the associated historical premium increases without such complete data.
- The timing of the industry-wide requests for premium rate increases of such exorbitant proportions only over the last few years deserves attention not just to Genworth. All these carriers should be investigated to see if
 - they colluded in any manner to lead to the current situations on premiums,
 - whether intentional underpricings in years past occurred,
 - whether they were waiting out until recent years when policy holders can hardly begin to look again for carriers years later, or
 - whether faulty parameters being used across carriers that would appear to justify their costs but which would suggest series of questionable models being proffered to State Regulators.

Expansion of the Summary Points Raised Above

Explicit Data are Needed by Policy Holder and MIA to Justify the Increases, including ALL assumptions used in their modeling and pricing for the totality of these increases Post-2011.

The care setting costs and demographics have been portrayed by Genworth in the April and October 2016 hearings as major, or the major reasons for the premium increases. However, as a consumer, I have absolutely nothing from them to quantify how these changes have impacted on the costs and, ultimately, their premiums sought for approval. Specific historical and trend data are needed to be released in order to respond to this complaint, else, there is no way to respond other than through generalities and additional ambiguities. There is no evidence provided to know, or even for MIA to know, the accepted sources of their demographic parameters, nor of other health, morbidity, mortality, and facility use data.

The Impact of Recent Low Interest Rates Compounding the Fact that the Policies were UnderPriced from the Start, likely knowingly UnderPriced

Genworth and MIA have noted the low interest rates that have kept the return investments on premiums very low – on the order of 3% for a decade as it was stated at the hearings. However, had Genworth properly priced its policies from the very start, including reasonable policy lapse rates as a critical basis of its pricing, the interest drought from the last decade would have had lesser impact because Genworth would have been earning higher return totals earlier to ride the storm better into the future. That is not the consumer's problem for the multiple adverse impacts of underpriced premiums from the start. For this, Genworth and MIA share in the responsibility for what appears in hindsight as bait & switch approaches to locking in policy holders to incessant increases that could have been otherwise forestalled had proper assumptions been integrated into the pricing projection models, proper assumptions of which were not mysterious and undetermined even two decades ago or more.

✓ Of great significance is the GE Capital/Genworth brochure statement from 2003, discussed above, that indicates that rates are determined in conjunction with the insurer's general investment account profits, which is likely to be a mark of OTHER investments that the entire company has outside of LTC premium reserves that are solely invested in guaranteed interest instruments. Thus, without a complete accounting of the entire company's performance on all of its investments, no one reviewing profit/loss information relating to premium increases could justifiably make a rate increase conclusion authorizing new premiums without holding the carrier to results stemming from its own policies internally.

Increase Coming on the Heels of Interest Rates and Inflation Climbing from their Lows

✓ Overall cost of living inflation has been relatively low for several years and cannot suddenly be the reason that back-to-back significant premium increases are sought based on long-term-care outlays from recent claims. In fact, the Federal Reserve had been concerned that inflation is too low and is below any forecasts they would have made a decade-plus ago. The claim that the premium increase was needed was due to claims experience and costs. General inflation over the past decade cannot be the real reason for the increases and the lack of reserves against claims. We are now seeing the expectation of higher interest rates and potentially higher inflation. So, for even 2017, the assumptions behind the rate increase justification may already be proving inaccurate. A year ago, it could be foreseen that interest rates would likely start rising, but did that go into the justifications for rate increases and the testimony of what would be needed in the future? The customer has no way of knowing, nor perhaps even MIA, as well.

The estimates in cost projections of inflation and medical inflation, in addition to interest rate forecasts, are critical aspects of any review for premium increase justification.

✓ Medical Cost Inflation, as with General Inflation, has been uncharacteristically low for the last decade

✓ Medical cost of living inflation has been relatively low for several years and cannot suddenly be the reason that back-to-back significant premium increases are sought based on long-term-care outlays from recent claims. The claim that the premium increase was needed was due to claims experience and costs. It would suggest that the companies gave this as a pretext, but it is not the real reason they sought premium increases, at least not a general underlying major cause of their increased claim costs.

According to HealthViewInsights, they graphed HEALTH CARE INFLATION 1 "Average Annual Percent Change in National Health Expenditures, 1960-2012" (See Attachment 2 from The Henry J. Kaiser Foundation: March 6, 2014. <http://kff.org/health-costs/slide/average-annual-percent-change-in-national-health-expenditures-1960-2012/> 2 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>) While health care inflation was approximately 3.6% in 2014, it was still more than four times the Consumer Price Index increase of 0.8%, continuing a long-term trend in which health care inflation is a multiple of CPI. ... However, since the Recession, health care inflation has fallen significantly below the long-term trend, which can largely be attributed to low interest rates and modest inflation.

One can see from the graph that National Health Expenditures peaked in 2002, the year before I took out my policy, and descended rapidly to a plateau of around 3.7%. This is certainly very low and cannot account for why sudden back-to-back increases in premiums are needed now, with untold maximum premium increases to come without advance announcement even a year ahead. How often in recent decades has medical care inflation been so low?

✓ If there were actual claims experience of baby boomers that have skyrocketed for long-term care services delivered, one would expect to first see huge increases in health care medical services costs which would precede debilitating ADLs, especially for younger middle age baby boomers and baby boomers around 65. My class is based on my age grouping, so, if baby boomers are not making exceedingly high claims in recent years, then Genworth has failed to explain why my class requires such premium increases based on claims experience before baby boomers even make claims in large numbers. The brunt of those who purchased the policies after 2000 were likely to have been baby boomers. I am 66 and that would be my class, based on age.

✓ People 65 years or old, or close to it, are not making such large claims for long-term-care in the last few years such that claims outlays have so far exceeded premiums across all those insured to the point where premium rises of 15% each year are justified. In fact, it is likely that my class would not be making claims of any significant nature for some years/decades coming. Such a hypothetical rate of mushrooming need for long-term care would imply that nearly everyone would need it by age 75-80, something that is not in evidence. More people want to live independently, not seek to be institutionalized at an early age. But, over the last two decades there was a loud cry to plan for the possibility of needing long-term care and paying for it through moderate insurance payments up front starting years ahead, not because everyone will be

needing LTC, but everyone needs to act financially rationally years earlier to deal with any possible need for LTC.

✓ Additionally, the figures for claims under Health Care Reform are not showing huge increases in medical costs overall to support any conclusion that baby boomers are in large numbers needing long-term care services at this time.

Both the carrier and MIA have to be careful when they talk about costs because what might be stated by MIA and the carrier as current annual costs may be reflecting of a mixing with future cost projections. In light of the discussion above, they are not likely to be reflecting the same conclusions. But, it appears that policy holders are being told that they are losing money on claims each year. If so now in this decade, this portends to be a problem long term of a magnitude even the carrier is not publicly commenting on in the hearings. And, the justifications had better clarify what is being portrayed in describing the catch-all of 'costs' because it could be very misleading.

The Critical Impact of Long-Term Use of Irrationally and Aggressively High Lapse Rates for this Type of Product That Policy Holders Would Expect to Maintain in Force Lifelong

From the start of the policies, continuing for many years and perhaps even until the recent time, Genworth assumed lapse rates for policy termination that were incredibly and incredulously high and unconscionable for the type of policy being purchased, particularly for middle age, middle class consumers. These consumers could not otherwise afford years of nursing home care out of their own pockets, and the impact on the premium rates in the current decade is so extraordinary as to expose the Genworth pricing as a practice that could or should have been seen as a means of underpricing to entice many consumers who priced what they expected they could afford.

As I will point out below, the difference in the faulty assumptions on lapse rates are so dramatic as to undercut the argument that care settings, longevity, morbidity, and interest rates were the main culprit why suddenly premium increases are needed. Furthermore, one can argue that Genworth initially forecast that hardly any of the original pools of customers would ever hold their policies long enough to be at an age likely enough and frail enough to make claims; thus, the comparison for Genworth regarding lapse rate assumptions was their faulty-assumption pathway for being responsible for paying benefits to almost no one versus being responsible for dealing with claims from a body of consumers who mostly kept their policies intact.

Interview of Genworth CEO by Pittsburgh Post-Gazette, Regarding Lapse Rates and Policy Holder Concerns

According to an article in the Pittsburgh Post-Gazette, Insurers' push for rate hikes in long-term care coverage prompts state hearing, March 7, 2016, Gary Rotstein staff writer, Tom McNerney, the Genworth chief executive officer, stated that

"I think that consumers are justifiably complaining" when learning of new hikes.

He went on to admit faulty assumptions by the insurance industry on long-term care insurance, including his astounding note that

“Fewer than 1 percent of customers annually drop their policies and give up their right to future benefits, when actuaries had assumed a lapse rate of at least 5 percent based on the history of their other products, such as life insurance.”

Implausibility of the Aggressive Lapse Rate Assumptions. Even More So When Maintained
This ‘had assumed’ admission over an undocumented assumption is so implausible as to defy logic for what was touted 15 years ago, as a product to protect oneself to the end of one’s independent living life and provide honorable and safe care beyond . It is so implausible that any rational company would know they needed future bait and switch practices to drive consumers out (as confirmed by Ms. Driscolls in a January 2011 Kiplinger article excerpted further below) or wildly accelerate premium level increases. The admission was stated in such a way that the reader could not help but come away thinking that the contrast between 5 and 1 percent was such that Genworth kept assuming 5 percent lapse rates when the evidence was showing otherwise. The real reason for the premium increases is – and was always -- to drive policy holders out of the insurance program, or to downgrade the policy benefit levels, with both motifs clearly in the interest of the insurance company, such as Genworth, not the policy holder consumer. In the past, if not greatly continuing into the future, if policy holders terminated their policies without any claims Genworth would keep ALL the premiums without any benefit to consumers; even with nonforfeiture clauses, Genworth would still reap the vast majority of the premiums paid without claims against it. If Genworth and other carriers could not goad policy holders to drop their policies earlier, they have been engaging in activities in recent years to scare and demean their policy holders in recent years such that many would give up in disgust and stress over keeping a policy with accelerating premiums sold as unlikely to experience any premium increases.

Am I only imagining this to be the case? Absolutely not. The insurance company has actually stated this intent and expectation of jettisoning all/nearly all policy holders after receiving premiums by way of the lapse rate statement of the Genworth CEO. His statement appears to indicate that, until recently, lapse rates were modeled at a 5% rate while consumers were lapsing policies at a level under 1%. Indeed, I cite Genworth itself making such statements which are tantamount to driving nearly all policy holders in the direction of lapsing or significantly downsizing their policies. Given the 1997 NAIC Report, it would appear that there was likely underpricing of policies that continued in a purposive manner after the industry and NAIC realized that the lapse rates modeled were much too high. If the inappropriate estimates of lapse rates continued past the mid-1990s it can only serve to prove the motive that the carriers, including Genworth, wanted customers out, even to underprice early with the expectation of increasing premiums when policy holders would least expect them – when older and less able to carry the extra premium costs.

✓ Genworth, as the insurance company, benefits while the policy holder loses because it would never have to pay any claims for policy holders giving up their policies, or pay significantly lower claims -- after receiving years of premiums -- for those continuously converting to policies of lower coverage. But, the miscalculations, whether purposive or not, are the fault of the insurance company, not the policy holder.

On the other hand, policies were sold to consumers with their expectation they would of course keep it active as a vital component of financial planning prior to retirement. The policies were greatly marketed and aimed at babyboomers

- who would not be retiring for 10-25 years longer,
- who would be living most probably 30-40 years longer, and
- who would not be in frail circumstances for much of that future period.

Given that, what is even more unbelievable is the realization that what Mr. McInerney is implying is that if 5% were to lapse every year, the following eye-opening statements could be made as to who would be left in the pool to insure. And, when Mr. McInerney cites lapse expectations of at least 5% annually, the effects are possibly even more skewed in favor of the insurance companies.

If 5 % of the original class of policy holders were to lapse their policy every year, at the end of 20 years not a single policy holder would remain. And, if the class were baby boomers who purchased around age 50 in 2000, then it is likely that hardly anyone would benefit from the policy other than the relatively few who did not lapse in these 20 years and needed Long-term care. In other words, all baby boomers, except the few actually getting long-term care under the policy at an early age, would lapse their policies by age 70, with the youngest baby boomers who took out a policy in 2000 eventually almost universally completely lapsing their policies even by age 75.

This is incredible and contrary to any possibility that a fairly-priced policy set, especially covering baby boomers who took out policies years ago, could ever pay out in claims 60% or more of the premiums. That Genworth is claiming quite the opposite loss ratio effect suggests that they grossly mispriced their policies from the start years ago. And, in continuing to do so, that circumstance supports the likelihood of gross underpricing with probable bait and switch that they should have known better years ago that lapse rates of 5% were simply extraordinary high and unrealistic for the market they were selling to.

✓ What appears is that the insurance company's model for coverage of LTC was based less on insuring policy holders than on seeking/expecting to NOT insure the vast majority of once-policy-holders to a great extent. This supposition based on their own statements reaches to such an extent that it appears to have been planned as a scheme to make a lot of money for the insurance company without paying out hardly anything in claims compared to premiums. And, when they discovered that their model did not fit with the realities of the circumstances under

which customers purchased policies to hold until they were in frail situations, it was too late to adjust their business model. And, the State did not see through this scheme either, to its own detriment in the long term. And, now policy holders are seeing humongous increases to their detriment and without specific penalty to Genworth.

Their assumption is so unrealistic, in comparing consumer behavior with life insurance as being intrinsically similar to long-term care insurance in consumers mind as to handling that asset, as to make one wonder whether they purposely mis-estimated lapse rates so as to convince the State regulators that their product was worthy of being sold to the public in the State, at a nominal premium. That would truly be a sorrowful state of affairs for consumers who bought policies hearing that the track records of these companies were very reliable. So, it appears that Genworth must have known by the 1997-2003 period (by the time my policy was priced and sold) that there would have to be sizable premium increases that they hid from consumers, brokers, agents, and insurance commissions, alike. They should not be rewarded for their treachery in mispricing and hiding it until policy holders had little choice but to stay with Genworth as their carrier.

Under the analytical approaches above used by Genworth in past years, just about the only way that claims payouts could ever equal 60% (i.e., go as low as 60%) of premiums paid (and premiums paid in cheaper dollars decades earlier) is if the very few who held onto their policies and received long-term care were individually so expensive compared with actuarial expectations that they outweighed the extent of the lapsed policies. The lapse rate effect would seem to outweigh all other actual, dynamic cost increase factors that have been purported. But, this high payout for the very few would appear to be mathematically impossible except in the cases of those under unlimited long-term care receipt at high daily rates for decades, not just under long-term care for a few years. That is, unless the premiums were grossly underpriced from the start.

The concerns of the above paragraph would make one wonder whether there could EVER be a time, even with 15% annual increases, that the loss ratio would go down as low as 60%, given nonforfeiture clauses and the pool of those remaining policy holders.

The data that Genworth should provide is how it was possible in earlier years of projections with these 5% lapse rates to have a Loss Ratio of 60% when the vast majority of policy holders would be terminating their policies with forfeiture of premiums years before most would be frail enough to justify or seek LTC. As an analyst modeler, it would appear to be essentially an impossibility to achieve that level of payouts with these high lapse rates. Furthermore, per the GE Capital/Genworth brochure I received when I opened my policy, they declared that they were required to have significantly higher loss ratios for premium increases. So, it is dual-fold here – what tighter loss ratio applies for premium increases and what loss ratio could Genworth be

reporting before and subsequent to these premium increases when the lapse rate was implausible for years/decades.

This assumption of near universal policy lapse is probably more significant in regards to prospective claims payouts from the insurance company than any other aspect, including rates of returns on investments, morbidity & aging trends in the population, and cost of living pattern increases.

The insurance companies could have, or more specifically should have, seen this model failing to meet reality many years ago. They did not have to wait until 10-15 years go by and realize no one was dropping their policies. This makes one wonder if there was also a form of collusion among companies to wait until a much later date by which time consumers would have no competitive price to turn to with another company when they were now 10-15 years older and looking for new policies. It appears that all of these increases by carriers are coming in this decade, not before.

And, any such delay of the obvious would have likely have been accompanied by a blind eye by State regulators who rubberstamped industry rates and policy assumptions. Again, as I repeat in this complaint, just when did MIA

- review the lapse rates,
- analyze them in conjunction with the NAIC 1997 Report on modified downward overly aggressive lapse rates, and
- monitor what Genworth was submitting for new policy assumptions and premium rate increases of recent years?

The effect of implausible lapse rates should have been so obvious and so effecting on rates that it could not have been ignored as a minor footnote in communications.

Interaction of Lapse Rate Downward Modification with the Characteristics of Those Policy Holders Who Would Have Terminated If Lapse Rates Were High But Who Would Be Active Premium Paying Customers with Lower Levels of Frailty If Lapse Rates were Very Low

Even more insidious is the interacting assumptions of lapse rates combined with the likelihood of those who stay in the pool who need care. One would expect that there would be a higher likelihood of the frailest policy holders not lapsing their policies when they might have a higher personal expectation of potentially needing long-term-care down the road. Therefore, one would logically expect the carrier to subsequently project, with more people including many healthy ones staying in the pool, that a lower percentage of non-lapsed policies would lead to receipt of claims & benefits, as it was then seen as not just the frailest policy holders to hold onto active policies. No such parameter discussion has been reflected in public discussions as it would appear to merit if long-term projections of expected costs go into the equation. To ignore the carrier's likely expectation of a shift to likely-lower percent of the policy-holder pool likely to

need care under lower lapse-rate assumptions would likely overshoot long-term need for increased need for premium increases/reserves per policy holder compared to original projection models of decades past with higher lapse rates.

Consumers are not being given data that can shed light on the exact need for additional premiums. Only generalities are given. Worse, however, is that MIA has given no indication in these 2016 hearings that it received all the actuarial and modeling information all these years for which premiums/classes were established and premiums increased. This is especially true of the lapse rate estimates and projections. At the hearings, MIA provided no comments that it fully knew of, and concurred with, the assumptions on lapse rates proffered by the insurance companies (including Genworth) for all the years since these policies started and accelerated in numbers 1-2 decades ago. If the responsibility is in part shared by MIA in not fleshing out critical, miscalculations with overriding impacts on pricing, then consumers in the State of Maryland should not be burdened with humongous increases that were not their fault for not shopping or pricing appropriately the policies they purchased.

MIA Application Review Policy of Assumptions AND the Lack of Premium Rate Stabilization

At the October 2016 hearing, Ms. Sarah Li of MIA entered into a discussion of the procedures for review, including review of the assumptions made in arriving at the costs and need for premium increases. However, in consideration of costs, Genworth's own statements expose that one cannot look merely at the assumptions of the current year's premium increase application.

Indeed, the insidious nature of the overwhelming implications of unconscionably high lapse rates from the 1990s going forward require complete rethinking as to whether Genworth knowingly -- if not deliberately -- underpriced its policies with the conscious or insidious impact that consumers would later face incredibly high increases when the effects of the miscalculations become so large as to endanger continuation of the policy underwriting without humongous premium increases. The term 'premium rate stabilization' she mentioned is deceitfully used, which is based on the earlier miscalculations and improper MIA approvals have led to a situation where these increases are anything but premium rate stabilization. Repeated 15% annual premium increases such that the premiums may likely be more than twice what they were until this decade is hardly a 'rate stabilization'. Thus, the time frame for review of critical assumptions of the industry going back 20 years or so must be examined very closely for impact to consumers of failures by industry to clarify the real sensitivity in their models and validity of their models in terms of the full nature of what lapse rate specifications mean towards the projections of costs and solvency of their LTC programs.

The increases of late, combined with the expected future increases Genworth alluded to at the hearing, do not make for 'premium rate stabilization'. This complaint is about the failure to stabilize assumptions such as lapse rate years/decades ago when the resultant adjusted premium would not have been driven up at the current rate without warning to the consumer. Indeed, Genworth prided itself that it prices its policies so well that it never had a price increase.

Assumptions that need to be released and reviewed by consumers and MIA, alike, are not just the current ones, but those that errantly got us where we are today in price increases through irresponsible or outright deceitful underpricing. It would appear that Genworth has deceived its customers for decades, perhaps knowingly or even purposefully.

For all the years prior to 2011 around when these premium increases started flowing in earnestly for MIA approval, was Genworth hiding something that made these increases currently worse when it continued to tell the insurance community that it did not have increases in premiums? Indeed, it would seem so that its projections must have been doing something far more dramatically negative than it was reporting in the first set of increases.

- How is it that these increases suddenly popped out of nowhere and continue without end at the rate of 15% annually (the cap) when there were none in any earlier years?
- When did Genworth know that it needed to raise rates, or, looking the other way, knew that it was losing money?
- What did Genworth do when it discovered that? And,
- What did the rest of Genworth do to support any losses it was incurring, based on Genworth expectations of never having to raise rates?

This suddenness of the increases, yea, the endless stream of increases, suggests Genworth was holding out longer to trap a captured audience of policy holders who, the longer they hold policies, could not switch even if they wanted to.

Belated Tinkering of Rates Cannot Undo the Impact of Probable Underpricing of Policies, including Probable Knowingly Underpriced Policies Being Issued 1, 2, or 3 decades ago

What was not estimated/projected properly for this kind of specialized insurance from the start CANNOT quite be made up by minor tinkering of premiums later on. This would be so because the entire foundation of the industry models is in question – from the 1990s onward when baby-boomers were being strongly encouraged to open LTC policies for their own life-cycle planning. It was based on unrealistically high lapse rates that never made sense in the context of this type of specialized policy.

Likelihood that MIA Has Not Fully and Properly Investigated Critical Lapse Rate Estimates and Resulting Projections by Genworth, Historically Going Back Two Decades

In fact, through direct and indirect comments made from the podium by MIA during the April and October hearings, it appears to be clear that MIA has neither investigated lapse rate projections closely nor is aware of what industry has been using for such parameters since the 1990s. Indeed, it appears that MIA never raised comment on the lapse rate assumptions decades ago or more recently; indeed, the MIA Commissioner could not say anything definitive about these historical lapses rates at the Oct. 2016 hearings when addressed on this very issue. A lack of definitive monitoring by MIA of realistic lapses rates by carriers is NOT very reassuring. If that is true, MIA and the State need to show responsibility to consumers as to how the consumers

✓ were deceived by lack of State action in conjunction with Genworth not publicly commenting until recently on its erroneous historical lapse rate assumptions. When the models and assumptions by industry to market their policies and premiums are far off the mark, the consumer should not be held responsible for the foibles of the industry which was approved seemingly without (apparent/reported) MIA intervention over recent decades. In two hearings, and the current MIA web site, there is no evidence that MIA disputed the veracity/validity of the industry assumptions for such critical parameters as lapse rates, or otherwise enforced better/best-estimate rates, rates that may have greater impact on the solvency of the premium-paid policy programs than any other cost-expense parameter mentioned.

MIA Enforces Premium Rate Instability of Genworth Policies, NOT Premium Rate Stabilization

✓ What might have been intended as a 'rate stabilization' program, with maximum 15% caps in any year (as if they were expected to be one-time rate hike applications) has simply become a means for industry to pass through unlimited series of 15% premium increases without being required to explain the totality of their solvency issues with LTC. So, instead of 'rate stabilization', customers are experiencing 'rate INstability' fully approved by MIA; this makes a mockery of the utility of the loss ratios when the issue is endemic to the entire program, not just their profit structures. And, in doing so, policy holders may in the end long-term have higher premiums from the annual cap application than if there were individual larger increases.

✓ In fact, as part of the loss ratio calculations, it is not even clear whether industry has attempted to reduce their internal distributions to shareholders and administrative costs as a means of controlling outlays, or is simply passing through these kinds of outlays as regular business while consumers are socked by out-of-sight increases. None of these increases could have been expected through the nature of the original marketing of their policies and the decade(s) history of NO earlier premium increases. If the premium increases also result in additional funds going to shareholders and staff employment increases, for example, then the Maryland policy holders are being continuously hit by accelerating Genworth money-making on the backs of consumers. In such a situation, these premium increases would not be purely cost increases from benefits but raise Genworth revenue to shareholders and other revenue outlays beyond consumer benefits and direct cost of administering the long term care insurance program.

✓ There is also no information provided as to whether funds in reserve for long term care have been dedicated 100% to the increases in claims cost, 85% to increases in claims costs, 60% to increases in claims cost, or any other ratio. The 'loss' ratio does not directly answer the question, nor is it clear when these annual increases will ever get the loss ratio to the threshold cap under NAIC regulations. Indeed, at the Oct. 2016 Hearing, I believe that the MIA Commissioner provided to me an oral response that suggested that the Loss Ratio for premium increases need only meet the 60% threshold, not 85% or higher levels. If this is true, it confounds GE Capital's own stated expectations for its policy holders, if not other regulatory requirements that expect higher than 60% Loss Ratios for all increased premiums. And, again,

just what are the 'significantly higher' loss ratios that GE Capital noted that must be demonstrated for premium increases?

Furthermore, nothing has been released regarding Genworth's general investment account profitabilities that could be shared with a Division that claims its product is losing money. One would wonder how any Genworth investments outside of fixed income could not have fared extremely well in recent years.

Genworth's Grossly MisEstimated Historical Lapse Rates Should Be the Subject of Historical Review as Part of Justification of Assumptions, Not Jettisoned as Being Almost Irrelevant to the Need for Premium Increases from Base Premium Rates of the Original Policy

As such, Genworth miscalculations on such critical matters as lapse rates should not be used to bolster their own coffers or the coffers of shareholders while policy holders are asked to face perpetual increases resulting from approved underpricing and bait & switch practices.

There is no evidence of any additional data provided or analyzed in-house to MIA that would go to the heart of the validity of these increases based on the company actuarial models and assumptions, together with actual premiums received and policy claims to date. This is especially relevant to the long-term impact of grossly overestimated lapse rates for years which pretended the assumption that the vast majority of policies would be closed before claims made and likely closed for baby boomers well before they even got into their 70s let alone 80s and 90s.

Instead of being merely a current-year review, MIA must examine the long-term history from whence these claimed deficits arose. To examine ONLY the current year undermines the cogency of the MIA review process model on assumptions where industry assumptions may have been so faulty and leading to significant underpricing as to raise issue. Such issues include whether consumers are now suffering due to bait-and-switch or intentional underpricing of policies that started long ago and entrapped aging consumers into their current policies for some critical assumptions that insurance companies should – and did – know better way back. It is not clear to consumers, and no evidence was provided to consumers to date by MIA, that MIA knew the companies had assumptions on lapse rates that were unrealistic or were at all becoming more realistic (and when they became more realistic), with the incipient impacts on premiums and losses. As early as 1997 – or even before – MIA SHOULD HAVE KNOWN that the industry models and pricings were unrealistic regardless lapse rates and their impacts on costs/profits.

The entire set of historical communications between MIA and Genworth on lapse rates model assumptions should be released to allow policy holders to see whether there was an acceptance of acknowledged miscalculations, whether tacit acceptance or explicit acceptance that led policies to be underpriced, knowing that premiums would likely rise, if not rise significantly, after policies such as mine were in force. What did GE Capital/Genworth do years ago – during the 1990s and soon thereafter -- to inform MIA that its lapse rate estimates were many times over too aggressive and significantly impacting its long-term cost projection models?

There is nothing in the packet to policy holders on the price increases to evaluate the extent to which Genworth is, and has been, meeting the acceptable loss ratios under NAIC and/or Maryland regulations, or that the applicable Loss Ratio for the increases is significantly higher than original filings (per GE Capital's own brochure to customers). There is also nothing to indicate what the loss ratio is projected to be after this premium increase.

✓ Factor (4) for determining the propriety of the Loss Ratio is
“**Concentration of experience within early policy duration**”.

We now know that Genworth had made grossly faulty assumptions, which it knew immediately almost two decades earlier from NAIC itself had to have been faulty regarding the rate of policy lapses by consumers; this is reinforced by the 1997 NAIC quarterly report cited below. By the time of my policy, soon afterwards in 2003, Genworth should have known that its assumptions were woefully improper. Yet, the Genworth CEO in his 2016 interview suggests that woefully high lapse rates were used in projections for many years. (It is likely that if a 1% Lapse Rate had been adopted by 1997, my initial premium should have been realistically priced higher. Thereafter, Genworth would not have been in the position it is now of endless 15% increases from a company that indicated it expected no future increases.) The propriety of any loss ratio proffered must be tempered by the propriety of the ‘concentration of experience within early policy duration’.

No information has been released on this, yet it is essential in justifying premium increases based on Genworth miscalculations of the long term past. The consumer should be given dispensation from the Company and the State with such a faulty model that significantly impacts on the series of recent and future premium increases years later. The policy holder should not be penalized for the Company's improper research and modeling, especially under a regulatory system of review.

The Huge Impact These Lapse Rate Estimates Have on the Numbers of Policy Holders Continuing to Hold Policies and Potentially Benefit from Active Policies

Permit me to reflect again on the huge difference in the impact of lapse rate projections on the size of the continuing policy holder pool of paying customers.

The Genworth CEO stated that Genworth historically had used a 5% lapse rate. If 5% annually from the original pool count were lapsed (consistent with the Genworth CEO's Pittsburgh Gazette interview statement), that would mean that, after 20 years, not a single person would still be paying (either you terminate your policy or are already receiving benefits as a few might by then). Inasmuch as the largest group of policy holders were likely baby boomers, like myself, this would seem to imply that almost NO ONE would be making claims because the vast majority of these customers would have been too young to have needed LTC in 20 years from policy inception, taking out during their peak years of work life.

In comparison, if the lapse rate were .9% (i.e., for discussion of a rate just less than 1%), after 20 years 82% of the original pool would still be holding their policies.

Clearly, these parameters as end points of the analysis, together with any intermediate rates that crept in surreptitiously over the years since before 1997 (if any), are critical to understanding what moneys Genworth has as reserve and how of these many babyboomers are likely to be in a position to use their policies for significant care expenses long-term. The difference between near-zero-percent continuing to hold policies with significant claim potential vs. 80+% continuing to hold such policies is so dramatic as to overwhelm any other cost component under modification with time, such as LTC venue choice costs, morbidity, or mortality. All the latter have evolutionary influences on cost/benefits; however, these pillar-to-post lapse rate figures have revolutionary influence on cost of orders of magnitude.

✓ Any premium increase I should receive due to Genworth miscalculations should go to entirely support increased claim costs, not be watered down by overhead and shareholder distributions. It appears that the loss ratio monitoring does not clearly prohibit increased profits while premiums go up substantially. In fact, when the carrier claims that the loss ratio is over 100%, there appears to be nothing stopping it from taking every penny of the 15% increases and applying it to overhead and shareholder distributions, knowing that the next year the same situation will recur, again, and again. It can ensure that it will NEVER get to 60% loss ratio by any such trickery.

It is a fact that the Genworth CEO reported in the Pittsburgh Gazette less than a year or so ago that Genworth was grossly overestimating policy lapse rates and that this overestimate was driving the growing losses for those holding policies longer. However, it would appear that this is a thinly-veiled excuse for bait and switch when it knew or should have known better when it priced its policies. The October 2010 NAIC Regulation, p. 109, contains two paragraphs from the 1997 Proceedings 3rd Quarter 1351 (prior to my policy issuance) that suggests that the Industry was well aware that policyholders were holding onto their policies and that there was underpricing as a result.

(*) "A representative from an insurer described the rating problem from an insurance company's point of view. He said the key drivers of the premium rate increases were untested assumptions, using an inadequate rating structure such as the one used for Medicare supplement insurance, inadequate long-term care insurance experience, and using quinquennial age rate bands. **These practices resulted in underpricing of policies by one third to one half. Also the first generation of long-term care insurance policies had higher utilization than expected. He said that underwriting practices have evolved substantially and he opined that now companies have better data and use less aggressive termination assumptions. 1997 Proc. 3rd Quarter 1351.** "

"An insurer representative said part of the solution to the rate stabilization problem was better upfront pricing. He said this is a fine line, because insurers do not want to price potential insureds out of the market, **but the initial rates needed to be adequate to provide sufficient**

reserves for future benefits. A consumer representative expressed concern that consumers were buying the cheapest policy they could find, and then facing large rate increases later in the life of the policy. She also expressed concern that the insurers that do price adequately upfront are being squeezed out of the market because the premiums for their policies are more expensive. **1997 Proc. 3rd Quarter 1351.**”

But, by the time of my 2003 policy, much of this should not have been a mystery. LTC insurance had been in place many years by 1997, and there is no indication that the lapse rates for most of the policies they issued over the years until very recently were anything less aggressive than 5% -- else it was in his interest to have reported that.

Just what was Mr. McInerney referring to in his 2016 interview for the period of 5% lapse rates modeled into the projections? – It did not seem from the interview results on the written newspaper page as likely that

- ONLY pre-1997 policies were modeled with 5% lapse rates, or that
- policies since 1997 were uniformly modeled with 1% or less lapse rates.

He seems to infer that Genworth continued to used high, apparently still 5%, lapse rates for years – even when it should have known better certainly by 1997. So, exactly what did Genworth do for policies written in the years around my policy inception and what has it done with its projections since then? The current increase cannot be taken out of context of the entire set of miscalculations since projections of the mid 1990s forward to see whether there was fault of Genworth.

In addition, the initial premium history of the years before 1997 and after 1997 (such as leading to my 2003 policy) should be examined to see whether initial premiums jumped significantly if lapse rates were being grossly downshifted by the time of the NAIC 1997 report, if not earlier. Brokers and agents have stated to me that premiums were stable around the time that I took out my policy and/or they did not remember any sudden uptick in premium rates back then. This would imply that Genworth knew that it was building in a gross underpricing strategy that would later backfire on consumers who would not realize the bait and switch at the time of policy inception or discussion with their agents/brokers. This history is pretty critical, and MIA should have the premium tariff rate charts to substantiate whether rates changed much if at all if lapse rates were dramatically being lowered based on policy experience. If GE Capital did NOT modify its premium charge tables for the same age class over the 1990s to early 2000's, then there is something seriously wrong with the carrier's premium rate justifications to the State because it would appear that they were seriously underpriced and not being adjusted based on critical, and large, lapse rate parameter modifications.

Given these findings, it would appear to be a ruse by Genworth to feign ignorance when they knew what they were doing in their policy pricing 15-20 years ago. If Genworth purposely deceived everyone about their knowledge of better data on higher utilization and termination assumptions, why are Maryland policy holders like myself being left holding the bag? Indeed,

it was the MIA and Industry, and Genworth in particular here, who allowed low premium rates to be marketed in recent decades? Policy holders should not be penalized for malfeasance by the carrier and unjustified approval processes at MIA that have led to the current premium dilemma.

The Unknown of Whether Genworth Has Moved Funding from Various Other Successful Insurance Programs Towards the LTC Insurance Program, and Whether Such Actions Are Normally Undertaken Though Not Here.

There is no information provided to ascertain whether Genworth has moved funds in reserve for LTC into other insurance funds within the Genworth insurance conglomerate, undermining reserves for LTC and giving rise to the so-called need for these premium increases. There is no information to synchronize with the GE Capital brochure I received that it bases rates on investments from the insurer's 'general accounts', implying not just the LTC Division. Indeed, the GE Capital brochure of terms suggests that the Carrier report on what actions it has taken. Whether it has or has not taken such moving of reserves internally within Genworth is within its own scope of practice for reporting, based on its own brochure of terms to policy holders. There is no information as to whether Genworth has moved investments from LTC reserves to other parts of the company, thereby claiming low LTC reserves and losses. There is no information about profits from its general accounts investments, not just LTC.

Likewise, there is no information as to whether it is customary for an insurance company such as Genworth to bolster reserves in one Division from another Division which has been making profits, in order to maintain the original Genworth claim that it has never needed to seek increases in premiums for LTC policies. Indeed, there is a worthy question as to whether Genworth has been doing this internally without reporting the internal bolstering to MIA and policy holders when it requests the premium increases and claims it has insufficient reserves.

Information That Needs to Be Released to Policy Holders and MIA to Explain Its Attested Financial Dilemma in Insuring LTC

This is all very disappointing, even threatening to those retired on very fixed budgets. There were very significant questions raised earlier as to whether the entire model underpinning the premiums was fair and valid. There were no answers provided as to

- the track records of Genworth in ensuring that at least 60% of all premiums (or 58% as mentioned at the hearing, though it appeared to me in reading the 2014 NAIC regulation that older policies were to be subject to 60% loss ratios going forward) are being returned in aggregate to covered customers,
- the extent to which the premium increases are greatly going to pay claims and build reserves rather than get pocketed for overhead and distributions when the loss ratio remains well above 60% and subject to approval for future increases in the same manner with the same possible loose requirements for where it gets expended,

- whether current policy claims overall or in my baby boomer cohort were so high as to outweigh all new premium payments,
- whether the assumptions on the expected rate of policy holders dropping their policies each year were so faulty as to be the liability of the company rather than the consumers who honestly subscribed expecting stability in premium pricing, nor
- how Genworth was treating funds, and investment/interest profits thereof, for policies that are not being renewed – especially due to premium increases. That is, before nonforfeiture lapses are to be treated in the future. Are they pure profit and disappear from the line balances or are they treated as funds against which future claims can be paid for those former policy holders and other current policy holders?

The Lack of a Complete Picture of ALL Anticipated Needed Premium Increases Going Forward, Not Just the Requirement to Justify Any Requested 15% Increase

There is no information provided on how much the insurance company truly claims it needs to balance its outlays long term OTHER THAN an annual 15% increase for this year, nor the applicable Loss Ratios. There is certainly nothing binding in either the notice of premium increase, nor from the recent hearing testimony, as to the long-term nature of the price increases because they were not long-term testimony, only short term testimony. This is critical because Maryland has had no requirement that complete pictures of losses be provided; the only justifications I was told by an MIA agent on the phone that the current 15% increase be justified in the respective year and that is ONLY what the companies submit to MIA. As such, MIA has become a willing intermediary to rubberstamping the increases for lack of any power/action being applied to take charge of the unlimited natures of these annual increases, which appear more modest in any given year but are gigantic when considered as long-term endless chains of 15% increases without clear horizon limits.

Given Gross Mis-Assumptions, Non-Forfeiture Should Not Be a Relatively Large Cost

If non-forfeiture provisions loom large in the series of increases, this is further evidence of long-term underpricing and irresponsibly-gross mis-projections on lapse rates. Genworth fully expected to keep all premiums from lapsed policies which it improperly expected to be essentially all lapsed without claims well before nearly all baby boomers would have been within the age of likely frailty. If Genworth had not underpriced the policies, the nonforfeiture amounts would have been relatively minor compared to claims, greatly because very few would have been expected to terminate policies other than for reason of not affording significant premium increases annually. In other words, even many years of premiums are hardly likely to scratch the surface compared to a year in a nursing home. And, only a fraction of policy holders will even get to need LTC and benefit from nonforfeiture reserves being held in the event of policy termination.

Noteworthy and Questionable Statements Made by Genworth at the Oct. 2016 Hearing

At the October hearing, Ms. Elana Edwards, Genworth Senior VP, LTC, made two noteworthy statements that should raise eyebrows when read in conjunction with the points I raise herein. This goes to the heart as to whether Genworth assumptions, especially assumptions that led customers to this premium rate increase predicament, were appropriate. And, if the statements were not appropriate/valid/demonstrable, why current premium increase requests should completely favor Genworth over its customer base in allowing all claimed costs which were based on the Genworth initial miscalculations.

1) She stated that Genworth 'employed the best estimates at the time of pricing'. However, this is debatable, especially in terms of lapse rates. It appears that there was no scientific study of what a reliable lapse rate for LTC insurance would be. As such, it appears that the industry was continually just guessing until it discovered that, instead of 5% (as quoted from the Genworth CEO, Tom McInerney, March 7, 2016 in the Pittsburgh Gazette) would be less than 1% annually, an incredible and critical difference. It is unconscionable for such a large company and large insurance product in general that there are no reports of even focus groups to discuss likely policy-holder behavior. Evidence of bona fide activities to project a valid rate, from consumers who would go on to hold such policies, should be uncovered from the entire period from 1990s to date, especially since NAIC reported in 1997 the fallacy of accelerated lapse rates and the reduction in lapse rates by companies thereafter. It is not clear, especially based on the CEO interview appearing in the Pittsburgh Gazette, that any realistic lapse rate was incorporated into the Genworth premium/cost projections before my policy started in 2003 or since then until 2016. The words of the Genworth CEO in his 2016 cited interview suggest that the 5% lapse rate was continuously applied in all historic projections within Genworth for decades up to the present times. All such evidence should be provided to justify the premium increase.

To further rebut her statement, it is the perfidy of industry that they apparently never convened consumer focus groups on LTC insurance-holding perspectives that has led to this predicament, perhaps far more than any changes in the health and predilections for care among those consumers who have needed care. Anyone who would have interviewed baby boomers working for the Federal Government around 15-20 years ago in the DC area (i.e., including much of the Maryland customers of Genworth today) would have understood that they were being convinced by the training instructors hired by agencies that they should purchase AND HOLD for dear life LTC policies as the only thing they could do to control their end-of-life finances with respect for them and their families. How is it that the companies as large as Genworth never learned this up front from them or the insurance agents locally who were marketing their business to these consumers making up a large part of the Maryland baby boomer population?

They rely on actuaries for the most-detailed and painstakingly-derived statistics to then rely on a simple and unstudied lapse rate parameter of 5% for LTC policies because life insurance lapse rates were 5%. This is hardly believable for such a critical parameter, and it smacks either of

- a coverup,
- gross incompetence they should be made liable for, or
- gross marketing error for which policy holders should not be held hostage later in life for exorbitant premium increases that could have been priced out in policies decades ago.

2) She stated that, at least at this juncture THIS YEAR, Genworth could justify a 48% increase. And, that is after several years already of 15% increases. But, what she does NOT say, and what MIA does not say, is that there is any handshaking agreement and understanding as to what that 48% means.

- Does it mean that such an increase would be truly justified under regulatory guidelines if estimated today?
- Does it mean that after three more years of 15% increases the rate would truly be essentially fully stabilized?
- Does it mean that Genworth in its discretionary modeling could well expect to pocket the 48% after three years and come up with future models that could well approach upcoming justification for another 48% or more right after that?
- Does it allow for, in light of lack of clarity to what the 48% is to be applied against, Genworth using most/all of these increases for overhead and distributions when their loss ratio is still over 60% and come back for more of the same?
- Could it mean that Genworth will force/scare so many customers to downgrade or lapse their policies that they will actually need less than 48% increases long-term because they will overshoot their cost needs? We don't know as consumers (and would only know if the consumer attended this hearing) and it does not appear that MIA truly knows either when the issue each year is justification for increases within the 15% cap.

It is critical that this be fully understood by MIA and policy holders alike.

What is the Impact on Genworth's Projections of Costs When Customers Downgrade Policies?

There is also no information as to whether the impact of these increases will be such that pressured-customer downgrading in policies will result in such savings long-term to Genworth's balance sheet that it will overshoot the claimed losses with new increases and claim future increased premium needs when the downgrading leads to increased profits. It was reported at the October 2016 Hearing that Genworth moves downgrading customers to the current increased cost of downgraded benefit levels, not modeled as if they started the policy with that downgraded level, nor does the customer benefit in any way from paying higher premiums from policy inception for foregone benefits it is basically just throwing away going forward. (It was

mentioned at the October 2016 hearing that other carriers do not follow suit and re-price policies for downgrading customers as if they purchased the lesser policy at policy origination) The more policy holders downgrade their policies – even every year with fresh increases – the more mysterious the cost projections become because the future bottom line impact of the downgradings is not clear nor separately described for impact on costs. It is a moving target, but one which has not been revealed for its impact on increases for active policy holders who do and do not downgrade their policies after premium increases are announced.

This non-transparent treatment of lapse rates and relationship to policy cost/premium increases has the earmarks of a bait and switch campaign, with consumers now caught in the bind that they cannot decades later merely switch companies when they are much older and subject to another companies higher premiums at older ages, let alone the risk of not passing new examinations decades after they opened their Genworth policy.

Are Policy Holders Benefiting Fully in the Long-Term from Benefit Downgrading Done Fairly?

It is inefficient and potentially financially counterproductive for consumers to downgrade their policies EVERY year in the wake of 15% increases; consumers doing so would be throwing money away when they are not in risky health circumstances because the interim downgrades buy them nothing which they could have applied to a bigger downgrade earlier with modification of some benefit terms in their favor long-run. The cited Kiplinger Magazine article, continuing with statements from expert Marilee Driscoll, suggests that insurance companies would prefer nothing better than that other than dropping the policy and walking away with nothing for years of paid premiums.

✓ “What are my options? ... You should hold on to your existing policy if you can afford it.


“When an insurer realizes it needs a rate increase, the company would love nothing better than for existing policyholders to reduce or drop their coverage,” says Marilee Driscoll, a long-term-care planning expert from Plymouth, Mass. That gets the insurer off the hook for potentially expensive claims.”


The conflict with consumers is exacerbated by the lack of agreement between the companies and MIA as to what is really the cost gap and what is best for consumers to do – not just for the next two years as a best strategy to get the best bang for their buck in their existing policies.

⊛ Furthermore, the attempt by the State and Genworth to encourage consumers to reduce their coverage levels to stave off the (annual) price increases is further compounding the impact of the premium increases. The premium increases come annually now and the encouragement of potentially annual downgrading of policies serve the insurance company more than the customer. By annual downgrading considerations that the customer is advised to consider, rather than a long term premium/benefit strategy adjustment, the customer is goaded on a path that is likely worse than a one-time downgrading because of the way the downgrading premiums are calculated each year. Stepping down policies with annual downgrades for someone without

impending expectation of making claims is undoubtedly more costly in the long run to the consumer than a larger downgrading based on the expected longer-term shortfall of Genworth. In other words, percent increases for a more expensive current premium cost additionally more dollars a year the following year(s) than similar percent increases for a less-expensive current premium.

Moreover, with a one-time increase, the carrier could not hide any attempt to pad overhead and shareholder distributions when it continues annually to remain above 60% loss ratio levels. A one-time increase would be scrutinized for the components and harder to shift to other pots internally because it would be expected that no further increases in premiums in the short term would be entertained.

 Each time a policy holder downgrades their policy benefits, they are treated by Genworth as policy holder of benefits at the current level of premiums inflated, not adjusted each time back to the original prices inflated to the chosen downgraded benefit levels. Thus, each stepping down of the downgrading sequence of actions essentially subjects that policy holder to the additional upwardly-increased costs of the intermediate benefit level. Genworth is building in presumed cost outlays for policy holders being at the higher, intermediately downgraded level going forward in their projections. This is undoubtedly worse for the individual customer, as well as the class of customers of that age as a whole, than downgrading a much larger step at the first rung of endless cost cuts, assuming that the policy holder will not be seeking care in the ensuing years of these 15% annual premium increases. They are basing premium increases on benefits that many policy holders will forego while downgrading in upcoming years at the times of additional price increases. This perspective is consistent with the expert advice of the Kiplinger article from Ms. Driscolls.

 Thus, given the endless series of 15% premium rate increases, are policy holders being duped by the advantage of annual downgradings without a sense of the long-term need for possible larger downgrading? Who benefits most from annual downgrading, in lieu of one-time overall downgrading when faced with the expectation of series of 15% increases coming? The policy holder? Genworth? The MIA cap, when combined with the series of rate increases and the lack of verified expectation of future increases, may actually hurt consumers more in the long run if they were to plan for downgrading. Annual downgrading to hold rates constant may not be the best strategy for consumers, but the information is unavailable to make this comparison because future increases are not verified in advance by MIA.

The Issues of Low Reserves, Low Interest Rates, and Initial Premium Pricing are Insidiously Related, Such That Any Underpricing Has Compounded the Problem of Interest Rates on Reserves

To wit, the very argument of current low interest rates being a major problem would have been greatly lessened as a pressure on premiums long term through this current decade had premium

✓ rates been somewhat, and more-realistically, higher from the start (and when baby boomers were still employed). Indeed, it was a decade or two ago when interest rates and reserves would have been higher and perhaps before lapse rates modeled to be very low. Had the lapse rates been appropriately modeled back in 2003 (inception of my policy) and the years immediately prior to that which led to my initial premium rate, rates would have likely been higher, but reserves would have increased more to ride out the storm of lower interest rates coming later on. As a result, Genworth would have been in a more financially-firmer position, and rates may likely not have needed the kind of 15% increases that are coming annually post-2011. It is not the customer's fault that they underpriced using invalid contemporary assumptions in earlier years.

The suspicious timing of the latest series of premium increases by Genworth and other Carriers that are large and keep on coming after years/decades of no premium increases

✓ Given the moderated cost of living increases in recent years, how is it that so many companies are suddenly seeking, over the last few years all of a sudden after years of no increases, to increase the maximum rate in such a concentrated period, after years of not raising premiums? This is very suspicious and unexplained as to why these concerns, even just based on lapse rate mis-projections alone, would not have been enough to require premium increase filings in past year. Are the companies recently colluding in some manner that is a violation of Federal or State regulations? After all, companies like Genworth did not have any increases until recently. Until ALL the cost components are fleshed out for Genworth, particularly components like lapse rate that normally are not discussed in terms of care venue costs of claims, it is hard to validate Genworth's claims of needing continual premium increases each year. Indeed, the argument that ALL the companies should be similarly thoroughly investigated is critical to evaluating this complaint, to see if they engaged in predatory pricing, bait & switch, or underpricing which they should have known about. Not all companies are seeking increases, and large overall increases, but those who are have suddenly been seeking rate increases years after they should have known that their lapse rates were not realistic much before 1997 or in years thereafter.

However, the history of recent years suggests that

- the sudden spate of annual, maximum increases in premiums by the insurance companies, combined with
 - the laxness of State of Maryland investigations in agreeing to original policy premiums and getting to the bottom as to why these increases are occurring,

reflect the extent to which the State was not monitoring the insurance product and the appropriateness of the rate structures from day 1. To date, the consumer sees no other evidence of **regulatory remedy** other than accepting the maximum rate increases allowed by law potentially indefinitely. This is not a remedy, nor is it even a relief when the increases are endless and may actually lead to higher levels of premiums in future years than would otherwise be the case with one-time increases. One can begin to see how much the insurance companies

are, in total, planning to increase premiums, and these are likely to be only the beginning of endless 15% increases because the plans were apparently grossly underpriced, under the eye of State regulators. It appears likely that Genworth is following industry trends, but the consumer and the State continue to be deceived as to the real reason for these significant and continuous premium increases.

It is highly likely that it may not be the actual, recent experience with long term care costs and actual claims outlays that are driving these rate increases. There may be other reasons for which they are trying desperately to increase capital inflows that may be even more significant as to the need for requesting these increases of such significant back-to-back increases. And, the State may continue to be deceived as to the manner of the succession of increases which might continue not for a couple of years, not just for a few years, but potentially for decades. The resulting rates may be well out of proportion to middle class pocketbooks, especially of retirees.

In fact, it would appear that the goal of the insurance companies has been, and is, to ensure that large numbers of policy holders cease their coverage under the terms originally purchased without regards to the public impact of the impacts on Medicaid from their underhanded approaches of forcing down-conversion lapses in policies. While it is the goal of the State that businesses continue to profit and maintain their markets in Maryland, it cannot be the goal of the State to drive so many elderly into Medicaid for LTC care that the State goes broke in lieu of the insurance companies who mispriced their policies to drive out customers but keep their premiums.

I have found little evidence that the State has been investigating and getting to the bottom as to

- why all of a sudden these increases are occurring this decade, or
- whether the justifications for the increases the companies provide are truly valid, especially in light of the critical lapse rate calculations underpinning the initial pricing of every policy.

I experienced no increases since I purchased my policy in 2003 for \$2583 until the last two cycles starting in January 2015 and January 2016, and now January 2017. In each of these two years, the rate increased by the maximal allowed 15%. But, this is 15% compounded, so future increases will start to mushroom the premiums compared to the original policy. So, my new increases since January 2015 have now been 52.38% over the original premium, with hearings in Oct. 2016 for another 15%, for requested increases of 75.23%. Based on Ms. Edwards testimony at the hearing, Genworth would like to get another 48% immediately for a cumulative increase of at least 159.34%.

And, there appears to be no end in sight of the significant premium increases, that is, until the companies force everyone to lapse their policies due to cost and the insurance companies have a profit of nearly 100%. Even this 48% claim of justified premium increases is in no manner an upper limit long-term and could be just the short-term next three years of increases being readied

for MIA review. If this annual 15% increase were to continue for 10, 20, or 30 years, it will make the policies all but unaffordable except for the wealthiest residents who probably might not need such a policy to withstand their financial footings even with years of long-term care costs. Indeed, 15% increases over 10 years would give a net 300%+ increase and over 20 years would give a net 1500%+ increase. So, my original premium of \$2583 would rise to over \$10,400 after 10 years of such increases and to over \$42,200 after 20 years of such increases. And, it would drive a large percent of the not-wealthy into Medicaid for LTC.

Where does the carrier make any promises or expectations now that their original pronouncements of no expected increases would be other than this incredible horizon of increases in the future? At this time, NONE.

Where does the carrier make any promises or expectations now that they will not be padding their overhead, profit, and shareholder distribution accounts from these increases while their claimed loss ratio remains above 60%, in what appears to be a Catch-22 for regulatory review oversight?

Summary Conclusion

In conclusion, there is a serious question as to whether the current increase of 15% in premiums is justified, based on a review of all the assumptions on this policy and the high likelihood that Genworth grossly underpriced the policy. This is on top of the serious questions for all recent-year increases. The assumptions since day 1 on this policy are critical to assessing whether another increase is justified, not just a short term analysis from the previous year to the review year. Policy holders such as myself should not be penalized by the failure of both Genworth, and apparently MIA as well, to catch the grossly-exaggerated lapse rates anticipated that have led to the brunt of the proposed premium increases. Both share responsibility in glancing over what may likely be the most significant factor in initial pricing and whether the prices established are adequate to keep the policies in operation.

The State needs to fully investigate the insurance company files, going back to the original plan actuarial models and continuing with current claims costs to see whether these significant premium increases are fully justified. This cannot be taken out of context with a current-year filing of claims costs as current claims experience for baby boomer class members of my age group are unlikely to be generating the high and accelerating long-term care needs that the carrier offers as justification for costs paid for claims. The information that is needed to understand the Genworth assumptions must be released to the State and to the policy holder. Clearly, I have identified many factors for which assumptions need to be made available in order to properly respond to this complaint.

The consumer suffers, and has already suffered, if the insurance company's actuarial model was woefully unrealistic of those that took out policies because they intended to hold them well into old age, lest they have to use long-term-care which a large percent are expected to need.

This appears to be a form of bait and switch which is usually deemed to be illegal in consumer matters, except in this case it is the State, as well as the consumer, who loses from the profits of the insurance company which were not large enough for them. It is too late for most middle-class baby-boomer consumers to buy new policies at advanced ages 15 years later, at much higher rates, after expending tens of thousands of their own hard-earned money for no gain. Was the actuarial model purposefully hiding expectations for consumers holding onto their policies long-term well into retirement and aging, hence pricing too low to attract consumers who would later find these policies unaffordably too high? It appears so, given

- the 1997 NAIC report,
- the general stability of initial premiums in the years after 1997, and
- the peculiarly self-condemning words of the Genworth CEO in 2016 that lapse rates were continuously modeled as 5% annually.

If this was the case, the policy holder should not be primarily held responsible for the foibles of the carrier in a regulated industry. Why is the policy holder the one being held responsible for this kind of deceit by having to pony up the losses resulting from the grossly-erroneous projections which Genworth could have foreseen in the 1990s at the latest? THE POLICY HOLDER SHOULD NOT BE THE PARTY WHO SUFFERS THE MOST FROM THE MISTEPS OF THE CARRIER.

Was this deceit by Genworth totally accidental? IT DOES NOT APPEAR THAT THE DECEIT WAS ENTIRELY ACCIDENTAL OR BEYOND THEIR CONTROL.

After many years of implied improbable lapse rates by Genworth, why is the policy holder the one who has to pay the difference out of his/her own pockets? IT DOES NOT APPEAR THAT THE CARRIER MADE TIMELY REPORTINGS OF ITS EXPECTATIONS OF UPCOMING LOSSES, EVEN CONTINUING LOSSES.

Was the silence by the State Insurance Commission totally benign for its lack of understanding of what the companies rated in its costs analyses or the State's own independent due diligence analyses and investigation? MARYLAND WAS AWARE BY THE END OF THE 1990S AT THE LATEST THAT THE LAPSE RATE ESTIMATES WERE WOEFULLY MUCH TOO HIGH BUT FAILED TO TAKE ACTION TO INVESTIGATE OR ACT WHEN THE LONG-TERM FIXES COULD HAVE BEEN LESS DRAMATIC OR EXORBITANT.

Even if the State was not aware of

- the underlying lapse estimate figures for the class at the time that policies were taken out, nor
- the actual rate of lapses over the years until recently or even now, nor
- the insurance company's target for lapses now and long term,

the State can hardly term what the insurance companies are doing for increases as reflecting actual **current** claims payments as the index of needing rate increases. The mess was not created for the most part as to business circumstances in the current year(s) out of context for gross mis-assumptions of decades past. Any such ignorance by the State is especially damning given the NAIC 1997 report on unrealistically high lapse rates having been used by companies. Maryland was not idly sitting out from NAIC activities and reports 20 years ago to have been ignorant of the lapse rate problems of the past, many of which appear to have been continued past 1997. It appears that this can be stated even regarding Genworth, based on the Genworth CEO interview statement in 2016.

✓ **For these reasons, especially, rollbacks negotiated between the State and Genworth are necessary**

The State should simply disapprove of all further premium rate increases until such time that it can figure out and demonstrate to the policy holders of Genworth if they are:

- 1) Warranted even under the insurance companies actuarial models and assumptions,
- 2) Based on assumptions that are fair and protect consumers,
- 3) Consistent with industry-wide assumptions and conventions for demographic and care parameters and not just claimed by Genworth as their own authorities into local/national trends that touch upon benefit cost outlays and projections,
- 4) Based on conventions consistent with NAIC research and reporting on consumer behavior pursuant to long-term care policy purchase, holding, and claim practice,
- 5) Are consistent with the State model for Long-term care budget planning under Medicaid,
- 6) Likely to go towards claims benefits rather than in large part be pocketed by the carrier for overhead and distributions at a time when the loss ratio is so averse that it could do so and remain still high after the increases, and
- 7) Legally appropriate under the Insurance industry's own regulations and guidelines from the date these plans were established until now.

Without ALL considerations put on the table, consumers are no better assured of any relief EVER in the long-term horizon than they had last year and the year before when all increases were simply rubberstamped by the Commission without apparent exception.

Consumers should believe that the State regulators are performing their job in protecting consumers. Currently, consumers can only see that increases have been limited to 15% annually, but that is

- insufficient to explain the situation,
- apply a remedy, or
- deny in whole or in part for reasons that premiums were not properly formulated over the period since the rates were first established until the present increases.

✓ Under the circumstances that I have outlined, consumers deserve more from State regulators, including assurance that regulatory monitoring is being appropriately conducted and consideration of real short and long-term remedies for the consumer who may have been deceived throughout the policy period. The policy-holder should not be the one to suffer from underpricing and improper projections when Genworth knew or should have known that critical parameters it was using, such as lapse rate, were grossly over-estimated. Under these circumstances, past, current, and potentially-endless 15% increase approvals by the State for Genworth are an abrogation of its oversight regulatory responsibility to consumers who purchased policies in Maryland. There must be effective regulatory oversight for relief to the policy holders who took out these policies in good faith of the policies being appropriately priced at the times they took out these policies, in conjunction with Genworth's pledges to consumers both oral and written that it did not expect premiums to rise in the future.

I await a response to this complaint, including the hard facts that are driving these premium increases.

The NAIC Long Term Care Insurance Model Regulation also includes a rigorous process for rate increase filings. Actuaries must explain which pricing assumptions are not being realized and why, and cite any other actions being taken by the insurer. It requires significantly higher loss ratio assumptions for the increased premiums than for the original premiums, and reporting of actual to projected results for three years. Based on these reports, a regulator could direct rate adjustments, special replacement offers or other indicated remedies.

Have GE Insurers ever raised rates on their existing policyholders?

To date, GE Insurers have never had to raise premium rates on any of their existing long term care insurance policyholders, dating back to 1974 when GE's Long Term Care Division pioneered long term care insurance. However, past performance is *not* a guarantee of future performance, and therefore our policies' premium rates *may* increase in the future for reasons including but not limited to the factors described above.

How frequently do I have to pay premiums?

Premiums may be paid annually in one single payment, or in two semiannual payments, four quarterly payments or twelve monthly payments through pre-authorized bank drafts only). If you choose a multiple payment mode (i.e., modal premium), you will have to pay higher actual premium amounts than if you made one annual payment, which helps cover the additional expense of collecting premiums more frequently, and takes into account the time value of money.

For example, assuming a \$1000 annual premium, the following modal premium factors would be applied:

Premium Payment Mode	Modal Premium Factor	Annual Percentage Rate	Modal Amount Due	Number of Payments	Total Annual Cost
Annual	1.00	0.0%	\$1000	One	\$1000
Semi-Annual	0.51	8.2%	\$510	Two	\$1020
Quarterly	0.26	10.8%	\$260	Four	\$1040
Monthly	0.09	17.2%	\$90	Twelve	\$1080

Will premiums ever be refunded?

If your application is not accepted by us, we will refund your premium (without interest) in full. After we send you your policy, you may return it within 30 days after you receive it for a full refund (without interest). Otherwise, only if you cancel your coverage and surrender your policy, or if you die, will any premiums be refunded to you. Any unearned premiums are required to be applied against future premiums due, or to provide benefits, so as not to disqualify your policy from the federal income tax advantages it enjoys.

We hope we have answered any questions you may have about long term care insurance premiums. Please keep this document with your important papers, and attach it to your policy when you receive it.

Important Information About Long Term Care Insurance Premiums from GE Insurers

Att. 1



GE Financial
We bring good things to life.

of the most important elements of a long term LTC insurance policy is its price - how will it cost you? The following questions answers contain important information about premiums.

much does my policy cost?

For an insurance policy by paying the premium due in a timely manner. You can select a level of daily and lifetime maximum benefit levels on an LTC insurance policy, different elimination periods, and various coverage options (such as the Increase Options, Nonforfeiture Benefit, and the Higher Benefit). If you choose more coverage, the premium cost will be higher. If you choose less coverage, the premium cost will be lower. The premium cost is a very important first step - you may not want to buy long term care insurance coverage unless you expect to be able to afford to pay the premiums every year, or if they were to increase in the future, for example, by 20%.

does my age affect my premiums?

The younger you are, the lower the premium rate for the coverage level(s) you choose. If you choose an LTC insurance policy at a younger age than at an older age, you would generally pay substantially fewer premium dollars over its life, and be insured for a longer period of time, meaning you keep the policy in force and do not lapse. Your age at time of policy application determines the initial premium rate you will pay.

Are premium discounts available?

Premium discounts are offered by General Electric Capital Assurance Company and, in New York, by GE Capital Life Assurance Company of New York, both insurers for GE's Long Term Care Division ("GE Insurers"). These discounts are based on good health and couples status. Currently, the discounts offered are 10% for good health, and 25% for eligible (including married) couples.

How do insurers determine the premium rates they charge?

The process for setting premium rate schedules is fairly complex. Insurers have to make assumptions about a variety of factors in determining the rate schedules for their policies. The more actual experience an insurer has to draw upon, the more accurate its assumptions are likely to be.

Factors taken into account in determining price include: benefits expected to be paid, percentage of policies expected to lapse, marketing and sales (acquisition) costs, costs of administering policies, investment returns on the insurer's general account assets, mortality, morbidity, plan, option and demographic mix assumptions, as well as other factors. Unpredictable factors, such as advances in medical care and treatment, changes in consumers' expectations and changes in social programs can impact the price of a policy.

The National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulation includes a rigorous process for rate filings. Although currently not implemented in many states, the Model requires professional actuaries to certify that the initial filed rate schedule is sufficient to cover anticipated costs under moderately adverse experience, and is reasonably

expected to be sustainable over the life of the policy form filed, with no future premium increases anticipated. The actuaries must certify that policy design, coverages, and underwriting and claims adjudication processes have been considered; that the contract reserves assumptions include reasonable margins for adverse experience; and that benefits are reasonable in relation to premiums, with sample calculations provided, among other things.

Currently, in all but a few states, insurers must demonstrate at least 60% of premiums paid will be returned to policyholders in benefit payments over the lifetime of their policies.

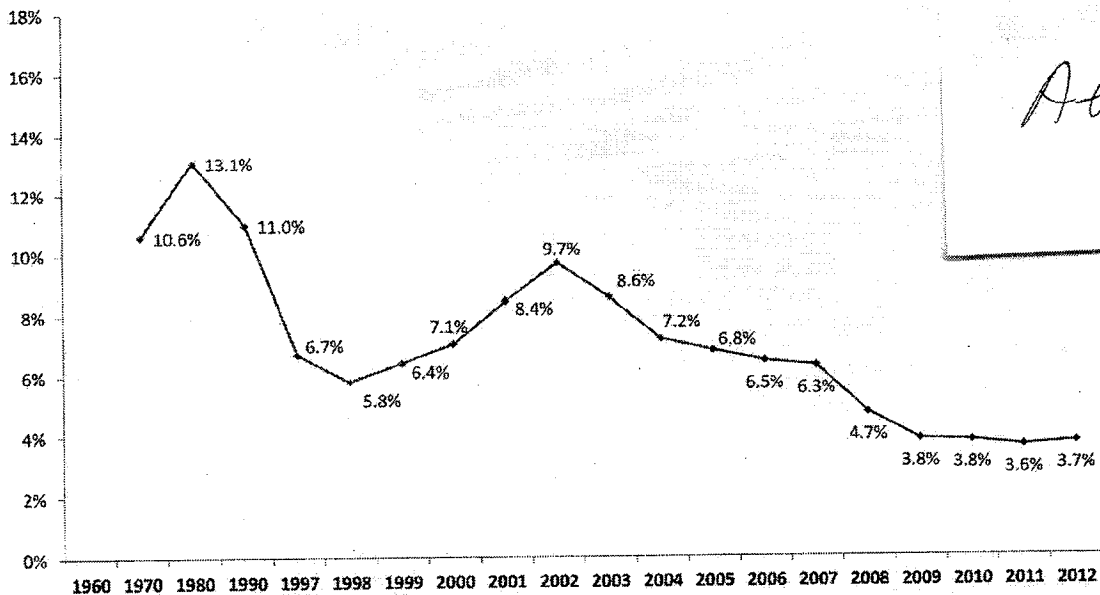
Can premiums increase over the life of my policy?

They could. *Insurers have the right to change their rates on new (or existing) policies at any point in time, providing the new rates are filed with the appropriate insurance regulatory authorities.* Your long term care insurance policy is "guaranteed renewable" which means you have the right to continue your policy in force as long as you pay the premiums that are due in a timely manner, during which time we may not unilaterally change any of the terms of your policy, or decline to renew it, except to increase premium rates. Our goal has been to price our long term care insurance policies so that premiums will remain at original levels for the duration of the policies. Nonetheless, it is possible that rates may have to be increased. If so, rates would have to be increased for all policies in the same state and class (i.e., with a policy similar to yours). A policy's premiums will not increase just because of the insured's age, deteriorating health or individual claims experience. For any increase, we would first need to get the approval of the appropriate state regulator(s), and would also need to give you reasonable advance notice (at least 31 days) of the change.

HEALTH CARE INFLATION

Over the last fifty years (excluding the Great Recession of 2008), health care cost inflation has averaged well above 6% - and even exceeded 10% at times (see chart below). However, since the Recession, health care inflation has fallen significantly below the long-term trend, which can largely be attributed to low interest rates and modest inflation. Looking ahead, health care inflation is expected to rise. In fact, the U.S. Department of the Actuary is projecting health care inflation to remain at approximately 6% for the next decade.

Average Annual Percent Change in National Health Expenditures, 1960-2012¹



SOURCE: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2012; file nhe2012.zip).



While health care inflation was approximately 3.6% in 2014, it was still more than four times the Consumer Price Index increase of 0.8%, continuing a long-term trend in which health care inflation is a multiple of CPI. The year-end 2014 summary from the Centers for Medicare and Medicaid expects retirees to endure at least eight years of health care inflation between 5% and 7%². This is consistent with HealthView's actuarial-backed projection that health care cost inflation will return to more normalized levels of approximately 6% over the next decade and continue to rise at a multiple of CPI.

1 "Average Annual Percent Change in National Health Expenditures, 1960-2012". The Henry J. Kaiser Foundation: March 6, 2014. <http://kff.org/health-costs/slide/average-annual-percent-change-in-national-health-expenditures-1960-2012/>

2 <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf>

Marshall Fritz Comments on Proposed 2017 MIA Regulations for LTC Insurance Due April 6, 2017

I appreciate the opportunity to respond to the MIA LTC Policy Proposals.

As an opening statement, I must state my disappointment with what appears to be MIA's inexpeditiously undertaken investigation and release of the responses from Genworth to MIA pursuant to my Complaint on Feb. 8, 2017 against Genworth and MIA. I understand ONLY, that, as of April 4, 2017, MIA has now received the response from Genworth and is reviewing it. Over the span of two months, I heard nothing from MIA on the investigation and only heard this much via Senator VanHollen's Office which is monitoring the processing of the complaint and release of information. Senator VanHollen's Office informed me that the initial date for Genworth response was March 7, followed by extension to Genworth of March 13. Consequently, with such delays even after granted extension, the rulemaking period needs to be extended without any reason provided for the delay of release of information on poignant aspects of Genworth's and MIA's handling of LTC projections, costing, and monitoring of the premium rate structures. Nevertheless, the complaint was against both Genworth and MIA, and no word has been forthcoming on the parallel, independent response from MIA on its activities cited in the complaint.

As a second statement, while I welcome any new regulations that might provide longterm policyholders with relief against incessant annual increases, these regulations may not achieve any relief or little relief. Policy proposals that may on the surface appear to benefit consumers may not have the intended consequences on consumers having longterm policies in place. In fact, these regulations may actually open the door to higher levels of TOTAL increases than could be contemplated by Genworth and others heretofore. Even when it initially appears there to be a possible benefit to myself and others who are longterm policy holders, other parts of the regulations raise significant doubt of assurance of any actual longterm relief (or the relief seemingly-included in one policy against other policies) based on the ambiguity of phrases and the likelihood of future loopholes for the carriers.

Under all of the policy regulations proposed here, MIA should understand that consumers may be driven towards bankruptcy or Medicaid in even larger numbers for an insidious reason having to do with the realities of LTC costs. If the consumer family needing LTC care cannot afford the difference between downgraded benefits and market rates, the consumer family may find that the only alternative is to head towards Medicaid much faster when there is no more cash liquidity to buffer the difference between the downgraded benefits and LTC costs.

✓ Thus, the insurance may become irrelevant for many who downgrade their policies because they will need to be on Medicaid, whether or not the carrier pays daily benefits to Maryland for LTC care under Medicaid. For example, the family with \$250-a-day benefits who downgrades to \$125-a-day benefit may well find that they cannot fill the \$125 gap from funds, putting them in line for Medicaid for lack of ability to pay the difference in LTC costs despite having LTC insurance coverage. Such a situation makes the insurance coverage almost irrelevant when they cannot afford the difference on a policy they studiously took out decades ago – the client stills goes on Medicaid, out of control of the individual family and on the dole of the State. The greater the unexpected premium increases or downgrades

occurring, the more the model for paying for LTC through insurance while staving off bankruptcy or family pennilessness goes awry/away. The very flexibility MIA now seeks may reward carriers for anti-consumer malfeasance of years back and severely harm consumers to the point that MIA may lead Maryland Medicaid to bankruptcy by administering the insurance programs with the flexibility it has or now seeks.

There is nothing in these policies that seemingly acts to constrain carriers from padding their justification for increases to include significant overhead, overhead of which means that increases are not just paying for claims themselves but for company internal funding. While Policy (6) seeks to examine company financial data, nothing here would constrain a company from claiming that it needs additional costs for claims administration in LTC for administration costs else in the company.

When prospective policyholders shopping for LTC insurance alternatives realize that MIA puts the burden of losses for carriers entirely on the shoulders of consumers to pay back funds in increased premium rate increases sufficient to put the company onto a positive financial footing, they will not trust MIA and the companies for setting up new policies in a fair manner. This will lead to additional pressure onto Medicaid, in a spiraling downfall. There must be another alternative towards keeping families solvent and providing care for those who need LTC in an aging population.

Policy (1). Phased-In Rate Increases.

There has been a fallacy in the MIA rate increases that they must be compounded over time rather than simple increases from the base premium rate, such as 15% simple rate cap each year from the base rate. The carrier failures hark back to the initial rates as much as any current compound rate needs. After 4 years, the rate increase should be no more than 60%, not 75%. The way these rates are going, the compounding takes off, further creating problems for consumers that were not of their doing in comparison to poorly derived models from the carriers that made gross mis-assumptions on lapse rates and the numbers of consumers who would drop out before they would be subject to extreme frailty to warrant such LTC. For example, 10 years of compound 15% rate increases adds 300% to the rate, while 10 years of simple 15% increases from the base rate only adds 150%, a dramatic difference to consumers. If MIA engages in talk of 'premium rate stabilization', as mentioned at the Oct. 26, 2016 hearing, compounding the rate increases certainly does nothing of the sort when the real question is whether the initial rate was appropriate.

Once again, MIA puts the responsibility almost entirely on the backs of consumers for being responsible for the increased claims while the greatest failure may well have been the initial underpricing at a time of higher interest rates of these policies for reason on grossly aggressive lapse rates.

The term 'actuarially-justified' 'phased-in' rate increases appears to grandfather any rates and projections of the past that were NOT truly 'actuarially-justified'. In particular, if lapse rates were projected to be many times over what experience (and logic would) have found, neither were initial rates nor proposed increases of recent/upcoming years properly justified. In other words, if rates were knowingly or should-have-been-known-to-be too low due to unrealistic lapse rates estimates, policy holders are now suffering from baiting techniques to buy policies that would have been realized by the carriers as having

been priced too low at times when consumers in their lives/careers could have made other choices/corrections/adjustments. It is too late decades later for consumers to easily entertain these kinds of rate increases decades later. Genworth has been interviewed and reported in the press, without retraction, that it used 5% for many years as the lapse rate whereas they discovered suddenly later that the lapse rate was less than 1%. This is so dramatic a difference as to throw out of whack any pricing mechanism, past or future, for which the carrier AND MIA should be responsible for not catching when NAIC reported overly-aggressive lapse rates in 1997 which industry supposedly had corrected. But, for Genworth, it appears that they did not reprice their policies around the turn of the century.

Given that Genworth appears to have grossly mispriced their policies and now is trying to collect for their mistakes by gross increases in order to drive out consumers from policy benefits, MIA should be talking about the possibility of how to deal with **rollbacks of rates** to account for the industry-mispriced policies. Maryland is a State with residents and consumers, not just a State where business are licensed to operate and sell policies.

A proposal to talk about actuarially-justified rates MUST examine the entire trajectory for rates, not just taking out of context an immediate request for increased claims while the apparent mispriced policies from the start are considered for their being knowingly mispriced. In an overall assessment, it may call for a rollback AFTER the recent increases of 4 years or so carriers have received 15% rate increases.

MIA has already approved rate increases tantamount to 75% over four years; certainly three years compound increases of 15% annually have been implemented for Genworth. So, it appears that MIA is posing what to do with FOUR more years of 75% increases, meaning that any innovative proposal might have to deal with rate/benefits that are equivalent compounding to $\text{base rate} \times (1.15)^{**8}$, or well over doubling of the initial policy premium rate. If, however, MIA is referring to increases it has already approved as being subject to simple rate increases over the base, then policyholders would indeed be due a rollback in premiums, now about 15%.

And, in the wording here, there is nothing to limit the increases even after another period of 4 years of additional increases. So, MIA is doing nothing more than proposing innovative ways of gutting any meaningful policy benefit for most Maryland policy holders. There is no limit in any of the proposed regulations as to how many increases or the totality of the increases they can request. Given the lapse rate fiasco, and, for example, Genworth's advisement to consumers that it never raised premiums and had no expectation to raise premiums, this only further exposes the anti-consumer aspect of MIA monitoring of insurance carriers. MIA and the State cannot ignore the company's own statements and literature which now appear to be bait and switch techniques for which carriers such as Genworth knew decades ago their policies were underpriced for the long haul and would require significant increases when policyholders were stuck with them.

Unlike other States that have proposed that increases ceased after certain levels of increases, this policy suggests nothing further than seeking innovative ways of reducing benefits every four years without limit. In such cases, MIA is not making any policy to regulate longterm 'offer[ing] more consumer alternatives', but simply asking carriers to provide new streams of ways in which to reduce benefits ad

indefinitum through consumer 'alternatives' of which way to downgrade benefits. Thus, the whole idea of 'landing spots' is a misnomer if alternatives do not recalculate from the base rate; where we are now and are headed are NOT landing spots at all. Instead, they are really way-stations towards further spiraling out of control in reductions of benefits. These policy proposals do nothing to clarify that landing spots are true premium rate stabilization. In fact, these landing spots are ephemeral, and, with annual increases portend to be nothing but premium rate destabilization, portending endless downgrading likelihood.

When a carrier reprices any alternative for benefit reductions or inflation protection, it should go back to the rates/projections of the base year, then go forward. Why do I make this point? Because, in the past Genworth has offered cascading benefit reductions but there is NO assurance that the new premium is consistent with what consumers would have paid as premiums if they had the similar benefit level/reduction from the policy inception. When consumers continually downgrade policies, each time they land in an interim 'landing spot' to save money, they are projected as being costed out at the higher benefit level, only to find themselves dropping to classes of policyholders at lower levels. Thus, it is very possible that the carriers bilk consumers again in an overall cost/benefit expectation model for benefits they would never be opting for longterm. And, while this is happening, the carrier has received higher levels of premium income for benefits that the consumer permanently foregoes. "Innovative" may not be the best or only term here; it needs to be a fair reassessment of expected claims as if the consumer started at the lower benefit level class which is the benefit against which the consumer will ever be able to make claims.

MIA MUST compare what rates consumers who started in lower benefit classes are paying for premiums now against the premiums which would be proposed for consumers who downgrade their policy benefits after paying for higher benefit levels for years which they can never recoup later when they downgrade. Policy holders must also be made privy to the premium rate price trajectory from the ORIGINAL CLASS for those who initially chose such a downgraded benefit level from the start. Else, every policyholder should be suspicious that it is the company who continues to benefit by offering a slightly lower rate for significant reduction in benefits, far less of a difference than what would have been offered for the lesser benefit levels in the year of the original policy going forward with the lesser-benefit-class.

Policy (2) 15% Cap

This policy calls for modification of currently allowing increases in excess of 15% 'if the carrier demonstrates the utilization of benefits is greatly in excess of the expected rate,' if the carrier may alternatively 'justify an increase excess of 15% if it can demonstrate that its claim experience is greatly in excess of the expected rate.'

Here, we have another ambiguity in terms of what is the expected rate of utilization or claims benefits. When carriers, such as Genworth, marketed policies one or more decades ago, they assumed a lapse rate of 5%. In other words, when baby boomers purchased such policies in large numbers 1-2 decades ago, it would be unlikely that members of this class would be in positions of frailty in 20 years from

policy inception (such as at age 65-70). In contrast, it appears that Genworth and other carriers had modeled their policyholder group classes in this age range as essentially completely dropping their policies before they would reach ages of frailty. These carriers modeled their policies such that they expected almost no utilization, nor claims benefits, while at the same time apparently expecting to be keeping nearly all premiums for their profit.

With such ambiguity, MIA would be giving carriers the option of increasing their rates proportional not just to the proportions utilizing their policies, but also to the costs of such utilization. If comparison were made against the original model when policies were being taken out, the latter comparison could justify infinitely large increases because the carriers predicted essentially no benefit claims when they marketed the policies and are now faced with dollars of claims, with the ratio of dollars/near-zero-dollars far exceeding the ratio of percentage of utilization/near-zero-utilization rates. Thus, this is a formula for MIA allowing incredibly high increases, far in excess of 15% in any given year. Instead of helping consumers, such a policy might result in nearly all policyholders dropping out who haven't made claims – a formula for WIN-WIN ONLY for the carriers. The 'flexibility' MIA seeks could now bankrupt consumers one way or another – being asked to pay skyrocketing premiums far in excess of 15% or keeping policies that are all but devolving to be near-worthless in value or utility toward paying for real LTC costs.

(3) Consumer Protection in Inflation Reduction.

This policy currently in effect reflects the fact that MIA has not been protecting long-term/current policy holders, while protecting under CoMAR 31.14.01.01.36(A)(3) those future policy holders at significantly higher premium levels for the same benefits package.

It was unreasonable to have so discriminated against existing policyholders in the first place. There should be no reason that MIA is only just "considering" amending the regulation to extend the provision to "policies issued or renewed on or after a certain date." However, as stated, this proposal makes no sense because it would NOT include any policies up for renewal for at least another 11 months, if not ambiguously indefinitely. NO date is included. If this regulation policy is implemented, it should be implemented RIGHT AWAY OR RETROACTIVELY. Why should any policyholders face another year or two or more of downgrading options only to find out that they were left out and penalized if they held out longer. This is another way in which MIA favors carriers who are free to discriminate against policyholders in the manner in which they are able to downgrade policies. As I understand it, Genworth has rewritten benefit levels for downgraders such that they lose the (payments for) higher benefit levels they have paid for all these years. MIA needs to make clear to consumers what this means in actuality with all the carriers. It should also be made retroactive for all those who needed to downgrade in recent years, greatly due to the malfeasance of carriers in proper pricing of their policies and the untimely premium increases they have forced on consumers.

The regulation should state that it is retroactive to any recent year downgrading of policies by consumers in the face of increased 15% annual premiums. Nothing less would be fair to consumers under the burden of downgrading benefits.

(4) Consumer Options Document.

I agree with what is written in the policy proposal, to the extent of what is written.

However, what is sorely lacking each year is the lack of knowledge by consumers when carriers are applying for increases in the first place, with justifications provided to MIA. There is a great disconnect between the hearings process and the increases, as consumers cannot be sure for what year of policy renewal the application and hearing is referred to. Consumers should know this well ahead because of the incessant numbers of increases. They should also know what the carrier is proposing, because under these regulations there are a panoply of alternatives. Consumers need time to react. When the notice of rate increase and notice of premium are received, it appears to be months/year(s) after MIA received and reviewed the increase. Indeed, at the Oct. 2016 Genworth rate increase hearing, I had no idea which year the increase proposed was to apply – Feb. 2017 or Feb. 2018. I also had no inkling that the approval for Feb. 2017 had taken place long before. It was not mentioned at the hearing and the only way to intuit this was to understand the time frames of MIA review which did not make much sense for letters going out to consumers in Dec. 2016 announcing the carrier's increase for a hearing that would lead to requests for further detailed information for MIA from the carrier. If I was mystified, I would believe that nearly all policyholders are mystified by the pace/timing of what happens with these rate increases.

The timelines of the rate review process need to be more transparent to policyholders.

(5) Connecting Consumers with Producers

This policy is jargoned to the point that consumers cannot understand what is proposed. What is a 'LTC insurance producer'? Even Googling the term did not provide 'hits' that clarified what is meant here. MIA needs to clarify what this means to allow for any consumers to have a chance to analyze and respond intelligently.

In addition, is MIA encouraging consumers to consult someone at cost to the consumer? If so, why? What is the net annual cost to policy holders? It seems to be clearly to be in the millions of dollars for such services – either paid by the consumer or absorbed by an unwitting insurance party.

If the purpose of such outreach is to consider buying a different policy in the future as part of the consideration of options, it is rather shortsighted as to be a waste of time for those of advancing years who purchased policies long ago. The price differential is likely to be so substantial as to constitute a waste of time in engaging in that direction with 'producers' outside of the carrier of record.

This sounds like a something that could even be a no-cost marketing consultation for other offers. In most cases of those holding policies, it would be an insulting joke to be offered another policy type at higher cost.

As such, unless this is clarified, it is hard for the consumer to even understand whether there is any value under any circumstances for such a consultation with an insurance producer after holding a policy.

(6) Study of Company Financial Data

The policy proposal is written more to deal ONLY with the future monitoring rather than uncover whether the carrier improperly treated LTC insurance as independent cost centers in the past no matter how well the rest of the company was performing. This would grandfather gross anti-consumer inequities totally to the benefit of the carrier and to the detriment of the consumer. In the case of Genworth, which promised that it had no reason to believe that LTC premiums would ever need to be increased, differential treatment among the divisions would severely challenge its integrity in marketing and dealing with consumers.

The manner in which this policy is phrased puts the carrier in complete control of the information that the carrier would propose to provide to MIA. This is misbegotten when MIA should be studying this in a manner that is under its regulatory monitoring responsibility within the State. Clearly, the carriers will offer little to expand knowledge beyond LTC products, in regards to company 'vitality'. What is unstated here is to understand the components of overhead, profit, and share distribution dividends that are hidden components above and beyond claims, yet enter in low ratios and premium increases. How are overheads, profits, and share distribution dividends treated in other divisions? How does this compare with insurance companies at large, not just those few still offering LTC in Maryland? How much cash/liquidity does the company have to support losses in any division?

In addition, there is the question with Genworth as to whether buyouts/merging with other companies adversely impacted the health of the original GECapital/Genworth policyholders such that the increases are predicated on other bad business investments GECapital made, not merely rising costs of LTC or claims. Should the longstanding GE Capital customers suffer through these mergers, especially if the mergers balance sheets were not shared throughout the insurance company?

MIA needs to lead the comments in particulars which are poignant to analyze, not to just let the carriers define how they see LTC insurance. They could say they have a wall around LTC for independence, but would that be true or just a cop-out to lead MIA astray from attacking its weak/untrue arguments? How would MIA know it is receiving the truth?

This is the key how a company claiming to have a losing division puts that division out to pasture for losses while winning divisions may be skimmed by the central company for its excessive profits.

Suppose MIA were to uncover bad business ethics on the part of a carrier who simply portrayed LTC as bleeding money when the company was not doing badly as a whole. Could MIA, under any regulatory formula, demand that premium increases be rolled back if they were not priced in good faith? Is the MIA regulatory authority ONLY focused on the LTC product balance sheet where the carrier could bleed excessive overhead not otherwise spread around the company in order to justify the LTC increases? Where there is smoke, there may be fire.

Did carriers collude on this in recent years to formulate ways to increase LTC premiums because they saw that it was easier to justify premium increases when overhead is heavily weighted in the cost premiums disproportionately for the company? It is odd that ONLY in the last 5 years have these increases been sought whereas the lapse rates were likely grossly unrealistic for policies issued in many of the recent decades to have caused balance problems for older classes long ago.

How does MIA know that the cost of overhead is fairly tabulated and not shifted into LTC administrative overhead to justify increases where the administrative overhead is greatly relevant in part/great part to other divisions?

(7) Notice of Hearing

MIA proposes that all stakeholders be alerted to the hearings process and be enabled to participate ("engage") in the hearing for that carrier. Unfortunately, there are several deficiencies here. The first, as mentioned in regards to Policy (4), is that consumers are not provided clarity as to which premium year the respective applies. Second, based on the experience of the Oct. 2016 Genworth hearing, MIA failed to provide adequate facility arrangements, i.e., the room was barely adequate for the numbers who were in attendance, there was not enough time for all those who wanted to speak to be given that opportunity and those who spoke were cut short in order to finish at the set time for the room reservation, and the telephone conference call hookup operated very poorly. Until MIA prepares for all of a multitude of speakers (let alone the thousands of stakeholders who are concerned but might not testify) to have their opportunity and sets better facility arrangements, it is likely that this intention of 'engagement' will fall short of satisfaction and only leave many to feel that their voices do not count.

What is also significant is that the proposal fails to suggest a timeframe for stakeholder customer notification. If this is not far enough in the future, any last minute notification will properly appear to be an attempt to prevent as many as possible from coming and testifying against them. So, without timeframes for the setting of the hearing event details, combined with speedy notification of policyholders, this proposed policy may result in few being informed with appropriate notice.

In addition, notifications should inform customer stakeholders of workgroup conference sessions, to participate as listeners. Previously, the MIA moderator informed one policyholder that he was not a stakeholder and could not participate on the call. Well, MIA here indicates that policyholders are stakeholders and should be informed of the WorkGroup conference calls. If policyholders are stakeholders, we must be treated respectfully as stakeholders.

In the interest of 'meaningful public hearings', MIA cannot just slapdash an event but has to plan well ahead, provide a proper venue, and ensure that carriers timely inform policyholders. It is likely that this notification process will take at least two weeks to get to policyholders via the carriers, a time period that must be built into the advance planning requirements of any hearing. Notices for hearings have not uniformly had the kind of cushion that would allow for any delays in secondary notification of policyholders.

MISSING FROM ALL THESE PROPOSALS:

The proposals do nothing to assure policyholders that Maryland will ensure that policies will stay in force, regardless of the legal/financial disposition of the carrier. Maryland needs a clear fund, and a means of funding it, that assures that policyholders will be able to continue with a policy in force in Maryland, lest a disaster occurs with a carrier that puts customers into bankruptcy and Medicaid should they need to make a claim of benefits.

* Given the increases in premiums that have occurred for Maryland LTC policyholders, Maryland should find a way in tax credits to adjust for policies that now exceed, and will likely greatly exceed in future years, the level of Federal medical deductions for LTC insurance. With the levels currently being charged, even most middle class policyholders will likely be able to do itemized tax deductions, with increasing likelihood of having medical deductions. This would be a small way of recouping some of the exorbitant premium increases, aimed at middle class policyholders.

* Policyholders get a Maryland tax credit in the year we sign up for LTC insurance, but never thereafter. Perhaps, there can be continuing credits devised for holding such policies in a manner differently from being able to claim the IRS Medical Schedule A tax deduction.

With Appreciation for Opportunity for Comment,

Marshall S. Fritz
[REDACTED] Rampart Way
Wheaton, MD. 20902

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April 26, 2017

Mr. Marshall Fritz
██████████ Rampart Way
Wheaton, Maryland 20902

RE: MIA File Number: 116135-L-2017-AJH-C
Carrier: Genworth Life Insurance Company (Genworth)

Dear Mr. Fritz:

We have reviewed your complaint regarding the rate increase on your long term care policy with Genworth. Attached is a copy of their response. Your premium rate is based on your age when the policy was issued, and can only be raised when the premium is raised for everyone in the same policy group. This is allowed by your policy contract.

One of our actuaries reviewed the response and compared it to the filed rates. The company is charging you the correct rate.

In order to have the rate increase approved, the company has to submit justification. The Insurance Administration has regulations that limit the increase to 15% a year in most cases. If the company wants to raise the rates again the next year, it must again show that an increase is needed. An increase above 15% has not yet been approved.

Beginning this year, before approval of a rate increase, there will be a public hearing. The purpose of the hearing is for the insurance company officials to explain the reasons for the proposed rate increase. Information on hearings is posted on the Maryland Insurance Administration's website. A copy of Bulletin 17-01 is included with this response.

The actuarial memorandum filed with the rate increase will also be posted on the Maryland Insurance Administration's website for public review. Some information may be redacted.

When long term care insurance was first issued, companies made assumptions about how many people would keep the policies in force and how much would be paid out in

needed to change the assumptions supporting their premium rates to show that more enrollees will keep their coverage over a longer period of time, will live longer, and will have greater needs for long-term care than initially expected. The changes in assumptions mean that premium rates need to be higher than they were originally. Insurers across the country have stopped offering long-term care insurance in light of their experience with this line of insurance. Over the last several years, many companies have asked for premium increases of 150% to 200%. It is important to ensure that the companies have enough money to pay the claims now and in the future.

Regulations also require an insurer or insurance agent selling long-term care coverage to deliver to a prospective applicant an outline of coverage that includes, among other things, a statement of probable or expected premium increases up to age 75. This outline must be presented before the consumer completes an enrollment form. In addition, a long-term care insurance policy or certificate must include a statement notifying the policyholder if premium rates for the policy are subject to change. The current form of these regulations took effect in 2007.

We hope this information is helpful to you. If you have any questions, please let us know.

Sincerely,



Paul Meyer
Senior Complaint Investigator
Life and Health Unit
410.468.2241

CC:
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Director, Office of Consumer Affairs
Genworth Life Insurance Company
Long Term Care Insurance
6620 West Broad Street, Building 2
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BULLETIN 17-01

Date: January 3, 2017
To: All Insurers Issuing or Renewing Long-Term Care Insurance in Maryland
Re: Public Rate Hearings and Posting of Insurance Actuarial Memoranda

The purpose of this Bulletin is to advise insurers that offer long-term care insurance products in Maryland that, effective immediately, the following long-term care initiatives have been implemented by the Maryland Insurance Administration (MIA):

- 1.) An insurer that files a rate increase request for a long-term care insurance product will be required to attend a public rate hearing before a decision is made on its request. The purpose of the hearing is for insurance company officials to explain the insurer's reasons for the proposed rate increase in a public forum, and to answer any questions raised by MIA staff. The insurer should send a company representative to provide testimony. Information pertaining to the rate hearings will be posted on the Maryland Insurance Administration's website:
<http://insurance.maryland.gov/Consumer/pages/LongTermCare.aspx>

Insurers will be notified of the date, time and location of the public hearing and public notice will be given to interested parties. A decision regarding whether the rate increase will be approved will be made after the hearing.

- 2.) An insurer that files a rate increase request for a long-term care insurance product is hereby notified that the corresponding Actuarial Memorandum will be posted to the MIA's website for public review. Prior to publication on the MIA's website, however, insurers will have an opportunity to submit a redacted copy of the Actuarial Memorandum omitting any material that the insurer contends is confidential, subject to the determination of the Commissioner, in accordance with the Maryland Public Information Act. *See* Md. Code Ann., Gen. Pro. Art. § 4-335.

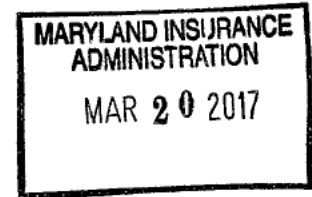
The purpose of these initiatives is to improve transparency for consumers and the public at large with regard to long-term care rate increases. Questions concerning this Bulletin should be addressed to Adam Zimmerman at adam.zimmerman@maryland.gov.

Alfred W. Redmer, Jr.
Insurance Commissioner
signature on original

By: 



Long Term Care Insurance
6620 West Broad Street, Building 2
Richmond, VA 23230



March 17, 2017

Mr. Paul Meyer
Insurance Investigator
Life and Health Section
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

RE: Your File: 116135-L-2017-AJH-C
NAIC: 70025 - Genworth Life Insurance Company
Complainant: Mr. Marshall S. Fritz
Insured: Mr. Marshall S. Fritz
Our File: LTC-2017-00184-01
Policy: [REDACTED]

Dear Mr. Meyer:

We take this opportunity to respond to your February 6, 2017 letter regarding Mr. Marshall S. Fritz’s complaint about the premium rate increases applicable to his Genworth Life Insurance Company (“GLIC”) long term care insurance policy (the “Policy”). Mr. Fritz’s Policy bears policy number [REDACTED]

Mr. Fritz’s long term care insurance Policy is an individual policy issued in the State of Maryland. The GLIC policy form number for Mr. Fritz’s Policy is 7035AT. Mr. Fritz is currently 66 years old and was 65 years old in 2016. Mr. Fritz has not elected to make any changes to his benefits since the Policy’s inception.

In his correspondence with the Maryland Insurance Administration (the “MIA”), Mr. Fritz raised several concerns, which we have further addressed below. Specifically, Mr. Fritz:

- expressed his opinions about and dissatisfaction with the size of the prior and current premium rate increases to his Policy, as well as with the possibility of additional future rate increases, stating that he purchased his Policy from GE Capital, which he understood was a company that did not have a history of raising premium rates;
- shared his concerns about the pricing of his policy form, the Maryland rate increase filing process, and the adequacy of the justification provided to the MIA for the prior and current premium rate increases, specifically questioning GLIC’s reason for the

- premium rate increases of higher than anticipated claims costs when overall inflation and the medical cost of living inflation have been relatively low for several years;
- requested that the MIA not allow any additional rate increases until GLIC demonstrates to policyholders and the MIA that the prior and current rate increases are necessary, justified, and legally in compliance with the State of Maryland’s laws and regulations;
 - shared his dissatisfaction with the options offered by GLIC to reduce the premium by reducing certain policy benefits; and
 - requested that the increases be rolled back, stating that policyholders, many of whom are now retired and on fixed incomes, should not be the ones bearing the full responsibility.

A. The Change in Corporate Ownership and Company Name

As an initial matter, regarding Mr. Fritz’s comment that he purchased his Policy from GE Capital, we note that the rate increase is not associated with the change in corporate ownership and company name from GE Capital Assurance Company (“GECA”) to Genworth Financial, Inc. As background, prior to May 24, 2004, GECA and its parents, affiliates and subsidiaries, were part of The General Electric Company. On May 24, 2004, GECA and certain of its parents, affiliates and subsidiaries were organized as part of an initial public offering of Genworth Financial, Inc. by The General Electric Company, which in the following years divested all of its ownership interest in those entities. As of January 1, 2006, GECA changed its name to Genworth Life Insurance Company (“GLIC”). In January 2006, GLIC sent to Mr. Fritz a Name Change Endorsement, which confirmed that GECA had changed its name to GLIC and specifically informed Mr. Fritz that: “No terms, conditions or benefits of your contract, policy or certificate have changed.” There have not been any changes to Mr. Fritz’s Policy as a result of the changes in corporate ownership and name, and the premium rate increase is not associated with the change in corporate ownership and company name. GLIC’s contractual right to seek premium rate increases was not affected by the January 1, 2006 name change or through any of the transactions described above. We continue to honor the terms of Mr. Fritz’s original contract.

B. Mr. Fritz’s Dissatisfaction with the Size of the Rate Increases

Regarding the premium rate increases, under his Policy, Mr. Fritz’s premiums cannot be increased based upon a change in his individual circumstances. However, a class-wide premium increase is permitted where the company’s experience with his policy form warrants it. The prior and current rate increases applicable to his Policy are not based on Mr. Fritz’s individual age, health, claims history, or any other individual characteristic. Rather, the increases apply to policies having benefits similar to those in Mr. Fritz’s Policy, which were issued in Maryland on the same policy form and are considered by GLIC and the MIA as part of the same policy class.

In regard to Mr. Fritz’s understanding that GE Capital was a company that did not have a history of raising premium rates, it is correct that at the time Mr. Fritz purchased his Policy, GLIC’s predecessors had not increased premiums on in-force policies. However, under

certain circumstances, as set forth in the Policy, a rate increase is warranted. The policy provision permitting premiums to be increased on a class-wide basis is set forth on page one of Mr. Fritz's Policy. Specifically, that provision states (bold in original):

OUR LIMITED RIGHT TO CHANGE PREMIUMS:

Premiums will not increase due to a change in age or health. We can, however, change premiums based on premium class; but only if we change the premiums for all similar policies issued in the same state and on the same form as this policy. Premium changes will only be made as of an anniversary of the policy's Effective Date. We must give you at least 31 days written notice before we change premiums.

In addition, also on page one of the Policy, in the section entitled “**RENEWABILITY - THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE**,” the Policy states: “We cannot change any of the terms of this policy on our own, except that, in the future, we may increase the premiums.”

Moreover, since 2002, we have routinely mailed to policyholders a brochure entitled, “Important Information About Long Term Care Insurance Premiums,” which also explains that premiums could be increased on a class-wide basis.

Furthermore, at the time of application, our standard business practice is to provide the applicant with an Outline of Coverage, a product brochure and the NAIC Shopper's Guide to Long Term Care Insurance, all of which clearly disclose that premiums can be raised on a premium class-wide basis. As part of Mr. Fritz's application, he signed a Long Term Care Insurance Personal Worksheet that discloses, “The company has the right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state,” as well as asks, “Have you considered whether you could afford to keep this policy if the premiums went up?” Mr. Fritz also signed the Long Term Care Insurance Potential Rate Increase Disclosure Form acknowledging that he had read the information on the Form concerning “Potential Rate Increases.”

We also note that when Mr. Fritz received his Policy, he had a thirty day “free look” period within which to review his Policy, ask any questions, request any available changes, and/or return his Policy for a full refund of any premiums paid. Mr. Fritz accepted his Policy and has continued to pay the premiums due for his coverage.

C. The Decision to Increase Premiums

Regarding Mr. Fritz's concerns about the pricing of his policy form and the justification for the premium rate increases, as he correctly understands, multiple actuarial factors are taken into account in determining premium pricing, including: expected benefit payments; the number of people who allow their coverage to lapse; marketing and sales costs; the cost of administering the coverage; investment returns on the insurer's general account; mortality; morbidity; plan, option and demographic mix assumptions; and other factors. The

performance of Mr. Fritz's class of policies was such that, after a careful review, we concluded that the prior and current rate increases were warranted. Consistent with the terms of Mr. Fritz's Policy, these decisions were based on our actuarial experience with the policy form at issue and not upon a change in his age, health, claims history, or any other individual characteristics. In regard to Mr. Fritz's reference to the reason for the rate increases, our decisions to increase premiums are primarily based upon the fact that the expected claims over the life of Mr. Fritz's policy form are higher than we originally anticipated when his policy form was priced.

With respect to Mr. Fritz's request that GLIC demonstrate that the prior and current rate increases are necessary, justified, and legally in compliance with the State of Maryland's laws and regulations, we note that we submitted our specific actuarial justification for these rate increases to the MIA on November 16, 2012, November 17, 2014, and December 21, 2015, respectively, and we are implementing the increases in accordance with Maryland's requirements. A copy of the SERFF "Filing at a Glance" with respect to each of these filings is attached for your convenience. The SERFF tracking numbers are GEFA-128775652, GEFA-129761067, and GEFA-130372471, respectively. Regarding Mr. Fritz's concern about the possibility of future rate increases, please note that in accordance with the terms of Mr. Fritz's Policy, GLIC reserves the right to change premiums and it is likely that GLIC will seek additional rate increases applicable to Mr. Fritz's policy form in the future.

D. GLIC is Sharing in the Losses

In further response to Mr. Fritz's request that GLIC demonstrate that the prior and current rate increases are necessary and justified, as well as with regard to his statement that policyholders, many of whom are now retired and on fixed incomes, should not be the ones bearing the full responsibility and his request that the rate increases be rolled back, we note that GLIC is sharing in the losses resulting from the adverse experience on Mr. Fritz's policy form. In the past several years, many insurance companies have exited the long term care insurance business, in part because of significant losses on their in-force long term care insurance policies. GLIC has decided to stay in the business but has filed for rate increases on certain policy forms such as Mr. Fritz's to keep the premiums in line with our experience of primarily higher than anticipated claims costs. Inclusive of all premium rate increases thus far to Mr. Fritz's policy form, the projected lifetime loss ratio on his policy form remains above 100%. In light of these facts, GLIC's actuarial experience with Mr. Fritz's policy form could have justified a much higher rate increase than we requested and received. Even including the current premium rate increase, the lifetime expected premiums on his policy form alone will be inadequate to cover lifetime expected claims and expenses for this policy form. As such, GLIC is sharing in the losses resulting from the adverse experience on Mr. Fritz's policy form.

E. The Rate Increases are Implemented in Accordance with Applicable Laws and Regulations of Maryland

Regarding Mr. Fritz's concerns about the Maryland rate increase filing process and the adequacy of the justification provided to the MIA for the prior and current premium rate

increases, as well as in further response to his request that GLIC demonstrate that the prior and current rate increases are necessary, justified, and legally in compliance with the State of Maryland's laws and regulations, as the MIA knows, a comprehensive set of laws and regulations currently exist for long term care insurance, which is regulated at the individual state level, including in Maryland. As such, the process for seeking to implement a rate increase varies by state. Some states require specific approval before an increase can be implemented. Other states require insurers to submit a request for a rate increase and then wait a certain period of time to hear from the state's insurance regulator, after which the increase can be implemented. Other states impose different kinds of conditions on insurers before premium rate increases can be implemented. Some states "deem" or "acknowledge" authorization, or require that the policy form or rate filing be "filed" by the appropriate insurance regulator, whereas other states "approve" the policy form or rate filing. When allowing a premium rate increase," the MIA provides a disposition status of "Received and Filed." In all events, before GLIC implements a rate increase in any particular state, it follows the requirements of that state, as GLIC has done in connection with the premium rate increases applicable to Mr. Fritz's Policy. We respectfully defer to the MIA to explain the process established by Maryland.

F. Options are Available

i. Mr. Fritz May Reduce His Benefits to Keep Premiums at Approximately the Same Level

With respect to Mr. Fritz's comment that policyholders are now retired and on a fixed income, in deciding to seek this rate increase, we were mindful of the difficulty that some of our policyholders might face in paying a higher premium. While we appreciate Mr. Fritz's dissatisfaction, we note that we created several options for policyholders like Mr. Fritz to help keep his premiums at approximately the current level. As was most recently explained in the Premium Change Notice (the "Notice") regarding the current 15% premium rate increase, which was mailed to Mr. Fritz on or about November 26, 2016, policyholders will be able to keep their premium levels about the same by choosing one of several changes to their benefit options, including reducing the policy's Daily and/or Maximum Benefits Amounts, or increasing the Elimination Period, or changing the policy's Benefit Inflation Option. The Notices included a toll-free Customer Service number for Mr. Fritz to ask any questions he may have and to make the appropriate changes, if he chooses to do so. We note some available options to reduce his benefits were sent directly to Mr. Fritz on or about February 2, 2017.

We have enclosed some available options for Mr. Fritz to reduce his Policy's benefits and keep premiums at approximately the same level, as well as the related premium amounts, including the current 15% premium rate increase that became effective on his Policy anniversary date of February 1, 2016. We encourage Mr. Fritz to carefully evaluate his individual situations, with professional assistance as needed, before making a decision to change his coverage.

Prior to the current premium rate increase, the annual premium for Mr. Fritz's Policy was \$3,416.02. Mr. Fritz's Policy currently has an annual premium of \$3,928.42, an Unlimited Benefit Period, a 50-day Elimination Period, Annual Compound 5% Benefit Increases, and a maximum Current Daily Benefit Amount of \$347.00 (rounded).

Please note that all benefit values presented in this letter and in the enclosed quotes for some available reduced benefit options are approximate due to rounding. Covered benefits payable at the time of a claim will be calculated to the exact amount due or payable in accordance with Mr. Fritz's Policy. Reducing the Daily Benefit Amount and/or the Benefit Period automatically reduces the policy maximum and may also reduce other benefit amounts. Changes to the Daily Benefit Amount and/or Benefit Increases Option ("BIO") will change the related original amounts and/or the amount of any BIO increases. Following 60 days from GLIC's confirmation of a benefits reduction, the reduction cannot be reversed. Any benefits paid or payable will be deducted from the reduced policy maximum. If the insured has previously been on claim, adjusting the Elimination Period may not be appropriate. We note some states require policyholders to maintain minimum benefit levels which may limit his reduced benefit options. Benefits are payable only when Mr. Fritz is benefits eligible and meets the Policy's provisions. We note that the benefit and any rider names in this letter and in the enclosed quotes are generic, and we respectfully refer the MIA and Mr. Fritz to his Policy for its specific benefit and any rider names and provisions.

ii. Mr. Fritz May Elect the Optional Limited Benefit

In addition to providing options to reduce benefits in order to keep premiums approximately the same, we also offered an Optional Limited Benefit (the "OLB") as a courtesy and at no additional cost to policyholders like Mr. Fritz. An OLB allows the policyholder to have a paid-up long term care insurance policy with benefits equal to the total of premium paid, excluding any waived premium, less any claims paid. No further premium payments would be due if Mr. Fritz's Policy is in force under the OLB. The premiums Mr. Fritz has already paid have been earned for the coverage already provided. Mr. Fritz has not paid and will not be charged any premium for the OLB. The OLB is available to policyholders from the date of the Premium Change Notice through 120 days after their next billing anniversary date on which the premium rate increase will become effective. Please note that the cancellation or lapse of a policy within the time period when the OLB is available will be deemed to be the election of the OLB. The current premium rate increase to Mr. Fritz's Policy became effective on February 1, 2017, and the OLB related to this rate increase is available to him until June 1, 2017.

We note Mr. Fritz has elected to maintain his current benefits level and to pay the new annual premium, including the current premium rate increase, for his Policy. Mr. Fritz's Policy is currently paid through February 1, 2018.

If Mr. Fritz has any questions regarding these options, please direct him to call Customer Service toll-free at 877-710-0817. A Customer Service Representative will be available to assist them Monday through Friday, 9:00 a.m. to 6:00 p.m., Eastern Time.

G. Inflation and Long Term Care Insurance

With respect to Mr. Fritz's question about GLIC's reason for the premium rate increases of higher than anticipated claims costs when overall inflation and the medical cost of living inflation have been relatively low for several years, we note that inflation and rising health care costs, by themselves, do not cause long term care insurance premiums to increase. While long term care insurance is for a fixed amount of benefits to the individual policyholder, the insurance risk to the insurance carrier is not fixed. As mentioned earlier in this correspondence, GLIC's decision to increase premiums is primarily based upon the fact that the expected claims over the life of Mr. Fritz's policy form are higher than we originally anticipated when his policy form was priced. Therefore, the company will be exposed to higher than actuarially anticipated claims costs (i.e., its class-wide risk, as opposed to its risk on Mr. Fritz's Policy alone, is not fixed).

H. The Benefits Mr. Fritz's Fully In Force Policy Can Pay Far Exceed the Premiums He Has Paid

We note that currently, Mr. Fritz has paid a total of \$41,414.01, and as of February 1, 2017, his fully in force Policy can pay up to a maximum Current Daily Benefit Amount of \$346.52 for an Unlimited Benefit Period, should he become eligible for benefits and meet the Policy's provisions. If Mr. Fritz was to become eligible for benefits in the future, it would only take 120 days of benefit payments at his maximum Current Daily Benefit Amount of \$346.52 before GLIC will have paid him the full amount of the premiums he has paid to date. Moreover, GLIC would continue to pay covered policy benefits thereafter for an unlimited time period so long as Mr. Fritz remains benefits eligible and meets the Policy's provisions. In addition, if and when Mr. Fritz meets the requirements of the Waiver of Premium provision of his Policy, no further premium payments will be due, so long as he remains benefits eligible and meets the Policy's provisions. Furthermore, as Mr. Fritz purchased the Annual Compound 5% Benefit Increases, his maximum Current Daily Benefit Amount will continue to increase as set forth in the Policy and any applicable riders, so long as the Policy remains fully in force with this Benefit, even when he is on claim for benefits and is no longer paying any premiums.

I. The MIA's Requests for the Rating Information and Documents

Regarding the rating information for Mr. Fritz's Policy, enclosed is a copy of the rate illustration that portrays the present and anticipated post-rate increase premiums for Mr. Fritz's Policy. Also enclosed is the applicable rate table with each factor used in the calculation of Mr. Fritz's premiums highlighted and a calculation of his premium rates using such factors. At the time Mr. Fritz purchased his Policy, he received a 10% preferred health premium discount. We note that the preferred health premium discount was filed with the MIA in the original product filing. As the original filing was a paper filing, we have enclosed the relevant pages for your convenience and ease of reference.

As requested, we have enclosed the following documents: a complete copy of Mr. Fritz's Policy that includes the above-referenced provisions and his application; Mr. Fritz's premium

payment history; and the November 26, 2016 Notice sent to Mr. Fritz regarding the current 15% rate increase.

We are pleased Mr. Fritz has decided to keep his valuable coverage in force and want him to know that we are committed to being here for him should he have a claim for covered benefits. Genworth companies have paid more than \$13 billion in long term care insurance benefits to over 224,000 claimants in our now over 40 years in business as a long term care insurance provider and continue to fulfill our commitments through our provision of more than \$6.1 million in claims payments each business day on average.

We hope the MIA finds that this letter was helpful and adequately addressed Mr. Fritz's and the MIA's questions and concerns. If you have any further questions, please feel free to contact this Office.

Sincerely,

A black rectangular redaction box covering the signature of Gail Cleary.

Gail Cleary
Director, Office of Consumer Affairs
Genworth Life Insurance Company
Tel: 800-267-1383
Fax: 804-662-7858
Gail.Cleary@genworth.com

Enclosures

Marshall Fritz Testimony at MIA Hearing on Genworth LTC Rate Increases May 2021

As a long-term LTC Genworth policy holder, I am testifying in 2021 as I had in 2016 and 2017 hearings. Much of the reasons for my concerns remained unresolved, as they go beyond the costs of claims that exceed premiums collected. However, my concerns are exacerbated that Genworth is providing arbitrary rate justification figures when they submit a notice in December 2020 that they are seeking a 160% premium increase, and then turn around this spring only weeks ago and then rescind it retroactively by a minimum 315% increase. There was nothing provided to customers to explain this exorbitant difference. Whether a clerical error or not, it suggests that Genworth's accounting is completely out of control. Worse, even the 160% increase is far and away exceedingly higher than the Genworth claims of 2016 and 2017 that they justified 48% and 75% increases, respectively. This is runaway scalping without any medical need reason why this is happening. Worse, even the 160% increase is far and away exceedingly higher than the Genworth claims of 2016 and 2017 that they justified 48% and 75% increases, respectively.

There is nothing in the hands of consumers to connect the dots as to why this acceleration is now occurring or whether it would/would not be expected to continue to accelerate further in future. There is little reason to trust any of the Genworth figures, perhaps at any time in the past to projecting the future, when they so flippantly can say that they really can be off by a factor of two in shortfall, just a factor of two, as if it were just a minor discrepancy. **Such a discrepancy is extraordinary and should be cause of MIA rejecting the application outright, especially coming from a history of unsupportable figures such as lapse rate projections. And, it raises questions as to how MIA has allowed such figures to be even considered as evidence of bona fide financial shortfalls by Genworth.**

In the submission accompanying the testimony, I have aggregated several sets of communications I have submitted or received earlier. I testified in 2016 and 2017. I submitted a complaint to MIA in 2017, but received a response from Genworth that overgeneralized responses pertaining to pool of policy holders and Genworth operations. Details sought such as asset growth, reserves, administrative expenses, and exactly how the increased premiums were calculated beyond claims experiences were totally lacking. I submitted comments about proposed 2017 regulations. I have checked off important paragraphs of these materials, indicating that many of the points I raised back then have yet to be fully explained or documented for consumers and remain as background concerns impacting all current and future rate increase reviews.

Thus, the acceleration of rate increases sought is so fast and furious that the implications for the future are extraordinary. And, annual increases of 15%, which will never catch up with these extraordinary Genworth rate increase claims, will in themselves lead long term to extraordinary premium levels or extraordinary converted policies that mean that almost no one could pay these premiums and almost no one will benefit much at all from the reduced values of the policies. Others may find that in future years they have paid so much in premiums that they could never recoup those amounts from future claims – that is not insurance and they might as well lapse their policies while increasing the rate of premium acceleration for everyone else.

And all this is happening without any clear substantiation to the consumer that MIA is in control over the true justification for these gigantic rate increase requests. There is more than mere claims payouts

and premiums collected that need to be evaluated to determine whether or not Genworth are cooking the books in other ways to make the picture favorable to them.

If I were to live to 100 as my mother did before needing LTC in a nursing home, about the age of her admission to a nursing home, my premium could be about \$400,000 a year if compounded 15% increases were approved every year. If exceptional premium rate increases were approved at the 315% justification rate for the current year, with acceleration into the future in like manner without any amelioration or flattening, my annual premium could well be in the millions of dollars. Perhaps even many millions of dollars. Such an acceleration is almost exponential, rising about 250% in 4 years, and will likely be worse with a shrinking non-institutionalized aging pool where administrative expenses will swamp claim benefits. And, I would have paid out millions of dollars in premiums, in all likelihood more than I could recoup through a claim.

In other words, there is nothing to stop the premium level from exceeding what the vast majority of my age cohorts could recoup in benefits, let alone the MILLIONS of dollars already spent on premiums to date. Under such an event not prohibited by current legislation or MIA purview, there would be NO consumer protection. Maryland does allow for extraordinary premium increases when the extraordinary need is justified under simplistic formulae that can belie true justification from behind-the-scenes insurer financial manipulations outside of claims benefits.

Testimony from MIA and Genworth in 2016 talked about the increases back then constituting rate stabilization'. I termed it in my testimony as RATE DESTABILIZATION. What we are seeing now makes that rate stabilization term a sick joke. My rates have more than doubled, with forecasts of upcoming tripling justified on the road to potential annual increases of 15%, OR HIGHER, forevermore into the 'future.

We all know that lapse rates were grossly underestimated in the 1990s by Genworth, basing them on different products with different consumer values for lifetime holdings. But, no thorough study has been reported to consumers that I am aware of, whether by independent actuaries, MIA, or national organizations that thoroughly examines other significant parameters as to whether policy holders have been wronged by unfair tabulations that ignore conditions of Genworth business outside of claims processing of benefits. Reading of the NAIC and Genworth publications over the years point to other critical aspects that should be fully reckoned with in rate increase justifications. These include:

- In 1997, NAIC reported underpricing of policies by 1/3-1/2. But, now going forward, premiums have more than doubled and Genworth is already seeking more than sextupling of the premiums in its latest notifications. Isn't something wrong here that premiums and pricing are already out of control, with forecast of further accelerated exponential premium requests, even before most baby boomers who took out such policies have any need to make LTC claims?
- Has Genworth already recouped from current premium levels the premium shortfall envisioned by NAIC in 1997?
- How Genworth overall assets have fared over a decade when equities have soared. Surely, Genworth corporation owns significant equities beyond fixed income holdings of premiums and reserves. These equity asset increases should be made to offset any claims losses. Note Bene: The Fidelity Investments Monitor & Insight analysis publication shows that over the last year the Select Insurance Portfolio increased in value by 57.5% and by 12.3% overall for the past 10

years. Did Genworth values not follow this trend, let alone its external investments they have which earn capital gains and dividends which might be booked separately?

- How Genworth spreads equity increases and reserves among the various insurance divisions, and whether funds have been moved away purposefully, and disproportionately, away from LTC to make it appear that LTC losses are intolerable to Genworth.
- Whether Genworth has provided distributions to shareholders that otherwise should have been used to bolster LTC insurance reserves or stave off excessive premium rate increases.
- The extent to which Genworth has followed normal business practices for covering losses in one Division by profits in another Division, and, if not, why not. Has Genworth engaged in contrary practices just because it knows that States will reward it for such non-customary business practices?
- Whether Genworth has reallocated its assets properly in a business model of supporting and shoring up Divisions that need additional support, drawing upon other Divisions doing well
- How administrative costs, staff, and resources have been allocated to LTC within the company. Have administrative cost centers been added to LTC unnecessarily from other Divisions to prime the pump of unacceptable Loss Ratios? Why have LTC admin costs gone up disproportionately over the years compared to claims? What MIA purview review procedure prevents excessive overpadding of administrative expenses to pump the prime of Loss Ratios in generating increasingly high 'justified' premium increases? There is no apparent regulation of administrative staffing and expenses that I can see from recent hearing experiences.
- Has Genworth made bad choices of mergers from other LTC insurance companies, to the detriment of those taking out Genworth policies decades ago? And, are the original Genworth customers suffering in their policy premiums and services from the financial impacts of even more poorly-managed merged policies coming into the Genworth fold? Is this a proper business practice to merge other policies in the pricings, even beyond claims benefits?
- How have the assets of lapsed policies been calculated into the cost projections, inasmuch as risk to Genworth on future claims can solely come from the value of premiums already paid and sitting in fixed income accounts earning interest?
- How have the significant future savings from policy conversions been factored into the projections, inasmuch as the customer loses premium-increase buying power compared to base policy increases every time customer converts? Genworth gains more than the customer does with these conversions, especially repeated downgrade conversions. This has been pointed out in hearings and the literature. Furthermore, isn't it possible under the Genworth policy conversion pricing policies of factoring in justified increased costs (even several hundred percent increases) for a customer to find that downgrading actually costs more than keeping the policy as is with limited annual 15% increases?
- There is no clear reporting as to what demographic and economic population statistics were used by Genworth over time and in projections into the future. Without being able to certify that official US statistics were used, it is impossible to validate their models.

After the 2017 Hearings, the Maryland Legislature showed their concern over the accelerating premiums by putting pressure on MIA to work with the insurance companies to lower their costs. Based on the current justification rates pursued by Genworth, supposedly-justifiable increases of over 300% in four years does not reflect any lowering of internal costs. In fact, being so much higher than claims could

have risen so fast, it likely reflects acceleration of administrative costs out of control or cooking of the books. Exactly what has MIA done to exert pressure to lower costs. If nothing, or inconsequential pressure on companies, then MIA has violated the spirit of the legislation and cannot be a fair arbiter of consumer protection in setting premium rates.

Medical costs and medical inflation have remained low in recent years; that cannot be the reason for accelerating cost benefit justification. This should well offset the low interest rates possible in fixed income accounts of premiums paid in.

Covid deaths in nursing homes removed many policy holders from active or future claims short of any projections. This, and the lowering of life expectancy, should have had a downward impact on last year claims or projections of 2020/21 cost tabulations for upcoming rate reviews. To what extent has the accelerated 315% premium rate justification incorporated such mortality, morbidity, and life expectancy already or will in the next year?

It is clear that MIA failed to properly review all the underlying assumptions in the rate structure. They, as well as Genworth, should be held accountable for the failures which are now costing consumers many thousands of dollars a year more than they could have expected in their wildest nightmares to encounter from the possibility of minor adjustments in rates down the road. Neither undertook due diligence in their actions, starting with initial premium rate setting. There is no evidence that an independent actuary thoroughly reviewed ALL of the cost, benefit, projections, and Genworth background financial status when premium rates were initially set. Nor was this evident at the 2016 and 2017 hearings. Both parties should be held accountable for their failures. MIA has a conflict of interest in reviewing any of these rates given their own consumer protection failures in the 1990s that left consumers holding the bag for either exorbitant cost increases or policies that need to be downgraded to the point where they no longer protect individuals from financial ruin upon need for extensive and expensive daily LTC.

CONCLUSION: GENWORTH'S AMBIGUOUS AND UNDERDOCUMENTED FINANCIAL STATUS INFORMATION AND JUSTIFICATIONS FOR EXTRAORDINARY PREMIUM INCREASES DO NOT MERIT CONTINUING AWARDS OF PREMIUM INCREASES BECAUSE THERE IS NO CERTAINTY FROM HIDDEN FIGURES THAT THESE PREMIUM INCREASES ARE ACTUALLY JUSTIFIED YEAR-AFTER-YEAR. MIA HAS NOT EXTENDED DUE DILIGENCE FROM THE 1990S FORWARD IN EXPOSING THESE AMBIGUITIES. CONSUMERS NEED MORE EFFECTIVE CONSUMER PROTECTION THAN MERE ALLOWANCE FOR CONVERSION DOWNGRADES THAT MAY NOT HELP FINANCIALLY-SCRAPPED CONSUMERS IN THE LONG RUN AND MAY ACTUALLY LEAD TO HIGHER PREMIUMS THAN NOT CONVERTING, BASED ON THE MANNER THAT GENWORTH HAS PRICED CONVERSIONS. CONTROL OVER THE ENTIRE PREMIUM RATE REVIEW PROCESS SHOULD BE TURNED OVER THE ATTORNEY GENERAL CONSUMER PROTECTION DIVISION. FURTHERMORE, INVESTIGATION OF ANY ETHICS VIOLATIONS FAVORING INSURANCE COMPANIES SHOULD BE EXAMINED BY THAT DIVISION AS TO HOW/WHY THIS IS ALL HAPPENING IN THE MANNER RECENTLY UNFOLDING, LET ALONE SINCE THE GROSSLY-FAULTY RATES WERE APPROVED DECADES AGO.

Marshall Fritz
Wheaton, MD
Genworth LTC Policy Holder



001 000104

Genworth Life
Administrative Office
3100 Albert Lankford Drive
Lynchburg, VA 24501

IMPORTANT Insurance Documents

PATRICIA A GEBHART
[REDACTED] LONG RIDGE DR
HAGERSTOWN MD 21742

Policy Number: [REDACTED]

Delivery Method: USPS First Class Mail

Insured name: Patricia A Gebhart

Patricia A Gebhart

Helping secure your financial future

Underwritten by Genworth Life Insurance Company



Genworth Life
Administrative Office
3100 Albert Lankford Drive
Lynchburg, VA 24501

Long Term Care Insurance
February 8, 2019
from Genworth Life Insurance Company

PATRICIA A GEBHART
[REDACTED] LONG RIDGE DR
HAGERSTOWN MD 21742

Insured
Patricia A Gebhart

Policy number
[REDACTED]

Customer service
1-800-456-7766
M-Th: 8:30 - 6PM ET
F: 9 - 6PM ET
Fax: 1-800-876-8220
genworth.com

Dear Patricia A Gebhart,

Thank you for choosing Genworth Life for your long term care insurance needs. As requested, enclosed is a copy of your long term care policy.

The enclosed copy, and any applicable amendments, will reflect changes made to your coverage as reflected in our administrative system as of the date this copy was printed, including any benefit increases or requested benefit decreases which took place after the date the policy was originally issued.

Due to the sensitive nature of claims and benefit information, the enclosed copy does not reflect information pertaining to any benefits that may have been paid in accordance with the terms and provisions of your policy. Likewise, this copy does not reflect any reductions in benefit maximums due to previously paid benefits or claims which we may have received but have not yet been processed.

If you have any questions, please contact our customer service center at the number shown above. We appreciate the opportunity to serve you.

Sincerely,

Your Customer Service Team

Genworth Life

Client Profile

LTCC COMPREHENSIVE-MD

POLICY NUMBER: [REDACTED]

POLICY EFFECTIVE DATE: October 28, 2002

POLICYHOLDER:

Patricia A Gebhart
[REDACTED] Long Ridge Dr
Hagerstown, MD 21742

PAYOR: (If different from Insured)

Phone: 301-733-2310
Birthday: [REDACTED]
Sex: Female
Age: 63

AGENT INFORMATION:

Thomas C Tucker
425 Phoenix Drive
Chambersburg, PA 17201-4534

Phone: 717-267-1426

POLICY COVERAGES & LIMITS

Elimination Period: 50 Days
Daily Payment Maximum: ~~\$170.00~~
Benefit Multiplier: 1,480
Lifetime Payment Maximum: ~~\$248,200.00~~
Inflation Protection: Compound

371.00

541,830

4 yrs. of benefit

PREMIUM INFORMATION

Payment Mode: Semi-Annual
Modal Premium: \$2,808.62
Total Annual Premium: \$5,507.04
Restoration of Benefits: None
Nonforfeiture Benefit: None
Preferred Discount: None
Spousal Discount: None

\$ 1,460.44 Day

19

365

4 yrs.

PLEASE CAREFULLY REVIEW THE FOLLOWING DOCUMENTS

The following documents contain important information and other details.

NOTICES & OTHER CORRESPONDENCE

Genworth Privacy Policy

from Genworth Life Insurance Company, Genworth Life and Annuity Insurance Company, Genworth Insurance Company and Genworth Life Insurance Company of New York[†]

Important information. **No action required by you.**

At Genworth and our family of companies, we appreciate your business and the trust you have placed in us. Our privacy philosophy reflects the value of your trust. We are committed to protecting the personal data we obtain about you. Please know that we do not sell your personal data. In order to provide services or products to you, we may use your personal data. To further understand our Privacy Policy, please review the following details.

What personal data may we collect about you?

We may collect your personal data to provide you with the products or services you requested. We may obtain it from your application, your transactions with us, outside parties such as health providers or consumer reporting agencies. We may collect personal data about you to process transactions or claims, to determine if you qualify for coverage and to prevent fraud. Where required, we will obtain your consent before collecting it. The personal data may include:

- Name and address
- Income and assets
- Credit and payment data
- Accounts at other institutions
- Medical or health data
- Social security number or taxpayer identification number

What do we do with your personal data?

We comply with Federal and State requirements related to the protection and use of your data. This means that we only share data where we are permitted or required to do so. We also may be required to obtain your authorization before disclosing certain types of personal data.

We may use your data in order to:

- Process transactions or claims
- Determine your eligibility for coverage
- Respond to your requests
- Prevent fraud
- Comply with regulatory requirements
- Share with you related products and services we offer

We do not sell personal data about current or former customers or their accounts. We do not share your personal data for marketing purposes with anyone outside our family of companies. When affiliates or outside companies perform a service on our behalf, we may share your personal data with them. We require them to protect your personal data, and we only permit them to use your personal data to perform these services.

Examples of outside parties who may receive your data are:

- Your agent or representative
- Your brokerage firm
- State or Federal authorities
- Your health care provider, where applicable
- Other companies or service providers supporting your policy, contract, or account

How do we protect your personal data?

In order to protect your personal data, we maintain physical, electronic and procedural safeguards. We review these safeguards regularly in keeping with technological advancements. We restrict access to your personal data. We also train our employees in the proper handling of your personal data.

Our commitment to keeping you informed

We will send you a Privacy Policy each year while you are our customer. In the event we broaden our data sharing practices, we will send you a new Policy.

**Genworth Life Insurance Company
Genworth Life Insurance Company of New York**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Effective Date: This notice became effective on September 23, 2013.

This Notice of Privacy Practices (the "Notice") describes your rights concerning your Protected Health Information ("PHI"). PHI is information that may identify you and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. This Notice also describes how we may use and disclose your PHI.

The Health Insurance Portability and Accountability Act ("HIPAA") requires us to:

- Provide you with this notice of our legal duties and privacy practices with respect to PHI.
- Maintain the privacy of your PHI.
- Comply with the terms of our privacy notice that is in effect.

We reserve the right to change this Notice as permitted by law, and such change will apply to all medical information that we maintain, including PHI that was received by us before the effective date of the new notice. If we make a material change to this Notice, we will post a copy of the revised Notice of Privacy Practices on our web site at www.Genworth.com and:

- In our next annual mailing to you, provide information about the material change and how you may obtain the revised Notice of Privacy Practices, or
- Communicate the changes in such other ways that HIPAA then allows.

This Notice applies only to individual or group products that provide, or pay the cost of, medical care including long-term care insurance policies, certain long-term care insurance riders on life insurance policies, and Medicare Supplemental insurance. It does not apply to products (such as a life insurance or disability insurance) that may involve some use or disclosure of health information, but whose primary function is not the reimbursement of the costs of medical care.

Use And Disclosure Of PHI Without Your Written Authorization

Below is a description of ways in which we may use and disclose the PHI we receive about you without your specific permission. Where state law provides additional restrictions on how we can use and disclose information, we will follow applicable state laws.

- **Uses and Disclosures for Payment.** We may use or disclose your PHI for payment-related purposes. Payment related disclosures may include disclosures necessary for: making claim decisions, care coordination activities, coordinating benefits with other insurers or payers,

and billing. For example, we may use your PHI to determine if you are eligible for benefits under the terms of a long term care insurance policy.

- **Uses and Disclosures for Health Care Operations.** We may use or disclose your PHI to support our health insurance operations. These functions include, but are not limited to: quality assessment and improvement, making claim decisions, billing, related health care data processing, licensing, business planning, care coordination activities, and business development. For example, we may use your information to respond to your customer service inquiry or to offer an enhancement to your existing coverage. We also may use and disclose your information for underwriting and premium rating our risk for health coverage (although, outside of long term care insurance, we are prohibited from using or disclosing any genetic information for these underwriting purposes).
- **Business Associates.** We contract with individuals and entities (known as "business associates") to perform various functions on our behalf or to provide certain types of services. These business associates may include insurance agents, claim payment administrators, information technology service, and others. We may disclose PHI to a business associate if they need the PHI to provide a service to us. We enter into contracts with these business associates concerning the privacy and security of your PHI and these Business Associates are obligated to follow federal rules concerning privacy and security.
- **Plan Sponsor.** If you are insured under a group long-term care insurance policy, we may also disclose your PHI to the sponsor of your benefit plan.

Other Possible Uses and Disclosures of PHI

The following is a description of other possible ways in which we may (and are permitted to) use or disclose your PHI without your authorization. We may disclose your PHI without your authorization:

- To a health oversight agency for activities authorized by law, such as audits; investigations; civil, administrative, or criminal proceedings or actions;
- As federal, state, or local law requires the use or disclosure;
- To a public health authority or cooperating foreign government official for public health activities;
- To a government authority authorized to receive reports of abuse, neglect, or domestic violence;
- In the course of any judicial or administrative proceeding; in response to an order of a court or administrative tribunal; and in response to a subpoena, a discovery request, or other lawful process;
- To law enforcement officials for law enforcement purposes;
- To a coroner or medical examiner, funeral directors, or for organ or tissue donation purposes;
- As allowable by law, for research purposes;
- If we believe that the disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public;
- For activities deemed necessary by appropriate military command authorities or for national security and intelligence activities;

- If you are an inmate of a correctional institution, to the correctional institution or to a law enforcement official; and
- To comply with workers' compensation laws and other similar programs.

Others Involved in Your Health Care. Unless you object, we may disclose your PHI to a friend or family member that you have identified as being involved in your health care. If you are not present or able to agree to these disclosures of your PHI, then we may, using our professional judgment, determine whether the disclosure is in your best interest.

Required Disclosures of Your PHI

The following is a description of disclosures that we are required by law to make.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services.** We may be required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Regulations.
- **Disclosures to You.** We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information.

Your Authorization To Use and Disclose PHI

We will not use or disclose your PHI without your written authorization unless the use or disclosure is described in this Notice. For example, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of PHI, require your authorization. Most disclosures of psychotherapy notes cannot be made without your authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect, or for any other situation where we have already acted in reliance on the authorization.

Your Rights

The following is a description of your rights with respect to your PHI.

- **Right to Request a Restriction.** You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by writing. In your request tell us: (1) the information whose disclosure you want to limit and (2) how you want to limit our use and/or disclosure of the information.
- **Right to Request Confidential Communications.** If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you can ask that we only contact you at your work address or via your work e-mail.

You may request an alternative means of communication by writing. In your request tell us: (1) the parts of your PHI that you want us to communicate with you in an alternative manner or at an alternative location and (2) that the disclosure of all or part of the information in a manner inconsistent with your instructions would put you in danger.

- **Right to Inspect and Copy.** You have the right to inspect and obtain a paper or electronic copy of your PHI that is contained in a “designated record set.” Generally, a “designated record set” contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or information we compile in anticipation of a claim or legal proceeding.

To inspect and obtain a copy your PHI that is contained in a designated record set, you must submit your request in writing to Genworth Life Insurance Company, Privacy Compliance, P.O. Box 40005, Lynchburg, VA 24506: 1-800-456-7766. If you would like to specify a particular form or format for the information, we will try to accommodate your request if it can readily be produced in that manner; otherwise, we will provide a paper copy or other form or format that we agree upon. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and obtain a copy of your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial.

- **Right to Amend.** If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by writing, and should include the reason the amendment is necessary.
- **Right of an Accounting.** You have a right to an accounting of certain disclosures of your PHI that are for reasons other than payment or health care operations. An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting by submitting your request in writing. Your request may be for disclosures made up to 6 years before the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To fulfill any of the above requests in writing, send the description of your request to: Genworth Life Insurance Company, Privacy Compliance, P.O. Box 40005, Lynchburg, VA 24506: 1-800-456-7766.

- **Right to be Notified Following a Breach of Unsecured PHI.** You have the right to and will receive a notification if we or one of our business associates has a breach of information security involving your unsecured PHI.
- **Filing a Complaint.** You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by writing to: Genworth Life Insurance Company, Privacy Compliance, P.O. Box 40005, Lynchburg, VA 24506: 1-800-456-7766.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem. We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

**GENWORTH LIFE INSURANCE COMPANY
NAME CHANGE ENDORSEMENT**

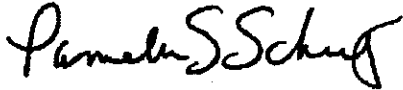
With the necessary regulatory approval, General Electric Capital Assurance Company has changed its name to Genworth Life Insurance Company, effective January 1, 2006.

The Company's administrative address and telephone number are:
3100 Albert Lankford Drive
Lynchburg, VA 24501-4948
1-888-436-9678

No terms, conditions or benefits of your contract, policy or certificate have changed. All servicing of your contract, policy or certificate will continue to be done by the Company or its affiliated representatives.

Please keep this endorsement with your General Electric Capital Assurance Company contract, policy or certificate.

For Genworth Life Insurance Company,



Pamela S. Schutz
President



Ward E. Bobitz
Secretary

NOTICE OF PROTECTION PROVIDED BY MARYLAND LIFE AND HEALTH INSURANCE GUARANTY CORPORATION

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Corporation are:

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance

- \$500,000 for basic hospital, medical, and surgical insurance or major medical insurance provided by health benefit plans
- \$300,000 for disability insurance
- \$300,000 for long-term care insurance
- \$100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

Annuities

- \$250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is:

- \$300,000 in aggregate for all types of coverage listed above, with the exception of basic hospital, medical, and surgical insurance or major medical insurance
- \$500,000 in aggregate for basic hospital, medical, and surgical insurance or major medical insurance.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

To learn more about the above protections, please visit the Corporation's website at www.mdlifega.org, or contact:

Maryland Life and Health Insurance Guaranty Corporation
8817 Belair Road, Suite 208
Perry Hall, Maryland 21236
410-248-0407

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Insurance companies and agents are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

**YOUR LONG TERM CARE INSURANCE POLICY OR
CERTIFICATE FOLLOWS THIS PAGE.**

PLEASE REVIEW IT CAREFULLY

LONG TERM CARE INSURANCE POLICY OR CERTIFICATE

GENERAL ELECTRIC CAPITAL ASSURANCE COMPANY
A GE Financial Assurance company, herein referred to as We, Us and Our
Administrative Office 1650 Los Gamos Drive, San Rafael, CA 94903-1899

LONG TERM CARE INSURANCE POLICY

Policyholder:
Patricia A Gebhart

Policy Number:
[REDACTED]

DECLARATIONS

We are pleased to issue this insurance policy. It has many important features. Please read it carefully.

RENEWABILITY - THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE: You (the Insured Person named above as the Policyholder) have the right, subject to the terms of this policy, to continue it as long as you pay the required premiums on time. We cannot change any of the terms of this policy on our own, except that, in the future, we may increase the premiums.

OUR LIMITED RIGHT TO CHANGE PREMIUMS: Premiums will not increase due to a change in age or health. We can, however, change premiums based on premium class; but only if we change the premiums for all similar policies issued in the same state and on the same form as this policy. Premium changes will only be made as of an anniversary of the policy's Effective Date. We must give you at least 31 days written notice before we change premiums.

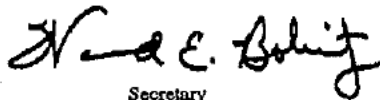
30 DAY RIGHT TO EXAMINE YOUR POLICY: Notice to Buyer: You may surrender your policy of long term care insurance without penalty or obligation within 30 days from the date of its delivery. If you decide to surrender the policy, you must provide notice of the surrender to us. Any attempt to obtain a waiver of your right to surrender is unlawful. Such surrender entitles you to a full refund of all moneys within 30 days after receipt of notice of surrender.

IMPORTANT CAUTION ABOUT THE APPLICATION: The issuance of this long term care insurance policy is based upon the responses to questions on the application for this policy. A copy of that application is enclosed. If the Insured Person's answers are incorrect or untrue, we may have the right to deny benefits or rescind the policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of the Insured Person's answers are incorrect, contact our Administrative Office at this address: 1650 Los Gamos Drive, San Rafael, California 94903-1899.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.

NOTICE TO BUYER: This policy may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

Signed for General Electric Capital Assurance Company.


Secretary


President and CEO, Long Term Care Division

This policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

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A copy of the application for this policy..... Attached

Any appropriate Riders, Endorsements, Notices and other papers..... Attached

Refer to the Schedule to determine the Benefits, Options and applicable coverage details.

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SCHEDULE

GENERAL ELECTRIC CAPITAL ASSURANCE COMPANY

Name and Address of Policyholder:

Policy Number:

Patricia A Gebhart
██████████ Long Ridge Dr
Hagerstown, MD 21742

Policy Effective Date:
October 28, 2002

POLICY FEATURES

Privileged Care Coordination Services	Included
Home Care Benefit	Included
Respite Care Benefit	Included
Caregiver Training Benefit	Included
Equipment Benefit	Included
Long Term Care Facility Benefit	Included
Bed Reservation Benefit	Included
Supplementary Care Benefit	Included
Waiver of Premium Benefit	Included
Survivorship Benefit	Included

COVERAGE LIMITS

Elimination Period (For the Long Term Care Facility Benefit)	50 Days
Daily Payment Maximum	\$170.00 ^{\$371.-}
Lifetime Payment Maximum	\$248,200.00

BENEFIT INCREASES

AUTOMATIC COMPOUND 5% BENEFIT INCREASES - The Daily and Lifetime Payment Maximum amounts will each increase on every anniversary of the effective date of this policy. Annual increases will apply to benefits payable for expenses incurred on or after the date of the increase. The first increase will be equal to 5% of the original amount; and each increase thereafter will be equal to 5% of the increased amounts that applied on the date of the prior increase. These increases are not affected by any benefit payments.

See the next page for Premium Information

SCHEDULE (Continued)

GENERAL ELECTRIC CAPITAL ASSURANCE COMPANY

Name of Policyholder:
Patricia A Gebhart

Policy Number:
UDG4393220

PREMIUM INFORMATION

RATE CLASSIFICATION: Policyholder - Standard

ANNUAL PREMIUMS: Basic Policy Coverage \$2,999.25
 Benefit Increases (N/A shown if no increases) \$2,507.90
 Optional Rider(s) (if any) See Rider(s)
 Annual Total \$5,507.04

FIRST PREMIUM
\$2,808.62

PREMIUM PAYMENT MODE
Semi-Annual

MODAL PREMIUM
\$2,808.62

GLOSSARY

This section defines some terms used in the policy. Also see the Index of Defined Terms.

Activities of Daily Living Each of the following is considered to be an Activity of Daily Living:

Bathing: Washing oneself: (a) by sponge bath; or (b) in either a tub or shower, including the task of getting into or out of the tub or shower.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

Contenance: The ability to maintain control of bowel and bladder functions; or when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving in and out of a bed, chair or wheelchair.

Adult Day Care

A program providing social and health-related services during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Chore Services

Assistance a person provides with light work or household tasks the Insured Person would normally perform. This is limited to assistance provided when:

- the Insured Person is no longer capable of performing the work or task (because of his or her need for assistance); and
- the work or task is necessary to or consistent with the Insured Person's ability to remain safely at home.

This may include such activities as: simple household repairs; taking out the garbage; and related tasks that do not require the services of a trained aide or attendant.

Daily Payment Maximum

The daily limit on the combined total for all benefit payments provided the Insured Person under: the Respite Care Benefit; the Long Term Care Facility Benefit; and the Bed Reservation Benefit. It is also used to determine other Benefit limits.

This amount is shown in the Schedule; and will increase over time in accordance with any Benefit Increases that apply.

Elimination Period The number of days for which you must incur expenses that qualify for payments under the Long Term Care Facility Benefit; but for which we will NOT pay benefits. It can be satisfied either by: days for which payment would otherwise be made under the Long Term Care Facility Benefit (including Bed Reservation Benefit days); or days you receive services covered under the Home Care Benefit in accordance with a Privileged Care Coordinator's Plan of Care. Days used to satisfy the Elimination Period do not need to be consecutive.

Once you have satisfied this requirement, you will never have to satisfy a new Elimination Period for the policy. The Schedule shows the number of days in your Elimination Period.

Family Member Your spouse and anyone who is related to you or your spouse (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Home Health Aide and Personal Care Attendant Services Assistance a person provides with the following tasks when necessary to, or consistent with, the Insured Person's ability to remain safely at home:

- simple health care tasks;
- personal hygiene;
- performing Activities of Daily Living;
- managing medications; and
- other related supportive tasks.

Providers of these services may be independent and do not need to be affiliated with a home health care agency.

Homemaker Services Assistance a person provides with activities necessary to or consistent with the Insured Person's needs to manage and maintain a household when he or she is no longer capable of managing those activities. This may include such activities as:

- preparing meals;
- doing laundry; and
- doing incidental household tasks.

Hospice Care Services that are designed to provide palliative care to the Insured Person or to alleviate the person's physical, emotional and spiritual discomforts because he or she is experiencing the last phases of life due to being Terminally Ill.

Covered Hospice Care	<p>The following items of Hospice Care not otherwise covered by other benefits in the policy and provided in accordance with a Hospice Care Program:</p> <ul style="list-style-type: none"> - 30 days of inpatient care (this is a lifetime limit); - part-time nursing care by or supervised by a registered graduate nurse; - counseling, including dietary counseling, for the Terminally Ill insured; - family counseling for the immediate family (spouse, parents, siblings, grandparents, and children of the Terminally Ill insured) and the family caregiver (a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the Terminally Ill insured) before the death of the Terminally Ill insured; - Respite Care subject to a 5 consecutive day limit for each inpatient stay and a Policy Year maximum of 14 days; and - medical supplies, equipment and medication required to maintain the comfort and manage the pain of the Terminally Ill insured.
Hospice Care Program	<p>A coordinated, inter-disciplinary program of hospice care and services for meeting the special physical, psychological, spiritual and social needs of Terminally Ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement prior to your death and meets all of the following criteria: part-time nursing care by or supervised by a Registered Graduate Nurse (RN); counseling, including dietary counseling for you; family counseling; and medical supplies, equipment and medication required to maintain the comfort and manage the pain of the Terminally Ill insured.</p>
Insured Person	<p>You, the Policyholder named in the Schedule.</p>
Licensed Health Care Practitioner	<p>Any of the following who is not a Family Member:</p> <ul style="list-style-type: none"> - a physician, as defined in Section 1861(r)(1) of the Social Security Act; - a registered professional nurse; - a licensed social worker; or - any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury.
Lifetime Payment Maximum	<p>The combined total amount we will pay as benefits under this policy. This amount is shown in the Schedule; and will increase over time in accordance with any Benefit Increases that apply.</p>
Medicare	<p>The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.</p>
Nurse	<p>Someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN), and is operating within the scope of that license.</p>

Policy Year	Each twelve month period beginning with the Effective Date of the policy, as shown in the Schedule.
Prevailing Expense	Expenses, fees or charges actually incurred by the Insured Person which do not exceed the level of charges normally made for similar care, service or other items provided to persons with comparable medical conditions or impairments in the locality where they are received. An expense, fee or charge is considered to be incurred on the day on which the care, service or other item forming the basis for it is received.
Qualified Long Term Care Services	Necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services, and Maintenance or Personal Care Services which: are required by a Chronically Ill Individual; and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner. "Maintenance or Personal Care Services" means any care which is furnished primarily to provide needed assistance with any of the disabilities you have that result in your being Chronically Ill (this includes protection from threats to health and safety due to Severe Cognitive Impairment).
Respite Care	Short-term care provided in order to relieve the Insured Person's primary informal (unpaid) caregiver in the Insured Person's home. It can be furnished in an institution, in the Insured Person's home, in the home of the primary caregiver, or at a community-based program.
Supportive Equipment	Equipment, such as the following: <ul style="list-style-type: none"> - pumps and other devices for intravenous injection; - ramps to permit movement from one level of a residence to another; - grab bars to assist in toileting; and - other mechanical aids. <p>It does not include either: equipment that will, other than incidentally, increase the value of the residence in which it is installed; or artificial limbs, teeth, medical supplies, or equipment placed in the Insured Person's body, temporarily or permanently.</p>
Terminally Ill	Having a medical prognosis given by a physician that the Insured Person's life expectancy is 6 months or less.
We, Us, Our	General Electric Capital Assurance Company. We are a stock life insurance company. Our Administrative Office is at 1650 Los Gamos Drive, San Rafael, California 94903-1899.
You, Your, Insured Person	The Policyholder named in the Schedule.

Additional Definitions

The following terms are not used by this policy but their definitions are provided for your information:

"skilled nursing care" is furnished on a physician's orders which requires the skill of professional personnel such as a registered or a licensed practical nurse and is provided either directly by or under the supervision of these personnel.

in home

"custodial care" or "personal care" is care which can be performed by persons without professional medical training and which is primarily for the purpose of meeting the personal needs of the patient, including feeding and personal hygiene.

"intermediate nursing care" is basic care including physical, emotional, social and other restorative services under periodic medical supervision. This nursing care requires the skill of the registered nurse in administration, including observation and recording of reactions and symptoms, and supervision of nursing care; however, it is not required that the actual care be performed by a registered nurse.

in home

"domiciliary care" is care, including general supervision and assistance in daily living, such as, but not limited to, aid in walking, getting in and out of bed, bathing, dressing, or eating, which is provided on a prearranged basis in a licensed residential facility for three or more unrelated individuals who need the care because of advanced age, infirmity, or physical or mental limitations.

"home care" is medical and nonmedical services provided to ill, disabled, or infirm persons in their residences.

3/16/20 - last meeting 3/16/20
 - walk with assistance only
 - walk 100ft.
 - CORONA
 - 60% physical therapy
 - incision not sealed
 - lives alone
 - not sure if can get help in...
 - not travel after 8:00
 - case of virus
 - State of M.D.
 - 2020-21
 - Jennifer

April 20th
 2:45 Dr. appt.
 - Corona Virus
 - Hand Therapy
 - Bad 2nd hip

- nurse bad, incision. Can't walk without help. Can't walk by herself around in room

BENEFIT PROVISIONS

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

This section describes the Benefits payable under the policy.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

For the Insured Person to be eligible for Benefits provided by the policy we must receive ongoing proof, including a Current Eligibility Certification, which demonstrates, based on information from care providers, personal physicians and other Licensed Health Care Practitioners, that the covered care is needed due to the Insured Person being a chronically ill individual which means that he or she continually:

- is unable to perform, without Substantial Assistance (either Standby Assistance or Hands-on Assistance) from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- requires Substantial Supervision to protect oneself from threats to health and safety due to Severe Cognitive Impairment

Current Eligibility Certification Defined

A **Current Eligibility Certification** is a Licensed Health Care Practitioner's written certification, made within the preceding 12-month period, that the Insured Person meets the above requirements.

The Claims Provisions section describes the claims evaluation process.

CONDITIONS

Benefits will be paid only to reimburse the covered expenses the Insured Person incurs for care and services that:

- meet the requirements for payment in accordance with the Benefits and other provisions of this policy; and
- are received pursuant to his or her Plan of Care as prescribed by a Licensed Health Care Practitioner; and
- are received while his or her insurance is in force or while covered in accordance with the Extension of Benefits provision on page 23.

Benefit payments are subject to: the Elimination Period requirements; the applicable Daily Payment Maximum and Lifetime Payment Maximum; and all other provisions of the policy.

Additional Definitions

An **Activity of Daily Living** is one of the following: Bathing; Dressing; Eating; Contenance; Toileting; and Transferring. Definitions of these activities are found in the Glossary.

Substantial Assistance is either:

- "**Hands-on Assistance**" which means the physical assistance (minimal, moderate or maximal) of another person without which the Insured Person would be unable to perform the Activity of Daily Living; or
- "**Standby Assistance**" which means the presence of another person within arm's reach of the Insured Person that is necessary to prevent, by physical intervention, injury to the Insured Person while he or she is performing the Activity of Daily Living.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that:

- is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and
- is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:
 - short-term or long-term memory;
 - orientation as to people, places, or time; and
 - deductive or abstract reasoning.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect the severely cognitively impaired person from threats to his or her health or safety (such as may result from wandering).

A **Plan of Care** is a written, individualized plan for care and support services for the Insured Person that:

- Has been developed as a result of an assessment and incorporates any information provided by his or her personal physician; and
- Has been prescribed by a Licensed Health Care Practitioner; and
- Fairly, accurately and appropriately addresses his or her long term care and support service needs; and
- Specifies: the type, frequency and duration of all services required to meet those needs; the providers appropriate to furnish those services; and an estimate of the cost of such services.

The Plan of Care must be updated as the Insured Person's needs change. We must receive a copy of the Plan of Care upon its completion and each time it is updated. We retain the right to request periodic updates not more frequently than once every 30 days. We will make a copy of the current Plan of Care available to the Insured Person's personal physician. No more than one Plan of Care may be in effect at a time.

**PRIVILEGED CARE
COORDINATION
SERVICES**

This is an option the Insured Person may choose to use.

These services are intended to help identify care needs and community resources available to deliver care.

We will pay for the services described below when a Privileged Care Coordinator provides them to the Insured Person while his or her insurance is in force under the policy. This payment will be at our expense; and will NOT count against any policy Payment Maximum.

When the Insured Person chooses to use these services, the Privileged Care Coordinator will:

- Meet with the Insured Person in his or her home to obtain a full understanding of the person's unique situation and condition. Based on that information the Privileged Care Coordinator will develop and prescribe a Plan of Care appropriate for the Insured Person's needs. This may include care in the home and in the community.
- Provide the initial and ongoing Current Eligibility Certifications.
- Suggest a variety of formal and informal care and support service providers. This may include negotiating service and care provider rates for the Insured Person; and identifying other financial resources available to meet the needs specified in the Plan of Care.
- Help with the completion of claims forms required to obtain payment under this policy.
- Assist with implementing the Plan of Care by scheduling and coordinating the care and support service providers chosen by the Insured Person.
- Monitor the care and support services being received. This will include periodic re-assessments to determine revisions to the Plan of Care warranted by changing needs.

A **Privileged Care Coordinator** is a Licensed Health Care Practitioner designated by us to assist the Insured Person in identifying his or her long term care needs and how to match those needs with the available care and service providers and resources. Privileged Care Coordinators are professionals whose duties are: to gather objective information specific to each person's circumstances; to use the information gathered to customize that person's Plan of Care; and to make recommendations for qualified providers that can deliver the needed care and services.

Privileged Care Coordinators are familiar with the care and service providers available in your area. Those providers vary greatly from skilled professionals to lay caregivers, based on the degree and type of assistance needed. Privileged Care Coordinators will help identify qualified caregivers that are acceptable to the Insured Person and his or her family. In all cases, the Insured Person is responsible for choosing the actual care and service providers to be used. If for any reason the Insured Person is not satisfied with a care or service provider, he or she may request that the Privileged Care Coordinator identify other providers from which to choose.

Additional Feature

When the Insured Person uses a Privileged Care Coordinator's Plan of Care, the Elimination Period for the Long Term Care Facility Benefit is reduced by the number of days for which Home Care Benefits are paid; and the monthly Waiver of Premium Benefit is activated.

**HOME CARE
BENEFIT**

Licensed providers

Other personnel

Community Care

We will pay the Prevailing Expenses the Insured Person incurs for the following care and support services that are consistent with his or her Plan of Care and are received other than while in a Long Term Care Facility:

- Health care services provided by a Nurse, or a licensed physical, occupational, respiratory or speech therapist;
- Home Health Aide and Personal Care Attendant Services;
- Homemaker Services; and
- Chore Services;
- Adult Day Care; and
- Covered Hospice Care.

We will pay this Benefit on a monthly basis. The total amount we will pay for all such expenses which are incurred by the Insured Person during a calendar month will not exceed 31 times the Daily Payment Maximum.

The payment of this Benefit is not subject to the Elimination Period. However, days the Insured Person receives services covered under this Benefit in accordance with a Privileged Care Coordinator's Plan of Care will be used to satisfy his or her Elimination Period for the Long Term Care Facility Benefit.

**RESPIRE CARE
BENEFIT**

Subject to the Daily Payment Maximum, we will pay the Prevailing Expenses the Insured Person incurs for the first 21 days of Respite Care he or she receives during a Policy Year. The payment of this Benefit is not subject to, nor will it satisfy, any Elimination Period.

**CAREGIVER
TRAINING
BENEFIT**

We will pay the Prevailing Expenses the Insured Person incurs for training an informal (unpaid) caregiver to care for the Insured Person in his or her home. All the following conditions apply to the payment of this Benefit:

- We will not pay for training provided to someone who will be paid to care for the Insured Person.
- The training cannot be received while the Insured Person is confined in a hospital or Long Term Care Facility; unless it is reasonably expected that the training will make it possible for the Insured Person to go home where he or she can be cared for by the person receiving the training.

Limitation on Benefit Payments: This Benefit is not subject to a daily or monthly payment maximum; but the lifetime maximum total amount we will pay with respect to the Insured Person under this Benefit is an amount equal to five (5) times his or her Daily Payment Maximum.

**EQUIPMENT
BENEFIT**

We will pay the Prevailing Expenses the Insured Person incurs for the purchase or rental of Supportive Equipment if:

- the equipment is intended to assist the Insured Person in living at home or in other residential housing by relieving his or her need for direct physical assistance; and
- as stated in the Plan of Care, it is expected that the equipment will enable the Insured Person to remain at home or in other residential housing for at least 90 days after the date of purchase or first rental.

Limitation on Benefit Payments: This Benefit is not subject to a daily or monthly payment maximum; but the lifetime maximum total amount we will pay under this Benefit is an amount equal to 50 times the Daily Payment Maximum.

**LONG TERM CARE
FACILITY BENEFIT**

Subject to the Daily Payment Maximum, we will pay the expenses the Insured Person incurs for care and support services (including room and board) provided by a Long Term Care Facility. This includes expenses an Insured Person incurs for private duty nursing care provided in such a facility by a Nurse who is not employed by the facility. The expenses must be consistent with the level of charges normally made for other inpatients receiving similar care in that facility. The Insured Person must be confined in the Long Term Care Facility as a resident inpatient.

A **Long Term Care Facility** is an institution* (such as a nursing home, assisted care facility or Alzheimer's facility) which is licensed by the appropriate federal or state agency to engage primarily in providing care and services sufficient to support needs resulting from inability to perform Activities of Daily Living or Severe Cognitive Impairment. It must also:

- Provide such care and services on a twenty-four hour a day basis;
- Have a trained and ready to respond employee on duty at all times to provide such care and services;
- Provide 3 meals a day and accommodate special dietary needs;
- Have arrangements with a duly licensed physician or Nurse to furnish medical care in case of an emergency;
- Have the appropriate methods and procedures to provide necessary assistance to residents in the management of prescribed medications; and
- Have accommodations for at least five resident inpatients in one location, unless it has been determined by us, based on information from our Privileged Care Coordinator, that it has the services and facilities required to appropriately address the Insured Person's needs as described in his or her Plan of Care (even with accommodations for less than five resident inpatients).

A Long Term Care Facility is NOT: a hospital or clinic; a subacute care or rehabilitation hospital or unit; a place which operates primarily for the treatment of alcoholism, drug addiction or mental illness; the Insured Person's primary place of residence in an area used principally for independent residential living (including, but not limited to, boarding homes and adult foster care facilities); or a substantially similar establishment.

- * If an institution has multiple licenses or purposes, a portion, ward, wing or unit thereof will qualify as a Long Term Care Facility only if it: meets all of the above criteria; is authorized by its license, to the extent that licensing is required by law, to provide such care to inpatients; and is engaged principally in providing not only room and board, but also care and services which meet all of those criteria.

Note: Medications are included in Covered Hospice Care provided in the Home Care Benefit.

**BED RESERVATION
BENEFIT**

We will continue to pay benefits, or give Elimination Period credit, under the Long Term Care Facility Benefit for each day the Insured Person:

- is temporarily absent during a stay in the Long Term Care Facility; and
- is charged to reserve his or her accommodations in that facility.

We will do this for a total of not more than the first 50 days (continuous or not) of such absence during a Policy Year.

**SUPPLEMENTARY
CARE BENEFIT**

(For expenses not otherwise covered;
upon approval by us.)

We will pay the Prevailing Expenses the Insured Person incurs for care, treatment, services, supplies or other items not otherwise covered by the policy when: (1) they are clearly specified in his or her Plan of Care; and (2) the Insured Person, his or her personal physician and we mutually agree that they are cost-effective alternatives to Benefits available under the policy. The agreement to using these alternatives will not waive any of the rights the Insured Person or we have under the policy; and it may be discontinued at any time without affecting the Insured Person's right to the Benefits otherwise available under the policy.

Benefits are not payable for any expenses that:

- are not for qualified long term care services as defined in Section 7702B(c) of the Internal Revenue Code; or
- are incurred prior to the date of mutual agreement; or
- are incurred after the Lifetime Payment Maximum has been reached.

Examples: Examples include, but are not limited to:

- In-home safety devices.
- Home delivered meals.
- Stays in types of facilities not otherwise covered by the policy.
- Additional equipment benefits.
- Rental or lease of emergency medical response devices.
- Other services designed to help the Insured Person remain at home.

**WAIVER OF
PREMIUM BENEFIT**



We will waive premium payments for each coverage month that begins while the Insured Person is receiving either:

- Long Term Care Facility Benefits (after satisfying the Elimination Period); or
- Home Care Benefits after satisfying a qualifying period which is equal, in number, to the number of days in the Elimination Period stated in the Schedule. The qualifying period will be satisfied by: (a) days used to satisfy the Elimination Period; or (b) days for which Home Care Benefits are received; or (c) any combination of (a) and (b); or
- Home Care Benefits in accordance with a Privileged Care Coordinator's Plan of Care without completing any qualifying period.

This waiver applies to premium payments for the policy and all attached forms. It stops when the Insured Person ceases to receive continuing benefits under the Long Term Care Facility Benefit or the Home Care Benefit. When the waiver stops, we will give credit for any premium paid for periods during which the waiver applied, against future premiums then due. You will then be required: to pay the remaining due in accordance with the policy's previous premium payment mode; and to continue to pay future premiums as they become due.

**SURVIVORSHIP
BENEFIT**

When your spouse dies after this policy has been in force for at least ten years, no further premium payments will be required for this policy if:

- Both you and such spouse continuously had long term care insurance coverage in force with us, other than under a Nonforfeiture Benefit, on the date of death of such spouse and for at least the prior ten year period; and
- Such spouse's coverage included a similar Survivorship Benefit; and
- No long term care benefits were payable by us for you or such spouse during the first ten years of such concurrent coverage.

EXCLUSIONS AND LIMITATIONS

This section states the conditions under which payment will be limited, or not made at all, even if the Insured Person otherwise qualifies for benefits. These conditions apply to all benefits provided by the policy and to all attached riders.

EXCLUSIONS

No payment will be made for any expenses incurred for any room and board, care, treatment, services, equipment or other items:

- Provided by a Family Member, unless:
 - the Family Member is a regular employee of the organization that is providing the services; and
 - such organization receives payment for the services; and
 - the Family Member receives no compensation other than the normal compensation for employees in her or his job category.
- For which no charge is normally made in the absence of insurance; but this exclusion does not apply to charges made under Medicaid.
- Provided outside of the United States of America or its territories or possessions.
- Provided by or in a Veterans Administration or federal government facility, unless a valid charge is made to the Insured Person or his or her estate.
- Resulting from war or act of war, whether declared or not.
- Resulting from attempted suicide or an intentionally self-inflicted injury.
- Provided for alcohol or drug addiction; unless the drug addiction results from administration of those substances in accordance with the advice and written instructions of a duly licensed physician.
- For which payment is prohibited by Section 1-302 of the Maryland Health Occupations Article because they are provided by a health care entity as a result of a referral made by a health care practitioner who has (or whose immediate family has) established beneficial interest in or compensation arrangements with the health care entity.

NON-DUPLICATION

Benefits will be paid only for covered expenses that are in excess of the amount paid or payable under Medicare and any other federal, state or other governmental health care plan or law (except Medicaid).

We will consider, for the purposes of satisfying an Elimination Period, days on which you incur expenses that would otherwise qualify as satisfying your Elimination Period, but are excluded from coverage because benefits are paid or payable under governmental health care plans or laws as stated above.

- facility kick into.

FEDERAL TAX QUALIFICATION PROVISIONS

This section describes our intent that this be a federally tax-qualified contract.

Our Intent that this be a Federally Tax-Qualified Contract

This policy is intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986 (as amended by the Health Insurance Portability and Accountability Act of 1996 - Public Law 104-191).

Conformity with Internal Revenue Code

If on its effective date, the policy does not comply with the requirements of the above-cited Section of the Internal Revenue Code, it will be treated as if it had been changed to comply with those requirements. Because the policy is guaranteed renewable, we will inform you in writing of any such required change in the provisions of this policy; and you will be given the choice of accepting the change, or retaining the policy without that change.

CLAIMS PROVISIONS

This section describes: when we must be notified of a claim; what to send us; how we evaluate and pay claims; and other rights and responsibilities under the contract.

Your Role in the Claims Process

Let us know at once, then follow these procedures.

Early awareness by our Claims Department will facilitate a timely claim review. You can help us greatly in the claims process and at the same time begin early planning of your covered care, by contacting us as soon as it appears you may meet the benefit eligibility requirements.

When you choose to use the services of a Privileged Care Coordinator, we may make arrangements for a coordinator to contact you immediately and begin providing Privileged Care Coordination Services. Of course, someone else who is authorized to act on your behalf can also contact us for you.

Assistance in Completing Claim Forms

You may call us if you need any type of assistance during any phase of the claim process at our toll free number listed on your ID card. When you use a Privileged Care Coordinator, we will work with that coordinator to ensure that we understand your condition, the prescribed Plan of Care, and any care and support services received.

Telling us About a Claim

Notice of Claim: We must be notified when you have a claim. The notice can be given to us at our Administrative Office or to our insurance producer. It must be received within 30 days of the date the covered loss starts, or as soon as reasonably possible. Include in the notice at least: your name; the Policy Number; and an address to which the claim forms should be sent.

How to File a Claim

Claim Forms: When we get notice of claim we will send out the necessary forms to be used to file proof of loss.

The forms will tell you how to complete them and where to send them. Read them carefully. Answer all questions and send all required information to the address on the forms. This will assist us in the evaluation of the claim so that we can determine the benefits for which you are eligible.

If you or your representative do not get the necessary claim forms within 15 days after sending us a notice of claim, proof of loss can be filed without them by sending us a letter which describes the occurrence, the character and the extent of the loss for which your claim is made. That letter must be sent to us at our Administrative Office within the time period stated in the next paragraph.

When to File a Claim

Proofs of Loss: When the policy provides for payment for continuing loss, written proof of the loss must be given to us within 90 days after the termination of the period for which we are liable. For any other loss, written proof must be given to us within 90 days after such loss. If it was not reasonably possible to give us written proof in the time required, we shall not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the claimant is not legally capable, the required proof must always be given to us no later than 1 year from the time specified.

**Our Evaluation Criteria;
and the Claims Payment
Process**

How We Evaluate Claims: We will obtain information about a claim you make by working with you, and your personal physician and any Privileged Care Coordinator used. We will also consult with any Licensed Health Care Practitioners, agencies and other care providers you used. We will then review that information to determine eligibility for benefits. We reserve the right, as part of the review and at our expense, to do an assessment or a physical examination of you. Similar reviews may be required, at reasonable intervals, to determine eligibility for continued benefits. We may use outside services to assist in evaluating your condition.

On an ongoing basis, we must receive updates to your Plan of Care and Current Eligibility Certifications. We will also need a copy of your Medicare Explanation(s) of Benefits (or similar form for other plans and programs subject to the Non-Duplication provision) to determine which expenses (if any) are excluded from coverage.

Physical Examinations: At our expense, we have the right to require a medical examination when a claim is made and at reasonable intervals while continued benefits are being claimed.

Time of Payment of Claim: After we receive the proper written proof of loss, we will pay any benefits then due immediately; and at the end of each 30 days thereafter, when the loss is expected to result in ongoing benefits.

Payment of Claims: Benefits will be payable to you. Any benefits unpaid at your death will be payable in accordance with the beneficiary designation in effect at the time of payment. If none is then in effect, the benefits will be paid to your estate. Any other benefits unpaid at your death may be paid, at our option, either to your beneficiary or estate.

If benefits are payable to an estate or beneficiary who cannot execute a valid release, we may pay benefits, up to \$1,000, directly to someone related to the Insured Person by blood or marriage who we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

We may pay all or a portion of any benefits for health care services you receive to the provider; unless you direct us to do otherwise in writing not later than the time of filing proof of such loss. We do not require that care or services be provided by a particular provider.

How to Appeal a Claim Decision

We will inform you in writing if a claim, or any part of a claim, is denied.

Appeal Process: If you believe that our decision on a claim is in error you may appeal; and we will reconsider the claim. If you wish to make such an appeal, you must send us a brief note (no special form needed) that tells us why you feel we should change our decision. You may authorize someone else to act for you in this appeal process.

The note should include the names, addresses and phone numbers of any providers you think we should contact to learn more about the health and the care received by you. This would include the physicians, health care professionals and other care providers who treated you; and the facilities from which you received care, treatment, services, equipment or other items.

We will provide you with a written explanation of the reasons for any claim denial and make available all information directly related to that denial within 60 days of the date of any written claims appeal. We will immediately pay any benefits due as a result of our reconsideration.

Legal Actions

You cannot sue on any claim before 60 days after written proof of loss has been given as required by your policy. You cannot sue after 3 years from the time written proof of loss is required to be given.

BASIC CONTRACT PROVISIONS

This section describes: the documents that state all the contractual agreements; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features.

The Contract

Entire Contract; Changes: The entire contract between you (the Policyholder) and us is as stated in this policy, your application and any papers we attach. No change in this policy will be effective until approved by one of our officers. That approval must be noted on or attached to this policy. No insurance producer may change this policy or waive any of its provisions.

Time Limit on Certain Defenses

We issued this policy based on information we were provided. As stated below, any incorrect or omitted information in your application may cause the policy to be voided or a claim to be denied.

Misstatements in the Application: During the first 6 months the policy is in force, we may rescind (void) the policy or deny an otherwise valid claim upon a showing of misrepresentation that was material to the acceptance of you for coverage. While the policy has been in force for at least 6 months but less than 2 years, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that is both: material to the acceptance of you for coverage; and pertains to the conditions for which benefits are sought. After the policy has been in force for 2 years it will not be contestable upon the grounds of misrepresentation alone; and may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

If we pay any benefits under the policy, the benefit payments will not be recovered by us in the event the policy is rescinded.

Pre-Existing Conditions: We will not reduce or deny any claim under this policy because of a sickness or physical or medical condition that existed before the policy's Effective Date.

Other Provisions

Misstatement of Age: If your age was misstated in the application for this policy, we will pay the benefits that the premiums paid would have purchased at your true age. If, based on that true age, the policy would not have become effective, we will only be liable for the refund of all premiums paid for this policy.

Governing Jurisdiction: This policy is governed by the laws of the state in which you reside on its Effective Date.

Time Periods: All time periods begin and end at 12:01 a.m. at your residence.

Non-Participating; Dividends Not Payable: This policy does not participate in our profits or surplus earnings; has no cash values; and will not pay dividends at any time.

Change of Beneficiary: The right to change a beneficiary is reserved to you and the consent of any beneficiary will not be required for this or any other change.

No Cash Values, Borrowing, or Use as Collateral: The policy does not provide for a cash surrender value, or other money that can be borrowed; or paid, assigned or pledged as collateral for a loan.

EFFECTIVE DATE AND PREMIUM PROVISIONS

This section describes such things as: when the policy becomes effective; how and when to pay premiums; the importance of paying premiums on time; what happens if premiums are not paid on time; and protection available in the event of unintentional lapse of the policy.

- The Policy Taking Effect** **Effective Date and Consideration:** This policy is issued based on: the statements made in its application; and payment of the First Premium shown in the Schedule; provided the first premium is paid at the time of application or at the time of receipt of the policy. It takes effect on the Effective Date shown in the Schedule. It can be continued in force by the timely payment of premiums until it terminates because the Lifetime Payment Maximum (including any increases due to any Benefit Increases) has been reached.
- Your Right to Cancel
The Policy at Any Time** You may cancel this policy at any time by sending us written notice. The policy will be cancelled as of the date we receive the notice, or the later date stated in the notice. We will refund the unearned portion of any premium paid. The cancellation will not prejudice any claim for any uninterrupted institutional confinement that begins before the effective date of the cancellation.
- Paying Premiums** The Premium Payment Mode shown in the Schedule states how often premiums are to be paid. Each premium after the First Premium is due at the end of the period for which the prior premium was paid.
- Currency** All payment by or to us will be in the lawful money of the United States of America.
- Limitations on the Refund
of Premiums** All refunds of premium or similar amounts under the policy shall be applied as a reduction in future premiums or to increase future benefits. This does not apply to any refund: on your death; or on a complete surrender or cancellation of the policy.
- What Happens When
Premiums are Not Paid** **Grace Period and Protection Against Unintentional Lapse - Lapse Notice to Someone Else:** A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force before it lapses. You have the right to designate someone else to receive notice of lapse or termination of this policy for nonpayment of premium. Your policy will not lapse or be terminated for nonpayment of premium unless we, at least 30 days before the effective date of the lapse or termination, have given a second notice to you and to those persons designated by you for the purposes of receiving notice of lapse or termination. Notice will be given by first class United States mail, postage prepaid; and notice may not be given until 30 days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.
- Your application shows whom you have designated to receive these notices. You can direct us, in writing, to change your designation and send the notices to someone else.

Extension of Benefits: Termination of this policy will not affect any claim for expenses incurred during uninterrupted institutional confinement that begins while the policy is in force and continues without interruption beyond the date of termination.

This extension of benefits, beyond the period the policy was in force, will terminate when the Lifetime Payment Maximum that applies on the date of termination is reached; and is subject to the Elimination Period and all other applicable provisions of the policy. For the purposes of this provision, an uninterrupted institutional confinement will include: being transferred to another Long Term Care Facility; receiving another level of care in the same Long Term Care Facility; and transferring back to a Long Term Care Facility from a temporary or acute hospitalization.

Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse.

Later acceptance of the premium by us (or by an insurance producer duly authorized to accept such payment) without requiring an application for reinstatement will reinstate this policy as of the date of premium acceptance.

If we or our duly authorized insurance producer require an application for reinstatement, and give you a conditional receipt for the premium, this policy will be reinstated upon either: our approval of the application; or, lacking such approval, the 45th day after the date of the conditional receipt, unless we give you prior written notice of our disapproval of the application.

In all other respects your rights and our rights will remain the same; subject to any provisions noted on or attached to the policy as reinstated.

Unpaid Premiums: When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Continuation for Lapse due to Alzheimer's Disease and Other Forms of Cognitive or Functional Impairment: We will provide a retroactive continuation of coverage if:

- the policy terminates due to non-payment of premiums (lapse); and
- within 7 months after termination we are given proof that you met the Eligibility for the Payment of Benefits requirements of the policy.

We must receive proof of your impairment or incapacity and all past due premiums within that 7 month period. Any benefits for which you qualified during the continuation period will be paid to the same extent they would have been paid if the policy and its riders had remained in force from the date of termination.

What Happens in the Event of Lapse and Reinstatement

If the policy lapses and is reinstated, and a Benefit Increases Option had applied prior to the date of lapse, the applicable benefit amounts for the reinstated policy will be those that applied on the date of lapse, unless either: you requested reinstatement for different benefit amounts; or the reinstatement occurs within 60 days of lapse with all past due premiums being paid, in which event benefit amounts will be those that would have applied if there were no lapse in coverage.

Please keep this policy in a safe place with your other important documents.

CONTINGENT BENEFIT UPON LAPSE

APPLICABLE ONLY IF PREMIUMS ARE INCREASED SUBSTANTIALLY

This provision describes a benefit which is available if and only if a substantial cumulative increase is made in the premiums charged for this policy. If your policy also has a Nonforfeiture Benefit Rider, the coverage provided by that Rider will apply whenever the policy lapses after having been in force for at least 5 years (even if there has been no change in premium rates).

When this Benefit Applies As stated in the Declarations on page 1 of this policy, we will give you at least 31 days prior written notice of any change in the premium rates for this policy. In the event the cumulative amount of all premium increases equals or exceeds the Triggers for a Substantial Premium Increase (as determined on the next page) we will:

- Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that the required premium payments are not increased; and
- Offer to convert coverage to a paid-up status with a shortened benefit period as described below. This option may be elected at any time during the 120-day period following the due date of the premium increase; and
- Notify you, the Policyholder, that a default or lapse at any time during the 120-day period following the due date of the premium increase will be deemed to be the election of the offer to convert as described above.

The Shortened Benefit Period Plan

If you convert the coverage provided by this policy in accordance with the above provisions, the same Benefits, with the same Elimination Period and Daily Payment Maximum in effect at the time of lapse or election to convert (but not changed thereafter because you have Inflation Protection), will apply. The amount of the reduced Lifetime Payment Maximum will be the greater of:

- thirty (30) times your Daily Payment Maximum at the time of lapse; or
- 100% of the sum of all premiums paid for the policy and any attached rider, including premiums paid prior to any change in benefits.

This amount will not be reduced by any benefits payable for expenses incurred prior to the date of lapse.

In no case will the sum of the benefits paid while the policy is:

- in premium paying status; and
- in paid up status;

exceed the Lifetime Payment Maximum that would have applied if the policy had remained in premium paying status.

TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

<u>Issue Age</u>	<u>Increase Over Initial Premium</u>	<u>Issue Age</u>	<u>Increase Over Initial Premium</u>	<u>Issue Age</u>	<u>Increase Over Initial Premium</u>
29 and under	200%	66	48%	79	22%
30 - 34	190%	67	46%	80	20%
35 - 39	170%	68	44%	81	19%
40 - 44	150%	69	42%	82	18%
45 - 49	130%	70	40%	83	17%
50 - 54	110%	71	38%	84	16%
55 - 59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	<u>58%</u>	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

This provision forms a part of the policy to which it is attached.

Signed for General Electric Capital Assurance Company.

W. E. Bolint
Secretary

Thomas M. Atkinson
President and CEO, Long Term Care Division

Long Term Care Insurance
Important Contact Information

Customer Service: 1-800-456-7766

Claims Service: 1-800-876-4582

genworth.com/service

2810 Beechland Avenue
Baltimore, Maryland 21214

May 15, 2021

Ms. Kathleen Birrane
Insurance Commissioner
The Maryland Insurance Administration
200 St. Paul Place, Ste. 2700
Baltimore, Maryland 21202

Dear Commissioner Birrane:

I am writing to object to the LTC rate increase requested by Genworth. I am 74 and retired. I purchased a policy in 2003 when my financial advisor indicated that many companies were offering new products that far exceed the original “nursing home” type of coverage. These policies were truly for long term care and offered financial support beyond in-patient care. Although these policies were expensive, I decided that such coverage was then worth the cost. We selected a policy now traded as Genworth. In recent years the premiums have risen sharply.

Genworth advised policy holders that their end goal was to increase premiums by 150%. Genworth offered alternatives with drastic reductions in benefits at high prices. One offering would terminate the present policy and establish a cash deposit that could be accessed upon a qualifying event. Another alternative would be to surrender the present policy and substitute a lesser one at current rates while indicating nothing about the stability of those rates. A third proposal would be to accept greatly reduced coverage for the present premium which would remain fixed for ten years. No mention of what would happen at the end of that period. It seems that their end game is to force policy holders who purchased coverage for peace of mind and as security against the possible infirmities of old age to relinquish their coverage or drastically reduce it.

My financial advisor now considers the strategies of the various players innovating in the long-term care market to have been aggressively trying to capture market share.

I would assert to the Maryland Insurance Administration the following points:

- It is not the policy holders' fault that Genworth underpriced its policies, and this should not be made their responsibility.
- It is not the policy holders' fault that Genworth unwisely underpriced its policies to buy market share.
- Genworth should bear responsibility for poor business practices and not be allowed to make its policy holders responsible for something that is not their fault.
- Genworth is a diversified company and should be made to take profits from other lines of business to support their LTC business.
- Genworth should not be allowed to constantly raise premiums to encourage policy lapses to secure their corporate profits.
- I have been paying the premiums for many years and have done all I could to manage prior increases in premiums. It is not right that after nearly two decades these premiums have not secured a policy that I can keep for the rest of my life.

The Maryland Insurance Administration should stand up for Maryland policy holders many of whom, by Genworth's own admission, are retired, on fixed incomes, and elderly. The Insurance Administration should state clearly that the goal to increase premiums by 75% through the next six years is unacceptable as the table they submitted of previous rate revisions indicates a cumulative increase of 101%. Genworth has had enough of these premium increases.

Thanking you for your attention in this matter, I am

Sincerely yours,

John E. Roach



Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov>

Fwd: Genworth Financial - 8-K (Current report filing) SEC Filing

1 message

1996nyy <jtmcl98@gmail.com>

Sat, May 1, 2021 at 8:23 AM

To: Kathy Schott -MDInsurance- <kathy.schott@maryland.gov>, Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov>

Good morning Ms. Schott,

Please forward or bring this to the attention of the Commissioner. I was not able to find his or her name on the website.

Attached please find Genworth's latest 8-K.

It is clear from the report that the tragedy of COVID 19 is having a significant positive impact on Genworth's LTC business.

Their quarterly earnings of \$95 million for the first quarter compares with \$1 million from the prior year.

"Likely the result of COVID 19 pandemic" "Company has assumed that COVID 19 pandemic has accelerated its mortality experiences on the most vulnerable claimants"

Adam, I believe when Genworth was requesting the latest rate increases they were asked about the impact of COVID and did not give a clear answer or withheld information. It is not possible given the size and sophistication of their research that they did not know that it would have a significant impact on their business. Of course they did not want to share that with the Maryland Insurance Administration.

I would think that given the data upon which the increases were granted has dramatically changed the Maryland Insurance Administration has the right and obligation to freeze the increases and require a resubmission with the accurate data.

Thank you both for your attention to this matter.

Best regards, John McLaughlin

----- Forwarded message -----

From: <GenworthInvestors@q4websystems.com>

Date: Thu, Apr 29, 2021 at 5:01 PM

Subject: Genworth Financial - 8-K (Current report filing) SEC Filing

To: <jtmcl98@gmail.com>

Genworth Financial has added a new SEC filing to its web site. For full details please visit the Genworth Financial web site at:

[8-K \(Current report filing\)](#)

[Click here](#) for a complete listing of Genworth Financial SEC filings.

To unsubscribe from this list please visit the [email alert section of the Genworth Financial site](#).

Kim Baker

Mon, May 17, 4:47 PM (13
hours ago)

Reply

to me

I apologize that I have missed the May 13th date for submission. I hope this brief email might still be reviewed by you. I attended a meeting on LTC in 2020. Thank you for inviting the public.

To avoid increased payments, I had to relinquish some of my LTC benefits in 2015 and did not understand that this could take place with an insurance policy. Also my understanding is that the person is not able to get their LTC investment back if they decide to cash it in because they can no longer afford the premiums.

I remain concerned that LTC costs are being increased or benefits decreased for people with LTC policies over 65 years of age. The LTC benefit is what will help residents age in place and, many seniors are unable to afford other options for support in their senior years.

In fairness to the insurance providers, I would recommend that they be able to increase policies or make policy changes for individuals with ages under 64. Those clients 65 and > already planned to make efforts financially to care for themselves while they aged, and the options and cost should not be negotiable at this time in their life.

Thank you for reading, Kim Baker, Annapolis, Maryland.



longtermcare mia -MDInsurance- <longtermcare.mia@maryland.gov>

Long term care update

1 message

Bill Phebus <bill@metrobobcat.com>
To: longtermcare.mia@maryland.gov

Tue, Apr 20, 2021 at 9:49 AM

Attention: Nancy Muehlberger,

I would like to express my opposition to any increase at the moment to Long Term Rates, as seeing this effects mostly older Maryland residents, who for the most part have had their Covid Shoots. Secondly at this time in our country it does not seem right to raise premiums when families are suffering enough already because of the Covid situation which has affected nearly everyone.

Please, do not allow cost increases to seniors concerning long term health care at this time, as it seems we had an increase not long ago and we cannot afford another now.

Thank you,

William & Helen Phebus

Woodbine, MD

Phone: 410-489-7774

bill@metrobobcat.com