



Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov>

Re: Maryland Insurance Administration Long-Term Care Information (LTCI) Update MIA Long-Term Care Policy Proposals Open for Comment until April 6

Robert Lyon <rlyon13@msn.com>

Mon, Mar 27, 2017 at 4:22 PM

To: "MDInsuranceAdmin@public.govdelivery.com" <MDInsuranceAdmin@public.govdelivery.com>, "longtermcare.mia@maryland.gov" <longtermcare.mia@maryland.gov>

Good morning and thank you for the opportunity, as a stakeholder, to review and comment on the "MIA LTC POLICY PROPOSALS". Sorry about the format that I am using, but I could not figure out a better way (??11):

IN GENERAL: Overall, these proposed alternatives do not appear to address the CURRENT needs and situations of current policy holders in a timely fashion(?!). The proposals seem to address the long term care insurance crisis in terms of future policy holders. Most proposals seem to address the future rather than "reaching back" to we current policy holders. Many, many of us are long term policy holders and vulnerable senior citizens living on a fixed income. We have and continue to invest large sums of money in our policies which, to a large extent, would be lost if we dropped our policies (lapse rates). Further, as stated in an article by Elenor Laise in the November 2016 issue of Kiplinger's Retirement Report, living in the state of Maryland, we are subject to little known "filial responsibility laws" obligating adult children to financially support their parents, making them legally responsible for their parents' nursing-home expenses and/or other care expenses (currently, Maryland is one of over 50% of states with filial responsibility. Long term care must be considered a significant retirement risk! Accordingly, we are in practical terms, locked into our policies,

IF (and this is a huge IF) there is any "good news" with regards to LTCI, it is that finally, long term care insurance companies seem to be recognizing the need for reform and innovation with examples listed below:

1. The mixing of private insurance with large government (state-federal??) sponsored social insurance systems such as opening the door for insurance companies to offer LTC coverage

through Medicare Advantage plans. (NOTE 1)

2. Streamline LTCI plan offerings into a short menu of understandable (!) options and offer them through a tightly regulated federal marketplace, similar to how Medigap plans are sold

today. (NOTE 1)

3. Proposing to reform LTCI to cover only high impact, low probability events - the industry begin to offer 2-3 deductibles instead of the 3 month that may now be typical (this would require changed thinking in the industry, as well as also states which regulate insurance - most states require LTCI elimination periods of no more than 365 days by law). (NOTE 1).

NOTE 1: "New Strategies For Covering Long Term Care Costs", Mark Miller-Remaking Retirement, March 19, 2015

4. Hybrid Public - Private Approach: calls for streamlining and simplifying private long term-care insurance to make it work better, but also covering the most extreme risk through a publicly

financed insurance program....."an ideological middle ground". (See #1 above ??). (NOTE 2)

5. An observation: "The financial risk is real, but our current system (not even a system at all) of insuring is a mess. What we have is a patchwork of private insurance that hasn't penetrated the market widely and an inadequate public social insurance safety net". (NOTE 2)

3. Research Recommendations: a NEED TO AVOID CONSUMER CHOICE PARALYSIS (editorial comment - In my opinion, this is a huge and significant current problem!). Re-examine the current daily benefit level, length of coverage and length of waiting period before coverage begins in terms of standardization and simplification. (NOTE 2).

4. A new federally (or state??) run "catastrophic" benefit that would shift coverage for patients with lifetime costs that would shift coverage for, patients with lifetime costs exceeding

\$250,000 to a public plan (it would of course be costly....possibly addressed by an increase in payroll taxes. (NOTE 2)

5. The modernization of Medicaid (a current safety net) that would make the program's long-term care coverage more flexible. (NOTE 2)

6. Current New Idea: Genworth - The IncomeAssurance Immediate Need Annuity - a just in time coverage for people with an immediate need to fund a long term care need, but did not

plan ahead.....a single premium income annuity. (NOTE 2).

7. A Current Concern: Genworth is marketing its LTC annuity to a customer base, more likely than average to experiencing cognitive decline. They have created several

"suitability" review procedures that brokers must follow in determining when a policy can be sold - must be absolutely sure that people understand what they are buying (editorial

comment - AMEN). (NOTE 2).

8. Short-Term Insurance - structured very much like LTCI, but provides coverage for one year or less. (NOTE 2)

9. New York Life: NYL Secure Care, a LTCI product that leverages the company's mutual insurance structure - policyholders are owners, Secure Carriers structured to allow them to benefit

from potential dividends in a rising interest environment.

10. John Hancock: Performance LTCI policy - the idea is to bring down the cost of LTCI premiums by offering potential "flex credits" if investment and claims results are favorable. (NOTE 2)

NOTE 2: " Fresh Approaches To Paying For Long-Term Care", Mark Miller - Remaking Retirement, May 5, 2016.

All of this being said, ONE point is that some fresh thinking to the problem issues is being considered. A SECOND point is TRULY and SINCERELY intended to provide some possibly useful information to the MIA and others including elected representatives, as they move forward in trying to resolve many complex and difficult issues. A THIRD point is to further make the point (see the second paragraph above) that all of the above is geared to future policy holders, WITH TO DATE, no help or relief to current and long term policy holders who continue to very much need on-going advocacy! At this point, I must say that the recent efforts by Maryland State Senators Mano, Feldman and Klausmeier and Delegate Kramer are very, very much appreciated.

CURRENT MIA PROPOSALS:

(1) PHASED-IN RATE INCREASES: addresses the FUTURE and not the CURRENT situation of long or short term policy holders! A good idea to "encourage" (strongly !) LTCI companies to provide innovative alternatives to rate increases! As is stated, additional "landing spots" - provide NOW to CURRENT policy holders as well as future policy holders, a number of of inflation factors such as 5, 4, 3, 2, 1 percent of compound interest or even simple interest. As Director Redmer has previously acknowledged, insurance policies are contracts. Contracts by definition can be amended to be modified after they have been initially issued or filed. Increased number of inflation factors would give consumers more cost effective and lower costs options, while

ALSO, providing LTC insurance companies with increased potential for reducing one of their stated most costly aspects of their payouts.

A "a phased in"rate increase - might be a good idea for all parties, since they should all benefit from planning ahead. HOWEVER, why "15% compound increase each of four years"?

Why not just 15% simple interest per year OR even something less than 15%?! Using your example, that would cost consumers an additional 15%. While reluctantly acknowledging

that the LTCI companies are experiencing financial difficulties, let's PLEASE not forget who caused their initial and current difficulties - it was NOT the clients, but the insurance companies

who are responsible for this crisis! They are on the record as stating that the policies were priced initially based on among other things, their "faulty assumptions"! An example is that they

missjudged the "lapse rates" - the percentage of LTCI buyers who decide to drop coverage before they were ever needed. This continues to be hard to accept given what have been

the well known facts of longtime increasing medical costs, increased life expectancy (until this year) and the "filial laws" that have been in existence for a number of years. Clearly, they

should be accountable for their actions, just as others, individuals and organizations should be and often are.

(2) 15% Cap, COMAR 31.14.01.04A(5): The idea that LTCI companies must "demonstrate its claims experience" is a good idea. LTCI companies should indeed be subject to the MIA examining their actuarial need for a premium increase in excess of 15% or for that matter, any increase at all - what is the ACTUAL and REALISTIC NEED REQUIRED? HOWEVER, with that being said, the wording in this paragraph appears to be heavily weighted to still give primary concern to the difficulties of the LTCI companies. Here, accountability should also be an issue.

(3) Consumer Protection In Inflation Reduction: Please see my response in # (1) above - the need/requirement for ADDITIONAL cost effective inflation factors, benefiting all parties.

However, while the idea and wording is good, reasonable and fair, it still does NOT address current policy holders! Why not apply this thinking and approach to existing policies as well?

The "mechanism" for doing so could/would be the yearly negotiation of any proposed yearly premium increases.

(4) Consumer Option Document: Good idea and well written, as is.

(5) Connecting Consumers with Producers: "to consult a LTCI insurance producer".....who and how (credibility, independence?). A good idea if it was an individual(s) such as some of those that recently served on your subcommittee that worked on LTCI. Two or three such ladies come to my mind. Because each individual situation is unique and complex in what could be many ways, this would be labor intensive. How would such individuals be compensated? Would it be possible to establish a "task force" department or office" within the MIA?

(6) Study of Company Financial Data: A very good idea! Well written. In particular and of interest, is the idea, "learning how that fits into the company's (overall?) financial health, as a whole". It is easy to feel, as many of we consumers do, that large financial institutions have greater options for financial "creative" thinking and innovative "out of the box" thinking that we

individuals have.

(7) This is a very good idea.

In summary, it still greatly concerns me that little if any solutions to and resolutions of, the difficult issues facing the aging and vulnerable citizens of Maryland have been developed or proposed. However, I do thank you for your efforts to date.

Respectfully,

Robert R. Lyon



Gaithersburg, Maryland 20878

Sent from [Outlook](#)

From: Maryland Insurance Administration <MDInsuranceAdmin@public.govdelivery.com>

Sent: Wednesday, March 8, 2017 4:03 PM

To: rrlyon13@msn.com

Subject: Maryland Insurance Administration Long-Term Care Information Update MIA Long-Term Care Policy Proposals Open for Comment until April 6

You are subscribed to Long-Term Care Information for Maryland Insurance Administration. This information has recently been updated, and is now available.

[MIA LTC Policy Proposals](#) Open for Comment until April 6

<http://insurance.maryland.gov/Consumer/pages/LongTermCare.aspx>



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longtermcare mia -MDInsurance- <longtermcare.mia@maryland.gov>

MIA, LTC Briefing - Policy Issues Comments

Bill <wenglefamily@verizon.net>
To: longtermcare.mia@maryland.gov

Tue, Mar 14, 2017 at 4:38 PM

This is a response to the MIA request for input from stakeholders regarding the following policy proposals. Submitted from a policy holder, and an unofficial ombudsman for all insured policy holders.

Discussion:

Item 1. Phased in rate Increases:

This is not a bad idea, however, the selection of alternatives to any proposed rate increase, NTE 15%, be established on the basis that there be innovative alternatives to rate increases, (Landing Spots), that provide realistic and controlled amounts for the rate increase. The sample identified adds a link to allow a 4 year span between successive rate increases and coupled to that limit would be added more innovative alternatives, as proposed as examples, to the policies being identified as those needing an increase by the carriers. It would not matter if that was based upon actuarial data or claims experience because the result would impact the insured parties identically. It seems to represent a matter of perspective regarding how palatable the alternative may be to the insured. The possibility of a 75% increase every four years would not be very palatable to me. The alternatives offered at that time would have to include options significantly less severe than any discussed in prior rate increase that were approved in the past.

Item 2. 15% Cap, COMAR 31.14.0.04A(5)

The existing cap at 15% per year cap on annual rate increases currently includes authorization in excess of that amount if the carrier can demonstrate that policy payouts currently exceed the expected rate representing actual claims experience. This proposal had two types of responses identified. Neither keep a carrier from submitting rate case every year within the 15 % yearly cap. This is correlated to Maryland's joining a group of states adopting this control several years ago. The two discussion point bullets seem to indicate that MIA is considering allowing rate increase above the 15% cap, if claims demonstrate that are in great excess of the expected and priced rate. It is my thought that there is too much flexibility in that approach because it reacts to the carrier's data without determining the validity of the information. It would be reasonable for carriers to want every insured to retain their policy in force rather than have the policy lapse. Logically the best result would be achieved when the policies in an insured pool have a premium base that matches claim history. This is difficult to predict and project into the future. The companies in this market have good data to build upon for future policy sales based upon experience. Attempting to recover the shortfall of actual payouts vs current cumulative premium income for the older policies is not a just way of solving the problem. It transfers the carriers risks to the insured.

Item 3. Consumer Protection in Inflation Protection:

The discussion in this item addressed a area that had not been discussed with the same level of understanding, as within this summary. Particularly to the recent adoption by MIA relative to:

COMAR 31.14.01.36(A)(3) applied to new policies written after 3/1/18. Questions: Why was that date extended so far into the future? Why did the consideration for applicability to prior policies get set aside during those discussions?

How will you gather the opinions and concerns of policy holders in the group prior to 3/1/18? Also, this is a rather cavalier action regardless of applicability to either group.

It is a statement of the carriers intent to change a policies specifications without any consideration or benefit to the insured. Hopefully, this amendment being considered will be extended to existing policy holders.

Item 4. Consumer Option Document:

This proposal should have been SOP and should be implemented . (ASAP)

Item 5. Connecting Consumers with Purchasers:

This discussion is interesting. It is obvious that the insures will be contacted by the carrier at the time a billing statement , annual or otherwise, is sent to the insured. I have received a notice from our carrier months in advance regarding each rate (premium) increase. If that is not the case for all carriers it should be required by MIA. That should always alert the insured and trigger interest and questions.

Item 6. Study of Company Financial Data:

This has been a point of concern for many insured. Not isolating the financial well being of a profit center when considering the validity of a carriers request for a premium increase seem to miss the view of a carriers total field of products. If a carrier is very stable and solvent with a solid balance sheet they should be capable of an introspective internal review prior to deciding to request a premium increase. The MIA should be privy to that data in their decision process of assessment as to approve or disapprove or modify a carriers request.

Item 7: Notice of Hearing:

This recommendation has some merit. However, the burden of responsibility should be upon the carrier seeking the premium increase. The only requirement that seems to be applicable related to the MIA should be their requirement to have the carrier contact all affected policy holders concurrently with the request to MIA for the premium increase. The cost of mailing and notification should be the burden of, and lie entirely with, the carrier.

Respectfully submitted;

William L. Engle, Jr

Ellicott City MD 21043

Telephone: 4

Maryland Insurance Administration
Long-Term Care (LTC) Briefing Follow Up: Policy Issues for Comment

Thank you for the summary of the March 6, 2017 policy briefing. Here are our comments concerning the seven policy issues discussed:

- (1) Phased-in Rate Increases: We strongly oppose phased-in rate increases that would allow companies to increase premiums beyond the current 15% increase per annum by allowing them to compound the 15% annual increases. Even without compounding, our carrier, John Hancock, will be asking annual 15% increases for the foreseeable future. In the example given, the companies would be allowed an additional 15% increase over 4 years. In our particular case, allowing compounding would mean adding many hundreds of dollars to increases that under current rules are going to cost us thousands of dollars more over the next four years. Allowing compounding will make it impossible for us to continue coverage.
- (2) 15% Cap, COMAR31.14.0104A(5): We also strongly oppose this proposal. It will just give companies another reason to ask to exceed the 15% cap.
- (3) Consumer Protection in Inflation Reduction: This proposal is acceptable. However, the MIA should amend its regulation so that it applies to all existing LTC policies upon renewal and not only to new policies issued after 3/1/2018.
- (4) Consumer Options Document: This is acceptable.
- (5) Connecting Consumers with Producers: No comment.
- (6) Study of Company Financial Data: This is very important. Many LTC providers, such as our provider, John Hancock, provide many other financial services including life insurance, annuities, investment services, etc. Companies should be required by the MIA to report the company's overall financial position in asking for premium increases and not just base them on utilization of benefits on one particular product line in one particular state, Maryland. Financial services giant John Hancock does not have solvency concerns.
- (7) Notice of Hearing: Acceptable, but of minor importance.

What Maryland seniors need is real dollars and cents relief from exorbitant premium increases, especially for seniors who have been paying premiums for many years and were led to believe that any price increases would be minor. The MIA should work with consumer groups to suggest to the legislature some real benefits such as further limiting premium increases for policies that have been in force for say, at least 10 years and providing paid up

long-term care in the amount, equal to all premiums paid plus an adjustment for inflation, for all seniors who have to cancel their policies.

Clarke N. Ellis and Giovanna Ellis

[REDACTED]

Bethesda, MD 20816

MEMORANDUM

E mail irvcohen41@gmail.com



3210 No. Leisure World Blvd
Silver Spring, MD 20906

To: Maryland Insurance Administration
Long Term Care Policy Issues

From: Irving P. Cohen 

Re: Comments Regarding Long Term Care Policy Issues

Date: March 27, 2017

Over the past year as a private citizen who has resided in Montgomery County, MD for more than 45 years, I have appeared at several of the hearing MIA has hosted. As such I have entered on to the oral and written record my major concerns regarding important policy issues that in my view (and the views of others that have also participated in those hearings) are not be being adequately considered by the MIA. In reviewing the Briefing Follow Up to the March 6, 2017 hearing I suggest that most of the issues listed below continue to be of importance and yet are not adequately addressed.

A brief summary of those policy issues is as follows:

- As a matter of explaining its view of public policy to MIA's decision making little if anything is said about (i) who is bearing the risks and rewards of *policy design performance; and actual performance* with respect to the various elements of the policy structure; or (ii) in light of MIA's mission to protect the policy, how should this issue be addressed in making rate setting decisions?

- If you will: To what extent is the policy holder to be allocated the risk of policy design during the full term of the policy? And how is that risk to be measured and accounted for so as to be fair to the policy holder?
- From my discussions with staff it seems that the current "loss ratio" is the only significant element under consideration. However, certainly common sense suggests there are other important factors. *As policies age over the decades* other factors need consideration if one is to be certain apportionment of the risk takes place so as to protect the consumer in a reasonable fashion.
- There is no indication that this type of analysis is taking place currently, or that MIA intends to make any such evaluation or pronouncement to the public of its criteria for allocating the major risks among those with a real economic interest in individual policies.
- There is no indication that MIA is taking into account, or has any concern with respect to the real and present economic incentive for the carrier to have policies terminated once the claims ratio appears to be headed towards exceeding current premium income.
- The pronouncements by MIA do not give any indication that once the carrier has extracted the economic benefit in the early years this is an element to be identified and accounted for. It does not seem as if MIA is taking this economic reality which exclusively benefits the carrier into account as a factor in arriving at any adjustments to the current premium. This becomes more of an issue as carriers shed their long term care business through sales or transfers to "free standing" related companies. (As has been the recent case with MetLife.)
- If you will, to what extent is the "profit"; or over allocations of costs, and overhead; or dividends to parent companies from the early years,

being accounted for in analyzing the carrier's request for premium increases. None of these factors seem to be addressed by MIA in its pronouncements.

- Furthermore, if there is any actuarial windfall due to termination/lapse of policies by otherwise healthy insureds -- how is this accounted for under the current model? Who is to obtain the actuarial benefit and how is that benefit determined?
- The issue of costs not accounted for in the initial policy design and the apportionment of that risk to the carrier and/or the policy holder does not seem to be addressed by MIA. A key public policy question needs to be answered and publically disclosed. *Who is able to better and equitably sustain those risks in the marketplace? Especially, if certain relationships with other insurance products or services of a related company are tied into LTC products?*
- There is no indication in the pronouncements by MIA of the probability that by its approving multiple rate increases over the years the Agency is effectively holding the carrier harmless from bad business decisions. MIA is thereby pushing those costs on to the remaining policy holders. Thereby providing an additional incentive for the policy holder to terminate before becoming a claim. *Query: Is this good public policy?*
- As a public policy issue MIA does not seem to address the question of whether holding the carrier harmless from bad business decisions is a proper role for a regulatory agency with a mission to ensure fair and reasonable insurance costs to the consumer? If not MIA, then what government agency is charged with protecting the policy holder?
- To what extent does MIA have an obligation to analyze alternative reasonable assumptions and models different from those proffered by the carrier's actuarial firm? Small changes in assumptions can

generate very significantly different results, which then demand different conclusions. In the files I have seen with respect to those policies I have purchased, other than those proffered by the carrier there is no documented process whereby MIA engages in sensitivity testing with regard to other reasonable assumptions.

- Since it appears that the premiums are actually deposits for payment of claims, is it good public policy to have the premium tax on those premiums added to the general funds of the State? Is this not *de facto* an additional state sales tax on medical costs of the consumer?

Overall there does not seem to be a realization by MIA that to the extent a policyholder terminates his or her policy because of the inability to continue to pay the ever increasing premiums, there is a strong possibility the policyholder may in fact ultimately become a Medicaid beneficiary.

Just as the need for the LTC coverage becomes acute, the benefit has been lost, the premiums paid of no future benefit to the policy holder; and hence the cost of long term care is now being shifted to the taxpayers of the State of Maryland. In the interim the insurance company has been able to collect increasing levels of premium dollars to add to its coffers for the benefit of its executives and/or shareholders.



longtermcare mia -MDInsurance- <longtermcare.mia@maryland.gov>

Comments on March 6th Proposals

John McLaughlin <jtmcl98@gmail.com>
To: longtermcare.mia@maryland.gov

Tue, Mar 14, 2017 at 3:24 PM

Thank you for the invitation to the March 6th public briefing and your interest in receiving comments to the proposals.

My comments address the issue raised in Proposal 6 - Study of Company Financial Data and the related Proposal 1 - Phased-in Rate Increases.

I do not know the depth of the financial information that an insurance company is required to provide when they ask for an increase so I apologize if you are already on top of what I suggest.

Insurance company expenses are made up of claims, corporate overhead, and operating expenses. Their income is from premiums, the return on invested capital, and the credits to the balance sheet when policies are cancelled, lapse, or terminated upon death of a policyholder.

In order to reach an informed and fair decision on a request for a rate increase all of the above factors should be audited by knowledgeable forensic accountants. By way of example, how does a firm show the credit when a policy ends and they have a reserve on the books for the policy? Another example: If an insurance company's investments have underperformed is it fair to ask for a rate increase? I can provide evidence of poor investment results by Genworth leading to multiple rate increases.

The example in proposal 1 has a 75% increase over 4 years in return for more consumer alternatives. This would totally disregard the potential to avoid future increases when their returns on invested capital improve. Why not demand more consumer alternatives as a condition of even considering a request for an increase?

Thank you again for the chance to participate and if you have any questions on my comments please let me know.

John G. McLaughlin
[REDACTED]
Potomac, MD
20854

Date: March 9, 2017

Re: Comments on March 6, 2017 MIA hearing on Long Term Care Insurance

While I appreciate the efforts being made by MIA to address the issue of multiple large increases in premium for policy holders of long term care insurance, I believe that a number of concerns important to individual policy holders are not being adequately addressed.

1. Although a number of bills have been introduced in the Maryland State Legislature, virtually none deal with the impact of rate increases on current policy holders, especially those who have had policies for many years and are now reaching the age when the need for maintaining the insurance is greatest. It appears that the insurance companies issuing the policies are engaged in a deliberate attempt through use of continuous large rate increases to force older policy holders to either cancel long held policies or to accept significant reduction in benefits in exchange for modulation of rate increases. It is essential that older persons who have been policy holders for many years be given protection from repeated large rate increases which may prevent them from utilizing the benefits earned through many years of premium payment. A moratorium and much lower cap on future rate increases is required for these policy holders.

2. Stronger justification of requested rate increases is needed. The overall financial health of the insurance company must be considered, not just the Long Term Care insurance line. It is apparent that most of the requested rate increases are based on future projections of reduced earnings from this line and not on actual losses. These earnings projections are based on drop out rates of policy holders and on mortality rates. Fewer drop outs and lower mortality adversely affect earnings since premiums paid by drop outs and by those who die without a period of disability represent pure profit to the insurance companies who have collected premiums but have not paid out benefits. Companies also benefit financially when persons receiving long term care benefits die before they have utilized the full pool of funds they have purchased – these unused funds go back to the insurance company.

Myron Miller, M.D.

Myrmiller1@verizon.net



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 $\text{base rate} \times (1.15)^{32}$, 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

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Wheaton, MD. 20902



April 6, 2017

Maryland Insurance Association
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Longtermcare.mia@maryland.gov

RE: Comments on Long-Term Care Policy Issues

To: Maryland Insurance Administration: Long-Term Care Working Group

Thank you for the opportunity to comment on the long-term care (LTC) policy issues that resulted from the March 6, 2017 LTC Briefing. We appreciate all the efforts of the Maryland Insurance Administration (MIA) and the LTC working group. We also appreciate the opportunity to participate in the working group and we look forward to continuing the open dialogue in Maryland on LTC matters.

The American Council of Life Insurers (ACLI) and America's Health Insurance Plans (AHIP) have reviewed the LTC policy issues for comment and offer the following comments for consideration.¹

- (1) **Phased-in Rate Increases:** The LTC industry supports the premium rate increase provisions provided for in the NAIC Long-Term Care Insurance Model Regulation. We are also supportive of the ability of the MIA to grant actuarially justified "phased-in schedule" rate increases as a means of providing more innovative alternatives ("landing spots") to rate increases for consumers, when such viable options are available.
- (2) **15% Cap, COMAR 31.14.01.04A(5):** We agree that the Commissioner should be allowed to accept more than a 15% rate increase in any given year if the carrier can demonstrate that claims experience is greater than expected.
- (3) **Consumer Protection in Inflation Reduction:** As stated above, we support the adoption and implementation of inflation reduction landing spots, when available. We also appreciate the MIA's desire to assure that that if a reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholders to continue the benefit in effect at the time of the reduction on a prospective basis. [See: COMAR 31.14.01.36(A)(3)]. We continue to support COMAR 31.14.01.36(A)(3), but have significant concerns with applying this regulation retroactively. We see some significant hurdles when applying this requirement retroactively. While some carriers administer inflation reduction landing spots in the manner described, some carriers do not, and so they allow the insured to go back and keep the accrued benefit levels by adjusting the original issue benefit levels and inflation provision with an adjustment to premium. We do not believe that a change in regulation should foreclose the carrier from administering their policies as originally written.

¹ ACLI is a Washington, D.C.-based trade association with approximately 290 member companies operating in the United States and abroad. ACLI advocates in state, federal, and international forums for public policy that supports the industry marketplace and the 75 million American families that rely on life insurers' products for financial and retirement security. ACLI members offer life insurance, annuities, retirement plans, long-term care and disability income insurance, and reinsurance, representing 94 percent of industry assets, 93 percent of life insurance premiums, and 97 percent of annuity considerations in the United States.

(4) **Consumer Options Document:** Industry has long been a proponent and supporter of clear and meaningful disclosure to our customers at time of a rate increase. In fact, we support the enhanced consumer disclosures as provided for in the NAIC LTC Model Regulation and the NAIC Guidance Manual for Rating Aspect of the Long-Term Care Insurance Model Regulation.

(http://www.naic.org/documents/committees_b_senior_issues_160609_ltc_guidance_manual.pdf)

Specifically, Section IX (A) discusses the Model Bulletin (adopted in 2013) and the insurer policyholder premium increases notifications. This section provides that the insurer must clearly disclose, among other things, available benefit reduction/rate increase mitigation options. "The insurer should focus on one option in detail and provide direction/contact information as to where the individual may seek information on additional options if available."

Industry agrees with this approach and consumers are instructed to contact the carrier's customer service team to review alternative offerings. Ultimately, we want to make sure that the insured has a clear and concise roadmap of the implementation/alternatives process.

(5) **Connecting Consumers with Producers:** Industry will be happy to work with the MIA and producer groups on how we may best facilitate connecting consumers with producers.

(6) **Study of Company Financial Data:** The NAIC LTC Valuation Sub-Group is currently considering a host of financial issues and we respectfully suggest that Maryland allow this subgroup to continue its work. This is an issue that must be discussed at a national level to ensure uniformity among the states.

(7) **Notice of Hearing:** Industry participated in the House Insurance working group on House Bill 493. During those discussions, industry agreed to the following provision in the bill: "A carrier shall provide a one-time written notice to its insureds that an insured may access information about proposed rate increases on the Administration's website" We continue to support that provision.

Thank you again for the opportunity to comment and we look forward to continuing to work with the LTC working group on these very important policy issues.

Sincerely,

Sincerely,



Rod Perkins
ACLI

Amanda Matthiesen
AHIP

MedAmerica Insurance Company to Maryland Insurance Administration
Re: Long-Term Care (LTC) Policy Issues for Comment

On March 6, 2017, the MIA held a public briefing in Annapolis, Maryland to vet new policy proposals for LTC Insurance, among other things. As a follow up to that briefing, the MIA solicited written comments from stakeholders on the following policy proposals. **Written Comments were to be sent to longtermcare.mia@maryland.gov by no later than 5pm on Thursday, April 6, 2017.** MedAmerica's comments are below, and the company thanks the MIA for soliciting industry input.

(1) Phased-in Rate Increases: Should the MIA grant actuarially justified "phased-in" rate increases to carriers, not to exceed 15% annually, if in doing so, carriers agree to provide more innovative alternatives to rate increases ("landing spots") for consumers? For example, should the MIA approve a proposed 75% increase over 4 years (15% compound increase per year) if it would incentivize a carrier to offer more consumer alternatives to the rate increase now (i.e., innovative benefit reduction options or reduced inflation protection benefit options)?

MedAmerica supports the idea of allowing "phased-in" rate increases, whether or not they are accompanied by more innovative alternatives. Allowing a carrier to phase in actuarially justified premium rate increases over several years gives the insured definite knowledge of future rate levels, rather than the uncertainty of multiple, separate approvals of 15% at a time. The consumer can then make a decision about appropriate and affordable future benefit levels with the advantage of more complete information about future premiums than the present regulatory structure provides.

(2) 15% Cap, COMAR 31.14.01.04A(5): Current regulations provide for a 15% cap on annual rate increases. However, an increase can be in excess of 15% if the carrier demonstrates that the utilization of benefits is greatly in excess of the expected rate. The MIA is considering a technical change to this language to provide that a carrier may also justify an increase excess of 15% if it can demonstrate that its *claims experience* is greatly in excess of expected rate.

- The MIA has observed that it is not utilization, but rather claims experience, that is driving the actuarial need for LTC rate increases. This change would empower the MIA to address a carrier's actuarial need for a premium increase in excess of 15% when claims are in great excess of the expected and priced for rate.
- This change would retain the 15% cap as the default, but would give the MIA the flexibility to provide for higher increases if needed.

MedAmerica supports this technical change to allow regulatory flexibility. We encourage the MIA to recognize that it is actual and projected claims experience that drives the need for a rate increase request.

(3) Consumer Protection in Inflation Reduction: Inflation Protection reduction is a viable "landing spot" for many consumers who are unable to bear the cost of a full premium rate increase. In this scenario, the carrier offers the consumer the option to reduce or eliminate the consumer's inflation reduction benefit (if the consumer has such a benefit) in lieu of paying an approved rate increase.

The MIA recently adopted regulations providing that for any policies issued on or after 3/1/18, **if a reduction in coverage involves the reduction or elimination of the inflation protection provision, the insurer shall allow the policyholders to continue the benefit in effect at the time of the reduction. See: COMAR 31.14.01.36(A)(3).** For example, for a consumer reducing an inflation protection benefit from compound to simple inflation, the new simple inflation provision would begin to accrue on the amount of benefit ALREADY accrued by compound inflation at the time the change is elected. This is a great consumer protection and is responsive to many complaints we have received. However, this provision only extends to new policies issued after 3/1/18, and not to policies issued prior to that date.

- The MIA is considering amending the regulation again to extend this provision to “policies issued or renewed on or after a certain date.” This will extend this consumer protection to existing policyholders upon policy renewal.

MedAmerica objects to an amended regulation that would apply such an additional provision to enforce policies on their future renewal, without an opportunity to adjust premium rates to reflect the change.

(4) Consumer Options Document: The MIA is considering a requirement that a written notice be sent by a carrier to impacted consumers each time a rate increase request has been **approved**. The notice would outline ALL CONSUMER OPTIONS, including the cost of the rate increase compared to all available rate mitigation options such as a reduction in benefits, reduction in inflation protection benefits, or nonforfeiture options (i.e., conversion to “paid up” status). This would give consumers an “apples to apples” comparison of all options at their disposal in the event of a substantial rate increase so that the consumer can make the best choice possible.

MedAmerica offers insureds affected by a premium rate increase the option of reducing their policy benefits to provide flexibility of choice for those insureds who wish to maintain a premium level reasonably similar to what they were paying prior to the rate increase. Furthermore, MedAmerica offers a Contingent Non-Forfeiture (CNF) benefit to all insureds affected by a rate increase, which means that a policy that lapses premium payments due to the requested rate increase remains eligible to receive some level of paid-up benefit in the future. MedAmerica makes this accommodation in the spirit of consumer consideration and as an advance response to consumer outcry to ‘not lose premium paid in.’ Our rate increase communications, distributed upon a rate increase implementation, already include these choices, and, where applicable, any tailored inflation reduction “landing spot” option that may be offered.

To help consumers navigate their options to continue premium payments, to accept a reduced paid-up CNF benefit, or to find a benefit reduction option that best suits them, all insureds are encouraged to call one of our customer service representatives for personal attention. Because each policyholder is unique, MedAmerica works with each person individually. There may be numerous benefit reduction options, or combinations of options, available to an insured. To include ALL options in a policyholder notice would be administratively infeasible and serve as a source of information overload fostering consumer confusion.

(5) Connecting Consumers with Producers: The MIA is studying formal outreach options to encourage consumers to consult a LTC insurance producer to discuss all options available in the face of an LTC rate increase. The MIA welcomes suggestions on how this might be accomplished.

MedAmerica, like most carriers who have exited the LTC insurance market, no longer maintains contracts with producers to represent the company. MedAmerica contends that Customer Service Representatives are most knowledgeable about the specific options available to any MedAmerica insured faced with a premium rate increase, especially on older policy forms, and that Producers would be unable to properly assist. Insureds should be encouraged to call customer service to discuss their options.

(6) Study of Company Financial Data: The MIA will be studying how the financial solvency of a company as a whole is impacted by its LTC Rate Experience. Many LTC carriers are actuarially justifying rate increases on LTC products—but the MIA is interested in learning how that fits into the company’s financial health as whole (i.e., on all lines of business), and is reviewing its regulatory authority in this area. The MIA welcomes comments from companies on how the vitality of LTC products interacts with the financial health of the company as a whole.

- For example, is a rate increase appropriate, even if actuarially justified, when a company is making significant profits in lines of business other than LTC, if the company as a whole is in good financial health, and there are no solvency concerns?

MedAmerica, as a mono-line LTC insurance carrier, is dependent on appropriate premium rate increases for its future financial stability. In general, principles of equity among policyholders across various lines of business and/or various products argue for the continued consideration of rate increases on LTC business where actuarially justified.

(7) Notice of Hearing: The MIA is considering a requirement that written notice be sent by LTC carriers to their customers directing consumers to the MIA’s website for information on the corresponding public rate hearings. This would ensure that all consumer stakeholders impacted by a potential rate increase have the opportunity to engage in the public hearing process established by the Commissioner—what one legislator called ensuring “meaningful” public hearings.

MedAmerica is concerned about this proposal for several reasons that include but are not limited to: (i) additional administrative burden and expense on the part of the carrier; and (ii) consumer clarity around the rate increase process. There is no question that there will be additional cost shouldered by the carriers if required to communicate with insureds every time a rate increase is requested. Not only will there be mailing expenses, but residual resources will be needed to address the phone calls and returned mail such a distribution would create. Additionally, given the short time frame afforded carriers by MIA when scheduling public hearings, there is little time to adequately notify the insured of an impending public hearing. As an alternative, MedAmerica suggests a coordinated web-

based notification, the carriers and MIA in sync, would be in the insureds' best interest. For example, a standing consumer notice on a carrier's website that links to the MIA. Or, in the alternative, a generic disclaimer by the carriers to the consumers (perhaps in the form of a premium invoice or annual statement stuffer) that directs insureds to monitor the MIA site.

Notification upon request, when paired with notification of implementation of an approved rate increase, could result in consumer confusion or worse detachment. The notices will undoubtedly bear different facts and figures when compared, what was requested versus what is being implemented. This will generate confusion no matter how clearly the correspondence is crafted, especially if multiple increases are filed as a result of the regulatory approval / negotiation process. Additionally, there is risk that an insured will lose a sense of importance regarding the implementation notice if there are too many pieces mailed – thereby possibly missing a response or election deadline for benefit reduction options of CNF.

MedAmerica thanks the MIA for soliciting industry input. If you have any questions regarding these comments please contact either Angela Hoteling-Rodriguez, VP Compliance & Regulatory Affairs, at angela.hoteling@medamericaltc.com, or Pat Kinney, Managing Actuary, at patrick.kinney@medamericaltc.com.

Dear Ms. Muehlberger,

I was just about to write a letter to the Maryland Insurance Administration objecting to the regulators' recent approval for a 15% long term care insurance rate hike by MetLife., and the company's plan to continue raising rates until they are up 50.43%. As I was looking for the right address for my complaint, I noticed that Commissioner Redmer will be holding a hearing on the subject on Monday, March 6.

My wife and I each have long term care policies that we purchased with TIAA/CREF, and which were later transferred to MetLife. We have held these policies since April, 2003. At various times we have accepted MetLife's offers of increased daily coverage at higher rates to keep up with rising care costs. A few weeks ago, we were notified by MetLife that Maryland state regulators had approved the 15% increase in our premiums . We were offered the following options: accept the rate hike; reduce our daily maximum coverage; reduce our lifetime benefit maximum from five to three years. They also said we could cancel our policies. This is no doubt what the company would prefer since we have paid many thousands of dollars over the past 14 years, and would get nothing in return.

We very reluctantly decided to reduce our daily nursing facility care benefit from \$257 to \$240, and keep premiums at roughly the current rate.

MetLife openly states that they will continue to seek approval for additional increases until they reach the 50.43% requested.

We entered into a good faith agreement with TIAA/CREF MetLife when we bought our policies, and have kept our part of the bargain by regular on-time premium payments. If MetLife and other insurers made a mistake in underestimating the cost of their insurance product, any loss should be borne by them.

We are both in good health, and are hoping that there should be no cause to make claims on our policy any time soon – or forever, for that matter.

We trust that the State of Maryland will stand by its citizens and refuse to approve any more of these unfair increases. Will you please convey our regards to Commissioner Redmer and other regulators and ask that they firmly oppose MetLife requests.

And will you please acknowledge receipt of this note and let us know the results of Monday's hearing.

Sincerely,

Edward R. Post
Elma Glen Post



University Park, MD 20782



Long Term Care premium increases

Inbox x



lfjohnwayne@aol.com <lfjohnwayne@aol.com> Feb 19 (2 days ago)

Reply

to me, gail.bates, governor.mail

Nancy,

Well, John Hancock has done it again. In less than 3 years they have increased our Long Term Care premiums by almost 90 %. This is totally unfair to customers that bought these policies in good faith.

Long Term Care Insurance is a product that everyone should purchase. However, the companies that sell this protection are abusing Maryland citizens with their ridiculous premium increases.

And the Insurance Commissioner seems to be defending the insurance companies and ignoring the problem these premium increases put on the policyholders.

How many years can these premium increases continue? When I ask customer service at John Hancock they seem to chuckle and say "they're not sure."

I'm 68 years old and I'm legally blind. I had to stop working at 62 when I lost most of my sight.

My wife is a retired instructional assistant (17 years) from Howard County Public Schools.

Just the premium increases alone that John Hancock has required us to pay them to keep this coverage in force

amounts to 40% of my wife Linda's annual School system pension.

The Maryland Insurance Department needs to protect the policyholders from any further premium increases.

Also, tax credits for policyholders over 65 may be a good solution that the Commissioner should seriously consider. The State of Maryland does not want people over 65 to drop their Long Term Care policies.

A State tax credit would help most policyholders keep their policies in force. And I do not believe that would be a costly solution.

Most seniors no longer have tax deductions (no dependents and most don't have home mortgage interest deductions). Giving them a tax credit helps both the seniors and the government entities.

The last thing the government should want is to increase it's exposure to Long Term Care expense. Especially when they have citizens who have already taken proactive steps to limit the State of Maryland's exposure.

Thank you for your interest and consideration.

Be well,
John Feldmann

[REDACTED]
Ellicott City, MD 21042

[REDACTED]

PS. - My wife and I will not be able to attend the Insurance Commissioner's meeting on March 6th. I have an appointment that day at Johns Hopkins' Wilmer Eye Institute. I have an injection of medication in my good eye every five weeks. I cannot miss or delay this appointment. The injections must happen on this schedule to save what is left of my eye sight.

Fwd: Input for LTC Hearing Mar 6

To: longtermcare.mia@maryland.gov

Commissioner Redmer,

To reduce premium costs this policy holder needs additional options.

One of the options offered is compound or simple inflation.

Why not mandate that LTC companies provide cost options for inflation rates of 4, 3 and 2 percent?

When my company was asked this question the response was that the MD MIA does not allow this option! I hope that is not so.

Richard Wahl
Millersville, MD

This written statement concerns what I believe may be a predatory practice targeting older persons who have purchased long term care insurance from insurance companies doing business in Maryland. In my specific circumstance, John Hancock Life Insurance Company has increased rates for insureds by 15% for each of the past 2 years and plans to submit for an additional 39% increase to take effect next year. In addition, John Hancock states that they will continue to file for rate increases in subsequent years to come. Such inordinately high rate increases for existing Long Term Care insurance policies apparently is common to all companies selling Long Term Care insurance in Maryland

My concern is that the targeted group for rate increases is the older policy holder who is approaching the point in life when the need for long term care insurance coverage becomes more likely. Long term care insurance has no cumulative benefits so that if an individual cancels long held insurance because premiums have become unaffordable, all benefits are immediately lost and not recoverable in the future. The older person who receives notices of present and future major premium increases is very likely to be living on either a fixed income or income with limited growth potential. Consequently, many such persons may be forced to cancel their insurance and lose their many years of investment in the policy or be forced to substantially reduce their level of coverage in order to keep a policy in force. Examination of annual financial reports of major insurers reveals that the rate increases are not due to financial losses by the insurers but rather are due to reduced profit forecasts as a consequence of a lower than anticipated dropout rate by aging insured persons and to a greater probability of long periods of disability rather than death, both of which result in greater likelihood of utilization of the insurance.

I request that the Maryland State Commissioner of Insurance take actions to develop procedures, including specified rate tables, to prohibit carriers from imposing inordinately high future rate increases. It will be helpful to have the Maryland Insurance Commission conduct a study to determine what has been the impact of past rate increases on policy cancellation or reduction in level of coverage on individuals age 65 years and above. Further, the Maryland Insurance Commission should seek to gather data on the likely impact of future rate increases on policy retention or coverage reduction. This can be accomplished by poll of policy holders in Maryland since policy holder lists can be obtained from the insurance companies

I write not only for myself but on behalf of all Maryland residents who may be affected by this dramatic and perhaps purposeful exploitive action of Long Term Care Insurance Companies taken against long term care insurance policy holders.

Sincerely yours,

Myron Miller, M.D., FACP, AGSF

[REDACTED]

Baltimore, MD 21209

Myrmiller1@verizon.net

[REDACTED]

Fw: SUBJECT: Long-Term-Care Costs Insurance Annual Premium Increases - My Testimony FOR THE WRITTEN RECORD AND a formal request to testify at the March 6, 2017 Public Hearing..

I continue to ask in writing to both Genworth and the MIA why Genworth has not/will not (??) update/revise their older long term care policies to offer at least one, if not more, additional inflation factors (for instance, at least a 3% compound interest factor, and possibly additional compound interest factors) other than their current TWO options - 5% compound and 5% simple interest. Other long term care insurance providers doing business in Maryland currently have and continue do this! I have have been told by Genworth that their newer policies do indeed provide additional inflation factors. I and others view these policies as "contracts" and by definition, contracts can and are indeed modified via "amendments" and "modifications" there to. From what I have learned and been told by Genworth, the compound inflation factor is one of their most costly factors of their long term care policies. The "proposed" inclusion of additional inflation factors would I believe, provide a tangible proactive benefit to their older policy holders, with a potential high probability of reducing Genworth's potential payout costs and their required reserve amounts, while consumers would have additional potentially more favorable and affordable options. Why would all parties not benefit from such revisions and why can the MIA and Genworth not at least discuss, if not implement, such options (regardless of "the terms of the initial filling") ?? To me, it seems that all parties would benefit financially from such actions taken together by Genworth and the MIA! I believe that this can and should be a part of the MIA approval process via the use of negotiation!

Genworth and most other carriers continue to state that one one of their biggest and most costly initial "poor assumptions" was that of the projected "lapse rate" of their policies. That is, the amount of time that the insurance carriers expected their clients to hold on to their purchased policies. These insurance companies are on the written record as stating that they expected clients to NOT hold their policies for as long as they have and are doing so. My on-going research has discovered a recent and relevant development that has significant impact to the "lapse rate" issue that is still another and significant issue that should cause clients to need to continue to hold onto their long term care insurance policies! " Can You Be Held Responsible For Your Parents' Long-Term-Care Costs?"..... "when an older adult racks up unpaid long-term care bills, who's responsible for paying the debt? In a growing number of cases, adult children are being held legally responsible for their parents' nursing home or other expenses. The reason: more than half of U.S. states have, including MARYLAND, "FILIAL RESPONSIBILITY" laws (state filial laws) obligating adult children to financially support their parents. These laws, which have gone largely unforced for decades, are reappearing in court cases as an aging population struggles with health care costs" (Kiplinger Retirement Report, November 2106 - Eleanor Lake).

For family members, the consequences can be severe! Surely, Genworth and other carriers must have been and are currently aware of this legal situation!

It does now appear that we consumers from the private sector have finally found for maybe the first time, willing and proactive advocates for our very real financial crisis! To quote from a recent letter from Senator Thomas V. Mike Miller, Jr., President of the Maryland Senate dated February 12, 2017, "As Maryland prepares for possible repeal of the Affordable Care Act, we cannot ignore the rising costs of long-term care that are not covered by Medicare or other forms of insurance. With many Maryland residents being affected by this, I appreciate you reaching out to share your thoughts and concerns. In response to extremely steep long-term rate increases, several members of the General Assembly have proposed mitigating legislation for this session. In the Senate, Senator Roger Mano is sponsoring Senate Bill 176, which establishes a moratorium on carriers increasing their renewal premium rates between 2017 through 2019. This legislation was recently heard before the the Senate Finance Committee and its discussion surrounds the impact of the moratorium on a carriers' ability to pay future claims and remain financially solvent, as well as its potential for dramatic rate increases or carriers market withdraw. Additionally, Senator Bill 432 Income Tax-Credit for Long-Term Care Premiums, sponsored by Senator Katherine Klausmeier, alters the limitations on and expands the amount that a taxpayer can claim as a tax credit for long-term care insurance. This legislation will be heard by the Senate Budget and Taxation Committee on February 14, 2107. in the House, Delegate Benjamin Kramer is sponsoring House Bill 493 that requires The Maryland Insurance Commissioner to establish rate tables for carriers and clarifies the situations in which carriers may or may not charge an increased premium rate. Currently, HB 493 will be heard in the House Health Government Operations Committee on March 2, 2017. As the discussion surrounding the need and impact of this legislation continues, I will keep your advocacy in mind should any of these bills come before me on the Senate floor. This issue seriously impacts the lives of thousands of Marylanders."

In addition, I have just recently learned of another proposed Senate Bill authored by State Senator Brain Feldman. This bill will propose that a task force be appointed by the Governor to examine the various issues and impacts associated with the current long term care insurance situation in Maryland. This task fore will consist of a number of parties involved in the issue of Long Term Care Insurance in Maryland.

Randy Lyon



Gaithersburg, maryland 20878



Testimony from Melissa Barnickel, CPA, CLTC, member of Maryland LTC Roundtable, Joint Legislative Committee for NAIFA/MAHU and the MIA LTC Workgroup

The Maryland LTC Roundtable and NAIFA-MD and MAHU are pleased with the initiatives of this MIA Commissioner. The essential point is to better serve the residents of Maryland and several activities have begun to do that. The adoption on 2/27/2017 of NAIC 2014 Long-Term Care Model Regulation encourages more conservative pricing, requires an annual actuarial statement to be filed with the Commissioner, enhances consumer contingent non-forfeiture benefits and improves consumer disclosures. The amendment will go a long way to see that future purchasers of LTCi in MD will enjoy enhanced protections. We appreciate MIA moving so quickly to make this a reality. Existing policyholders are already experiencing greater transparency for the premium rate increase process and active exploration of other ways to assist current policy holders.

And the MIA LTCI Workgroup has spurred several pieces of LTCI legislation to be submitted to and considered by the current Maryland Legislature. One of these is the Joint Legislative Committee of NAIFA-MD and MAHU SB 0696 and HB 0593 calling for a joint public/private task force to be formed to enable the goal that no Marylander will reach the age of 50 without understanding LTC risk and private options to address that risk and Marylanders will be educated about the Maryland Medicaid system, how it is funded, and who it is intended to serve. MIA inspired this legislation by the creation of the MIA LTC Workgroup.

We urge the MIA to continue their efforts. All members of the Maryland LTC Roundtable are not only LTC Insurance Specialists, but also consumers, owners of LTC insurance policies as are many of the members of NAIFA and MAHU.



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The Next Ponzi: \$4.6BN Long-Term-Care Insurer To Liquidate In Pa; Biggest Healthcare Failure Ever

By Tyler Durden

Created 03/02/2017 - 12:55



[1]

by [Tyler Durden](#) [1]

Mar 2, 2017 12:55 PM



[2] [3]

We spend a lot of time talking about the various pension ponzi schemes that will inevitably wreak havoc on the global financial system at some point in the not so distant future. That said, you should also be keeping an eye on so-called long-term-care (LTC) health insurance providers who, as Penn Treaty Network of America Insurance teaches us this morning, have been perpetuating a ponzi scheme of their own.

After eight full years of legal battles between state regulators, investors, and policyholders, Pennsylvania Court Judge Hannah Leavitt signed off on a plan Wednesday to liquidate Penn Treaty Network America Insurance and its affiliate, American Network Insurance, the largest such health insurance liquidation in history. The decision leaves solvent insurers, their owners, and customers to pick up the cost for more than 70% of the up to \$4.6 billion in projected long-term-care claims expected for 76,000 aging Penn Treaty customers nationwide.

Pennsylvania Insurance Commissioners Teresa Miller said that after a grueling eight-year legal battle the companies' financial difficulties were deemed **"too great to be remedied."** Per the [PA Insurance Department](#) [4]:

Insurance Commissioner Teresa Miller today announced the Commonwealth Court approval of petitions to liquidate Penn Treaty Network America Insurance Company and American Network Insurance Company, with policyholder claims to be paid through the state guaranty association system, subject to statutory limits and conditions.

"After a long and difficult eight-year legal process, the Court's decision to approve the liquidation recognizes the companies' financial difficulties are too great to be remedied, and that consumers are best protected through the state guaranty association system," Commissioner Miller said.



Just like their pension ponzi brethren, long-term-care health insurance providers take in premiums today and make a series of actuarial assumptions that justify a promise that they'll be able to satisfy a steady stream of payments at some point in the distant future. Unfortunately, like with pensions, the math all works out beautifully when the insurance companies model 7.5% annual returns on assets, but, in the real world where global bond yields are hovering just above 0%, the math is slightly less rosy.

*Over the past several years, long term care insurance has posed significant challenges to insurers on a national level. **The pricing of these policies for many insurance companies has proved to be insufficient as a result of claims greatly exceeding expectations and low investment returns.** Claims have exceeded expectations due to incorrect assumptions concerning the number of policyholders who would drop their coverage and the number of policyholders who would utilize their policy benefits, as well as the cost of providing those benefits. The pricing deficiencies and resulting financial losses have resulted in many long term care insurers seeking large premium rate increases and some leaving the market.*

*In the case of Penn Treaty and American Network, the Pennsylvania Insurance Department determined that the magnitude of **additional premium rate increases needed to remedy the companies' financial difficulties (exceeding 300% on average)** would severely harm policyholders and would not be permitted by state regulators, leaving*

no alternative other than to place the companies into liquidation.

And while payments from other insurance companies will cover these abandoned Penn Treaty policyholders, only so many insurers can fail before taxpayers will be called upon to bail them out.

"Policyholder claims will continue to be covered by the state guaranty association system pursuant to law, and policy claims will be paid subject to the applicable state guaranty association coverage limit and conditions. Policyholders should continue to file claims as they have been in the past, and must continue to pay their premiums in order to be eligible for guaranty association coverage," Commissioner Miller said. "State guaranty associations were created to protect state residents who are policyholders of an insolvent company that has gone out of business. In each state, other insurance companies licensed in that state pay into a guaranty fund, and that money is used to cover claims when a company becomes insolvent and is liquidated."

But don't worry, there's only about \$2 trillion worth of LTC claims [5] that will need to be covered at some point in the future...should be fine.

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[5] http://naic.org/documents/cipr_current_study_160519_ltc_insurance.pdf