

## Comments for the October 27 Hearing on Long-Term Care Insurance Premium Increases

Please include the following comments in the record of the above-cited Hearing:

Why is there a need for long-term care insurance? People are living longer, but this increased life span is frequently accompanied by marked decline in physical and/or mental capacity. In the past, sons and daughters generally cared for aging parents in a family setting. In today's very mobile society and with the economic necessity for both husbands and wives to work outside the home, children are increasingly unable and/or unwilling to care for aging parents. The elderly thus are increasingly faced with the necessity for long-term care - either by providers in their own homes or in a long-term care facility. The question is, how to pay for it? The rich, with millions of dollars in retirement savings, can self-insure. The poor have long-term care provided through Medicaid. For middle class seniors, long-term care insurance seemed to provide the answer: By paying moderate premiums over a decade or more they would have some guaranteed amount of long-term care available if it became necessary. The insurance companies' salespersons assured us that premiums on individual policies could not be raised; raises would only take place if premiums were raised on an entire class of policies, and that was highly unlikely.

In the last few years, middle class seniors have suffered a rude awakening with the insurance companies announcing and requesting astronomical premium increases on long-term care insurance policies. The insurance companies state that they need massive premium increases due to "future claims anticipated on these policies," and in the case of our insurer, John Hancock, that they were "not [due] to the recent recession, interest rate environment, or any other investment related reason." At the public hearing last April 28, several companies were a little more forthcoming: They admitted that they had expected that large numbers of people to whom they had aggressively marketed long-term care policies would, after a period of years, let them lapse. The companies would then have received thousands of dollars in premium payments from customers but not be on the hook to pay them any benefits! *What a cynical business model!* Surprise, surprise: seniors seeing that more and more of their contemporaries were requiring long-term care, continued paying their premiums and held on to their policies for dear life. Bad investment decisions by the insurance companies before and during the recession and the extended period of near zero interest rates, as some companies admitted, are also factors. Insurance companies are not allowed to raise premiums on some insurance lines, e.g., whole life policies, and thus raising premiums on long-term care policies has become a convenient vehicle for them to recoup their reduced earnings. In our particular case, last year John Hancock asked the Maryland Insurance Administration for a 71.33% increase based on their experience through 2010 and an additional 39% increase on top of that based on experience through 2013 for a total increase of 138%. Now in 2016 the companies are requesting yet further increases!

Fortunately, the Maryland Insurance Administration limited the 2016 premium increases to 15%. Even with that limitation, the prospect of continuing increases far above the rate of inflation have caused us to reduce our coverage. Annual premium increases of 15% or more for the foreseeable future will make it impossible for many of us to continue our coverage. The companies will win: many policy holders will give up their policies thus eliminating the need to pay any claims on them; the few that maintain their policies will be required to pay huge amounts.

What should the Maryland Insurance Administration do concerning the latest requests for increasing long-term care insurance premiums?

1. Require detailed justifications for *any* premium increase requests and continue the 15% *maximum* for premium increases.
2. Require the companies to provide detailed information on how they plan to cut expenses due to their decreased earnings; for example, by demonstrating that they are reducing significantly executive compensation and bonuses.
3. Take action against any companies whose policies promised in writing that premiums would not be increased or that increases would be limited to a certain amount or that did not comply with all Maryland underwriting requirements. (For example, the John Hancock agent did not provide us with the required "outline of coverage that includes, among other things, a statement of probable or expected premium increases up to age 75" before we completed enrollment.)
4. Require that companies writing long-term care policies in Maryland provide paid-up long-term insurance, amounting to the amount of premiums paid, to policyholders who let their policies lapse after having paid premiums for a period of years (nonforfeiture clause).
5. Ask the Maryland House of Delegates to legislate premium relief for Maryland seniors who are over age 70 and who have had long-term care insurance policies in force for at least 10 years.

The current situation is untenable and unsustainable. The Maryland Insurance Administration and the Maryland State Government must take corrective action to protect our citizens from unfair practices by these giant insurance companies.

Clarke N. Ellis and Giovanna Ellis

[REDACTED]  
Bethesda, MD 20816

October 10, 2016

Cc: Governor Larry Hogan  
Delegates Marc Korman, Ariana Kelly, and Bill Frick  
Representative Chris Van Hollen



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

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## Comments for consideration before the hearing

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Ed Hutman <ed@baygroupinsurance.com>

Thu, Oct 20, 2016 at 1:04 PM

To: "adam.zimmerman@maryland.gov" <adam.zimmerman@maryland.gov>

Cc: Sally Leimbach <Sally.Leimbach@tribridgepartners.com>

Adam

Please add my name to the list of attendees. I also want to testify at the hearing

if time is available.

I would request that before the hearing that MIA consider the following questions for the insurance companies requesting rate increases:

1. What is the percentage and number of full lapses, partial lapses (client chooses to reduce benefits) and contingent non-forfeiture?
2. When company representatives (not agents but employees of the companies) discuss options when policyholders call in for more information about a rate increase, do they explain the impact of a reduction in benefits at the time a person is likely to file a claim, i.e. age 80, 85 or 90? The only thing that counts is how much the policy will pay in benefits at the time of claim. For example, if a person is age 60 and has an option to reduce inflation from 5% to 2.5% to mitigate a rate increase, at age 85 his benefit will be 45% less than he originally expected the policy to provide. So if his benefit at age 60 is \$7,500 per month, projected to be \$25,398 per month at age 85 and he accepts the alternative offer of 2.5% compound inflation, at age 85 his benefit will be \$138,000 per year LESS. If a policyholder does not have the information regarding the future impact of the alternatives, he is making an uninformed decision.
3. Why can't the companies find a way to have an age limit on rate increases to help reduce the uncertainty posed by these too frequent, and in my view, excessive rate increases? (see my testimony at the April 28, 2016 hearing.

Thanks for your consideration.

Ed Hutman

Member of the Maryland Long Term Care Insurance Roundtable

Edward S. Hutman, CLTC, LTCP

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*Independence & Experience Matter*



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

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## Long-term care insurance hearing Oct. 27

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Fran Patch <fpatch@axion-it.com>  
To: adam.zimmerman@maryland.gov

Wed, Oct 12, 2016 at 2:46 PM

I am 82 years old and have had a John Hancock individual long-term care insurance policy since March 2003. In that time quarterly premiums have increased from \$822.31 to \$1,250.63 for three year coverage. The original policy states that premiums may increase with the rate of inflation. Inflation has been pretty low this past decade. The latest rate increase permitted by the Maryland Department of Insurance comes when it is increasingly likely that I may need the long-term care. I would never have purchased the policy originally if the payment had been that high, and I have since opted for a policy that provides two rather than three year coverage in order to reduce my rates to a (barely) affordable level.

Insurance companies are supposed to manage risk. It appears that John Hancock has failed mightily in this regard. Has any responsible official of the company taken a cut in pay or lost a bonus because their actuaries were inept or their investments unproductive? I doubt it. Yet the Maryland Department of Insurance has continued to permit John Hancock to get its policy holders to pay for the company's mismanagement. I hope they won't do it again.



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

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## LTC Insurance Hearing Oct 27

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Greg Fox <mrgregfox@gmail.com>

Tue, Oct 11, 2016 at 6:52 AM

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

Adam - here are my questions. They are specially for John Hancock with whom I have a policy. The first two, however, might be more generally applicable given the clustering of rate increases slightly below 15%.

1. I notice that the requested rate increase is slightly below 15%. Will the requested increase put the plan into an actuarially sound position, or was it constrained by the Maryland annual rate increase limit, requiring another increase next year to achieve actuarial integrity for the plan?

2. Do the requested rate increases reflect increased rates for new plans (those sold subsequent to the rate increase) or do they just apply to established plans without affecting pricing of plans you currently sell?

2. At the last hearing I believe I heard the John Hancock representative say that plans undergo actuarial revalidation every 3 years. You requested an increase on my plan 2 years ago, which was spread over 2015 and 2016 because it exceeded the Maryland 15% cap on yearly increase. Based on a 3 year reevaluation I expected no increase this year and possibly one next year. Are you now being more aggressive in how frequently you reevaluate pricing the plans?

Greg Fox

[REDACTED]  
Joppa, MD 21085

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**From:** Adam Zimmerman -MDInsurance- [mailto:adam.zimmerman@maryland.gov]

**Sent:** Tuesday, October 11, 2016 6:38 AM

**To:** Greg Fox

**Subject:** Re: LTC Insurance Hearing Oct 27

[Quoted text hidden]

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**JOHN F. McAULIFFE**  
[REDACTED]  
**Germantown MD 20876**

Telephone: [REDACTED]  
E-mail: [MCAULJF@verizon.net](mailto:MCAULJF@verizon.net)

Fax: 301-972-0786

September 7, 2016

**Al Redmer, Jr.**  
**Insurance Commissioner**  
**200 St. Paul Street Ste 270**  
**Baltimore MD 21201**

**Re: Genworth Long Term Care Insurance**  
**Policy No. [REDACTED]**

**Dear Commissioner Redmer:**

I last wrote you about Genworth Long Term Care Insurance on August 1, 2015, after that company proposed another 15% increase in the annual premium. A copy of that letter is enclosed. My complaint was ineffectual. My letter to RaShaunda Benson, of your office, is enclosed, and you will note I advised her I was paying the then current premium under protest and I was urging the Administration to carefully consider the consumer if there were any further requests for rate increases.

I am now in receipt of another notice of proposed increase from Genworth, requesting another 15% increase -- not 15% above the initial premium I agreed to, but 15% above the present rate, which is a product of multiple increases. If the current increase is allowed, the annual cost to me will be \$4,345, compared to my original agreed rate of \$2,238. If allowed this will be close to a 100% increase in premium, with *no increase* in possible benefits beyond those I originally bargained for and paid for.

This is unconscionable. When I took out this policy it was with GE Capital Assurance, a good, solid name. I do not know much about Genworth, but a quick search on the computer shows that Genworth does NOT participate in the Consumer Affairs Accreditation Program, and that there are a substantial number of written complaints about these increases, in many cases from persons who had to forfeit their rights because they could no longer pay the increased premiums.  
See: [https://www.consumeraffairs.com/insurance/genworth\\_ltc.html](https://www.consumeraffairs.com/insurance/genworth_ltc.html)

In addition to requesting that you deny the proposed rate increase, I think it is time you took a long, hard look at Genworth and its Long Term Care Insurance practice. Also, I suggest you consider issuing a strong warning to prospective purchasers of long term care insurance policies that their premium may substantially increase in the future.

If Genworth bought a bad deal from GE Capital Assurance, it should have the burden of reasonably shouldering that burden.

Thanking you in advance for a serious inquiry into this matter, I am,

Sincerely, yours,

A handwritten signature in dark ink, appearing to be 'S' or 'JF', written over a diagonal line.

John F. McAuliffe

cc: Governor Lawrence J. Hogan, Jr.  
Genworth Life



**JOHN F. McAULIFFE**

**Germantown MD 20876**

Telephone: [REDACTED]

E-mail: [mcaulif@verizon.net](mailto:mcaulif@verizon.net)

September 30, 2015

**RaShaunda Benson  
Insurance Investigator  
200 St. Paul Place, Suite 2700  
Baltimore MD 21202**

**Dear Ms. Benson:**

Thank you for your letter of September 18, informing me that over my objection the Maryland Insurance Administration approved the recent increase in premiums which effectively increases my premium by 69% over the inception premium of 2002.

I am not told what portion of my premium goes to agent commission or other administrative costs or profit vs. the portion that is committed to reserves for claims.

I hope the Insurance Administration will keep in mind that this policy has a 100-day waiting period, is limited to a 3-year benefit period and the carrier may never be called upon to pay a single dollar.

I have paid my current premium under protest, and I urge the Administration to very carefully consider the consumer when evaluating any further request by this carrier for escalation of premiums on these policies.

I am at present not in a position to initiate a class action lawsuit, but I hope to be advised if such an action is brought by others. Please place my earlier correspondence and this letter in a file that could be considered by the Administration in the event there are further requests for rate increases.

Sincerely,

**John F. McAuliffe**

cc: Gail Cleary, Genworth Life

**JOHN F. McAULIFFE**  
**11421 Staten Court**  
**Germantown MD 20876**

Telephone: [REDACTED]

E-mail: [mcauliff@verizon.net](mailto:mcauliff@verizon.net)

August 1, 2015

**Al Redmer, Jr.**  
**Maryland Insurance Commissioner**  
**200 St. Paul Place Ste 2700**  
**Baltimore MD 21202**

**Re: Genworth Long Term Care Insurance**  
**Policy No. [REDACTED]**

**Dear Commissioner Redmer:**

I am asking you to look into the payment increases demanded by Genworth Life for my long term care insurance, and particularly the increase proposed for 2015.

I took out my policy in September of 2002, at age 69. In addition to basic coverage, I pay for inflation protection and for a restoration of benefits rider. The initial premium was:

Basic coverage:	\$1,459.50
Inflation protection:	672.00
Restoration of benefits rider:	<u>106.57</u>
<b>Total:</b>	<b><u>\$2,238.07</u></b>

Genworth has raised the cost in the following manner:

2002	\$2,238	Base
2008	2,484	11% increase
2011	2,857	15% increase
2014	3,285	15% increase
2015	3,778	15% increase (proposed)

Thus, the proposed 2015 increase, which comes hard on the heels of the 2014 increase, will result in a 69% increase in the annual premium from the inception price.

I have paid the 2014 increase under protest, and I am hoping that you will disallow the proposed 2015 increase which the carrier hopes will take effect  
*September 23, 2015.*

I protested the 2014 increase with the company, pointing out that the modest benefits for which I contracted in 2002 were not being increased, but my cost was skyrocketing. I received a multi-page reply, the bottom line of which (as I read it) is that the Genworth is paying (or expecting to pay) more benefits than it had originally contemplated.

Genworth makes reference to its right to change premiums "based on premium class." The carrier then tells me that these increases apply to everyone in my class. I am not familiar with this multiple grouping of members, and I have no idea how Genworth arrived at the group in my "class." I can guess that we are somehow the more advanced in age (I am 82). My notion of fair insurance is with a diverse group – some who will never need to make a claim (my wife was also insured with this company but died five years ago without making any claim against her policy); some who may qualify for some benefits during their lifetime, and some who will drop out because of increased charges or a change in their incomes. Genworth never told me how, or when, they constituted the "group" that I am in, but I suspect it is not a very broad based group.

I have no idea whether Genworth has received affirmative approval of past increases, or simply proceeded with the increases when there was no denial after the passage of a set time.

I do not believe that an insurer should be allowed by these increases to drive people out of policies they have paid for over the years (or force them to take significantly reduced benefits).

I am protesting the most recent increases and I would be most appreciative if you would look into these policies and Genworth's practices, and hopefully provide some relief to the policy holders. Please put their pending increase on hold until you have had ample opportunity to study this matter.

Sincerely,



John F. McAuliffe

cc: Genworth –Long Term Care Divison



Adam Zimmerman -MDInsurance- &lt;adam.zimmerman@maryland.gov&gt;

## Long Term Care Insurance

merle.goldman1@gmail.com <merle.goldman1@gmail.com>  
 To: adam.zimmerman@maryland.gov

Tue, Oct 11, 2016 at 10:41 AM

Dear Mr Zimmerman,

Regarding LTC insurance , I would like to point out an issue that I am greatly concerned about; the difficulty I experienced when I filed a claim on my sisters behalf when she was diagnosed with terminal cancer in June , 2014. She passed away May, 2015.

I have held a Md Health insurance license for about 20 years, although I haven't been active for many years now. I started in the business when LTC insurance was a new product. I had never previously sold anything else in my life, but I decided to sell LTC insurance because I firmly believed and still do that it is essential to protect ones assets. Over time many of the insurance companies who once sold LTC insurance have left the marketplace because they were loosing money. And in that vein ("the bottom line") I have witnessed first hand how difficult a company can make the claim process; I can't help but wonder if that is not intentional. In my sister's situation, the LTC policy was issued by CNA ... the policy was their original Classic LTC policy which included HHC and NH. She purchased a unlimited/lifetime benefit period, with a 5% annual automatic compound inflation rider. My sister was one of my first clients so she must have purchased the policy about 20 yrs or so before she made this one and only claim. I also own the same policy and sold it to other clients based on policies provisions, CNA's reputation as an upstanding company, and their financial strength at that time. I am therefore, very knowledgeable with this particular policy's contractual provisions. The problems I encountered with CNA were inexcusable. The details of the problems with submitting forms and medical documentation are too long to describe here. But briefly,

\*Staff were not competent in providing accurate, succinct and consistent instructions.

\*There were no written instructions provided to the policy holder to navigate the claims process. The only instruction were provided verbally over the phone.

Forms were mailed or faxed, but no information was provided in writing to explain how the claims process would proceed and what would be required by or on behalf the policy holder. Consequently, just completing the paper/ documentation process took far too long to complete. "Benefits delayed are benefits denied"

\*CNA insisted that a physician provided by CNA would have to visit with my sister and assess her face to face to determine her eligibility to receive reimbursement for home health care. This is after her oncologist provided his medical diagnosis. More

importantly however, her LTC policy contained NO SUCH PROVISION. There was no such provision in the contract that authorized CNA to have their appointed physician evaluate the policy holder as a condition of receiving benefits.

The insurance agency with whom I was associated, only sold one kind of insurance... LTC insurance. They represented all the major insurance carriers who offered highly rated LTC coverage at that time

( except those policies sold by captured agents) It was adamantly opposed to and did not represent or sell any policy that included such a provision. I was going to advise my sister to refuse such an assessment, however I caved on the issue because I thought it would only delay the process. The CNA assessment did approve her request for HHC, but here again the approval process to receive benefits was stretched out, which again means benefits are not being paid for by the insurer.

\*When I contacted CNA to facilitate the claim and ascertain her daily benefit amount for home care, the representative with whom I spoke gave me an incorrect daily benefit amount. The calculation methodology she was using was completely wrong.

The calculation for the home care benefit stated clearly in the policy provisions says that the home care daily benefit amount is 80% percent of the policy's current nursing home benefit. I however, was told by the CNA representative that the amount of the home care benefit was 80% of 80% of the nursing home benefit. Again 80% of the 80%, which was absurd....

I do not remember now what the outcome of that dispute was, but I think that CNA should be investigated to see if they are in fact using an incorrect, illegal calculation.

My biggest concern is that CNA and all of the LTC insurance carriers provide honest and complete coverage to their clients. As an agent I knew what CNA was doing ... things they were not permitted to do according to the insurance contract. But many people filing a claim would not be equipped with the knowledge to challenge the insurance carrier. As such, they may get cheated out of the full benefit they purchased and are legally entitled to.

I hope the information I have provided will be helpful to the MIA. If this information should be submitted to a different state agency please feel free to forward it.

Sincerely,

10/11/2016

Maryland.gov Mail - Long Term Care Insurance

Merle H. Goldman  
Merlegoldman1@gmail.co  
m  
[REDACTED]  
Lutherville, MD 21093

Sent from my iPhone



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

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## Maryland Insurance Administration Hearing Oct 27, 2016

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John McLaughlin <jtmcl98@gmail.com>  
To: adam.zimmerman@maryland.gov

Sun, Oct 9, 2016 at 9:55 AM

Dear Mr. Zimmerman,

Once again I would like to thank the MD Insurance Administration for their attention to this issue so critical to the financial well being of many Marylanders.

In my last e-mail to you dated Jan 15, 2016 I outlined my primary concerns about Genworth Financial's operations. So, rather than restate the points I would greatly appreciate your review of that e-mail in order to develop appropriate questions for Oct. 27.

After reviewing Genworth's Second Quarter Results for 2016 I cannot imagine that the MD Insurance Administration will grant any increase.

### **Here are the facts as published by Genworth on August 2, 2016:**

Genworth has a market cap of \$2.54 billion.

Their total revenue for 2015 was \$8.5 billion

The quarter produced net income of \$172 million compared to a loss in the same of 2015 quarter of (\$193) million for a net improvement of \$365 million - very strong results.

**Long Term Care net operating income increased from \$10 million in the 2nd quarter of 2015 to \$37 million in 2016.** This trend alone provides enough information for the Insurance Administration to reject another rate increase request.

Genworth attributes the increase in net operating income from long term care to:  
**"Results versus the prior quarter reflected stable claim experience, a more favorable benefit from rate actions and higher net investment income"**

Adam, thank you again for the opportunity to provide input. While I understand why Genworth continues to ask for increases that would add to their bottom line, someone has to protect the policyholders. Given their own published results I believe the MD Insurance Administration has a basis to turn down the request.

Thank you. I am not yet sure whether I will be able to attend on Oct 27.

10/11/2016

Maryland.gov Mail - Maryland Insurance Administration Hearing Oct 27, 2016

John G. McLaughlin



Potomac, MD

August 25, 2016

Dear Mr. Hogan :

My wife and I are residents of Maryland and live in Montgomery County. I am 84 years old and my wife is 78 years old.

We have purchased Long Term Care Insurance policies from General Electric Assurance Co. (now Genworth) effective October 1999. The Policy Form is Number [REDACTED]

Our combined premiums were \$4,054.70 in October 1999. However, our premiums increased 11% in 2009, 15% in 2011, 15% in 2014, 15% in 2015, and 15% in 2016. As of October 2016 our combined premiums amount to \$7,871.77, almost double what they were in October 1999 when we first purchased these policies. Genworth's letters to us state that it is likely our premiums will increase again in the future.

It seems that whenever Genworth requests a rate increase, it is granted by the Maryland Insurance Administration. We are retired senior citizens on a fixed income, and we are looking for the Maryland Insurance Administration to protect senior consumers like us. There does not seem to be any end to these yearly increases of 15%. If they continue at 15% increases per year, in seven years our combined premiums would amount to about \$21,000.00 per year.

My wife and I are very concerned that we will not be able to keep paying these premiums if they continue to increase. These policies are very important to us and we do not want to drop these policies. We thought that we were doing the right thing in purchasing these policies in 1999, but now it seems that, after paying in all this money in premiums, Genworth wants us to drop these policies or to drastically reduce our coverage in order to stop some of these premium increases.

We desperately need your assistance in putting an end to these yearly increases in premiums so that we can continue to keep these Long Term Care Insurance policies at the level of coverage in 1999 and not have to drastically reduce our coverage.

Perhaps you could issue an Executive Order to stop increases in premiums for retired senior citizens on a fixed income after age 78 or younger, as some insurance companies have done. Or, no premium rate increases should be permitted for a period of ten years after many rate increases of 15% have already been allowed.

Please give a copy of this letter to Wendy Hershey and Chris Shank.



We hope to hear from you soon with respect to the above matter, as we feel trapped with no clear path ahead.

Sincerely,

[REDACTED]

Neil Sandberg and Tonia Sandberg

[REDACTED]

Silver Spring, MD 20902

[REDACTED]



Adam Zimmerman -MDInsurance- &lt;adam.zimmerman@maryland.gov&gt;

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**:Subject: Your Email of October 13, 2016; Submittal of Comments To Be Placed in the Public Record**

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Robert Lyon &lt;rrlyon13@msn.com&gt;

Mon, Oct 17, 2016 at 9:59 PM

To: Adam Zimmerman -MDInsurance- &lt;adam.zimmerman@maryland.gov&gt;

**Long Term Care Hearing to be Held October 27, 2016**

In response to and in accordance with your subject email, I am respectfully submitting comments that I understand will be placed in the public record. There is an issue that is already impacting many, many citizens of the state of Maryland and will certainly continue to do so. The greatest impact is being felt by many, many of us very vulnerable senior citizens living on a fixed income with little reason to expect meaningful increases in social security based on the last several years of minimal or no increases at all. In accordance with a recent study provided by the Nationwide Retirement Institute (Tom Anderson - Charles Schwab - October 12, 2016) "the average woman could expect to spend 70% of her retirement check on health costs according to the Nationwide Retirement Institute. The average man will use nearly half of his benefits to cover medical expenses." This issue is the on-going and continuing out of control escalating yearly premium rate increases to Long Term Care Insurance policies! Many of these policies were purchased a number of years ago and after more than just a few years, the yearly premiums are being raised because the long term care insurance providers failed to do their job in an adequate fashion. These companies who of course employ professionals whose job it is "to get it right" and accordingly, are paid well to do so. They are now taking the position that they failed to charge enough when they started to sell this product some forty (40) years ago. They state that at that time they did not adequately "predict" increasing health care costs or increases in life expectancy. Further, they say "they misjudged the requirements that they have experienced pertaining to payouts to customers and that the product is still a new insurance product "(40 years and it is still considered to be "a new product"??) They are now being provided with what amounts amounts to a "do over. In fact, I see no other way to

look at this on-going trend as any thing other than a "customer bail out" for their industry. Clearly, it is not the "bail out" provided to the auto industry or big Wall Street Banks by the U.S.Government a number of years ago.

A specific example, not at all unique to so very many of us in the private sector and living in Maryland, is that of I and my wife. We each purchased long term care policies nine (9) years ago from the Genworth Insurance Company. Our premiums have now increased by 15 % each for each of July 25, 2016) that we can expect these increases to continue! As stated above, we

consumers are in essence funding a "consumer bail out" for the the long term care insurance companies. Genworth and other such companies have provided two options to us in order to keep the cost of our yearly premiums down. We can cut the daily rate for care that we signed up for and purchased nine years ago and/or cut the built in inflation factor that we signed up for and purchased nine years ago. Neither of these "proposed options" are in any way cost efficient or practical given what we and they now know. Life expectancy will continue to grow and health care costs will continue to increase. To date, if I may, the Maryland Insurance Administration has seemed to have done little if anything to provide current or long term solutions to we customers. We certainly had hoped that the Maryland Insurance Department would have taken a measured and balanced approach to acting in a fair and equitable approach and solution for all parties involved, Genworth and its many, many customers! How and to what extent are we consumers and citizens having our interests represented and by whom? To date, I believe that the State of Maryland has put a ceiling on the yearly premium rate increases for long term care insurance policies of 15 % per year. A possible even reasonable perception, would be that such actions have encouraged Genworth and other such companies to move forward for a number of past years and clearly for some to-be-determined number of years, with proposed annual rate increases of 15 %. The consumer/client is having to bare an extraordinary cost burden! I will acknowledge that the contract that we signed with Genworth indeed permits the company to increase premiums over a "class of policy holders" (what does this mean?) We have been told that these annual premium rate increases have nothing to do with any individual action taken by us. I would respectfully offer that what CAN be done from a contractual standpoint and what reasonably SHOULD be done from an ethical and moral standpoint, are not always the same. Genworth and other companies providing long term care insurance have yet to to be held accountable for what may be technically and contractually legal, but certainly raise legitimate questions about the moral and ethical actions they are and have been taking and can continue to take, This is a good example of what I have just said. What other other type of insurance policy (auto, home owner, etc) raises annual premiums for reasons other than the actions of the individual policy holder? I am very hard pressed to think of another consumer product (auto, home, household appliances, etc.) that is allowed to come back some number of years after the fact and state that they are now having to go back and substantially increase the cost of the product (an auto loan would be Exhibit A), because they misplaced the initial price that an individual was charged and signed up for! Further, in the aforementioned letter of July 25, 2016, Genworth provided a chart showing that since 1973, the have proposed or received premium rate increases covering 64 "policy form series" (what does this mean?) with rate increases of 0 to 10, 14, 88, 12,25,118,11, 25,97,60,35 and 60 percent. This is certainly a large amount of "do over" requests!

A recent editorial in the Washington Post addressed the recent and terrible actions and performances of Wells Fargo and questioned their business actions. In the editorial , they stated that,".....there is no excuse for (for their actions); the definition of ethical business is to figure out how to make a profit honestly even when conditions beyond your control create temptations to do otherwise". In my opinion,

this line of reasoning indeed can and should apply to not only Genworth, but all companies that have sold long term care policies.

Accordingly, without some amount of support from the Maryland Insurance Administration and our elected officials stepping forward to provide some sort of advocacy for we citizens, we have no one to look out for and represent our interests. To date, I have submitted these very same comments and concerns to my two U.S. Senators, two members of the U.S. House of Representatives, The Attorney General of Maryland and every elected official of the Montgomery County House of Delegates and The Maryland State Senate. Thank you for your time and consideration. I am more than happy to speak further with you or your staff about this issue, as well as provide additional information that you feel could be beneficial or of use.

Respectfully,

Robert R. and Catherine S. Lyon

[REDACTED]

Gaithersburg, Maryland 20878

Telephone: [REDACTED]

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Joseph A. Sviatko -MDInsurance- <joseph.sviatko@maryland.gov>

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## Fwd: MIA LTCI Hearing 10/27/16 Testimony

1 message

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**Adam Zimmerman -MDInsurance-** <adam.zimmerman@maryland.gov>  
To: "Joseph A. Sviatko -MDInsurance-" <joseph.sviatko@maryland.gov>

Fri, Oct 21, 2016 at 7:08 AM

Hi Joe:

Can you please include this email below in our comments received for the hearing?

Thanks

Adam

----- Forwarded message -----

From: **Sally Leimbach** <[Sally.Leimbach@tribridgepartners.com](mailto:Sally.Leimbach@tribridgepartners.com)>

Date: Thu, Oct 20, 2016 at 5:20 PM

Subject: MIA LTCI Hearing 10/27/16 Testimony

To: "Adam Zimmerman -MDInsurance- ([adam.zimmerman@maryland.gov](mailto:adam.zimmerman@maryland.gov))" <[adam.zimmerman@maryland.gov](mailto:adam.zimmerman@maryland.gov)>

Cc: "Ed Hutman ([ed@baygroupinsurance.com](mailto:ed@baygroupinsurance.com))" <[ed@baygroupinsurance.com](mailto:ed@baygroupinsurance.com)>, "Melissa Barnickel ([melissa@baygroupinsurance.com](mailto:melissa@baygroupinsurance.com))" <[melissa@baygroupinsurance.com](mailto:melissa@baygroupinsurance.com)>

MIA should be complimented on holding this Hearing in a fashion to begin to allow transparency to Maryland Residents owning long term care insurance policies who have already been presented with rate increases and those that may experience this in the future. Following are things that the insurance companies need to make clear to MIA and MD policy holders:

Why are the increases needed?

What is the overall intent of each insurance company concerning rate increase fillings? Is this a onetime request for the foreseeable future (perhaps five years) or will the request be repeated each year until a certain total increase is reached?

Are the insurance companies hampered in providing the most advantageous consumer alternatives due to the 15% cap maximum rate increase allowed by Maryland in any one year?

What are the insurance companies providing to MIA as specific data to back up claims of need for rate increases?

Are policies sold since adoption by Maryland of NAIC rate stabilization model foreseen to be subject to future rate increases at this time?

When providing alternatives to mitigate rate increases to individual consumers, are the following vital questions presented to the insureds, perhaps in the letters sent to the insureds advising them of the upcoming rate increase action, before they choose to reduce their coverage:

What is your current age?

What is your current health?

Are you aware if on claim your premiums will cease? (true for most policies).

What is cost of care where most likely to receive it?

What resources are to be used if there is a difference between cost of care and benefits from your policy?

If a female, has it been considered that females are more likely to need care than men?

Do you realize that even with the rate increase, your policy still is providing significant leverage on your premium dollars paid to pay long term care costs? (there can be simple formulas to show this so the insureds can judge for themselves).

Questions also important asked by fellow Maryland LTCI Roundtable member Ed Hutman are:

What impact are the rate increases having specify, by actual numbers, on insureds fully lapsing, partially lapsing, or using the Contingent Non forfeiture option?

Why can there not be a way to reduce or eliminate rate increases after a policyholder reaches a certain age?

MIA can assist Maryland LTC insureds facing rate increases by having MIA personnel better able to offer generic education of what to consider when evaluating a rate increase. Perhaps all the insurance companies could work together to create and adopt a generic piece to go with their notifications. If they will not, MIA could for those insureds seeking assistance from MIA. Perhaps this could serve as a model to ask NAIC to make available to consumers in other states.

Thank you for this opportunity. As a Maryland resident since birth, a long term care policy holder since 1992, an insurance broker specializing only in LTCI since 1992, and a member of the Maryland LTCI Roundtable, NAIFA-MD and MAHU, I, as many, am most anxious to have better understanding about the need for current and potential future long term care insurance rate increases.

Sally H. Leimbach



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Testimony from Marshall Fritz Before the MIA Hearing  
on Long-term Care Insurance Increases; Oct. 27, 2016

This testimony falls on the heels of the testimony provided in April 2016 at the Catonsville hearing before the same MIA Commission.

The Commissioner's Oct. 5, 2016 invitation provides absolutely no sense that any investigation into the most recent rate increases approved, or any earlier increases previously approved, has transpired. This is almost 6 months after the hearing. Consumers like myself cannot feel as if our Maryland Government is fulfilling its obligations for appropriate review of applications for increases for many reasons that were raised. Yes, the Commissioner notes that a democratic process for hearing reasons and concerns over the increases is being conducted. But, this does not get to the heart of the matter. If there has been no investigation into the cogency and sufficiency of the Insurance Industry figures by now, there will not be one by the time the rates MUST be announced for many policies such as my Genworth which renews at the end of January, 2017.

This is very disappointing. There were very significant questions raised as to whether the entire model underpinning the premiums was fair and valid. There were no answers provided as to why the companies could not ensure that at least 60% of all premiums are being returned in aggregate to covered customers, whether current policy claims overall or in my baby boomer cohort were so high as to outweigh all new premium payments, nor whether the assumptions on the expected rate of policy holders dropping their policies each year were so faulty as to be the liability of the company rather than the consumers who honestly subscribed expecting stability in premium pricing. We were given no information as to how the companies are treating funds, and investment profits thereof, for policies that are not being renewed – especially due to premium increases. Are they pure profit and disappear from the line balances or are they treated as funds against which future claims can be paid for those former policy holders and other current policy holders. There is no information provided on how much the insurance company truly claims it needs to balance its outlays long term OTHER THAN an annual 15% increase for this year.

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

I am also concerned that the location of this hearing in Perry Hall is a bald attempt for discouraging the majority of Maryland interested consumers in long-term care policy issues to attend. Perry Hall is on the outside of all Maryland population centers, with the vast majority of its population being south of its location and only a small fraction being north, east, or west of its location. Catonsville in April was at least in between Baltimore and DC suburbs where the vast majority of State population resides. It is as if the MIA is trying to discourage attendance from



most impacted consumers. Yes, there is a phone audio link set up, but that does not allow testimony to be given over the phone by those who cannot drive this distance and attend.

I wrote to Mr. Zimmerman with some questions after receiving the invitation. The invitation was vague as to anything that had transpired within the State and the Insurance Commission in the interim months since the last hearing. His response was hardly assuring that the MIA will or can do anything other than rubberstamp the proposed increases, especially in the short term. There is no evidence of any additional data provided or analyzed in-house that would go to the heart of the validity of these increases based on the company actuarial models and assumptions, together with actual premiums received and policy claims to date.

Nevertheless, in pertinent part, Mr. Zimmerman did indicate the following to me on October 7 in response to my inquiries upon receipt of the current hearing invitation:

“Additionally, the Maryland Insurance Administration (MIA) is engaged in national discussion on the challenges in the long-term care insurance marketplace. The MIA sits on the NAIC Long-Term Care Innovation Subgroup as an interested party. Furthermore, Maryland is one of the first states planning to propose additional long-term care regulations that will impact consumer options in the event of a long-term care premium increase. These proposed regulations will update current regulations to conform with the 2014 changes to the NAIC "Long-Term Care Model Regulation", and will provide greater value to many consumers who decide to lapse their policy following a rate increase.”

While this review by the MIA indicates there is some activity that could lead to more restricted premium increases in the future, it is quite clear that there is no new regulation in Maryland that would even conform to the 2014 NAIC “Long-Term Care Model Regulation.” This is tragic because even the current premium increase reviews will not conform to the established industry norms for valid increase justifications. Nevertheless, this notification should have been part of the invitation or link to current activities on behalf of consumers. The reader of the invitation could not see any activities that would limit or roll back premium increases to less than the endless series of 15% increases we have been experiencing.

The MIA needs to state unequivocally whether implementation of these regulations will result in review of ALL increases, not just upcoming increases, especially since 2014 and possibly lead to rollbacks where the company has not justified its increases pursuant to the regulation.

If regulation has been proposed for the MIA, whether internally-generated or through the State Legislature, such progress should have been clarified to the parties before this hearing.

I look forward to seeing actual regulations implemented that would provide validation under the industry standard and consumer protection protocols for the endless series of 15% premium increases I and other have been experiencing. These MIA activities and legislature activities

need to be shared in a timely basis with the interested party consumers that MIA has been contacted by within Maryland. It should not wait for inquiries to senior staff after receiving an invitation for a hearing without a report on its recent activities on behalf of consumers.

My April 2106 Testimony follows below as the contents are still very much appropriate after the last increase and upon the posting of new, requested premium increases by the companies.

Testimony of Marshall Fritz, Wheaton, Maryland April 28, 2016

On Consumer Issues with the Spate of Long Term Care Premium Increases

I am a retired resident of Maryland who originally purchased a Long Term Care Policy in Maryland in 2003 with GE Capital, now Genworth. I have a Bachelor's Degree from MIT with a major in Mathematics. I will provide some quantitative figures to support my contentions, but the real figures are kept hidden by both the insurance companies and the State. I base my testimony on publicly-available information.

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

Indeed, in the pamphlet from GE Financial that I received upon opening my policy, "Important Information About Long Term Care Insurance Premiums from GE Insurers" (Attachment 1), under the heading "Can premiums increase over the life of my policy?" is stated:

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

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

However, the history of recent years suggest that the sudden spate of annual, maximum increases in premiums by the insurance companies, combined with the laxness of State of Maryland investigations in agreeing to original policy premiums and getting to the bottom as to why these increases are occurring, reflect the extent to which the State was not monitoring the insurance

product and the appropriateness of the rate structures from day 1. To date, the consumer sees no other evidence of regulatory remedy other than accepting the maximum rate increases allowed by law potentially indefinitely. One can begin to see how much the insurance companies are, in total, planning to increase premiums, and these are likely to be only the beginning of endless 15% increases because the plans were apparently grossly underpriced, under the eye of State regulators. It appears likely that Genworth is following industry trends, but the consumer and the State continue to be deceived as to the real reason for these significant and continuous premium increases. It is highly likely that it may not be the actual, recent experience with long term care costs and actual claims outlays that are driving these rate increases. There may be other reasons for which they are trying desperately to increase capital inflows that may be even more significant as to the need for requesting these increases of such significant back-to-back increases. And, the State may continue to be deceived as to the manner of the succession of increases which might continue not for a couple of years, not just for a few years, but potentially for decades. The resulting rates may be well out of proportion to middle class pocketbooks, especially of retirees.

This is a problem that is not merely a private sector matter. It is a matter of the greatest importance to the public sector of the State of Maryland because what the insurance companies are now doing may portend the eventual bankruptcy of the State of Maryland through long-term care of last resort under Medicaid which it did not plan for and cannot afford en-masse if the insurance companies have their way and force impoverished insureds to lapse their policies after years of maximal rate increases. Indeed, the State could have planned that a significant number of senior citizens would be holding long-term care policies, but the insurance companies are pushing the envelope to negate any such expectation, for their own bottom lines. In fact, it would appear that the goal of the insurance companies has been, and is, to ensure that large numbers of policy holders cease their coverage under the terms originally purchased without regards to the public impact of the impacts on Medicaid from their underhanded approaches of forcing down-conversion lapses in policies.

But, my inquiries with the State of Maryland suggest that the State is doing little more than rubberstamping these premium increases without examination the impact on consumers and the impact on future State budgets. In fact, I found little evidence that the State has been investigating why all of a sudden these increases are occurring or whether the justifications for the increases the companies provide are truly valid. In fact, I understood that there were no investigations commissioned and NONE were being planned by the Insurance Commission or the Legislature. As a result, whether intended or unintended consequences of the applications for premium hikes, the State effectively appears to be rubberstamping these increases under the current Hogan Administration. Does this meet the State's fiducial responsibility to its consumers? Is this effective management for a State oversight program requiring appropriate justification for premium increase approvals?

I experienced no increases since I purchased my policy in 2003 until the last two cycles starting in January 2015 and January 2016. In each of these two years, the rate increased by the maximal allowed 15%. But, this is 15% compounded, so future increases, as I will explain later, will start to mushroom the premiums compared to the original policy. So, my new increases since January 2015 have been 32.25% over the original premium. And, there appears to be no end in sight of the significant premium increases, that is, until the companies force everyone to lapse their policies due to cost and the insurance companies have a profit of nearly 100%. In fact, if the same rate of increase were to occur for another year, the increases would total in the range of an official 'Substantial Premium Increase'. And, if this were to continue for 10, 20, or 30 years, it will make the policies all but unaffordable except for the wealthiest residents who probably might not need such a policy to withstand their financial footings even with years of long-term care costs.

Last fall, I contacted the State Insurance Commissioner's offices out of concern not so much with the first increase received but with the back-to-back hits of the combined increases. I was told that some companies have indicated or have already applied for 4 years of maximal 15% increases, which, when compounded, are already raises of about 75%. For reasons that I discuss here, there is no reason for assurance that these increases are stabilized and self-limited for the time being. These raises could be requested continuously and the State may be likely to accept them for criteria presented by the insurance companies that may not be what the insurance companies believe are the real reasons they are seeking maximal increases. Hence, the State may well have been deceived at repeated junctures, and, certainly consumers feel confused and deceived by both parties.

At this point, consumers have NO good choice. And, for many, this comes AFTER they have retired.

I was informed that the State accepted the applications for increases because the claims expense experience claimed by the insurance companies showed that they were effectively losing money in claims outlays compared to premiums. But, that is unlikely to be the real case for many reasons. If the State is not closely investigating the nature of the insurance company figures and accepting the applications on this basis as the justification for an increase, then the State may be perpetrating a bait and switch type of fraud on the policy holders where the purported reason for accepting the increase and the underlying modeling approaches from the insurance companies in setting the premiums do not jive. And, that is aside from any issue whether the insurance company figures are valid. The evidence from the Insurance Company's own literature and communications is so startling that only a State that aimed to rubberstamp rate requests and not fully investigate could have even permitted these premiums when these policies were created, let alone let more than one increase through to implementation.

In other words, a consumer would expect that the terms relating to actual claims experience does not equate to prospective claims funding; instead consumers would think that actual claims

experience refers to actual claims payments by the insurance companies on recent past claims for long-term care. I suspect that the companies and the State are speaking two different languages, but the State is so far unwilling to call the question and investigate closely what is going on that suddenly merits such increases based on claims costs. It is highly likely that the State is now fully aware of the flaws of the insurance company's faulty actuarial assumptions but does not want to admit it. I certainly did not hear any convincing justification reasoning when I called the Insurance Commission.

In the conversation with the Insurance Commission, nothing was mentioned about the industry's false assumptions on the expectations on the rate of consumers lapsing policies, nor discussion of profit and overhead in the evaluation of claims experience costs. It is possible for an insurance company to keep upping its profit and overhead as a major driver of costs, up to the 40% limit (as I will cite from GE Capital/Genworth's own literature when examined in the light of a consumer), rather than attribute elevated premiums just for the costs to long-term care service claims outlays to the policy holder. Overhead increases would be plowed into the insurance company's coffers and its profit margins would continuously increase at the expense of consumers and perhaps at the expense of the State Medicaid future expenditures as well. These increases are hardly purely for current claims expenses for a baby boomer bulging class that is hardly reaching into the 65-70 age group and generally is not seeking long-term care. Supposedly, the industry's regulatory restraints are supposed to provide solid financial reasons for increases, but overhead increases may unduly creep in with these increases.

So, the State has been basically punting on acting against or even investigating the validity of the premium increases, which, for some companies, are reaching the official levels of 'Substantial Premium Increases.' The State may be helping the insurance companies in a manner contrary to the State's interests in restraining Medicaid obligations. The greater the increase in premiums approved, especially when the State is not closely investigating the validity of the claims for increased claims costs as the basis of the merit for the premium increases, the greater the likelihood that one arm of the State is leading another arm of the State toward busting Medicaid budgets in the long term. Whether this is being done consciously or unconsciously, the effect is the same to consumers and eventually to the State's coffers. Perhaps no other type of hidden long-term cost can have as much of a negative effect on State budget requirements as the eventual conversion of lapsed baby boomer long-term care policy holders into Medicaid dependency for long-term care. With the advent of health care reform, Medicare, and Medicare Advantage plans, even medical care for seniors may not cost the State nearly that much down the road for its seniors.

The State Insurance Commission further informed me that insurance companies are loath to show their cost needs increasing by more than 15% in a given application for premium increases. So, the State may not, and apparently does not, get any official clue that the increases are not just one-time requests. The State does not ask for its overall cost needs and the insurance companies are not providing the State with such information. In theory, the breaker limit of increases at

15% in theory should be helpful to consumers, but that assumes that this was a fair game and the need for higher premiums was near achieved with the first increase.

However, the State is essentially blindsided by what the intention of the insurance company is long-term for premium filing. This yearly incremental approach leads to rubberstamping tendencies when the individual year increase is not so exorbitant as to appear unconscionable. And, the State does not investigate fully what is going on trend-wise with the claims outlays, costs, and needs for the companies to maintain profits of any level, let alone with assumptions that are so out of whack as to have been unbelievable when policy rates were approved. So, the 15% limit without the insurance company showing their complete hand does not protect consumers from the incredible increases they seek; it only delays it and fails to explain what will be happening each year for years or decades to come given the flaws in their original pricing assumptions.

Among these reasons to give pause to the argument of claims experience and expense outlays driving these premium increases are:

- 1) Medical cost of living inflation has been relatively low for several years and cannot suddenly be the reason that back-to-back significant premium increases are sought based on long-term-care outlays from recent claims. The claim that the premium increase was needed was due to claims experience and costs. It would suggest that the companies gave this as a pretext, but it is not the real reason they sought premium increases. See the Att. 2 chart.
- 2) Overall cost of living inflation has been relatively low for several years and cannot suddenly be the reason that back-to-back significant premium increases are sought based on long-term-care outlays from recent claims. In fact, the Federal Reserve is concerned that inflation is too low and is below any forecasts they would have made a decade-plus ago. The claim that the premium increase was needed was due to claims experience and costs. General inflation cannot be the real reason for the increases.
- 3) Given the moderated cost of living increases in recent years, how is it that so many companies are suddenly seeking to increase the maximum rate in such a concentrated period, after years of not raising premiums? Are the companies recently colluding in some manner that is a violation of Federal or State regulations? After all, companies like Genworth did not have any increases until recently.
- 4) If there were actual claims experience of baby boomers that have skyrocketed for long-term care services delivered, one would expect to first see huge increases in health care medical services costs which would precede debilitating ADLs, especially for younger middle age baby boomers and baby boomers around 65. The figures for claims under Health Care Reform are not showing huge increases in medical costs overall to support any conclusion that baby boomers are in large numbers needing long-term care services at this time.

- 5) The brunt of those who purchased the policies after 2000 were likely to have been baby boomers. I am 65 and that would be my class, based on age. People 65 years or old or close to it are not making such large claims for long-term-care in the last few years that claims outlays have so far exceeded premiums across all those insured such that premium rises of 15% each year are justified. In fact, it is likely that my class would not be making claims of any significant nature for some years/decades coming. And, if it were true that claims in my class have mushroomed out of sight at my age, woe to Maryland and its Medicaid program which could never handle this kind of financial catastrophe, let alone find staff to care now for a large percent of baby boomers who are under 70, perhaps even well under 70. There would not be enough institutions in existence nor health aides to serve these kinds of trends. Such a hypothetical rate of mushrooming need for long-term care would imply that nearly everyone would need it by age 75-80, something that is not in evidence. More people want to live independently, not seek to be institutionalized at an early age. But, over the last two decades there was a loud cry to plan for the possibility of needing long-term care and paying for it through moderate insurance payments up front starting years ahead.
- 6) The real reason for the premium increases is – and was always -- to drive policy holders out of the insurance program.

Am I only imagining this to be the case? Absolutely not. The insurance company has actually stated this intent and expectation of jettisoning all/nearly all policy holders after receiving premiums. Indeed, I cite Genworth itself making such statements which are tantamount to driving nearly all policy holders in the direction of lapsing or significantly downsizing their policies.

The insurance company benefits because it would never have to pay any claims for policy holders giving up their policies, or pay significantly lower claims -- after receiving years of premiums – for those continuously converting to policies of lower coverage. The companies do not care if they drive Maryland residents to future dependency on Medicaid; they made their killing over the past two decades and cut their outlays.

Premium increases are not wholly claims outlays to consumers – it includes significant internal overhead and profit components.

The consumer suffers if the insurance company's actuarial model was woefully unrealistic of those that took out policies because they intended to hold them well into old age, lest they have to use long-term-care which a large percent are expected to need. And, if so, the State bought off on the premium price structure model which perhaps could have been foreseen as unrealistic and, perhaps, the only reason these companies did such business in Maryland. And, consequently, the State will suffer as well by simply buying



whatever the insurance companies offered without looking at the expectation that the rates were woefully low when they were based on faulty premises that consumers would be unlikely to keep such policies in force for very long into the future.

This would be a form of bait and switch, except in this case it is the State, as well as the consumer, who loses from the profits of the insurance company which were not large enough for them. It is too late for most middle-class baby-boomer consumers to buy new policies at advanced ages 15 years later, at much higher rates, after expending tens of thousands of their own hard-earned money for no gain. Was the actuarial model purposefully hiding expectations for consumers holding onto their policies long-term well into retirement and aging, hence pricing too low to attract consumers who would later find these policies unaffordably too high? If so, who is responsible for this kind of deceit? And, was this deceit by the companies totally accidental? And, was the silence by the State Insurance Commission totally benign for its lack of understanding of what the companies rated in its costs analyses or the State's own independent due diligence analyses and investigation?

The State Insurance Commission gave me no inkling that a reason for the premium increases had to do with the failure of policy holders to lapse their policies or significantly downgrade their benefits. As the literature suggests, policy lapse miscalculations from the start may be the greatest source of future insurance company deficits on long-term care plans, not just a minor issue. If the State was not aware of the underlying lapse estimate figures for the class at the time that policies were taken out, nor the actual rate of lapses over the years until recently or even now, nor the insurance company's target for lapses now and long term, the State can hardly term what the insurance companies are doing for increases as reflecting actual current claims payments as the index of needing rate increases.

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

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

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

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

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

“I think that consumers are justifiably complaining” when learning of new hikes. He went on to admit faulty assumptions by the insurance industry on long-term care insurance, including his astounding note that

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

This admission over an assumption so implausible as to defy logic for what was touted 15 years ago, as a product to protect oneself to the end of one’s independent living life and provide honorable and safe care beyond that, is so implausible that any rational company would know they needed future bait and switch practices to drive consumers out or wildly accelerate premium level increases. One the other hand, policies were sold to consumers with their expectation they would of course keep it active as a vital component of financial planning prior to retirement. The policies were greatly marketed and aimed at babyboomers who would not be retiring for 10-25 years longer, who would be living most probably 30-40 years longer, and who would not be in frail circumstances for much of that future period. Given that, what is even more unbelievable is the realization that what Mr. McInerney is implying is that if 5% were to lapse every year, either of the following eye-opening statements could be made as to who would be left in the pool to insure. And, when Mr. McInerney cites lapse expectations of at least 5% annually, the effects are possibly even more skewed in favor of the insurance companies.

Analysis approach 1: If 5 % of the original class of policy holders were to lapse their policy every year, at the end of 20 years not a single policy holder would remain. And, if the class were baby boomers who purchased around age 50 in 2000, then it is likely that hardly anyone would benefit from the policy other than the relatively few who did not lapse in these 20 years and needed Long-term care. In other words, all baby boomers, except the few actually getting long-term care under the policy already, would lapse their policies by age 70, with the youngest baby boomers who took out a policy in 2000 eventually completely lapsing their policies even by age 55.

Analysis approach 2: If 5% of the remaining policy holders sequentially lapse the insurance each year, then

- \* after 10 years only 60% of the original class would remain holding the insurance,
- \* after 20 years only 36% of the original class would remain holding the insurance,
- \* after 30 years only 21% of the original class would remain holding the insurance, and
- \* after 40 years only 13% of the original class would remain holding the insurance.

Given that most of the class were baby boomers, the likelihood of more than 20% even remaining eligible for LTC care by the time they were fragile is very unlikely under this model alternative though more optimistic than under Analysis approach 1, above.

In either case, what appears is that the insurance company's model for coverage of LTC was based less on insuring policy holders than on seeking/expecting to NOT insure the vast majority of once-policy-holders to such an extent that it appears to have been planned as a scheme to make a lot of money for the insurance company without paying out hardly anything in claims compared to premiums. And, when they discovered that their model did not fit with the realities of the circumstances under which customers purchased policies to hold until they were in frail situations, it was too late to adjust their business model. And, the State did not see through this scheme either, to its own detriment in the long term.

On the other hand, their assumption is so unrealistic, in comparing consumer behavior with life insurance as similar to long-term care insurance, as to make one wonder whether they purposely mis-estimated lapse rates so as to convince the State regulators that their product was worthy of being sold to the public in the State, at a nominal premium. That would truly be a sorrowful state of affairs for consumers who bought policies hearing that the track records of these companies were very reliable.

Under the analytical approaches above, the only way that claims payouts could ever equal 60% of premiums paid (and premiums paid in cheaper dollars decades earlier) is if the very few who held onto their policies and received long-term care were individually so expensive compared with actuarial expectations that they outweighed the extent of the lapsed policies. But, this would appear to be mathematically impossible except in the cases of those under unlimited long-term care receipt at high daily rates for decades, not just under long-term care for a few years.

And, this assumption of near universal policy lapse is probably more significant in regards to prospective claims payouts from the insurance company than any other aspect,

including rates of returns on investments, morbidity & aging trends in the population, and cost of living pattern increases.

The insurance companies could have seen this model failing to meet reality many years ago. They did not have to wait until 10-15 years go by and realize no one was dropping their policies. This makes one wonder if there was also a form of collusion among companies to wait until a much later date by which time consumers would have no competitive price to turn to with another company when they were now 10-15 years older and looking for new policies.

And, it would have likely have been accompanied by a blind eye by State regulators who rubberstamped industry rates and policy assumptions.

- 7) While the State informs that the premium request was based on claims outlay experience, even if one looked at the underlying financial integrity of the companies, the last number of years since the recession have seen equities jumping to their highest levels and not a need for emergency capitalization of the companies underlying capital worthiness. Under their own assumptions, there was hardly any expectation of consumers benefiting from these policies, so there does not appear reason to leave these funds in short-term instruments with low interest rates.
- 8) What is not obvious to consumers is the large profit percentages that have been accepted for long-term care insurance companies as a matter of business – as large as 40%. So, for every dollar of premium increase, they stand to profit up to \$.40 without any additional effort needed other than to gain the premium increase requested. So, they continue to allow for increased infrastructure within the company for each remaining policy holder. There is no evidence provided to me so far that increased premiums were subject to examination of significantly increased loss ratios than the original premiums to justify continuing high overhead rates of return.  
Under Health Care Reform, medical insurance profits are limited to half or less of that level.

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

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

Should premiums continue to increase by the maximal 15% annual increase, after 10 years of such increases the premium would QUADRUPLE. After 20 years, the premium would increase by a factor of 16x higher. So, my original premium of \$2583 would rise to over \$10,400 after 10 years of such increases and to over \$42,200 after 20 years of such increases. Not only would such levels knock out policy holders from maintaining their original plan, but would likely knock them out from maintaining ANY long-term insurance plan, hence forfeiting all premiums and family savings only to be left with Medicaid as the last resort for any long-term care needs as they age. But, given their ridiculous assumptions on lapse rate, no one – neither the State nor the consumer -- could dismiss that the insurance industry, individually and collectively, is out to do this to drive everyone out. Who would ensure – and how would they do so -- that consumer payouts totaled at least 60% of premiums, especially when nearly everyone would be driven out before such time as long term care were needed?

With the arrival of the higher premiums after these increases, and the likelihood that significant numbers of the policy holders are retired and on Social Security, the increased premiums are likely to be increasingly high percents of their income coming at a time when the middle class can less afford them. Thus, the very population that these plans were designed to help assure old age with dignity will be left more likely to be at the mercy of Medicaid institutionalization when they become frail.

I suspect that the insurance companies want to indeed quadruple – or worse – the premiums given their faulty model of 5% lapses each year until essentially no one is left insured. If that were to happen without 15% caps, almost everyone would lapse their policies and the insurance company wins. Even with the 15% caps, it would not take long before most would drop their policies. Again, a win for the insurance companies now and a huge loss for the State future Medicaid budgets.

On the other hand, the ‘Haves’ won’t care so much because they can either self-fund long-term care or pay sizably-increased premiums.

There is another economic impact that must be mentioned when rates rise as much as they currently are doing. The Federal (and State) maximum tax deductions for Long-term care premiums were predicated on rates before these significant premium increases. Undoubtedly, Congress heard from insurance companies when they set the maximum deductions. Well, if these premium rates keep rising as they are currently, the lobbying by and consulting with

insurance companies to set appropriate deduction levels will go by the boards. There will be a distinct mismatch between what is allowable and what is actually encountered by policy holders. It would be a good question for fair treatment of their customers as to whether the insurance companies now seek to consult with Congress to inform Congress that the premium deductible limits are now too low. But any such consultation would only focus attention as to why they are rising and whether there are valid justifications for the full extent of these premium increases as being related to long-term care claims or whether they were bad business models of the companies that deceived and continue to deceive consumers.

The State should have been well aware of the industry premium increase approaches in recent years and should have geared up to fully investigate what claims experience meant in terms of rising costs and whether the State needed to step in for protection of consumers from predatory approaches to force policy holders to lapse their policies or hold overall, total increases to verifiable need-driven current year and actuarial formulae. My contacts with the State did not provide me any assurance that this was done, especially because they only mentioned the criteria of current claims outlays.

A January 2011 Kiplinger article, entitled Long-Term-Care Rate Hikes Loom, included general trends discussion as well as focus on Genworth.

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

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

“But it might be tough to get approval for the rate hikes this time. “I think a lot of regulators are suspicious of this,” says Bonnie Burns, a policy specialist with California Health Advocates. “They want the companies to prove that things are as bad as they say they are and to explain why they didn’t know this sooner.”

“What are my options? ... You should hold on to your existing policy if you can afford it. “When an insurer realizes it needs a rate increase, the company would love nothing better than for existing policyholders to reduce or drop their coverage,” says Marilee Driscoll, a long-term-care planning expert from Plymouth, Mass. That gets the insurer off the hook for potentially expensive claims.”

In conclusion, there is a serious question as to whether the State Insurance Commission and the State Legislature are fully protecting consumers from predatory pricing through significant premium increases annually. The State needs to fully investigate the insurance company files, going back to the original plan actuarial models and continuing with current claims costs to see whether these significant premium increases are fully justified. This cannot be taken out of context with a current-year filing of claims costs as current claims experience for baby boomer class members of my age group are unlikely to be generating high and accelerating long-term care needs.

The State should simply disapprove of all further premium rate increases until such time that it can figure out if they are:

- 1) Warranted even under the insurance companies actuarial models and assumptions,
- 2) Based on assumptions that are fair and protect consumers,
- 3) Are consistent with the State model for Long-term care budget planning under Medicaid,
- 4) Legally appropriate under the Insurance industry's own regulations and guidelines from the date these plans were established until now.

Consumers should believe that the State regulators are performing their job in protecting consumers. Currently, consumers can only see that increases have been limited to 15% annually, but that is insufficient to explain the situation, apply a remedy, or deny in whole or in part for reasons that premiums were not properly formulated over the period since the rates were first established until the present increases. Under the circumstances that I have outlined, consumers deserve more from State regulators, including assurance that regulatory monitoring is being appropriately conducted and consideration of real short and long-term remedies for the consumer who may have been deceived throughout the policy period.