CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

October 25, 2016

Commissioner Alfred W. Redmer Jr.
State of Maryland Insurance Administration
Attention: Adam Zimmerman, Actuarial Analyst
200 St. Paul Place, Suite 2700,
Baltimore, MD 21202

RE: Long Term Care Insurance Rate Increase Hearing October 27, 2016

Dear Commissioner Redmer:

I am submitting these comments for the hearing record regarding the premium increase hearing on October 27th in the event I am unable to comment by phone about the requested rate increases on that date. As you know, I have been a long time participant in the National Association of Insurance Commissioner's (NAIC) consumer participation program, and I frequently testify and comment on behalf of consumers during the proceedings of the NAIC Senior Issue Task Force (SITF) and other NAIC Committees and subgroups.

Rate increases in long term care insurance have been an ongoing topic of concern for the NAIC members, and specifically for the SITF, as members have struggled for decades to regulate the pricing of long term care insurance and prevent large, unexpected rate increases. Since the 1990's and at least 3 regulatory attempts by the NAIC to limit these increases, this now seems to be a failed regulatory task.

The large ongoing rate increases being requested in Maryland and other states and the continuing inability of state regulators to protect their consumers, regardless of the regulatory controls that states establish, are obvious. Regardless of how pricing is regulated, companies continue to demand these rate increases leaving behind anguished policyholders struggling to pay those increased premiums. The pain inflicted on Maryland policyholders is evident in the testimony already submitted for this hearing by the very people who will be paying those increased costs. Policyholders who have spoken out in their testimony represent hundreds, maybe thousands more policyholders unaware of the hearing, unable to participate, or simply assuming that their protest is useless.

These policyholders have a series of untenable choices. Faced with paying steadily increasing premiums late in life robs people of resources for other needs, and pushes some people into dropping coverage, some of whom may later require help from the state's Medicaid program.

Mailing Address: 5380 Elvas Ave., Suite 221, Sacramento, CA 95819
831-438-6677 (Satellite office) bburns@cahealthadvocates.org

Some may have previously downgraded their benefits to reduce a rate increase, and now have little room for further downgrades, making retention of their policy impossible.

I am not certain which NAIC consumer protections Maryland has adopted, or the extent of your regulatory authority, but here are some suggestions for mitigating the effect of these ongoing rate increases on consumers.

- No amount of a rate increase should be applied to any of the company's administrative costs
- No amount of a rate increase should be applied to any agent compensation
- Any rate increase of 20% or more during the lifetime of the policy form should require offsetting reductions in company expenses
- Any cumulative rate increase of 50% during the lifetime of the policy form should require the company to pool all of their existing long term care policy forms issued, bought, or assumed by the company to calculate the amount of a rate increase
- Any cumulative rate increase greater that 50% during the life of the policy form should not be granted, except when company solvency is in question

A rate increase notice should allow 90 days of consideration by the policyholder and a referral in writing for face-to-face counseling with the Maryland State Health Insurance Program (SHIP) to ensure that policyholders have all the information they need to make an informed decision about their benefits, options, and any benefit reductions.

- Policyholders who have previously downgraded their daily benefit amount to an amount less than 70% of the current cost of nursing home care, and reduced their duration of coverage to 2 years should be exempt from any further rate increases
- Policyholders age 70 or older who've had their policy for at least 10 years should be exempt from any rate increases
- Policyholders age 80 or older should be exempt from any rate increases, regardless of the duration of their coverage
- Policyholders who have had their policies for 10 or more years should have the option of choosing a paid-up benefits equal to the premiums they've previously paid
    - The amount of benefits subsequently paid under their paid-up policy should qualify as protected assets under the state Medicaid program

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- Any policyholder who reduces or drops their inflation protection should be entitled to retain the current amount of their inflated daily benefit amount and lifetime benefit amount

    - The amount of benefits subsequently paid under their paid-up policy should qualify as protected assets under the state Medicaid program

I am well aware that some of my suggestions are extreme, and some would require a change in state law or regulations. But after three decades of helping policyholders hang on to coverage through numerous rate increases I believe companies should bear the burden of decisions they've made about the products they've sold, not policyholders.

The burden of mistaken assumptions and experience should not be borne by consumers who placed their trust in the industry by buying this coverage. Consumers have no expertise to verify assumptions made by actuaries that result in the premium they've agreed to pay. Policyholders don't participate in the profitability of an insurance product, except to the extent that they rely on the benefits they've been sold. And policyholders certainly wouldn't participate in any excess profit a company made based on their previous assumptions.

Policyholders have done what the federal and state governments asked, and the industry has promoted, by taking responsibility to pay for their own care. They should not now be faced with losing both the premiums they've invested in that promise and the benefits they bought.

Thank you for the opportunity to comment on the subject of your hearing. I hope you're able to mitigate some of the effects of these rate increases on the policyholders in your state.

Sincerely,

Bonnie Burns

Bonnie Burns, Consultant

Mailing Address: 5380 Elvas Ave., Suite 221, Sacramento, CA 95819
831-438-6677 (Satellite office) bburns@cahealthadvocates.org

MARYLAND

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

CNA LTC premium increases

Bruce Shapiro <shapirbr@gmail.com> Tue, Oct 25, 2016 at 5:17 PM
To: adam.zimmerman@maryland.gov

Just spoke with I believe Simon Sigena at the Maryland Insurance Administration on the phone concerning my CNA LTC policy which is now undergoing a third rate increase (each 15%) in about the last 4 years. Originally contacted the Administration's office after the first increase indicating that I could understand an increase after the 10 year no increase period indicated on my policy and my wife's, but was concerned about what would prevent CNA from continuing to have increases in the future. Response I received at the time was that CNA was in their rights to have the increase (15%) since it applied to everyone. However, the current 15% increase is the 3rd in the past 4 or 5 years. I tried yesterday talking to a CNA representative to just get an idea as to what the projections are in the future for this to continue. I was told she did not have that information. When I probed further and asked if I could speak to someone else she continuously indicated that there was no one else I could talk to. Obviously continued 15% increases will price people out of the market forcing drastic cuts in benefits or cancelling policies which would waste all the money put into it. Can't insurance companies absorb some of the costs without putting such a burden on the consumer. It is just like a "bait and switch" tactic. My next premium payment is due on November 7 and my wife's about a month later, so I have to decide quickly what to do.

I won't be able to attend the hearing on the 27th, but I hope this information will help. I was given your email address by the investigator at the Maryland Insurance Administration. Please contact me if I could provide you with more information (email: shapirbr@gmail.com).

Incidentally, I also noticed, based on some online statements, that CNA seems to have a bad reputation when the time comes to file claims. Another issue to worry about.

Thank you for any help you can give me (an others) on this matter.

Regard,

Bruce A. Shapiro

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 the15% *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
4920 Sentinel Drive, Apt. 204
Bethesda, MD 20816
October 10, 2016

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

MARYLAND

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

Comments for consideration before the hearing

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 reduces 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

MARYLAND

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

Long-term care insurance hearing Oct. 27

Fran Patch <fpatch@axion-it.com> Wed, Oct 12, 2016 at 2:46 PM
To: adam.zimmerman@maryland.gov

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.

MARYLAND

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

LTC Insurance Hearing Oct 27

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

2711 Clayton Rd

Joppa, MD 21085

[redacted]

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]

MARYLAND

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

Genworth Long Term Care

Frank Bernstein <frankbernstein@verizon.net> Mon, Oct 24, 2016 at 6:08 PM
To: lhcomplaints.mia@maryland.gov, adam.zimmerman@maryland.gov

Dear Ms Kwei and Adam,

My wife and I purchased separate Long Term Care policies from GE Capital Assurace.

My wife's policy was effective September of 2003 and was a four year policy with an initial daily benefit of $150 per day and an annual premium of $2048. The her daily benefit increases annually at a 5 percent compounded rate.

My policy was effective July of 200 and was a four year policy with an initial daily benefit of $175 per day and an annual premium of $2094. My daily benefit increases annually at a 5 percent simple rate.

In 2006 GE sold their LTC policies to Genworth Financial in 2006.

My wife's policy premiums remained unchanged from inception through May 2014. They then increase 15 percent compounded annually from June 2014 through May of 2016 by which time my wife's premiums had risen to $2708 per year. Genworth was then granted another 15 percent compounded rate increase which would have raised my wife's premium to $3114 per year. At that point we elected to reduce her coverage to a three year policy with a new annual premium of $2740.

My policy premiums remained unchanged from inception through May 2014. They then increase 15 percent compounded annually from June 2014 through May of 2016 by which time my premiums had risen to $2769 per year. Genworth was then granted another 15 percent compounded rate increase which would have raised my premium to $3185 per year. At that point I elected to reduce my coverage to a three year policy with a new annual premium of $2770.

Genworth is again partitioning the MIA to allow another compounded 15 percent increase.

- This should be rejected since the company, the corporate officers, and the shareholders will greatly benefit by a buyout offer from China Oceanwide Holdings Group Co worth **2.7 Billion Dollars** (see the attached). With this buyout there is no chance of Genworth floundering.
- Also those retired persons on a fixed income should not be fleeced by an incompetent management who is requesting a 75 percent compounded rate increase during a period of low inflation.

Sincerely,

Frank & Carol Bernstein
frankbernstein@verizon.net
[redacted]

China Oceanwide to Buy Genworth Financial for $2.7 Billion - WSJ.pdf
1459K

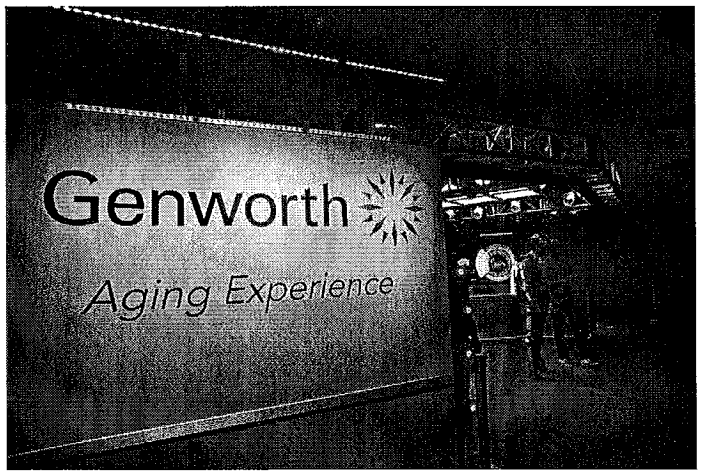
THE WALL STREET JOURNAL.

http://www.wsj.com/articles/china-oceanwide-to-buy-genworth-financial-for-2-7-billion-1477263521

MARKETS

China Oceanwide to Buy Genworth Financial for $2.7 Billion

Deal will help Genworth complete restructuring of U.S. life-insurance business



Genworth Financial hosts a conference on aging in Jersey City, N.J., in April. *PHOTO: SHANNON STAPLETON/REUTERS*

By **LESLIE SCISM** and **KANE WU**
Updated Oct. 23, 2016 11:44 p.m. ET

Genworth Financial Inc., a dominant carrier in U.S. long-term-care insurance, agreed to sell itself to a Chinese investment firm as persistent low interest rates and rising costs hobble its business.

The Chinese investment firm, China Oceanwide Holdings Group Co., will pay about $2.7 billion for Genworth. The deal comes as China Oceanwide has been pouring hundreds of millions of dollars into U.S. commercial and residential properties in the past two years. The privately held firm, which is based in Beijing, was founded by Chinese businessman Lu Zhiqiang.

Genworth has struggled since the financial crisis, one of the insurers hardest hit by the bursting of the real-estate bubble and later by ultralow interest rates.

RELATED COVERAGE

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- Five Things to Know About China Oceanwide
- Heard on the Street: China's Big Insurance Buy Leaves Lots of Risk

China Oceanwide, founded in 1985, has grown from a local property developer in eastern China into a nationwide conglomerate with investments in banking, insurance and technology.

The company has been an aggressive investor in U.S. commercial real estate, putting money into deals from Hawaii to New York. It has been particularly active in California, where Oceanwide is putting the finishing touches on a downtown Los Angeles mixed-use complex called Oceanwide Plaza and laid plans to build the second-tallest tower in San Francisco, a Norman Foster-designed 910-foot office building. Oceanwide's Mr. Lu has also amassed an unusually large collection of mansions in the Silicon Valley town of Atherton and a $41 million ranch in Sonoma County that can hold a winery.

China Oceanwide was a founding investor of a big Chinese lender, China Minsheng Banking Corp., in which it owns a 4.6% stake. China Oceanwide controls a Shenzhen-based property-and-casualty insurer and a domestic insurance brokerage business. It also owns a big stake of the company that controls Lenovo Group Ltd., the world's biggest personal-computer maker, whose founder is a close friend of Mr. Lu.

Despite his growing holdings in the U.S., Oceanwide founder Mr. Lu, 64 years old, has cut a lower profile abroad than many other Chinese tycoons like Alibaba Group Holding Ltd.'s Jack Ma or Dalian Wanda Group Co.'s Wang Jianlin. His holdings and his family's put him among the ten wealthiest people in China, according to the 2016 Chinese rich-list called the Hurun Report.

China Oceanwide will pay $5.43 a share for shares of Genworth, which closed trading Friday at $5.21 each.

Genworth, one of the nation's biggest sellers of mortgage insurance, saw its earnings hurt by waves of homeowner defaults on mortgages and then foreclosures. Homeowners' woes caused losses on Genworth's large blocks of mortgage-insurance policies, which are sold to protect mortgage lenders from losses.

As the real-estate market rebounded and its mortgage-insurance business

improved, Genworth's problems with its long-term-care insurance worsened, resulting in hundreds of millions of dollars of charges.

Genworth's sales of traditional life and certain annuities fell over the years, and the company slashed costs.

As part of the transaction, China Oceanwide will contribute about $600 million to address Genworth's debt maturing in 2018 and $525 million to the firm's U.S. life-insurance businesses.

Separately, Genworth disclosed preliminary charges unrelated to the transaction of $535 million to $625 million associated with long-term-care insurance claim reserves and taxes.

"The China Oceanwide transaction is the result of an active and extensive review process conducted over the past two years under the supervision of the board and with guidance from external financial and legal advisers," said James Riepe, nonexecutive chairman of Genworth.

China Oceanwide said the transaction will help Genworth complete a previously announced U.S. life-insurance restructuring plan. Following completion of the deal, Genworth will be a stand-alone unit of China Oceanwide, and Genworth's senior management team will continue to lead the business from its headquarters in Richmond, Va.

"In acquiring Genworth and contributing $1.1 billion of additional capital, we are providing crucial financial support to Genworth's efforts to restructure its U.S. life-insurance businesses," said Mr. Lu, adding, "we have structured the transaction with the intention of increasing the likelihood of obtaining regulatory approval."

The transaction, which has been approved by both companies' boards, is expected to close by the middle of 2017, subject to the receipt of regulatory approvals. Both China Oceanwide and Genworth have initiated discussions with regulators in key jurisdictions, according to the companies.

Genworth is the offspring of General Electric Co. It split off from its parent in 2004 and quickly launched an advertising campaign to stake out its own territory.

Long-term-care policies are among the life-insurance industry's most vulnerable to low interest rates, because insurers typically collect the premiums on the policies for decades before paying out clams. So as interest rates fell, long-term-care insurers like Genworth were putting those premiums to work in their investment portfolios at yields far lower than they anticipated when the policies were sold.

Genworth is a longtime market leader in selling these long-term-care policies, with nearly a quarter of sales to individuals in recent years. Genworth has acknowledged underpricing many older policies, saying it misjudged important cost factors such as health-care inflation as well as the amount of interest it would earn by investing the premiums

Genworth has cut costs in recent years as it struggled with large charges against its earnings tied to its long-term-care insurance business. It sold or reinsured parts of what years ago was a thriving life-insurance business, after sales fell in the wake of downgrades of its credit ratings.

In 2015, Genworth tallied its losses on long-term-care policies, many dating to the 1970s, at more than $2 billion.

Write to Leslie Scism at leslie.scism@wsj.com and Kane Wu at Kane.Wu@wsj.com

OUTLINE OF COMMENTS BY
IRVING P. COHEN
OCTOBER 27, 2016

- My name is Irving P. Cohen and I am a resident of Montgomery County, MD for the last 45 years. I gave testimony at the April 2016 meeting called by the Commissioner earlier this year.

- While I incorporate my comments as provided to the Agency by reference, it is sad to observe almost none of the questions regarding the Agency's processes and policies with respect to LTC have been responded to in any meaningful way.

- While this Agency is charged with protecting consumers by assuring fair treatment of consumers and assuring that insurance is available at fair prices. The failure of this Agency to publically respond to hardly any of the serious questions raised in April **ONLY FEEDS THE NARRATIVE BEING EXPRESSED BY POLICY OWNERS IN THEIR COMMENTS ALL READY SUBMITTED FOR THE RECORD THAT THE AGENCY IS ACTING AS A "RUBBER STAMP" IN PROTECTING THE PROFITS, EXPENSE STRUCTURE, AND UNDERWRITING ASSUMPTIONS OF THE VARIOUS CARRIERS.**

- As I did earlier this year I ask of the Agency the following:

- **What is the cost and actuarial structure supporting the existing policies over ALL the years since a policy is purchased?**

- **Who is bearing the risks and rewards of performance with respect to the various elements of the policy structure?**

- That is, once the analysis of the causes of differentials from the underwriting assumptions are understood, in exercising its powers and goals regarding reasonable premiums and fair treatment of the consumer:

    - How does this Agency determine who is to reap the reward of those differentials and who is to pay the cost of adverse performance of each of the elements?

    - To what extent was there an "investment risk" or other strictly business risk that should not in all fairness be passed on to the current policy holders?

    - To what extent are administrative costs (with emphasis on compensation arrangements with senior executives); intercompany transfers of funds and investments -- or other assets; payments to shareholders; or actual use of cash flow; all analyzed by the Agency in protecting the assets of policy holders – for they paid the premiums and are to have the first call on reserves for future benefits to be paid.

    - For clearly, policy holders generally are the least able to sustain risk that was understood by them to now have been assumed by the more knowledgeable sophisticated insurance company and blessed by this Agency in approving the policy and the premium design.

    - To what extent are other statistical models for the evaluation of requests for premium increases considered by the Agency? And if at odds with those presented by the carrier, how are those model's results different from the carriers? And why are they not utilized.

- **Why does the Agency not view it role as a regulator similar to that of other Agencies charged with protecting consumers (ie the policy holder) from unreasonable increases in costs and unreasonable business practices?**

- The time is well overdue for the Agency to respond to these very basic questions. The failure to do so in any meaningful way is shameful. **This failure again supports a perceived narrative the Agency is not looking out in any understandable way for its client -- the citizen-policy holders of the State of Maryland, as described by this Agency's mission statement.**

Finally with regard to the allegations that the business model of the industry is viewed by many as a "bait and switch" or "bait and then terminate" approach to fleecing the original policy holder, I ask the following:

- **To what extent should this Agency take into account the potential economic incentive for the carrier to have policies terminated once the claims ratio exceeds current premium income?**

- **That is, once the carrier has extracted the economic benefit in the early years, is it fair to not take this into account as a factor in arriving at any adjustments to the current premium.**

- **If you will, to what extent is the "profit" from the early years being accounted for in analyzing the carrier's request for premium increases? Is there an actuarial windfall due to termination/lapse of policies by otherwise healthy insureds? If there is, how is this accounted for under the current model?**

In closing, at a most basic level many of those here today are questioning the ability and commitment of this Agency to protect their interest as seemingly mandated by the General Assembly. The quandary facing the US Government's program is one many of them have been facing for many years.

If you will, it is clear to me that it is the view of many of your constituents this Agency has failed to respond to meaningful questions as to the Agency's role and the execution of the Agency's mandate from the Legislature.

The Agency's failure to respond in public written statements to policy questions and its approach to analyzing and deciding premium increase questions, has given support to the narrative of "rubber stamping" the business models seemingly used by the carriers – which models upon further analysis in the view of LTC owners might have questionable elements; some of the carriers' executives appear to already admit to certain unsavory practices that are (or were) their way of doing business in the LTC market.

I would add that as an economic policy issue, **IT IS IMPORTANT THIS AGENCY RECOGNIZE AS LTC POLICIES ARE DROPPED AND FAMILIES ARE UNABLE TO FUND LTC COSTS FROM SAVINGS, THEN THOSE COSTS BECOME COSTS OF THE CITIZENS OF THE STATE OF MARYLAND VIA INCREASED MEDICAID COSTS.**

If for no other reason, this Agency owes a fiduciary obligation to ALL OF MARYLAND CITIZENS TO PROTECT THE LTC ASSET MANY POLICYHOLDERS AT YOUR ENCOURAGEMENT NOW DEPEND ON.

MARYLAND

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

Oct. 27,2016 Long Term Care Meeting

john genga <popopjrg@gmail.com> Mon, Oct 24, 2016 at 3:54 PM
To: adam.zimmerman@maryland.gov
Cc: darcim.smith@maryland.gov

Re:MIA File 114349-L-2016-DMS-C
Carrier: METLIFE

Dear Adam,
We received, today, a letter from Darci Smith in reference to my complaint about METLIFE rate increases. We will not be able to attend.

I understand the rules regarding the the MIA and rate increases as explained in Darci's letter. Unfortunately, the rate payers still suffer because of METLIFE's inability to foresee the future in the long term care industry.

With METLIFE no longer issuing Long Term Care Policies, the chances of any real relief to existing policy holders is non-existent. Thus the premiums will continue to rise until we all cancel our policies, run out of money. or die. This is a downward (or upward) spiral for us. If you can convey this thought to the commissioner at the meeting it would be appreciated.

Than you for your time is this matter.

John and Nancy Genga

JOHN F. McAULIFFE
11421 Staten Court
Germantown MD 20876

Telephone: [redacted]
E-mail: 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

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,

S/

John F. McAuliffe

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

JOHN F. McAULIFFE
11421 Staten Court
Germantown MD 20876

Telephone: [redacted] **E-mail:** mcauljf@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] and [redacted]

E-mail: mcaulif@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:	106.57
Total:	$2,238.07

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

MARYLAND

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

Maryland Insurance Administration Hearing Oct 27, 2016

John McLaughlin <jtmcl98@gmail.com> Sun, Oct 9, 2016 at 9:55 AM
To: adam.zimmerman@maryland.gov

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.

John G. McLaughlin
7809 Cadbury Ave
Potomac, MD

LAWRENCE CAPLAN
INSURANCE BROKER
44 YEARS OF SERVICE
410-484-1308
lmcins@hotmail.com

OCTOBER 27, 2016

INSURANCE COMMISSIONER
HONORABLE: AL REDMER

I RECOMMEND A CHANGE IN THE LAW REGARDING THE RENEWAL OF LICENSES AND LONG TERM CARE CREDITS. AS AN OCCASIONAL WRITER OF LONG TERM CARE I DID NOT KNOW THAT THOSE CREDITS HAD A DIFFERENT RENEWAL DATE THAN MY LICENSE. I THINK THE LAW NEEDS TO BE CHANGED TO PREVENT STAGGERED RENEWALS OF LTC AND YOUR LICENSE. IT SHOULD READ "RENEWAL OF INSURANCE LICENSE AND LTC CREDITS AND LICENSE WILL COINSIDE TO THE RENEWAL OF YOUR INSURANCE LICENSE WITCH EVER IS LATER" THIS WILL PREVENT CONFUSION AND EXTRA WORK FOR THE COMMISSIONERS OFFICE IN THE LICENSING DEPARTMENT

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

Maryland Insurance Administration Hearing Oct 27, 2016

John McLaughlin <jtmcl98@gmail.com> Mon, Oct 24, 2016 at 1:02 PM
To: Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov>

Dear Adam,

If have not already read the article today regarding the Chinese investment firm buying Genworth Financial please look it up.

Today's Wall Street Journal, October 24, Page C1.

China Oceanside Holdings Group are paying $2.7 billion for Genworth.
Genworth now is resetting the financial model for their long term care business by writing off $625 million, obviously taking advantage of the buyout.

The Chinese are contributing $1.1 billion of additional capital.

Given the magnitude of this change, the Maryland Insurance Administration *must reject any requests for increases* from Genworth.

Please enter the article or this e-mail into the record.

Best regards,

John McLaughlin
Potomac, MD

On Tue, Oct 11, 2016 at 6:39 AM, Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov> wrote:

[Quoted text hidden]

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 where 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 unequivocably 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 insurants 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.

Testimony from Marshall Fritz for the MIA Hearing

on Long-term Care Insurance Increases; **revised for Oct. 27,** 2016 hearing and revised again for Nov. 3, 2016 submission

This testimony falls on the heels of the testimony provided in April 2016 at the Catonsville hearing before the same MIA Commission (past testimony incorporated here to follow at end of this new testimony). A supplementary testimony adds recent information and analysis to the earlier testimony. Additions, corrections, and modifications were made pursuant to the dispensation from the Commissioner for written submissions through Nov. 3, a week after the hearing.

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 April ('informational') 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. In fact, Ms. Li of MIA gave such frightening short time frames for review and approval that it is all but impossible to expect compliance for detailed additional information before MIA makes the decisions on rate hike approvals.

Discussion of the procedures for review laid out by Sarah Li at the hearing will be discussed below, reflecting why a fair review of the rate increase is far more complicated when consideration is made of the industry assumptions. This is greatly so because those assumptions have, in significant part, led us to this annual, renewed juncture point of mispriced premiums that haunt consumers years later and the deceitful use of the term premium rate stabilization which is anything but that in recent years. Thus, the time frame for review of critical assumptions of the industry going back 20 years or so must be examined very closely for impact to consumers of failures by industry to clarify the real sensitivity in their models and validity of their models in terms of the full nature of what lapse rate specifications mean towards the projections of costs and solvency of their LTC programs. As I will demonstrate, this is not a zero-sum game – what was not estimated/projected properly for this kind of specialized insurance from the start CANNOT quite be made up by minor tinkering of premiums later on because the entire foundation of the industry models is in question – from the 1990s onward when baby-boomers were being strongly encouraged to open LTC policies for their own life-cycle planning – was based on unrealistically high lapse rates that never made sense in the context of this type of specialized policy.

In fact, through direct and indirect comments made from the podium by MIA during the hearing, it appears to be clear that MIA has neither investigated lapse rate projections closely nor is aware of what industry has been using as for such parameters since the 1990s. If this assumption of mine is incorrect, then it would have been expected that MIA would have raised comment on its extensive knowledge of the parameters used by industry and its impact on costs all along the way from the time that the premium rates were approved for new policies. And, subsequently made decisions based on more-realistic lapse rates. When the models and assumptions by industry to market their policies and premiums are far off the mark, the consumer should not be held responsible for the foibles of the industry which was approved seemingly without (apparent/reported) MIA intervention over recent decades. In two hearings, and the current MIA web site, there is no evidence that MIA disputed the veracity/validity of the industry assumptions for such critical parameters as lapse rates, rates that may have greater impact on the solvency of the premium-paid policy programs than any other cost-expense parameter mentioned.

If you read the invitation, and even the material contained on the MIA Web Site, you would not know that NAIC had a 2014 Regulation or that Maryland has given any consideration to incorporating this regulation or a revised one of its own. The reader would not know that any premium rate stabilization policy has existed in Maryland since 2000. And, if even if the reader had an inkling that rate stabilization referred to the compliance with threshold loss ratios, the reader experiencing significant premium increases this decade might wonder how that could be termed as a 'rate stabilization' formula when 3 or 4 or 5 years of 15% increases back-to-back have occurred after no increases in over a decade earlier. What might have been intended as a 'rate stabilization' program, with maximum 15% caps in any year (as if they were expected to be one-time rate hike applications) has simply become a means for industry to pass through unlimited series of 15% premium increases without being required to explain the totality of their solvency issues with LTC. So, instead of 'rate stabilization', customers are experiencing 'rate INstability' fully approved by MIA; this makes a mockery of the utility of the loss ratios when the issue is endemic to the entire program, not just their profit structures. In fact, as part of the loss ratio calculations, it is not even clear whether industry has attempted to reduce their internal distributions to shareholders and administrative costs as a means of controlling outlays, or simply passing through these kinds of outlays as regular business while consumers are socked by out-of-sight increases that none could have expected through the nature of the original marketing of their policies and the decade(s) history of NO earlier premium increases.

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

- the track records of the companies in ensuring that at least 60% of all premiums (or 58% as mentioned at the hearing, though it appeared to me in reading the 2014 NAIC regulation that older policies were to be subject to 60% loss ratios going forward) are being returned in aggregate to covered customers,

- 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/interest profits thereof, for policies that are not being renewed – especially due to premium increases. That is, before nonforfeiture lapses are to be treated in the future. Are they pure profit and disappear from the line balances or are they treated as funds against which future claims can be paid for those former policy holders and other current policy holders? There is no information provided on how much the insurance company truly claims it needs to balance its outlays long term OTHER THAN an annual 15% increase for this year, nor the Loss Ratios. This is critical because Maryland has had no requirement that complete pictures of losses be provided; the only justifications I was told by an MIA agent on the phone that the current 15% increase be justified in the respective year and that is ONLY what the companies submit to MIA. As such, MIA has become a willing intermediary to rubberstamping the increases for lack of any power/action being applied to take charge of the unlimited natures of these annual increases which appear more modest in any given year but are gigantic when considered as long-term endless chains of 15% increases without clear horizon limits.

At the October hearing, Ms. Elana Edwards, Genworth Senior VP, LTC, made two noteworthy statements that should raise eyebrows when read in conjunction with the points I raise herein.

1) She stated that Genworth 'employed the best estimates at the time of pricing'. However, this is debatable, especially in terms of lapse rates. It appears that there was no scientific study of what a reliable lapse rate for LTC insurance would be and the industry was continually just guessing until it discovered that, instead of 5% would be less than 1% annually, an incredible and critical difference. Evidence of bona fide activities to project a valid rate, from consumers who would go on to hold such policies, should be uncovered from the entire period from 1990s to date.
2) She stated that, at least at this juncture THIS YEAR, Genworth could justify a 48% increase. And, that is after several years already of 15% increases. But, what she does NOT say, and what MIA does not say, is that there is any handshaking agreement and understanding as to what that 48% means. Does it mean that such an increase would be truly justified under regulatory guidelines if estimated today? Does it mean that after three more years of 15% increases the rate would truly be essentially fully stabilized? Does it mean that Genworth in its discretionary modeling could well expect to pocket the 48% after three years and come up with future models that could well approach upcoming justification for another 48% or more right after that? We don't know as

consumers (and would only know if the consumer attended this hearing) and it does not appear that MIA truly knows either when the issue each year is justification for increases within the 15% cap. It is inefficient and potentially financially counterproductive for consumers to downgrade their policies EVERY year in the wake of 15% increases; consumers doing so would be throwing money away when they are not in risky health circumstances because the interim downgrades buy them nothing which they could have applied to a bigger downgrade earlier with modification of some benefit terms in their favor long-run. The conflict with consumers is exacerbated by the lack of agreement between the companies and MIA as to what is really the cost gap and what is best for consumers to do – not just for the next two months as a best strategy to get the best bang for their buck in their existing policies.

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's 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. And, that audio link was an amateur hookup with an individual cell phone, not part of a typical professional conference room hookup of microphones and speakers for in-person and phone audiences, respectively. Had a larger in-person attendance occurred, the room could not even house more attendees. As it was, testimony from individuals called in order was limited by time; had there been more attendees in a more central location the effect would have been stifled democracy. Some in attendance did not get to deliver their testimony.

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 reassuring that the MIA will or can do anything other than rubberstamp the proposed increases, especially in the short term. In fact, he presupposes that all proposed increases will be accepted. 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. This is especially relevant to the long-term impact of grossly overestimated lapse rates for years which pretended the assumption that the vast majority of policies would be closed before claims made and likely closed for baby boomers well before they even got into their 70s let alone 80s and 90s.

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, particularly for recent policies not greatly at issue now, it is quite clear that there is no new regulation YET in Maryland that would even conform to the 2014 NAIC "Long-Term Care Model Regulation," let alone go beyond it as protection for consumers holding recent or long-term existing policies. This is tragic. The apparent goal, largely for keeping companies solvent rather than primarily serving the public who hold these policies, is for rubberstamping increases, force consumers to convert their policy coverage downward, and, in the worst case, lapse their policy with a remaining fixed benefit of minor value at best. 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 or foresee there any activities that would limit or roll back premium increases to less than the endless series of 15% increases we have been experiencing. No mention whatsoever is given as to whether the companies are even validly justifying acceptable Loss Ratios.

The MIA needs to state unequivocably 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 (including making the case for all of its data and assumptions as being valid and consistent with other established data sets).

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 against the endless series of 15% premium increases I and other have been experiencing. Indeed, the justifications are based on faulty original pricing models that the companies knew by 1997 were invalid based on policy experience. Instead of being merely a current-year review, MIA must examine the long-term history from whence these claimed deficits arose. To examine ONLY the current year

undermines the cogency of the MIA review process model on assumptions where industry assumptions may have been so faulty and leading to significant underpricing as to raise issue. Such issues include whether consumers are now suffering due to bait-and-switch policies that started long ago and entrapped aging consumers into their current policies for some critical assumptions that insurance companies should – and did – know better way back. It is not clear to consumers, and no evidence was provided to consumers to date by MIA, that MIA knew the companies had assumptions on lapse rates that were unrealistic or were at all becoming more realistic (and when they became more realistic), with the incipient impacts on premiums and losses. As early as 1997 – or even before – MIA SHOULD HAVE KNOWN that the industry models and pricings were unrealistic regardless lapse rates and their impacts on costs/profits. As far as transparency goes, consumers have no idea of what MIA knew or did in regards to woefully aggressive estimates of lapse rates that greatly led to the current predicaments.

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.

Upon review of the NAIC 2014 regulations, I have the following points to raise here, particularly as it impacts long-standing policy holders in Maryland:

No mention was made at last spring's hearing of any NAIC 2014 regulations. No mention of any consideration in Maryland was made. No explanation as to why it is only at the end of 2016 that the MIA has mentioned it, and only upon my individual inquiry to Mr. Zimmerman. The vast majority of the policy holders are totally unaware of it. I have to ask why this was so?

At the April hearing, I testified that there was apparently a standard in the industry for having claims expenditures be at least 60% of the funds received annually through premiums. I had only picked up from Internet articles that there was some industry-wide standard that was supposed to be met. I was unaware of the term Loss Ratio at that time, nor how the mechanism was expected to work, including its components. In Section 19 of the Regulation, a more extensive description is made. I received no immediate feedback from the podium last spring, from a body of officials who clearly were aware of this concept and the Regulation. There is nothing in the website or any report provided the public to explain how these ratios bear on the policies that have been granted premium increases or have applied now for premium increases. I have to ask, why this is hidden? Doesn't Maryland know how it would impact long-term policy holders? If not, why not after two years of being aware of the Regulation? And, if companies are meeting it, why is it all but impossible for MIA to report to consumers who have been seeking information about their Genworth premium increases about the loss ratios without even mentioning any reason to withhold that information? What is the big secret? Is the secret that

they are failing to meet the ratios but increases are still being approved?? And, within these ratios are components such as distributions, profits, administrative expenses, and the like. Is it a secret to reveal the trends as to how the industry has been sheltering these funds while consumers face humongous increases? Is industry simply saying that increases are business as usual for profits and that the increases to consumers are partly/greatly not the costs of LTC increasing but the costs of keeping their staff and shareholders happy?

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

We now know that Genworth had made grossly faulty assumptions, as I testified in April, which it knew immediately almost two decades earlier were faulty regarding the rate of policy lapses by consumers; this is reinforced by the 1997 NAIC quarterly report cited. By the time of my policy soon after 2000 Genworth should have known that its assumptions were woefully improper. How is the consumer to be given dispensation for the Company and the State having concurred with such a faulty model that significantly impacts on the series of recent and future premium increases years later? Why is the penalty habitually going to the consumer for the Company's improper research and modeling? What did the State know about the lapse rate modeling from industry, including its realism and its sensitivity impact on company profits and foreseen difficulties? And, when did it know it? Why is there no report by MIA to the public/consumers regarding its knowledge of lapse rates and impact on the cost assumption models? Did the State ever do any sensitivity testing on its own to see the kind of incredible difference there was after 10-20 years down the road between a 5% lapse rate, a 3% lapse rate, and a less-than-one-percent lapse rate reported by Genworth this year? (perhaps the first time Genworth has admitted the extent of their missed assumption decades ago) It would be even more remarkable a statistic if the less-than-one-percent rate held even AFTER these premium price increases have been cascading over recent years.

Permit me to reflect again on the huge difference in the impact of lapse rate projections on the size of the continuing policy holder pool of paying customers. As I remarked in April, a 5% lapse rate annually from the original pool count would mean that after 20 years not a single person would still be paying. Inasmuch as the largest group of policy holders was likely babyboomers, this likely would imply that almost NO ONE would be making claims because the vast majority of these customers would have been too young to have needed LTC in 20 years from policy inception, taking out during their peak years of work life. In comparison, if the lapse rate were .9% (i.e., less than 1%), after 20 years 82% of the original pool would still be holding their policies. Clearly, these parameters as end points of the analysis, together with any intermediate rates that crept in surreptitiously over the years since before 1997 (if any), are critical to understanding what moneys the companies have as reserve and how of these many babyboomers are likely to be in a position to use their policies for significant care expenses long-term.

Even if there is a new Loss Ratio applicable to older policies, why is it that the company's increases can continuously pump portions as large as 40% if the increases into profit and administrative expenses for repercussions greatly arising out of their faulty model? New policies would only be subject to 15% of the increases to go to profit and administrative

expenses, much smaller in comparison. (my reading of NAIC Sections 19-20 give me a different perspective on loss ratio constraints for existing policies than was stated at the October hearing)

It is a fact that a Genworth high-level officer reported in a published interview (as I testified in April) a year or so ago that Genworth was grossly overestimating policy lapse rates and that this overestimate was driving the growing losses for those holding policies longer. However, it would appear that this is a thinly-veiled excuse for bait and switch. The NAIC Regulation contain a paragraph from the 1997 Proceedings 3rd Quarter 1351 (prior to my policy issuance) that suggests that the Industry was well aware that policyholders were holding onto their policies.

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

Just what was Mr. McInerney referring to in his 2016 interview for the period of 5% lapse rates modeled into the projections – it did not seem from the written page as likely to have been ONLY pre-1997 policies or that policies since 1997 were uniformly modeled with 1% or less lapse rates.

Given these findings, it would appear to be a ruse by the companies to feign ignorance when they knew what they were doing in their policy pricing 15-20 years ago. If Genworth purposely deceived everyone about their knowledge of better data on higher utilization and termination assumptions, why are Maryland policy holders being left holding the bag when it was the MIA and Industry who allowed low premium rates to be marketed in recent decades?

At the hearing in October, Ms. Jamala Roland, Genworth actuary, reported to me afterwards that there was a curve of continually dropping termination rates. But, unless their assumptions and impacts of assumptions on rates, profits, losses, and build-up of reserves are able to be cogently studied, no one would know whether there was improper pricing and termination rates that led to current losses. Her statement to me does not quite match what Mr. McInerney stated to the Pittsburgh Gazette in 2016, as I testified in April, 2016. And, what did MIA know about these envelopes and sensitivity testing of the assumptions?

To wit, the very argument of current low interest rates being a major problem would have been greatly lessened as a pressure on premiums long term through this current decade had premium rates been somewhat, and more-realistically, higher from the start (and when baby boomers

were still employed) when interest rates and reserves would have been higher and lapse rates modeled to be very low.

The actuarial presentation made by Mr. Eaton claimed that interest rates of 3-4% recently were quite different from earlier 6-8% interest rates of a decade earlier. But, this is NOT a zero-sum game. If premiums had been somewhat higher 2-3 decades ago, all those extra funds not being used by younger baby-boomers still in good health could have substantially increased the reserves! That is why the review of industry assumptions now for the current year CANNOT be taken out of context. It is the perfidy of industry that they apparently never convened consumer focus groups on LTC insurance-holding perspectives that has led to this predicament, perhaps far more than any changes in the health and predilections for care among those consumers who have needed care. Anyone who interviewed baby boomers working for the Federal Government around 15-20 years ago in the DC area would have understood that they were being convinced by the training instructors hired by agencies that they should purchase AND HOLD for dear life LTC contracts as the only thing they could do to control their end-of-life finances with respect for them and their families. How is it that the companies never learned this up front from them or the insurance agents locally who were marketing their business to these consumers making up a large part of the Maryland baby boomer population?

I discovered on Internet the following USNEWS story for Pennsylvania. Perhaps, as the Commissioner informed me during my testimony, he was indeed aware of the activities in Pennsylvania and that the result of the negotiations with industry was that Pennsylvania did not accomplish more than set an annual cap, a cap slightly larger than we already have in Maryland. Nevertheless, this sets the tone for the region-wide concerns over incredibly-large rate increases sought this decade and the confusion with which the public fully understands what happens with loss ratios, caps, and these incredibly high increases sought by companies after many years of no increases. Here, as in Pennsylvania, the existence of a limited cap does not accomplish 'rate stabilization' when the hidden losses keep getting reported annually for large premium increase applications. It is presumptuous to describe the endless 15-20-30% caps allowed between these two States as tantamount to 'leveling out the big bumps in premiums … consumers are experiencing." A sharply-rising premium curve is not a hallmark of any stabilization.

There was a May 2016 USNEWS.com article written by Maryalene LaPonsie, "Out-of-Control Premium Hikes for Long-Term Care Insurance." It was sub-titled "State regulations are intended to keep rising long-term care insurance premiums in check, but are they working?"

> "All but nine states have adopted a long-term care insurance rate stability regulation, and in most cases, it's based on a model recommended by the National Association of Insurance Commissioners. Some people in the industry, like Olson, say these state

regulations are key to leveling out the big bumps in premiums some consumers are experiencing.

State rules limit company profits. The NAIC long-term care insurance model regulation was first modified to include rate stabilization provisions in 2000. An updated model was developed in 2014. While 41 states have adopted a rate stability regulation, only 11 have published the most recent amendment.

Even in states that don't have the recent updates suggested by the NAIC, Olson says the regulations should provide peace of mind…..

…However, those with older policies aren't entirely out of luck. Some state insurance commissioners are working with companies to reduce rate increases for these plan holders as well.

When Pennsylvania residents were hit with rate increases earlier this year, ….Genworth customers who were facing premium increases that averaged 80 percent and were as high as 130 percent were able to significantly reduce their costs. Premium increases were limited 20 or 30 percent, depending on the type of policy, and customers who agree to concessions such as lowering their daily benefit or shortening their benefit period can further reduce their premium increase. ”

What insurance premium stability regulations are there in Maryland for long-time policy holders? Proposed in Maryland? If not, why not?

Did Maryland adopt premium stability regulations advocated by NAIC in 2000? If not, why not? 41 States already have. Where does the MIA web site clearly and meaningfully mention this or discuss this?

Is the MIA Commissioner doing anything to reduce rate increases for existing policy holders, especially given the sizeable increases already in place in recent years? Why isn’t the MIA Commissioner already doing what was done in Pennsylvania to substantially limit the increases, even before reducing benefits in the policy to save money?

I have concerns about the Actuary Society’s posting on the MIA web site of their slide set. Some of their assumptions may be out of context for what long-held policies may be experiencing and present stalk assumptions that may not be valid or as clear cut as they suggest in their generic model. One might get the impression that OF COURSE premium increases are justified because it is ordained based on the example they have created. Mr. Eaton mentioned at the hearing that the images and statistical relationships were only for example, but the picture is painted in ways that could be deceiving and implying the cogency of the industry’s activities with these LTC plans from the start decades ago. Furthermore, the Society of Actuaries is

actually an industry-controlled group who work in the context of the best interest of insurance companies rather than for consumers.

Slide 16 talks about low interest rates of recent years, but inflation has never been lower in recent times – far less than the 3-4% interest rates they cite for investments which is on par with medical inflation of the last decade. Furthermore, insurance companies have far-flung investments in all sorts of instruments, not just bank interest, at a time when the stock market and corporate bond market have done better than inflation in recent years under low interest rates. So, when it comes to share distributions and administrative costs from the company as a whole, the interest rates for long-term fixed instruments may not reflect that which can be moved around from within the entire company when there is a need to shore up one Division. Furthermore, the difference between the previously assumed 5% lapse rate and an observed 1% lapse rate essentially completely wipes out any difference in interest rates over recent decades.

Slide 18. Genworth assumed a policy lapse rate much greater overall than 50% by two decades out from policy creation, so the actuary models being portrayed may be quite misleading and invalid given the assumptions made by Genworth.

Slides 17 and 18 do NOT APPEAR to agree for the reality perspective of keeping the policy active in later years. In response to my inquiry from the floor at the hearing, that the two slides appeared to give different numbers of consumers holding their policies until needing care, his explanations did not clarify how they matched the printed page diagram and wordings. Perhaps, there is some difference among the two charts due to individuals living longer but having greater health needs, but he could not clarify how that fed into the chart diagrams, not do the text boxes in each chart explain such a difference.

Slide 19 Assumes that assisted living costs are completely throwing out of whack the long-term care model coverage because of their high costs. To the contrary, assisted living typically costs a fraction of nursing home costs and is what the insurance companies would prefer compared to nursing home care. Without further explanation how it increases costs rather than holds the line on costs by forcing customers to go earlier to nursing homes, the conclusion is not self-evident.

Slide 22 makes it appear that the need for a catch up premium increase came ONLY in later years. But, given Genworth's assumption of high policy lapse rates and what was known in the industry by 1997, almost 20 years ago, the need for adjustment should have been foreseen years earlier. Prices were not significantly adjusted around the turn-of-the-Century, suggesting intentional deceit to market at low prices then come back with bait & switch dramatically higher price increases. These concerns tie into my earlier discussion as to why this is NOT a zero-sum game of unbiased and fair adjustments because they would have earned more for the reserves in earlier years, with lower premium increases later on, had they priced the policies appropriately from the start knowing that very few would drop their policies and potentially seek to apply their premiums to actual claims.

Slide 23 is misleading against reality. The increases being experienced in recent years, and likely to continue without abatement, overwhelm this example of 20% premium increase. Just because the increases are spread out with maximal 15% annual increases does not mean that the increases are overall modest and inconsequential to consumers. The increases are on the way to becoming many times over higher than 20%.

Slide 25 mentions the Reserve Fund, but Maryland consumers are totally unaware how any Reserve Fund levels have been reviewed in the annual large premium increases. In recent years, MIA has stated that costs exceeded premiums, but NO mention of any reserve was mentioned for mitigating the increases.

Thus, the use by the Actuary of these generalized circumstances makes the impression given misleading, biasing, and potentially inappropriate to the situation we are facing in Maryland from long-time-held policies.

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 insurants 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.

MEDAmerica
An Excellus Company

MedAmerica Insurance Company
Home Office: Pittsburgh, PA

MedAmerica Insurance Company of New York
Home Office: Rochester, NY

MedAmerica Insurance Company of Florida
Home Office: Orlando, FL

William L. Naylon
President

October 26, 2016

Honorable Al Redmer, Jr.
Insurance Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

Via email to adam.zimmerman@maryland.gov

RE: October 27, 2016 Public Hearing on Long Term Care
Testimony of William L. Naylon, President, MedAmerica Insurance Company

On behalf of **MedAmerica Insurance Company** and **Principal Life Insurance Company**

Dear Commissioner Redmer:

Thank you for the opportunity to submit this written testimony regarding our Long Term Care premium rate increase filings.

MedAmerica has filed for 15 percent rate increases on its Simplicity Individual policy form and associated riders, which were issued in Maryland from October 2005 through December 2008. We have also filed for 15 percent rate increases on Individual and Group policy forms issued by Principal Life Insurance Company ("Principal") in Maryland from July 1989 through March 2000. MedAmerica acquired the long-term care business of Principal in 1996, and acts as administrator and 100 percent reinsurer of the Principal policies. These policy forms are no longer being marketed in Maryland or any other jurisdiction.

Earlier this year, MedAmerica ceased sale of all LTC policies nationwide. MedAmerica has 120 Simplicity policyholders in Maryland, and 26 Principal insureds. We remain committed to providing promised LTC benefits to the over 100,000 people nationwide who rely on us to continue their coverage long into the future. We believe that premium rate increases are necessary now to assure our ability to pay LTC claims in the long term.

Like most insurance carriers who sold LTC policies, MedAmerica has experienced significantly unfavorable changes in policy persistency, morbidity, and interest since the time these policies were issued. This adverse experience threatens the financial health of MedAmerica, especially since we are a mono-line LTC company with no other insurance products to offset projected shortfalls from long term care coverage.

We acknowledge that there have been two prior 15 percent rate increases on our Simplicity policy form, and one prior 15 percent increase on the Principal policy forms. In each case, including the current rate

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165 Court Street • Rochester, NY 14647

increase filings, larger premium rate increases are actuarially justified and supportable under loss ratio and/or rate stability regulation. MedAmerica has limited its rate increase requests to 15 percent as required by COMAR 31.14.01.04.A(5). As detailed in our Actuarial Memoranda associated with the rate filings, the needed rate increases range from 56 percent to over 100 percent, and the company plans to request additional rate increases until the cumulative rate increase approved in Maryland is sufficient to alleviate the poor performance on these blocks of business. If the Administration were to accept rate increases greater than 15 percent, the company is prepared to offer multiple-year phase-in of the increases, and will consider other options that may be available to reduce the impact on consumers.

Like the Administration, MedAmerica is also concerned about consumer protection. Our rate increases are determined in such a way that the company is sharing in the cost of rate increases with consumers and is not attempting to recover past losses. We need to place our LTC products on a more sound financial footing for the future.

Similar to prior increases, MedAmerica is offering insureds affected by the premium increase the option to reduce their policy benefits, providing 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 is offering a Contingent Non-Forfeiture (CNF) benefit to all insureds affected by the rate increase. This means that insureds who let their policy lapse due to the requested rate increase remain eligible to receive some level of paid-up benefit in the future.

To help consumers navigate their options to continue premium payments, accept a reduced paid-up CNF benefit, or find a benefit reduction option that best suits them, our insureds are encouraged to call our toll free customer service phone number. Because each policyholder is unique, MedAmerica works with each person individually.

At MedAmerica, we continue to pride ourselves on providing quality service to our insureds. Each claimant is assigned a dedicated Personal Care Advisor who establishes a relationship with the insured and their family to assure the very best service and support when they need it most. In fact, over 90% of claimants surveyed rate their experience with MedAmerica as above average or excellent, and our average time to pay claims is currently six days. We believe this service excellence is a critical component to fulfilling our promises and taking care of our insureds, and we will continue to provide this level of service going forward.

In closing, I'd like to reiterate that despite the fact that we no longer sell long term care insurance, MedAmerica remains committed to delivering on all of our promises to our customers. Granting these rate increases will help assure we have the financial strength to continue providing the benefits and service our insureds expect and deserve. Thank you for your time and consideration.

Sincerely,

William L. Naylon

William L. Naylon
President

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165 Court Street • Rochester, NY 14647

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

Long Term Care Insurance

merle.goldman1@gmail.com <merle.goldman1@gmail.com> Tue, Oct 11, 2016 at 10:41 AM
To: adam.zimmerman@maryland.gov

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,

Merle H. Goldman
Merlegoldman1@gmail.com
11946 Thurloe Drive
Lutherville, MD 21093

Sent from my iPhone

MARYLAND

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

Comments on LTC hearing held on Thursday, October 27, 2016

Harringtonl14@aol.com <Harringtonl14@aol.com> Sun, Oct 30, 2016 at 12:42 PM
To: adam.zimmerman@maryland.gov

Commissioner Redmer /MIA,

We appreciate the opportunity to attend the hearing and to learn more about the process MIA goes through in reviewing a rate increase. We also appreciate the opportunity to hear from the Insurance companies. Especially interesting were some of the different approaches being taken by individual companies to assist their policy holders.

Our comments concern two areas which we feel are critically important.

First, the Maryland law (as we understand it) offers insufficient consumer protections. The criteria in the law for determining whether a rate increase will be approved have to do with the actuarial justifiability of the increase and the protection of the insurance company from default. Although the law protects the consumer from frivolous rate increases because of the rigorous process MIA goes through to determine if a rate increase is reasonable (from an actuarial point of view), the consumer is left with a 15% cap as there only real protection. My husband and I have had four 15% rate increases in a row and more are promised. Our policies are held with John Hancock. We hope MIA will consider some kind of limit to the number of these consecutive increases or a reduction in the 15% cap.

Second, the policy holders should not be asked to bail out the insurance companies for their errors. Some of these errors, it could easily be argued, had no basis whatever in present day reality. We hope that MIA will look further into the insurance companies reserves and their overall profitability - not just the LTC division. Just maybe, some of these companies do not have to place the full burden of these rate increases on the consumer.

Patricia Martin
Harry Harrrington

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,

Neil Sandberg and Tonia Sandberg

Neil Sandberg and Tonia Sandberg
911 Annmore Drive
Silver Spring, MD 20902
[redacted]

Prudential

The Prudential Insurance Company of America
751 Broad St
Newark, NJ 07102

Written Testimony of

Keith Burns, ASA
Vice President & Actuary
The Prudential Insurance Company of America

Before the

Maryland Insurance Administration
Maryland Long Term Care Rate Increase Hearing - October 27, 2016

The Prudential Insurance Company of America (Prudential) is currently seeking approval for a 12.8% - 15% increase on 4 Individual Long Term Care Insurance products sold in Maryland by Prudential between 2000 – 2012. There are 1,952 policyholders in Maryland that own an impacted policy. The average amount of the increase is $37 per month.

Prior rate increases that we have implemented in Maryland have not been sufficient, which is why we are currently seeking another rate increase. In these prior rate increases a large majority of the policyholders have paid the increase, while some have opted to continue their coverage but with lower benefits to offset the increase, and very few policyholders have stopped paying their premiums.

The primary factors driving the industry's need for Long Term Care Insurance premium increases include deterioration in insured experience relative to original pricing assumptions including voluntary lapse rates, mortality and morbidity rates. Investment earnings on the accumulated policy reserves have been significantly less than anticipated due to the historically low interest rate environment over the past decade. Prudential's rate increase needs evolved around our experience with voluntary lapse rates and mortality.

LTC insurance is a lapse supported policy, meaning that the premiums were developed assuming that the reserves that were set aside for those policyholders that lapse will help fund the remaining policyholders when they go on claim. Since the first product was developed until now, ultimate lapse rates have gone from 5% per year to 1% or less.

Mortality rates continue to fall, leading to more policyholders living to those older ages where LTC claims are most prevalent.

Due to improved voluntary lapse rates and mortality it is assumed that a significant number of policyholders will remain inforce during their older attained ages when they are more likely to go on claim. Which is good, as this is what the coverage is intended for, but was not anticipated at this level at the time the policies were priced. The current rate increase request is intended to partially, but not fully, offset this adverse experience, therefore future rate increases will likely be needed.

Prudential

The Prudential Insurance Company of America
751 Broad St
Newark, NJ 07102

Prudential understands that these rate increases can be challenging for some policyholders. In an effort to make this difficult situation easier and to help mitigate the rate increase, Prudential's policyholder notification letters will offer a number of options and an 800 number. The customer service representatives in this call center have been trained to handle rate increase situations. The call center is 100% dedicated to Prudential Long Term Care matters.

Policyholders have voluntary options to help mitigate a rate increase which include:

- Reduce policy benefits such as the daily or lifetime maximums
- Remove optional riders that provide additional benefits
- Stop paying premiums and exercise the non-forfeiture benefit (available for all insureds regardless of the size of the increase)

The majority of these Maryland policyholders have some form of cash benefit on their policy. Cash benefits, unlike the typical reimbursement benefits, pay the insured the daily maximum or a percent of the daily maximum as long as the policyholder is benefit eligible and has an approved plan of care in place. With the cash benefit, the insured does not need to submit proof of receiving LTC services to collect benefits. The insured will have an option to avoid the premium rate increase altogether (and perhaps even pay a lower premium depending on plan coverage) without the need to reduce the dollar level of policy benefits. They can choose this option by voluntarily removing their Cash (or cash alternative) benefit. If the insured voluntarily removes the cash benefit in lieu of the rate increase they will then need to receive and submit proof of formal LTC services to collect benefits.

An impacted Policyholder can also elect to pay the increased premium and maintain all of their existing benefits.

As stated in this testimony, Prudential does understand the challenges to the policyholder when rates are increased. Rate increases are needed to help ensure the future premiums, in combination with existing reserves, will be adequate to fund the anticipated claims. By providing a number of options, we assist policyholders with opportunities to minimize the impact of a rate increase. We appreciate the Department's time and attention to this matter and are available for further discussion.

MARYLAND

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

Long term care premium increases

Ray Schmier <prmschmier@aol.com> Fri, Oct 21, 2016 at 9:06 AM
To: adam.zimmerman@maryland.gov

Adam I hope is well. I am unable to attend the upcoming town hall meeting. Here are my points concerning long term care premium increases. While the State of Maryland caps the increase at 15% per year the Companies ask for a set percentage increase i.e. 80%. The consumer should be advised of the specific percentage increase (which increases notices may state) so consumers will know how many (on average) increases to expect. As I have experienced with CNA four 15% increases over the past four years. When will CNA reach the max percentage increase requested approved by the Department?

The other issue I raised, at last year's town hall meeting, many of the Long Term Care Companies no longer write on going business and exited the long term care market years ago. Therefore no "new" premium being added to reserves, etc. As consumers we did not expect the carrier we purchased long term care coverage through to pull out of the market. Therefore who has to bare the burden of future rate increases? Existing policyholders. How much can existing policyholders handle this burden until the increases become such a burden that the coverage is dropped, implement non-forefeiture option or drastically modify the coverage. These adjustments most likely provide inadequate coverage when doing this planning years ago. I believe Insurance Departments should take into consideration those carriers who exited the market and limit or refuse rate increases

Just some thoughts that maybe of value.

Thanks

Ray Schmier

MARYLAND

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

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

Robert Lyon <rrlyon13@msn.com> Mon, Oct 17, 2016 at 9:59 PM
To: Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov>

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 employe 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 form 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 of 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

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Gaithersburg, Maryland 20878

Telephone" [redacted]

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

Fwd: MIA LTCI Hearing 10/27/16 Testimony

1 message

Adam Zimmerman -MDInsurance- <adam.zimmerman@maryland.gov> Fri, Oct 21, 2016 at 7:08 AM
To: "Joseph A. Sviatko -MDInsurance-" <joseph.sviatko@maryland.gov>

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>
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)" <adam.zimmerman@maryland.gov>
Cc: "Ed Hutman (ed@baygroupinsurance.com)" <ed@baygroupinsurance.com>, "Melissa Barnickel (melissa@baygroupinsurance.com)" <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 then 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 for 10/27/16 MIA LTCI Hearing to be Placed in Record

Sally Leimbach <Sally.Leimbach@tribridgepartners.com> Fri, Nov 4, 2016 at 4:48 PM
To: "Adam Zimmerman -MDInsurance- (adam.zimmerman@maryland.gov)" <adam.zimmerman@maryland.gov>
Cc: "Melissa Barnickel (melissa@baygroupinsurance.com)" <melissa@baygroupinsurance.com>, "Ed Hutman (ed@baygroupinsurance.com)" <ed@baygroupinsurance.com>, "Jeff Merwin (jeff.merwin@capitolmetro.com)" <jeff.merwin@capitolmetro.com>, Chris Wilson <chris.wilson.9604@gmail.com>

Adam

Below is the Testimony I would have provided if called on at the 10/27 Hearing. I remain disappointed not to be called on, but sincerely appreciate MIA assuring me that below will be included in the public record for that Hearing.

My testimony is not only as a Maryland resident since birth and LTCI policyholder since 1992, but also as an insurance broker specializing only in LTCI since 1992. I am also representing the Maryland LTCI Roundtable, and MAHU and NAIFA-MD as the LTCI member of the JLC (Joint Legislative Committee (of MAHU and NAIFA-MD). I, as many Marylanders, am most anxious to have a better understanding about the need for current and potential future long term care insurance rate increases.

MIA should be complimented on holding this Hearing in a fashion to begin to allow transparency to Maryland Residents owning and for agents and brokers who are selling long term care insurance policies. Much has not been clear or even available information to date.

Following are items that the insurance companies need to make clear to MIA and MD policy holders and agents and brokers:

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? MIA should insist on uniformity of reporting from all the insurance companies as much as is possible. One example is that MIA decide which are the most appropriate mortality and morbidity tables to use for LTCI rate determinations. Better yet, NAIC should make a determination and then all states insist on the same tables.

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

Does MIA understand that some insurance companies when providing an option to reduce inflation protection, require that the new inflation option is calculated not going forward from the benefit amount reached, but instead requires the insured to go back to their ORIGINAL benefit amount and the new lower inflation protection % is used to determine the amount going forward? I have never seen this in a contract. Are insurance companies allowed to do this if the insured has never been advised?

When providing alternatives to mitigate rate increases to individual consumers, are the following vital questions presented to the insureds for consideration, perhaps in the letters sent to the insureds from the insurance companies 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 you are 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 then men?

Do you realize that even with the rate increase, your policy still is providing significant leverage on your premium dollars paid, to be available 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? NOTE: I read this week that Unum increases in both New York State and Kentucky have rate increase schedules that are "0" at age 80 or older.

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 to be a part of the Testimony from the 10/27/16 Hearing.

Sally Leimbach

REPRESENTING: Maryland LTCI Roundtable, MAHU, NAIFA-Maryland, and myself as LTCI Specialist broker and Maryland Policyholder

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