COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT

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IN RE: LONG TERM CARE INSURANCE

PUBLIC MEETING

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BEFORE: TERESA D. MILLER, Commissioner
JOHANNA FABIAN-MARKS, Director, Bureau of Life, Accident and Health Insurance
JAMES LAVERTY, Actuary
SANDY YKEMA, Department Counsel

HEARING: Thursday, March 10, 2016
9:00 a.m.

LOCATION: Rachel Carson State Office Building
400 Market Street
Harrisburg, PA 17101

Reporter: Seth R. Baier

A P P E A R A N C E S

ALSO PRESENT:

JOSEPH DIMENNO, Office of Liquidation, Rehabilitations and Special Funds

VINCENT L. BODNAR, Long Term Care Group

THOMAS J. MCINERNEY, Genworth Life Insurance Company

ELENA EDWARDS, Genworth Financial, Inc.

STEVE ZABEL, Unum Life Insurance Company

DAVID PLUMB, John Hancock Life Insurance Company

JONATHAN E. TREND, Metropolitan Life Insurance Company

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P R O C E E D I N G S

COMMISSIONER TERESA MILLER:

Welcome to today's hearing, and thank you all for being here. My name is Teresa Miller, and I have the pleasure of serving as Pennsylvania’s Insurance Commissioner. And I want to introduce a few people here with me.

To my right is Johanna Fabian-Marks who leads our Bureau of Life, Accident and Health Insurance. And over here --- Jim is going to be joining me up here shortly --- Jim Laverty is one of our life and health actuaries in the Department. And to my left is Joe DiMemmo who heads up --- he’s our deputy over corporate and financial regulation. So Johanna and Joe will be providing presentations here as soon as I finish my comments. But I just wanted to share a few opening comments before we begin.

This hearing is going to focus on long-term care rate requests that the Insurance Department is now considering from the four companies who will testify today. Additionally, we want to use this opportunity to provide information about the process the Department uses when reviewing rate requests. We’ll also look generally at why long-term care health insurance rates have been rising so much in recent years and ask the representatives of the companies to explain the reasons for their rate requests that they've submitted to us.

I'm holding this hearing as part of Governor's Wolf's commitment to transparency in government. I believe it's important for the public to understand how we, as government regulators, review rate requests that insurers bring to us. The public needs to know that we're closely reviewing this information insurance companies give us.

As I said, when we were considering and approving rates for health insurance plans last year, the impact on consumers is always our top priority when we're looking at premium increases and the impact on consumers is really what's at the forefront of our mind, as Governor Wolf has made consumer protection the top priority for the Insurance Department.

A key component in consumer protection is making sure companies are able to pay all the claims submitted to them. If companies don't have the financial resources to pay claims, consumers obviously suffer, and this is a key consideration as we review rate requests as well.

I'd like to just begin before we start

through all the presentations to note briefly how we got to this place in the long-term care insurance market and what's happening in this market is taking place across the country, not just here in Pennsylvania. Twenty-five (25) to 30 years ago long-term care insurance was seen as a good way for people to plan for the possibility that they may some day need skilled nursing care for a long period of time. Long-term care insurance was designed and sold as a product to prepare for this possibility by paying relatively low and stable premiums which would earn interest over a long time before they were used. The premium and interest would then cover the costs of care.

Unfortunately, the long-term care insurance industry made some assumptions in pricing their products that turned out not to be accurate and that's caused many companies to incur deep financial losses on their long-term care policies.

That the cost of long-term care insurance is a problem, is borne out by the rate increases that the Insurance Department has approved over the last four years. The Department has approved 143 rate increase filings over that time period with an average approved increase of 16 percent. Before us today we have rate increase requests ranging from 13 to 130 percent which collectively impact more than 46,000 policyholders.

Another point which dramatically shows the seriousness of the long-term care insurance problem is that in 2002 slightly over 100 companies were in the long-term care insurance market nationally. The number now is estimated at somewhere around 16, perhaps less. And in fact, one of those, MedAmerica Insurance Company, recently announced that it will no longer be selling long-term care insurance policies. We will also hear from consumers today around Pennsylvania and how the rate increases are impacting them.

We also want to hear about some of the options for consumers such as working with their insurers to agree to a reduction in certain types of benefits under their polices in return for either a lowering or elimination of the rate increases. This is a relatively new idea but one I believe holds promise for helping to protect consumers by providing a meaningful, if reduced, level of benefits while containing costs for companies so they can continue to pay the claims of the policyholders.

The National Association of Insurance

Commissioners estimated in 2012 that approximately 288,000 Pennsylvanians had long-term care insurance. This is an important issue for these Pennsylvanians and their families, and I hope to provide them and all Pennsylvanians a better understanding of what is happening in the long-term care insurance market and the Department's role in reviewing rate requests through today's hearing. I'd now like to ask Johanna Fabian-Marks to provide a short presentation on the Department's long-term care rate review process.

MS. FABIAN-MARKS:

Thank you, Commissioner Miller. As the Commissioner mentioned, I'm going to give an overview of how we review companies' requests to change their long-term care insurance rate. So first I'll talk about our timeline and review process when we get a rate change request.

So first, of course, the insurer has to file their request with the Department. Once we get that filing, we publish it in the Pennsylvania Bulletin and on our website. And that kicks off a 30-day comment period for the public.

After that 30-day public comment period, we have 45 days to review the filing. We usually have questions about the filing so we'll correspond with the company and get those questions answered, and if necessary we can extend that 45 days for review. So that's our timeline and process at a high level.

And now I'll talk a little bit about our regulatory authority to review rate increases. So this ---.

MR. HAVER:

Excuse me. Is it appropriate to ask questions about the presentation?

MS. FABIAN-MARKS:

I think we're ---.

MR. HAVER:

Like for example, you said that we say questions and we get answers. My question is, when you talk about transparency, does the public get a right to look at those questions and look at those answers?

MS. FABIAN-MARKS:

The public gets access to the full filing. And we weren't anticipating we would have a Q and A during our presentation so ---.

MR. HAVER:

Will you consider that now, because to me that seems like a fairly serious question. If you're sending questions to an insurance company and getting answers, how does the public know what those answers are?

MS. FABIAN-MARKS:

I appreciate your question, and I'd be happy to follow up with you more to discuss precisely how our correspondence process works after the hearing.

MR. HAVER:

You're not going to ---.

MS. FABIAN-MARKS:

Let the rest of people make their presentations. You'll have your time.

MR. HAVER:

Don't you think everyone should know?

MS. FABIAN-MARKS:

I would be happy to share that publicly, but right now I'm going to get through my presentation. Thank you.

So a little bit about our history of where our authority to regulate long-term care comes from, and where we get the standards that we use when we're looking at long-term care increases.

So Pennsylvania enacted its first long-term care regulation in 1995. It was based upon a model developed by the National Association of

Insurance Commissioners for NAIC. And this regulation includes many consumer protections that we enforce. And I have listed just a few of those on the slide here. But I'm going to focus on the standards for reviewing rate increases which were in that model regulation.

So you'll see this slide is broken into two chunks, pre-2002 and post-2002. And that's because in 2002 we enacted an updated model regulation. But to first talk about those pre-2002 policies that are governed by the standards in that 1995 model regulation.

So under that 19995 model regulation, a rate increase can be justified if a company can demonstrate that their expected claims over the life of the policy would exceed 60 percent of the expected premium. So this means that a company can justify a rate increase if they can show us that for each dollar in premium that they take in, they expect that they're going to pay out more than 60 cents in benefits.

Then in 2002, Pennsylvania adopted an updated model regulation that was put together by the NAIC. And this model regulation is known as the rate stability regulation because it was developed in reaction to some of the emerging issues that regulators around the country were seeing with the long-term care market. And it was meant to help to try to address those with products filed going forward. So this updated model regulation encourages insurers to price conservatively.

That means it encourages them to build a margin into the initial rates they file so that if things don't turn out quite as the company had anticipated, they won't need to come in for a rate increase because they have some room in their rates. The 2002 model regulation also tweaked the thresholds that were in the prior regulation.

So under the 2002 regulation, a company filing for a rate increase had to demonstrate that they expected a 58-percent loss ratio on the initial premium and an 85-percent loss ratio on additional premium collected due to the rate increase.

So that means that the company had to show that they were going to spend 58 percent of the premium they had initially planned to collect on benefits, and 85 percent of any additional premium they'd be collecting due to the rate increase on benefits.

So I just discussed the last ratio standards that we used to evaluate requests to increase rates. But in addition to just those standards, we also consider several other things when we're looking at these rate filings. So first off, we'll evaluate the reasonableness of company projections.

Companies make projections in a number of areas. And I have listed three of those key areas here. First off, companies will project mortality, which is how long a policyholder is expected to live. They'll also project morbidity, which is how healthy policyholders are expected to be. And they'll project lapse rates, which is how likely policyholders are to cancel their policies.

So these three projections really influence how much the company anticipates spending on benefits, and in conjunction how much they then need to collect in claims. So we evaluate those for reasonableness. We also look at company solvency. And my colleague, Joe DiMemmo, is going to talk about our regulation of solvency more in a moment.

And lastly, but very important to us and always at the forefront of our minds, is the financial impact to consumers. This is really something we take very seriously when we're reviewing these rate increases. And so we look at the history of past rate increases to see what consumers have faced up to now, and if they've already had to deal with rate increases. And we also look at the availability and type of options that the company is offering consumers to limit rate increases by potentially reducing benefits.

So that's a quick overview of how we review rate increase requests, and that concludes my presentation. So now I'll turn it over to Joe.

MR. DIMEMMO:

Yes. My name is Joe DiMemmo. My responsibility with the Insurance Department is to monitor the financial solvency of Pennsylvania domestic insurance companies. We exist to protect --- can you move the slide?

Okay. We exist to protect policyholders by ensuring companies are financially strong. Our shared goal is to ensure that insurance claims can be paid when they are due. We regulate companies through licensing, approving corporate transactions, certain transactions that have to have our pre-approval.

We analyze company financial reports. If it's a Pennsylvania domestic, we look at quarterly reports and we also analyze annual reports. We require CPA audit reports that attest to the validity of the numbers reported on the annual report, and we require actuarial opinions to opine on the policyholder obligations. And we also conduct onsite examinations of company financial operations once every five years.

The examination process sends a group of our folks out to examine the company. We look at key risk areas of the company to identify what controls the company has in place to mitigate those key risks. For long-term care companies, the subject of discussion today, rate adequacy is always an issue that needs to be addressed by the companies. When we examine those companies, we're looking to see what they're doing to try to mitigate that risk and also we have solvency concerns regarding that issue.

We coordinate with other states for the monitoring of foreign insurance companies. What I do in Pennsylvania someone else does in Virginia, Alabama, across the country. We all have the interests of the policyholders in mind, and we're all monitoring for solvency. So when there's crossover issues between states, we coordinate them between us.

We work with companies to regain financial strength when we identify a company that may be troubled. I identify a troubled company as a company that has financial stress for whatever reason. It may be an asset issue. It may be a liability issue. But it's impacting its surplus and it needs to be addressed.

Our Department has the authority to institute additional oversight in monitoring as needed. Generally, if we have a troubled company, we're going to require the company to submit a corrective action plan. The plan has to include specific actions that they're going to take, that they're going to do in order to get back the financial strength. The plan would also include a timeline for that to occur and would have benchmarks for us to measure the progress along the way.

Even in the best of the intents in regards to a company pursuing a way to get out of a financial difficulty, sometimes there's nothing that can be done and the company needs to be liquidated. One of my duties as the Deputy Insurance Commissioner is to recommend when those companies can no longer handle ongoing concerns. And we would petition Commonwealth Court for an order of liquidation. The good thing, if there is a good thing about liquidation, is that it's part of the regulatory process.

The Insurance Department still oversees it. Policyholders come first before anybody else gets paid in the estate. The guarantee associations are triggered as part of the process. A guarantee association is established by statute. It's a creature of state statutes across the country.

When a liquidation occurs, guarantee associations are triggered to pay policyholder claims within limits. Each state establishes its own limit in which it will pay under a policy obligation. Most of them --- and I'm speaking generally --- across the country are around $300,000, P&C and on the life side. But they step in to pay those claims, and they then seek assets from the estate to reimburse them, or they access the industry to cover the costs of those policy obligations.

So even though if a company ultimately ends up in liquidation, policyholders are protected and covered, and they come first in regards to the Department's regulatory scheme.

And with that I'm going to conclude.

MS. FABIAN-MARKS:

Thanks, Joe. And now we're going to hear a presentation from Vincent Bodnar, who is a Chief Actuary with the Long Term Care Group. And he is going to give us a presentation on financing of long-term care insurance.

MR. BODNAR:

Thanks, Johanna. As Johanna said I'm Chief Actuary of the Long Term Care Group. But I am also --- I'm here really on behalf of --- in my role as the chairperson of the Long Term Care Section of the Society of Actuaries. So I'm here really in an educational nature to present certain concepts that relate to long-term care.

So I'm going to go over --- I'm going to give you a basic explanation of long-term care as a product. It has some very unique product features and pricing that make this very much a challenge to price and also contributes to a need for rate increases. If experience deviates from what was expected, there's --- because of the pricing mechanics and the funding of claims which is much a pre-funded element, the companies have to establish reserves.

So I'll talk about what causes that to happen. And then I'll also talk about, you know, premium rate increases, what causes that and how the timing of when experience deviations will affect the amount of a premium rate increase.

This is a very simple explanation. It's

meant for a non-technical audience. If I was presenting to an audience of actuaries, I would use all kinds of terminology that nobody would understand. So hopefully you all will be able to follow along. I'm going to use some very simple parallel examples.

So as far as the product goes, long-term care is an insurance product that pays out when somebody becomes disabled. And by disabled, we typically mean in most insurance policies that a person is unable to perform two out of what we call the six activities of daily living. And examples of this would be eating, transferring, bathing.

There's a total of six, and in general if a person cannot perform two of these without some kind of supervision, they're considered to be disabled. Many policies will also require that people are receiving services. In addition to being disabled, they must be receiving some kind of long-term care in a predefined setting such as your home, which is home healthcare, assisted living facilities or in a nursing home.

Benefits are not paid as a lump sum. So if you become disabled, the insurance company doesn't just write the claimant a check for some lump sum. It's paid out as a daily benefit for every day that you're disabled. And it's usually to cover your services up to a certain maximum daily benefit.

There are policies that will just pay a daily benefit for each day that you're disabled, but usually it's to cover your expenses up to a maximum amount per day. And there's usually a limit on how much will be paid out over a person's lifetime. Some policies are unlimited, other policies will stop making payments after a period of, say, two years or three years or four years. And many policies require the person to be disabled for a certain period of time before they begin to pay.

And this is called the elimination period. These are typically 90 days. And by law, policies must provide coverage to the insured for their entire life. So these are lifetime guaranteed renewable products. The insurance company cannot cancel them. And so because they're meant to insure the claimant or the policyholder for their entire life, most of the policies are --- policies are required to be offered with some kind of inflation protection benefit so the insured has the option at the point when the policy is issued to increase their benefits automatically every year for the duration of the policy.

And that was meant to keep up with the cost of care. The chance of using benefits is quite dynamic, and it also presents challenges for actuaries when they price the products. In general, people have a lower chance of using their long-term care benefits when they're married. And that's because typically a healthy spouse will take care of a disabled spouse informally and will not trigger a long-term care policy, and also right after a policy is issued.

Insurance companies will underwrite the policy, usually using quite strict underwriting, particularly these days. And so generally your chance of using long-term care initially is quite low. This changes though. People will have a higher chance of using their long-term care benefits once they get into a situation where they're living alone.

So they might start off as a married couple but later on during the policy they may be living alone. That increases their chance of needing long-term care, formal long-term care services. And also, as you get older, the chance of needing long-term care as an 82-year-old is much greater than the chance of needing long-term care when you're a 55-year-old.

And so these factors all create this

dynamic where over time the chance of needing long-term care greatly increases after a policy is issued. So in the beginning of a policy lifetime, the chance is almost zero. But further out, many, many years later, decades later, the chances are very great.

And so this is what we call pre-funding. So the premiums are --- really, the same laws that require the policies to be enforced for a person's lifetime also require premiums to be expected to be level for a person's lifetime. So it can't go up by attained age. The rate is set when the policy is issued.

And so that's a level amount and that gets sent against a claim cost. So these are the expected claims, the red line that increases dramatically, as I mentioned on the prior slide, over time. And so this creates a cash flow mismatch for insurers.

During the early part of a policy the insurance company will put away some of the premiums into a reserve. So while claims are lower than premiums, insurance companies are funding a reserve. That's used later on when that claim curve comes above premiums. And at that point the reserve fund is released to pay the claims. So you've got a lot of cash coming in, in the beginning. That's put away in a reserve to pay the cash that needs to be paid out later on.

And so not all of the premium is generally set aside in that early part of a policy. The premium dollar is really divided into different pieces. So an insurance company will take part of the premium to pay for the cost of administering the policy. And this is the cost of collecting premiums and running the insurance company.

It also will take some of the premium away to pay agent commissions and it will take some of the premium to pay for state and federal taxes. It will take some as distribution of profit to shareholders. But the vast majority of the dollar is set aside to fund these future benefits. In actuarial literature, we call this the net premium, so this is what's left over after these other components of the premium dollar are carved out.

And so one easy way to think about this reserve account is that it behaves an awful lot like a savings account. And these net premiums are really deposits that get put into this savings account early on, and then at the end when benefits are paid out, these are the withdrawals from the savings account.

And just like a savings account, this reserve fund earns interest. However, the savings account is really --- the best way to think of it is as a communal account. It's there for the benefit of all the policyholders, not any single policyholder. It can only be used to pay benefits for those people who become disabled. And it's not paid to people who die without using their benefits, and it's not paid out to people who decide to cancel their policies. The money, the reserve fund, stays there for the benefit of everybody who has kept their policies and may need to withdraw it for benefits.

And so if you think of it as a savings account you can think of the net premiums as a scheduled deposit plan. And this scheduled deposit amount is calculated based on how much the actuary thinks will need to be withdrawn in the future. And the amount that needs to be withdrawn is based on a few things which we'll get into next, and also the interest rate that will be earned.

So these two things are used to determine what the payment schedule will be or your premium amounts. If either one of these are off, there may not be enough in the savings account to pay for the benefits later on. And I'll talk about some of the things that can go wrong and some of the things that have gone wrong with this product.

First of all, the interest rates. Interest rates can change if the economy changes. And certainly the economic conditions of the last 20 years have caused interest rates to decline dramatically. When products were priced in the early to mid 1990s, interest rates were assumed to be six to eight percent because that's what they were at the time. Nobody at that time could foresee that interest rates would drop to where they are today. And currently they're about three to four percent. So the interest rates have dropped so much that there's not enough in the savings account to pay benefits right now.

So the other thing that can affect a need for the funds to be depleted is that there's just the amount that you expect to be withdrawn is more than you thought it was going to be. And that's driven by three key things.

And the first is just simply if there's more people around in later durations that have kept their insurance policies. So if at the beginning of an insurance policy, an actuary in this example assumes that there are 20 people that are issued a policy. And early on, nobody is being paid a benefit because of underwriting. But later on, in a later year, the chance of needing benefits is three out of nine. There's nine people left with their policy and three go on claim, that's a one in three chance of triggering your policy and using benefits.

However, if in reality, out of those 20 people you have 12 left and you, again, have that --- and if everything plays out as who you think will need benefits is correct, now that one in three chance means that there will be four people going on claim.

You'll have 12 people paying premiums, you'll have 12 people in force and four people go on claim. That creates an imbalance. Although you have the extra three people around to pay the premium, it's not enough. You needed to collect more premium from all 20 people at the beginning of the policy.

And what we've seen in the industry is that more people have kept their policy than originally expected. Originally, original pricing assumptions were that ultimately in general about four to five percent of people would voluntarily cancel their policies every year. And that's turned out to be virtually zero.

And so in other words, everybody is keeping their insurance policies. And we're also seeing that people are living much longer than we expected. And so we call this the mortality rate. The mortality rates on these products have been much, much lower than anybody had anticipated. So there are more people with these policies in later years than we had thought.

The other thing is if the number of people who use the benefits is greater than was originally anticipated. So even if in that prior example where the actuary had assumed one out of three people would use benefits, if that turns out to be another, greater amount, say five out of nine people, then again there would be more withdrawals from the account than was expected.

And in general in the industry this has been mixed. Some companies have not had this happen, other companies have. So this has been mixed across the industry.

And the third thing that can cause the withdrawals from this account to exceed expectations is just the amount that's paid out to people who do go on claims. So if you remember, it's not a lump sum that's paid to you when you go on claim. Instead it's some amount that is not known in advance. So when someone goes on claim, we don't know how much is going to be paid out to them. It really is dependant on the number of days that they're going to be disabled and in a lot of cases where they're receiving the care and how much that care will be as far as cost. And so we don't know what that's going to be. It's instead based on past observations, what's happened historically.

And in the early days, most of the experience that actuaries had was really focused on skilled nursing facilities. And the amount of time that people spend in skilled nursing facilities hasn't really changed in the last 30 years. But what we have seen is that people are beginning to receive care in other places.

So we've seen a rise of assisted living facilities in the last 25 years. And more people are receiving care in assisted living facilities when they need facility care. Although it's cheaper every day, people are living much longer in these assisted living facilities. And it's causing claims to be longer and more expensive than insurance companies first thought they would be.

So now I'll get into what happens when the estimates are not what people realized. And I'm going to use a simple example of a savings plan. And

I'm going to take interest out of the equation just to keep it very simple. If you start off with a goal of saving $10,000 over a period of ten years, well, a good savings plan would be to save $1,000 a year.

And so in this graph, the bright red portion of every bar is the $1,000 that you're putting into the savings account, and the darker color is what had accumulated prior to putting that in. So you'll see under this plan in ten years, you save $10,000.

But what happens if you're going along and you're putting your $1,000 a year away, and then at the end of the 6th year you realize that you don't need $10,000, you're going to need $12,000? Well, your goal just increased by $2,000, and you've only got four funding years left.

And so now you've got to take that additional $2,000, divide that by four because you have four years to make that up. And it's an additional $500 per year. And so that's 50 percent more than you had been saving. And so now you have what I call a catch-up deposit. And so in addition to the $1,000 that you had been putting aside, you need another $500 per year. And only through that will you get this $12,000.

And so another way to look at this is if you could get in the time machine and go back to the first year that you set your plan up. If you had known from the beginning that you needed $12,000, you would have put $1,200 aside every year, $12,000 divided by ten is $1,200. That's only 20 percent more than the $1,000.

And so if you'll remember from the other slide, if you find out in the sixth year that you needed $12,000 ultimately, well, you needed to increase your deposit by 50 percent. But if you had known from the beginning, you would have only needed to increase your deposit by 20 percent.

And so this was really meant to illustrate that when you find out when you need to increase your savings goal is very important. And the analogy here is that in the long-term care insurance space, you know, many insurance companies are finding that they need to increase their savings goal and it's usually halfway through or more than halfway through the life of a policy.

So that makes the increases that they need higher than they would have been if they had known everything from the beginning. And so now I'll just shift to how things should work in a long-term care product. So in general, at any given time ---

and I'll show a model here. On the left side --- and I've depicted this as a balance, as a scale, really. And this scale needs to be kept in balance. On the left side, you have the amount in your savings account or your reserve fund. And in addition to that, you have the future net premiums that you expect to collect from the policyholders.

That has to be the same as what you expect to pay out in future benefits. And so at any given time in an insurance product's life this balance has to be kept. But it can get out of balance if for some reason the future benefits become more than you had expected they would be. And so in this depiction you have the same reserve fund, the same future net premiums but now your future benefits have grown and you're out of balance.

If this continues there will not be enough money in the fund to pay future benefits. And so it can be restored through premium rate increases. That's one way to try to restore this. So in this picture we have, you know, the same future benefits, reserve fund and future net premiums. But in this case, a premium rate increase has been requested and has been granted. That's enough to restore the balance.

So that's one way that the balance can be restored. And in general, when this happens, by the way, when insurance companies realize that they need to implement a rate increase, in general these days they've also determined that they're probably not going to be able to realize any future profits out of the business. If you remember that premium dollar, there was a sliver for distributions to shareholders. That usually stops at this point for a product that needs a rate increase.

If you can't get the premium --- if you cannot restore balance using a premium rate increase --- and this will happen if the premium rate increase that's been requested is insufficient to restore the balance --- the funds have to come from other sources. And there's really only --- an insurance company doesn't generally have access to creating money. They can't print the money so it has to come from someplace.

And these are one of two places. It either has to come out of their surplus, so they'll take a one-time deposit, they'll take it out of the surplus which was created by the other policyholders, and it's there for the benefit of those other policyholders or the shareholders. It'll have to take some of the surplus and put some into this fund.

If it doesn't do that it can also, going forward, charge other policyholders more money. We call that a subsidy to help the future losses of the block.

And so that concludes my part of the presentation. Hopefully that was helpful.

MS. FABIAN-MARKS:

Thank you. That was very educational. And we appreciate your joining us at the hearing today. Now, I think Jim is going to come up and join us at the front. Jim is an actuary with the Department that the Commissioner mentioned.

And we're going to move onto the portion of the hearing where we hear from companies that have filed increases with the Department recently. We have about ten minutes for each company. And the company representative will first discuss their filing and then Commissioner Miller, Jim or I will ask some questions of the Company.

So first we're going to hear from Genworth. We have two representatives from Genworth here today. We have the President and CEO, Tom McInerney. He's with the Genworth Life Insurance Company. And we also have Elena Edwards, the senior

Vice President for long-term care with Genworth Financial. And I'll just note quickly here that Mr. McInerney rearranged his schedule to be here today, which we appreciate. Depending on how long the hearing runs, he may have to leave a little early but Ms. Edwards will be here for the duration to represent Genworth. So I just want to note that for the audience.

MR. MCINERNEY:

Thank you very much. And we're pleased to be here on behalf of Genworth. And I'd like to express our appreciation to the Department and Commissioner Miller for holding today's hearing and for giving us a chance to participate.

I'd also like to thank all of you, all of the consumers who are here today, and also who are watching from various sites around the state. We certainly understand how difficult these large premium increases are for our customers, and we work hard to explain their options to them. And that's a big part of the reason why Elena and I are here today.

During my remarks today, I want to talk about why Genworth is seeking these large long-term care premium increases. I'll also touch on the value of long-term care insurance, even with these large premium increases. And also explain what options policyholders have to either take the premium increase or work out some other arrangement with us.

So why are we seeking these large premium increases? And I would also say that I think Vince gave you a very good description of how the economics of these policies work. And I'll touch a little bit on and just reinforce some of the things he had to say in his presentation.

So Genworth has three series of older generation policies that are particularly challenged. Most of these policies were written or issued between 1974 and the early 2000s. We are seeking to actuarially justify premium increases so that these very unprofitable policies have a premium screen that is sufficient to pay the claims, much like what Vince talked about earlier.

We also have requested a premium increase for one series of newer generation policies. And our objective with that premium increase, we are expecting now that claims will be higher than we thought. And we also have experienced a much lower policy termination or lapses, as I think Vince called it, than we expected.

We have already absorbed substantial

losses on this group of policies issued between 1974 and 2002. From 2009 through the end of 2014, Genworth has lost in excess of $2 billion collectively on all these policies taken as a whole. Even after including all rate actions currently approved and those that are still planned, we expect losses to continue to be substantial, several hundred millions per year, and we expect that to occur for several more years.

We have agreed with Pennsylvania and other regulators around the country that we will never recover any of those losses on the three older generations of policies, so for Genworth we view those $2 billion of losses --- and those losses are growing each year --- to be sunk costs for our company. And we've used our surplus funds, as Vince explained, to cover those.

The premium rate increases on the older generation policies help us to reduce future losses on those policies. And our ultimate goal over time is to bring those policies closer to break even going forward so we eventually get the annual losses close to zero. But that also means that we have locked in the $2 billion of losses and whatever losses we continue to experience until we get it to break even.

Genworth has received significant

increases in the past few years. It varies by state. And they've helped us reduce these ongoing losses but they have not been enough and our losses continue to be large and continue to grow.

As Vince described, long-term care insurance is guaranteed renewable, which means that as long as the policyholder pays the premium the carrier cannot cancel or change the policy terms. The only way an insurance company can manage the risks associated with a guaranteed renewal policy is to adjust premium rates when necessary as experience emerges.

I think Vince also described very well with his graphics the fact that if you find out much later, years and years, 10 or 20 years into a policy's life, the amount of premium increase you need to recover is much larger.

And I just want to give you a different way to look at it, but I think Vince's presentation showed it very well. A five percent required increase, if we implement it today, to ensure that a policy is adequately funded, if we waited or we didn't know for 20 years that we needed the five percent increase in order to get to the same actuarially equivalent basis, instead of five percent we would need 80 percent.

And if a company waited 25 years for the premium increase, we would need a 160-percent increase. We are applying for very large premium increases in large part because actuarially it's been only recently that we've become aware because of much lower interest rates, much higher costs, many more people claiming that we needed much higher premium increases.

And just the way that we look at it is for every five years that you wait to seek a premium increase to get back in line on that savings account to refer to --- for every five years the amount of increase you need doubles.

I wanted to note that we cannot change premium rates for specific policyholders because of their individual health or other circumstances. We are permitted under state regulations and subject to Insurance Department approval to receive premium rate increases that are actuarially justified but on the overall class of policies taken as a whole.

There is no doubt that private long-term care insurance helps to filter a huge financial burden for our customers, and it reduces the risk that taxpayers will pay much higher future taxes for

Medicaid. Pennsylvania's Medicaid plan is the payer of last resort for Pennsylvanians who do not have private long-term care insurance or adequate financial assets to play for the claims themselves.

These policies offer tremendous value to policyholders even after significant premium increases. Our policyholders generally have access to long-term care benefits that are many multiples of the premiums they have paid and will pay in the future. With the cost of a private nursing home room now averaging approximately $250 per day across America and over $300 per day in Pennsylvania, it's fair to say that the cost of care almost always will greatly outweigh the cost of insurance and premiums paid many times over.

Genworth has paid over 200,000 claims in the last 40 years, totaling approximately $12 billion. In Pennsylvania, over that same period of time Genworth has paid approximately $655 million in insurance benefits to approximately 10,800 Pennsylvanians.

In 2015 Genworth, paid approximately 2,300 claims on behalf of Pennsylvanians totaling over $70 million of benefits. Our claimants and their families express gratitude every day for the value of their policies and services, particularly when they go on claim. We need the premium increases we have requested on our older products to help ensure that Genworth can continue to pay all of our long-term care insurance claims as they arise.

Now we understand that large premium increases are a significant burden to our policyholders because we talk to our customers every day. In fact, almost 200,000 policyholders all around the country, including in Pennsylvania, have called us to discuss their premium rate increases over the last two years. We always welcome the opportunity to share information with our policyholders about the need for the premium increases, and it's also why we're here today.

We currently offer policyholders subject to premium rate increases a number of different options. And our customer service representatives in Virginia, which is our home base, and other locations are ready and willing to help each of them understand their options so they can determine the best course of action in their individual situations. Our policies have three basic options which they can choose.

First, they can agree to pay the full amount of the premium rate increase that's been approved by the Insurance Department. And if they do that, that will maintain their coverage and their benefits at currently levels. They can also make custom changes in their benefits, generally reducing their benefits in lieu of instead of paying the higher premiums. And so ultimately we think this allows them to find the right balance between affordability and the amount of protection they want in the future.

And finally, on a voluntary basis, this is something that is not required by most of the policies, but we have agreed that when policyholders no longer can afford to pay any premiums or don't want to continue their policies, we voluntarily agree to what's --- in the insurance lingo is called a nonforfeiture option.

What that really means is whatever they pay in premiums to date, we give them a paid-up policy. And the paid-up policy we will agree to pay claims equal to the amount of premiums that they've paid in under their policy.

So in effect, they don't lose any of the premiums that they've paid in. From our overall nationwide experience on all of the rate increases we've implemented in the last four years between 2012 and February of 2016, we have seen that approximately

86 percent of our policyholders pay the full amount of the increase, approximately eight percent take a reduced benefit and approximately six percent take that paid-up policy feature that we voluntarily offer.

So in conclusion, I want to say that Genworth recognizes and respects that this situation requires a balance of interests of many different stakeholders. We’re committed to work with Commissioner Miller and the Insurance Department in Pennsylvania to implement actuarially justified rate increases in a reasonable and responsible manner, keeping consumer interests and concerns top of mind.

Commissioner Miller, I want to thank you and your staff and everyone else for the opportunity for us to be heard today. Again, I express my thanks to all of those participating, all those consumers or policyholders participating. And Elena and I would be happy to answer questions that any of you have.

COMMISSIONER:

Thank you so much for being here. I appreciate it. And again, thank you for changing your schedule so you could make this work. I do have a couple questions for you. As you can imagine, when the announcement came out about this rate increase we started hearing from a number of policyholders concerned about the impacts, as you can appreciate. And one of the --- and some of the concerns we heard from policyholders related to concerns that Genworth might be seeking these large long-term care rate increases to make up for losses in other lines of business, which I hadn't necessarily heard that concern elsewhere. But can you address that concern?

MR. MCINERNEY:

Sure, Commissioner. First of all, our long-term care insurance policies are generally in one company. We have many subsidiaries, but we have them in one subsidiary. As I mentioned in my remarks, through the end of 2014, we had lost $2 billion of losses in that company. And we put surplus in. And we also view that $2 billion of loss --- and we're losing several $100 million each year. So that $2 billion will grow over time.

We view that as a sunk cost. So not only are we not trying to use these premium increases to cover other policies, we're not even trying to get that $2 billion loss. We're just trying to get the policies from losing hundreds of millions per year each year going forward, closer to break even.

COMMISSIONER:

Thank you. The current rate filing

notes that consistent with Genworth Life Insurance Company's 2014 asset adequacy testing, we anticipate future rate increase requests of similar magnitude. Is that accurate?

MS. EDWARDS:

Yeah. Commissioner, that is accurate. We do expect on the three older generation policies that we'll be looking for significant rate increases in the future as we go forward, and that's again to get those blocks, as Tom mentioned earlier, to break even over the next several years.

On the one series of the newer generation policies, we'll also look to seek significant rate increases because as we're watching our projected claims experience emerge, we're seeing that come in higher than expected and certainly the lapse rates are lower than expected.

COMMISSIONER:

So can you talk about why you didn't come in with everything you think you're going to need all at once versus coming it at different times?

MR. MCINERNEY:

You know, I think these policies will be enforced for 20, 30 or 40 years. The reason for these large losses --- and I think Vince did a great job explaining that --- is because many more policyholders than we thought maintained their policies. I think that’s because they realized what a great deal they have and how much the benefits are. And so they hold them and it’s more than was calculated back when we started 20, 30 years ago.

Clearly, no one anticipated the great recession that we had in the mid 2000s. And it's been said --- you know, I think in our case like most insurance companies we invest the premiums and the reserves are invested in high quality government bonds, treasury bonds, state, municipal bonds and corporate bonds. And we assumed, up until the crisis, it was generally holding true that we’d earn somewhere between six and eight percent interest. And for those of you who have CDs and other savings, you know that no one is earning that today.

In our case because these are very long liabilities, we invest them in long-term bonds. I believe those bonds are only around four percent today versus the six or eight percent. Now, it could be that --- you know, I don’t expect Janet Yellen and the Federal Reserve to raise rates any time soon. But if they do raise rates, it is possible that we would begin to earn more on the reserve funding and therefore would not need as much of an increase.

I'm not predicting that's the case. I actually think rates will be low for a long time. Also, we could see --- I don't expect this either --- that Vince is right. Our actual lapse rates or policyholders who no longer keep their policy in force, we, like the industry --- and it's pretty typical in insurance, that around five percent of policyholders do lapse for whatever reason. They have other needs. They no longer desire to pay the premiums in our case, I think, because of the richness of the benefits, how high the benefits are that we've provided, particularly in these old policies. In many cases they're lifetime benefits. They don't have a limit. And so the lapse rate has been well under one percent versus five percent. Now that could change. I don't expect it to change. It could change. We could find that more people turn in their policies. If that is the case, again, we would not need premiums. So we try to balance.

Again, we're not trying to recover the losses we've had. We're not trying to make money on these old policies going forward. We're just trying to get them to break even. So I do think, unfortunately, we probably aren't going to see interest rates go up or lapses go down, so we probably will, as Elena said, need to seek future increases. But we're looking at those increases and we'll look over the next five or ten years to see if, in fact, we really need the additional increases.

COMMISSIONER:

Okay. Will you be communicating that message to policyholders that you potentially anticipate seeking future significant increases as well?

MR. MCINERNEY:

We do. And we give policyholders 60 days' notice and then a 30-day grace period. But Elena really designed our system, and she oversaw our long-term care policyholder communications for a long time. So Elena, you may just want to comment on the letters and the type of letters and the phone calls we have with our policyholders ---

MS. EDWARDS:

Sure.

MR. MCINERNEY:

--- including in Pennsylvania.

MS. EDWARDS:

Sure, Tom. Thanks. Yeah. We definitely --- we've set up a separate customer service team to answer those specific questions from policyholders on purpose. That's what their job is all day, every day, is to take those calls and explain to policyholders what their options are so it's clearer. We do provide 60 days notice before their billing period to policyholders who are being impacted by a rate increase, and then another 31-day grace period afterwards. And we've found that that 90, 91 days seems to be sufficient over the years for policyholders to make those decisions. We do notify them and will continue to do so as the rate increase gets approved.

COMMISSIONER:

Thank you. I know in the interests of time, we need to move on. We've got other companies to hear from and consumers to hear from, but thank you very much for being here.

MR. MCINERNEY:

Thank you very much.

COMMISSIONER:

I appreciate it.

MR. MCINERNEY:

Thank you, every one.

MS. EDWARDS:

Thanks.

MS. FABIAN-MARKS:

Yes. Thank you. And now we're going to hear from Unum Life Insurance Company. Steve Zabel, the president of the closed block operations for Unum Group is here to discuss their recent filing with the Department.

MR. ZABEL:

Great. Thank you. And thanks for inviting us here today. A very important topic and I appreciate the partnership. So good morning. My name is Steve Zabel. I'm the president of Unum Group's closed block operations. And that operation is comprised --- it is one of Unum's four main business segments and includes those products that we no longer market, but we do actively service by the company.

Long-term care comprises about half of the premiums for that business operation. It's about a $600 million business operation. The vast majority of Unum's long-term care policies were issued between 1989 and 2012, and include over one million insureds currently. We take very seriously our commitment to providing service to our current policyholders, and we have a team of more than 150 professionals who both adjudicate claims and pay benefits to our policyholders, as well as provide customer service which is very important in these types of situations.

We do have a dedicated customer service team. They field calls, answer questions on these types of increases. They also provide different options to the policyholders that may help to mitigate those increases. Last year we paid over $370 million in benefits which we believe reflects the value of these policies to consumers.

Unum determined the prices for its long-term care business using the best data available at the time, pricing and applying assumptions and predictions about how future experience would develop. Unfortunately, us, like many in the industry, our actual experience in the years or really even decades since we issued the policies has turned out to be significantly different than those original actuarial assumptions used to set those original premiums.

Individuals covered under the policies are both living longer and hold onto their coverage longer than anticipated, similar to what Vince described earlier, which has led to more claims being made. Once our claim insureds are all sustained on claim longer than we had assumed, and at the same time investment earnings, which are used to support the payment of claims, continue to be significantly lower than anticipated given the overall sustained lower interest rate environment.

As a result, Unum has lost significant amounts of money annually for the reasons that you heard earlier. These losses had and will continue to have significant adverse impacts on our operating companies which have also written and continue to write other lines of business including disability, life, dental and vision, mostly in the group insurance space.

One of the steps we have taken at Unum to decrease the financial risk posed by our long-term care block of business is to file premium rate increases as allowed under the contracts and the law. Although we understand the significance of these filed increases, we have tried to file timely rate increases as soon as our experience deviations became credible. And you know, as described earlier, that can take decades for that information to actually become credible in order to support the rate increases being filed. We tried to strike a balance by filing increases that are only 24 percent of those that would actuarially justified. Under the formula as written, you'd be able to actually recoup potentially some of the past losses.

We have only filed 24 percent of those actuarially justified because we are trying to strike that balance between the consumer and, really, the company. Unum’s goal in seeking rate increases is not to restore the financial performance of the block to our expected profitability at the time of pricing. In fact, we will still experience losses on these blocks subsequent to the filed increases. And we will also not recoup any of the losses we have experienced.

We believe that our responsibility is really twofold regarding this difficult issue. First and foremost, we need to live up to our contractual obligation to consumers and provide the benefits to policyholders at their time of need. We take that very serious. Second, we must manage all of our insurance products to ensure the financial stability of our companies for all of our policyholders and not just our long-term care policyholders. We manage the stability for both the short-term horizon as well as the long-term sustainability. This is important for not just our long-term care insurance policyholders but for all of Unum’s policyholders. With all that said, we recognize that the rate increase amounts we are seeking are significant and they present many of our consumers with a substantial challenge to maintain their coverage.

So for each of our customers faced with an individual long-term care rate increase like those currently under consideration here in Pennsylvania, we have developed and proposed to offer a coverage change option that was not part of our original contract as filed during pricing. Simply put, this option allows the policyholders who have lifetime inflation benefit increases in their policies to avoid the entire rate increase by adjusting their go-forward benefit inflation rate from five percent to three percent. Note that all benefits accumulated in the past at five percent will be maintained. Given the current low inflationary environment for those services covered under our policies we believe that the five percent benefit inflation accrued plus the three percent going forward continues to provide a very valuable coverage to our consumers.

Also, our proposed rate increase would leave in place the current premiums for individuals whose coverages actually do not include lifetime inflation benefit increases. This new benefit coverage option is included in our pending filing with Pennsylvania. It has been approved already in 35 other states. Although it is still very early in the implementation process, we have seen very high election of this reduced inflation option for those states where it’s been implemented to date.

It’s also important to remember that people continue to have the option at any time to adjust other benefit features on a go-forward basis as defined within the contract and will have their premiums adjust prospectively for those new, lower levels of coverage. These options include things like reducing the benefit period from lifetime, say, to a three year or a six year benefit as well as adjusting the daily benefit levels provided.

In conjunction with all of Unum’s premium increase filings, we also provide the policyholder the ability to take a non-forfeiture option. That was also described earlier, most carriers are doing that, whereby they no longer pay premiums going forward and can receive a benefit if they are claim eligible that’s equal to the cumulative premiums paid in the policy historically. We believe no policyholder should lapse their policies as a result of a rate increase and believe we offer reasonable alternatives at various levels of affordability. We also make outbound calls any time we do just get a surrender of the policy, really to make sure that the consumer understands all the options, one of which is to have the paid up policy going forward.

In closing we acknowledge how difficult rate increases can be for our policyholders. We will continue to provide alternatives to manage affordability for our consumers and will stay vigilant in providing quality service during the life of the policy, most importantly, at the time of claim. I want to thank the Commissioner for inviting us here today. It's a very important topic for us, it's a very important topic for the industry, and I think the transparency is very good for the process. And we will continue to support both the Department and consumers, as we can, going forward. Thank you. Thank you, Commissioner.

MS. FABIAN-MARKS:

And thank you. We appreciate the information you conveyed there. You mentioned that there's a high election rate for policyholders who are offered the option to reduce their inflation protection in order to avoid the rate increase. Do you have a percent on average that you've been seeing in other states with policyholders who take that up?

MR. ZABEL:

Yeah. So just as a little perspective, we began implementing in November of last year. When you work through the communication process and notification process --- in it's very early days so the credibility is fairly light --- what we've seen is pretty consistent with our expectations. It is greater than 50 percent of the policyholders that have been selecting that. The exact, I guess, measure of that we haven't made public. But I'll just say that we're very satisfied with it. And what it shows to us is that the consumers understand the option.

I mentioned outbound calls. We've made a lot of just sample outbound calls to try to gauge and understand the ability of our communication to make sure that the consumers actually do understand the option around reducing from five to three. We feel pretty good that there's good understanding, and we think that the percentage of election has really borne that out.

MS. FABIAN-MARKS:

That's interesting to hear. And the landing spot, as it's colloquially known, the inflation reduction option, is fairly complex in the filing that you've made here, and that it's spread over three years and policyholders could select that inflation reduction at each of the one-year intervals in those three years. So you mentioned your communication process. Could you go into a little more detail in how you explain that option to policyholders?

MR. ZABEL:

Yeah. So I think a couple points to be made. First of all, we've always felt it's very important to lay out all the appropriate information for a consumer to make the decision upfront. And that's why, whether it's approved and implemented at one time or it's tiered over multiple years, we do believe it's very important to communicate that upfront to the consumer, so they have that information, they can make that decision and they're not surprised when their second and third tiers of that increase are implemented. We give the consumer the ability at each increase to elect the landing spot and elect the benefit reduction.

We believe that people's circumstances change. And although at the beginning of the implementation they may have felt that the affordability would work for them, circumstances change. And so at each point, at each implementation, we would continue to give that election to them. We also make that very clear in the communication that we give them. We make it very clear in the communication what the total approved increase is as well as how that's going to be phased in over a period of years. And that's pretty consistent with all states. We see the spectrum of one time implementations all the way up to, you know, three to five year types of implementations.

MS. FABIAN-MARKS:

And then in the interest of time just one more question. On some of these policies the first rate increase you filed was in 2011, but you began filing these in the early '90s and closed some of them by the early 2000s. So why did you wait until 2011 to file those increases?

MR. ZABEL:

Yeah. And it gets back to a lot of what Vince described earlier. When you think about the percentage of claims that you pay in the first decade of these policies, it's in the mid single digits. It might be five percent of the lifetime claims that you end up paying over the life of the policy. And we, like many companies, wanted to balance, making sure that we had credible data before we went forward with rate increases, against making sure that we didn't get too far into the future of the policy before we started to ask for the increases. Did we strike the right balance? That can be debated, but we made the decision when we felt like we had the right credible data to move forward with those rate increases, and we felt pretty confident that we, in fact, were going to experience losses and would experience those losses in the future as well.

MS. FABIAN-MARKS:

Okay. Well, thank you for coming to Harrisburg today. We appreciate your time.

MR. ZABEL:

Thank you again.

MS. FABIAN-MARKS:

Now, we're going to hear from John Hancock Life Insurance Company. And here to represent them is David Plumb, vice president and actuary for long-term care in force management.

MR. PLUMB:

Thank you, Johanna. And thank you Commissioner Miller and your staff for allowing us the opportunity to participate in today's important forum. I'm Dave Plumb, vice president of John Hancock, in charge of our in-force management for our long-term care business. We've been providing this product since 1987. We believe that long-term care insurance plays and should continue to play a vital role in financial planning in the lives of our insureds and their families, especially with strained Medicaid budgets and the need for LTC services rising dramatically. The long-term care can end up costing hundreds of thousands of dollars, and that can easily deplete someone’s savings and then some. And pooling your risks with others through long-term care insurance is a much more affordable way than trying to earmark savings to potentially cover the hundreds of thousands of dollars that some of the unfortunate people do spend.

Now this is a very long duration product. People buy in their 50s and most claims happen in the mid-to-late 80s and even into the 90s. And the costs of this protection are very difficult to predict many decades in advance. So providers really need to have the ability to adjust premiums to reflect actual experience. If not, I don’t think there would be any market for this type of insurance and many, many more people would end up depleting their savings and then accessing Medicaid after they’ve done so. In the earlier premium increases in the industry, or at least with John Hancock, our earlier premium increases were caused by low lapse rates. Everybody has already talked about that and we'll get into that. Our current rate increases are driven by mortality and claims experience. So really our lapse issue we think is behind us. Our assumption has been very low, less than one percent for a long time. You can't go much further. But now we're seeing mortality and claims experience deterioration.

And I would say that this is still a very young product, and companies are just recently beginning to see their insured life experience at the older attained ages and later policy durations. And that's where the vast majority of claims would be expected to happen over the life of a policy. And we are seeing more people live to those older ages. And when they get there, unfortunately, we're seeing a higher claims rate for people at the older ages and claims lasting longer when they're incurred at the older ages.

And again, rate adequacy I think is critical for this product to be sustainable in the future. Now, of course, we recognize that these increases that we're filing may be difficult for many of our customers. So we've taken some major steps to help ease the burden on our customers. One, we're applying the more restrictive rate stability regulations to our older block of business, the free rate stability block. And even then we're not asking for the most the rate stability regs will allow us to ask for. We're also ensuring that on all of our business that the rates on our in-force policies after the rate increase are not more than what we're currently charging for new business. That's a requirement for rate stability policies, but for the older blocks it's not required. But we are applying that.

And in fact, very often our in-force rates after the rate increase are substantially less than our new business rates. So people are still paying less than what someone would pay off the street today for the same policy at the same issuance as they originally bought. We do provide typical benefit reduction to help mitigate the impact of rate increase, daily benefit, benefit period, elimination period adjustments. But most importantly in 2010 we pioneered a unique alternative where those who have automatic inflation protection can completely eliminate the rate increase by reducing their future inflation accruals.

As Steve mentioned, the same with John

Hancock, that anything you accrued in the past at the older --- at the higher rate of inflation will stay with your policy. You don't lose that. It's only going forward that the accruals are less. And we call that the future inflation reduction landing spot or landing spot for short. And in Pennsylvania, 62 percent of those who are eligible for the landing spot actually took advantage of it in our prior increases. And typically, we see about 70 to 80 percent of the customers impacted by a rate increase are eligible for the landing spot.

And one of the reasons I think that this inflation landing spot works so well is that recent inflation in long-term care costs has been between one to four percent, really one percent for home care, which is the number one use that --- you know, people use home care more than anything else if you have a long-term care insurance policy. It's really not that often that people actually use nursing homes when they have a long-term care policy that will pay for home care. But the facilities are up there towards the four percent and home care is one percent.

And we develop this option for one reason only. It's to help our customers retain their valuable protection. We don't want to lose customers and have them not receive anything of value from us. And our experience has shown us that this has been a tremendous benefit in helping people do just that, retain their valuable policies.

Now, a little bit on our current filing. It affects about 7,000 of the 25,000 Pennsylvania policyholders that we have in-force. The average increase is 20 percent and the range is from two-and-a-half percent to 88 percent. And we had a filing in 2014 that was capped at 20 percent. I think the average was about 18 percent, but the maximum increase was 20 percent. And this filing is just for the unapproved amounts from that prior filing. So it's not from any new developments in our experience. It's just the amounts that weren't approved in the past. And the larger amounts are for the insureds who were capped at 10 to 20 percent in various filings between 2010 and 2014.

And mostly those are policies that weren't eligible for the inflation reduction landing spot whereas in the past oftentimes if you were eligible for that option we would receive the full amount of the rate increase and then the increases were capped on policies without reduction. We do actively support the 2014 model regulation and the

2013 model bulletin and we would encourage Pennsylvania and every state really to adopt those models because I think they provide greater consumer protection. There are more stringent loss ratio requirements for all business, particularly the pre-rate stability of business. There is a prohibition against recouping past losses in the revised model, in the NAIC model. And there is enhanced consumer disclosures and more accessible contingent nonforfeiture benefit.

So I’d just like to close by saying that we’re committed to working with you to ensure a vibrant and responsible long-term care marketplace. And again, thank you very much for having us to the important meeting. We’d be happy to take any questions you might have.

MR. LAVERTY:

Thanks, Dave. Now, would John Hancock make the landing spot available if the Department approved your full increase but over a series of years, say we approved it over three years?

MR. PLUMB:

Yes, we would. And we have done that in other states. What we do is at the outset of the rate increase we will notify the customer of the landing spot option. If they have automatic inflation and if they take the landing spot option, then none of the scheduled rate increases, whether it's two, three years or whatever, would apply to them.

MR. LAVERTY:

Okay. That's all my questions. Thanks.

MR. PLUMB:

Okay. Thank you again for having us.

MS. FABIAN-MARKS:

Thank you. And last up, we're going to hear from Metropolitan Life Insurance Company. Jonathan Trend, assistant vice president and actuary, is here to talk about their filing.

MR. TREND:

Good morning. And thank you for having us. It's good to be here and we appreciate the opportunity. As you said, I'm Jonathan Trend. I'm an actuary with Met Life and have responsibility for our long-term care product. I did send some slides, and I have a few prepared remarks to accompany them. Do I need to ---? Thank you.

Basically I really have two message points. And obviously I'm not going to rehash a lot of what's been said by the other speakers. I think they did an excellent job laying out the framework and the issues which, you know, are relatively similar across the industry. I did want to highlight really just two topics.

One is Met Life's approach to rate action, kind of our philosophy and methodology, and then separately discuss our experience from a consumer point of view in terms of the reactions we've had over the last several years. I really want to emphasize our balanced approach. We have a lot of stakeholders. Obviously, first and foremost, are our policyholders and we understand the burden this can have upon them. We also have, obviously, regulators, you and the other jurisdictions. We have agents, group policyholders and shareholders.

So our view is to take a balanced approach. We think long and hard about taking action. Every year in the normal course of action we do an in-depth experience study on our entire book of business to basically re-project what we think the assumptions will be. We look at the experience of the block and we also look at our assumptions regarding the key things you had outlined in your opening remarks, Johanna, lapse rates, morbidity rates, mortality rates and basically say this is our best estimate view of the world today. And based on that analysis we look at our current rate basis and make the determination as to its adequacy.

As others mentioned there's no attempt to recover past losses. So whatever has happened in the past has happened. Really our objective is to set the ship on the right course going forward. So what we're trying to do is solve for the premium that should have been charged on day one if we knew then what we know now. And so we request rate increases consistent with what that rate basis should be with no attempt to recover past losses. So we have a bunch of math to go through to do that, which Jim has seen, and I won't belabor you with the guts of that.

The other point here I want to make on the slide is Met Life's --- part of this balanced approach is flexibility and transparency. So we understand there's a lot of ways to deal with the issue and we are flexible both in how we deal with the regulators in terms of --- you'd mentioned, Jim, spreading the costs out over a multiple phase-in period of time versus doing it all at once. And on the policyholder side, we, as the other carriers, offer a lot of options to help insureds keep their coverage. If they choose to lapse it, we do have a no-cost nonforfeiture option which gives them a paid-up remaining benefit. But we hope they can either afford to pay their new rate basis or can modify their contract to keep the premiums at or close to their original level. And there is a myriad of ways they can do that. Our communications, we try to be very clear. We give them some options around daily benefit amount and maximum lifetime benefit, which are the most common ways people modify their policies. But they can always call our consumer number and work with an individual rep to change or drop a rider, change an elimination period, many other options, to work with them.

Transparency, I mentioned. So we're trying to be transparent with everybody. You know, we do the math as I described. We're not trying to hide anything. We share it with the regulators so you understand what the business looks like and what we're trying to achieve. And when we communicate to our policyholders we try to bring that same level of transparency. So when we have a rate increase we're not only tell them obviously what the rate increase is and how it affects them, but we also indicate what we applied for. And if the amount that was granted by the Department were less than that amount, we indicate what the potential implications of that are so that they can make informed choices. And you know, sometimes that might be pay it and I'll see what happens. Sometimes it might be I want to act now. But we want to make sure our customers and their financial representatives, their agents or their financial advisors understand the full picture and can make informed and smart choices for their personal situation.

Last of all there, I'll just emphasize that we're committed to this process. Annually we look at our experience, annually we calculate what an appropriate current rate basis would be and then we would make a management decision at that point whether to seek a rate increase, if appropriate, based on that policy form series.

My second topic, as I said, is just to provide some view to everyone as to our experience, as did some of the other carriers. Complaint levels have been very low, surprisingly low. We have they're less than one percent nationally. Pennsylvania has been consistent with that. Well, well below one percent of policyholders write to us with a formal complaint.

Lapse rates, the people who choose to move to that nonforfeiture status and have a residual paid-up policy, I have about two percent, two to five percent, a relatively low number of people choosing that option, which again speaks to what we think the value is of the product and the fact that the consumers understand that value.

And then lastly, about 15 percent of insureds choose to adjust their policy benefits to keep their premium at a similar level to what it was before. So that leaves over 80 percent of people just paying the new rate basis.

Last bullet there, I just want to highlight, you know, we are here to pay claims. Like, we wrote this business, we took a risk. It provides valuable coverage. That's what we're here to do. We have a growing claims team to adjudicate these claims and we're here to pay them. We've paid over $3 billion to date, including $400 million last year. And that's obviously going to grow for decades. And, you know, we're here to be here for our policyholders when they need us, and I'm proud of the service we provide. So that concludes my prepared remarks. I'd be happy to take any questions.

COMMISSIONER:

Thank you for being here. So I understand your requests range from about 43 percent to 60 percent. And so the question I have is, do you think that's going to stabilize these blocks of business or do you think future rate increases are likely to be necessary?

MR. TREND:

Yes. I do think those will stabilize the block. Obviously it's hard to make long-term predictions, but our approach to calculating the justified amount, which is consistent with the regulatory environment and then on top of that we say we're not going to recover past losses. So the requested amounts of 43 to 60 percent are the necessary amounts to bring the current rate basis to an appropriate level going forward. And unless there's a deterioration of assumptions, which is a possibility, we don't and wouldn't expect to need any more if that full amount were approved.

COMMISSIONER:

Okay. And can you clarify for me? I think in your slides you suggested the lapse rate might be two, to two and a half percent. But my notes show that in the filing there were was a .5 percent lapse rate assumed. Can you just clarify that for me in terms of what you're anticipating?

MR. TREND:

Well, our filings discuss both our

baseline lapse rate, so just normal lapses. The slide was referring to what we call shock lapses. So people who basically get a letter and say I'm going to choose the nonforfeiture option. The reason we're all a little bit couching --- it's about this --- policyholders don't say I'm lapsing because you gave me a rate increase. So there's no hard way to discern who would have lapsed anyway in the normal course of their life versus their specifically responding to the rate action. So our filings disclose both our baseline assumption around lapse, mortality and morbidity and specifically our assumptions around the shock lapse and shock downgrade.

COMMISSIONER:

Thank you very much. I know we're running a little behind and I want to make sure we give consumers an opportunity, so thank you so much for being here.

MR. TREND:

Thank you.

COMMISSIONER:

I appreciate it.

MS. FABIAN-MARKS:

And now we're going to take a short ten minute break, and after that we will hear from consumers. So we’ll reconvene. It’s 10:35. We’ll reconvene at 10:45 for the consumer portion of the hearing.

SHORT BREAK TAKEN

MS. FABIAN-MARKS:

We have a number of folks who have signed up to testify. And we’re looking forward to hearing from all of you. But due to the number of people we have in attendance, we’re going to ask people to limit their testimony to about two minutes, please. And just to sort of frame this portion of the hearing, this is an opportunity for us to hear from you, for us to hear your thoughts and what you would like us to consider when we’re reviewing these filings. This isn’t necessarily designed to be a question and answer session. If you want to raise questions that you want us to think about as we’re reviewing filings, we welcome that and we’re also happy to speak with anyone after the hearing to respond to questions.

And so we have some satellite locations around the Commonwealth. At this point we only have members of the public who wish to speak in Scranton. So we have them live now and we’re going to hear from them. If anyone else at the other satellite locations does decide that they want to speak, just let the coordinator there know and they'll get in contact with us. But at this time we'll hear from Scranton.

MS. CROMARTIE:

Good morning. My name is Pat Cromartie. Can you hear me?

MS. FABIAN-MARKS:

Yes.

MS. CROMARTIE:

Okay. Good. I appreciate the opportunity to hear this presentation by the panel. And Commissioner Miller, I thank you for setting this up. I am here as a citizen. I don't represent anyone but myself and my elderly brother-in-law.

Just as a quick overview so you understand why I'm even involved in this, my eldest sister died 15 years ago. She and her husband had no children. I was four years old when they got married, so I'm the next best thing to a child for them. And my brother-in-law was 69 years old at the time, had a lot of concerns about really never wanting to go to a nursing home, never wanting to be in an assisted living facility. He has a little house on a lake in the Poconos and said to me, if there's anything I could possibly do to live my life here and die here, this is what I want to do.

So we went to a financial advisor --- I was very aware of long-term care insurance --- and purchased a policy with Unum. So Steve Zabel, Mr. Zabel, a lot of this information is really about your company. We selected Unum because I have a background in healthcare administration. I was very aware of what a wonderful company Unum has been. So we purchased the policy and the policy had a clause, a rider in it, that his monthly benefit for either skilled assisted living or homecare --- and believe me, we were heading for --- the homecare was what we were really after --- was a $4,000 a month benefit. But we have a rider on it that says that there would be a five percent increase of that benefit compounded annually. So roughly if you compounded that out now he'd have about an $8,300 monthly benefit that he could collect if he needed it. Luckily that has not happened. He's 82 years old and he's a very healthy guy.

We started paying premiums --- I say we because I handle his financial information. In 2000 is when the policy was written. In 2006 --- and I'm assuming, Commissioner Miller, you weren't in this seat at that time. In 2006, the Pennsylvania

Insurance Commission granted an increase to Unum. So in the effort of being transparent, we really need to be transparent here. This is not like these policies are old and this is the first time insurance companies are coming and asking for a premium increase. The real transparency is that --- and I have all the documents. I'm a little crazy about saving stuff, and I'm glad actually I did. It took me three minutes to get ready for this.

In 2006 he got a letter from Unum stating that the Pennsylvania Insurance Commission had approved an increase. And my brother-in-law's premium was going to go from $3,700 a year up to $4,900 a year, $4,950 or something like that, so roughly around a 30 percent increase. At that time he was fully retired and living --- they had assets saved, but his annual income is $12,000 a year. He lives on Social Security. Okay? But this is a big priority for him. So when that came through, his first instinct was I can't pay $4,900 a year and then two years from now it's going to be $5,500. And we had a long talk and the truth of the matter is he's very knowledgeable and so am I. Insurance is a risk. It's a risk company. You can have a $1 million 20-year term policy and if you live to year 23 the insurance company won the policy premium money and the person who died's family lost. We understand how that works. And our theory, his and mine both is, we hope you pay this premium until you're 90 and go to bed some night and die in your sleep and never collect a penny of it because then you would have won the elderly lottery of not having to go through losing your ability to care for yourself and needing money and needing assistance.

So when this increase came up in 2007 we checked out what our options were. This whole idea of forfeiting some benefits or changing the policy so that he can have a better premium and especially of forfeiting the inflationary clause, this is not new. Please understand, I think there's some confusion out there that this is something knew that the insurance companies have come up with now because they want to be helpful. In 2006 we were offered that option.

So in 2007 for our premium, which I think is 60 days later, we did indeed drop that rider. So what we said was, okay, we will not take a five percent compounded unlimited, which is the terminology, increase. We will hold our benefit at $4,000 a month and let's get this increase off the table and see if we can have a reduced premium. And we did get a reduced premium. He went from paying

$3,750 roughly a year down to about $3,300 a year. Okay? So we already, he already waived all the inflationary costs. But again, keep in mind he's in a different situation. The goal was not to have to pay for the huge costs of skilled nursing or long-term care, but yet to keep him at home with family members, no children but other family members chipping in and maybe needing, you know, one or two people to come in and help at night. So we already did waive that. And we already did concede to that.

So I just wanted it to make it clear that that's not a new thing that's on the table. Now that ---.

MS. FABIAN-MARKS:

And Mrs. Laverty (sic), we definitely appreciate your testimony. I'm afraid we are asking folks to limit themselves to about two minutes. I don't want to cut you off but I do want to ---.

MS. CROMARTIE:

Okay. Okay. Well, I think you needed to know where I was coming from, and that's why I gave you the background because those are things that I think were confusing to anybody who was listening to this. Okay?

My point now is, if the insurance

companies are going to offer other ways for people to not pay these increased premiums, perhaps one of the things that should be considered --- and Commissioner Miller, I would be happy to send you all of the information, do anything after this meeting that would be helpful to this. But right now if my brother-in-law goes into forfeiture for his policy and then collects the $52,500 of premiums in terms of benefit that he's already paid in, well, again, the insurance company would then win on that gamble because basically then what they've done is set up a savings account for his premium money. And if he does die in his sleep like we hope he does when he's 90, they still keep all of that premium money.

And I understand everything about --- everything that people presented is valid about all the things that they expected to do and didn't. But I think there's a point here where then people should be offered also refund of their full benefits plus the three percent interest that came across the board.

And my last point and I'm finished is that I also went online and looked up the 2015 and 2016 stockholders' perspectives and all of their stockholder information for Unum. Every company is on there. I understand that this a subdivision of Unum, this closed business subdivision of Unum, but Unum on a whole from 2007 up to and including today has had a steady increase in all of their stock values and in all of their dividends and they're a very solid, good company. So I don't know if the bad investments get spun off from the side company or what. But that needs to be, really, looked at closely. Thank you very much for your time.

MS. FABIAN-MARKS:

Thank you.

MS. CROMARTIE:

And if you would like any information from me I will copy policies, letters, anything that anybody would like.

MS. FABIAN-MARKS:

Thank you.

MS. CROMARTIE:

Thank you.

MS. FABIAN-MARKS:

We appreciate that and appreciate your comments. Was there anyone else in Scranton who wanted to speak at this time?

SCRANTON COORDINATOR:

No. That's all for us.

MS. FABIAN-MARKS:

Okay. Thank you. With that, we'll go to consumers in Harrisburg. We'll take a couple comments from Harrisburg, then we'll switch to Pittsburgh and then we'll come back to folks here in Harrisburg. So first on my list I have Kenneth Yoder. I think he may have had to leave early. Okay. Next up I have Brad Shepard. Are you present?

MR. BRAD SHEPARD:

Where shall I sit?

MS. FABIAN-MARKS:

Right here, sir.

MR. BRAD SHEPARD:

Right here?

MS. FABIAN-MARKS:

Okay. Thank you.

MR. BRAD SHEPARD:

Thank you. Good morning, everyone and thank you, Commissioner. My name is Brad Shepard and thank you for allowing me to speak today about a topic that is near and dear to my heart. I have been helping families plan for long-term care needs for 17 years and have spent a large part of my career either affiliated with or employed by Genworth or one of its predecessor companies. In addition, I've trained agents and advisors on long-term care insurance products and often speak on the topic of long-term care planning.

Very briefly, I would like to share some thoughts about the value of long-term care insurance. This planning solution is more than just an insurance product, which stereotypically is sold to elderly people across the United States. As you have learned this morning, when people make the decision to obtain long-term care insurance as their best planning solution they take true ownership of the policy. You've heard many comments about lapse rates. In fact, I've heard many times from policyholders that they consider their policy to be equivalent to an extended healthcare checking account, therefore strengthening their first line of defense and creating a moat of protection around their savings, personal independence and the looming possibility of needing care provided by family members.

We also realize as a nation the fastest growing segment of our population is age 65 and above. In my opinion only one of the toughest challenges that we as a country face is educating the masses about the need for long-term care planning. Long-term care insurance is just one planning solution and not appropriate for everyone. Once a person has enough knowledge to make an informed decision, they are empowered to act accordingly. I encourage all parties, both public and private, to provide more avenues to educate Americans on this critical risk of needing extended healthcare that we face together. An idea would be to introduce educational campaigns targeted to all Pennsylvania residents age 50 and above. The campaign could be associated with a neutral website created by the state as a way to begin the conversation among friends and family.

Other ideas may require legislation changes at the state and/or federal level to allow residents to use different levels of pre-tax dollars to fund more long-term care planning solutions. There are many ideas that are out there being thrown around. It could be such things as using 401(k) dollars to pay for tax qualified long-term care. There could be other things such as higher levels of deductions and/or tax credits like a neighboring state, New York, allows for, because this in the end is all about, you know, having more people protected.

In closing, as a country, state, county, city, community or each household we live in, we are all in this together. By working together, we all benefit from the creativity, teamwork and compromise.

I am very proud to be a member of this education team and will continue to do so with my head held high. I want to finish though with saying thank you. And by the way, I am also a consumer. I bought my first long-term care policy at age 23. Thank you, everyone.

MS. FABIAN-MARKS:

Thank you. We appreciate those comments and suggestions. Next up I have Sandra Curley. Are you present?

MS. CURLEY:

Good morning. Good morning, Commissioner. And thank you very much for allowing us to do this. I am a registered nurse of many, many years. And I've been a long-term care insurance specialist for about 21 years. And Mr. Shepherd said just about everything I wanted to say. Thank you, Brad. So I'm not going to repeat most of my notes. Many of my notes are exactly what Brad has shared with you.

I too am a consumer. I own a long-term care insurance policy. But I also had a mom that had a long-term care insurance policy who could not afford to pay the premiums, didn't have assets, had very little income. But I bought that policy for her and she was age 70 when she purchased the policy. I paid for it for about 10 years. I put in about $35,000, and we got back about $145,000. That allowed my mom to live in dignity for seven years that she required care. It allowed me to get a choice for her so that she could be in dignity where she received her care and nobody knew that she didn't have any money or that she couldn't really afford to be at the Bridges, which is a beautiful assisted living facility not far from here.

Long-term care insurance is a Godsend to most of my clients. I have about 2,500 clients. Many of them are on claim. Because I'm a nurse I help them with their claim, when they open up their claims and I see the impact on their families, not the least of which is their financial impact, but most of all their families. Long-term care and the need for it tears families apart. And long-term care insurance truly is a Godsend for them. Please consider tax credits, as Brad has shared, taking the money to pay for 401(k).

I believe over the years, I respectfully say as well, I was so excited about one of the benefits that was offered. I represent all of the companies that are here today and we have a survivorship benefit. And if you understand how that works, if you are a policyholder for ten years and didn’t file a claim and then there is a death of one the survivors, the survivor person never pays another dime to the insurance company. Is that one of the reasons why we are having problems here today?

And also, there is a waiver of premium whenever one begins using the policy. I don’t stop paying my State Farm if I have a car accident, you don’t either. We don’t stop paying our medical premiums, our Medicare or health insurance if we get sick. These are some of the things that I respectfully think that should be considered. We can’t promise everything, but at least if they would give the base benefit. I thank you very much, Commissioner. Thank you for allowing me to share.

MS. FABIAN-MARKS:

Thank you. Yes?

COMMISSIONER:

And I want to hear from the rest of the consumers so I’m going to be very quick. But I want to say I really appreciate the comments that were just made because I think one of the things for those of you who don’t know --- one of the things we’ve been thinking about a lot from the Department’s perspective is the future of long-term care insurance. Clearly we’ve heard this morning about a lot of the challenges facing this market. And I think we all appreciate those challenges and that this is just a really challenging market for everyone, for consumers, for industry, for regulators. So we actually are chairing a work group through the National Association of Insurance Commissioners, since --- I mentioned at the beginning this is not just a Pennsylvania issue. This is a national issue. We're chairing an innovations --- a long-term care innovations work group where we're going to be looking at some of these things you just raised and trying to figure out how can we address some of these challenges of the market going forward because we do recognize the impact that long-term care costs have on Medicaid and our state budgets. So I really appreciate those comments and we're certainly thinking along these lines as we chair that work group.

MS. FABIAN-MARKS:

And now we're going to go to Pittsburgh to hear from some members of the public who are there.

MS. PEPPERMAN:

Hi. My name is Sarah Pepperman. I'm with Family Services of Western Pennsylvania and the Apprise Program here in Allegheny County. And we have a few questions. First is, if rate increases are approved, when will they go into effect?

MS. FABIAN-MARKS:

I think that varies depending on the kind of company and when they're rolling out their rate increases after approval, but there is a notification process for the consumers.

MS. PEPPERMAN:

Okay. Our second question is from one of the attendees here, Erika, who is asking how do companies determine which plans specifically will get increases in their rates and how much of a rate increase there will be. She has Genworth so we're particularly interested about that company. For example, are the plans chosen based on health rating or date of purchase or some other criteria?

MS. FABIAN-MARKS:

So I can't speak for any specific company, but in general the companies look at how much money they're spending on benefits or how much they project they'll be spending on benefits. And then if they need to make up more money, as I discussed at the beginning of this hearing, they evaluate their loss ratios which is the ratio of how much they're spending on benefits to how much they're bringing in, in premium. And if that starts exceeding a certain level then they can come in for a rate increase. It's not based on health or date of purchase specifically. It's more looking at that loss ratio.

MS. PEPPERMAN:

Okay. On a plan-by-plan basis?

MS. FABIAN-MARKS:

They don't look at it for like individual consumers. They'll look at it --- they have blocks of policies that they group together.

MR. LAVERTY:

In Genworth's case they're asking for higher increases if you have an unlimited benefit period. If you have a shorter benefit period, the increase is lower.

MS. PEPPERMAN:

Thank you very much. Another question from our participants here is wondering if long-term care is becoming a product for the one percent?

MS. FABIAN-MARKS:

I don't know about the one percent, but certainly premiums are increasing and we're aware of that. And it can be out of reach for many folks. And as the Commissioner mentioned, that's why she is chairing this work group that's beginning with the National Association of Insurance Commissioners to look at ways that we can get the market to a place where it's working better.

MS. PEPPERMAN:

And we have one last question which is asking if there's a difference between cancellation of a policy and nonforfeiture, and if you could explain that, please.

MS. FABIAN-MARKS:

I believe nonforfeiture typically occurs within a certain period after a rate increase is how it's kind of differentiated from a cancellation. But I'll actually turn that over to Jim to answer.

MR. LAVERTY:

Well, if the policy had a nonforfeiture rider then the person would receive a paid-up benefit if they chose to stop paying premium. In other cases, if a policy was sold after our rate stipulated regulation went into effect, they would have something called a contingent nonforfeiture, which means if they were subject to a large enough rate increase they could receive a paid-up benefit. But again, if you merely stop paying your premium and you don't have a nonforfeiture rider, you didn't buy it initially with your policy, or you haven't faced a substantial rate increase, then if you cancel, you do not receive a benefit.

MS. PEPPERMAN:

Okay. Thank you very much. That was my last question.

MS. FABIAN-MARKS:

Thank you. So with that we'll return to members of the public who are here in Harrisburg. And next up --- is Garrett Mowry present? Thank you.

MR. MOWRY:

Hi. Good morning. Good morning, Commissioner, thank you for having me today. I'll just start off by saying I'm a third generation licensed insurance professional, and I'm here to talk on behalf of my grandfather, Former Senator Hal Mowry. I was very lucky that the beginnings of my insurance career were the end of his, and I was able to work with him, which is a really unique thing. Not only as, you know, a professional mentor but as my grandfather.

The last five years of his life, he was in still in our office daily, still coming into my office every day, checking into to be sure I was making something happen. And, you know, one day really similar to the weather we've been having we met in the morning, went out to our usual lunch spot, came back. And he said, all right, you know, I'll see you tomorrow. I'm going to go smack some golf balls. And that evening we get the phone call that he dropped. You know, he dropped over out of nowhere. And what ensued, you know, the next 11 months were terrible, you know. It was our family going through three different nursing facilities, in and out of intensive rehab care and a horrible thing. But he was a Genworth policyholder and that was, as some other people before me have said, a true blessing to me and my family.

As everybody knows who has loved ones and have gone through hard things, the last thing you want to do is get in a discussion about money and who's going to pay for what. And, you know, the policy alleviated that for us and our family. And I'm forever grateful for that. So he would always say, you know, don't try to get in this business to sell somebody something or show them something on a brochure. Tell a story. And I have his story to tell and that's why I'm here today. So thank you.

MS. FABIAN-MARKS:

Thank you. Now, Ben Iancavetti, are you present? Okay.

MR. IACOVETTI:

I only have two minutes. I have to talk fast. Thank you so much for having me and giving me the opportunity to be here. Welcome to Pennsylvania, Commissioner, first of all. AF&L and Senior American are two companies that we own. As I look around this audience today, I was talking to people earlier. I said it's important for people to know who we are and what we do. Because where we are is where they will be. And I look at this and I go no greater companies that Genworth with the GE Heritage, with Met Life, with John Hancock and with Unum. Fantastic companies, all of them.

The one thing that we have in common with them is we are a long-term care insurance company. Ninety-six (96) percent of our business is long-term care. We have done many rate increases for the reason no other than sick people are living on claim much longer than anyone has ever anticipated. And we could tell you with no degree of error how many people with blue eyes go on claim versus with green eyes. And interestingly people that are left-handed are more likely to go on claim than people that are right-handed. How about that for detail?

We're here and the point that I'm trying to make is, the only reason we're here is because of the Pennsylvania Insurance Department. Our shareholders have lost everything. We operate AF&L without a profit motive but we do anticipate honoring all of our obligations to policyholders, to our agents and to that few number of employees that we have left.

So with a degree of specificity we have blocked our business into different groups. Small, medium and large risks with inflation and without inflation. And in our most recent rate filing that was approved I believe in 2014 --- which Johanna and Jim have so eloquently worked with us to try to get done --- we requested a zero percent increase on the small policies. And that with coverages that were limited to just two years. The three and four year policies are our medium risks. The five year and lifetime are large risks. And the people with inflation are different than the people without.

We are very happy to report that we fixed the rates for the small policies without inflation. We are unhappy to report that after all these years, and I believe we're up to six rate increases since 2002, we still have not fixed the rates for the unlimited lifetime policies, and we have not fixed the rates for the inflation policies and there's nothing more that we can do. We operate AF&L

at, we think, for free. We had our agents agree to a voluntary commission reduction, unprecedented. We run the company on excess investment income. There is nothing more that we can do.

I'm looking at Genworth there. For years we admired Genworth because when we were only earning four percent on our portfolio, they were earning six. For whatever reason, we repositioned our portfolio during the great recession. Now we're earning six percent and Genworth is now only earning four. Our greatest investment, my favorite investment, are Build America bonds issued by the Pennsylvania Turnpike Commission. Every time you use the Easy Pass we get paid 6.6 percent. That is not our money. That is policyholder money that we put to great work and we're just here to say, listen.

I was talking to Vince earlier. We have the smartest guys in the room, and Jonathan Trend is there looking at me as well. We had the smartest guys in the room help us to design these policies. They are rocket scientists. We missed. We missed. There was a little story about the Hubble telescope. When they designed the Hubble telescope, the smartest rocket scientists in the world did it, they put it into outer space, it didn't work because there was some correction that they needed to do to the lens. It's the same thing with us. What are we going to do? Our average claimant is now 87 years old at time of claim. Eighty-seven (87). All of our policyholders that are not on claim are 83. Most of our policyholders have outlived their expected lives. We didn't do it. We look at the smartest guys in the room and we're like, we don't know what more to do. We can't change the policies, we honor our obligations. The only thing that we can fix are the rates. So we don't want to do this, we have no interest in raising rates.

When policyholders call they'll get me and they'll complain to me about you people, you people keep raising their rates. And I say, sir or ma'am, it's not you people, it is me. And they're, well, what do you mean? I'm the guy that raised your rates. I'm the guy that pushed the button. You're talking to me, I'm responsible. And then their whole demeanor changes and it comes down to this. You know what Ben, we understand. We understand that old people are living on claim forever. We don't make any judgments about whether or not it's a quality of life issue, we just pay the claim. In the last eight years we collected $275 million in premium. We paid out

$325 million in claims. Cash in, cash out. Thank you.

MS. FABIAN-MARKS:

I'm just going to have to ---.

MR. IACOVETTI:

We understand. I'll have my time some other time. Thank you.

MS. FABIAN-MARKS:

All right. Thank you. We appreciate your testimony. Okay. Next up Brian Donmoyer.

MR. DONMOYER:

Good morning, everyone. It's still morning. I'm the first consumer you're going to hear from today. I'm a little disappointed at that, I have to say. I think there should have been consumers at this point, not producers and not people that have a vested interest in the industry. So maybe in the future I would do that. So, thank you.

The reason I'm here, I've been a Genworth policyholder since 2003. We had the experience of having a father-in-law live with us and we decided we're not going to do that to our children. So we ran out at 49 and bought a long-term care policy. When we bought that policy we had lots of things presented to us and the lady sitting beside me was actually my agent and she did her very best to present a very balanced and appropriate presentation including a brochure that Genworth produced. It's the Pennsylvania brochure, 2238, so this was for PA. And I'm going to read where it says, and while past achievement is not an indicator of future performance, we're proud to tell you that since we developed the coverage in 1974, we have not raised premiums for any of our long-term care policyholders. If we do have to raise premiums in the future, it will be done by class of insureds and state with advance written notice to you.

Well, when I bought this policy, I had full thought that if it didn't happen for 30 years, it's probably not going to happen for the next 30 years. Well, I was wrong. And we all heard why I was wrong and lots of other people were wrong. But it's been a little disturbing. I have had two increases. I've filed complaints with the Insurance Department both times. One of the times I thought, well, gee, let's change this five percent that's such a burden to the insurance company from compounded. I'm in my 60s now. I'm not in my 40s. I'll change it to simple. Well, unlike the landing spot, Genworth chooses to go back to the original issue date and recalculate a simple five percent. So I end up losing what I had paid for, for 12 years. Well, that wasn’t a very good move so I certainly didn’t do that. And in all fairness, I’ve spoken to the Genworth people here today and having the president here was, I think, an honor and that’s appreciated. And it’ll be interesting to see, you know, if that policy does change. Because from hearing other companies, it works. When they give people that opportunity, they take it.

And the other suggestion that I had made in my last complaint to the state was I think the companies should notify the insured when they apply for a rate increase, not after the fact. By the time I was complaining it was too late. I did see today with the presentation that there is a website that I guess if you check it all the time you can see if your rates are going to go up. But it would seem to me that it would be appropriate for the insurance companies to provide the insured a notification that they are applying for a rate increase and at that point the public can be heard more easily than finding it on a website.

Again, I appreciate everything the companies are doing, including Genworth, to try to lower the rates for us insureds that have policies. But I have to say that after hearing that the increases are probably not over, I think my next stop is an elder law attorney and it might just be easier to be on Medicaid. And I never thought I'd say that, but it has to cross everyone's mind that has to go through these increases. And especially now after hearing that they may not stop. So thank you.

MS. FABIAN-MARKS:

Thank you for your testimony. Next, Richard Arnold. We invite you to come up.

MR. ARNOLD:

Thank you for the opportunity to testify here today. I'm Richard Arnold and I'm here on behalf of myself and my wife Ellen. We have companion long-term care policies issued at the same time in the year 2000, and on the same policy form by one of the companies seeking a rate increase.

At the time we purchased these policies, we were led to believe that our age or health condition would not affect the policy as we got older. We were told the only way the premium could increase would be if the Pennsylvania Insurance Department would approve an increase and that premium increase would have --- were very rare. There's actually a statement in our policy that says we cannot change the provisions of this policy without your consent.

For several years there wasn't a rate increase. We got the policy 16 years ago. But in the past six years we've seen three rate increases. On a compounded basis, my premium has increased 116 percent and my wife's premium has increased 128 percent, more than doubling the cost of our insurance. We've been forced to substantially reduce the benefits in order for our premiums to be affordable.

Are the company's actuarial assumptions that they need to more than double the cost of the policies? As my policy is situated now, by the time I reach age 89 my premium payments will have been $4,039 more for $190,000 less lifetime maximum benefit than specified by my original policy, and a reduction of my daily benefit from $368 to $316. A substantial portion of my premium, about a third of it, is for an automatic benefit increase rider which is supposed to protect us from the effects of inflation as we grow older. Instead the premium is inflating drastically.

I recognize the Department's dual responsibility of protecting consumers and making sure that insurance companies can pay their claims. But the process has become unbalanced. I cannot find that any of the companies currently seeking increases are in financial difficulty. I've looked at their SEC filings and they all seem to be very sound companies, and they don't need government's help. I have found that one of the companies paid their top executive $11 million last year, hardly an indication that they need government help to raise their profits. Is it right to squeeze policyholders in order to pay their CEO $11 million?

It's probably the case after what I've heard here today that the insurance companies are --- too big a portion of that premium is going to the shareholder part and not to the reserve account. The increasing cost of skilled nursing care is not a valid argument for increasing premiums because the companies' liability for those benefits is capped, both in the daily benefit and the length of time spent in skilled nursing care. And irrespective of how much the care actually costs. This is not an actuarial assumption. This is a certainty at the time the policy is written, what their liability would be.

And the actuarial estimate of how many people would die before using their coverage is a weak argument for raising premiums because life expectancy tables are well founded as used in the pricing of life insurance. It has been explained to me that the Department reviews actuarial assumptions and allows premium increases if there's not a good reason to disallow them.

Well, there is a good reason to prohibit increases. An insurance policy is a contract between the company and the policyholder and it's unconscionable for the more powerful party in the contract to be permitted to unilaterally change the terms. Policyholders are locked in. So far my wife and I have paid over $37,000 in premiums. If we lose that investment because we can't afford our premium anymore, it's like a bad investment. If the Department would allow further rate increases, there might be the possibility that it could done conditionally such that the policyholders who have not claimed any benefits have the option to cancel their policy and receive a full refund of their premiums paid. Thank you.

MS. FABIAN-MARKS:

Thank you for your comments. Now, Rae Shan Lin, would you like to speak?

MS. LIN:

Thank you, the Commissioner, for the opportunity to be here to speak. And I'm a consumer.

I have no link with any insurance company. I'm here just speaking for myself and my own policy. I subscribed to a long-term care insurance when I was in my 50s. And now I'm in my 60s. And I still expect to pay, hopefully, with God's blessing, for many, many more years to come.

Saying that, I was urged by my colleague who had a mother that had a fall and went to the hospital. After the hospitalization, her mother was deteriorated substantially that she was urged to go find a nursing home placement for her mother. And when she was looking for a nursing home, she said her mother actually had a very good pension and whatever --- her pension income plus Social Security income should have been able to pay for the nursing home care. However, none of the nursing homes that she had looked at that were appropriate for her mother would take her mother on unless her mother could put down a three-year cost, nursing home cost, escort money. And the reason for that, that's my speculation, at that time since I was --- first in my early career I was working in a nursing home. Then later on I became a nursing home --- quote, unquote, nursing home inspector. I was in Department of Health, health facility examiner. So I know about the cost of nursing homes, and I have some idea of the costs and the care.

And she said my mother could have afforded a good nursing home, but none of them will take me because my mother just does not have any of those cash reserves to put in the escort. And the reason for that escort was at that time the average nursing home stay from the time the elderly entered the nursing home until the time the elderly deceased --- the average at that time was two and a half years. So to prevent their nursing home resident from cover by Medicaid and receive the lower Medicaid reimbursement, that was what a reputable home, a well-run home, had to do to make sure there's enough escort money to make sure all their residents are in private payment. And therefore, my friend told me, look, if you don't have a long-term care insurance, you go get it now because if you have long-term care insurance, you would not have run into the problem my mother is having.

So I want to share this with all of you for your consideration. Now just this year in January, I got my 40-percent premium rate increase. Before when I was working, I could afford those increase because I was having an income. But now I'm retired. I'm having a fixed income. With this magnitude of the increase, my Social Security income plus my pension will not be able to keep up with the rate of this premium increase. So therefore, with this kind of rate increase, it's going to force me eventually to drop this long-term care insurance because now the insurance company has reached --- I heard the presentation earlier, mortality, morbidity and lapse rate will determine their premium. The insurance company has no control over mortality rate, has no control over morbidity rate. So the only thing they can control is lapse rate. So substantial increase of the premium is going to make the retired people unwillingly drop out of this insurance market. And that's unconscionable, and that's really a fraudulent practice. And thank you very much.

MS. FABIAN-MARKS:

Thank you for your comments. Now, Ray Landis, would you like to speak?

MR. LANDIS:

Thank you. And thank you for the opportunity. My name is Ray Landis. I am the advocacy manager for AARP in Pennsylvania and I represent our 1.8 million members in the state. I'd like to thank the consumers who have just testified and praise their courage for coming up and discussing their individual situations. And what they have just described is what we hear from members every day. Every week, I think I hear from an AARP member who has a complaint about the increasing premium of their long-term care insurance policy. And this is not a new situation. This is something that has been going on as one gentleman mentioned since 2006, 2005, 2004.

We have been hearing from consumers who did the right thing. And I can’t emphasize more, that these are consumers who took responsibility for their future long-term care costs by buying insurance policies in their 40s, in their 50s, when these insurance policies were affordable. Now 20, 30 years later, they are in situations as you just heard described, where the individuals are on fixed incomes. They are no longer earning their salaries. We saw a zero percent increase in Social Security cost of living increase last year. Yet these insurance products are requesting significant increases.

And I guess I should say at the outset, AARP urges the Commission to reject these premium increases in their entirety. Consumers cannot afford these increases in today’s economy.

I would like to associate myself with

the comments from the gentleman who mentioned the situation that these larger companies are in financially. They have chosen to isolate these long-term care insurance products in small pools where the products are showing great losses. But that does not take into account the larger net earnings of the corporation. And it seems to me that consumers should not bear the entire risk of the actuarial difficulties and problems that have been encountered by long-term care insurance. The companies should and their shareholders should bear an equal amount of the risks of the mistakes that were made in accounting for these policies and the current costs of these policies.

And Commissioner, I'm so pleased to hear that you are serving on a national task force to look at how long-term care insurance fits into the overall picture of long-term care. We have such a dilemma with long-term care as it is right now and how we will pay for it as a society.

I fear, however, that by approving these kinds of premium increases, it will drive more people out of the market that are in it right now, and it will discourage more and more people from buying policies that could address the rising costs and the rising costs in society of long-term care services and support. And if we see fewer people in the marketplace because of the costs, that is going to come back on all taxpayers with increasing utilization of Medicaid, something none of us that are involved in long-term care want to see. So I think that in conclusion I’d like to say that individuals who are now in their 70s and 80s on fixed incomes cannot afford these premium increases. And we’ve got to balance the risks to these individuals because we don’t want them to drop their policies that they have paid into for years and years.

You know, we heard talk about the value in long-term care insurance and how companies feel that consumers still feel there is a value in it. I would argue that these consumers see a value in the investment that they have made over the past 20 and 30 years. And that they are not --- even though they are scraping to afford the premiums they are not willing to give up the investment that they have made for many, many years because they did the right thing. Thank you.

MS. FABIAN-MARKS:

Thank you. Next, I’m not sure if I'm going to get this right, but Russ McDaid?

MR. MCDAID:

McDaid (corrects pronunciation).

MS. FABIAN-MARKS:

Oh. Sorry. Yes.

MR. MCDAID:

No. Not a problem. Good morning and thank you, Commissioner Miller and your senior executive team. My name is Russ McDaid. I am the president and chief executive officer of the Pennsylvania Healthcare Association. We're a statewide association representing both for profit and not for profit senior care and service providers from retirement communities, nursing facilities, assisted living providers. Many of the stories we've heard here today from both sides, quote, unquote, from the consumers and insurers, speak to the challenges that our members see each and every day.

And I wanted to share some of those with you here this morning and some recommendations that we have. I have written testimony which I will leave you with in the spirit of your two-minute rule. Also, I learned I'm a lefty so I might have less than two minutes in front of you. So I'm going to have keep this very brief before I need to tap into my own long-term care insurance policy.

You know, when you read through the

written testimony, you know, we talk about the challenges of the state and the federal financing, you know, the financing mechanisms we're facing right now with our boomers, with the significant number of people living longer and tapping into insurance. All the dynamics that we've heard here this morning. And as the president and CEO of a statewide long-term care association, I'm often asked should everyone have long-term care insurance or should I buy it?

And I tell them there's no way to answer. It depends on how much money you have. Financial advisors will tell you that if you're very low income, it might not make sense. You'll go onto Medicaid very quickly. If you're wealthy enough to afford your long-term care costs, it might not be a good investment for you. However, I think as we've heard here today most of us fall into that middle ground where it probably does make some sense.

And it's critical that we have viable long-term care products in the marketplace. Thirty-five (35) percent of individuals believe they'll need long-term care in their lifetimes, age 65 and older. The real number is actually 70 percent of people 65 and older will need some type of long-term care over their lifetime. Of those, 15 percent are, based on projections, guaranteed to spend some time in a nursing facility of up to one year. That might not be an extended one-year stay, it's cumulative. But the point is, as we live longer, while we're staying healthier longer, as there are more 90-year-olds, 95-year-olds and 100-year-olds among us, it's important that we have the ability to pay for that care and services. The state Medicaid program and the federal Medicare program simply can't sustain the burden that our aging population is placing on us.

I have several recommendations in my testimony which you have in writing. I want to go over a few of them as I close. The first would be, and you've heard it from several individuals here, some type of tax credit whether it's above the line or not for the purchase of private long-term care insurance. We feel very strongly --- we've seen the impact and our state policymakers who are here with us today know the impact of asking the Medicaid program at the state level and the Medicare program at the federal level to be all things to all people. It simply can't bear that burden. We have to have a robust individual marketplace. And it's kind of a Catch-22. The marketplace has to come to all of you for the type of rate increases they're asking for because it’s not as robust as it might be, but it will never be as robust as it needs to be until we make it more affordable and fix some of those fundamental flaws in the insurance market. We think the tax credit is a piece that could do that.

Alternatively, Pennsylvania could pass legislation that would allow individuals to access their life insurance if they have a residual value in some type of a whole life policy to pay for their long-term care. Some type of an accelerated death benefit. A similar concept would to be look at passing legislation that would allow people to engage more easily in reverse mortgages and manage that and tap the equity in their homes. And, you know, finally, as I would like to raise --- I mean, many here have noted that there are a lot of challenges and there’s got to be some type of personal accountability and some type of private side solution to this.

I was pleased to hear that you, Commissioner, are on a NAIC commission looking at innovative ways because we believe that we need to do that. It’s going to take a combination of things, a robust private insurance market, people tapping into their own individual equity with some type of Government backstop on a subsidized catastrophic type of benefit and the political will to hold consumers accountable for accessing their own equity.

Theoretically, the Medicaid program is that Government catastrophic backstop except all too often it's not a catastrophic backstop at all, it's the payer first resort based on the cottage industry that people use to protect assets instead of engaging in personal responsibility and those type of things. So we applaud you for your work. It's been my pleasure to be here sharing these issues with you today. PHA appreciates your commitment to this issue. As you go through your NAIC work, if you ever the input providers themselves, we'd more than happy to step into the room with you all and give you our thoughts and the challenges that we see on a daily basis. And I look forward to working with all of you for solutions. Thank you.

MS. FABIAN-MARKS:

Thank you. The last person on our list is Lance Haver so you can come up. And then after that if there's anyone else in the audience who would like to speak I'll check in and ask if there's anyone else who wants to come up before we close.

MR. HAVER:

Using the standards that you've outlined today none of the companies deserve a rate increase. None. Let me be very clear. I had a very difficult personal situation ten years ago. My economic situation wasn’t as good as I projected. My healthcare costs were much higher than what I projected. And I petitioned the Insurance Commissioner five years ago to lower my car and homeowners' insurance by 59 percent because I made bad projections. The Insurance Commissioner said, no, I’m not entitled. It’s my mistake, as this gentleman just said. I have a personal responsibility. I accept that. But then I expect you to hold these insurance companies to the same standard.

They made the bad projections. They made the bad promises. They were the ones who told us how important these policies were for us and that we should keep them. And they said that again today, and then they say because we listened to them they have to raise our rates. It is unfair. The set criteria you use is, are these companies financially solid? So I have brought you evidence because it doesn’t appear that you’ve done your own due diligence or you would have asked them these questions when you had the chance.

Met Life. Met Life announces first

quarter 2016 preferred stock dividend action. They are paying a dividend of over 25 cents a share for a single quarter. That is not a company that is in financial stress. John Hancock, which didn't announce that it's now owned by Manual Life. John Hancock is not stressed. Manual Life, the owner of John Hancock, reports third quarter 15-percent core earnings of $870 million and claims it has a strong top line growth and continued to have positive net flows in its wealth and asset management business. It, again, is not stressed. Unum, Unum in its press release, writes reported net income of $226.1 million, 93 cents a share for the fourth quarter of 2015 alone. It is not stressed. All of their claims that they are stressed are outright fabrications with the exception of Genworth, which I'll get to in a second.

All of these companies have purposefully used long-term care as a loss leader item to get people to buy other products from them. And then when they have an opportunity to say they need a rate increase they separate it. Genworth, on the other hand, has had a dismal economic record in the last two years. But I notice you didn't ask them what they have done to keep their costs down. So I ask, what's the top CEO who was here today, what's he paid a year?

MS. FABIAN-MARKS:

That’s not information I have.

MR. HAVER:

Why don’t you have that?

MS. FABIAN-MARKS:

We evaluate rating increases as I described by looking at that loss ratio which is the premium to benefit. That’s our regulatory authority to evaluate.

MR. HAVER:

I want to express to you, you said that you also considered consumers’ needs. Is there a consumer ratio? Is there a ratio that’s too much for me to pay that you decide you can’t raise rates because the amount that I have to pay for insurance is too high a ratio? Or is the ratio only there to protect the insurance companies?

MS. FABIAN-MARKS:

We certainly do consider consumers. We often approve rates that are below what the companies have asked for.

MR. HAVER:

What is the ratio for a consumer?

MS. FABIAN-MARKS:

We only have authority to consider the

ratio in law.

MR. HAVER:

What's the projected ratio for a consumer?

MS. FABIAN-MARKS:

Again, we have to refer to our regulatory authority and I ---.

MR. HAVER:

And by the way, was there a reason why so many of the insurance industry were calling you by your first names? Are we to infer that you have private conversations with them?

MS. FABIAN-MARKS:

We discuss their solvency and their rate increases with them, yes.

MR. HAVER:

So you have private conversations that the public is not allowed to know what's being discussed?

MS. FABIAN-MARKS:

No. We want to conduct our business in a transparent manner. That's why we're having this hearing. That's why we make the filings public.

MR. HAVER:

So again, I asked earlier and I was told

I would have time. These letters that you send to each one of the insurance companies, can I get a copy of those letters?

MS. FABIAN-MARKS:

That's ---.

MR. LAVERTY:

You can access them via surf after the filing is approved.

MR. HAVER:

That doesn't help me. I want to know before a decision is made so I can have my opinion listened to. You're obviously listening to their opinion. Why doesn't my opinion count as much as theirs?

COMMISSIONER:

That's why we're here.

MR. HAVER:

But you have private conversations with them. They have private answers to you that I can't see. So how could I possibly comment on those?

MS. FABIAN-MARKS:

The initial filings do contain the bulk of the information, and we do make those public. We can discuss other opportunities or ways that we could make our correspondence more transparent.

MR. HAVER:

I want it to be part of the record that I am asking now for every single letter that you have sent in these rate requests and every single answer that they have given.

MS. FABIAN-MARKS:

Thank you. We note that request.

MR. HAVER:

I'd like to now cross examine the witness for Genworth, please.

MS. FABIAN-MARKS:

I am sorry. That is not how this hearing is structured. This is simply an opportunity for multiple parties to give their testimony. It's not meant as a Q and A process.

MR. HAVER:

Under the Administrative Law and Procedure, Section 505, evidence and cross examination. Commonwealth agencies, which you are, shall not be bound by technical rules of evidence at agency hearings, which this is. And all relative evidence of reasonably probative value may be received. Reasonable examination and cross examination shall be permitted.

MS. FABIAN-MARKS:

I believe Sandy, our health insurance counsel, will answer.

ATTORNEY YKEMA:

Well, then allow me to comment on that. My name is Sandy Ykema. I am the counsel for the Department. This hearing is not a hearing subject to the Administrative Code. It is rather a public comment period subject to Title 40, PS 3801.310. This is not an opportunity for cross examination.

MR. HAVER:

So when the Department sends me an email saying it's going to be a hearing, is that incorrect information? Is the Department misleading me?

ATTORNEY YKEMA:

Sir, it is an informational hearing. It is not an administrative hearing subject to the general rules for administrative proceedings.

MR. HAVER:

I sat through the slideshow presentation, the PowerPoint. It didn't say that. Again, was I being purposefully misled that this was a public hearing?

ATTORNEY YKEMA:

A public hearing does not mean that is subject to the administrative rules.

MR. HAVER:

What does it mean?

ATTORNEY YKEMA:

We appreciate your comments.

MR. HAVER:

You may appreciate my comments, but I'm not finished. What does it mean?

ATTORNEY YKEMA:

Sir, it is a public comment period under 40 PS 3081.310. Thank you.

SECURITY:

Let's go. Come on, sir.

MR. HAVER:

I'm not done.

SECURITY:

Let's go.

MR. HAVER:

I'm not done.

SECURITY:

Your turn is done. Your turn's done.

MR. HAVER:

Who said my time is done?

SECURITY:

Sir. Let's go.

MR. HAVER:

I'm not done.

SECURITY:

Let's go. She told you you're done. Let's go.

MR. HAVER:

She's not in charge of the hearing.

SECURITY:

Sir, leave or I'm going to have to remove you.

MR. HAVER:

Why am I being removed?

SECURITY:

Sir. It's time to go.

MR. HAVER:

I have questions.

SECURITY:

Your time is up. It's time to go.

MR. HAVER:

Why can't I ask questions?

MR. BUONO:

Mr. Haver, you may stay with us. The one thing that I do request is that we have all been participating in this hearing in a way that we can communicate with everybody. What we're hoping for is that you could respect the individuals that have taken the time to be here. And we will be happy to continue to consider the information that you provided. Is that fair?

MR. HAVER:

It's fair. Are there any consumers here who are opposing what I'm saying? Not people who work for the industry. Are there any consumers who want me to stop? Because I will.

Hearing none, I want to second the request that whenever a rate increase is asked for that the insurance companies do exactly what every utility company does, which is put a bill stuffer in and tell people that these hearings are happening. Notifying people after the fact is horrendous public behavior. How can anybody participate if they don't know the hearing is taking place?

And if you believe that people read the Pennsylvania Bulletin you don't belong in a public role. People do not read the Pennsylvania Bulletin. Regular people do not get it every week. Every insurance company should do what the phone company does, what the electric company does, what the water departments do. Send the notice in the bill. We're asking for a rate increase. If you want to be heard, come to the hearing.

I've brought with me comments from people from Philadelphia who were unable to attend. I'm just going to read the top one.

Dear State Insurance Commissioner, I urge you to block the proposed rate increase for long-term care insurance policies. I am a 73-year-old, widowed and living in a one bedroom apartment in Center City, Philadelphia. I purchased a long-term healthcare policy with John Hancock in 2003. The monthly fees are already high. The costs of care here in Philadelphia are also expensive, but my sole safety net. If monthly costs for my policy increases, I fear not being able to pay the given cost. What then for hundreds of thousands in the same predicament? The fear of this is unbearable and the shock, affecting me physically and emotionally, my wellbeing. The cost to individuals in my category is unacceptable and inconvenient. I urge you not to permit, to block and rebuff this effort.

I've given you a list. Part of the difficulties with the long-term care product is it often offers a payment at a time when people are struggling cognitively. The Friends Life Care model is an HMO model, it's not being discussed. It should be discussed.

You should be asking, again, Genworth who claims that it has financial difficulties to explain what it means when it says --- and I’m going to again leave this as evidence --- when it says as its strategy and priorities that it’s going to maximize our mortgage insurance opportunities and restructure U.S. life insurance to rebuild shareholder value. U.S. life insurance restructuring plan is to separate and isolate long-term care business. Are they getting ready, declaring solvency? Are you just taking more money out of consumers' pockets so that they can raise their price share, because that is, in fact, what they say?

What Genworth says is the reason why they need the rate increase is so that they can build up their stockholder value, quote, we are seeking to rebuild stockholder value through the following key initiatives, cost and portfolio rationalizing. We are embarking on a multi-step restructuring plan targeting cash savings in excess of $100 million, which means they have a reserve already. In addition, we are evaluating potential changes to our portfolio business that will, we believe, improve our ability to reduce debt levies, increase capital buffers and improve earnings and return on equity.

If what you're looking is forcing consumers who were tricked into buying these policies at a much lower rate, and now are facing rate increases because the company's experts made bad decisions, you have to do one of three things. You have to allow me to get a reduction in my homeowners' and car insurance because I had bad projections. Two, you have to deny the rate increase completely. Or three, you have to give every ratepayer equity in the company through a stock option. It is unconscionable to tell these people, to tell me that I have to pay more so that their stock price can go up. You are forcing me to be an equity investor.

MS. FABIAN-MARKS:

I'm sorry to interrupt. We are over our time so if you would be able to wrap up?

MR. HAVER:

I will wrap up, but I would point out that you gave every one of the insurance companies ten minutes and you've given consumers two minutes. I don't know how less fair you could possibly be. Why is it, again, what they want is so much more important than what the public wants?

MS. FABIAN-MARKS:

I think in the end we did end up giving

up many consumers closer to ten minutes to comment. And we certainly value the input.

MR. HAVER:

Then what you should do is force the insurance companies to put up money so the consumers can hire their own public advocate to participate in these rate proceedings. If a utility asks for a rate increase, there's a public advocate to represent consumers. Telephone, landline telephone, which is much less important than health insurance, car insurance, homeowners' insurance or long-term care insurance, has a full adversarial hearing.

Here you won't even let me ask what their salaries are. You will not let me ask about their overhead. You won't let me ask what have they done to lower their overhead costs? Those are your decisions, not the law. You are saying you will not let me ask those questions.

The process is unfair because you have made it unfair. People are suffering because you are choosing to ignore their needs, and that is wrong. Thank you.

MS. FABIAN-MARKS:

Thank you. We appreciate your comments and the passion with which you are representing consumers.

MR. HAVER:

I don't want your appreciation. What I want you to do is change. I want you to do what is right. I don't care what you think about me. What I care is how are people treated. And what you personally, not some amorphous government, what you're personally doing is wrong. It's that simple. It's wrong.

MS. FABIAN-MARKS:

Thank you. Is there anyone else who would like to speak here in Harrisburg? Yes? Please come up.

MR. BRIAN SHEPARD:

Good afternoon. My name is Brian Shepard, and I have been affiliated in the long-term care industry for 17 years as well. And I've been employed by Genworth for a period of that time. When I heard about the hearing, I was compelled to reflect on some of the policyholders that I was privileged to serve. And the first person that came to mind is Ms. Foley. She wants me to call her Jean.

So Jean and Tom, I had the privilege to meet with back in 2001. And we had great conversation. Ultimately they decided that a long-term care policy would be the roadmap, the playbook for which they could help the impact of a long-term care need on their family and finances. So I want Jean to speak her mind as to what long-term care insurance met to her. And that’s why I brought her here today.

MRS. FOLEY:

My husband’s mother passed away with Alzheimer’s. When we discovered that we could get long-time insurance, even though she had passed away, we felt that it was a very good idea. My husband now is starting dementia. Well, he’s in the middle stages. And we will probably have to use this policy in the near future. However, I have Genworth, and I have not had any policy increases until the last two years. And I just feel that the payments are getting to point where they’re going to be too high.

He might be all right for five years or seven years or ten years because it’s just so slow. But the percentage of Alzheimer’s is growing so much that people are not going to be able to afford the insurance for people who know that that could be possibly in their situation within the next 10, 15 years. And then these people are going to end up going to Medicaid, and then the people who pay for the

Medicaid are people who pay taxes.

So it is just --- if you're going to increase these payments, then people aren't going to be able to afford it and then the state is going to have to get money from the taxpayers to pay for the Medicaid. With the increase of Alzheimer's, I just think you need to find a way to decrease these payments so that the other person who doesn't have this situation has to pay all that money.

MS. FABIAN-MARKS:

Thank you.

MR. BRIAN SHEPARD:

I'll just leave you with reiterating around tax credits. Certainly the State of Pennsylvania is on the hook for the last payer, I.E. Medicaid. And it's the single largest line item on the budget. What about being a partner on the front because the liability is on the insurance company and the insureds? How about participating as a partner to reduce and help subsidize these rate increases that are imminent or existing now with some sort of a significant tax credit such as New York or even better where that can help reduce those rate increases as well? Thank you.

MS. FABIAN-MARKS:

Thank you. Is there anyone else in the audience who would like to speak?

Okay. With that, I think we've heard from everyone who came to speak and we can wrap up. Commissioner Miller? Oh.

MR. HAVER:

When is the record closing for today's public hearing?

MS. FABIAN-MARKS:

I don't have the dates in front of me. It's in April and May is when our 45-day review period expires. It varies for each of the rate increases. They came in at different times. But as I mentioned, if necessary we can extend that period of review.

MR. HAVER:

Will there be a written decision for each case?

MS. FABIAN-MARKS:

That's something that we're thinking about starting to institute. We haven't done that in the past, but we are thinking about doing that for these in going forward.

MR. HAVER:

I'm sorry. Is that a no or yes?

MS. FABIAN-MARKS:

It's something we're considering.

MR. HAVER:

Then it's no.

MS. FABIAN-MARKS:

It does not mean no.

COMMISSIONER:

So I just want to thank everyone for coming to this hearing. The Governor believes, as I do, in transparency in government, which is why we had this hearing. I don't think the state has had a hearing on a long-term care insurance filing in the past, that I am aware of at least. But it's really important to us to hear from consumers.

We know the impact these increases have on consumers and wanted to give consumers the opportunity to really participate in this process through this hearing. And we are working very hard to try to make our processes more transparent, which is again why we're here. We made lots of changes to our health insurance rate review process last year, and I think we'll continue to look for opportunities to improve our long-term care insurance rate review process as we're looking for opportunities, frankly, to be more transparent about the way we operate generally.

This has not historically been the way the Department has operated. So we're breaking new ground here. So we're not going to get there overnight, but we're certainly going to make any effort we can to keep this process as transparent as possible.

And again, I really appreciate everyone taking the time to be here. Thank you to the companies for making this work for your schedule and being here to talk about why you're coming in with some of these significant increases. And thank you very much to all the consumers who took the time to be here to share your thoughts about how these proposed increases will have an impact on you. So thank you very much.

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HEARING CONCLUDED AT 12:12 P.M.

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CERTIFICATE

I hereby certify that the foregoing proceedings, hearing held before Commissioner Miller was reported by me on 3/10/16 and that I, Seth R. Baier, read this transcript, and that I attest that this transcript is a true and accurate record of the proceeding.

Court Reporter
Seth R. Baier