CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

TESTIMONY of CALIFORNIA HEALTH ADVOCATES

Gambling on Consumer Ignorance: Comprehensive Consumer Protections and Regulatory Scrutiny Are Required To Protect Purchasers of Long-Term Care Insurance Products

Senate Special Committee on Aging Hearing
Private Insurance and Long-Term Care
Hart Senate Office Building, Room 216
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INTRODUCTION

California Health Advocates (CHA) is an independent, non-profit organization dedicated to education and advocacy efforts on behalf of California's Medicare beneficiaries. We provide support, including technical assistance and training, to the network of California's Health Insurance Counseling and Advocacy Programs (HICAP). HICAP is California's federally funded State Health Insurance Assistance Program (SHIP) that assists California's Medicare beneficiaries and their families. CHA also provides statewide technical training and support to social and legal services agencies and other professionals helping Californians with questions about Medicare, Medigap, and long-term care. Our experience with many health and insurance related issues is based in large part on our close work with the HICAPs and other consumer assistance programs that are on the front line assisting older consumers and their families.

In 1992 I served on the Consumer Standards Working Group, the founding committee for developing the Partnership for Long-Term Care in California.[1] I also served as a funded consumer representative to the National Association of Insurance Commissioners (NAIC) from 1991 to 2006 where I successfully advocated for many of the consumer protections added to the NAIC Model Act and Regulation for Long-Term Care Insurance, some of which reflect specific protections in California law. I have testified before Congress on consumer issues pertaining to long-term care insurance beginning in the late 1980s, and most recently before the House Energy and Commerce Subcommittee on Oversight and Investigations on July 24, 2008, on long-term care insurance premium increases and denied claims.

[1] The authorizing legislation for the California Partnership for Long-Term Care established the Long-Term Care Task Force, an inter-agency workgroup of staff from the state agencies that had responsibilities for implementing the Partnership to oversee the design and implementation of the demonstration. In April 1992, the Long-Term Care Task Force established the Consumer Standards Working Group to develop advisory recommendations regarding the product, and consumer standards that should apply to all insurance policies approved by the Partnership.

Thank you for the opportunity to comment at today's hearing. We appreciate the committee's interest in protecting purchasers and increasing the quality of long-term care insurance products.

I. Long-Term Care and Health Care Reform

Long-term care is unpredictable. Few people can predict what condition will trigger a need for care decades later, the range or intensity of services they may need, or, whether institutional care will be required because of the severity of their condition. Planning for long-term care is complicated because of the unpredictable fact of whether it will ever be needed, and the wide array of potential services included in long-term care. Institutional care, and home and community based care is often used in combination with acute care services and ongoing medical care. Some long-term care services are provided through public programs with differing eligibility requirements, and some services are privately paid requiring large monthly payments.

Long-term care is expensive. It is the primary cause of catastrophic out-of-pocket spending, often leading to personal impoverishment and subsequent reliance on state Medicaid programs.[2] Middle-income people with modest amounts of assets have the greatest risk of future financial impoverishment when faced with the high cost of Alzheimer's disease or other conditions that may require years of care.[3] In 2008, the national average cost of nursing home care was $69,715 annually, while assisted living care averaged $36,372 annually.[4] These are costs that few families can afford.

Long-term care services are fragmented and uncoordinated. When people require long-term care services, they and their family members are met with a fragmented system of care facilities, community services, and providers. No roadmap exists to easily connect people with the services they need; no coordinated system helps arrange and monitor their care, or evaluate and adjust services when care needs change. Such coordination of care only exists if a family has the means to hire a geriatric care manager,[5] and one is available in their community. Each family must patch together their own set of services based on whatever information they have or are able to find in their own community, or the community of their family member.

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[2] "About $193 billion was spent nationwide on long-term care services in 2004, including nursing home care and other assisted-living services. Most of this care was financed by government programs, primarily Medicaid……." Government Accountability Office 6/30/08 letter to Congressional requesters, "Long-Term Care Insurance: Oversight of Rate Setting and Claims Settlement Practices," GAO-08-712.

[3] Miners, Mark, PhD, George Mason University, "Medicaid Eligibility Issues for Long-Term Care Partnership Programs," Issue Brief for Centers for Health Care Strategies, Inc., March 2008.

[4] The MetLife Market Survey of Nursing Home and Assisted Living Costs, October 2008, http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-studies-2008-nhal-costs.pdf.

[5] Geriatric care management is generally defined as a service that assesses an individual's medical and social service needs, and then coordinates assistance from paid service providers and unpaid help from family and friends to enable persons with disabilities to live with as much independence as possible, live in one's home with assistance, or to assess other living arrangements such as supportive housing or assisted living facilities. See the National Association of Professional Geriatric Care Managers website: http://www.caremanager.org.

Long-term care is part of health care reform. As Congress wrestles with health care reform legislators should focus on creating an integrated and coordinated system of care and services, both medical and non-medical, which families can easily access in their local communities. Services should be easy to find, arrange, and monitor. Geriatric care management and coordination should be an integral part of long-term care services to allow older Americans to live as independently as possible in the least restrictive environment. Elders and people with disabilities who need long-term care should have a seamless transition to long-term care services, coordination with medical care, and a support system to help them find and access the services best suited to their needs.

II. Financing Long-Term Care

Long-term care today is largely financed through private payment with people using their personal income and assets to pay for care, or purchasing insurance that will pay for care later. State Medicaid programs pay when people's income is insufficient to pay for care and their asset are mostly gone. Increasingly elders are being sold reverse mortgages, the proceeds of which can pay for care, or more recently, be used to finance the cost of a long-term care insurance policy. Others move into arrangements such as continuing care retirement communities that combine housing with a continuum of long-term care services they can use as needed.

Long-term care insurance products are sold to individuals, or to members of a group through an association or faith-based organization's sponsorship, or through the sponsorship of a private or public employer. The federal government created the Federal Long-Term Care Insurance Program (FLTCIP) for the federal family of employees, active duty military, retirees, and qualified family members in 2002, and many states also offer access to long-term care insurance to public employees. Few employers, including the federal government, pay any part of the premium for this type of insurance.

Some insurance products provide benefits only for long-term care, while others are sold as riders to life insurance, annuities, and disability policies. Life insurance policies and annuities are complex financial instruments on their own. Adding long-term care benefits to these products increases the complexity and makes them even more difficult to compare with each other, or with policies that only pay for long-term care.

Long-term care insurance was formerly sold only to people in their 60s and 70s, yet more recently it has been marketed and sold to younger people through the employer and association group market who will need to pay premiums for several decades to cover the cost of care in their later years.[6]

Amid concerns about increasing Medicaid payments for long-term care services and the growing numbers of people who exhaust their assets and turn to Medicaid for help, Congress enacted the Deficit Reduction Act (DRA).[7]

[6] The cost of long-term care insurance for working age people often competes with the cost of other necessary protections such as disability income, retirement savings, and life insurance.
[7] Deficit Reduction Act of 2005 (DRA), PL 109-171.

The DRA allows states to ignore assets above the Medicaid limit and waive estate recovery of certain assets when people buy long-term care insurance policies that meet federal requirements as part of a public–private Partnership program recently extended to all states by the DRA.[8] This arrangement is often referred to as "asset protection," a formal agreement between the state Medicaid program, the insurer issuing the policy, and the purchaser.

Long-term care insurance is an investment in the product, and in the company selling it. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, benefits have to be in place when care is needed and must cover a substantial amount of the cost. Making sure adequate consumer protections are in place will help ensure that policies live up to their promises. Whether a policy will perform as expected decades later depends on the quality of the product purchased, whether policy benefits keep up with inflation or lose value each year, whether the premiums consumers initially agreed to pay remain stable over several decades, and whether the individual still has those benefits decades later when care is needed.

III. Protecting Consumers

If consumers are to be adequately protected when buying long-term care insurance then members of Congress must enact the strongest protections possible. The National Association of Insurance Commissioners (NAIC) Model Act for Long-Term Care Insurance and Model Regulation to implement the Model Act serve as an advisory regulatory foundation for state laws and regulation.[9] Congress selected certain provisions of the NAIC Models to be national standards for tax-qualified policies in the Health Insurance Portability and Accountability Act (HIPAA),[10] and for Partnership policies authorized by the DRA.[11]

However, national standards for long term-care insurance products should not be based on a compilation of the lowest common denominator that can be reached by the NAIC, but on the strictest standards enacted by the individual states. The NAIC should be required to annually survey the states and incorporate into the Model Act and Regulation biannually any provisions adopted by other states that provide stronger or more meaningful standards and protections than the existing Model Act and Regulation provide.

For example, California, and perhaps other states as well, have enacted a number of standards and consumer protections that are not included in the NAIC Models and should be included in national standards for these products.

[8] PL 109-171. See Section 6021 that amends Section 1917(b) of the Social Security Act to provide for Qualified State Long-term care Insurance Partnership programs. See: http://www.dehpg.net/LTCPartnership/map.aspx.
[9] The NAIC adopted the first Model Act for Long-Term Care insurance in 1986 followed by the Model Regulation in 1987.
[10] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191).
[11] P. L.109-171.

A selection of requirements for every long-term care insurance contract in California:

- 6 required categories of services, such as personal care and homemaker services, in every home care benefit to ensure a comprehensive benefit, and consistency among products.[12]

- Nursing home benefits can't be limited to room and board charges only, and must include all long-term care services delivered in that setting. This rule ensures that policyholders can receive benefits for all appropriate services delivered in a nursing home.[13]

- Nursing home, assisted living, and home care benefits can't be separately limited by duration, such as 4 years of nursing home care with only 1 year of home care. This rules ensures that policyholders can receive benefits in the setting of their choice.[14]

- Maximum policy benefits must be expressed in total dollar amounts, and must be interchangeable and available for all covered services (except those with express annual limits such as respite care) to ensure the greatest flexibility in receiving and paying for care.[15]

- Benefits must begin for all covered services when a person is unable to do 2 of 6 Activities of Daily Living (ADLs) or has cognitive impairment, to ensure that consumers are not restricted to one kind of care and can choose the most appropriate place to their receive care.[16]

- Assisted living benefits must be no less than 70 percent of a nursing home benefit and must be paid in any licensed facility in California. Companies must use a verbatim definition for such facilities outside the state. These requirements ensure that benefits will be paid in every place that is licensed to provide assisted living care in California, and increases the likelihood of payment outside the state.[17,18]

- Ancillary benefits such as home modification with a known market value must be at least 5 times the daily benefit to prevent the inclusion of illusory benefits in long-term care insurance contracts.[19]

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[12] California Insurance Code §10232.9.
[13] California Insurance Code §10232.95.
[14] California Insurance Code §10232.93.
[15] California Insurance Code §10232.93.
[16] California Insurance Code §101232.8, §10232.92, and §10232.97.
[17] California Insurance Code §10232.92.
[18] State regulation of assisted living facilities varies across the country and there is no consistent definition of these places of care to ensure that assisted living benefits will be paid in any facility advertising or providing these services.
[19] California Insurance Code §10233.2(f).

A selection of consumer protections required in California:

- Every Outline of Coverage for long-term care insurance must include a notice of the availability of HICAP[20] services and their toll-free number to ensure that consumers have independent, unbiased assistance in choosing benefits and coverage.[21]

- Agents have a statutory duty of honesty, good faith, and fair dealing to ensure that consumers are treated honestly and fairly.[22]

- Agents must complete 8 hours of training specific to long-term care before marketing or selling long-term care insurance, and must complete an additional 8 hours of long-term care insurance training during each 2-year licensing period thereafter. Agents selling Partnership policies must have a separate 8-hour training specific to the Partnership in a live classroom setting, and an additional 8 hours in a live classroom setting during each 2-year licensing period.[23] Adequate training is necessary to ensure agents fully understand long-term care and the connection between a commercial insurance product and the state's Medicaid program.[24]

Incorporating these standards, along with those required in other states, into the NAIC Model Regulation would increase the quality of products and consumer protections across the country. However, there are many other issues that have neither been addressed by states nor by the NAIC. One example is the illusory nature of an "alternate plan of care" benefit that purports to be adaptable to future care needs.

This benefit promises that when care is needed the company may consider paying benefits in an "alternative setting" (which isn't clearly defined), or for benefits not covered under the policy. Yet exercising this option is completely at the discretion of the company, which, as shown by at least one company in the example below, may make this benefit illusory.

Example of a failure to provide alternate care or services:

> Mr. and Mrs. M replaced their existing AMEX long-term care policies in 1988 with 2 new policies from Continental Casualty Company specifically because the new policies included a benefit for an alternative plan of care in addition to benefits for nursing home care. These 2 highly educated elders believed the benefit described in the new policy was superior to their existing policies, and would allow them the flexibility to receive benefits in whatever setting best met their needs, an impression reinforced by the policy language and the agent who sold them the policy.

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[20] California's Health Insurance Counseling and Advocacy Programs (HICAP) is California's federally funded State Health Insurance Assistance Program (SHIP).
[21] California Insurance Code §10233.5h(13).
[22] California Insurance Code §10234.8.
[23] California Insurance Code §10234.93a(4); Cal. Code Regs., tit. 22, §58056.
[24] Both the California Department of Insurance and the Partnership program design a training outline and approve the courses and trainers who teach those courses.

> Eighty-nine year old Mr. M recently needed assistance in caring for his wife who has dementia, and filed a claim for the policy's long-term care benefits. The claim was denied with the explanation that benefits would only be paid when Mrs. M, now 86 years old, is confined to a nursing home.
>
> Mr. and Mrs. M have paid approximately $98,000 in premiums for their 2 policies since 1988 and will apparently receive no benefits unless they each enter a nursing home, regardless of the alternate plan of care promise made to them.[25] In the meantime, Mr. M continues trying to provide care for his wife at home, adamantly refusing to send her away to a nursing home. Recently, a lawsuit was filed by a private attorney on their behalf to force the company to live up to its promise. A previous lawsuit against the company on the same issue was resolved with a confidential settlement.

The NAIC Model should address vague promises of future benefit adaptation to ensure that consumers will have coverage when they need it, and coverage that adapts to the evolving environment of long-term care services.

IV. Premium Stability

When consumers buy an insurance product to pay for prospective care years or even decades later they are buying a promise of benefits in an uncertain future. Long-term care insurance is expensive because the cost of care is high and many people need it late in life, and often for long periods of time.

Insurance to cover these costs is pre-funded by collecting enough premiums in the early years to build adequate reserves for claims in later years, although none of the built up cash reserves in these policies are available to the policyholder unless they purchased a specific additional and expensive nonforfeiture benefit.[26] When this type of insurance is not properly priced, with less premium collected than needed to build appropriate reserves, policyholders will inevitably pay the bill later with large, and often multiple premium increases. When the deficit between claims and reserves grows too large and a company becomes financially unstable, the state insurance department where the company is located may be forced to seize it and take it under state supervision. This was recently the case with Penn Treaty Network America Insurance Company in Pennsylvania.[27]

During the 1990s long-term care insurance was seen as a growth product with more than 100 companies competing for the attention of consumers who were healthy enough to qualify for coverage, and wealthy enough to pay for it. Companies often competed for consumers on price and features, while competing for brokers and agents by offering high commissions, expedited underwriting, and quick issuance.

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[25] California law has no specific requirements related to an alternate plan of care, and the California insurance Commissioner has no authority to order a company to pay a disputed claim.

[26] Life insurance presents a similar pattern of low losses in the early years and higher losses later. To compensate "whole life," life insurance products build an internal cash value over time that can be taken out in the form of a loan or taken in cash when lapsing the policy.

[27] See, e.g.: http://www.ins.state.pa.us/ins/cwp/view.asp?a=1285&q=549650.

Some companies may have under-priced their policies knowing they could rely on increasing premiums later if their losses exceeded a statutory limit. A 2008 report by the GAO noted that some state regulators confirmed that mistakes in pricing older policies have played a significant role in rate increases that have occurred in those policies.[28]

When establishing the price of a long-term care policy, companies make assumptions about a number of factors, including: the number of claims that will be filed and when; the duration and cost of those claims; how many people will drop their policies due to death or other reasons; and the amount of interest the company will earn on collected premiums. The true cost of claims develops over many years, after policies are sold. Pricing assumptions require careful analysis by a qualified actuary of a state insurance department to ensure that policies are fairly priced, and that consumers will not be subjected to increases that may price them out of their coverage later due to unrealistic assumptions in any category.

In most states companies are permitted to seek a rate increase when projected claims costs are expected to reach more than 60 percent of the premiums collected over the life of the policy form, unless a policy was issued in a state after the effective date the state changed its law or regulation. Under-pricing sometimes takes 10 to 15 years to become apparent, but can have profound consequences for consumers who are often in their 70s and 80s when rate increases are applied, leaving them with few good options. In most cases these elders have paid substantial amounts of premiums over many years.

Two of the most aggressive retailers of long-term care insurance during the 1990s have each sought enormous rate increases; in 2007 Penn Treaty Network America filed for a 73 percent rate increase in Indiana, and various amounts in other states, and Conseco Senior Health filed for a nationwide 40 percent increase this year. Neither request was the first time these companies have imposed rate increases. The 2 cases below illustrate dramatic increases compared to the initial premiums these elders agreed to pay.

- Mr. and Mrs. B each bought a nursing home only policy from Penn Treaty in 1998. Mrs. B, then age 65, bought coverage for 4 years with a $110 daily nursing home benefit and 5 percent compounded inflation protection. Mr. B, then age 69, bought the same coverage for 2 years. In 2009 they both received notices of a rate increase.
    - Mrs. B's premium jumped **from $1,570** annually **to $3,020** at her current age of 76 years. She has paid $17,903 during the last 11 years.
    - Mr. B's premium jumped **from $1874** annually **to $4,050** at his current age of 80 years. He has paid $30,744 during the last 11 years.
- Mrs. C, age 80, received a letter from Penn Treaty on March 7, 2009 notifying her of a 21 percent increase and a new monthly premium of $512.55.

[28] Government Accountability Office, Long-Term Care Insurance: Oversight of Rate Setting and Claims Settlement Practices, GAO-08-712.

The letter noted that the company had requested a *53 percent increase*, and that they would be filing an additional request for the difference between the 21 percent approved by the state insurance department and the 53 percent they had originally requested. On April 23, 2009 Mrs. C received yet another letter notifying her of another rate increase and a new monthly premium of $621.12.

- Her annual premium is **now $7,453.56**, an astonishing amount for the policy she purchased in 1998, just 11 years ago. She has paid $47,309 in premiums during the last 11 years.

These policyholders each had the right to lapse their policy and retain the premiums they had paid in future paid-up benefits, known as "contingent benefit on lapse," or CBoL. However, each of them chose to reduce their policy benefits instead, in return for a lower premium increase. That decision may actually leave them with less benefits in the future than if they had taken CBoL since they have agreed to a reduced amount of coverage. For instance, if they agreed to a reduction in the daily benefit amount, the reduced daily benefit amount would be the benefit available to them for each day of paid-up coverage if they are ever able to exercise CBoL in the future, and not the amount they originally purchased.

Conversely, rate increases and contingent benefit on lapse may actually benefit companies more than consumers if it ultimately reduces the number of insured persons and the company's exposure to future claims.[29] And, if it forces policyholders with lifetime or unlimited benefits to reduce their coverage to a specific number of years, it also limits a company's claims exposure to a reduced number of years.

Although the NAIC adopted initial rate stability in Section 10 of the Model, and premium increase restrictions in Section 20, only half the states have adopted these requirements, and only policies issued in a state after the effective date of that change are required to comply with them. California adopted a similar requirement in 2000, but added some additional requirements:

Initial rate filings and requests for rate increases in California:

- Rate filings submitted to the department must be reviewed by a qualified actuary with no less than 5 years experience in pricing long-term care insurance[30]

- If an issuer requests a rate increase greater than 15 percent on a policy form approved under the new law, it must pool all its long-term care business before calculating the need for a premium increase[31]

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[29] The Bankers Life unit is reporting an $11 million increase in earnings from the long-term care block as a result of "the release of liabilities for insurance products on lapsed policies and policy owner benefit reductions following recent rate increases, partially offset by an increase in incurred claims." See article by NU ONLINE NEWS SERVICE published 5/15/2009. Accessed on 5/19/09 at http://www.lifeandhealthinsurancenews.com/news/2009/5/Pages/Earnings-Conseco-NFP-Others.aspx

[30] California Insurance Code §10236.11(a) and §10236.12.

[31] California Insurance Code §10236.14(d).

It will take years to prove whether or not the NAIC rate stability requirements will stabilize long-term care insurance premiums despite moderately adverse conditions. However, the Closed Block Sub-group of the NAIC Accident and Health Working Group is conducting a state survey to collect rate increase data both before and, if applicable, after the effective date of rate stabilization in a state. The survey information collected may prove helpful in understanding whether further work is needed on rate stability.

V. Making Premiums Cheaper In The Group Market

Long-term care insurance can be purchased in the individual market or through the group market, which includes large and small employers, public and private employers, and association groups and faith-based organizations. Large employers may pay some of the premium and allow every active employee to enroll without health underwriting. A small employer may only sponsor coverage that is sold to its employees with or without medical underwriting and with or without paying any part of the premium. Association or faith-based groups may sponsor or offer long-term care coverage to their members. The policies sold in the group market may have been approved in the state where they are being sold, or approved in another state where the group is headquartered and the master policy is issued.

Competition, and ultimately market share, for the long-term care insurance industry is often based more on the cost of a premium than actual benefits. Convinced that the price of long-term care insurance policies must be lowered to entice consumers to buy it, companies have begun offering stripped down, less expensive coverage in the group market that also includes modifications made to traditional benefits. In some cases small employers may employ an executive carve-out to provide Cadillac coverage to owners, while offering stripped down base policies to employees who can, if they choose, add additional benefits at extra cost.

These pricing strategies allow insurers to offer long-term care insurance as an additional benefit to employees or group members at very little cost. Policies sold in the group market may also provide insurers with the lapse rates they were unable to achieve in the individual market since working age people are less likely to keep these policies throughout their working lives and into their 80's when benefits are most likely to be used. Some benefit modifications in the group products have migrated to the individual market allowing companies to offer policies at lower premium cost.

Younger policyholders often have little knowledge of long-term care services. Employees or members are often offered the opportunity to upgrade their base policy by adding missing features such as inflation protection, but may not understand the significance of those missing features or be willing to pay the higher cost of adding them to their policy. Some examples of modified benefits are listed below:

- Offering the right to purchase inflation protection at a later date, and at an additional premium cost based on the current age of the policyholder at the time the additional benefit is added.

This future purchase option (FPO), selected by 72 percent of group purchasers,[32] is a thinly disguised effort to push the cost of inflation protection into the future, and simply provides guaranteed insurability for the future purchase of this benefit at attained age rates. In addition, an FPO is a limited option that can only be rejected a few times before the offer expires. Buying built-in inflation protection at the time of purchase would add 100 percent to 300 percent to the premium, an amount few working age people are willing to pay.[33] Yet, an FPO leaves consumers at risk for steadily building an unaffordable co-payment liability that will come due when they need care. Alarmingly, only 37 percent of FPO options extended in 2008 to people with group coverage were accepted.[34]

- Offering a policy that does not include a waiver of premium but instead the waiver is offered at extra premium cost. Without a premium waiver, a policyholder must still continue to pay an annual premium, whatever the cost, even when they are receiving care and collecting benefits. Without a premium waiver some people might need to use some of the benefit they receive to pay the premium, thereby reducing the benefit amount available to pay for their care.

- Separating the cost of the housing component of assisted living and paying only for direct assisted living services, resulting in a benefit similar to a home care benefit that fails to cover the expense of living in an assisted living facility. This benefit design allows companies to reduce the premium cost of an assisted living benefit, the result of which is seldom obvious to purchasers.

- Offering an insufficient daily benefit amount without inflation protection that is less than 80 percent of current costs, resulting in policyholders having a large and growing out-of-pocket cost when care is needed later. This benefit design transfers the bulk of the cost of care to the policyholder, who pays the difference between the cost of care and the benefits they receive. In 2008, 42 percent of group purchasers bought a daily benefit of $150 or less, and 72 percent of group purchasers choose a future purchase option for inflation protection.[35] This is a troubling combination when claims are not expected for 20 or more years. The daily benefit amount available to pay for care may only be a small portion of the actual cost of care at that time care is needed.

- Charging premiums that automatically increase over time on a scheduled basis until age 65, known as attained age rating, increasing the chance that policies will lapse as the cost of coverage increases with age.

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[32] The 2009 Source Book, the American Association of Long-Term Care Insurance.
[33] General Accountability Office (GAO) noted in its May 2007 Report, "Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings," that the primary reason people don't buy Partnership policies that include inflation protection is due to the increased cost of that benefit.
[34] The 2009 Sourcebook, American Association for Long-Term Care Insurance.
[35] The 2009 Sourcebook, American Association for Long-Term Care Insurance.

All of these "innovations" are far more likely to benefit the insurance industry than consumers. Policymakers and regulators need to pay greater attention to the group market and to the innovation occurring in long-term care insurance products to ensure that benefits will not become illusory over time, and will cover insignificant amounts of the cost of care. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, then benefits have to be in place when care is needed and must cover a substantial amount of the cost. Many of the products being sold today may not meet that criteria, and could leave consumers with huge out-of-pocket costs when care is needed 20, 30, or even 40 years later.

VI. Partnership Programs

A Partnership program, in theory, allows consumers to shelter certain amounts of their personal assets from the state Medicaid program by buying a long-term care insurance policy that meets federal rules and pays benefits for their future care. In return, the state promises that if the individual later qualifies for Medicaid benefits, each dollar of insurance benefits paid out will protect one dollar of their assets from the state's spend down requirements, and later estate recovery actions.

Careful consideration must be given to the state's role in the promotion, marketing, and sale of a commercial product that may be in conflict with their role as a government agency and thereby draw public criticism.[36] Such a relationship with the private market requires careful monitoring of the products and the people who sell them to maintain the program's integrity and ensure continuing consumer confidence in the program.

Commercial insurance companies and their sales agents clearly have a compelling and valuable marketing advantage when a state Medicaid program enters into a long-term care insurance Partnership program. This is because an insurance policy that is endorsed by the state makes it instantly both more attractive and credible. While sales opportunities for these products begin immediately the effect, if any, on a state's Medicaid program will not be known for many years.

To ensure that companies and sales agents don't exploit their connection to state government, states must develop strong standards for marketing and sales conduct, and comprehensive and ongoing training requirements. Consumers must be protected from overzealous advertising and misleading sales promotions, particularly older purchasers who may be a prime market for agents selling a state-approved product, and one that the state may even promote and encourage its residents to buy. Insurers often offer bonuses, incentives, and other sales reward programs to agents to increase sales of long-term care insurance, and those financial rewards may compete with a state's interest in the appropriate marketing and sales of these state-endorsed products.

[36] See e.g.: "States Draw Fire for Pitching Citizens On Private Long-Term Care Insurance," Wall Street Journal, Jennifer Levitz and Kelly Greene, 2/26/08. http://www.consumerwatchdog.org/patients/articles/?storyId=18819.

Taking advantage of the halo of state endorsement, sales agents may also include other insurance products in the same sales session, such as life insurance, annuities, burial insurance, and even reverse mortgages as a method of financing the premiums of a long-term care insurance policy. States should fully consider the effect of cross selling other insurance products to prospective purchasers of Partnership policies.

State Medicaid programs may benefit if a person uses their insurance benefits instead of Medicaid, or delays accessing Medicaid until their insurance benefits are exhausted. However, a 2007 study by the GAO found that it could be just as likely that these Partnership arrangements may actually increase Medicaid costs if people qualify for Medicaid benefits sooner than they would have with a traditional long-term care policy, or with self-financing.[37] The asset protection provided by the Partnership shields money that people would otherwise have to spend down before being eligible for Medicaid coverage. As a result, people may be able to qualify for Medicaid sooner than they would without a Partnership policy.

Advocacy groups are justifiably concerned that some people with moderate incomes will spend a large percentage of their income to protect small amounts of assets that may already be exempt under federal spousal impoverishment law for purposes of Medicaid eligibility. Another concern is that these policies will be inappropriately sold to people who have neither the income to pay for them over time, nor significant assets to protect. Other concerns focus on whether the promised asset protection can ever be used since at least some number of people who buy these policies will never qualify for Medicaid because their incomes are too high. Other issues include concerns that policyholders may have insufficient daily benefits, or may have failed to buy enough asset protection, and their assets will be consumed by out-of-pocket costs that are greater than the benefits they are collecting.

Because asset protection is only accumulated as benefits are paid some people of modest means may have to spend down some of their assets at the same time benefits are being paid if their out-of-pocket costs are greater than can be absorbed by their income. In other cases one spouse might be prevented from seeking spousal impoverishment protection[38] while the other spouse is in a nursing home and waiting for policy benefits to be exhausted and asset protection to apply to their non-exempt assets. Younger purchasers who buy a policy that qualifies for Partnership status with the required inflation protection could lose the Partnership status if their right to a future purchase option expires and the policy no longer meets federal requirements for inflation protection.

For many of the reasons stated above, the promises being made about Medicaid and Partnership policies may not be met in the future. While the 4 original Partnership states[39] require a minimum daily benefit and a built-in method of inflation protection, most of the newer Partnership states do not, and rely instead on policies that meet their own state requirements and have inflation protection that complies with federal law.

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[37] "Long-Term Care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings" GAO May 2007 http://www.gao.gov/new.items/d07231.pdf.
[38] Section 1924 of the Social Security Act; U.S. Code Reference 42 U.S.C. 1396r-5.
[39] Connecticut, New York, Indiana, and California.

Consumers may be buying benefits in the newer Partnership states that will be insufficient to pay a substantial portion of their long-term care later, either because the daily benefit amount is too low, and/or because the method of inflation protection they chose is insufficient to keep up with the cost of care. The out-of-pocket expenses that result may exceed an individual's current income, thus causing a person to spend down assets that are not yet protected.

In other cases people may not understand that even though they have the promise of asset protection, or may even have accumulated a specific amount of asset protection, their income, and/or non-exempt assets, could prevent them from qualifying for a state's Medicaid benefits. The 2007 GAO report found that 55 percent of Partnership purchasers over age 55 had monthly incomes of $5,000 or more that would disqualify them for Medicaid, and 53 percent had assets of more than $350,000.[40] Even with a policy that paid $200 a day, it would take almost 5 years of benefit payments to provide asset protection equal to $350,000 when the average nursing home stay is less than 3 years.

The relationship between commercial insurance products and a public benefits program through a Partnership agreement is a complicated arrangement, with many opportunities for confusion. Written descriptions and explanations of a Partnership program, and the interaction between a commercial insurance policy and a state's Medicaid program should be drafted by the state Medicaid office with verbatim use required by agents and companies. Consumers need an official explanation of Medicaid eligibility requirements, Medicaid benefits, asset protection accumulation and application, and estate recovery actions in their own state. They also need information about how the Partnership protection might work in other states, if at all, in the event that they use their policy in a state different than the state of purchase. The opportunity for confusion is significant for people living near state borders where differences between Medicaid programs in the bordering states can add even more confusion and complexity.

Additionally, consumers need to be aware that states can change their Medicaid program at any time, and that they will have to meet the eligibility requirements in place at the time they apply for benefits in the state of purchase, or the state they move to later. Consumers also need to understand that: 1) asset protection reciprocity is not assured; 2) Medicaid benefits available in their own state may not be covered in another state; 3) another state may apply a different standard to achieve complete asset protection than the state in which they bought their policy; and 4) states can withdraw from active participation in a Partnership at any time.[41]

Much of the success of long-term care insurance, in or out of a Partnership program, depends on the quality and dependability of the products that are purchased, adequate regulatory oversight, and whether people buy and keep these policies far into the future and are able to collect later on the promises they purchased.

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[40] Long-term care Insurance: Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings, GAO May 2007 http://www.gao.gov/new.items/d07231.pdf.

[41] Reciprocity standards issued by the Department of Health and Human Services allows states with Partnership programs to apply their own Medicaid rules to a Partnership policy purchased in another state. States may opt out of reciprocity, or participation in a Partnership program, at any time. See Reciprocity Standards Draft 2 at http://www.dehpg.net/LTCPartnership/generic.aspx?idir=federal%20guidance%20documents.

VII. Regulatory Oversight

During the last decade insurance companies and industry groups have argued for the option of a federal charter to regulate the business of insurance, which would essentially allow companies to select their own regulator by choosing between state or federal regulation. A New York Times May 21, 2009 editorial opined that if legislation introduced in the House to create an option federal charter [42]were to pass that "the race to the regulatory depths would continue, and the nation would be headed in exactly the wrong regulatory direction."[43] Such a choice would allow companies to escape the more rigorous regulatory requirements of many states like California that impose strict standards on companies and the long-term care products they sell. For instance, more stringent requirements for initial rate approval in California and the requirements that apply to rate increases could both be avoided by companies seeking another venue of regulation, and the careful scrutiny that some states provide to each policy filing might also be avoided.

Federal law does though, provide important protection by establishing minimum federal standards for long-term care insurance products, as it did in the Health Insurance Portability and Accountability Act (HIPAA)[44] and in the Deficit Reduction Act (DRA).[45] In an effort to further improve consumer protection, however, federal law could mandate additional minimum standards by directing the NAIC to gather data from the states, form a working group to identify the strongest standards and consumer protections enacted in states, amend those standards and protections into the NAIC Models, and then incorporate the NAIC Model into federal law by reference. This process was used when standardizing Medigap policies under OBRA '90, where federal law mandated the participation of federal agencies, consumer groups, industry representatives, and regulators to work together to accomplish that task.[46]

Greater state oversight is needed of long-term care insurance products, and riders that are attached to other insurance products like life insurance and annuities, and the agents who sell these products. Long-term care insurance products contain an assortment of benefits and features, and come in policy designs that vary from one company to another, leading to significant product differences within a single state despite what appear to be similarities of benefits. In addition, an assortment of riders can be added to policies that enhance, change, or modify the benefits of a base policy.

Few elements of a long-term care insurance policy or rider are standardized leaving consumers unable to compare several different policies. Benefits may appear to be the same, but the details of those benefits make it impossible to do a side-by-side comparison among several products or know how the benefits will work when needed.
Many consumers simply rely on choosing the policy with the lowest premiums even though it may have fewer benefits, expensive gaps in benefits, higher out-of-pocket costs than expected,

[42] H.R. 3200, Rep. Melissa Bean (D-Ill) and Rep. Ed Royce (R-CA).
[43] New York Time Editorial, "Regulator Shopping," May 21, 2009.
[44] The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191).
[45] The Deficit Reduction Act (DRA) of 2005 (P. L.109-171).
[46]Omnibus Budget and Reconciliation Act (OBRA) of 1990, Pub. L. 101-508.

and the potential for a steep increase in premiums later.[47] It is even more complicated for consumers when a policy is paid with a single, large premium, or when long-term care benefits are combined with a life insurance product or an annuity.

The NAIC and state regulators can play an important role in bringing some standardization to this market, eliminate some of the current confusion, and make it easier for consumers to make a choice between different products. Even when consumers have a fair idea of the benefits they bought, those benefits often don't keep up with changes that occur in long-term care services over time. In addition, since these products are usually purchased years or decades before care is needed, the individual arranging care for the policyholder will have to figure out how the policy works, what is covered, and how to comply with the various requirements for filing a claim. When a claim is filed policyholders are at the mercy of a company's interpretation of their benefits.

For example:

> General Electric Capital Assurance Company (now Genworth) denied assisted living benefits described in a policy issued in New York, because at the time of the claim, the state of New York did not license assisted living arrangements.[48]
>
> In a more recent example Mrs. KC, who bought her AMEX (now Genworth) long-term care policy in California in 1992, was denied her assisted living benefits because the state licensed assisted living home her family chose has only 6 beds and not the 10 beds required in her policy. Her family chose that particular assisted living home because of its individualized dementia services but now must move her back to a larger facility, losing the individualized services they valued so highly, and which have made a marked difference in Mrs. KC's day-to-day life. Since purchasing her policy Mrs. KC has paid approximately $50,000 in premiums for benefits she is now unable to collect because of a difference of 4 beds.
>
> Mrs. K. bought a Pioneer Insurance Company (now Conseco) long-term care insurance policy in 1990 that only pays for care at home and has no other benefits.[49] She did, however, have the foresight to purchase an 8 percent compounded inflation protection benefit, a very rare benefit to be offered or purchased in 1990 which illustrates the seriousness with which she attempted to plan for her future care. Despite Mrs. K's prudent planning her claim for benefits was denied. Now 86 years old, Mrs. K has dementia and is living in a state-licensed assisted living home in California that is also licensed to provide specialized services to residents with dementia.

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[47] See: Burns, Bonnie, Comparing Long-Term Care Insurance Policies: Bewildering Choices for Consumers, May 2006, http://www.aarp.org/research/longtermcare/insurance/2006_13_ltci.html .

[48] See *Van Houten v. General Electric Capital Assurance Company (GE).*

[49] Conseco recently settled a multi-state market conduct examination related to long-term care claims practices and procedures, complaint handling, and sales and marketing practices in which almost 40 states participated, led by Pennsylvania, Illinois, Indiana, Texas and Florida. See also California Department of Insurance Order to Show Cause and Notice of Hearing File No. 05048841 in regard to long-term care insurance claims, for engaging in unfair acts or practices of the Fair Claims Settlement Practices, and unfair acts and deceptive practices of the California Insurance Code.

Mrs. K is getting the same personal care services she could receive if she were living in her single family home, but in this home she has round the clock supervision, specialized activities for people with dementia, and socialization with other people who have the same condition. This assisted living home is not licensed to provide skilled nursing care nor is it a skilled nursing facility.

Yet the company refuses to pay her home care benefits arguing that this assisted living home meets the definition in the policy of a licensed skilled nursing facility and is therefore excluded as a place of care, and that the personal care services described in the policy which Mrs. K is getting are not being provided by a licensed home health agency as required by the policy but instead are provided by the staff of the assisted living home. Nowhere in the policy is a person's home defined, nor is there a definition of where policy benefits will be paid.

These cases illustrate how companies rely on the fine print in a policy, and what is not in the fine print, and is often at odds with the advertising material a consumer sees that implies coverage is more generous than it is. State insurance departments may not have the authority to force a company to pay benefits when there is a dispute involving interpretations of policy language, but issues like these could be minimized with greater standardization and more oversight and review of how these products are marketed and sold.

Rules could be developed to prevent companies from using language in advertising that is subtly different than the language of the contract, and policy review and approval by people experienced in long-term care would allow them to catch and correct policy language that conflicts with long-term care services and the delivery system for care.

CONCLUSION

The success of long-term care insurance products depends on the quality and dependability of the products, regulatory oversight, whether people buy and keep these policies until they are needed, and whether they are able to collect benefits later based on the promises they purchased. If the goal is to have more people buy commercial products to pay for long-term care and relieve pressure on state Medicaid programs, benefits have to be in place when care is needed and must cover a substantial amount of the cost.

Minimum national standards allow states to enhance those standards and develop other standards for issues not yet addressed by the NAIC Models and help ensure that the quality of a long-term care policy is not completely dependent on the state in which the policy is purchased. However, the NAIC process does not lend itself to finding and including in the Models the best standards that have been developed by the states. Nor is a scheduled periodic review performed to find changes that may have occurred in long-term care services or the long-term care delivery system. Having a regular process to find the best standards among the states and to track changes in LTC services and the care system are important components to strengthening consumer protections and quality of LTC insurance products.

As part of health care reform, elders and people with disabilities who need long-term care should have a seamless transition to long-term care services, coordination with medical care, and a support system to help them find and access the services best suited to their needs.

With the expansion of the Partnership program in approximately 20 states, closer coordination and monitoring is required between the state Medicaid agency and the insurance department in each state, to ensure that marketing and sales materials accurately portray the interaction between a commercial insurance product and the state's Medicaid program. States must be vigilant to ensure that consumers are not being promised state benefits they may not get, and that consumers fully understand both the commercial and public promises they buy. Sales and marketing materials must accurately reflect a state's Medicaid program, and sales agents must be carefully trained to understand the limitations and restrictions of Medicaid eligibility, and accurately communicate that information in to consumers.

We thank you for the opportunity to testify today on these important issues and welcome any questions you may have.

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ATTACHMENT A

Conseco Senior Health Insurance Company's Transformation to a Non-Profit Company

Background

In 1996 Conseco acquired American Travelers Life and Transport Life and the long-term care business of the 2 companies. Conseco previously acquired Pioneer Life and a number of blocks of long-term care insurance from other companies in an effort to become a major player in the long-term care business during the 1990s. In 1998 Conseco merged most of their long-term care business into a new subsidiary company named Conseco Senior Health Insurance Company (CSHIC). Conseco also owns Bankers Life and Casualty Company that has substantial long-term care business and remains a subsidiary company.

CSHIC stopped selling long-term care insurance in 2003 after incurring substantial losses. The magnitude of those losses, and the capital contributions made by Conseco to CSHIC to mitigate some of those loses, caused significant stress on Conseco's financial resources. As a result, Conseco approached the Pennsylvania insurance department with a proposal to spin off CSHIC into a trust arrangement.

In November 2008 the Pennsylvania insurance department allowed Conseco, Inc. to implement this unique arrangement and separate its failing subsidiary company CSHIC from Conseco's holding company system into a trust that has been renamed Senior Health Insurance Company of Pennsylvania (SHIP). This new arrangement eliminated the potential of any further losses to Conseco's holding company system.

The new company holds all the assets, liabilities, and surplus of CSHIC, for the sole benefit of the policyholders. Closed blocks of long-term care business from other Conseco subsidiary companies were transferred to the new company for administration, bringing the total number of covered lives in the new company to 177,000.

Financial Condition

Between 1998 and 2008, Conseco made 10 capital contributions to CSHIC totaling $915.1 million. As a condition of the separation of CSHIC into the trust, Conseco agreed to make a final contribution of $50 million in cash or cash equivalents, and another $125 million in the form of a senior note, a combined amount far less than the capital contributions made by Conseco over the last 10 years.

The new company SHIP, has no further access to any assets or capital of the holding company system. It must rely solely on current capital and reserves of CSHIC, and the revenues that can be generated from premiums paid by policyholders transferred to the trust, except for those policyholders who have triggered a survivor's benefit and no longer pay premiums. In 2008 the company expected to pay out $1.35 in claims for every dollar of premium collected, as reported in documents filed with the Pennsylvania insurance department.

A 2008 actuarial report by Milliman, Inc., an actuarial consulting firm referenced in the Separation and Transition Agreement, included solvency projections that assumed 5 additional rate increases would be needed for the policies transferred to the new company as of 2009.[1] Premium increase notices for CSHIC products have already been received across the country within the last few months, most in the range of 40 percent. For some consumers with a policy issued by Conseco, this rate increase follows previous rate increases of 18% in 2002, 20% in 2004, and 15% in 2008. The latest rate increase is apparently the first of the 5 additional rate increases projected in the Milliman report.

Consumer Protections

As a result of the recent round of rate increases by Conseco Senior Health Insurance Company on behalf of the non-profit Senior Health Insurance Company of Pennsylvania, policyholders may have one or more of the options listed below, depending on the state they live in.

- In states that have adopted Section 28 of the NAIC Model Regulation pertaining to Contingent Benefit on Lapse (CBoL), consumers might trigger the option to lapse their policy and retain paid-up benefits equal to 100 percent of the premiums they have paid, depending on a state's implementation of that requirement.

- Policyholders with policy form numbers that were included in a national class action lawsuit may have the option to exercise a non-forfeiture benefit equal to some percentage of the premiums they have paid.

- In states that have adopted Section 27 of the NAIC Model Regulation pertaining to the right to reduce coverage and lower premiums, policyholders may have the right to reduce their coverage by shortening the duration of coverage, lowering the daily benefit amount, dropping inflation protection, or increasing the waiting period before benefits are paid. Each of these choices, alone or in combination significantly affects future benefits.

- Rate increase notices may include offers of specific reductions that can be made in a policy's benefits in return for a reduction in the premium increase.

In some states a policyholder may be offered more than one of these options at the same time. Notice of a rate increase may include a list of options that are available to a policyholder that will reduce the amount of the scheduled premium increase.

[1] See Exhibit O at http://www.ins.state.pa.us/ins/lib/ins/conseco/018.pdf

Most consumers will need assistance deciding which of the options offered to them is best suited to their needs. It will be particularly difficult for policyholders with unlimited benefits to choose one of the options offered to them in lieu of those lifetime benefits. These notices should have, but were not required to, include information about the availability of assistance from the federally funded State Health Insurance Assistance Program (SHIP) that is available to consumers in every state.

The Future of Senior Health Insurance Company of Pennsylvania

A significant, but unknown number of current policyholders have exercised a survivor option that was widely sold to couples, and owe no further premium payments for the benefits they purchased after one of the spouses died. Some number of current policyholders will be eligible for this feature upon the death of their insured spouse. Some policyholders who have the option to lapse their policy and retain paid-up benefits instead of paying the increased premium are likely to do so. In each of these situations there will be no more premium revenue available from those policyholders, and no access to capital contributions from any other source. Any remaining rate increases will have to take into account these and other factors, including shock lapses[50] that occur as a result of this current rate increase, and any additional increases.

Professor Joe Belth, University of Indiana, submitted comments to the Pennsylvania insurance commissioner, Joel Ario prior to the transfer of Conseco Senior Health to the trust, stating, "The Department should disapprove the Plan, Conseco should *not* provide the additional capital contribution of $175 million, and the Department should seize CSHI as soon as possible. The Plan postpones the inevitable. A prompt seizure of CSHI would provide the Department with a better chance of selling or rehabilitating CSHI, and therefore a better chance of avoiding the drastic alternative of liquidation, than a postponed seizure."[2]

In the June issue of his newsletter, The Insurance Forum, Professor Belth calls into question the ability of Conseco to meet their obligation under the senior note owed to SHIP, based on their delayed 10-K filing with the Securities and Exchange Commission, and an opinion by its independent auditors. Professor Belth also calls into question a permitted accounting practice approved by the Pennsylvania insurance department that allowed SHIP to account for the Conseco senior note as though it had been fully paid in cash, leading to a higher score for their statutory risk-based capital requirements than they would have had otherwise.

In addition to the normal business related expenses of an insurance company, the new company SHIP must still meet all the capital requirements of an insurance company to remain in business. In the current financial climate that may be difficult to do.

[50] A shock lapse is one that occurs when the size of the rate increase is too large for a policyholder to absorb and they simply stop paying premiums and allow the policy to lapse.

[2] See: Opinion of Professor Joe Belth at http://www.ins.state.pa.us/ins/lib/ins/conseco/034.pdf

ATTACHMENT B

Seizure of Penn Treaty Network America Insurance Company
By the Pennsylvania Insurance Commissioner

Background

Penn Treaty Network America Insurance Company (PTNA) and American Network Insurance Company (ANIC) are both subsidiaries of Penn Treaty American Corporation (PTAC), a holding company domiciled in Pennsylvania. PTAC through its subsidiary companies has been writing long-term care insurance since 1972, and by the year 2000 had 250,000 covered lives. By 2008 that number had dropped to 142,000.

Products sold by both companies were offered through a network of 17,000 agents with substantially lower premiums than other policies on the market at the time. Rosanne Placey, a spokesperson for the Pennsylvania Insurance Commissioner, recently explained that policies written prior to 2000 had been under priced, and the company had had difficulty getting approval for the rate increases in the amounts they had requested from the various states in which it had sold policies.[1]

Financial Condition

The company is currently under a voluntary rehabilitation order in the state of Pennsylvania due to the historical and current inadequacy of its rates on policies sold prior to 2002. The ability to emerge from rehabilitation is dependent on the company's ability to substantially increase rates across the country, and to cut its operational costs.

The inadequacy of its rates was identified in 2001 following a series of rate increase requests that some states approved, some resisted, and some approved less than requested. Between 2000 and 2008 the company shed more than 100,000 covered lives through death or lapse.[2] Some of the lapses were undoubtedly in response to previous rate increases that could not be absorbed by elderly policyholders.

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[1] See: Long-Term Care Insurer Penn Treaty American Fails 01/08/09 - 05:26 PM EST
http://www.thestreet.com/story/10456908/long-term-care-insurer-penn-treaty-american-fails.html

[2] Pennsylvania Rehabilitation Order
http://www.ins.state.pa.us/ins/lib/ins/liq_rehab/penn_treaty_nework_america_ins_company_rehabilitation_order_jan_6,_2009.pdf

The size of the rate increases that may now be requires to restore Penn Treaty Network America to financial health may be too large for some state insurance departments to swallow. However, state guarantee funds with statutory limits on coverage would effectively reduce some policyholder's benefits, in particular those with unlimited or life time benefits. State regulators will be in a difficult position faced with a choice between approving large rate increases that will keep Penn Treaty Network America in business, or allowing the company to become insolvent with the result that at least some consumers will lose some of their benefits in the state guarantee funds.

Consumer Protections

As a result of the recent round of rate increases by Penn Treaty Network America Insurance Company, policyholders may have one or more of the options listed below, depending on the state they live in.

- In states that have adopted Section 28 of the NAIC Model Regulation pertaining to Contingent Benefit on Lapse (CBoL), consumers may trigger the option to lapse their policy and retain paid up benefits equal to 100 percent of the premiums they have paid depending on how this feature was implemented in a state.

- Policyholders with policy form numbers that were included in a national class action lawsuit may have the option to exercise a retention benefit equal to 50 percent of the premiums they have paid.

- Policyholders with policy form numbers subject to other class action remedies may have retention benefits equal to 100 percent of the premiums they paid.

- In states that have adopted Section 27 of the NAIC Model Regulation pertaining to the right to reduce coverage and lower premiums, policyholders may have the right to reduce their coverage by shortening the duration of coverage, lowering the daily benefit amount, or increasing the waiting period before benefits are paid. Each of these choices, alone or in combination significantly affects future benefits.

In some states a policyholder may be offered more than one of these options at the same time. Notices of the rate increase typically include a list of the options available to a policyholder that will reduce the amount of the scheduled increase. If the option of a retention benefit, or paid up benefit on lapse applies, the amount of premium that will be set aside to pay future benefits is typically included in the notice.

Most consumers will need assistance deciding which of the options offered to them is best suited to their needs. It will be particularly difficult for policyholders with unlimited benefits to choose one of the options offered to them in lieu of those lifetime benefits. These notices should have, but were not required to, include information about the availability of assistance from the federally funded State Health Insurance Assistance Program (SHIP) that is available to consumers in every state.