Testimony of

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Before the
Senate Special Committee on Aging

"Boon or Bane: Examining the Value of Long Term Care Insurance"

June 3, 2009
2:00 P.M.

Good afternoon Chairman Kohl, Ranking Member Martinez, and members of the Committee. Thank you for the opportunity to testify concerning the regulation of long-term care insurance. My name is Sean Dilweg, and I am the Insurance Commissioner for the State of Wisconsin. The primary objective of insurance regulators is to protect consumers of all lines of insurance, including long-term care insurance, and to ensure that insurance markets function appropriately and efficiently.

I would like to begin by thanking you for holding this hearing on a very important topic. As our population ages, more and more Americans will be confronted by the need for long-term care services and the financial burden of paying for that care. Already, long-term care services account for over half of all Medicaid spending in the United States, adding to the strain of health care costs on state budgets. Long-term care insurance is one way to finance these costs, providing individuals with protection against the financial burdens associated with the need for long-term care services.

Long Term Care Insurance has proven to be a very challenging product to regulate. In this testimony, I will briefly discuss the long-term care marketplace, the types of policies available, as well as the difficulties that regulators have encountered and the steps that have been taken to overcome them. Finally, I will discuss current and future National Association of Insurance Commissioners (NAIC) activities dealing with long-term care insurance, as well as federal involvement in the marketplace.

For those who have accumulated savings over their lifetime, long-term care insurance can be a way to protect some of their assets in the event they enter a nursing home or assisted living facility, or receive long-term care services in another setting. Whether to purchase a long-term care insurance policy is an individual decision and should take into account the potential purchaser's age, health status, overall retirement goals, income, and assets. For instance, if an individual relies solely upon Social Security as an income source, their income is not likely sufficient for them to afford long-term care insurance. Individuals should not purchase long-term care insurance if paying premiums will prevent them from paying other important bills, such as shelter, food and clothing expenses, or if they are already enrolled in Medicaid.

For consumers with significant assets, a long-term care insurance policy may be a good way to protect their assets against large long-term care expenditures. For these people, long-term care insurance may be a viable option.

Last year, the average annual cost of nursing home care was nearly $76,500, while assisted living facilities cost, on average, about $36,100 per year[1], amounts that could quickly deplete even a sizeable retirement nest-egg. People pay for this care in a variety of ways. Some choose to set aside a portion of their savings to finance long-term care, while others, who have fewer assets, will rely upon the Medicaid program to fund their long-term care needs. For some, long-term care insurance may be the best way to finance this care.

Those who elect to purchase long-term care insurance pay a premium to mitigate the risk of incurring long-term care expenses, which may not occur until well into the future. Long-term care insurance policies provide protection, up to the limits of the policies, against the financial burdens of long-term care, thus protecting some of the assets that have been accumulated over the years. With long-term care insurance, policyholders usually have greater flexibility in choosing the source of their care than they would if they were relying upon the Medicaid program.

In the future, long-term care insurance could also be an important product from the perspective of state and federal Medicaid budgets. Approximately 40 percent of all long-term care and 50 percent of all nursing home care is financed by state and federal governments through Medicaid.[2] Additionally, demographic trends are likely to increase the expenditures of long-term care services to governments, at the same time that the percentage of Americans who are of working age and paying taxes to support Medicare and Medicaid decreases. To the extent that long-term care insurance is able to help people avoid spending down their assets in order to receive care through Medicaid, long-term care insurance may be helpful to state and federal Medicaid budgets.

The Long-Term Care Insurance Market

Though long-term care insurance, in its current form, has been available since the 1980s, it is still a relatively new product. The first long-term care policies, issued in 1965, were designed to supplement the limited benefits provided by the new Medicare program for skilled nursing facility care. These early long-term care policies functioned much like Medicare supplement policies, covering deductibles and coinsurance associated with care in a skilled nursing facility that was covered by Medicare. For this reason, they, like Medicare, required that the policyholder spend at least three days in the hospital prior to their admission to the skilled nursing facility and required that care in the facility be "medically necessary."

By the 1980s, long-term care insurance had evolved into a product that stood on its own. It still generally covered only nursing home care, but it no longer was designed to wrap around Medicare's skilled nursing facility coverage. It covered nursing home admissions even if they were not immediately preceded by a hospital stay, as required under Medicare. The benefit triggers were redefined from a medical necessity trigger to the policyholder's inability to perform defined activities of daily living (ADLs) and cognitive impairment.

Since that time, the product has further evolved by adding more comprehensive coverage for additional types of long-term care services, such as home health

care, respite care, hospice care, personal care in the home, and services provided in assisted living facilities, adult day care centers and other community facilities. Furthermore, in addition to individually purchased policies, group long-term care insurance policies began to make up a significant and growing portion of the market.

As the long-term care insurance product has developed, so have the states' long-term care insurance regulatory programs. States enacted additional consumer protections designed to keep up with changes in policy design and pricing and address the problems encountered in the market place by consumers.

Though long-term care insurance has not been a major player in funding today's long-term care expenditures, financing less than 10 percent of long-term care services in the United States, it has been growing steadily in recent years. In the past ten years, the market has grown from one that covered less than 3 million lives to one that now covers more than 7 million. In terms of premium volume, the market has grown from a $16 billion marketplace to one in which consumers paid over $110 billion in premiums in 2007.[3]

One factor in the growth of long-term care insurance has been the growth in sales of group long-term care policies offered as employment benefits. Group policies have grown from a small portion of the market to approximately 20 percent in 2006 and continue to grow faster than individual plans. One advantage of group coverage is that enrollees may not be required to meet medical underwriting requirements in order to purchase coverage, or the medical screening criteria may be more relaxed than for an individual long-term care insurance policy. Generally, group coverage may either be continued after an individual's employment ends, or the policy may be converted into an individual long-term care policy, though benefits and premiums may change.

In 2002, the federal government began offering long-term care insurance to its employees and their family members through the Federal Long-Term Care Insurance Program. As of September 2006, approximately 214,000 federal

employees and their families had enrolled in the program, making the federal government the largest group sponsor of long-term care insurance in the country.

Another factor in the growth of long-term care insurance has been the deductibility of all or part of the premiums of tax-qualified long-term care policies. The Health Insurance Portability and Accountability Act (HIPAA) includes standards for qualified long-term care insurance policies, which must meet a number of consumer protection standards drawn from the NAIC's Long-Term Care Insurance Model Act and Regulation. The tax treatment that accompanies tax qualified long-term care insurance policies is that premiums are considered a Schedule B itemized deduction, the same as medical expenses, after meeting the 7.5% of adjusted gross income limit. In addition, is the law clarified that benefits received from tax qualified long-term care insurance policies are not considered taxable income. In 2002, 90 percent of individual long-term care insurance policies were tax-qualified.[4]

Finally, the product itself has evolved significantly in recent years by providing more comprehensive coverage, more stable premiums and consumer protections that make it more attractive in the market. These improvements to the product were, in part, the result of a collaborative effort between the long-term care insurance industry, state insurance regulators (NAIC) and consumer advocacy groups to improve the coverage and the market for long-term care insurance.

More recently, the Deficit Reduction Act of 2005 (DRA) included a provision authorizing long-term care (LTC) partnerships. A LTC Partnership program allows an individual with a qualified long-term care insurance policy to retain a portion of the policyholder's assets for the purposes of Medicaid eligibility determination and protect those assets from estate recovery. The level of asset protection provided is equal to the amount of benefits paid by the policy. Partnership policies must be tax-qualified and contain all consumer protections required of a tax qualified plan and must provide inflation protection for all policies issued to those under 76 years of age.

The Regulation of Long-Term Care Insurance

Long-term care insurance has, for several reasons, been a particularly challenging product to regulate. Besides being a relatively new product with claims experience just beginning to accumulate, the product combines both life and health insurance features in a single product. The product is sold as a means to mitigate future long-term care expenses where those expenses may not occur until fifteen to thirty years into the future, depending upon the age at which the policy was purchased, much like a life insurance policy. Once the policyholder develops a condition that makes them eligible to collect benefits, however, the policy acts more like a health insurance product. As in the health care industry, long-term care services are evolving and are subject to high levels of inflation in the cost of services and growing utilization of the services. Long-term care policies need to be able to provide meaningful coverage at the time they are needed in this evolving environment. Long-term care insurance is also subject to the same rapid changes in delivery of care that affect health insurance. The combination of these factors results in a situation where insurers must price their insurance policies so that they will pay for services fifteen or thirty years from the date of purchase of the coverage, when the cost, utilization and nature of those services may have radically changed.

Coping with these and other regulatory challenges in this market requires a determined effort and constant attention from state regulators. Our three main priorities in regulating these products are (1) ensuring the solvency of companies offering long-term care policies so that the companies can pay claims for the policies they have sold; (2) ensuring that sufficient consumer protections are in place so that premiums are relatively stable over the life of the policy and that consumers receive the benefits promised them in a timely and accurate manner; and (3) ensuring that all long-term care insurance sales are done in an appropriate manner and are suitable for those purchasing the policy.

Solvency

One of the most important responsibilities of state insurance regulators is to ensure the solvency of the companies doing business in the market. This applies to all lines of insurance, including long-term care insurance. State insurance laws and state insurance regulators take this consumer protection very seriously. Over many years, state insurance regulation has developed a solvency regulatory system, grounded in each of the states and coordinated through the National Association of Insurance Commissioners (NAIC), that has served insurance consumers well. Today, this is evidenced by the relative financial stability in the insurance market place during these extraordinarily difficult economic times.

The state-based insurance solvency regulatory system reflects conservative solvency standards developed by the states and, in some cases, the NAIC, and shared amongst the states through various means, including minimum reserving standards, minimum capital and surplus requirements, statutory accounting principles, and NAIC state insurance department accreditation. In addition, states have developed, internally and through the NAIC, a financial analysis and monitoring system that targets potentially troubled, nationally significant insurers for regulatory action and monitors domiciliary state activity on these companies. While the primary solvency regulatory authority lies with the domiciliary state, the insurer's home state, the NAIC offers assistance to the domiciliary state through its Financial Condition Committee structure, if requested. Those non-domiciliary states in which a potentially financially troubled insurer does business also have the ability to take regulatory action they deem necessary to protect their consumers.

The above standards and processes apply to the regulation of long-term care insurers as well. In virtually all states, long-term care insurers are required to maintain a minimum amount of claim reserves based upon the amount of business they write. Additionally, long-term care insurers are subject to the same conservative statutory accounting principles as other insurers and are subject to the same rigorous financial analysis by their domiciliary states, non-

domiciliary states and the NAIC. Conservative asset valuation standards and conservative standards for the amounts and types of assets in which an insurance company can invest to meet its statutory financial obligations apply to long-term care insurers.

Even with these conservative solvency standards and rigorous oversight, a few insurance companies will get into financial difficulty. So long as we have a competitive marketplace in a capitalistic economic system, there will be companies who are successful and there will be a few who are not. It is my responsibility, as an insurance regulator, to ensure insurance consumers are protected from poor business decisions made by those few companies so that the obligations under their insurance contracts are fulfilled. Early detection of potential financial difficulty is, by far, the best way to achieve this goal. To that end, state insurance regulators have developed a sophisticated financial analysis system along with an insurance company financial data base that is second to none.

Early detection gives the company and the regulator an opportunity to address financial problems before they result in potential consumer harm and more formal regulatory action. Corrective business plans can be developed, implemented and carefully monitored to determine whether they can bring the company out of its financial difficulty.

If the situation is such that a rehabilitation or receivership is required, early detection and action on a financially troubled insurer minimizes the amount by which a financial hole needs to be filled. It also allows the rehabilitator or liquidator to develop a strategy to sell or transfer the troubled company's insurance business to another, financially healthy insurer thus minimizing any disruption to the policyholders. As a last resort, if no other insurer can be found for the business, the insurance guaranty funds are activated to provide protection for the troubled company's policyholders and claimants.

These consumer protections have been developed and refined over many years. They continue to serve the insurance market place well. Of course there are

instances where state insurance solvency regulation could have performed better. However, the important thing to realize is that insurance regulators have learned from these situations and have adjusted their solvency regulatory processes accordingly. My colleagues and I are very confident that state insurance solvency regulation is one of the best financial services regulatory processes in the world. Additionally, insurance regulators are committed to continuously improving an already successful system.

The NAIC is continually monitoring these standards to determine if they are achieving their intended goal, and, if not, works to improve them. Many of the problems we see today in the long-term care insurance market are the result of long-term care policies sold when there were insufficient regulations in place. Today, the market seems to have stabilized and the newer long-term care insurance policies are sold at a more realistic and thereby more suitable price.

Stabilizing Premium

Long-term care insurance is a very difficult product to price for two reasons. First, claims for long-term care insurance are likely not to occur until fifteen to thirty years after a policy has been sold. Second, the long term care services delivery system is an ever-changing system.

For example, when long-term care insurance first came onto the market, it was primarily nursing home care coverage. That has now evolved into not only nursing home coverage, but adult day care coverage and home care coverage, to name a few. To price for this type of coverage, so that the prices are stable, competitive and profitable, is very difficult, especially with the uncertainty in the market place.

Some insurers in the 90's priced primarily for market share and offered the least expensive policies available. However, when claims started to come in beyond what they priced for, these insurers had to raise their prices to cover claims. In some instances, significant price increases were imposed in an effort to meet claim obligations and remain in business. In fact, some long-term care

insurers dropped out of the market entirely by selling their business to another long-term care insurer while others just stopped issuing new policies.

Recognizing the problem of under pricing early on, state insurance regulators through the NAIC developed rate stability standards to basically force long-term care insurers to reasonably price their products up front. These rate stability standards evolved over the years from rate increase restrictions to requiring insurers to actuarially certify that the rates they file will not increase over the life of an insurance policy under moderately adverse conditions.

The original NAIC model regulation, adopted in 1988, contained a provision that required all individual long-term care insurance policies to meet a minimum 60 percent loss ratio. This meant that over the life of the policy, a minimum of 60 percent of the premium had to go towards the payment of claims. A maximum of 40 percent of the premium could be allocated to administrative costs and profit. This requirement, though an important consumer protection to ensure that a majority of the premium was being used for paying claims, did not address the potential under pricing of policies and the resultant premium increases. In response to this problem, the NAIC adopted amendments to the model regulation in 2000 designed to ensure greater premium stability. These amendments eliminated the 60 percent minimum initial loss ratio requirement, and substituted an actuarial certification that must be filed with the initial premium rate filings, attesting that premiums will not increase over the life of the policy under moderately adverse conditions. However, in the event that future premium increases became necessary and were filed with the insurance department, the original premiums filed now needed to meet a 58 percent loss ratio, and the premium increases needed to meet an 85 percent loss ratio. Furthermore, following each rate increase, the insurer must file its subsequent experience with the Commissioner for three years. If the increase appears excessive, the Commissioner may require the company to reduce premiums or take other measures, such as reducing its administrative costs, to ensure that premium increases that turn out to be unnecessary are returned to policyholders.

The 2000 amendments to the model regulation also put in place two additional levels of protection against premium increases. If premiums rise above a given level, based upon the age of the policyholder, for a majority of policyholders, the company is required to file a plan for improved administration and claims processing or to demonstrate that appropriate claims processing is in effect. Furthermore, if the Commissioner believes that a rising rate spiral exists, he or she may require the company to offer policyholders affected by the premium increase the option to replace their existing policies with comparable ones currently being sold, without underwriting. This allows policyholders trapped in a rising rate spiral to switch to a more stable policy. Finally, as a last resort, if the Commissioner determines that a company has persistently filed inadequate initial premium rates, the Commissioner may ban the company from the long-term care insurance marketplace for up to five years, essentially putting the company out of business in the state.

These changes created a strong incentive for companies to price policies accurately up-front, in an effort to avoid future increases and to encourage suitable sales of the products. To assist consumers in selecting a policy with premiums that do not drastically increase over time, insurers are required to disclose to prospective policyholders all prior rate increases for the past ten years. I believe these provisions, plus the additional experience that companies have gained in pricing long-term care policies, will be effective in promoting long-term care insurance premium stability. Nevertheless, state regulators, on their own, and through the NAIC, will continue to watch the situation closely to see how these standards affect future premium increases.

Marketing and Suitable Sales

The long-term care insurance market has also experienced some marketing and sales challenges. In the 1980s and 1990s, the product was primarily sold to seniors. Some companies and their agents used deceptive and high-pressure sales tactics. Many sales were considered unsuitable because policies were sold to individuals who did not have the financial wherewithal to afford the premium for the long-term care insurance protection and were already close to qualifying

for Medicaid. There were also instances of improper long-term care insurance policy replacements, where one long-term care policy was replaced by another, to the benefit of the replacing insurance agent and company, but to the detriment of the consumer.

The question of suitability has always been an issue with these products. In the past, these products were sold on a standalone basis, outside of a consumer's financial plan. Now, because of the all the options that consumers have to pay for long-term care services, buying a long-term care insurance policy without a financial plan would be unwise. In addition, these types of standalone sales often result in unsuitable purchases for the consumer. Consumers who have few assets to protect and are relatively close to qualifying for Medicaid should think carefully about whether they will benefit from the purchase of a long-term care insurance policy. In response to the suitability concerns, many states and the NAIC developed suitability standards and processes to minimize unsuitable sales of long-term care insurance policies.

Older long-term care insurance policies do not have some of the consumer protections that are available in the current regulatory environment especially in the area of rate stability, benefit adjustments, unintentional lapse protection, and inflation protection. Many of the problems we are seeing in today's market can be, in my opinion, attributed to policies that were issued prior to the implementation of many of the consumer protections we have today.

The NAIC's Long-Term Care Insurance Model Regulation requires all long-term care insurers to develop suitability standards, based upon general categories contained in the regulation outlined below, to determine whether the purchase of a long-term care insurance policy is appropriate for the applicant. These standards must take into account (1) the ability of the applicant to pay the premiums and other pertinent financial information related to the purchase; (2) the applicants' goals with respect to long-term care; and (3) the advantages and disadvantages of insurance to meet those goals and any insurance that the applicant may already have. The NAIC model also contains a worksheet for insurance agents to use to determine suitability prior to selling a policy. This

worksheet collects relevant information about the prospective policyholder and helps to ensure that the applicant is aware of the various options available under the policy, and the consequences of decisions regarding those options with respect to both premiums and future benefits under the policy.

The insurer must review the worksheet prior to issuing the policy. If the insurer finds that the policy would not be suitable for the applicant, based upon its suitability standards, it must either reject the application or inform the applicant that the policy may not be suitable. Written confirmation must be obtained from an applicant who wishes to purchase the policy anyway.

The NAIC Model Regulation also requires agents to provide purchasers with copies of the NAIC's "Shopper's Guide to Long-Term Care Insurance" and a fact sheet entitled "Things You Should Know Before You Buy Long-Term Care Insurance." These publications outline some of the considerations that consumers should take into account when purchasing a policy so that all consumers have the opportunity to be informed prior to committing to a purchase. All states have this requirement in their long-term care insurance regulations.

Finally, the Long-Term Care Insurance Model Act and all states' long-term care regulations provide consumers the right to return the policy within 30 days of receipt of the policy for a full refund if they are not satisfied for any reason. Notice of this right must be prominently included on the first page of the policy. This provides an opportunity for the applicant to reconsider the decision to purchase coverage and acts as a defense against high-pressure sales tactics and unsuitable sales.

State regulators work to ensure that consumers are treated fairly and receive the benefits they are entitled to under their long term care policies. Due to the fact that most policyholders are elderly and living on fixed incomes when collecting benefits under a long-term care policy, and are likely suffering from a physical incapacity, cognitive impairment or both, consumer protections for access to benefits are of the utmost importance with long-term care insurance.

States already have prompt claim payment laws that apply to long-term care insurance. The long-term care insurance market needs consumer protections for claim denials based upon the insurer's assessment of whether the policyholder has met the benefit trigger requirements under the policy. I led the work of the NAIC Long Term Care External Review Subgroup which is poised to approve model language for the implementation of an independent external review process for these types of situations. I anticipate full NAIC action on this proposal before the end of the year.

Prior to being revised in 2000 and 2006, the NAIC Long-Term Care Model Act and Long-Term Care Insurance Model Regulations already contained many important consumer protections. These protections were designed to help ensure that consumers understand what they are purchasing and that the purchase is suitable and affordable over the life of the policy. These protections include:

- **Guaranteed renewability:** All policies must either be guaranteed renewable or noncancellable. Guaranteed renewable policies may not be altered by the insurer, nor may they be cancelled except for the policyholder's failure to pay premium, but premiums may be increased. Noncancellable policies are similar to guaranteed renewable policies, except premiums may not be increased.
- **Mandatory offer of nonforfeiture benefits:** All applicants must be offered the opportunity to purchase nonforfeiture benefits, whereby if the policy were to lapse, the policyholder would be issued a paid-up policy with reduced benefits based upon the length of time the policy was held. Applicants who decline to purchase nonforfeiture benefits are still entitled to receive contingent nonforfeiture benefits, which are provided if premiums rise above a percentage of the initial premium. That percentage varies depending upon the policyholder's age at the time of purchase of the policy and ranges from 200 percent, for those purchasing prior to age 30, to 10 percent, for those purchasing after age 90.

- **Limitation on benefit triggers:** The conditions that must be satisfied before the policyholder becomes eligible to collect benefits are known as "benefit triggers." Benefits must be triggered when no more than three activities of daily living (bathing, dressing, eating, continence, toileting, and transfer) are impaired or the policyholder suffers from cognitive impairment. Additional benefit triggers may be added, but the policy may be no more restrictive than the model's requirements.
- **Limitations on rescissions:** Policies may only be rescinded for fraud or misrepresentation during the first six months of the policy. After that time, and for the first two years of the policy, policies may be rescinded for material misrepresentations that pertain to the condition for which benefits are being sought. After two years, policies are incontestable, except for intentional and knowing misrepresentation of relevant facts about the insured's health. Once a policy is rescinded, previously paid benefits may not be recovered by the company.
- **Limitations on post-claims underwriting:** Health questions on an application must be clear and unambiguous. For applicants over the age of eighty, insurers must receive health information through a physical examination, an assessment of functional capacity, an attending physician's statement, or medical records.
- **Mandatory offer of inflation protection:** Applicants must be offered the opportunity to purchase inflation protection in the form of compound annual inflation protection of at least 5 percent or the opportunity to increase benefits by at least 5 percent every year without additional underwriting, as long as previous offers to increase benefits have not been declined. An applicant's rejection of inflation protection must be explicit and in writing.
- **Protection against unintentional policy lapse:** Each policyholder must be allowed to designate an individual who will be notified at least 30 days before the policy is cancelled for nonpayment of premium. If the policyholder suffers from a cognitive impairment, the insurer must reinstate a lapsed policy if back premiums are paid within five months.

- **Prohibition on waiting periods on replacement policies:** If a policyholder who has begun collecting benefits replaces one contract with another, or the policyholder converts a group policy to an individual policy, the insurer may not require a new waiting period to be fulfilled. To qualify for this protection, the new policy must be from the same company, and the policyholder may not increase the benefits of the policy.
- **Standardized outline of coverage:** The insurer must provide a standardized outline of coverage to the applicant at the time of initial solicitation. The outline must describe the principal benefits and exclusions and limitations of the policy and must state the terms under which it may be continued or discontinued, as well as any right the company has to raise the premium. It must also inform the policyholder whether the policy is intended to be tax qualified.

More recently, regulators determined that additional changes to the models were necessary, and in December, 2006, adopted revisions to the model act and regulation. These revisions added several important new consumer protections, including a requirement that insurers offering new policies that cover new long-term care services or providers must make the new coverage available to existing policyholders. The intent of this change was to ensure that long-term care insurance coverage keeps pace with the changing nature of long-term care services.

Additionally, the model regulation was amended to require long-term care insurance policies to include a provision allowing policyholders to reduce their coverage and lower their premiums in order to avoid lapse due the policyholders' inability to pay the current premium. This provision will help ensure that if a policyholder's financial situation changes and they cannot afford their coverage at the current premium level, they can reduce their coverage to lower the premium.

Finally, new producer training requirements were put into place to ensure that agents selling long-term care insurance products, particularly Long-Term Care

Insurance Partnership policies, are properly equipped to accurately explain coverage options to consumers. Long-term care insurance is a complex product to pay for care in a constantly changing long-term care service system. As a result, it is imperative that agents and brokers selling these products are adequately trained. Under the new producer training section of the model, agents and brokers must complete eight hours of initial training before they can sell long-term care insurance and then four hours of continuing education on long-term care every two years. The training must cover state and federal requirements pertaining to long-term care services, the relationship between qualified state long-term care insurance partnership programs and other public and private coverage of long-term care services.

These changes have been in effect for two years. However, more and more states have decided to implement the Long-Term Care Partnership and, as part of that process, have revised their laws to incorporate the most recent versions of the NAIC model act and regulations. We believe that these changes will prove to be valuable consumer protections.

Moving forward, state regulators continue to carefully monitor the market and make adjustments as necessary. Last year, the NAIC's Senior Issues Task Force and Market Analysis Working Group coordinated a data call by the domiciliary states of the 23 largest individual long-term care insurers in the United States. The call collected data from 2004 through 2006 including, premiums, claim payments, consumer complaints, and the promptness of claims payments, claims denials, and cost containment expenses.

The data showed that the individual long-term care insurance industry continues to grow, with the majority of the growth in the comprehensive policies. Complaints regarding claims have been increasing over time. In part, this is to be expected, as each year there are more policies in force with policyholders at an age where claims are likely to be filed. However, the data also showed an increase in the percentage of claims being denied, from 3.2 percent of claims submitted in 2004 to 3.9 percent in 2006. While this is not a statistically significant result, it may reveal a trend that we believe needs to be

addressed. A separate survey conducted by the insurance industry found similar results.

In response to the results of the data call, the NAIC's Senior Issues Task Force is considering further revisions to its models. As I mentioned earlier, the Task Force created a Subgroup to recommend a process for independent external review of benefit trigger determinations. This consumer protection will give a consumer an outside determination of whether a policyholder has met the conditions for benefit eligibility under the insurance policy. Currently, in most states, a policyholder's only avenue for appealing claims denials are through appeals or grievances filed with the insurance company that denied the claims, complaints to their insurance department and litigation. Independent external review will give consumers a new avenue for expeditiously resolving these disputes without resorting to litigation.

As with anything developed by a voluntary organization such as the NAIC, unless there is an outside force that requires adoption, not all member states agree with or adopt suggestions promulgated by the organization. To that end, Congress could assist in making sure that the long-term care insurance standards thoughtfully developed and promulgated by the NAIC are the standards in all states; at a minimum those states that have tax-qualified long-term care insurance policies and the Long-Term Care Insurance Partnership Program. Specifically, I would urge you to consider requiring the Secretary of the Department of Health and Human Services and the Secretary of Treasury to require the rate stability standards in the current NAIC long-term care insurance models be required in the states where tax-qualified policies are authorized to be sold and in the Partnership States. In addition, the Secretaries should also be required to review all subsequent amendments to the NAIC long-term care insurance models to determine whether they should be required for tax qualified and LTC Partnership Policies.

Chairman Kohl, I appreciate that your bill sets forth a process for accomplishing much of what I have just outlined. You recognize the value of state regulatory authority over long term care insurance, as well as the

significant impact NAI C models, developed in collaboration with interested parties, bring to consumer protection. I, and I know the NAIC, look forward to reviewing your proposed legislation more closely and continuing to work with you on this very important issue.

Again, thank you for the invitation to testify here today. I look forward to answering any questions that you might have.

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[1] Genworth 2008 Cost of Care Survey

[2] Kaiser Commission on Medicaid and the Uninsured, Medicaid's Long-Term Care Beneficiaries: An Analysis of Spending Patterns, November 2006, accessed July 8, 2008 at http://www.kff.org/medicaid/upload/7576.pdf.

[3] National Association of Insurance Commissioners, Long-Term Care Insurance Experience Reports for 2007, p.9

[4] America's Health Insurance Plans, Long-Term Care Insurance in 2002, June 2004, accessed July 15, 2008 at http://www.ahipresearch.org/pdfs/18_LTC2002.pdf, p. 25.