

**TESTIMONY BEFORE THE
UNITED STATE SENATE
SPECIAL COMMITTEE ON AGING
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by

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on

LONG TERM CARE INSURANCE

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A. INTRODUCTION

I want to thank Senators Grassley and Breaux, and the hardworking staff of the Senate Special Committee on Aging, for their outstanding record on elderly issues, for holding this hearing to focus attention on the vital issue of ending abuses in the long term care insurance industry and ensuring a solid foundation exists for the Long-Term Care and Retirement Security Act of 2000 or any comparable legislations, and for giving me this opportunity to discuss my views on this issue.

From 1998 until the present, I have been lead counsel for plaintiffs in the class action lawsuit, *Hanson v. Acceleration Life Insurance Company*, Civ. No. A3:97-152 (D.N.D.), which has now been successfully settled. My average client in that case is about 92 years old and has suffered an approximate 700% rate increase in the cost of their long term care ("LTC") insurance policy between 1989 and 1996. Most of my clients live on fixed incomes and were unable to afford these increases which for some people went from about \$700 to \$10,000 per annum. State insurance departments were powerless to stop these unconscionable increases, and repeatedly expressed their frustrations to policyholders throughout the United States. Most of my clients were forced to lapse or drop coverage which was sold as "guaranteed renewable for life".

I commend defendants in *Hanson* for reaching a mutually satisfactory settlement of that matter which was ultimately approved without a single objection by any class member by the Honorable Karen Klein, Magistrate Judge, U.S. District Court for the District of North Dakota. My comments today address the fact that what happened in the *Hanson* case is not a one time event, that there are other bad LTC policies in the marketplace, and that this situation is unacceptable and threatens an important public interest in protecting the elderly from fraud. However, my comments are not intended to disparage all LTC insurers, but only those few which have systematically preyed on the elderly. Nevertheless, the problem is not limited to a few fly-by-night companies, and the problem persists today.

In addition, based on my experience representing victims of fraudulent practices, my view is that the National Association of Insurance Commissioners ("NAIC") Long-Term Care Insurance Model

Regulations (as approved August 17, 2000) does nothing to help existing LTC policyholders, and does almost nothing to prevent unscrupulous vendors from committing *Hanson*-style frauds and taking advantage of the elderly with future policies.

B. THE ISSUE IS HOW BEST TO HELP THE ELDERLY AND THEIR FAMILIES TAKE MORE RESPONSIBILITY FOR THEIR LONG TERM CARE NEEDS

My clients in LTC cases like *Hanson* are the people who are making financial sacrifices in order to take responsibility for their long-term care needs. As a society, we should applaud and encourage this sort of conduct, and Senator Grassley has consistently championed responsible personal planning in this context. At the onset, these sacrifices in the form of premium payments (and lost opportunity costs, e.g., leaving the money in a savings account) were manageable. What is most terrible about cases like *Hanson* is that the most responsible people--the people trying to buy protection for their LTC needs--were the victims.

The limited resources of the elderly should not be squandered on the purchase of insurance products that contain excessive and unnecessary charges, or that fail to provide benefits commensurate with premiums charged, or that do not remain affordable until needed, or that otherwise lack quality. The last thing anyone wants is to see the elderly or their families, especially those who are responsible enough to prepare for their LTC needs, move closer to poverty with effectively worthless coverage and nothing to show for their LTC payouts.

Fraudulent practices by some in the LTC insurance industry cause additional damages by undermining public confidence in those valuable and already underutilized insurance products sold by responsible companies. As Senator Breaux has said, "New services that meet the needs of our growing senior population are necessary and exciting. But the facilities are market driven and are susceptible to a bottom-line mentality that can lead to consumer fraud and abuse." [fn-1](#)

A few things are clear to me from my involvement in *Hanson* and other cases. First, there are some companies that consciously engage in low ball pricing. Second, in other insurance companies, there is a tension between the marketing people and actuarial people on the LTC issue. The marketing people see a tremendous demographic opportunity; the actuarial people see a lack of generally accepted data, including data regarding utilization rates. Experience shows that the resulting product is often poor priced from a rate stability point of view. Third, good companies are also being victimized by the fraud of a few bad companies in that bad products also tend to squeeze legitimately priced products out of the marketplace, and damage the ability of legitimate companies to grow market share. [fn-2](#)

These issues are especially important as the Congress considers whether to create additional tax incentives to stimulate the sale of potentially defective LTC insurance products. Private LTC insurance is undeniably one means for lessening the growing burden of claims on limited public resources. The public interest clearly supports the efforts of this Committee and, at least, the spirit behind the Long-Term Care and Retirement Security Act of 2000. However, the federal tax system should not be used to encourage the purchase of bad LTC insurance products, or to lessen the level of critical scrutiny any consumer brings to his or her evaluation of whether LTC insurance products serve his or her needs. Obviously, the proposed tax deduction will be used aggressively to market these products.

C. FACTUAL BACKGROUND OF *HANSON*

The *Hanson* class action originally arose because over 2,000 of North Dakota's senior citizens purchased long-term care or nursing care ("LTC") insurance policies from Acceleration Life Insurance Company ("Acceleration") and its licensed agents (collectively referred to as "defendants") between 1984 and 1990. [fn-3](#)

The stories of Harold Hanson, Nellie McIlroy and Gladys Schimke are illustrative. My client, Harold Hanson was born on December 3, 1904 and is currently 96 years old. He resides in Reeder, North Dakota, where he has lived since he was three years old. He was in the cattle business for most of his life and his family has a ranch near Reeder that his grandson maintains. Mr. Hanson's wife, Dexter, has passed away and he lives alone, and does all of his own cooking and housework.

In 1987, he purchased a long term care policy with a premium of \$1,498.00 per year. In 1991 the premium was increased to \$1,717.24 and by 1996 the premium was \$6,158.13. When the insurance company began raising his rates, he wrote letters to the North Dakota Department of Insurance and was told that the Department could not stop the rate increases. He decided to drop the policy because it was too expensive, even though the company kept all of his prior premium payments.

Commissioner Glenn Pomeroy, used Mr. Hanson's letters in his legislative efforts to argue for increased authority to prevent this sort of thing from happening again. However, despite these efforts, effective legislation on the state level has still not been passed. This underscores the fact that NAIC recommendations are not always enacted on the state level.

My client, Nellie McIlroy was born on September 28, 1905 and is currently 94 years old. She was born and raised in Tolna, North Dakota. She was a school teacher, wife and mother of four. She and her husband Dean ran a grain and cattle farm in Glenburn North Dakota. Ms. McIlroy is now a widow and, despite serious problems, lives with her son Carl and his wife.

Mrs. McIlroy purchased a long term care policy in 1987 for \$829.86. In 1992 her premiums were \$1,860.96 in 1995 they were \$3,386.96 and in 1997 they were \$6,638.00. Several years ago, Mrs. McIlroy was diagnosed with Alzheimer's Disease. However, her family does not want to put her into the nursing home, so the children pitch in each year to make the premium payment which increased dramatically each year until the settlement of the law suit led to a reduction of Mrs. McIlroy's premium.

Gladys Schimke was born on March 30, 1915. She purchased a long term care policy in 1987. At that time her premium was \$834.87 per year. Mrs. Schimke's premiums began to increase in 1990. In 1997 her premium was \$2,411.20 at which time she dropped the policy because the premium was too high for her to pay.

Under the terms of the subject LTC policies (Forms 520, 521 and 522), as long as the insureds paid the premium, the policy was "guaranteed renewable" each year. As commonly understood, this means you can keep the policy for the rest of your life. According to Section 45-06-05-04(1)(b) of the North Dakota Administrative Code:

The term "guaranteed renewable" may be used only when the insured has the right to continue the long-term care insurance in force by the timely payment of premiums and when the insurer has no unilateral right to make any change in any provision of the policy or rider while the insurance is in force, and cannot decline to renew, except that rates may be revised by the insurer on a class basis. [fn-4](#)

Acceleration admitted in the actuarial memorandum underlying these policies that the policies were supposed to be "level premium" policies, *i.e.*, the premium would remain constant for every year that the

policy was renewed.^{fn-5} However, the policies contained a provision which read as follows:

PREMIUM RATES-CHANGES

We may change the premium rates. A change will apply to all contracts with the same form number as yours which are in force in the state you live in. A change will apply on the next due date after we give you at least 30-days written notice at your last known address.

The plaintiffs charged that the *Hanson* defendants intentionally created a "low ball" priced policy and then used this language, especially the phrase "We may change the premium rates," as, in effect, a "blank check" to improperly justify the exorbitant rate increases that led to the lawsuit. The LTC policies at issue in *Hanson* operated in fact as rising premium policies, caused in part by an escalating "death spiral." Such a policy is indisputably inappropriate for elderly people on fixed incomes because LTC insurance is worthless unless the insured can afford to keep it until it is needed. In effect, even though the policy was "guaranteed renewable," the up to 700% rate increases made it impossible to keep.

A core element of the *Hanson* plaintiffs' complaint was that the LTC policies were sold as coverage that customers could realistically maintain for the rest of their lives or until needed. This is the plain understanding of the promise that the policy is "guaranteed renewable for life." This required the policies to have essentially level premiums. The *Hanson* plaintiffs also claimed that the defendants knew at the time of sale and renewal that the policy premiums would increase dramatically to unaffordable levels and that the defendants not only intentionally withheld this information from new customers and renewal customers, but they affirmatively and falsely told customers in form renewal letters that these policies were "competitive" and "one of the best policies available in your state." Likewise the risk of rate increases and future unaffordability of the policies was not raised in the brochure at the time of application when the first premium check was written. Instead, when the policy arrived, it stated that premiums "may" increase, omitting the fact that rate increases were planned and inevitable. The policies also stated that they were "guaranteed renewable for life," suggesting falsely that they would be affordable for life.

Due to the fact that premiums rose over 700% between 1989 and 1996, less than 200 North Dakota citizens were paying the annual premium on these policies at the time of the *Hanson* litigation. According to the North Dakota Department of Insurance ("NDI"), this was the worst LTC policy sold in North Dakota. Those who were still paying the premiums did so because they were trapped and were too old to switch coverage.

Essentially, the *Hanson* plaintiffs claimed the LTC policies purchased by North Dakota citizens were fraudulently sold because they were, in effect, defective products. In addition, the facts underlying these defects were fraudulently withheld from the plaintiff class to enable defendants to continue to sell, and annually renew, these policies.

The class action law suit was originally filed in October of 1997 on behalf of North Dakota purchasers of long term care policies from Acceleration Life Insurance Company and Commonwealth Life Insurance Company. A class was certified in February 1999 and a trial was set for October 1999. During the course of the litigation, the attorneys representing the class uncovered numerous internal documents from the companies that showed that the companies knew of the problems with the policies early on and made a conscious decision to pass on the mistakes of their underpricing and poor underwriting on to the policyholders. The companies also made efforts to keep this information from the policyholders and actually encouraged policy renewals knowing that they were going to raise the premiums to unaffordable levels. When questioned by policyholders as to the reasons for the rate

increases, the companies told them that it was due to high claims and hid the fact that it was actually due to the companies' poor pricing and inadequate underwriting practices.

A few days before trial, after the class had won most major pre-trial motions, the insurance companies made a settlement offer. This settlement, which was supervised by the Magistrate Judge, included available relief to over 13,000 purchasers of the long term care policies at issue in the litigation nationwide. The settlement terms included \$12.6 million in cash which resulted in significant cash payments to all claimants, an immediate roll back of premiums for all current policy holders valued at \$2.1 million, and a ban on any future rate increases. Some claimants were paid as much as \$8,879.09. As a result of the settlement in October, 1999, claimants were paid in July 2000. Had the case been tried successfully, an appeal (again, if successful) would have delayed payments at least until 2002. The settlement does not count as an admission of any wrongdoing by any of the settling defendants, and, if anything, their actions in working to settle the matter should be commended. However, without the litigation, nothing would have been done for these consumers.

D. SOURCES OF SUBSTANTIVE TROUBLE FOR LTC POLICIES

Based on the record in *Hanson*, a review of public filings and discovery in pending litigation, it is clear that, the success of a "guaranteed renewable for life" LTC insurance is dependent on the underlying actuarial, financial and underwriting assumptions on which the policy is structured. By success, I mean the ultimate ability of the policy to pay benefits over time at the initial premium rates.

The important point is that there is inadequate data to price LTC insurance with the same certainty as there is for other insurance products (e.g., life insurance) that consumers are familiar with that shape their reasonable expectations about how an insurance product will perform.

It is also important to focus on actuarial, financial and underwriting problems because of the role they play in facilitating bad policies. The single most important reason for the rate stability problems we see in LTC insurance is the lack of generally accepted or standardized utilization rates for actuaries pricing LTC.^{fn-6} This problem was well known in the industry^{fn-7} and is one reason some critics refer to LTC insurance as experimental.^{fn-8} This lack of a sound actuarial foundation (as compared to pricing life insurance) is not addressed in the NAIC proposals and should concern consumers.^{fn-9}

The next important factor in rate stability is underwriting practices. Underwriting refers to the process by which the insurance company screens applicants to determine who is entitled to buy the policy. The stricter the medical criteria, the less likely it is that there will be early claims for benefits, and the more time accumulated premiums payments can grow until needed, and the lower the number of claims for benefits.^{fn-10}

An example of an actuarial assumption that is often intentionally abused is the lapse rate. One common trick seen in intentional underpricing cases is the assumption of an extremely high lapse rate -- *i.e.*, the number of people who will voluntarily drop the policy each year which number may or may not be combined with a mortality assumption. For example, a lower price follows from the fact that it is assumed that the pool of insureds shrink at a 40% per annum rate. (Why anyone would market or buy such a product is unclear.) If, however, the pool of insureds shrinks at only 5% per annum, additional premium income in the form of rate increases will be needed. Thus, if the actuarial memorandum underlying the policy assumes that a significant number of insureds will lapse after making a number of payments but prior to collecting benefits, the actuarial memo could justify a lower premium for those

who are likely to complete their payments, because future claims under the policy would be diminished by the lapses and, in the case of a non-forfeiture policy, the pre-lapse payments would be available to pay the claims of the remaining policyholders. The higher the assumed lapse rate, the lower the initial premium. [fn-11](#)

An example of a financial assumption is rate of return on future investments. If the memorandum assumed a high rate of return on investments, it would justify a lower premium by increasing the pool of money available to pay benefits. Likewise, assuming unrealistically low administrative costs in the future when claims are being made will lead to erroneous premium settings. [fn-12](#)

Intentional or inadvertent miscalculations on any of these assumptions, or improper underwriting, or both, could lead to the need for future rate increases. Unfortunately, the policies with the erroneous assumptions would have the lowest premium price and would enjoy a competitive advantage in the marketplace. All other things being equal, if two policies promise the same benefits, experience tells us that the lower priced product will be purchased. To the extent consumers are not purchasing insurance in a transparent market, but rather are choosing among options selected by agents, the commission structure will also give some policies a competitive advantage.

E. PRICING AND INFORMATIONAL PROBLEMS

The greatest source of trouble in LTC insurance is a too low initial price followed by unaffordable rate increases. [fn-13](#) Inadequate early premiums almost guarantee astronomical rate increases in the future, nullifying a promise of "guaranteed renewable for life." [fn-14](#) By contrast, adequate premiums (after 40% deductions for commissions and expenses) combined with sound underwriting, create the reserves plus interest over time that ultimately pay the lion's share of the legitimate claims of policyholders. If the initial premium is inadequate (or the underwriting is substandard, or both) rate increases will be necessary to pay future claims, unless the issuing company is willing to bear the risk of loss associated with erroneous pricing.

Price variations for virtually identical products should generally be disturbing as indicating that at least some policies are not grounded on sound actuarial principles. [fn-15](#) The following charts indicate some of these current price disparities: [fn-16](#)

**CHART 1
LONG TERM CARE PREMIUM COSTS**

Avg. Annual Premium At Issue Age:

Company	40	50	60	70	80
UNUM Life Ins. Co.	\$400.48	\$548.72	\$1,070.21	\$2,191.38	\$5,079.77
Pyramid Life Ins. Co.	\$215.70	\$472.00	\$940.90	\$1,795.00	\$5,345.70
Southern Farm Bureau Life Ins. Co.	\$212.00	\$375.00	\$850.00	\$2,226.00	\$6,832.00
Gen. Electric Capital Asr. Co.	\$466.05	\$496.51	\$830.70	\$1,925.35	\$5,511.63
John Hancock Mutual Life Ins. Co.	\$311.50	\$420.40	\$784.24	\$1,739.10	N/A

Travelers Life & Annuity Co.	\$339.28	\$469.14	\$784.12	\$1,772.59	N/A
Physicians Mutual Ins. Co.	\$286.85	\$450.84	\$756.40	\$1,582.11	\$3,937.58
Fortis Co. Inc.	\$367.05	\$406.94	\$658.72	\$1,593.37	N/A
Continental Casualty Co.	\$303.01	\$406.94	\$658.72	\$1,463.83	N/A
Penn Treaty Network America Ins. Co.	\$109.00	\$312.00	\$604.08	\$1,462.32	\$4,161.72

The problem of price differentials among policies, and of "low ball" pricing tactics of some companies is part of a larger informational problem for buyers of LTC products. No one would knowingly buy, or be allowed to buy, an underpriced LTC product,^{fn-17} or a LTC product where the actuarial risk is shifted back to the consumer, or a LTC product that would become unaffordable before it is needed. Appropriate information for the elderly and their families about the benefits and risks of a LTC policy are essential to ensure an informed consumer and to avoid bad situations that harm otherwise prudent individuals or would undermine public confidence in this type of product generally.

Yet such information is hard to come by for consumers. Many agents acknowledge the difficulty of explaining the risks and benefits of these products to customers.^{fn-18} This limits the number of agents selling the product.^{fn-19} More troubling, many state insurance departments too often refuse to turn over key information about complaints or rate increases.

F. THE TEMPTATION

It is easy to see now that the graying of America tempted many companies to provide elder care products before acceptable actuarial data became available:

Demographic indications in the 1970s led the first enterprising companies into the field, and subsequent population patterns suggest a burgeoning market. The life expectancy of the average American man is projected to increase from 70 to 87 years, while the average American woman, who is expected to live until age 92, will add 14 years to her lifespan. Individuals turning 65 this year have a 40% chance of residing in a nursing home, and 10% of these will live in such a facility for five more years. Fully 90% of those needing assistance require help at home, and more than 7 million Americans struggle every year to remain there. With nursing home costs averaging \$20,000 to \$30,000 and home care costs reaching \$10,000 annually, the need for coverage is tremendous.

Actuaries deal with these facts when pricing long-term-care coverages, but they continue to work with a lack of claims information on either an insured or uninsured basis.

Despite the risks, carriers have been entering the LTC market steadily since 1985: More than 140 companies offer LTC coverage products today. There have been departures as well, including that of United Equitable Life in 1987, one of the first insurers to enter and dominate the market. Aetna Life, American Republic Insurance Co. and AIG Life followed.^{fn-20}

This growing market provides a significant economic opportunity for responsible vendors. Unfortunately, some insurance companies have opted to develop cheap products to gain sales with the

idea of passing the costs of poor actuarial assessments or bad underwriting back to the elderly consumers.

G. IS IT EVEN INSURANCE?

One of the most troubling aspects of this problem is whether LTC insurance even deserves the name. Insurance involves the "transferring or spreading" of a policyholders' risk.^{fn-21} "The primary requirement essential to a contract of insurance is the assumption of a risk of loss and the undertaking to indemnify the insured against such loss."^{fn-22} The contract ("policy of insurance") and, its language cannot be construed so as to frustrate its essential purpose. Thus, insurance companies attempts to construe the contract to shift the risk back to the insureds with unlimited rate increases should be rejected as contrary to the notion of insurance and the implicit representations of expertise in risk management contained in this product. Simply stated, selling insurance means assuming an actuarial risk in return for a fixed payment. According to the Supreme Court,

The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk. "It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a significant fraction of the possible liability upon it."^{fn-23}

People buy LTC insurance with the common goal of exchanging the gamble of going it alone -- whereby he or she could either escape all loss whatsoever or suffer a loss that might be devastating -- for the opportunity to pay a fixed and certain amount into the fund knowing that this amount is the maximum he or she will lose on account of the particular type of risk insured against.

The business of insurance is appropriately limited to companies which hold themselves out as actuarial experts in evaluating covered risks and appropriately pricing those risk. The business involves expertise^{fn-24} and affects the public interest,^{fn-25} and so is well recognized as being something more than a pure commercial contract.^{fn-26}

A product is an insurance product only if it shifts the risk of loss from the insured to the insurer,^{fn-27} which in turn manages its risk by creating a sufficiently large pool of insureds over which to spread the risk, by reinsuring all or part of the risk, and by investing premiums now to help pay claims later. This expert task is undeniably in the public interest.

H. NATURE OF THE MARKETPLACE

There are two unfortunate dynamics in the LTC marketplace. First, on the demand side, too few people are informed about the limitations of Medicare/Medicaid, social security and their already existing health insurance to provide for their long term care needs. This means that less desperate and lower risk people (generally, the young-old) avoid the product while higher risk people (generally, the old-old) tend to want it more. This situation both drives honest prices up to often unaffordable levels (given the relatively higher risk pool), and makes the old-old vulnerable to fraudulent sales practices.

The risks associated with the fact that the old-old rather than young-old will be disproportionate consumers was also recognized early on by the Society of Actuaries:

Let me say a few comments about some of the many markets that there are within this field. The most obvious market are the already old, the already frail, by which I mean mostly people over age 80 but also in their 70's when they go through the period of retirement in which they are active and able to enjoy life and start reaching the period in which they become more and more aware of their limitations and what the future holds for them.

The experience so far has been that people are mostly interested in buying nursing home insurance when they get into their late 70's and that it is extremely difficult to get their attention to their potential need for this at an earlier age. The last thing they want to think about is going to a nursing home when they are in their 50s and 60s. It's very much like the similar phenomenon in insurance like the difficulty of persuading any employee under age 40 that they may retire someday and, therefore, that the pension is worth any money to them. This seems to be projected even further into the age span. The lack of publicity, the lack of information that is generally available to promote the need for these services and the nature of the aging process seem to reinforce the difficulty that you have in persuading people that there's a real need.^{fn-28}

The other side of the LTC marketplace is the fact that, while there are many insurance companies willing to sell the product, the channels of distribution are highly limited today to relatively few managing general agents ("MGA"). This situation causes some insurance companies to compete in relatively unwholesome ways to secure a prominent place on the shelf.^{fn-29}

In addition, there are a number of well known reasons why a seemingly rational insurance company would intentionally or knowingly underprice a product. First, low-ball pricing is rational where the proponent of the policy is more interested in the agency or administrative income, or has reinsured the risk away, or both. For instance, in *Hanson v. Acceleration Life Insurance Company*,^{fn-30} the LTC policy was developed by a super salesman with a network of MGAs. He then persuaded a company to front his policy for a fixed percentage of the premium after promising to reinsure 100% of the risk. Clearly, his primary goal was to maximize commission income for himself, and his MGAs. Second, some companies are anxious to acquire market share^{fn-31} to lower administrative costs. Third, some companies will price a policy as a loss leader in a bundle of elderly insurance products.

All LTC policies should be guaranteed renewable for life in a meaningful way. The key concepts are affordability and suitability. The proponents of a policy should make an affordability showing at the front end prior to approval rather than being allowed to plead solvency concerns at the back end and/or exploit the weak regulatory loss-ratios standards at the time of rate increases.

I. RECENT NAIC PROPOSALS

1. Introduction

The NAIC's proposed model regulations do nothing to ensure that LTC insurance is safe in the long run, or that consumers are fairly informed of the risks of rate increases. They are only a work in progress. Indeed, it is generally agreed on many important issues that these proposals still require a Guidance Manual which remains to be drafted in the future. This fact reflects an unfortunate rush to get some rate stabilization rules out, perhaps, for this very hearing:

NAIC Vice President and Kansas Commissioner Kathleen Sebelius said that adoption of the model was important not only to strengthen state insurance regulation, but also to ensure

that regulators can fully participate in Congressional hearings on tax qualified long-term care policies scheduled to take place next month.^{fn-32}

The incomplete nature of the proposed regulations raises question about their likely impact, if implemented as written nationwide. Two examples from the disclosure rules suffice to make the general point. First, § 9.B(2) now requires "[a]n explanation of potential future premium rate revisions, and the policyholder's or certificate-holder's option in the event of a premium rate revision." This could be a good rule to ensure that consumers make informed choices, but a great deal depends on how it is ultimately interpreted and enforced. Second, § 9.B.(5)(a) now requires "[i]nformation regarding each premium rate increase on this policy form or similar policy forms over the past ten (10) years for this state or any other state. . . ." Again, this rule only goes to information about past rate increases and not other, perhaps more pertinent, information regarding the known and quantifiable risk of future rate instability for the particular insurance product. Its usefulness, again, depends on how the rule is interpreted and enforced. However, § 9.B.(5)(c) appears to create an undesirable disclosure loophole for "blocks of business acquired from other non-affiliated insurers."^{fn-33}

In addition, the proposal only applies to future policies sold after the various states consider and promulgate these regulations. § 20.A.(1); § 3. This provides no help to existing policyholders, and people who purchase these policies in the interim period, and people who live in states that opt not to implement these regulations.

2. Ratings Practice

The NAIC proposal is unlikely "to guarantee rate stability and level premiums over the life of a policy." There are no absolute limits on rate increases. In addition, these proposals ignore the goal of developing substantive criteria that will only result in the approval of policies for sale that are unlikely to increase premiums. The dual goals of enabling people to retain coverage and encouraging other people to purchase coverage are never advanced by any form of rate increase.

Only two things will "guarantee" rate stability, and neither the use of sound actuarial data nor objective limits on rate increases are mandated by the NAIC. In other words the core problem is not treated.

First, rate stability depends on a sound actuarial foundation. To my knowledge no one takes the position that there is enough good data today to accurately price LTC insurance. However, the NAIC seems to acknowledge this point indirectly by acknowledging a distinction between types of rate increases. Specifically, a distinction is drawn between regular "rate increases" and "exceptional increases" § 4.A; § 20. The distinction seems to turn on the cause of the increase. Exceptional increases are linked to new legal requirements, § 4.A.(1)(b), and new actuarial data, § 4.A.(1)(b). Such increases seem superficially fair, if explained initially to the purchaser and if limited to truly unforeseeable developments. However, there is no requirement that these changed circumstances be truly unforeseeable to the actuary. This problem is exacerbated by the fact noted above that the insurer is not expressly obligated to identify for the customer known or foreseeable risk factors that could lead to future rate increases. In addition, the exceptional increase allowed may still be greater than the new facts or law warrant. § 20.C.(1) ("Exceptional increases shall provide that seventy percent (70%) of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits"). Yet there need be no showing of 30% extra administrative cost associated with that foreseeable or unforeseeable increase (over and above the existing administrative expenses priced into the original premium).

Second, rate stability can also be achieved by firm limits on rate increases which, in effect, would mean that the insurer would have to cover the risk of its actuarial mistakes from its own capital. The NAIC ignores absolute rules--e.g. no rate increases for the first five years, no rate increases in excess of some percent, etc.

Regulators are rarely able to discern that a policy is priced too low (as opposed to being priced too high). More troubling, most states allow automatic (or "deemer") rate increases whenever the company's loss ratio exceeds a certain percentage, commonly 60%, meaning that more than 60¢ of every premium dollar are going to pay benefits. [fn-34](#) This makes meaningful regulation of rate increases virtually impossible. [fn-35](#)

It is true that the old loss-ratio concept is no longer necessarily a part of the initial price setting process, although it continues to be utilized for rate increases. Some had thought this tended to lead to a lower initial price separate and apart from competitive market forces. This view misses three points. First, the pressure on initial price due to competition is real. Second, as indicated, utilization data is not standardized. Third, the problem is that low ball pricing and rate instability is often accomplished by other non-ratio deceits, such as unrealistic lapse rate assumptions and bad underwriting. This loss ratio change does little then to improve the status quo. Although, strictly speaking, elimination of the loss ratio requirement does allow companies of good faith to set more conservative initial premiums, this ignores the fact that conservative companies in the past repeatedly managed to develop good policies, despite this rule. The loss-ratio rule is not the problem and did not cause the fraud; it simply failed to help regulators stop or identify poorly priced policies. Moreover, for companies desiring to get market share by underpricing competitors, this change creates no deterrent.

The limits on expense allowances and profits on rate increases do continue to use the loss ratio concepts, and are a move in the right direction. However, it is not clear why a company that has priced a policy too low (in the case of a non-exceptional increase) should receive any portion of the additional premiums for commission and profit. The first priority should be to stabilize the block of business by identifying some combination of rate increases (and/or capital contributions by the insurer) to achieve that end; otherwise, a cycle of increases is started. Forcing a company to dig into its own pocket, instead of the pockets of the elderly who relied on, and paid for, the company's expertise, would provide an even more powerful incentive for companies to charge an adequate initial premium.

Reimbursement of unnecessary rate increases is a good idea, but misses the boat for many people. If people are forced to lapse by a rate increase, they get no money back. They are simply older and probably sicker, which means that affordable coverage from other companies simply is not available to them. It also begs the question of how, if at all, the states will police this.

Companies already have powerful economic incentives to administer well. In my experience, bad claims practices do not cause increased premiums. Instead, bad underwriting leads to foreseeable claims by people who never should have been in the group in the first place. Currently, most states require the company to honor the claim of someone who did not hide their medical condition at the time of sale. I have seen market conduct exams dealing with the problem of mass denial of claims. This should not change, but the tenor of the NAIC proposal suggests the contrary. What is troubling is when a company engages in "claims underwriting" which now arguably appears to be tacitly approved by the NAIC, or tries to pass the added costs of these claims to the other insureds in the form of rate increases. A company should bear the economic risk of bad underwriting and bad administration, since the customer has already paid the company for these services in his or her premium.

The idea of taking a bad block of business and pooling it with a non-closed block of business is

generally a good idea, although arguments about the triggering events for action could delay its implementation. However, there are some other open questions. First, do the significant number of policyholders who lapsed get an opportunity to opt in, or is that benefit limited to those policyholders who have continued to pay the increasing premium? Second, what rate is to be charged for that new policy? Third, who bears the financial risk that the more stable current policy may be destabilized by this change?

The idea of banning "bad" companies from the marketplace has been rejected in numerous other contexts. However, this sort of corporate death penalty will likely suffer from the same enforcement problems that we currently see with lesser sanctions. Most states already have the power to stop approving new insurance products from a bad company or to take the license of a bad company that does not play by the rules.

Actuarial certifications are already used with new filings and rate increase filings, and most reputable actuaries would follow existing actuarial standards, which provide in substance that no hidden rate increases is planned. This leaves us in essentially the same position. Some actuaries will sign off on bad policies.

State regulatory ability to adopt appropriate regulations, monitor compliance with those regulations and police fraud is likewise tempered by their responsibility to see that insurance companies remain solvent enough to pay all claims. Too often the company that knowingly or negligently engaged in low ball pricing points to prospective financial problems of its own creation as the justification for future rate increases. Unfortunately, state regulators do a bad job of worrying about solvency at the time of initial filing (as opposed to waiting until it is too late and a rate increase is being sought).

3. Consumer Awareness

In addition, there is the disclosure question: When is the customer told about known problems with some of these assumptions. Obviously, insurers should make meaningful disclosures at the time of purchase^{fn-36} and thereafter before annual renewals. The importance of timely and meaningful disclosure is increased by the fact that as an insured ages it becomes both more difficult and more costly to buy substitute coverage.

Disclosure must also be substantively meaningful. Boilerplate language that premiums "may" go up does little to provide meaningful information to the consumer (or independent agent) about the possible range of rate increases and the attendant risk factors.

Little is being done to ensure that consumers have substantive knowledge as opposed to getting a form disclosure. What consumer really understands the difference between coverage that is "guaranteed renewable" or "noncancellable"? § 8.A.(1). In addition, systemic marketing abuses such as pressure sales are ignored.

Rate increase history disclosure is a good idea in general. As indicated above, the incomplete nature of the regulations and lack of a Guidance Manual makes it difficult to assess the eventual impact of these regulations.

The § 9 requirement of more information is good. However, most policies currently contain language that rates may be increased. This point is not driven home given the general expectation of company expertise and rate stability. In other respects, § 9 is currently too vague to assess its likely

impact.

The timing of disclosure is less than adequate if it first comes in the policy, as opposed to the application and advertising material. § 8.A (limited to "policies"); § 9. In my opinion, a better disclosure would relate to rate increases -- by the issuing company and companies it has acquired or divested -- on all prior and current LTC policies. These and other disclosures should appear on the application. This is more meaningful than disclosures about the risk of rate increases on the contract (as some states require) and/or suitability worksheets (often filled out by agents) which are no substitute for better information and clearer warning on the initial application regarding (i) the risk of future rate increases, (ii) the history of rate increases, and (iii) the companies' experience with LTC. In addition, I would also require insurance companies in their billing statements and in their renewal letters to provide meaningful notice of future anticipated rate increases and problems. Currently, regulators are often told that a proposed rate increase is not enough (and that more may be needed), but consumers are not. This is highly relevant to the decision to buy or renew. More important, many policies are sold in one push and the block is closed before the rate increase begin.

The signed acknowledgment of potential rate increases without a disclosure of risk factors is less than worthless. First, is the risk 1% or 50% that rates "may" go up? Is this truly informed? Does the customer know the company lacks adequate utilization data, or that this policy might perform very differently from other policies? Second, this would enable a company that was selling experimental coverage to say the customer's consent (as opposed to its intent and undisclosed knowledge at the time of sale) is the only issue and should bar any recovery. Third, it shifts blame to agents who can honestly tell the client that this is just legal boilerplate or something similar. Fourth, and most important, it begs the question of corporate responsibility. A better way of reaching this sort of result would be something like this: **I UNDERSTAND THAT MY (MONTHLY/QUARTERLY/ANNUAL) PAYMENT FOR THIS POLICY IS \$ _____. YOU UNDERSTAND THAT I CAN ONLY AFFORD (OR I AM ONLY WILLING TO PAY) \$ ____ PER MONTH FOR MY LONG TERM CARE INSURANCE. I UNDERSTAND THAT MY RATES WILL NOT BE RAISED BEYOND THAT AMOUNT.** This sort of statement will alert the conscientious company to the limited ability of the customer to pay for future discovered shortcomings in the insurance companies current actuarial analysis.

Training of agents and setting standards for marketing is always important. But ask yourself this, why do companies put self-serving and exculpatory language on insurance contracts that expressly disavows any responsibility for what was said by the agent during the sales process?

The emphasis on disclosures misses the point that pressure sales tactics may be occurring and would likely override formalistic disclosures. The relatively high initial lapse rates of between 30-40% on some of those policies suggest pressure sales tactics are occurring in some cases. The companies are in the best position to police their agents.

J. PERSONAL RECOMMENDATIONS

In addition, there is some question about whether the market will ever perceive this as a valuable stand alone product in sufficiently large and diverse numbers to allow meaningful risk spreading, especially after twenty years of largely unsuccessful marketing efforts:

We think there is an awful lot of problem with trying to market just a long-term care benefit and if you try to offer a free-standing long term-care product to people there's going to be a great potential to adverse selection and moral hazard. One of the ways to cut down is to

offer it as part of a much more comprehensive marketing strategy to say, "This is a total health plan for you, the older person". It has all kinds of services, not just long-term care. It's also clear to me that people who need long-term care will find you anyway but that clearly marketing a health product which has all the benefits including long-term care is preferential to marketing just a long-term care product.^{fn-37}

By the same token, from a real cost and actuarial view, the best LTC product may be a subpart of an integrated product that combines other protections such as life, medical, Medigap, disability and/or annuities.^{fn-38} The question then becomes what form that integrated product should take. Certainly, it should be one that does not waste income on unnecessary marketing compensation such as excessive commissions. It should also be modeled on something people do feel comfortable with.

The solution may be to empower elderly consumers and their families to deal with this bundle of health care issues in a privately held medical savings account, modeled on the popular IRAs, that the holder can either manage independently, or in tandem with a traditional insurance provider willing to develop reasonable vehicles for helping the elderly and their families to manage their money better, and select their care options in cost a effective manner.^{fn-39} My recommendation is expanding the utility and desirability of the concept of private medical savings accounts that can be used by the individual for his or her needs as well as those of immediate family members (parents and children). To accomplish this, some people may need to abandon current assumptions about medical savings accounts, and limitations on the development of these accounts.

Under my proposal, 100% of what people invest on behalf of themselves or their family will grow on their behalf to be used when needed in a flexible manner (as opposed to insurance where a substantial amount of money is lost in "transaction costs"). We know from experience with IRAs and 401(K)s that more and more people are willing to save to provide future needs in tax-free accounts.^{fn-40} To ensure that more rather than less money is saved, you have to allow for current deductions for such investments, for tax-free growth of these accounts and for tax-free transfers of these funds to spouse, parents, or children on death. You also allow for these products to be used to help parents as well as children, who consume a significant percentage of LTC services. Unlike existing LTC insurance products, which generally are sold with fixed limits on daily care costs and policy maximums, medical savings accounts could potentially provide a higher level of coverage and thus minimize the need to use limited public resources which will still occur in many cases with people who have LTC coverage. Medical savings accounts can also be more flexible and adaptable to new varieties of care along the continuum of care alternatives, especially the development of home care and community alternatives that maximize care for the elderly while minimizing stresses on the family.^{fn-41} These monies can also be used to pay the significant out-of-pocket expenses not covered by public programs or private insurance.^{fn-42}

Insurance companies could profitably compete for the business of helping families develop saving strategies, manage these funds, and where necessary, provide supplemental coverage for certain defined risks, as well as the 5 to 10 year period in which these accounts need to grow.^{fn-43}

Medical savings accounts are obviously not for everyone and not for every situation. They certainly favor the currently healthy and young-old, as well as the wealthy. However, these people are future claimants on public monies, and their savings can be used for their parents and children as well. These accounts do little directly for those high risk people who are likely to file claims in the near term, although they may do quite a lot for their families who would rather provide home care than institutionalization. Some high risk state pools may be necessary for these high risk people.^{fn-44}

However, needs based coverage for some Americans is not inconsistent with encouraging individuals of all ages to use their own resources to protect their families and themselves.^{fn-45}

K. CONCLUSION

People of all ages need long-term care because they suffer serious chronic illnesses that lead to disability. However, the elderly and especially women are most in need of long-term care services. As the population ages and Americans live longer, the demand for long-term care will increase exponentially during the 21st century. We must look for innovative and cost-effective ways to provide care and to help caregivers. The older population is diverse, their needs are diverse, and the solutions must be diverse.

And by diverse, I mean that private alternatives and solutions must be created and supported, because public programs are neither big enough nor efficient enough to handle the problem of long-term care. Certainly, the public cannot afford to pay for all of these services and we should encourage the private sector to help meet these growing needs. On the other hand, the resources of the elderly and their families are limited and should not be wasted by fraud or on LTC insurance products that do not work.

Ultimately, what we see in the case of LTC is that both sellers and consumers are doing a bad job of evaluating risk. The consumers, except for the highest risk subclass, are generally ignoring the very real need to provide for LTC costs for themselves and their parents. The problem of the highest risk people is that, while they want LTC protection, they are the least qualified for LTC as seen by the problem of anti-selection bias. The people in their 50's who should be buying LTC insurance in greater numbers are not interested or operate under the delusion that Medicaid will pay for it. At the same time, the insurance industry in many cases is not showing the consumers that it is adding value at this point, and some of its members are clearly acting inappropriately if not fraudulently.

I am concerned about permitting tax deduction for long term care premiums because it subsidizes the purchase of potentially fraudulent products and risks causing the taxpayer to pay twice: once for the deduction, and again to pay for the LTC care of the defrauded individual from public monies. If appropriate safeguards existed, the question for this Committee would then be whether to encourage more LTC insurance or to invest in medical savings accounts, or both, matters of which are beyond my expertise.

Safeguards mean at least avoiding fraud. But it should also include protection against exorbitant commissions. Why should taxpayers subsidize 40%-60% commissions? These commissions encourage some agents to recommend the wrong policies initially or to switch policies later.^{fn-46} Maybe the deduction should be limited to the net amount of money actually being reserved by the company to pay the claims. Why should taxpayers subsidize anything else?

However, if we choose to allow tax dollars to be used for long-term care insurance in the form of credits, there must be strong consumer protections to ensure that these tax dollars are well spent, and that the costs of care do not come back to the public because the policyholders (now out the monies paid for premiums) have been forced to lapse their coverage due to rate increases.

Footnotes:

1. TIME (August 30, 1999), Vol. 154, No.9.
2. *E.g., LTC Abuses: Can The Industry Act in Time?* BEST'S REVIEW (Oct. 1990) (attacking the marketing of LTC policies and the claims' practices of some LTC companies).

Consumers, especially elderly consumers on fixed incomes, are price sensitive and will buy "lowball" priced policies and marketing people know it. Useful information about planned or future rate increases is also withheld to encourage sales and renewals.

Fraud is not simply a private sector issues. As this Committee knows, the level of fraud, waste or abuse in some federally administered programs remains a serious problem. *E.g., Pound, Program Billed Medicare Improperly*, USA TODAY, (March 21, 2000), p.1 (questionable charges found in rehab program administered by HCFA, which contracts with insurance companies to pay claims to outpatient facilities).

3. *Hanson v. Accelerated Life Ins. Co.*, No. A3-97-152, at *3 (D.N.D. Mar. 16, 1999); available at http://www.ndd.uscourts.gov/dndopinions/html/A3_97_152_251.htm. LTC is only one of a number of "over-age" insurance products, which also include medical supplement, major medical and/or hospital indemnification policies, that were sold (generally in tandem) by defendants to the plaintiff class, and renewed annually thereafter by plaintiffs.

4. N.D. ADMIN. CODE § 45-06-05-04(1)(b) (1994). This is similar to the provisions in most states.

5. Level premiums are actuarially possible because the benefits under the policies are capped, unlike many true health policies. In a properly designed level premium policy, the policies are rated such that the premiums paid in the first years of the policy are in excess of what is needed to pay the commissions, administrative costs and claims (if any) so that there will be remaining funds to invest. As the years pass and the pool grows older and claims increase, the premiums paid are less than the yearly cost of running the block. However, the pool is supported by the current premiums as well as the accumulated earnings from the premiums paid in the first years. In order for a level premium policy to meet its intended purpose it must be priced in a manner which accounts for the age of the policy holders, it must be underwritten in a way to avoid high risks or excessive, early claims and the premiums paid by the customers must be reserved and managed properly in order to pay claims throughout the years. If the policy is priced correctly and the premiums remain level, both healthy risks and unhealthy risks will remain in the pool thus providing continuing premiums to help support the block as a whole and keep the loss-ratio to a minimum.

6. Standardized tables for reserving, which are different than utilization rates, became generally accepted around 1996.

7. As far back as October, 1985, the Society of Actuaries, acknowledged that data was limited and insurers should proceed cautiously:

There is also a major data problem. The main sources of data that are now available come from national surveys and other public sources like Medicaid programs which are not applicable to any insured population that any company is likely to assemble. The remedy may be to offer insurance policies on an experimental and limited basis in order to gather the data that is necessary to be able to proceed further.

1985 Proceedings, p.15 (Statement of Gordon Trapnell). Yet no company has ever labeled a LTC

product as "experimental." On the other hand, some companies have elected to absorb the risk of rate increases to facilitate the development of sound and profitable products over time.

By 1993, an even broader array of problems with LTC products were being recognized:

Pricing assumptions for LTCI have none of the traditional bases for comfort; claims costs are estimated primarily from data on the general population, not the insured population; persistency rates are little more than a good guess; underwriting has just started up the learning curve; and claims handling is more than only a step or two behind. In addition, the relative success of underwriting and claims activities is unknown, the contract language has yet to be tested in court, and much of the tax code surrounding this product is undefined and uncertain.

Gary Corliss, *Reinsurance: The Key To LTC*, BEST'S REVIEW, Vol. 94, No. 2 (June, 1993) (Life/Health Insurance Edition).

This lack of data or product maturity need only adversely impact the consumer if (1) he or she is not told about the experimental nature of the product; and/or (2) the insurer decided to pass on the cost of its risk of miscalculations in the form of rate increases without the customers' informed consent. This lack of disclosure, and practice of passing costs back to the consumer, accompanied too many of the older policies and persists to this day.

8. Some companies use their own experience as a data set. This is kept generally confidential and is not subject to peer review. Others have used med supp data which was found to be problematic--e.g., utilization rates for LTC, say, post op are not comparable to the LTC of Alzheimer patients. *Supra*, note 7 (1985 Proceedings).

9. Claim practices are also important to price stability. However, what we see in these abusive cases is companies engaging in claims underwriting. In other words, they take premium dollars from anyone, until a claim is made. Then they deny coverage on the grounds, that the insured withheld information. This practice occurred in *Hanson*, but the Department intervened in times to protect the insureds' coverage. However, the cost of that coverage (for people who never should have gotten the coverage in the first place) was passed on to the other insureds (as opposed to making the company pay for its mistake).

10. Meaningful underwriting should be conducted, which means something more than field underwriting (except perhaps in the case of relatively young customers and certain group policies). Every applicant 75 years of age or older should have an Attending Physician Statement (APS) attached to their application. This should remain in their file as a permanent record. This is because the agent is the one who conducts the field interview is motivated by the commission, whereas the company must be concerned with whether this person even qualifies medically for the policy in order to protect the group as a whole.

Underwriting mistakes should not be passed on to other policyholders, *i.e.* if the insurance company accepts applicants who are not medically qualified and they file a claim within a short time of taking out the policy, the fact that the amount of claims is increasing should not be considered when the company files for a rate increase. Given that the most likely applicant is the person who believed themselves in need of coverage soon, the importance of good underwriting cannot be overstated.

11. The loss-ratio concept, which is designed to ensure that over time 60% of every premium dollar

goes to pay for benefits, is also easily manipulated. For example, by projecting future losses on dubious assumptions, an insured can justify a rate increase, even though its loss ratio is well below 60%. With respect to new policies, the new model NAIC rules will eliminate the loss-ratio concept at the time of initial filing, but not for rate increases.

12. Other factor examined in pricing or rate calculations are utilization (current and future), cost trends, reserving commissions and profits.

13. Most insurance regulators try to assure that initial rates are not too high. It is very difficult to police rates that are too low. *See also*, Gary Corliss, *The State of Long Term Care Insurance: 1998*, D&H ADVISOR (1998):

Rate increases, which were considered anathema for a level lifetime premium product, are becoming more common.

14. This happens for two reasons. First, future rate increases are needed to pay claims when reserves have not built up. Second, as rates increase, an anti-selection spiral begins in which those least likely to need the benefits of the policy are priced out, leaving in effect a higher risk pool of insureds who will make more claims than originally projected. If that adverse impact is great enough, the policy goes into a "death spiral."

15. Some variations might be explainable by better corporate ratings or superior underwriting. Nevertheless, these disparities should concern the actuaries at the companies selling the lower priced products. Unfortunately, consumers rarely see price comparisons or get information about the value of various policy features.

16. The charts are based on the work of Martin Weiss, Weiss Ratings Inc., West Palm Beach, FL at <http://www.insure.com/health/ltc/policycosts.html>. For purposes of this comparison, these policies share similar care benefits, consisting of

100 percent nursing home coverage
100 percent community-based facility coverage
100 percent home care coverage
60-day deductible period
Four-year maximum benefit period
\$100 daily benefit
Tax qualification

These prices do not include non-forfeiture benefits or inflation protection. Long term care insurance policies vary widely in the coverage they provide, and consumers are wise to do some research before purchasing any long term care insurance policy.

It should also be noted that such comparison have been criticized as apples-to-oranges comparisons. I do not think that is true of all such comparisons, but if it is, it suggests that a consumer could rarely make sense of the offerings in the marketplace. *Long Term Care Insurance: Risks To Consumers Should Be Reduced*, GAO-HRD-92-14 (Dec. 26, 1991).

17. Appropriate underwriting criteria would generally disqualify applicants who were about to file claims.

18. Barry J. Fisher, *Rate Viability in LTC Insurance: Is There Cause For Concern?* BROKER NEWS, (Dec. 1999), p.13; Gary Corliss, *The State Of Long Term Care Insurance: 1998*, D&H ADVISOR (1998):

LTC insurance agents screamed for someone to provide them with knowledge and products about which they could make cogent and absolute statements.

19. Agents who market primarily to seniors have been tainted in the minds of some by the misconduct of a number of over-zealous Medicare Supplement agents.

20. Gary Corliss, *Reinsurance*, *supra*.

21. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

22. 1 COUCH ON INSURANCE, § 1.9 (3 ed. 1997); "the usual purpose of insurance is to shift risk from an individual or other entity that is risk averse, and so would prefer to substitute a cost certain (a fixed insurance premium) for the risk of incurring a larger cost, to an entity that by pooling independent risks can minimize the overall risk to itself." *Adams v. Plaza Finance Co., Inc.*, 168 F.3d 932 (7th Cir. 1999); *see also*, *State of South Dakota, Division of Insurance v. Norwest Corp.*, 581 N.W.2d 158 (S.D. 1998):

The essence of an insurance contract is the shifting of the risk of loss from the insured to the insurer. "Shifting the risk" can be defined as "the transfer of the impact of a potential loss from the insured to the insurer." *Id.* at 161 (internal citations omitted).

23. *Group Life & Health Insurance Company v. Royal Drug Company*, 440 U.S. 205 (1979)(quoting 1 G. COUCH, CYCLOPEDIA OF INSURANCE LAW § 1:3 (2d ed. 1959). The Supreme Court also recognized the indispensable nature of risk in insurance in *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959).

24. This expertise by the insurer is reasonably expected and relied upon in the marketplace. This expertise combined with the use of "form contracts" explains the well known fact that most consumers do not understand their insurance contract.

25. *E.g., Cataldie v. Louisiana Health Service and Indemnity Co.*, No. 83-C-1750, 456 So.2d 1373 (1984) ("Insurance is a business affected with the public interest . .").

26. A contract for insurance is one for indemnity against loss, and it is personal. *German Alliance Insurance Co. v. Ike Lewis*, 233 U.S. 389, 411 (1914). "The effect of insurance - indeed, it has been said to be its fundamental object- is to distribute the loss over as wide an area as possible." Referring to fire insurance, the Court expounded on the public interest as follows:

[T]he loss is spread over the country, the disaster to an individual is shared by many...Contracts of insurance, therefore, have greater public consequence than contracts between individuals to do or not to do a particular thing whose effects stops with the individuals . . .

* * *

We have shown that the business of insurance has very difinite [sic] characteristics, with a reach of influence and consequence beyond and different from that of the ordinary businesses of the commercial world, to pursue which a greater liberty may be asserted. The transactions of the latter are independent and individual, terminating in their effect with the

instances. The contracts of insurance may be said to be interdependent. They cannot be regarded singly, or isolatedly, and the effect of their relation is to create a fund of assurance and credit, the companies becoming the depositories of the money of the insured, possessing great power thereby, and charged with great responsibility.

German Alliance Ins. Co. v. Ike Lewis, 233 U.S. at 389, 413-414 (1914). Insurance "is of the greatest public concern." *Id.* at 415. The states generally agree. For example, the North Dakota Supreme Court has also recognized the public interest implicit in the business of insurance. *Bekken v. Equitable Life Assur. Soc. of United States*, 293 N.W. 200, 210 (N.D. 1940).

27. *E.g.*, *People v. Dollar Rent-A-Car Systems, Inc.*, 211 Cal.App.3d 119, 259 Cal. Rptr. 191 (Ct. App. June 1, 1989) (contract "was misrepresented as 'insurance' . . . [i]n truth, upon execution of the contract, the renters became absolutely liable for damages. . .").

28. *Id.* pp.15 - 16 (Statement of Gordon Trapnell); *see also*, U.S. Administration on Aging, (2/28/00):

For instance, the strict income limits of the Medicaid program are not widely known or understood. In general, Baby Boomers were less aware than seniors about long term care insurance and few individuals had purchased insurance. Among those who are considering this option, questions were raised about affordability and the best age to purchase.

Another excellent source on public attitudes on Long Term Care comes from the University of Maryland Center on Aging. *See*, Mark R. Meiners, Research Bulletin R-589.

29. *E.g.*, Gary Corliss, *The State of LTCI*, D&H ADVISOR. (Jan/Feb. 1997).

To date the primary successful distribution source has been the brokerage system, and carriers have chased this limited commodity with commissions ratcheting upward regularly.

30. Civ. No. A3:97-152.

31. *E.g.*, Fisher, "Rate Viability in LTC Insurance: Is There Cause for Concern?" BROKER NEWS (12/99), pp. 13, 20 ("a few 'bad players' who introduce low-ball premiums to increase market share, only to raise rates shortly thereafter").

32. Jim Connolly, *LTC Rate Model Adopted By NAIC*, NATIONAL UNDERWRITER (8/21/2000).

33. This exception is ostensibly justified "to prevent insurers from being discouraged from buying bad blocks of business." Fair enough. However, there has to be a plan to fix the problem--rate increases or capital contributions or rewriting the block--and this should be disclosed at the earliest possible time to the consumers who may buy the policy and the insureds who are renewing their policies.

34. The 60-40 "loss ratio" concept is a well recognized life insurance regulatory device that appears to have been improperly transposed in the LTC area. *E.g.*, Gary Corliss, *The State of LTCI*, D&H ADVISOR (Jan./Feb. 1997):

LTCI is a new coverage. Traditional logic suggests that reserves and capital/surplus requirements should be greater for LTCI than for other more traditional insurance products. *E.g.*, Gary Corliss, *The State of Long Term Care Insurance*: 1998, *supra*:

State regulators started way behind everyone else and tried to alter their regulations and practices to fit into a new reality.

35. Nevertheless, insurance companies attempt to avoid civil liability by hiding behind regulatory rate approval or inaction. The vehicle for this excuse is an improper attempt to move the filed rate doctrine into the insurance context. Allan Kanner, The Filed Rate Doctrine and Insurance Fraud Litigation, 76 NORTH DAKOTA LAW REVIEW 1 (2000).

36. In litigation, companies deny any obligation to disclose or claim that minimum regulatory disclosures bar any stricter common law standards. For example, in one case, an insurer (Conseco) has taken the position that it has no duty to disclose risks prior to the initial sale. "[Conseco does] not owe any such duty [to disclose] prior to policy inception because an insurer is not a fiduciary to the insured, and is not in a confidential relationship with the insured before the contract of insurance is issued." Because there is "no duty to disclose, it is immaterial whether [Conseco] had knowledge at the time that Plaintiffs were considering their purchase of long-term care insurance of the purported fact the premiums would increase because of the allegedly inherent defects in the LTC-6 policy." Conseco's Demurrers to First Amended Complaint (8/22/00), Memorandum pp. 5-6, *Blau, et al. v. American Travellers, et al.*. This litigation context claim of lack of duty is inconsistent with the public interest associated with the business of insurance.

37. 1985 Proceedings, pp. 28-29 (Statement of Dennis Kodner). With stronger regulation, public confidence in LTC insurance could increase. Likewise, certain group initiatives (such as the one for government employees) might change this perception.

38. Gary Corliss, *The State of LTC Insurance*, (1997), *supra*.

39. A different proposal is offered by John C. Goodman, *Prescription Drugs for Seniors: The Roth IRA Solution*, (National Center for Policy Analysis: March 16, 2000), www.ncpa.org.

40. Compare this to the relatively low interest in LTC. E.g., Kevin Gough, Conning & Co., *Long-Term Care Insurance, Baby Boom or Bust?* (penetration of senior market is between 5-7%). This study attributes this primarily to two facts: (i) lack of awareness of need or limitations of federal programs, and (2) the current heavy reliance on a relatively small number of MGAS and brokers who specialize in the senior market. This trend may be changing due to increased group sales, especially among governmental employees.

41. "Both the levels of care and the mix of long-term care services available concomitant with the improving health and increased use of assistive devices, social conditions, and desire for independence among older adults may shift care for older patients to a community-based approach." JAMA, (1/26/00) Vol. 283, No.4.

The Balanced Budget Act of 1997 hurt the homecare industry, with over 2,500 agency closures according to the National Association for Home Care. This was due to increasing governmental regulations, such as the surety bond requirements, the Interim Payment System, and Operation Restore Trust. A Prospective Payment System is slated for implementation in FY 2000, and with the latest requirements to transmit patient outcome data via a uniform data set, known as OASIS, or the Outcome Assessment Information Set, homecare agencies have been put on notice to perform in all aspects of survival--both clinical and financial management. LTC NEWS & COMMENT (2/00), Vol. 10, No.6, p.1.

42. The average Medicare beneficiary spent \$2,430 out-of-pocket for healthcare in 1999, according to

new report by AARP. Premiums for private insurance (such as Medigap and Medicare+ Choice) represent 27% of this amount, while B premium weighed in with 19%. Prescription drugs comprised 17% of average out-of-pocket expenses. These out-of-pocket do not include payments for long-term care nursing home care or home healthcare.

Persons with lower incomes spent a greater percentage of their income for medical care, than those with higher incomes. "Out-of-pocket Spending on Health care by Medicare Beneficiaries Age 65 and Older: 1999 Projections," December 1999, AARP.

43. This is not to write off the LTC insurance industry. Rather it is to incentivize them to create new and valuable products to justify the approximately 40¢ of each premium dollar that they currently keep for their expertise, their overhead and their agent's commissions. For example, the insurance industry still has a useful role because it can pool risks, especially the risk of a long stay. However, the idea of giving tax credits to people to buy LTC, even, assuming fraudulent pricing could be effectively policed (say, by creating standardized policies akin to the 10 Medigap plans), seems less efficient than medical savings accounts.

44: *See also, Medicaid Long-Term Care: Successful State Efforts To Expand Home Services While Limiting Costs*, GAO/HEHS-94-167 (Aug. 11, 1994).

45. Average net worth of the elderly, as well as all families, has grown significantly between 1995 and 1998. *Recent Changes In U.S. Family Finances: Results From The 1998 Survey of Consumer Finances*, Board of Governors, Federal Reserve (January 2000) (mean net worth of elderly increased 26%).

46. The NAIC currently recommends that states require LTC companies to report lapse rates, and replacement rates by agents (*i.e.*, twisting).