To: Lawmakers of Minnesota

From: C. Lynn Cox, wife of Gerald ("Jerry") L Cox

Re: Bad Faith of Long Term Care Company

Date: October 31, 2023

I am finding that I am one of many who have had a lot of difficulty accessing payment of long term care claims. It has been very challenging to get benefits/paid claims from my husband's (Gerald "Jerry" Cox's) long-term care insurer, Transamerica Life Insurance Company, as well as getting them to refund overpaid premiums. Jerry died of Alzheimer's Disease in August 2023 and I am still fighting with Transamerica for the payment of his claims. I made unending attempts to communicate with Transamerica through numerous phone calls to customer service (the only phone option), where the call would be re-connected to different departments and after 90-plus minutes they would drop the call. Certified mail was sent in a timely manner with claims data including all the validation they requested, and their claims department (delegated to another company) frequently asked for repeated submissions. The monthly costs for my husband's care were surmounting higher and higher which led to the necessity to hire an attorney to help with obtaining the claims and overpaid premiums.

Jerry and I, as Minnesota school teachers, purchased our long-term care insurance through Education Minnesota in 2002 from Bankers United Life Assurance, which was later transferred to Transamerica.

Jerry's first diagnosis of mild cognitive impairment in 2017 was followed by assessment by a neuropsychologist (2020) and then a neurologist, with the diagnosis of middle stage Alzheimer's Disease. He had difficulty recognizing people, names, recent events and information, and difficulty communicating/finding words. Although he struggled, I was able to care for him in our home and in March 2022 he began services from an Adult Day Care program two days a week. It was not safe for him to be home alone and I also hired a home health program (supervising nurse and home health aides) to assist with ADLs, cognitive activities, and supervision two mornings per week. There were times that I needed to leave the home for my own medical appointments and respite so I also hired a private LPN one afternoon per week. His primary care internal medicine MD in December 2022 determined that his needs were increasing, so they ordered home health PT, OT, and other nursing services. Again I sent all the needed paperwork details/invoices/provider licensure validation to Transamerica by certified mail. Transamerica sent "Evaluators" (an RN hired from a local company) to our home to validate Jerry's needs and the credentials of his providers.

Transamerica sent Explanations of Benefits often denying his claims, saying paperwork was missing or that there were duplicate claims –the reasons for denial did not make sense or were not consistent with the paperwork I had submitted. Jerry's 90-day elimination period should have been met on January 2, 2023, at which time his benefit payments should have begun.

In mid-February, Jerry moved into Trouvaille Memory Care Suites, which had the necessary licensure qualifying him for continuing long-term care. Based on his LTC policy, his premiums would be waived after 60 days in residential memory care. However, Transamerica kept taking Jerry's premiums (required auto-pay) until he died on August 2, 2023.

I repeatedly tried to communicate with Transamerica to determine when his benefits would be paid and it wasn't until May 2023, nearly 6 months AFTER his claims should have been paid, that I received a first payment of only $798.00. This was a pittance of payment for the claims made including his residential care that began in February and started around $8500/mo and in the last month, with much more intensive care, increased to over $9000/mo.

After the initial payment, only some claims payments trickled in. Knowing we could not afford to have memory care costs go unpaid by Transamerica, I was forced to hire an attorney for assistance with his overdue claim payments. In early July, our attorney wrote Transamerica requesting payment for claims beginning in January 2023, again providing all the needed paperwork related to payments and other requested documentation.

In early August, Transamerica started to make more significant payments toward Jerry's residential costs. They also repaid his overpaid premiums. Nevertheless, despite all the clear documentation and our attorney's diligent work, Transamerica still owes Jerry's estate nearly $2,000.00.

This has been a most difficult year for me----moving Jerry to a memory care facility and then losing him to Alzheimer's Disease. All the while, I was forced to fight Transamerica for Jerry's benefits. There was never a dispute that Jerry was eligible for benefits or that his providers were not authorized. Transamerica was very sloppy handling the insurance claims. How Transamerica handles its business is unconscionable and no spouse should have to spend the final days with their loved one at battle for insurance coverage after paying 20 years of premiums.

I hope we can be partners, working in advocacy together in an effort to give other spouses/families the support needed for payment of long-term care claims. Adding a long-term care claims amendment to the "Bad Faith Law" already passed by the Minnesota Legislature would allow the most vulnerable of us the justice needed.

I SINCERELY HOPE THAT YOU WILL SUPPORT THIS AMENDMENT AND HOLD LONG-TERM CARE COMPANIES TO THE HIGHER STANDARDS THAT VULNERABLE MINNESOTIANS DESERVE.

Sincerely,

C. Lynn Cox

C. Lynn Cox

My name is Mary Colleran and I am from Bloomington, MN. I am Patricia ("Pat") Haugh's daughter and her Power of Attorney. I am one of Pat's 5 children and although they are all involved helping in some way, I primarily oversee her health and finances. My mother has been diagnosed with Alzheimer's, Atrial Fibrillation and Macular Degeneration and is currently 89years old. Pat recently moved to a memory care facility, near her home in Albert Lea. However, when we had a dispute with her long-term care insurer, Transamerica, she was living in her home of over 60 years. While living at home, she required home health care and was receiving it from a Certified Nurse Assistant, Kayla Smith, approved by Transamerica. At the time Transamerica approved Kayla as an independent caregiver and paid her claims for HHC, she was engaged to my son and Pat's grandson. Transamerica was aware of their relationship and never indicated it was a problem.

However, after Kayla and my son married, I received a call from a Transamerica representative stating that Kayla could no longer care for Pat since she was now married to her grandson. Transamerica considered Kayla to be "immediate family" and an excluded caregiver under the terms of the policy. To be clear, my mother's policy lists "Immediate Family" as "Your Parents; Spouse; Siblings; Children or Grandchildren, including natural and adopted, step and son-in-law and daughter-in-law." The policy does not, however, list as a prohibited caregiver, a granddaughter-in-law.

The representative told me they would not be reimbursing my mother's care, beginning immediately and gave us no transitional time to find a new caregiver. This has placed my mother in an unsafe and unacceptable position to try to find, hire and train a new caregiver, especially in southern Minnesota where there are less available caregivers, compared to the Twin Cities. It is important to note that Transamerica had my mother assessed several times by an outside nursing agency and each time the nurse indicated that Kayla was an "exceptional" caregiver and that they "wished they could clone her."

By denying my mother's HHC claims, this placed a huge financial burden on her, since she was living on a fixed income. Pat was forced to pay out-of-pocket for all her care until the dispute was resolved. Pat was receiving 4-5 hours of care, 7 days per week.

I immediately attempted to appeal Transamerica's denial but I was ignored. It was not until we were forced to hire an attorney did Transamerica respond -- and even then, our attorney had to ultimately reach out to an inside contact at Transamerica she had worked with on a previous matter. It was not until months later, and after my mother incurred over $12,000 in unreimbursed claims, did Transamerica finally pay her.

What happened to Pat is unacceptable. Not everyone has children and an attorney to advocate on their behalf. Transamerica or any other company, should be held accountable for the words in the contract and made to pay the policy holder by reimbursing CNA wages. My mother has paid thousands and thousands of dollars in premiums over many years to Transamerica and she trusted that they would pay her claims when the time was needed. Instead, my mother was forced to hire an attorney to get what she was clearly owed to her.

Thank you for your interest in my mother's long- term care dispute. I am asking you to support the amendment to Minnesota's Bad Faith Insurance law so that long-term care insurers, who act in bad faith may be held accountable.

Thank you,

Mary (Jan 12, 2024 16:24 CST)

To the Lawmakers of Minnesota,

I am writing to implore you to support the bill to hold Long Term Care (LTC) companies accountable when they act in bad faith and hold them to higher standards of operation as well as Bad Faith claims and penalties. My mother, Mildred Haugan, is a longtime Minnesota resident and I, her daughter and Power of Attorney, am writing on her behalf. At age 97, she is particularly vulnerable to financial exploitation. It is infuriating that a company my parents trusted to look after them if they were in need, would be the one to hurt her.

In 2020, during the pandemic, it became clear my mother's dementia was quickly progressing and for her safety she required 24 hour care in a Memory Care setting. My parents had planned for just such an event by purchasing LTC insurance in 1994. After 26 years of premium payments, I expected that making a claim would be a straightforward matter. Instead it took me a year of lies, manipulations and denials to realize I needed to hire a lawyer to get my mother what she had paid for. Some of the obstacles the LTC company put in my way were: requiring documents by fax knowing I had no access to a fax machine, acknowledging receipt of a document then claiming they did not have it, denying me online access to the claim file and requiring I reapply for access, denying my POA, and asking for vague items, such as a letter from her doctor but refusing to provide information they needed within the letter. Overall their mission was to stonewall me hoping I would give up or my mother would die.

Fortunately, I found attorney Elizabeth Wrobel of St Paul, who was able to successfully make the claim. It took her months (due to the stalling of the company), cost my mother thousands and in the end the threat of a lawsuit caused them to pay my mother what she was owed. By the time the LTC company paid my mother her benefits, she had already spent nearly $43,000 in memory care living expenses. Services for which her company should have paid. In total, it took the LTC company 15 months to pay my mother's benefits after she qualified.

We will never get back the money spent making the claim because Minnesota currently does not have a Bad Faith provision for LTC Companies. I worry for other families who have spent their hard earned funds to protect themselves from the high costs of frailty. Not everyone has the time to do battle with an insurance company or can find and afford a skilled attorney.

I sincerely hope that you will vote to hold LTC companies to higher standards. Some of them prey on the most vulnerable of us, like my dear mother. Minnesota can do better to look after them.

Sincerely,

Ann Okada (Feb 23, 2023 09:51 CST)

Ann Okada

When my father, Carlton Ruud, purchased his PFL Life Insurance Company (which has since been taken over by Transamerica) in 1995, he understood the policy would cover "long-term care facility" benefits and not just a nursing home. Carlton already had another individual insurance policy for nursing home benefits and was very careful with his financial decisions – he purchased this additional policy in the event he needed a facility that was not "medically based" and skilled nursing care was not needed.

In December 2020, in the height of the pandemic, my dad was 91 years old, blind and his significant other and caregiver had died earlier that year. She did everything for him. My only sister (who lives in Wisconsin and I live in New York) and I were left to sort out my dad's life, including where he lived. It was clear he could not live alone, so we started to check out Assisted Living Facilities in northern Minnesota, where he lives. This was especially difficult because of COVID restrictions – many places were not accepting new residents due to staffing shortages.

I spoke with Transamerica, asking for clarification about my dad's benefits. I was given the breakdown of what $115/day covered but no mention of facility licensing requirements. I called again in March 2021 for clarification and got the same information – no mention that the facility itself may not qualify.

Transamerica denied my dad's claims but it was not clear why. In my appeals, my focus was on his Activities of Daily Living. I was led to believe this was the issue, again not the type of facility. Had we understood the licensing of the facility could be in question, different decisions would have been.

Transamerica continually told me I needed proof of my dad's inability to perform his ADLs. Between August 2020 and June 2021, I made at least 23 telephone calls to Transamerica. I reached the same person only once. Each time I was told something different, told I would receive a return call (which I did not) and so on. Transamerica can only be contacted by phone; no email address is given – I would typically be on hold for at least 15 or more minutes. It should not have been this hard or confusing. I was always having to provide "proof" with no one helping me through the process. It felt like they were delaying, hoping I'd give up.

Finally, I hired an attorney to help me sort out the mess. Even then, it took a monumental effort to get even basic home health care benefits on his policy and NOT the LTC facility benefits my dad thought he had purchased. So much time and energy has been wasted. Even now, I dread investigating upgrading his level to Basic Level I or even filing claims for other services provided in the policy. I can't imagine how many more people they have done this to.

Rebecca Russell
315-256-5568
russellmusic@aol.com

My name is Don Blakeslee and I am a resident of Fridley, Minnesota. I served as the Power of Attorney for my mom, Hazel Blakeslee, who suffered from Alzheimer's Disease and passed away in 2019. In September 2016, when Hazel was 89 years old, we made the difficult decision to move her from Seattle, Washington, where she was living in an independent living apartment with optional care services. She could no longer live safely on her own in Seattle and her caregivers requested that she move to a more secure setting. We moved my mom directly into the locked memory care floor at Sunrise Assisted Living Facility in Roseville, MN.

Around the time of her move, we contacted Hazel's long-term care insurer, Continental Casualty Company, also known as CNA, to start the claims process. CNA refused to pay for her long-term care expenses, however, claiming that because Sunrise was licensed as "Housing with Services" it was not considered a "long term care facility" under the contract -- despite Sunrise meeting the contract requirements and providing the exact same care and services as a number of other facilities we considered. At no time did any facility present itself as being different from any other as far as licensing or status and we chose Sunrise of Roseville because of their superior reputation and staffing. Instead, CNA wanted us to move Hazel to a "different" skilled nursing facility. The other facilities CNA suggested were not appropriate for Hazel's memory loss care needs and we did not want Hazel to endure the trauma of a second move. We needed to hire a lawyer to help us after CNA continued to refuse our claim. By March 2017, we had already spent more than $35,000 on Hazel's care. Hazel's daily care costs in 2017 were $200 a day or $6,000 per month.

Fortunately, my mother had my sister and I to advocate for her. She was at the mercy of CNA, who she trusted to take care of her in this situation by paying thousands of dollars over the years in insurance premiums. We searched for and found an appropriate attorney for this specific type of litigation, who was able to get CNA to pay for Hazel's on-going care costs at Sunrise. However, it was not without a significant effort of gathering information and ultimately negotiating with CNA. I feel that if CNA had solid grounds for denying coverage at Sunrise of Roseville, we would have had to take them to court. Instead, our attorney, an expert in this area, was able to help them to see it was in their interest to do what they were supposed to do. Even at that, we had to "re-apply" for coverage once a year or risk having it denied again.

Thank you for your interest in my mom's long-term care insurance dispute.

FEB 19, 2023
Date


Don Blakeslee

Statement of Impact by Bad Insurance Behavior

February 22, 2023
Laurie Biagini

In early May, 2021, I initiated the process of accessing long-term care benefits through CNA Insurance policies for my parents, Jim and Treslyn Koskan. They are currently 99 and 98 yrs. of age, respectively. They receive and pay for assisted living and home care services at this time. My expectation was to basically assist them with completing claim forms in order for them to receive their policy benefits - benefits for which they have paid over $87,000 in premiums the last 25 years. I trusted this process would be straightforward and CNA's agents would be knowledgeable, competent and honest in representing a reputable company.

Instead, I had countless phone conversations with CNA, requiring copious note-taking to keep track of wildly disparate information from a multitude of "representatives." I repeatedly received assurances that benefits were forthcoming, but the assurances were nothing more than superfluous distortions that I believe served to derail the claims process. I did not expect to spend hundreds of hours attempting to decipher voluminous *Explanations of Benefit* documents, which can only be characterized as incoherent and unintelligible – simply in an effort to understand CNA's denials. Nor did I expect to find myself, *a year later*, seeking the legal services of a long-term health care insurance attorney to sort out this web of deliberate prevarication created by CNA with the apparent intent of minimizing payments to its policy-holders.

Initially, CNA ignored our attorney's internal appeal and subsequent telephone calls. Only after receiving a civil complaint, did CNA begin paying my parents the assisted living benefits covered under their policies. However, CNA still continues its predatory practices by denying home care benefits to which Jim and Treslyn's policies clearly entitle them. Vulnerable policy-holders denied legitimate benefits with no recourse for redress need laws to protect their interests from the insurance behavior I have described above.

Thank you for the opportunity to share my experience.

From: **Jim and Treslyn Koskan** jimandtreslyn@gmail.com
Subject: Bad Faith Law
Date: February 23, 2023 at 2:55 PM
To: Elizabeth I. Wrobel elizabeth@wrobelsmithlaw.com

Dear Elizabeth,
I hope my comments below will be helpful toward your efforts to amend Minnesota's Bad Faith law. Good Luck!
Treslyn

Treslyn and James Koskan
Policyholders; CNA Long Term Health Care Insurance

My name is Treslyn Koskan, and for 6 years, I have lived with my husband, Jim, at The Glenn in Hopkins, Mn, an assisted living residence. We were able to make this move, because, earlier---not wanting to be a burden on our children or the state---seeking health care and financial security-- we had taken out a long term care policy with Continental Casualty Company.

This move has been disappointing due to the lack of accurate payment to us of "billed charges". As a few examples, I give you:

Billed $5,102.32 - paid $0.00
Billed $4,449.40 - paid $0.00
Billed $4,442.85 - paid $0.00

- and so on,---time after time.

When you are depending only on work pensions to fund your daily living expenses, you are devastated to find one of your major "comfort sources" --your long term care policy--is not funding your health expenses as required. It is my sincere hope that changes in Minnesota law will stop insurance companies from this type of harm, because policyholders, on their own, cannot.

My mom, Kae Ziehl, has a family history of Alzheimer's disease. Both of her parents suffered from the disease and lived out their years in facilities to care for them. My mom purchased a Prudential long-term care insurance policy in 2001 so she would be taken care of and not be a burden to her family.

Eighteen years later, in November 2019, we moved Kae to Cherrywood Advanced Living in St. Cloud, Minnesota to their locked unit for memory care. Just before Kae moved in, she was hospitalized for a fall she could not even remember happened or report to the doctors her injuries. The hospital staff would not let Kae return home, it was not safe.

It took Prudential five months after Kae moved into Cherrywood to send out a nurse to determine if Kae qualified for benefits. I was present during the nurse assessment and recall that when my mom struggled to answer questions, the nurse would try to help her. The nurse mentioned to me "I don't do too many of these." After the assessment, Prudential denied Kae's claim stating she did not have a "severe cognitive impairment" and she did not qualify for benefits. Because Kae required 24/7 supervision, I knew it was not safe to move her. Instead, we decided to find an attorney to help us.

Our attorney requested Prudential's file and when she looked over the nurse's cognitive testing form, she found several scoring errors that gave Kae an inflated score. Also, our attorney noted that the test was incomplete and would not show the extent of Kae's memory struggles. We were frustrated because Kae's medical records clearly showed her cognitive problems but Prudential relied on a quick assessment done by a nurse who did not know my mom and did not appear qualified to assess her. Eventually, Prudential paid Kae for the cost of her care, but but it was nearly 6 months after Kae should have received the payments. Meanwhile, Kae had to pay thousands of dollars each month for her care, in addition to her premiums to ensure her policy was not cancelled. We were beyond frustrated with the whole situation and still can't believe it took such an effort for my mom to get the insurance benefits she paid and clearly qualified for.

Scott Ziehl
Clear Lake, MN 55319
320-743-3347

TO THE LAWMAKERS OF MINNESOTA:

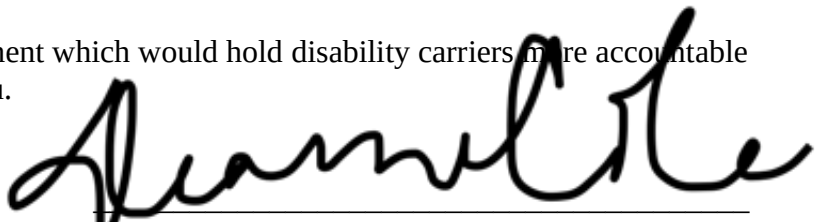
I worked many years as a Deputy/Correctional Officer for Roseau County until April 2018 when I was forced to stop working due to several medical conditions, both physical and mental health conditions. I had disability insurance through my employer's group long-term disability policy insured by Hartford. I felt fortunate to have a policy with a generous disability definition. I had to prove that my medical conditions prevented me from performing only one or more of the essential duties of my occupation for the first three years and thereafter only one more of the essential duties of any gainful occupation. Despite this, the task of proving my disability was very difficult.

Hartford's handling and decision making has been careless and adversarial. Hartford initially approved my claim, but after 24 months, Hartford terminated my benefit claiming it had approved my claim only as a mental health benefit which was limited to 24 months. Hartford's claim file showed that it terminated my claim without conducting a review of the records based on my physical conditions. It also showed that Hartford accepted a medical opinion from its reviewer without having updated records. I complained to Hartford about its unfair treatment and received a response from Hartford's Customer Relations that it would do a better job.

I hired an attorney and appealed. The appeal included the determination from the Social Security Administration finding me disabled from any substantial gainful employment and the opinions from several treating physicians supporting my inability to work. Hartford reversed its opinion and agreed I was disabled from performing my own occupation for three years from a physical standpoint. However, Hartford immediately denied the claim again, stating I could work in other jobs. This time we learned that Hartford had only considered the physical evidence and not the mental health evidence. Hartford agreed to review the mental health evidence before I was required to file another appeal. Hartford took another six months (despite many calls to Hartford) but decided it would stand by its decision.

We filed another appeal and demonstrated that Hartford again had failed to review all pertinent medical information. Hartford ultimately agreed and reinstated my claim. Shortly after my claim was approved, Hartford terminated the disability claim of my spouse who has terminable cancer, so we are again going through the stressful task of trying to get benefits reinstated. Hartford's lack of reasonable and fair review of my claim over a several year period caused an exacerbation of my medical conditions and significant financial distress.

I urge you to pass the amendment which would hold disability carriers more accountable for their bad faith conduct. Thank you.



Deaune Cole

TO THE LAWMAKERS OF MINNESOTA:

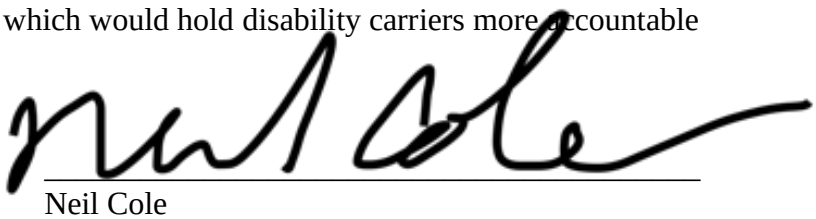
I am the spouse of Deaune Cole who has also provided a statement in support of the bad faith bill. I observed the distress she was put through to receive benefits from Hartford that were rightfully owed to her. I see her struggle every day with daily life activities due to numerous medical conditions.

Unfortunately, at the same time Deaune was having trouble with Hartford, I was on medical leave and receiving disability benefits from Hartford. I was diagnosed with incurable cancer in March 2020 and had to take leave from my supervisor position at Marvin Windows. Hartford paid my benefits for the first two years based on own occupation but then terminated my benefit claiming I was able to work full time in another occupation.

Hartford's claim file shows that it used deception to terminate my claim. Hartford sent a letter to my physician, misrepresenting the facts, and indicating the purpose of the letter was to provide vocational rehabilitation services to me. Hartford asked my physician to provide a release to work in some capacity so that it could start the vocational process. My physician indicated what he had provided in the past, that I experience extreme fatigue and need frequent breaks to finish any tasks. My physician responded "yes" as to whether I could perform various physical tasks, such as walking, standing, sitting, etc. However, key words (can work) were cut off the fax. Despite this, Hartford issued a denial letter claiming that my physician supported my ability to work. Just two months prior, my physician had completed a form for Hartford stating I was not able to work. Hartford did not conduct its own medical review before terminating my claim. Nor did Hartford contact me about any of its vocational rehabilitation services as it represented it was planning to do.

My attorney wrote to Hartford requesting a reconsideration before the expense of an appeal, pointing out that language was cut off the fax sent to my physician, that the letter misrepresented Hartford's intentions, and that my physician continues to support my disability. Hartford has refused to reconsider its decision or respond to the concerns. The Social Security Administration has found me disabled from any substantial gainful employment.

I urge you to pass the amendment which would hold disability carriers more accountable for their bad faith conduct. Thank you.



Neil Cole

To the Lawmakers of Minnesota,

I am writing to urge you to amend Minnesota Statute Section 604.18 to hold disability insurers accountable for their bad faith conduct. I was shocked at the treatment I received from Unum Insurance Company after filing a disability benefit claim. I spent thousands of dollars on an attorney and medical care, but it did not seem to matter how much proof we provided. In the end, I was devasted by the unfair process and I ceased pursuing my disability benefit claim.

I work as a Senior Development Officer for the University of Minnesota. The position is both physically and intellectually challenging. Prior to July 2019, I was healthy and able to perform my job responsibilities at a very high level. In July 2019 I suddenly became very ill, which was later diagnosed as Lyme Disease, Myalgic Encephalomyelitis/Chronic Fatigue Syndrome (ME/CFS), and Fibromyalgia. The University granted me significant accommodations including reducing my workload by 50% for a time and allowing remote work. I continue to be impaired by these illnesses and still cannot work full time.

Part of my compensation package included disability benefits. Unum administered the self-insured short-term disability benefits on behalf of the University and fully insured the long-term disability benefits. Unum approved short-term partial disability benefits for the full one-year period paid by the University. A few months before the claim would turn to long-term disability and Unum would be liable for the benefit, Unum asked for more information and stated the information was insufficient despite no change in my condition. I underwent objective testing, at considerable personal expense, to help support my claim and ultimately, Unum approved my long-term disability claim. However, Unum's approval of long-term disability was delayed more than three months after my short-term benefits ended. Unwilling to acknowledge my Lyme, ME/CFS, and Fibromyalgia diagnoses, Unum approved the benefit based on mental illness and not physical illness. Unum's liability under the policy is drastically limited if the claim is based on mental illness.

After reviewing Unum's claim file, we learned that Unum had not conducted a full medical review during its more than 3-month review process despite assurances from Unum that a full medical review was conducted. Within two months of approval, Unum decided to conduct another full review. Two treating physicians provided several reports explaining the basis of my continuing disability, and objective testing supported physical impairment. Under a multi-state regulatory settlement agreement, Unum is required to give significant weight to treating physician opinions. Nevertheless, Unum terminated my claim a few months later, giving virtually no weight to my treating physicians. My condition had not significantly improved. In fact, at the time my benefit was terminated, my illness required me to stop working altogether for a brief period. Unum's reviewing physicians cherry picked the evidence and even claimed that I was able to work full time in my occupation because I was able to finally drive on the highway. The entire process with Unum was adversarial and exacerbated my condition.

Without any penalty for its bad faith, Unum has no incentive to improve its claims handling. The most that is at stake for Unum in litigation is to pay the benefits it should have paid in the first place. Thank you for your consideration.

Shannon Wolkerstorfer

ACLI
Financial Security for Life

Karen Melchert
Regional Vice President, State Relations
773-575-6849 t
karenmelchert@acli.com

March 8, 2024

The Honorable Zack Stephenson
Minnesota House of Representatives
Chairman, House Commerce Committee

The Honorable Carlie Kotyza-Witthuhn
Minnesota House of Representatives
Vice Chairwoman, House Commerce Committee

The Honorable Kelly Moller
Minnesota House of Representatives

Re: HF 1791 – State of Opposition

Dear Chairman Stephenson, Vice Chairwoman Kotyza-Witthuhn and Representative Moller,

I am writing on behalf of the American Council of Life Insurers ("ACLI") and our 280 member companies to express our opposition to House File 1791 which seeks to expand the scope of Minnesota's bad faith insurance law to apply to long-term care ("LTC") and disability income insurance ("DI") products as well as other health-related insurance products including vision, Medicare, supplemental, blanket accident, income replacement and dental insurance written by any carrier other than Delta Dental.

House File 1791, while brief in words, would have a far-reaching, negative impact on Minnesota insurance consumers that would far outweigh any benefit the proponents of this bill claim to be addressing. The bill would allow for breach of contract lawsuits related to these health-related insurance products that would carry with them claims for up to $100,000 in attorneys' fees and up to $250,000 in non-economic damages if the insurance carrier did not have a reasonable basis for denying the benefits of the policy. This would result in an additional $350,000 in costs beyond the policy limits and would increase litigation and nuisance lawsuits that would lead to higher premiums for all consumers.

Unlike auto and home insurance, mandated coverages to which this law currently applies, the products swept in by this legislation are voluntary products that the state encourages individuals

to purchase. These products help protect consumers from financial hardship resulting from unexpected expenses from health-related incidents. Adopting legislation that would add increased costs to these products would discourage consumers from purchasing them, thus exposing them to financial hardship and a higher dependence on state-funded services.

Insurance policies are not tangible goods. They are a promise to provide financial protection. Insurers take those promises very seriously, as it is their reputation that stands out most to their customers. When a consumer believes the insurer has not acted fairly, they can turn to the Department of Commerce ("DOC") who can swiftly and effectively address the consumer's concerns. The Department of Commerce has almost unlimited authority to impose a fine, pull an insurer's authority to do business in the state and to require carriers to pay wrongly denied claims. For health-related products, unlike with auto and home insurance, carriers are required to pay interest on delayed claims. Seeking redress through the consumer complaint process at the Department of Commerce is the most effective and efficient way to address consumers' concerns without imposing additional costs that will drive up the cost of these products for all consumers.

Finally, we would like to note that there isn't a need to be addressed here. The proponents have been circulating a list of consumer complaints they compiled from information they received through a Freedom of Information Act request of the Department of Commerce. That list does not include the outcomes of those complaints and it fails to illustrate that the Department of Commerce took regulatory action against one company who was the subject of the majority of complaints. This illustrates that regulatory oversight currently in place is effective and efficient in addressing consumers' concerns without resorting to litigation that can take years to reach a resolution.

We encourage you to vote "No" on House File 1791 and to keep these products that protect Minnesotans from financial hardship affordable and readily available for years to come.

Sincerely,

Cc: Robyn Rowen, Executive Director Minnesota Insurance and Financial Services Council