

April 14, 2015

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Re: Field Claims Examination Report
Genworth Life and Annuity Insurance Company, NAIC #65536

Dear Commissioner Jones:

Pursuant to California Insurance Code section 12938(b)(2), Genworth Life and Annuity Insurance Company ("We" or "GLAIC" or "the Company") hereby submits its response to the California Department of Insurance ("Department") report of the market conduct examination of its claims handling practices of long term care insurance and fixed life claims closed during the period from April 11, 2011 through March 31, 2012, adopted March 19, 2015 ("Exam Report").

GLAIC has carefully considered and responded to each of the Department's criticisms in the Exam Report. While we appreciate the Department's feedback, we vigorously object to and deny any allegation that GLAIC engaged in a pattern or practice of claims handling that violates California law. Throughout the examination process, the Department has attempted to enforce standards that are outside the requirements of California law, sometimes to the detriment of California insureds. In addition, in some instances, the Exam Report mischaracterizes, misstates or simply misunderstands GLAIC's practices. In addition, the Department has taken a few isolated instances of inadvertent error and unjustifiably characterized them as demonstrating a general unfair business practice. For these reasons, GLAIC disputes the accuracy of the findings in the Exam Report and maintains that it has acted in compliance with California law. GLAIC does not herein address every issue raised in the Exam Report and, accordingly, reserves its right to raise any and all objections to the Department's findings at the appropriate time.

1. GLAIC's claims handling practices are in compliance with and, in many instances, exceed the requirements of California law.

GLAIC believes strongly in the quality of its claims handling and has established a robust, efficient and high-quality claims experience for its insureds. While GLAIC objects to any assertion that its claims handling is non-compliant, We continually strive to meet and exceed the requirements of California law and industry best practices. To that end, GLAIC invested significant time and resources into enhancing its claims handling policies and procedures, often in cooperation with the Department, in order to provide the best possible customer experience.

For example, in an effort to improve insureds' understanding of the equipment benefit, GLAIC agreed to provide an advance approval determination (without requiring additional documentation) on certain pieces of equipment specified in the insured's approved Plan of Care, to discuss the equipment benefit with the insured during Approval Calls, and to revise its approval letter to list certain equipment items in the Plan of Care that have been approved under the policy. In addition, while the Company has always had a comprehensive process and sophisticated system to ensure that claims are promptly, but thoroughly, reviewed and paid, GLAIC agreed to remind its benefit analysts not to require submission of multiple proofs of claim where coverage may exist under more than one policy and now accepts a single copy of an invoice as proof under multiple policies. Also, in an effort to improve insureds' understanding of the content of each benefit payment, GLAIC enhanced its Explanation of Benefits ("EOB"). The new EOB is written in an easy-to-read format that includes policy details such as applicable maximums, service dates considered, excluded amounts, including dates for which Medicare non-duplication was applied, and deductible/elimination periods.

The enhancements and commitments made by GLAIC exceed the requirements of California law, were undertaken voluntarily, and represent GLAIC's ongoing commitment to its customers and industry best practices.

2. The Department seeks to enforce standards that unreasonably exceed the requirements of California law.

Despite GLAIC's cooperation throughout the examination process and the tremendous effort made to reasonably respond to the Department's criticisms, the Department persists in imposing standards which are outside the requirements of California law. For example, the Department alleges that in certain claims the Company failed to conduct and diligently pursue a thorough, fair and objective investigation prior to applying Medicare offsets. In determining the amount of a Medicare offset, the Company relies on information provided by the Skilled Nursing Facility (SNF) confirming the charges submitted to and covered by Medicare, referred to as a UB-04. GLAIC believes that the use of the UB-04 is the most efficient and accurate means of confirming Medicare coverage for a SNF stay. This aspect of Medicare Part A is routine to a SNF and the billing department knows which costs will be covered by Medicare when the UB-04 is submitted. In addition, the Company's approval letter provides a notice to insureds that the policy will not reimburse for any care or equipment paid or payable under Medicare and that if expenses have been incurred beyond what Medicare allows, the insured should submit them to the Company. Despite this, the Department insists that in order to properly ascertain the amount of any Medicare offset, GLAIC must secure Medicare Remittance Advices. Waiting months to receive confirmation through the Medicare Remittance Advice would either delay payment of benefits to the insured or would result in a substantial reconciliation of overpayments. Furthermore, this position exceeds the requirements of California law which simply provide that the Company must thoroughly, fairly and objectively investigate claims. GLAIC's process for investigating Medicare offsets is diligent, thorough, fair and objective.

Similarly, the Department alleges that GLAIC failed to disclose all benefits, coverages, time limits or other provisions of the insurance policy that may apply where an insured owns multiple policies, specifically the provisions which reduce and/or offset benefits. GLAIC agrees that the relevant policy provisions should be clearly and sufficiently explained to insureds. To that end, the Company revised its approval letter in situations where an insured owns multiple policies where one or both have non-duplication provisions. Notwithstanding, the Department continues to insist that the language in the approval letter is insufficient because it does not "address the other options available for the insured such as initial access to one policy and whether a policy held in reserve may be used for later dates of services or retroactively applied." Here, the Department seeks to impose standards that are contrary to the policy language and, again, exceed the requirements of California law. GLAIC's approval letters sufficiently and accurately explain how non-duplication provisions are applied where an insured owns multiple policies. The Department's displeasure with the plain language of the policy is not grounds to allege that the Company has failed to properly disclose the policy's provisions.

GLAIC believes it is patently unfair to impose standards upon it that were previously undefined and exceed the requirements of its policies and California law.

3. The Department has mischaracterized, misstated or misunderstood GLAIC's claims handling practices.

In certain instances the Exam Report either mischaracterizes, misstates or misunderstands GLAIC's claims handling practices. For example, the Department alleges that GLAIC failed to effectuate prompt, fair and equitable settlements where an insured owned two policies, purchased at different times, where only the second one contained a non-duplication provision. The Company analyzed the benefits available under each of the insureds policies concurrently and paid benefits under the first policy up to the daily maximum then paid benefits under the second policy, up to the expense incurred for care (when it was less than the daily maximum of the second policy). The Department argues that the concurrent method of handling multiple policies results in unfair settlements and that, instead, the Company should have paid benefits under the second policy first, ignoring the fact that the other policy existed, and then paid benefits under the first policy. The Department misunderstands the policies and GLAIC's process. If the Company were to, as the Department suggests, pay under the second policy first and then pay benefits under the other, this would result in the insured being reimbursed for more than the expenses incurred, which is prevented under both policies. GLAIC paid benefits to the insured that fully reimbursed for the expenses incurred, a result that was both fair and consistent with the policies and California law.

4. The Department has taken a few isolated instances of inadvertent error and unjustifiably branded them as demonstrating a general unfair business practice.

Despite its statements to the contrary in the Exam Report, the Department has failed to identify any violations of CIC section 790.03(h).

CIC section 790.03 defines certain unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. Subsection (h) provides that "knowingly committing or performing with such frequency as to indicate a general business practice" any of the settlement practices listed therein is considered an unfair method of competition and unfair and deceptive act or practice. CIC § 790.03(h). A plain-language, grammatically accurate reading of section 790.03(h) shows that "knowingly" modifies both "committed" and "performed." Accordingly, GLAIC must have "knowingly committed" or "knowingly performed" "with such frequency as to indicate a general business practice" the alleged unfair settlement practice in order to violate section 790.03(h). Instances of inadvertent error cannot constitute a "knowing" violation of section 790.03(h). Moreover, a violation of section 790.03(h) must be based on a practice, not a single act. Section 790.03(h) refers only to "unfair claims settlement practices" and requires that such practices be so frequent as to indicate a general business practice. GLAIC disputes many of the allegations in the report. However, in the handful of instances in which it acknowledges an error, these errors were inadvertent and not committed knowingly nor with sufficient frequency as to indicate a general business practice.

In addition, a violation of section 790.03(h) cannot be inferred, as the Department attempts, from a violation of the California Fair Claims Settlement Practices Regulations (10 CCR section 2695.1 et seq.) or any other provision of the Insurance Code. The language of 10 CCR section 2695.1(a) impermissibly expands the scope, nature and reach of section 790.03 beyond what was intended by the Legislature. Applying the principle of *expressio unis est exclusio alterius*, it is clear the Legislature expressed the intention to make exclusive the list of unfair methods of competition set forth in section 790.03 and the addition of purportedly unlawful settlement practices is prohibited unless the process set forth in section 790.06 is followed, or the Legislature itself acts. Accordingly, the Exam Report's allegations of violations of the Fair Claims Settlement Practices regulations cannot serve as the basis for a violation of CIC section 790.03(h).

We appreciate this opportunity to provide comments to the Exam Report.

Sincerely,

A handwritten signature in black ink that reads "Allison Kusel". The signature is written in a cursive style with a long horizontal stroke extending to the right.

Allison Kusel
Adjudication Leader, Long Term Care Claims