# MEDI-GAP: PRIVATE HEALTH INSURANCE SUPPLEMENTS TO MEDICARE

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

PART 1—WASHINGTON, D.C.

MAY 16, 1978

Printed for the use of the Special Committee on Aging


U.S. GOVERNMENT PRINTING OFFICE

32-703 O WASHINGTON : 1978

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock No. 052-070-04737-2

## SPECIAL COMMITTEE ON AGING

FRANK CHURCH, Idaho, *Chairman*

EDMUND S. MUSKIE, Maine
LAWTON CHILES, Florida
JOHN GLENN, Ohio
JOHN MELCHER, Montana
DENNIS DECONCINI, Arizona
PETE V. DOMENICI, New Mexico
EDWARD W. BROOKE, Massachusetts
CHARLES H. PERCY, Illinois

WILLIAM E. ORIOL, *Staff Director*
DAVID A. AFFELDT, *Chief Counsel*
LETITIA CHAMBERS, *Minority Staff Director*
GARRY V. WENSKE, *Assistant Counsel for Operations*

Medi-Gap: Private Health Insurance Supplements to Medicare:
Part 1. Washington, D.C., May 16, 1978.
Part 2. Washington, D.C., June 29, 1978.

# CONTENTS


| | Page |
|---|---|
| Opening statement by Senator Lawton Chiles, presiding | 1 |
| Statement by Senator Pete V. Domenici | 27 |
| Statement by Senator John Glenn | 28 |


## CHRONOLOGICAL LIST OF WITNESSES


| | |
|---|---|
| Lowry, Robert E., Raleigh, N.C. | 30 |
| Klowden, Jules L., volunteer insurance counselor, Senior Citizens Service Center, San Diego, Calif | 46 |
| Grubbs, William E., associate legal counsel and director of government relations, Bankers Life & Casualty Co., Chicago, Ill.; accompanied by Duane Chapman, administrative vice president; Russell Van Kampen, marketing vice president; and Michael Dressendorfer, associate | 53 |
| Wilde, Harold R., Madison, Wis., commissioner of insurance, State of Wisconsin | 75 |
| Cooper, W. W., Tallahassee, Fla., administrator, health insurance section, Office of Florida Insurance Commissioner | 85 |


## APPENDIXES


| | |
|---|---|
| Appendix 1. Additional material submitted by Robert E. Lowry: | |
| Item 1. Further comments of Robert E. Lowry | 95 |
| Item 2. Exchange of correspondence between Robert Lowry, the North Carolina commissioner of insurance, and Bankers Life & Casualty Co., Chicago, Ill | 96 |
| Appendix 2. Additional material submitted by Harold R. Wilde: | |
| Item 1. Booklet entitled, "Health Insurance Advice for Senior Citizens," prepared by the Office of the Commissioner of Insurance, State of Wisconsin | 110 |
| Item 2. "Outline of Coverage" letters required and approved by the Wisconsin insurance commissioner | 131 |
| Item 3. Excerpts from public testimony at a hearing of new Wisconsin insurance rules governing sales of medicare supplements, April 20, 1976, before commissioner of insurance, State of Wisconsin | 136 |
| Item 4. Examples of misleading mailings and solicitations which misrepresent the relationship between private health insurance plans and the Federal Government; submitted by Office of Commissioner of Insurance, State of Wisconsin | 137 |
| Appendix 3. Additional material submitted by Bankers Life & Casualty Co. of Illinois: | |
| Item 1. Letter from Michael J. Dressendorfer, government relations department, to Kathleen M. Deignan, Senate Special Committee on Aging, dated June 23, 1978 | 143 |
| Item 2. Agent's contract form | 144 |
| Item 3. Career agent's health commission schedule | 147 |
| Item 4. Career agent's life commission schedule | 149 |
| Item 5. Career agent's group commission schedule | 154 |
| Item 6. Field office bulletin | 155 |
| Item 7. Medicare supplemental policy forms, outlines of coverage | 158 |

Appendix 4. Statements and letters from individuals and organizations: Page
Item 1. Statement of Mary M. Bach, staff attorney, Center for Public Representation, Madison, Wis ........ 162
Item 2. Statement of Jo Pebworth, benefit specialist, Access for Senior Citizens Project, Center for Public Representation, Madison, Wis ........ 162
Item 3. Letter to Richard Audetat, Grant County Commission on Aging, Lancaster, Wis., from Denise Hill, Platteville Municipal Nursing Home, Platteville, Wis., dated May 1, 1978 ........ 166
Appendix 5. "What You Should Know About Health Insurance When You Retire," publication of Health Insurance Institute, Washington, D.C. ........ 167
Appendix 6. Decision by California Department of Insurance regarding amendments and additions to regulations relating to individual disability policies designed to supplement medicare, dated March 21, 1978 ........ 183
Appendix 7:
Item 1. "Public Regulation of Private Supplements to Medicare and Medicaid in Oregon," by Ron Wyden, excerpt from Connecticut Law Review, vol. 9, No. 3, Spring 1977 ........ 195
Item 2. Decision by Oregon Division of Insurance regarding information insurers must disclose to prospective purchasers of health insurance to supplement medicare and medicaid, dated December 21, 1976 ........ 207

# MEDI-GAP: PRIVATE HEALTH INSURANCE SUPPLEMENTS TO MEDICARE

---

**TUESDAY, MAY 16, 1978**

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, D.C.*

The committee met, pursuant to notice, at 9:35 a.m., in room 357, Russell Senate Office Building, Hon. Lawton Chiles, presiding.

Present: Senators Chiles, Glenn, and Domenici.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff member; Garry V. Wenske, assistant counsel for operations; Letitia Chambers, minority staff director; Margaret S. Fayé, minority professional staff member; Alison Case, operations assistant; and Madonna S. Pettit, research assistant.

## OPENING STATEMENT BY SENATOR LAWTON CHILES, PRESIDING

Senator CHILES. This hearing of the Senate Special Committee on Aging is a preliminary inquiry into the extent and patterns of purchase of private health insurance supplements to medicare by older Americans.

A number of questions have been raised about such insurance, including suggestions that many older Americans purchase policies of questionable value, multiple policies well in excess of probable need, and policies offering benefits inappropriate to need.

The committee wants to know how pervasive these problems are and what factors may contribute to unnecessary expenditures of precious retirement income.

There is very little information available now. The committee issued a report in 1974 [1] which estimated that older Americans spent over half a billion dollars annually on private health insurance to supplement medicare. We now believe this is a very conservative estimate.

The Social Security Administration reports that almost 63 percent of all Americans over age 65 had some private health insurance coverage for hospital care alone in 1975. Up to 55 percent of all older Americans had some form of private insurance coverage for physician's services. This is a lot of insurance, but only 5 percent of the health care bill for older Americans is paid for by private health coverage.

---

[1] "Private Health Insurance Supplementary to Medicare." a working paper prepared in December 1974 for the Senate Special Committee on Aging by Gladys Ellenbogen, Ph. D., consultant to the committee.

### "Taking Advantage of Fear"

Clearly, older Americans fear health care costs well beyond what medicare will cover. Why else would there be such a large market for supplemental health insurance? And no wonder. When medicare cost-sharing amounts are deducted, medicare pays for only 38 percent of the total health care bill for older Americans.

One need only look at the advertising used in these two examples [1] here to see that this fear is taken advantage of in insurance policy sales to older Americans—whether by mail, through newspaper ads, or door to door by agents who sometimes sell policies from a number of different companies at the same time. These examples, by the way, are the first pages of advertising brochures stuffed in Florida Sunday newspapers.

There also appears to be a lot of confusion about what medicare will and will not pay for. We have heard allegations about individual insurance agents who take advantage of this confusion. Some have even represented themselves as Federal employees of medicare and suggest medicare will cover a lot less than is actually the case. At the same time, false claims may be made about benefits provided by the health insurance they have to sell—all in the interest of a large commission—without due regard for appropriate insurance protection for the elderly consumer.

### Largest Gaps Left Uncovered

Ironically, most of the insurance sold to medicare beneficiaries does not cover the real gaps in medicare protection, such as prescription drugs, dental care, or custodial nursing home care. According to the Social Security Administration, only 22 percent of older Americans have private insurance coverage for out-of-hospital prescription drugs; less than 3 percent have any form of dental coverage; and less than 20 percent have any form of coverage for nursing home care. The insurance is sold more often simply to fill in the deductibles and coinsurance charges required in medicare hospitalization and outpatient service plans.

The situation the committee is concerned about is best illustrated, I think, by the following letter received by the Wisconsin Commissioner of Insurance, one of our witnesses this morning. Since an investigation is now in process, the names of the individuals and companies involved have been changed, but I would like to read that letter.

Dear Sir: My name is Jane Doe. I was born April 20, 1891. I seem to buy an awful lot of insurance lately. Since January 8, 1976, I purchased from Company, A, Agent No. 1, four policies for $320. Then on January 6, 1977, Agent No. 1 sold me replacement nursing home insurance with Company B for $330. I don't have the policy for that yet.

On March 17, 1976, Company C sold me nursing home insurance for $342. Then on July 17, 1976, Agent No. 2 sold me a hospital indemnity policy for $600 in Company D. Then Agent No. 2 came back and sold me, in October 1976, two Company B policies for $287.40, indemnity and cancer insurance. I found a receipt signed by Agent No. 2, dated July 26, 1976, for $390.25 from Company B, and I don't even know what that is for.

Then on October 7, 1976, Agent No. 3 was here and wrote me a life policy dated October 19, 1976, from Company E. That is for $1,500 of insurance and it cost me $538.76 a year, and I really don't care to have it.

---

[1] See pages 21–26.

Then on December 9, 1976, Agent No. 4 wrote me a nursing home policy with Company B, again for $140 a year. Then on January 5, 1977, Agent No. 5 wrote me two policies for hospital and nursing home that cost $192 with Company F.

Then on February 9, 1977, Agent No. 6 wrote me hospital and nursing home insurance with Company G for $364. Then the same fellow came back again on February 18, 1977, and wrote me two more policies for cancer and hospital for $222, and I don't have these policies.

I also have Company H and Company I cancer insurance.

There may be some other policies here, but I think I am afraid to look.

I have spent for insurance, since January 1976, about $3,675 (actually, $3,726.41), and I am appealing to you to help me recover as much of this as humanly possible. I really want all my money back and I want to be left alone by these insurance agents.

Most of them don't even tell me what they're selling me and half the time I don't get receipts and they keep coming back every so ofter for more money.

It is your duty to help a poor widow, as the help I'm receiving from other people does not have your authority.

JANE DOE.

P.S. I had someone write this as I have a little arthritis which impairs my handwriting.

In case you didn't catch that, this 87-year-old woman had been sold 19 separate policies from 9 different companies by 6 agents in just over 1 year. She was committed to payments of almost $4,000 a year in premiums for insurance, which, even from the sketchy information provided in this letter, has to be largely worthless to her because of the duplication and overlap in coverage. I also wonder how she became so well known to so many agents in such a short time.

A number of our witnesses today will, I believe, recount similar situations. We hope they will also offer suggestions for ways to prevent this from happening so often.

The committee is not alone in its concern. I would like to insert into the hearing record excerpts from a speech delivered to the Health Insurance Association of America, representing insurers who write 85 percent of the private health insurance in the country, by Mr. Robert A. Beck, chairman of the association and president of the Prudential Insurance Co. of America.

## INDUSTRY SHORTCOMINGS

Mr. Beck said that "the few companies" selling medicare supplement policies to the elderly give a bad name to the whole industry. He suggested many medicare supplements have a ratio of benefits to premiums far too low to ever be expected to provide a reasonable return, and he charged the association to recognize certain industry shortcomings and face up to its responsibilities in correcting them.

[The speech referred to follows:]

### EXCERPTS FROM A SPEECH BY ROBERT A. BECK, CHICAGO, ILL., MAY 1, 1978 [1]

Good morning:

This past year has been a busy and productive one for the association and very rewarding to me personally.

But the pleasure I feel at addressing this 22nd annual group insurance forum is mixed. For today marks the end of my tenure as chairman of the board of the HIAA. It is traditional for the outgoing chairman to review the association's accomplishments over the past year. Let's do that—briefly.

---

[1] Full text retained in committee files.

At the State level, our actions have helped hold the line on State health insurance plans. At the beginning of 1977, there were four State plans in effect. Although more than a dozen State legislatures introduced bills proposing such plans last year, none was enacted. In another problem area—mandated coverage of maternity benefits—the private insurance industry is seeking to affirm an important decision in New York. Our position—that the legislature may not force amendments of those in-force contracts which cannot be terminated or nonrenewed by the insurer—was upheld on first appeal. We trust that the New York Court of Appeals will affirm this. The court of appeals has heard the arguments and we expect a decision soon. That's the good news. The bad news is that the diversity of mandated state benefits continues to plague us. Each new legislative session brings renewed efforts to impose additional State requirements.

More important, however, than the absence of new State health insurance plans, are the positive accomplishments that have been achieved. At the top of the list is the fact that people now realize that the private health insurance industry has viable and constructive alternatives to State health insurance plans. There is a portfolio of State activities and legislation we support. State prospective hospital budget review is one example—it's effective in five States already and being considered in several more. Peer review programs are another. Effective health planning at the local level is a third. Some 250 insurance industry people are now involved in the health planning agencies, the HSA's and the SHCC's.

In a similar vein, the model group health insurance continuation and conversion bill should be supported.

These measures promote cost containment, quality assurance, and adequacy of coverage, without setting up a State health insurance plan.

On the Federal level, relatively few adverse actions have been taken. The private health insurance industry is a key participant in both the cost containment and the national health insurance debates. Federal legislators and Federal agencies know that we have positive programs to meet society's needs—that we are not just against everything. Our support of a public-private partnership for NHI is embodied in our continuing advocacy of the Burleson-McIntyre National Health Care Act. In the present debate over what form national health insurance should take, we have made our views known in meetings with congressional, HEW and White House staff officials.

But this retrospective look at our recent successes: support of positive programs, effective advocacy of the insurance viewpoint, and increased public awareness of the problems of our business—must not blind us to the concerns we face.

The problems of the HIAA—or challenges, as I prefer to call them—are the results of the times we live in; challenges we experience by our very nature as a large association with diverse membership. They are crucial. If we are to overcome them, we must recognize certain industry shortcomings and face up to our responsibilities in correcting them.

### "Some Plans Do Not Provide Good Value"

One of these problems is the sale of plans which do not provide good value—policies whose benefits are unreasonably small in relation to premium. Recently in New Jersey, the commissioner charged 71 companies with the sale of such policies. Unhappily, I have to tell you that Prudential was one of them.

We were cited because the loss ratio on one of the plans we currently sell was below the commissioner's 50 percent loss ratio standard. The plan is a daily hospital indemnity plan which we began selling in 1970. It represents only a very small fraction of our business. We have about 19,000 of these plans in force nationwide and last year the premiums were less than 1 percent of our total individual health care insurance business.

In our response to the commissioner, we explained that our loss ratio on this plan has been steadily increasing as the policies aged and this year we expect the cumulative loss ratio to exceed 59 percent. In retrospect, it is a pity that we did not give a more detailed explanation when we first replied to the commissioner's request for information. I think we could have avoided some criticism which I think was really unwarranted.

I believe that some of the other 71 companies which were criticized can give similar justification for their situations. There are some companies, however—particularly some selling medicare supplement policies to the elderly—where

the ratio of benefits to premiums is really far too low and can never be expected to reach a reasonable figure. These companies can be fairly criticized. Those few companies give a bad name to the whole industry, and I urge them to change their practices.

"INDUSTRY HAS BEEN LAX"

I submit that we have been lax, as an industry, in policing our fellow companies. We can't just sit back and do nothing for fear of antagonizing some of our members. When companies sell plans which are clearly inappropriate or overly expensive, we should criticize them—rather than wait for the public, the press, regulators or legislators to point out our deficiencies.

HIAA has more than 300 members. In an association like ours, we need companies of every size and every type: large and small, Eastern and Western, mutual and stock, because every company has essential talents to offer. The 20 largest companies represent over half of the HIAA dues assessments. On the other hand, the many smaller companies are located in every area of the country. They know local conditions and can keep on top of local situations. It's they who generate our grassroots political clout. We depend on them to tell the private sector story—to be our advocates before State and local governments.

The diversity of our membership sometimes makes it hard for us to unite. It should not. Our diversity—our mix of different companies—gives us strength, flexibility, and the ability to work simultaneously on many levels.

So far I've mentioned two main policy concerns: unfavorable industry publicity resulting from questionable marketing practices, and the association's need for active member companies of all sizes and types.

HIAA policy on State versus Federal regulation of our business is a third area where we need to constantly examine our position. Our stand on this difficult question is somewhat inconsistent. On the one hand, when we approach the question of State or Federal regulation in the abstract, we opt for State regulation. We fear the increasing encroachment of the Federal Government. State officials, we say, are better able to appraise and control affairs according to the uniquely varying local conditions that affect the citizens of their State.

Then too, it's often easier for a company to communicate with its State legislators, regulators, and insurance department officials than with far-off Washington leaders.

But the nonuniformity of the State-by-State approach can cause us serious problems and make us think pleasant thoughts of the virtues of a uniform Federal standard. We recognize that we're going to have Federal and State regulation. Our objective should be to reduce the duplication and make sure that regulation is in the best interest of the consumer.

Senator CHILES. Reporter Herb Jaffee, investigating medi-gap policy sales in New Jersey, has written a series of articles detailing many of the problems faced by the elderly as they purchase health insurance policies. He charges that some policies are designed to deceive and exploit unwary policyholders and that others are relatively useless. And elderly consumers have paid annual premiums ranging into several hundreds of dollars for these policies.

I would like to also enter these articles into the record.

[The articles referred to follow:]

[From the Newark, N.J., Star-Ledger, Feb. 26, 1978]

LAX REGULATION FAILS TO PROTECT BUYERS

(By Herb Jaffe)

More than half a billion dollars a year are paid by Jerseyans for health insurance policies that are neither regulated, carefully scrutinized by the State nor formally approved by the insurance commissioner.

In some cases these policies with their "fine print" and vague disclosures of benefits, sold by agents of commercial insurance companies, are designed to deceive and exploit unwary policyholders.

Instances of relatively useless health insurance policies, for which consumers have paid annual premiums ranging into several hundreds of dollars, have been discovered by the Star-Ledger.

"Realistically, some of these contracts could be covert misrepresentations and distortions of what policyholders were actually promised by their agents," a Federal Trade Commission official stated, concerned by the rise in complaints nationally from victimized consumers.

By deceiving the consumer into buying a more expensive health policy that is less suited to his needs, an unscrupulous agent is better able to enlarge his earnings through sales commissions.

In some cases, the company which employs the agent also is a victim of misrepresentation, having issued the policy on the agent's recommendation.

Information on the extent of such health insuance practices, while still generally scant in New Jersey and elsewhere across the Nation, is starting to reach Congress and the State insurance departments which have been entrusted by Congress with the regulation of insurance.

Studies have found that most insurers "appear to be operating in a reputable manner." However, the lack of State laws that would impose strict regulation by most insurance departments make it impossible to determine how wide the health insurance irregularities extend. With the exception of the nonprofit Blue Cross and Blue Shield plans, which in New Jersey are regulated even more stringently than the property and casualty insurers who sell auto and home-owners coverages, health insurers are almost free to operate at will.

"Health insurance is like the illegitimate child," State insurance department actuary William White commented. "The regulation of health insurance today is about where the regulation of property and casualty insurance was 20 years ago."

Twenty years ago the magnitude of the auto insurance problem was just beginning to become known, and closer State supervison of the regulatory system was unfolding.

But the newly emerging concerns over questionable health insurance practices cannot be attributed to the watchdog responsibilities of the Nation's State insurance departments. Rather, it is due to a growing number of complaints to State and Federal agencies which protect the interests of senior citizens.

"The elderly as a class are the greatest victims of health insurance ripoffs, which occasionally transcend the line into such criminal practices as fraud, forgery and embezzlement," explained Dr. Gladys Ellenbogen, former professor and chairman of the economics department at Montclair State College.

In 1974, Dr. Ellenbogen researched and wrote the most comprehensive report known on the victimization of the elderly in the sale of supplementary medicare insurance. She was commissioned by the U.S. Senate Special Committee on Aging, and in her report she supports a statement attributed to the Florida insurance commissioner:

"Senior citizens are probably the most duped of all the public as far as the accident and health insurance field."

With the establishment by the Federal Government of medicare in 1966 came an accompanying need for supplementary medicare insurance, also known as "medigap," which supplements the medicare deductibles and other areas of health care which medicare does not cover.

As a result, an entirely new element in the health insurance industry emerged, to prey on the fears of the elderly.

A number of smaller insurance companies in particular "have been engaging in some of the most unconscionable abuses imaginable," Wisconsin Insurance Commissioner Harold Wilde stated.

Wisconsin is one of only two States which have enacted strict regulations and harsh penalties aimed at curbing deceptive and fraudulent practices in the sale of medigap coverages.

"Before we began to crack down about 3 years ago, we found that some of these companies and their agents were at best misleading—and at worst criminal," Wilde said.

In New Mexico, where similar regulation will become effective next June 1 to protect the elderly from unscrupulous health insurance practices, Commissioner Kenneth Moore explained:

"People who qualify for medicare have a minimum resistance to a smooth sales talk. We had some bad cases show up of senior citizens who bought medicare supplemental policies on top of medicare supplemental policies—far above what they needed."

Symptomatic of the problem surrounding the lack of regulation in health insurance is the number of complaints registered by insurance departments.

In her report to the U.S. Senate Committee on Aging, Dr. Ellenbogen wrote: "The major source of complaints from people of all ages, received by the departments of insurance in many of our States, concern health insurance policies.

"Of 17,697 complaints, for example, disposed of by the California Department of Insurance, as reported in its annual report for 1971, there were 8,305, or 47 percent, concerning health insurance policies.

"Some complaints, of course, are justified and some are not. A high proportion of the complaints come from the elderly."

Dr. Ellenbogen told The Star-Ledger she was unable to obtain any information on complaint from the New Jersey Insurance Department.

One reason for the State's inability to maintain accurate annual statistics on the number of complaints is the insurance department's lack of personnel, and particularly the need for a larger investigative staff.

Mrs. Helen Thompson, actuarial assistant to William White in the New Jersey department, explained that she is one of only two investigators for all health and life insurance complaints that are referred to the department.

"For about 6 months of the year we have a third investigator, and we do the best we can under the circumstances," Mrs. Thompson commented.

"We try to follow through with each complaint, but we just don't have the manpower to always do the job that has to be done," Mrs. Thompson added.

A far more serious problem is the fact that most consumers do not know they can lodge complaints with the State insurance department.

A Pennsylvania woman whose hospital and medical bills totaled almost $2,200 didn't realize that the insurance department might have been able to help her after the company refused to pay the claim in 1976.

"We still owe $710 on bills that they wouldn't pay," her husband said. "They said there was a pre-existing condition—but the pre-existing condition was mine, not my wife's," he added.

A pre-existing condition is an illness which the policyholder had before the policy was written. Such a clause in a health insurance policy means that the company has the right to refuse payment of any claim with a deductible time period for any illness arising from the pre-existing condition.

Dr. Ellenbogen explained that "a major source of complaints reported to insurance departments by the elderly is the refusal of their insurance company to pay a claim on the grounds it involves a pre-existing condition."

In her report to the Senate committee she gave a typical example of problems arising from pre-existing condition clauses in health insurance policies:

"Mr. X suffers from arthritis in his knee and has been suffering from arthritis for some time. After the effective date of his insurance policy, an intense arthritic pain in his knee causes him to lose his balance. He falls and breaks his leg.

"With an ironclad pre-existing condition clause, Mr. X's insurance policy would not pay for any hospital or medical costs incurred for his broken leg.

"Because persons 65 and over may have multiple health problems, a pre-existing condition clause, in the extreme form presented in the case of Mr. X, could provide no coverage at all to many aged persons.

"Therefore, the pre-existing condition clause has become a very critical issue in health policies for the elderly."

In the case of the Pennsylvania family, the husband said the company informed him it would not be responsible for her illness because of a pre-existing condition. "But the pre-existing condition pertained to me and not her. Furthermore, my pre-existing condition wasn't even the same as the illness that put her in the hospital.

"That agent of theirs did a hell of a sell job on me. He made me knock out a good policy which I had before," he added.

The man said the company refunded his premium for the policy of $792. "I guess that was a lot cheaper for them than paying the claim."

The practice of agents urging senior citizens to cancel good policies, on the pretext that they have better replacement policies, is one of the most serious abuses. The practice is intended primarily to foster the larger first-year sales commissions for agents, and insurance departments in other States have revoked the licenses of agents for such actions.

Dr. Ellenbogen said in her Senate report:

"Cancellation and sale of a new policy is an unfortunate tactic which has resulted in revocations of agents' licenses. For example, a policy is sold and some months later the insured elderly person is advised by the agent to cancel the policy and purchase a new one. The major advantage for the agent is the commission he receives on selling each policy."

Data filed with the State on the percentage of sales commissions paid out of each premium dollar indicates wide disparities between Intercontinental Life Insurance Co., which is the State's 13th leading health insurer, and the three leading private insurance companies.

According to the 1976 annual statements, which companies must file, Intercontinental collected $9.4 million in total health premiums in the 26 States where the company is licensed. It paid out 45.4 percent of this amount in claims, while 42 cents out of every premium dollar was used to pay sales commissions to agents. Statements for 1977 have not yet been submitted.

Correspondingly, of $1,696 million in premiums on health insurance written by Prudential across the country, 85 percent was used to pay claims and 3.6 percent paid agent commissions. Prudential is the State's largest private health insurer.

The claims percentages are still higher and the sales commissions lower for Travelers Insurance Co. and Aetna Life, the second and third largest private health insurers in New Jersey.

The percentage of claims paid is called the "loss ratio," and Dr. Ellenbogen's report explains:

"A very low loss ratio may indicate a company is disallowing many claims."

Ephraim Weiniger, chief executive officer of Intercontinental, explained the differentials:

"We're basically a young company. We put on new business without much renewal, and we pay a heavy cost to acquire this new business. Our incurred claims are inordinately lower. This relates to our volume of new business."

He attributed the disparities against the top three in commissions and claims percentages to the large volume of group insurance sold by the other companies. Group policies reduce sales commissions drastically, and Intercontinental writes almost no group insurance.

But according to the annual statements filed by all companies with the insurance department, Intercontinental sold $8.6 million in premiums in 1976 for individual health policies. It paid 45.8 percent of this total in claims and 38.9 percent for agent commissions.

By comparison, Prudential, with $232.5 million in individual health policies for 1976, paid 66.5 percent in claims and 12.8 percent in agent commissions. The gap between claims paid and commissions for Travelers and Aetna on individual health policies was even greater than that of Prudential to Intercontinental.

A detailed "Discussion Paper on Administration of National Health Insurance," issued last month by the U.S. Department of Health, Education, and Welfare, explains:

"Commissions for sale of new health insurance policies average about 1 percent of premiums for group business and 25 percent for individual policies."

Reports of agents' commissions found to actually exceed the amount of a policyholder's entire annual premium have come from insurance departments where there is strict regulation.

In Wisconsin, for example, Commissioner Harold Wilde said he found "one company paying commissions of 103 percent on a certain health policy.

"One of our regulations mandates comparisons of premiums to policy benefits. For example, we found Blue Cross was selling a policy for $211 a year. A private insurer was selling a policy that was less comprehensive than the Blue Cross policy for $400 a year.

"The big difference, of course, was the high sales commission the private insurer paid," Wilde explained.

William White, the New Jersey department's health insurance actuary, acknowledged, "Health insurance regulation in New Jersey has been something less than a priority. In fact, until now the chief concern in health premium rates has been Blue Cross and Blue Shield."

Commenting on private health insurance rates and regulations, he added, "The factor after that (concern over Blue Cross and Blue Shield) has been to let the health rates find their own way."

## State Retains Barriers Against Cancer Policies

(By Herb Jaffe)

New Jersey, which has one of the highest cancer mortality rates in the Nation, is one of only three States which prohibits the sale of insurance against cancer.

Since the late 1940's the State has not permitted the sale of "dread disease" insurance policies, although it will permit such coverage as a rider to basic health policies, State Insurance Department actuary William White explained.

Despite a declaration 2 years ago by the National Health Institute that New Jersey ranks highest in the Nation in bladder, colon and rectal cancers, and is one of the leading States in cancer mortality, the insurance department's position is that "cancer insurance is a scare tactic."

White said the insurance department has been "concerned with the total field of dread diseases insurance since the days when polio was a major dread disease, and our policy against licensing such insurance was formulated sometime in the late 1940's."

Only New York and Connecticut, aside from New Jersey, prohibit cancer insurance as a separate form of health insurance.

"Our department's present position, established in the late 1950's, is that dread disease coverages can be bought as a rider to a conventional health insurance policy," White added.

He explained that the reasoning for permitting the purchase of cancer insurance only as a rider, or an amendment, to a separate health policy "is to avoid the scare tactics."

White equated cancer insurance to a form of "gimmickery," and said "it's like a person with a life insurance policy who buys insurance at the airport every time he flies."

A survey of cancer insurance claimants conducted by Opinion Research Corp. of Princeton last year found that most were favorable to the concept.

---

[From the Newark, N.J., Star-Ledger, Feb. 27, 1978]

## Agents Take Big Bite in Company Which Byrne Helped Found

(By Herb Jaffe)

An insurance company that Gov. Brendan Byrne helped establish and in which he has long held a financial interest is deeply involved in the sale of health insurance. Some of the company's agents have been accused of deceiving policyholders and of misrepresentation in order to increase sales commissions.

The company, Intercontinental Life Insurance Co. of Newark, which State Sen. Martin L. Greenberg (D-Essex) also helped establish and in which he remains an active officer, pays sales commissions to its agents that are almost equal to the amount it pays to all health insurance claimants.

Intercontinental concentrates most of its volume on two types of health insurance markets—senior citizens and "groups."

In the company's dealings with senior citizens, files obtained by The Star-Ledger reveal allegations of signatures forged by agents of Intercontinental on health insurance applications.

Other documents show that company agents dwell heavily on the sale of "group" insurance policies.

But statements filed by the company with the New Jersey Insurance Department show Intercontinental has almost no income from the sale of actual "group" health insurance policies. The "group" policies which the company sells are basically the same policy any individual can buy, for the same price.

Much of the reason for unethnical practices by agents of the company is attributed to the lack of regulatory enforcement over all health insurers, coupled with the inability of the legislature to enact strict laws to administer this segment of the insurance industry.

Due to laxities in New Jersey's regulations of health insurance, Intercontinental has been successful in eliminating types of health insurance policies that might benefit policyholders for long periods.

It has also been permitted to remove health policies if they do not provide the degree of high profits the company requires in order to continue to pay sales commissions that in 1976 averaged 42 cents out of every premium dollar collected.

In the same year, the most recent for which annual statements are filed with the State insurance department, Intercontinental paid health claimants just over 45 cents out of every premium dollar collected.

Ephraim Weiniger, chairman and president of the company, explained in a shareholders report that was contained in the most recent annual report for Intercontinental:

"Intercontinental Life Insurance Co. has improved its profit potential by moving rapidly to reduce its exposure on long-term disability policies; terminating specific marginal policy forms; obtaining premium rate increases on other forms, and placing greater emphasis on the marketing and sale of health insurance policies having a limited exposure and a greater profit potential."

Weiniger does not believe any further restrictions on health insurance practices are needed. "We are quite heavily regulated. New Jersey is one of the toughest States," he said, even though there is no regulatory standard for profits in health insurance.

In the regulation of auto and homeowners insurance, New Jersey is in fact "one of the toughest States." But in health and life insurance, companies for all practical purposes need only file their policies and rates with the State insurance department, then sell their products.

Intercontinental was founded in 1964 by four individuals, including Byrne, who was then a practicing lawyer, and his two law partners at that time.

Byrne told The Star-Ledger that at the time he became Governor he owned "about 100,000 shares of Intercontinental," but that he remembers there was a stock consolidation some years ago.

"The stock is in a blind trust, and I really don't know how much Intercontinental stock I own. I'm not supposed to know. That's the purpose of a blind trust," Byrne said. The blind trust is administered by Byrne's personal attorney, who has the right to deal with these assets while Byrne is Governor.

Intercontinental stock is presently being marketed at $2.37 a share. In 1974, when Byrne became Governor, 100,000 shares represented almost 9 percent of Intercontinental's outstanding stock.

Byrne served as chairman of the board of Intercontinental from 1966 to 1970, during which medicare was established and the company became heavily involved in the sale of supplementary medicare health coverages to senior citizens.

Greenberg, a former law partner of Byrne and chairman of the Senate Judiciary Committee, is presently secretary of the company. Greenberg also is a substantial stockholder and a member of the company's four-member executive committee.

Harold R. Teltser, Byrne's other former law partner, also is a large stockholder and a member of the company's board of directors. He, too, is a cofounder. Lawrence E. Stern, onetime State insurance commissioner and the first president of Intercontinental, is the fourth co-founder.

One illustration of the company's practices involves a woman who insists that a policy she bought from Intercontinental was not the one delivered by her agent.

"I never signed that application. My name was forged," the woman asserted.

The woman explained she bought the health policy for her husband, who died since the incident. "We bought the policy with a 10-day right to return it if it was not what we expected it to be. The agent kept delaying an appointment to explain the policy.

"When he finally came, we told him we didn't want it because it had a $500 deductible, and we were led to believe we were buying a $100 deductible.

"By then our 3-month premium had expired, and he told us not to worry about it, that he would make the correction and apply our first 3-month premium to the second 3 months, since it was his mistake," the woman explained, adding:

"During the second 3 months I went to the hospital for a matter that was to have been covered by the policy. But the company informed me that there was no policy, that I had let it lapse because I didn't pay the premium."

The woman said she could not reach the agent so she contacted the State insurance department. "All they did was give me a run-around."

She explained that she eventually got her money back for the 3-months premiums with the assistance of another agent from another company.

"He told me what to do to get my money back," she said. The woman said of the policy, "I know the agent forged my name. Otherwise Intercontinental would never have issued the policy, and he would have lost his commission after spending so much time with me doing a selling job."

Another elderly couple did in fact have a premium of more than $400 refunded by Intercontinental after the matter was investigated by the insurance department.

In a letter to the insurance department, the woman explained how she bought the health policy. "He also said it would be advisable to drop my husband's policy and he would write my husband a policy which would take over after Blue Cross, Blue Shield and medicare." The letter continues:

"When I wanted to go upstairs and get my husband's signature, he (the agent) said it was unnecessary and I could sign for him, which I did.

"About 3 weeks later I received my husband's policy and noticed they paid only $5 per day for the first 60 days. I decided to wait till I got my policy before calling him about this.

"About a week after receiving my husband's policy I received mine, but also received an additional policy he had written for me that we had not even discussed and never thought of. It was to pay $75 per week while hospitalized.

"The address on my policy was incorrect, and I called him to tell him about that and ask why he had written a policy I had not even discussed with him. He said I needed it and could cancel after the first year if I didn't want it.

"About my husband's policy, he said not to concern myself because if the difference of a hospital stay between Blue Cross, Blue Shield and medicare was more than $5 a day, his company would absorb it even if it was $15 or $20 a day.

"After our telephone conversation I read my husband's policy as well as I could and found nothing to indicate they would pay any more other than $5 per day plus the extra allowance for nurses and first-day extras."

The woman explained she returned the policies and demanded her money back from the company. Following her demand for a refund, based on misrepresentations and other irregularities, the woman received a form letter from Intercontinental which said in part:

"We have received your request for cancellation of your policy with Intercontinental Life. As your policy does not contain a refund provision, the policy will lapse 31 days after the next due date, as there is a 31-day grace period in your contract."

In effect, the company was refusing to refund the $410 in premiums. The insurance department investigated the matter, then wrote to the company:

"Please provide the sworn statement of (agent) as to his solicitation, presentation and representations to (the woman). Since there appears to have been several irregularities in this transaction, including the possibility that some signatures were forged, we request that you rescind the enclosed policies and refund the premiums to (the woman)."

The premiums were refunded in full.

As for the sale of "group" health policies, agents of the company have used letters of endorsement from companies and associations to sell members of those organizations policies that are supposed to be less expensive "group" plans.

---

[From the Newark, N.J., Star-Ledger, Feb. 28, 1978]

## Agents Use "Scare Tactics" With Elderly

### Insurers Exploit Deficiencies in Medicare

(By Herb Jaffe)

Concern has been growing in Congress, Federal agencies and the private sector that medicare may be responsible for the "scare tactics" health insurance companies are using to "hard-sell" expensive but inadequate policies to senior citizens.

"Medicare is paying for a steadily decreasing share of the health costs," Dr. Gladys Ellenbogen, former chairman of the economics department at Montclair State College, reported to the U.S. Senate Special Committee on Aging.

"A large number of the elderly are living on low incomes. Some have assets in the form of savings accounts or savings bonds or other securities," Dr. Ellenbogen wrote in the report commissioned by the Senate committee, adding:

"Aware of the high cost of medical care and fearful of the risk of great depletion in their liquid resources, they purchase private health insurance protection."

Her report explains that medicare is paying for less each year, largely as a result of inflation and rising costs in hospital, medical and nursing home care.

The result is that more senior citizens are being forced to buy additional private health insurance. In fact, the Social Security Administration last August reported that medicare's responsibilities have shrunk to an average of less than 43 percent of all health costs for the elderly.

Commenting on the experiences of senior citizens in buying private health insurance, Dr. Ellenbogen said:

"As reported to us by consumer service bureaus of State insurance departments and by State and local offices on aging, many of the elderly are puzzled by the complexities of private health policies."

Her report adds that many senior citizens who never bought health insurance before, because of employer group coverages prior to their retirement years, are now experiencing "the hardsell, scare tactics of some of the insurance companies, particularly those companies offering them policies by 'mail order.' "

An example of the "scare tactics" is a mail order card that is being sent to senior citizens in New Jersey. The card advises the recipient of "Senior Care 3" which provides coverage for "hospitalization, surgery, doctors' fees, anesthesia, private nurse, transfusions and ambulance."

However, the card is an official-looking document, with the senior citizen's name and address typed in. Among other things, it says:

"Advance information for New Jersey senior citizens. Announcing Senior Care 3—the new health care plan designed to fill the gaps left by medicare."

Nowhere on the information side of the card is there any mention of an insurance company, agent or anything else to represent that the card came from the private health insurance sector.

On the mail side of the card, it is addressed only to I.L.I.C. information center, with a post office box number in Bridgewater.

Most senior citizens might not be expected to know that I.L.I.C. is Intercontinental Life Insurance Co., a private health insurer with its home office in Newark.

"The card looked a little suspicious to me, but it was in the shape of the social security card I get in the mail, so I sent it in anyway just to see what would happen," an 80-year-old man, who is a retired RCA engineer, explained.

"A couple of weeks later this young man came and made like he had something special for me. But when I began to ask him some questions, I couldn't get any sense out of him. Sure enough, he was trying to sell me insurance," the senior citizen explained.

"He wouldn't tell me how they got my name, all he kept saying was that I needed extra coverage. Well, I got Blue Shield, Blue Cross, Prudential, Colonial Penn and medicare. But he kept saying that wasn't enough," the man continued.

He said he was angered by what he considered "a colossal deception to sell me insurance."

Practices of this type of health insurance companies are of special concern to David Fox, an attorney for the Federal Trade Commission (FTC).

"The elderly are very ripe for abuses by health insurers, and this is an area in which I have a strong personal interest," Fox said. "The elderly are tremendously afraid of going to the hospital and not having enough insurance, so they often use their limited income to buy four or five policies that duplicate each other."

Fox said that while the FTC does not have jurisdiction, since insurance is regulated by the States, "we can at least keep an eye on the situation and alert States to what's happening in their midst."

Congress also is keeping an eye on how the elderly are being treated by insurers. While Senate hearings have been held almost annually since the early 1970's on the difficulties senior citizens face with health care, with the thrust of the Senate's concern on medicare, some senators have pointed to the inadequacies of private health insurance.

During one hearing before the Special Committee on Aging, Vice President Walter Mondale, then a senator from Minnesota, commented:

"I had a mother that went to a hospital with cancer, and they canceled her insurance. So I am not convinced that private insurance companies are the same as the United Fund."

During another hearing before the same committee, Dr. Joseph Ingber, a New York chiropractor, testified.

"Maybe you will be investigating 5 years from now what is being done in the private sector with the major medical insurance companies—what kind of fraud is going on in major medical insurance."

An American Bar Association (ABA) committee has been studying the problem for some time. San Francisco attorney Luther Avery, vice chairman of the

legal problems of the aging committee of the ABA's Family Law Section, said the committee is "analyzing cases of senior citizens who have been gypped and swindled by health insurance companies."

Avery said the committee's concern has been enhanced by evidence from the National Council of Senior Citizens in Washington and the National Senior Citizens Law Center in Los Angeles.

"We see this as a serious problem, and we may either report our findings to the ABA's house of delegates, or in the form of recommendations to some Federal agency, or even as a report that will be made available to senior citizens," Avery said.

One of the most common complaints by senior citizens centers around decisions by insurers that the policyholder is not eligible for benefits under his policy because of pre-existing conditions.

In a letter from Intercontinental to an 84-year-old man, the company said it would not honor his claim, explaining:

"We have reviewed the claim recently submitted, and medical information in our possession indicates the condition for which claim has been presented began prior to the effective date of your policy. Consequently, we are unable to be of service to you on this claim."

The language of the letter is "form" language, appearing on many others obtained by The Star-Ledger.

"Pre-existing condition my foot," the man said. "I paid them too soon. My premium for the year was around $500. I was operated for an aneurysm, and I never had any problem before. Their information is hooey.

"I succumbed to high pressure salesmanship," he said. The man added that medicare and his Blue Cross and Blue Shield coverage paid most of the cost.

"Do you know that company had the gall to try to sell me another policy about a year after they gave me all that trouble. This young agent came around and told me that the other agent was fired because of the way he was selling," the man stated.

Another senior citizen explained that he "dropped the policy because their agent misrepresented what he was selling me." The man contended that the Intercontinental agent sold the policy with a premium of about $180 on the basis that the policy would entitle him to coverage for visits to a doctor's office.

During the course of the year he held the policy, both he and his wife were denied claims by the company for doctor visits. In one letter a company examiner wrote:

"We sincerely regret we are unable to provide benefits in connection with this claim because the policy provides benefits for office visits, provided that these expenses are incurred following a hospital confinement. Since there was no indication of hospitalization, the charges submitted for office visits are not eligible for benefits."

"That's not the way the agent sold it to me," the man said. "He told me we could use it for any doctor visits."

Asked if he read the policy, the man said: "Who could understand that insurance language? I trusted the salesman."

Ephraim Weiniger, chief executive officer of Intercontinental, acknowledged that his company sells a large volume of health insurance to senior citizens.

Weiniger added that while many complaints come from senior citizens, "we can't pay a claim if it involves a condition that an elderly person didn't tell us about when we sold the policy.

In a "confidential memo" to his agents 3 years ago, Weiniger referred to "something to be desired in our marketing methods." He also emphasized "selling honestly" and mentioned "the administrative expense which comes with refunds and some other practices which will tend to hurt our company and put the man's insurance license in jeopardy."

The memo refers to another problem which concerned Weiniger. The problem dealt with agents so eager to earn a commission that they had little regard for the medical history of the persons they solicited and tended to ignore an applicant's true medical problems. Moreover, they had little concern for whether the policyholder had the financial means to keep up their premium payments. According to the memo:

"Men are selling us claims. For a $40-$50 commission we are buying a $1,000-$2,000 claim. The agen't concern is getting the first premium only and as much as he can get with little concern about whether or not the person can afford the renewal."

[From the Newark, N.J., Star-Ledger, Mar. 1, 1978]

HEALTH INSURANCE: STATE FAILS TO REVOKE LICENSES OF FLAGRANT AGENTS

(By Herb Jaffe)

The State insurance commissioner is empowered to lift the license of any agent who has committed insurance irregularities, but no one can remember the last time an agent selling health insurance in New Jersey lost his license.

By comparison, in Wisconsin, where special regulations were recently invoked to protect senior citizens in particular from being swindled in the sale of health insurance, Commissioner Harold Wilde says he won't hesitate to revoke or suspend the licenses of agents who commit indiscretions.

"When I came here 3 years ago, we were revoking two or three licenses a year. Now we're acting against 10 to 12 agents a month. Among them we're lifting a lot of licenses, and many of them were health agents. We're trying to guarantee as much as possible that no consumer will get swindled," Wilde said.

"We even suspended a health insurance company recently for a year and a half," he added.

Sidney K. Decker, chairman of the ethics committee of the New Jersey State Association of Life Underwriters, has been involved with the selling and upgrading of health and life insurance practices in New Jersey for more than 20 years.

"I don't recall any agent selling life or health insurance ever being revoked or suspended in this State, at least since I've been around," Decker said.

"As I understand it, one of the problems is that the insurance department does not have the funds for an investigative staff. The department is certainly empowered to lift licenses, but they have been very lenient.

"Some practices have been brought before our ethics committees where not only should the agent's license have been revoked, but there should have been criminal action taken," Decker said.

Asked why the insurance department refuses to lift licenses, especially in blatant cases of irregularity, Decker said, "I don't know. But I do know that some very serious ones have been recommended to them by our ethics committees.

"But then the department asks us, 'do you realize what it takes to lift an agent's license?' Our position is, what good is a license if there are no ethical standards to support it.

"There has to be sanctions. If not, then the agent who steals and only gets a slap on the wrist will do it again," Decker said.

He explained that in New York and other States there is a public record of agent license revocations. "There have been a few casualty agent licenses lifted in New Jersey over the years, but I don't recall ever hearing of a life or health agent losing a license," he added.

Decker explained that the Association of Life Underwriters—a nationally recognized professional body—maintains a code of ethics, adopted by its Washington-based national association. "We have 15 local associations with working ethics committees in New Jersey and a membership that includes about half the agents in the State who write health and life insurance," he said.

One of the association's most important functions, he said, is to maintain its peer review ethics committees which gather evidence and evaluate charges of unethical practices by agents.

"If we can't resolve a charge through the committee, or the agent's company, we will recommend it to the insurance department, in behalf of the insured making the charge. But that's as far as we're permitted to go. We have no subpena power," he explained.

Decker said that five or six agents a year are referred to the insurance department. "There are some good people in the insurance department, but they have no investigations staff," he commented.

Recommended legislation for model regulatory standards in the agent ethics area has been devised by the National Association of Insurance Commissioners (NAIC), and while New Jersey does not enforce a strict watch on health agent activities, many other states do.

In the NAIC's January 1977, reaffirmation of its model regulations on duties of insurers and agents, the text focuses on such problems in New Jersey as agents who misrepresent the contents of health policies to their applicants

According to this proposed regulation by the NAIC, which has been promulgated in other States:

"The insurer's agent has an obligation to be sure that all pertinent information revealed to him by the applicant is adequately set forth in the application.

"Failure to do so is a disservice to himself, his company and the applicant, because it may prevent accurate evaluation of the risk and may lead to cancellation or to defense of a claim based upon failure to disclose material information."

A Star-Ledger survey has found that failure to disclose material information on health insurance applications is a frequent occurrence with some agents, resulting in claims controversies between the policyholder and the company.

The most common indiscretion by some agents is the failure to disclose the applicant's complete medical history, especially where senior citizens are the applicants.

Medical examinations are not required in the purchase of such policies, and to avoid a denial of the application by their home office—resulting in lost sales commissions—agents in some instances will ignore pertinent details in the applicant's medical history.

In this respect, the NAIC's model guideline for regulation continues:

"An insurer will normally take disciplinary action, which may include discharge, against an agent who submits an application which is materially inaccurate or incomplete.

"In the event an insurer discharges such an agent, an insurance commissioner, charged with protection of the public interest, may terminate the agent's license, and the insurer should disclose appropriate information to the commissioner when it can do so without exposing itself to legal action.

"An agent who is unwilling to abide by the high standards required in the business of health insurance should make his living in another business which does not rest so strongly on a necessary assumption of good faith."

Federal Trade Commission attorney David Fix, concerned with potential violations of the unfair trade practices act, said that disclosure regulations by State insurance departments could help minimize the victimization of health insurance consumers by unscrupulous agents.

"For example, disclosure regulations should force companies to detail exactly what a policy does include in the simplest terms. Many of these policies are incomprehensible even for lawyers. So how can they expect the average layman to understand what is included?" Fix asked.

"I'm also concerned with the health policies that overlap. Too often high-pressured sales approaches will sell a consumer a coverage that he already has either through medicare or another supplementary medicare policy," he added.

New Mexico Insurance Commissioner Kenneth Moore said regulations that will protect senior citizens from high-pressure health insurance agents will become effective in June. "Our regulations are intended to stop agents from taking advantage of the elderly."

"Senior citizens are often lonely and anxious to talk to people. Some agents know that, and too often the senior citizen ends up getting fleeced into some policy that he or she doesn't really need," Moore stated.

The New Mexico regulations will be similar to those in Wisconsin, the first State to adopt such strict standards for agents in the sale of health insurance.

Wisconsin Commissioner Wilde called senior citizens the "most vulnerable market" for fraudulent selling practices. "I saw volumes of complaints in this area, largely because this class of victims has fewer defenses," Wilde added.

He said among the regulations is one that makes it an unfair trade practice to use the word "medicare" on any commercial health insurance literature, thus avoiding certain deceptive sales approaches.

"But we found that when you chop off one head, three new ones grow back," Wilde commented. "There are many elements involved in the sale of health insurance, and we're taking them on one by one."

He said that in addition to revoking agent licenses for unscrupulous practices, "we're also working with our State Association of Life Underwriters and chambers of commerce to set up senior citizen counseling services. This is intended to prevent such common abuses as finding people with 15 health policies—sold through scare tactics."

Wilde has invoked special regulations which mandate clearly explained minimum levels of benefits in easy-to-read policies, standardized health policies for all companies, and a withdrawal of all former policy forms.

"We also have prepared a booklet for senior citizens that tells all the do's and don'ts, and we mandated a rule that this book must be presented by agents with every solicitation.

"We have made it clear to every company that if they want to sell Medicare supplements they must abide by the regulations," he added.

Wilde said that all policies used in the State must be approved by him before they can be sold. New Jersey is a "prior approval" State in auto and homeowner insurance, but in health and life coverage the companies simply file their policies with the insurance department and use them.

"Our next stage will be to compare price differentials that exist. No one really knows what the profits are in health insurance. We attempt to judge this on the basis of loss ratios," he said. Loss ratios are the percentages of the premium dollar used to pay claims.

Wilde said one of his greatest concerns has been to crack down on agents who urge policyholders to cash-in an existing policy so they can sell the consumer a new one and earn a new first-year sales commission.

"First-year commissions are enormous. I think it's a disgrace to switch off a senior citizen, especially, from a perfectly good policy just so an agent can earn more commission. Meanwhile, the consumer is stuck with a new set of deductibles, which can often present a hardship," Wilde said.

---

[From the Newark, N.J., Star-Ledger, Mar. 2, 1978]

## Health Insurance: Jersey Substitutes a "Booklet" for Regulation

(By Herb Jaffe)

New Jersey's inadequate regulation of private health insurance is attributed by some to the effectiveness of the insurance lobby—plus considerable apathy in both the legislature and the State insurance department.

Typically, one insurance department official commented, "With the exception of Blue Cross and Blue Shield, health insurance regulation in New Jersey has never really been much of a priority."

The fact that the insurance department gathered 3,600 health insurance complaints from consumers in 1976 may have prompted the preparation by the department of a handbook for senior citizens. As a class, the elderly are the most common victims of abusive practices by private health insurance companies.

The newly prepared booklet alerts senior citizens to the potential pitfalls when buying health insurance. It offers "helpful hints" on how to shop for health insurance wisely.

The booklet, which includes a friendly opening letter from Gov. Brendan Byrne, was financed by a federal grant in an effort to better educate the elderly against "gimmickry."

According to one piece of advice in the booklet:

"Health insurance policies are very complicated. Reading and understanding policies as well as making price comparisons is not easy. Health insurance for senior citizens is one field in which the insurance industry has generally done a very poor job."

The booklet is similar to one distributed in Pennsylvania, Wisconsin and other States—where tighter regulations exist to protect senior citizens more than just advise them of "complicated" insurance policies with incomprehensible language.

As a regulatory agency, the insurance department is aware of the dangers in the merchandising of some private health insurance policies. But while New Jersey concentrates more on alerting senior citizens to potential dangers that the legislature can easily empower the insurance department to eliminate, other State insurance departments are acting in a more direct manner to remove such threats.

For example, legislation in 1973 empowered the New York Insurance Department to standardize basic health policies and eliminate many of the kinds of deceptive practices that exist in New Jersey.

"It took us 2 years before we could enact that legislation. Obviously, the insurance companies didn't like the idea because it put an end to policies and practices that many companies had become accustomed to," New York Deputy Superintendent of Health Insurance James Clyne said.

"New York was the first State to adopt such regulations. It resulted in a cleansing of the health insurance field. We eliminated a lot of policies from being sold in New York," Clyne explained, adding:

"Companies were required to examine their own portfolios, and that had the greatest effect on what could be sold in New York State. We were able to eliminate many of the dead-wood policies, as well as the questionable ones.

"I think this was a very worthwhile effort, because in the process we were able to review every policy being sold so that we could compare and determine what was needed to best protect the consumer. The legislature since then has adopted a series of additional laws mandating that certain health coverages be made available."

Clyne said that in his judgment, and from his experience, "health insurance really has to be watched closely and differently from other lines of insurance," referring to the ease with which sophisticated forms of abuse can be incorporated into policies by insurers.

"There was much objection to our standards from the carriers. It was an invasion into areas insurance companies did not want invaded," Clyne added. "Regulations of our type are very controversial, which is why they haven't spread into too many other States."

For one thing, Clyne emphasized that insurance companies in New York must now have the prior approval of the insurance department before they can market a policy, rescind existing policies or alter rates. The Department also has invoked strict disclosure requirements to avoid deceptive practices as much as possible.

"Many of the features and provisions in the NAIC's (National Association of Insurance Commissioners) model health insurance bill are patterned after our system," Clyne added.

Many health insurers in New Jersey include provisions in their policies that prohibit cancellation and imply automatic renewal. However, the provisions do not prohibit an insurer from deciding not to renew everyone insured under a certain policy—in effect, terminating the entire policy if the company decides it is not earning sufficient profits from the policy.

"That kind of thing is a problem. When a company decides to terminate a class of business, we become very conscious of it in terms of approving any replacement policy," Clyne explained.

"We want to include a provision in all health contracts that termination of the entire policy must be with the approval of the superintendent of the New York Insurance Department, and that the company must provide an adequate alternative policy for the same policyholders," he said.

Clyne also explained that his department maintains well-staffed consumer services bureaus in New York City and Albany. "We have investigators and examiners who check out all complaints."

He said there is also much concern in behalf of senior citizens "who tend to overbuy health insurance. I don't know if it's victimization or just some inherent fear elderly persons might have which makes them prone to purchase such policies as those that will pay them a lump sum a day if they're hospitalized.

"They tend to feel insecure, and they'll buy the lump-sum policies even though they have medicare and good medicare supplemental coverages. There are companies who deal heavily in hospital indemnity policies. The question is whether there is a real need for such policies, or whether those companies are using fear tactics on the elderly," Clyne commented.

The New York regulations were established only after a 2-year legislative battle. Sponsors of legislation that would impose stronger regulations over health insurers in New Jersey have never even reached the battle stage.

Many legislators have been repeatedly unsuccessful in getting their health insurance bills out of committee. There was a flurry of bills in the last legislature that would have begun to impose minimum regulatory standards, but they all died in committee when the Legislature expired last month.

A bill sponsored by Sen. Joseph J. Merlino (D-Mercer) would have established minimum standards that would have included "full and fair disclosure for the form, content and sale of health insurance."

While Merlino said the measure was particularly aimed at Blue Cross and Blue Shield—which already are heavily regulated—it would, nevertheless, have affected all private insurers. But the bill was stuck in a committee for 8 months.

However, Merlino said he intends to reintroduce the bill in the present legislature. The bill would include:

"Reasonable standardization and simplification of language and coverages to facilitate understanding and comparisons."

"Elimination of provisions which may be misleading or unreasonably confusing in connection with either the purchase of such insurance or the settlement of claims."

"Elimination of deceptive practices in connection with the sale of such insurance."

"Elimination of provisions which may be contrary to the health care needs of the public."

"Elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof."

"Elimination of unfair renewal practices which are contrary to the health care needs and economic wellbeing of the public."

Another bill, introduced by Sen. Garrett Hagedorn (R-Bergen) and co-sponsored by 11 other Republican and Democratic senators, was lodged in committee since it was submitted in September, 1976. The bill was specifically concerned with health insurance policies that are misleading.

It would have given the insurance commissioner powers to disapprove a policy if it "contains provisions which are unjust, unfair, inequitable, misleading or contrary to law or to the public policy of this State, or if it is sold in such a manner as to mislead the public."

Hagedorn already has resubmitted the bill in the new legislature. "Something has to be done to equalize regulation in this area and make what is good for Blue Cross good for every other health insurer in this State," Hagedorn said.

"Two other bills that would impose health insurance regulations were filed 2 years ago by retired Sen. Anne Martindell. Both remained in committee until the legislature expired.

The summary statement attached to one of the bills said:

"An insurance company may stipulate in a health insurance policy, other than group or blanket, that the policy can be canceled at any time by the company by written notice to the insured.

"When this option is taken by an insurance company, it can, and often does act to the severe detriment of policyholders, especially those who have paid premiums for years, then find their policies canceled after a difficult illness.

"This bill amends the relevant provisions of the law by repealing the option presently afforded insurance companies."

The statement attached to Martindell's other bill said:

"This bill provides that an insured would have an automatic option to renew a health insurance policy, other than group or blanket, without prejudicing the terms and conditions of the policy to be renewed.

"The insurer would be obligated to offer renewal of the policy between 30 and 60 days prior to the expiration thereof, and the insured would opt to renew by payment of the premiums during the grace period."

There were other bills in the last legislature which touched on health insurance regulation, in an effort to protect consumers from misrepresentations, distortions, and fraudulent selling practices. They all died in committees.

---

[From the Newark, N.J., Star-Ledger, Mar. 3, 1978]

## NATIONAL INSURANCE: U.S. DISTURBED BY HEALTH COVERAGE "GAPS"

(By Herb Jaffe)

Insurers are fearful that revelations of inadequacies in the cost, benefits and State regulation of health insurance could trigger a new movement for national health insurance (NHI) that might have serious consequences for the private insurance industry.

An analysis prepared last month by the U.S. Department of Health, Education, and Welfare (HEW) delves into the regulation and administration of NHI even before the proposal of an actual national health plan.

The report analyzes two basic questions in any proposed administration of NHI:

"What should be the role of the Federal Government, of the States and localities, of the private insurance industry?"

"How should these sectors interact in an overall NHI organizational arrangement?"

In analyzing any role for the private industry, if in fact the private sector should be permitted to underwrite NHI, the HEW report says:

"Supporters of a private sector underwriting role in NHI argue that competition gives private insurers incentives to perform functions more cheaply in order to increase profit margins or to gain a larger share of the market.

"Critics contend that industry underwriting practices conflict with some goals of NHI and that competition leads to higher profits and marketing costs which could be better used to pay the provision of health insurance."

But then the report goes on to say:

"At present it is very difficult to determine how many people have adequate coverage for medical expenses. Private insurance policies range from comprehensive major medical coverage to plans providing a fixed per diem payment for hospitalization.

"Many persons purchase several policies as supplements to basic coverage but are still uncovered for major expenses. The Congressional Budget Office estimates that between 19 and 38 million people with insurance have less than adequate protection against catastrophic expenses."

Still another indicator of the Federal Government's growing concern over the nation's private health insurance system is a statement last June in the Social Security Administration's monthly bulletin:

"That the insured person cannot expect to receive truly comprehensive health care services in return for his premium payments is just one of the deficiencies in the private health insurance system."

The bulletin said that in 1975 consumers under age 65 paid $33.6 billion in private health premiums, but that this "resulted in the return of only $28.9 billion in benefits."

Pointing to the inadequacy of the insurance system, the social security report adds that this represented only 44 percent of the total personal health care expenditures of Americans under 65.

Other reports are equally critical of the private health insurance sector, its manner of operation and what many consider to be inadequate regulation that has resulted in confusion, complexity and needless expense for consumers.

An illustration of the confusion thrust on policyholders by private insurers, from inadequate regulation, is the following letter a claimant received from her health insurance company:

"We sincerely regret we are unable to provide benefits in connection with this claim because expenses incurred for normal childbirth, a caesarian section or a miscarriage are not covered. In cases of pregnancy, the policy provides only for expenses incurred as a result of complications thereof."

"What is that supposed to mean?" the woman asked, "funeral costs?"

Private health insurance is being marketed in such a blatant manner in some instances, stemming from the lack of regulation, that even "unlicensed insurance brokerages" can operate in New Jersey.

State Sen. James H. Wallwork (R-Essex) told of an agent who knocked on his door last month to sell a health policy.

"He had no business card, no promotional literature, nor anything else that could identify he was an insurance agent. But he did have a good sales pitch and an application form for me to sign, at a premium of $164.85 a year," Wallwork said.

Upon checking with the State insurance department's licensing division, Wallwork was first told that the man was a licensed agent, but that the insurance brokerage employing him was unlicensed, which is a serious offense.

However, several weeks later Wallwork received a letter from Arthur M. Keefe, chief investigator of the insurance department, after the senator formally filed a complaint with the department. Following a more thorough review, Keefe said records show the insurance brokerage is licensed.

"The incident covering the solicitation at your residence does leave something to be desired," Keefe wrote, advising Wallwork that if he wished the department would pursue the matter further.

In similar cases, the insurance department, which earns almost $40 million a year for the State in the form of insurance taxes and licenses fees, says it does not have sufficient investigative and examining personnel to protect the public adequately from unscrupulous practices by health insurance companies, agents or brokers.

The HEW report of last month referred to its concern over the true effectiveness of the private health insurance industry if it ever became properly regulated in order to serve a major role in NHI:

"It should be noted that extensive regulaiton and alteration of current industry practices might lead to fundamental change in the character and nature of the industry itself."

The report also expresses concern that lax regulation has made it almost impossible to understand the health insurance industry's true profit picture, which would be a major factor if a national health insurance program were forced to rely on administration from the private sector. According to the report:

"The true extent of insurance industry profits and marketing costs is difficult to determine from existing data."

It explains the underwriting and accounting principles vary among the different companies. As a result, "marketing costs are difficult to measure and categorize appropriately."

The report adds that "inclusion of commercial insurers as underwriters of NHI virtually implies an allowance for profit. Profits could be regulated, along the line of a public utility, if that were desired."

But based on the complexities of profit regulation by the States in other lines of insurance, the report says:

"The necessary regulation could become so extensive and complex that it might make more sense for the Federal Government to operate the program directly."

Extensive hearings in the last several years before the U.S. Senate Special Committee on Aging have raised questions concerning the effectiveness of the private industry just in its role as intermediary in the administration of federal medicare funds.

There is also testimony before the committee that has raised concern over practices by the private sector in providing supplemental medicare coverages.

The Special Committee on Aging is a fact-finding body, and Sen. Harrison A. Williams (D-N.J.) served as its chairman for 6 years, until 1970. Williams remained a ranking member of the committee until last year when he became chairman of the Senate Human Resources Committee—the committee that could sponsor legislation to correct any abuses found by the Special Committee on Aging.

"I know that in my years as chairman of the Senate Aging Committee we found that senior citizens indeed were often special targets for fraud in the area of health care," Williams stated.

"Certainly there are now serious questions being raised about certain aspects of the supplemental insurance fiield, and these are a matter of very grave concern to the Aging Committee," he added.

"I would expect that this will be a subject of special and particular interest to the committee, and I would hope that we could formulate a plan of action so that senior citizens can obtain the coverage they need without falling prey to any abusive or fradulent practices," Williams said.

Dr. Gladys Ellenbogen, former head of the economics department at Montclair State College and the Committee on Aging's nationally recognized authority on private health insurance, said that most consumers know very little about how to buy health insurance.

"Generally, people are totally inexperienced in buying health insurance because during most of their lifetime it is their employer's problem," Dr. Ellenbogen explained.

"At the age of 65 you're on your own. If you take an early retirement you are not yet eligible for medicare and you have to pray that you don't get sick. With homeowners and auto insurance the average person is experienced, because you're confronted with it all your life," she said, adding:

"When you buy car insurance there's unit pricing. You know what you're paying for collision, liability and comprehensive.

"But when you buy health insurance you can't pick and choose. It's very tough for the consumer to be selective in health insurance, partly because they have no experience in buying and partly because there is no unit pricing."

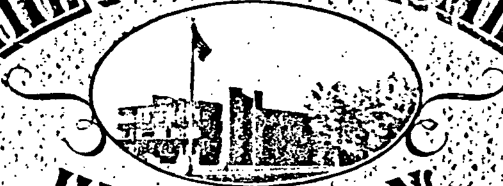
"The average person knows nothing about how to buy nursing home coverage, or a policy that would cover prescription drugs, or private duty nursing—even if there were policies just limited to those areas. But they give you a whole package, and there is no comparison shopping from company to company, which makes it so difficult, especially for the elderly.

"On top of everything else, State insurance departments have limited power over premium charges because most States have no legislation or very limited legislation concerning health cost containment."

GUARANTEED ACCEPTANCE
YOU CANNOT BE TURNED DOWN

Plan A Plan A

THE NATIONAL HOME



HEALTH PLAN

Guarantees you Hospital Cash Protection from the VERY FIRST DAY . . . up to

$40.00 A DAY

$1,200.00 EVERY 30 DAYS

NO DEDUCTIBLES ON

NO WAITING PERIODS

- Pays You Cash direct, or anyone you choose.
- Pays You Cash for life if necessary.
- Pays You Cash regardless of any other plans you have.
- Pays You Cash for both covered accidents and illnesses.

National Home Life Assurance Company—Established 1920
Budget Plans Also Available—See Inside For Details

Advertising supplement to: Daytona Beach Sunday News-Journal, The Fort Lauderdale News and Sun Sentinel, Fort Myers News-Press, Hollywood Sun-Tattler, The Miami Herald, Sarasota Herald-Tribune, Palm Beach Post-Times

NO AGE LIMIT • ONE RATE FOR ALL AGES

NO OBLIGATION

FULL BENEFITS OVER 65

# THE UNION FIDELITY CANCER BENEFITS PLAN

## Guarantees To Pay You Cash For The Treatment of CANCER

- CASH for covered Cancer treatment both in and out of the hospital.
- CASH in addition to any other plan you may have — even Group or Medicare.
- CASH benefits paid direct to you or anyone you choose.
- FULL BENEFITS for folks over 65.
- ONE RATE for all ages; rates do not increase as you grow older.
- CASH to spend any way you see necessary.
- CASH paid for hospital room, drugs, medicines, surgery, X-ray, radium, cobalt, nursing and doctors' fees.

SEE DETAILS INSIDE

***CANCER WILL STRIKE 55 MILLION AMERICANS ALIVE TODAY... THAT'S 1 OUT OF EVERY 4 OF US... 2 OF EVERY 3 FAMILIES... AND IT WILL COST THE AMERICAN PEOPLE $3 BILLION A YEAR!***

*— these facts from the American Cancer Society —*

**APPLY BY JUNE 15, 1978 AND RECEIVE FREE... YOUR OWN CANCER FACT PACK!**

**AND CANCER DID STRIKE!**

But the following people received financial help when they needed it most because they are UFL Policyholders:

Male.... Age 20 ... malignant melanoma of skin
Female .. Age 65 ... cancer of breast
Female .. Age 4 ... cancer of large intestine
Male.... Age 53 ... cancer of trachea, bronchus, lung
Male.... Age 31 ... cancer of floor of mouth
Male.... Age 62 ... cancer of prostate
Female .. Age 53 ... Hodgkins disease
Male.... Age 70 ... cancer of larynx
Male.... Age 31 ... cancer of nasopharynx

Advertising supplement to: The Fort Lauderdale News & Sun Sentinel, Cocoa Today, The Miami Herald, Sentinel Star, St. Petersburg Times.

# On January 1, 1978, Medicare Deductibles - The Part You Pay Out of Your Own Pocket - Jumped 16%! YOU are Paying these Higher Bills!

THE UNION FIDELITY

# MEDICARE SUPPLEMENT PLAN

## PAYS ALL THE PART A IN-HOSPITAL DEDUCTIBLES YOU HAVE TO PAY YOURSELF!

NO OBLIGATION

**PAYS** a maximum of $50,000 in cash benefits.

**PAYS** the $144.00 Initial Medicare Deductible.

**PAYS** the expenses for your first 3 pints of blood.

**PAYS** the $36.00-a-day Deductible from the 60th to 90th day totalling $1,080.00.

**PAYS** the $72.00-a-day Deductible from the 91st to 150th day . . . totalling $4,320.00.

**PAYS** 100% of your total eligible Hospital bill up to $144.00 per day when Medicare stops paying.

**PAYS** cash benefits direct to you, or anyone you choose.

**ALL CASH** benefits are paid in addition to any other plan you have.

**GUARANTEED ACCEPTANCE,** regardless of your age or health history, if you haven't been confined in a hospital or nursing home in the last 60 days.

NO OBLIGATION

YOURS FREE if you apply before MAY 31, 1978 The Exclusive MEDICARE REFERENCE CARD

SEE DETAILS INSIDE

See Medicare Reference Chart Inside

GUARANTEED ACCEPTANCE
WE CAN'T SAY "NO" TO YOU!

Guarantees You Hospital Cash Benefits from the very FIRST DAY

$30.00 A DAY
$900.00
EVERY 30 DAYS

FOR
SICKNESS!
ACCIDENTS!
MATERNITY!

PAYS 50% INCREASED BENEFITS FOR:
CANCER!
HEART ATTACK!

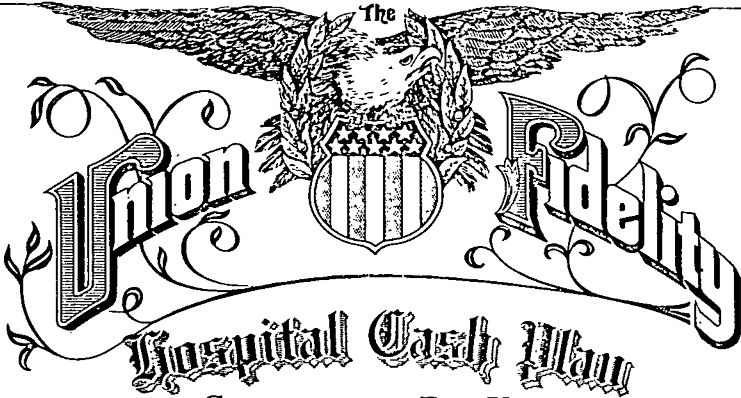
**Now $1 starts you in the Physicians Hospital Policy. Then renew for as little as $7.55 a month, depending on your age.**

We guarantee to issue you this insurance regardless of age, or family size.

- Your first month covers accidents only. Then both new sicknesses and accidents are covered immediately.
- Pays $30.00 a day cash—$900.00 every 30 days—for you, your wife and children.
- No limit to number of days you can collect cash benefits.
- Cash benefits paid direct to you—to spend as you wish—unless you tell us otherwise.
- Guaranteed renewable for life.
- Pays in addition to any other insurance you may have.

Advertising Supplement to
The Miami Herald

Advertising supplement to: Gainsville Sun, Lakeland Ledger, Lake City Reporter, Leesburg Commercial, Ocala Star-Banner, Palatka News, The Miami Herald, Naples News, The Stuart News, Bradenton Herald




**Guarantees to Pay You**
**Cash from the Very First Day**

*up to* **$40.00**
**A DAY**

**$1,200.00**
**every 30 days**

*Cash paid direct to you or anyone you choose from the very first day of covered hospitalization.*

*Cash in addition to any benefits from any other plan, even Group or Medicare.*

*Cash for Mental Illness, occupational injuries and V.A. Hospitals.*

*Full cash benefits for folks 65 and over.*

*50% Cash Increase for Cancer and Heart Attack.*

*Cash for both covered sickness and accidents.*

*Cash to spend any way you see necessary.*

APPLY BEFORE
January 31, 1978
and take advantage of our
ADDITIONAL
NURSE-AT-HOME
CASH BENEFIT

# SENIOR CITIZENS, PLEASE NOTE:

# Government Has Increased Your Medicare Deductibles Again For 1978

## You have until February 8, 1978, to add this In-Hospital Medicare Part A Supplement Insurance Protection

APPLICATION FORM ENCLOSED

SENIOR CITIZENS DEPARTMENT

Bankers Multiple Line Insurance Company
4810 No. Kenneth Avenue • Chicago, Illinois 60630

NOW...PAYMENT FOR ALL YOUR NECESSARY IN-HOSPITAL COSTS THAT MEDICARE PART A DOESN'T PAY—STARTING WITH YOUR FIRST DAY IN THE HOSPITAL

- Pays you before Medicare starts (the first $144)
- Pays you when Medicare reduces ($36 a day)
- Pays you when Medicare reduces again ($72 a day)
- Pays you when Medicare stops completely
- Pays you up to $50,000 maximum in lifetime benefits

Dear Friend:

Government Medicare is a fine thing for Americans 65 and over. It means that every senior citizen can get the medical attention he or she needs. However, even from the start, Medicare was never intended to cover all of your hospital expenses. The Government has had to establish limits on the benefits you receive as a patient in a regular, general hospital.

This means that you must pay part of your hospital bill yourself. And the amounts you must pay have increased for each of the last 10 years. They had to. Skyrocketing costs have forced the Government to pay out more and more, and to increase the share you must pay, too.

(over, please)

Senator CHILES. The committee has more examples of exploitation of older Americans and concern on the part of State insurance regulators.

Subsequent to this hearing, we will make a thorough evaluation of the testimony presented and determine further steps to be taken by the committee.

Senator Domenici, we are delighted to have you here to participate in this hearing. Do you have an opening statement?

## STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. Yes, Mr. Chairman. I commend you for your opening statement; I think it clearly defines the parameters of a very serious problem.

Adequate health insurance is a protection everyone needs, particularly in these days of ever-increasing hospital costs. The elderly, however, are most concerned about insurance coverage as they fear the prospect of a catastrophic illness or prolonged ill health, either of which may deplete their life savings. As a result, the elderly have become a new and expanding market, as well as an easy mark, so to speak, for insurance salesmen who sell expensive policies to the elderly, assuring them that the insurance will pay for what medicare does not cover. Unfortunately, this is not always the case. The insurance itself may not be faulty but the fine print regarding exclusions for coverage, such as "pre-existing conditions" can often make the insurance useless to the elderly who may have multiple health problems. For this reason, although an individual may hold various insurance policies, medical expenses may not be covered.

### MEDICARE PAYS LESS AND LESS

The fact that medicare pays less and less proportionately of the total medical bill has led to the rise of the development of what are called medi-gap policies. Insurance agents sell insurance to fill the gap but often sell more than the individual needs or can afford. It has been documented that the elderly often have overlapping policies but sometimes are not able to receive the coverage expected from any one of them.

State insurance commissions are beginning to take note of this problem as you noted, Mr. Chairman. Wisconsin has adopted strict standards which we will hear more about today. I am pleased to note that my own State of New Mexico has adopted similar standards to be effective in June. The commissioner of insurance in our State, Kenneth Moore, said in a recent interview:

> Our regulations are intended to stop agents from taking advantage of the elderly. Senior citizens are often lonely and anxious to talk to people. Some agents know that, and too often the senior citizen ends up getting fleeced into some policy that he or she doesn't really need.

Most insurance salesmen are in the business to help people of all ages. Some, however, are overzealous, shall we say. The elderly are uninformed about the intricacies of the wording of insurance policies.

It would seem that there is a need for insurance counseling as a part of the legal services we are offering the elderly. It could also be designed in much the same way as we now offer assistance to the elderly in the preparation of income taxes.

I look forward to the testimony of the witnesses and hope that this issue may become widely recognized, that the elderly will be helped to become knowledgeable consumers, and that the insurance industry and State insurance commissions will set standards to avoid the problems associated with medi-gap insurance policies.

Thank you, Mr. Chairman.

Senator CHILES. Thank you, Senator Domenici, for your comprehensive statement.

Senator Glenn is also here today. Senator Glenn first brought to the attention of our committee the Lowry case. Mr. Lowry, son of Mrs. Lowry, is going to be a witness here today.

Senator Glenn, we are glad for your endeavor in bringing that case to our attention. That is certainly one of the prime reasons that we are focusing on this subject today and we would be delighted to hear from you.

## STATEMENT BY SENATOR JOHN GLENN

Senator GLENN. Thank you vey much, Senator Chiles.

I think rather than thanking me we ought to thank Mr. Lowry who is with us here today and who will bring out some of the things we passed on to the committee. Mr. Lowry was instrumental in having these hearings held as early as they are being held after he contacted us. The committee staff was looking into some of these general problems that he brought to our attention.

I won't try and pre-empt Mr. Lowry's statement, which he will make here in a little while, by going into all of the details. I am sure he will put it forth eloquently, as he has in the past, to us and to the committee. It is a story that I think is all too typical of what is happening too many times these days.

I might add one other letter we received in mid-February of this year from a gentleman who is 79 years old. He is a farmer. He says, "My good wife is 77." He goes on talking about an operation he had and about paying for it. This is in Alvada, Ohio, and I won't use his name, but let me read the last couple paragraphs from his letter.

> Recently a young fellow, a fast talker, and an agent from this insurance company came, so he said, to help us process our papers. When he got his foot in the door he proceeded to tell us we did not have enough health insurance. In his fast talk he told us that medicare was in bad shape and that it would run out or be defunct in 1979. Well, I wrote him a check for $787.80, which I am going to try to recover.
>
> Now how about it, is medicare sound? I hope so. If it is, we had plenty of insurance before we took out more, and I will tell this young fellow to return our old policies and reimburse us for what we paid him.
>
> Yours truly.

[The full text of the letter follows:]

ALVADA, OHIO, *February 14, 1978.*

DEAR SENATOR GLENN: I am a farmer, 79 years old; my good wife is 77, and we are Democrats. We think you are doing a fine job as Senator and we don't think you will have any trouble being reelected.

Now, my reason for writing to you. Recently I had major surgery resulting from an aortic aneurysm. As you may know, the hospital and surgical bills were enormous. Medicare paid most of the hospital bill and all but 20 percent of the surgical bills, for which we were very grateful and fully satisfied.

We have hospital, surgical, and accident policies from a well-known insurance company. We have had these for 20 years, which helped pay the incidentals and the 20 percent surgical which medicare did not pay.

Recently, a young fellow—a fast talker—and an agent from this insurance company came, so he said, to help us process our papers. When he got his foot in the door, he proceeded to tell us we did not have enough health insurance. In his fast talk, he told us that medicare was in bad shape and that it would run out or be defunct in 1979. Well, I wrote him a check for $787.80, which I am going to try to recover.

Now, how about it—is medicare sound? I hope so. If it is, we had plenty of insurance before we took out more, and I will tell this young fellow to return our old policies and reimburse us for what we paid him.

Yours truly,

[Name withheld.]

Senator GLENN. I think that is all too typical of some of the things going on these days. Therefore, we obviously wish to explore here what the relationship is between the agent who is out doing this fast talking with his foot in the door and the companies that should be controlling those agents to a better extent than they do.

## "A FLIM-FLAM SITUATION"

I think, as Mr. Lowry will point out, the volume of policies sold to his mother, and the other examples that we will have brought forth here today, are the result of scare tactics. Too often, there is no control exercised by the companies involved. How can we correct this? How can we get these people recompensed for their expenses and the excess policies they have already bought? More importantly, how can we control this better in the future, through whatever Government action, if that is required, or through action by the insurance companies and State insurance commissions controlling what has gotten to be a real flimflam, a real fraud situation?

Those are the things that we want to get into day. I, in particular, wish to compliment Mr. Lowry in his coming forth with the information he gave us and being willing to come up here and spend his own time in bringing this to the attention of the committee so we can hopefully get cooperative action out of the companies and agents and, if not, do something about it with Federal legislation.

Thank you, Mr. Chairman.

Senator CHILES. Thank you, Senator Glenn.

I think many times people ask, does it do any good to write a letter? I think sometimes it does do some good to write a letter, and today is an example of that in our hearing.

Our first panel of witnesses will be consumer representatives consisting of Robert Lowry of Raleigh, N.C., and Jules L. Klowden, counselor of the Senior Service Center, San Diego, Calif. If you will come to the witness table.

Mr. Lowry, we will allow you to lead off. We do appreciate your appearance here today and your effort.

## STATEMENT OF ROBERT E. LOWRY, RALEIGH, N.C.

Mr. LOWRY. Thank you, Senator Chiles; thank you, Senator Glenn and Senator Domenici, for your comments.

I should like to express my appreciation for the invitation to appear before this committee and to congratulate the committee and its fine staff for the demonstrated determination to probe into the complexities, pitfalls, and problem areas encountered by the elderly as they seek adequate insurance protection. I think it is a tragic state of affairs, Senator Chiles, if the case history I am about to present can equal or top the story you told regarding the elderly Wisconsin woman. I suspect there are many similar, but untold stories of insurance exploitation throughout this country.

My name is Robert E. Lowry and I am a resident of Raleigh, N.C. My present involvement in this subject matter is accidental, but it has stimulated the creation of a personal commitment to assist in the exposure, correction, and prevention of unfair or abusive practices in the sale of insurance to the elderly. From the outset, I should make it clearly understood that I am not trained nor highly knowledgeable in matters of insurance. I am not an attorney, but have often wished I were, in view of the present circumstances. At the time of my initial involvement last August, I was in the terminal stages of a program of graduate work at North Carolina State University. Prior to that. I was with the U.S. Department of Justice here in Washington.

Today I represent, by proxy, my 76-year-old mother, Mrs. Lucille W. Lowry, a resident of the United Methodist-sponsored retirement community of Otterbein Home in Lebanon, Ohio. She wishes you well in your efforts and sincerely hopes that whatever mistakes, suffering, expenditures, and problems she has experienced in her serious over-involvement with insurance may serve a positive purpose in alerting others to the need for caution and access to sound, impartial advice. Both of us also hope to encourage the creation or improvement of effective and easily accessible avenues for correction or adjustment once a problem situation is discovered.

With the Senator's permission, I shall attempt to briefly describe the development of my mother's insurance problem, and equally important, the difficulties we encountered in attempting to resolve the situation. In July 1973, Mrs. Lowry moved from her home in California to a small apartment within the "independent living" complex at Otterbein Home. My mother is a very proud, independent, and private person, having adequately managed her business affairs and much of the family finances in the past. I respected these qualities and did not attempt to meddle in her affairs, although I had assured myself that her income from various sources was sufficient to meet the expenses of her new life at Otterbein Home. I might also mention that she had, in my estimation, a more than adequate insurance program at the time of her arrival in Ohio, both in life and in health coverages.

During the spring of 1977, I was puzzled by my mother mentioning, in several telephone conversations, that she was feeling financially strapped and was finding it necessary to defer certain planned expenses. I knew that her income averaged slightly over $1,000 per

month and that Otterbein Home expenses would not normally exceed half that amount.

In August, I drove my family to Ohio for a planned 1-week visit with my mother, but we remained for nearly a month when it was discovered that she was experiencing a major financial problem. I reviewed her record of expenditures and was startled to find a recent and extremely large outlay of funds to one insurance company. From her bank deposit box I obtained a variety of insurance policies and attempted to match these to the canceled checks which reflected her rapidly increasing involvement with additional insurance purchases since 1975.

FOUND A NUMBER OF POLICIES

Four health policies and three expensive life insurance policies issued by Bankers Life & Casualty Co. of Chicago were identified as representing Mrs. Lowry's major insurance expenses over the previous 2 years. However, I also encountered several canceled checks made out to the same company which, in the memo portion, made reference to policies or forms which were not in her possession. Two of these had my brother's and my initials. Automatic bank draft payments were also being made on policies which could not be located.

My mother was unable to recall what these policies represented and I then contacted one of the seven Bankers agents who had recently sold my mother insurance and requested an explanation of her entire program. He said that the two local Dayton, Ohio, offices did not attempt to maintain such information on its customers, but that he would contact the home office in Chicago. On August 25, the agent telephoned to inform me that several policies had been purchased in April 1977, among these an annuity policy on my life and one on the life of my brother, Kenneth. He further indicated that these policies had apparently never been "placed" or delivered to my mother and then, rather surprisingly, offered to have them canceled and refunded. Neither my brother nor I had previously known of the existence of these policies and I was aware that most States prohibit the creation of life insurance on a mature person without his knowledge, consent and signature. It was for these reasons that I postponed acceptance of the offer to cancel. I wished very much to see these highly questionable policies.

OVER $13,000 PAID TO ONE COMPANY

With the concurrence of my mother, her attorney, and the administrator of Otterbein Home, a power of attorney was created in order that I might act in her behalf due to the precarious state of her finances and a condition of failing health and capacities. Alarmed that over $13,000 had been paid out in premiums to Bankers Life & Casualty during the previous 2 years for an extensive, and largely unnecessary, insurance program, and outraged at the discovery of a new and unwanted policy on my life, I contacted the Ohio attorney general's consumer protection section for guidance.

An investigator was immediately sent to Lebanon for a review of the materials I had accumulated, and interviews with my mother and

myself. Despite the attorney general staff's demonstrated concern and interest in the matter, it was later determined that the Ohio Consumer Fraud Act specifically prohibited their intervention in problems of insurance. The attorney general's office did provide me, however, with some information which was of considerable help and which enabled me to understand that my mother's over-involvement with insurance was neither a unique nor isolated situation.

I should like to submit these copies of press releases from the Pennsylvania Department of Insurance for the committee's review. These press releases relate to the years 1974 and 1975, but I found them of considerable relevance. Some striking similarities exist in the abuses cited in Pennsylvania and my mother's insurance problem.

I would like to read brief sections from several of the releases:

[PENNSYLVANIA] INSURANCE DEPARTMENT ANNOUNCES "CRACKDOWN" ON COMPANIES, AGENTS EXPLOITING ELDERLY

Those (agents) found to be engaged in fraud or forgery have been turned over to local authorities for criminal prosecution. As a result of these investigations, around 50 agents have lost their jobs and 10 have been indicted.

There are various methods employed by agents to exploit the elderly. Among these are:

—Recontacting longtime elderly insureds of the companies, getting them to lapse their policies and buy new ones.

—Passing the names of elderly, sometimes senile consumers from agent to agent and thus causing multiple sales of insurance policies.

—Forging signatures of applicants on the applications.

—Writing policies on sons, daughters, nephews, and nieces of elderly persons.

WHAT THE PUBLIC CAN DO

Elderly citizens throughout the State must be extremely careful they do not fall prey to these smooth talking charlatans. Younger people with parents of advanced age should check into their financial affairs to be quite sure victimization is not taking place. Here are some "warning signals" which may suggest you or a loved one is becoming a victim:

—An agent suggesting you replace an older health insurance policy with a new one.

—Several agents from the same insurance company calling on a regular basis to make new sales.

—An agent trying to get you to purchase insurance on a fully grown child, nephew or niece.

—A "helpful" agent who wants to complete all questions on the application for you.

Senators, in the course of my investigation of Mrs. Lowry's insurance problem, I became convinced that most of the tactics described had been utilized in the company's contacts with her. I also learned that Bankers Life & Casualty was one of the companies involved in the problem situation in Pennsylvania.

Senator CHILES. Without objection, those press releases will be made a part of the record.

Mr. LOWRY. Thank you, Senator.

[The press releases referred to follow:]

PRESS RELEASES FROM THE PENNSYLVANIA INSURANCE DEPARTMENT

SEPTEMBER 25, 1974.—Insurance Commissioner William J. Sheppard today announced an intense "crackdown" on insurance companies and their agents who have been engaged in a disgraceful exploitation of the senior citizens of our commonwealth through the sale of health insurance.

During the past several months, the department's bureau of policyholder services and enforcement has been investigating the activities of a number of health insurance companies and their agents, most of whom have been operating in Western Pennsylvania. Communities that have been major targets of these unscrupulous people include Pittsburgh, Greensburg, New Castle, Mount Lebanon, Erie, Altoona, Meadville, Sharon, Oil City, and Franklin. As a result of the department's efforts, nine agents have been arrested and seven of those indicted.

### CHARACTERISTICS OF THE EXPLOITATION

The characteristics of this type of selling include:

Recontacting longtime elderly insureds of the companies, getting them to lapse their policies and buy new ones.

Passing the names of elderly, sometimes senile consumers from agent to agent and thus causing multiple sales of insurance policies

Taking premiums for annual policies and having them issued on a quarterly basis to get a larger commission.

Writing many policies under a variety of names to avoid detection of the multiple sales ("Mary Smith," "Mary A. Smith," "M. Ann Smith," etc.).

Forging signatures of applicants on the applications.

Writing policies on sons, daughters, nephews, and nieces of elderly persons.

Before delivery of policies, tearing out riders which exclude payment for various health conditions the insured may possess.

The worst case to come to our attention is that of an 80-year-old woman from Meadville who spent $50,574 in a recent 3-year period on 31 policies, all of which lapsed. We requested the presidents of the nine insurance companies involved to refund her money. So far, six have done so.

In still another case, an 87-year-old Greensburg woman bought 22 policies in 28 months from six different agents. Three policies were issued on nieces and a nephew.

Another lady in her seventies was spending $100 of her monthly $109 social security benefit on various insurance policies. She told our investigator she sold baked goods and dipped into her savings to make ends meet.

The Pennsylvania Insurance Department is presently contacting, via personal interview and questionnaire, several hundred elderly Westmoreland County and Blair County residents suspected of having been victimized.

### CAUSES

There are several causes of the problem. First, the companies involved have been very lax in screening the type of agent they hire. We find many of these problem agents go from one such company to another, lapsing and rewriting their client's health insurance as they go. These companies only seem to care about placing new business on their books. Second, life-health insurance companies pay very little commission on renewals. Thus there is an incentive for the unscrupulous agent to rewrite policies. Additionally, some of these companies pay a higher commission for the shorter term policy. One insurance company recently informed us their commission scale (percentage of initial premium paid to the agent) was: Annual premiums, 50 percent; semiannual premiums, 65 percent; and quarterly premiums, 85 percent. Third, many of these insurance companies have chaotic records systems and do not notice multiple sales.

Finally, the companies in question do not send out investigators to randomly review sales their agents are making.

### WHAT THE INSURANCE DEPARTMENT IS DOING

First, we are arranging for formal departmental legal action against those agents found breaking our laws. Those found to have engaged in fraud or forgery are being turned over to local authorities for prosecution. The Post Office Department is also looking into our findings for possible prosecution for mail fraud.

Second, thorough investigations of companies whose agents are engaged in such practices will be conducted. We are going to require refunds of premium, payment of denied claims and will take formal action under the Unfair Insurance Practices Act, which was signed into law by Governor Shapp on July 22, 1974.

Third, we are considering the requiring of all health insurance agents, when they replace a policy, to give the consumer a comparison of both the new and the old coverages.

Fourth, new guidelines covering the conduct of insurance agents have been completed and will be published shortly. These will go a long way toward removing such agents from the marketplace.

WHAT THE PUBLIC CAN DO

Elderly citizens throughout the State may be extremely careful they do not fall prey to these smooth talking charlatans. Younger people with parents of advanced age should check into their financial affairs to be quite sure victimization is not taking place.

Here are some "warning signals" which may suggest you or a loved one is becoming a victim:

An agent suggesting you replace an older health insurance policy with a new one;

Several agents calling from the same insurance company on a regular basis to make new sales;

Failure by the agent to give you a receipt for your premium on the new policy which indicates the name of the insurance company and the type of coverage;

An agent trying to get you to purchase insurance on a fully grown child, nephew, or niece;

Evidence that a new health insurance policy or life insurance policy delivered by your agent has been torn apart;

A statement by the agent that your policy is being billed on a quarterly or semi-annual basis when you thought the premium was for an entire year;

A "helpful" agent who wants to complete all questions on the application for you;

Failure of the insurance company to pay a claim due to a "pre-existing health condition" when you are under the impression you have carried coverage with them for many years.

If any resident believes he or she has been a victim of one of these ripoff artists, they should immediately contact the Pennsylvania Insurance Department at one of its four regional offices located in Pittsburgh, Harrisburg, Philadelphia, and Erie. We will immediately investigate the matter.

---

APRIL 8, 1975.—In September of 1974, the insurance department launched a crackdown on insurance companies and agents who specialize in ripping off the elderly. This was precipitated by our regional offices in Pittsburgh and Erie reporting cases of exploitation with regards to insuring senior citizens.

The worst case to come to our attention involved an 80-year-old woman from Meadville who spent over $50,000 on 31 policies over a 3-year period, all of which lapsed. The insurance department contacted the presidents of the nine companies and ordered them to refund her money. To date, she has received around $30,000.

To remedy this growing problem, Commissioner Sheppard has sent complaint teams into the smaller communities outside urban areas, because it is these smaller towns that have reported the most cases of elderly abuse. These complaint investigators listen to the problems and then initiate investigations into the agent and company involved.

The department has also filed formal departmental legal action against agents found violating the law. Those found to be engaged in fraud or forgery have been turned over to local authorities for criminal prosecution. As a result of these investigations, around 50 agents have lost their jobs and 10 have been indicted.

There are various methods employed by agents to exploit the elderly. Among these are:

Recontacting longtime elderly insureds of the companies, getting them to lapse their policies and buy new ones.

Passing the names of elderly, sometimes senile consumers from agent to agent and thus causing multiple sales of insurance policies.

Taking premiums for annual policies and having them issued on a quarterly basis to get a larger commission.

Writing many policies under a variety of names to avoid detection of the multiple sales ("Mary Smith," "Mary A. Smith," "M. Ann Smith," etc.)
Forging signatures of applicants on the applications.
Writing policies on sons, daughters, nephews, and nieces of elderly persons.
Before delivery of policies, tearing out riders which exclude payment for various health conditions the insured may possess.

There are several reasons the problem exists. First, the companies involved have been very lax in screening the type of agent they employ. Often, problem agents float from company to company, lapsing and rewriting their clients' health insurance as they go. Second, life-health insurance companies pay little commission on renewals. Because of this, there is a very great incentive for an unscrupulous agent to rewrite policies. Third, many insurance companies have chaotic records systems and do not notice multiple sales. Finally, many companies do not send out investigators to randomly review the sales their agents are making.

The insurance department has four branch offices, in Philadelphia, Harrisburg, Pittsburgh, and Erie, but it's the latter two which receive the most complaints concerning elderly insurance ripoffs.

In Pittsburgh, the number of cases involving alleged ripoffs has been dwindling, but one very recent case is noteworthy. It involved a very old woman who had paid premiums of about $42,000 on various policies. The agent who sold her the policies allegedly pocketed some of her premium checks and as a result, she was paying for coverage that she did not have. One of the Pittsburgh office's investigators, Ralph Hartford, learned of the case and began investigating. After many phone conversations with the insurance company president, the department was able to get back every penny of the woman's original outlay of $42,000. Meanwhile, the agent who allegedly forged her signature, cashed her checks, signed her up for policies she could never qualify for, and broke her savings, is now up before the insurance department for possible disciplinary action.

In Erie, our regional office serves a 14-county area and has a caseload of around 200, which keeps our two investigators, Jim Crawford and Bill Christ, quite busy, to say the least. The two of them are well known in the area for resolving complaints and consequently, many consumers experiencing problems with their insurance companies contact them for help. To date, the Erie office has gotten back over $60,000 for consumers who were taken advantage of by agents and companies. When those agents were reported, the Erie office informs us that so far nine have been arrested and charged in Western Pennsylvania. As shown by these figures, the Erie office has led the way in investigations and the removal of agents from the marketplace.

In addition to these programs designed to provide help for the elderly after the misdeed has been committed, the department has taken other steps to educate senior citizens so these abuses don't happen in the first place.

The department has maintained a systematic distribution to the elderly of the latest consumer guides, advising them on different lines of insurance and how they can avoid deception. Also, we are cooperating with Penn Dot in a new program which ensures that all Pennsylvania drivers over 65 will receive along with their drivers license renewal, computer cards stating where elderly insureds can go to resolve their insurance problems. One million cards are now being printed and they will be sent out starting in May.

Also, special circuit offices where investigators spend a day answering questions and complaints have been established all across the state.

In the past 6 months, the Pennsylvania Insurance Department has made great strides in eliminating the abuses inflicted on the elderly by unscrupulous agents and companies. Through the cooperation and dedication of our investigators throughout the State, the department has ferreted out these abuses, investigated them, pressured company executives for refunds to consumers, and hand delivered the refund checks to the senior citizens involved. These investigations take time and perseverence but the satisfaction involved in helping those who can't help themselves is well worth the time and effort spent.

Mr. LOWRY. I was referred to the insurance warden, the Ohio Department of Insurance. I filed a complaint and request for clarification of this matter. He, in turn, requested the company to provide copies

of missing documents and an accounting of all premium moneys received. A meeting with representatives of the company was scheduled for October 13. Shortly prior to this meeting I learned of the existence of four additional policies—one accident policy on Mrs. Lowry and three life policies on her grandchildren—bringing the total of policies in force with this company to 13. I also learned that a total of 17 sales had been accomplished but 4 policies were canceled and refunded, at least 3 of which were apparently duplications of coverage. With the exception of the original health coverage sold in November 1973, all sales took place within a 2-year time frame.

### 13 Sales by 5 Agents in 5 Months

Please refer to the sheet containing a list of policies sold to Mrs. Lowry. The list is submitted as an integral part of this presentation. You will note from the column of issue dates, or date sold, the rapidly increasing frequency of sale, similar to a snowball rolling ever more rapidly down hill and increasing its mass in premium dollars. In 1975, 1 major life policy; in 1976, 1 major life policy, 1 small life policy—refunded—and 2 health policies; and in 1977, 11 sales: 6 small life policies and 5 health policies—three refunded as duplicates—for a total of 16 sales. Within the 5-month period of December 1976 and April 1977, some 13 separate sales were accomplished by 5 agents. That averages out to approximately one sale every 11 or 12 days. I cannot avoid wondering how far the company representatives would have pursued this situation or just how large the "snowball" might have become had no one interceded. By June 1977, Mrs. Lowry's contractual obligations for premium payments amounted to $9,158.61 per year or approximately 68 percent of her annual income.

## BANKERS LIFE & CASUALTY INSURANCE POLICIES

| Policy No. | Date sold | Coverage | Agent | Actual annual cost | Paid |
|---|---|---|---|---|---|
| 1. 730-576-561 | Nov. 9, 1973 | Health, medical surgical, extended care | Carson | $109.64 | Annual. |
| 2. 5-248-470 | June 3, 1975 | Life, $17,145 | Keller | 3,090.00 | $257.50 per month. |
| 3. 760-175-115 | April 19, 1976 | Health, intensive care | Walsh | 73.09 | Annual. |
| 4. 4-854-476 | June 14, 1976 | Life, $17,358 | Keller | 3,364.64 | $841.16 quarterly. |
| 5. 5-393-843 | Dec. 15, 1976 | Life, increasing to $2,480 | Walsh | (272.73) | Refunded. |
| 6. 760-392-452 | Dec. 16, 1976 | Health, hospital medicare supplement | do | 76.91 | Annual. |
| 7. R-831-018 | Jan. 9, 1977 | Health, intensive care (duplicate) | Walsh (?) | (109.64) | Refunded. |
| 8. 770-052-917 | do | Health, hospital indemnity | Walsh | 284.72 | Annual. |
| 9. 5-413-376 | Mar. 2, 1977 | Life, increasing to $3,200 | Grooms/Rainey | 446.51 | Do. |
| 10. 770-150-792 | April 2, 1977 | Health, intensive care (duplicate) | Montgomery +A4544 | (129.82) | Refunded. |
| 11. 770-149-043 | April 22, 1977 | Health, accident, $10,000 to $50,000 | LaBovick-Montgomery | 27.82 | Annual. |
| 12. 5-432-306 | do | Life annuity, $2,000 each | Montgomery | 842.64 | $70.22 per month. |
| 13. 5-432-307 | | R. Lowry and K. Lowry | | 842.64 | $140.44. |
| 14. R-844685 | April 25, 1977 | (?) | (?) | (109.64) | Refunded. |
| 15. | | | | | |
| 16. | | 3 life policies on grandchildren | | | $1,000. |
| 17. | | | | | |
| Total | | 5 life policies in force, annual premiums | | | $8,586.43. |
| | | 5 health policies in force, annual premiums | | | $572.18. |

How did this happen? It is, perhaps, unnecessary to observe that my mother was a prime target for relatively easy sales. Her pride in, and love for, her two sons and their families is quickly apparent in any conversation, as is her continuing need to feel she can still do something nice for them. Certainly, in this, she is no different from millions of other senior citizen parents. She was, therefore, susceptible to sales arguments utilizing such terms as "estate expansion," "free of probate,' and "tax-free income for your loved ones."

"TRYING TO COVER THE MEDICARE GAP"

Again, like millions of others, Mrs. Lowry was terribly concerned about the possibility of a long-term or chronic illness and the catastrophic effects that this could have on her savings and her small income producing investment program. Unfortunately, neither medicare nor private insurance carriers attempt to offer much protection against the long-term illness and she was persuaded to attempt to cover the medicare gap with a multitude of small specialized health policies.

She was also very trusting of the "professional guidance" so generously offered by the various insurance sales representatives and felt a genuine friendship and affection for some. When finally faced with the realities of what had grown to be an extremely heavy financial commitment to premium payments, the personal anguish she experienced was made doubly painful with the realization that none of her "friends" had bothered to warn her she was getting in too deeply.

During the course of my own efforts to unravel and understand this problem, I learned that seven or more separate agents, including branch managers, from Bankers Life & Casualty had dealt with and sold insurance to Mrs. Lowry. Six of these agents worked with her during the 2-year period of June 1975–May 1977. Both my mother and several of her neighbors at Otterbein Home recall that a large number of the agent's visits were in groups of two and sometimes three. This type of group visit was particularly distressing to me for I know how difficult it would be for my mother to reject their combined "guidance."

The October 13 meeting in the offices of the Ohio Department of Insurance was relatively unproductive and unpleasant. Present were Robert Katz, Ohio insurance warden; William Grubbs, director of government relations, and Mr. William Tobin, regional manager, representing Bankers Life & Casualty; Miss Warner, business manager, and Eugene Strawn, resident, both of Otterbein Home, and myself.

From the outset, the atmosphere was that of adversaries. Mr. Grubbs demanded to know why Miss Warner and Mr. Strawn were present and what interests they represented. He questioned the validity of my power of attorney and my personal motivations for involvement in my mother's business affairs, stating that the company's "first obligation" was to Mrs. Lowry. When issue was made about the frequency of sales visits to my mother by groups of agents, this was denied by Mr. Grubbs as impractical; it would not happen. Subsequent correspondence from Mr. Grubbs has made much of this denial with assertions that such group visits would occur only in the training program

and then only on rare occasions. I sincerely resent the fact that my mother's doorstep was apparently used as a training ground for new agents and the occasions were not rare.

## Questionable Signatures

The two missing policies on my life and that of my brother were delivered, but were stamped "duplicate," an identification which I protested. The contract signatures were not in our handwriting and I indicated they might have been signed by my mother. However, the signatures had been witnessed or authenticated by the selling agent, Ronald Montgomery. Mr. Grubbs commented that the policies were not properly written. My mother's apparent participation in the creation of these questionable contracts was represented as a serious inconvenience to the company, but Mr. Grubbs said we would be permitted to choose whether to continue the policies in force or rescind them for a full refund of premiums.

During this meeting, it soon became apparent that the only "adjustment" the company was willing to make to Mrs. Lowry's 13-policy insurance program was in reference to the forged policies. Their recommendation was to lapse any other policy which we found burdensome. "No free rides" was the comment I recall hearing. In good conscience, and in my mother's best interest, I could not accept this as the only alternative.

A brief explanation was provided of the various life and health coverages and the meeting terminated with an agreement that the family would have a month in which to discuss and decide upon those policies which would be maintained and those for which a refund would be requested. Mr. Grubbs' parting comments referred to the meeting as a needless waste of time and included an estimate that the actions brought about by my "unfounded" complaint had cost the company nearly $4,000 thus far.

On November 3, a formal letter indicating the family's decisions was sent to both Mr. Grubbs and the Ohio insurance warden. Referring to the "unreasonable financial burden" which this recent and largely unnecessary 13-policy insurance program represented, the letter specifically requested rescission and refunds for the three expensive life policies on Mrs. Lowry and also for the recently "upgraded" hospital indemnity policy. These cancellations would have had the net effect of reducing her annual premium expenditures from $9,158.61 to $1,972.74, or approximately 15 percent of her annual income. It was clearly stated that the premiums would be paid on other health policies as they became due. The company was also duly informed that no decision had been reached as to the course of action we would take with regard to the highly questionable policies on my brother and myself.

My mother wrote her own letter to Mr. Grubbs to confirm the unity of the family decision and I would like to read just a portion of her letter. I feel it rather eloquently portrays the frustration and anguish she was experiencing. After requesting cancellation of the four policies, she says: "I trusted your salesmen to help me set up an insurance program. * * *" "Sincerely, L. Lowry." Both of these letters are submitted as part of this presentation.

Senator CHILES. Those letters will be admitted as part of the record.
[The letters referred to follows:]

RALEIGH, N.C., *November 3, 1977.*

Re: Lucille W. Lowry.

Mr. WILLIAM GRUBBS,
*General Counsel, Bankers Life and Casualty Co.,*
*Chicago, Ill.*

GENTLEMEN: This letter will acknowledge receipt of the three missing policies purchased by Mrs. Lucille W. Lowry from Bankers Life and Casualty Co. on the lives of her three grandchildren. These three policies, as well as the life and annuity policies on Kenneth F. Lowry, Jr. and Robert E. Lowry, delivered on October 13, 1977, were erroneously stamped and identified as "duplicate policies." It is our contention that, in fact, these policies had never been previously delivered to Lucille Lowry.

The information derived from our meeting at the Ohio Department of Insurance on October 13 has been communicated to both my mother, Lucille W. Lowry, and my brother, Kenneth F. Lowry, Jr. Both of them have empowered me, in notarized documents, to act in their behalf. As was expressed at the meeting on October 13, our concern centers on the extensive variety of insurance policies sold to my mother between June 1975 and May 1977 (sixteen policies sold, of which four were cancelled and refunded as duplicate coverage). This insurance program represents considerable unnecessary coverage in view of her pre-existing insurance and now constitutes an unreasonable financial burden in monthly or annual premium payments amounting to approximately 68 percent of her present income. A proper financial analysis of Mrs. Lowry's needs and present situation as a resident of Otterbein Home would have revealed her permanent financial obligations to the home as well as other commitments. We therefore request the following:

(1) Rescission and refunds on the whole life policies No. 5,248,470, issued June 3, 1975; No. 4,854,476, issued June 14, 1976; and No. 5,413,376, issued March 2, 1977. These policies represent the heaviest financial drain on Lucille Lowry's resources and were unnecessary in view of the coverage which already existed in other life policies.

(2) Rescission and refund on the hospital indemnity policy No. 770,052,917.

(3) Compensation for the expenses incurred in attempting to investigate and resolve this matter. In their negotiations with Lucille W. Lowry, the actions and sales practices of the various agents representing Bankers Life and Casualty Co. raise serious questions regarding the lack of fiduciary responsibility, the resultant effect on her well-being, and her right to be compensated beyond the expenses mentioned above.

The premium will be paid on GR717 medical surgical policy No. 730,576,561, and on other health policies as they become due. At the present, no decision has been taken as to the course of action which will be followed in reference to the life and annuity policy No. 5,432,306 on Kenneth F. Lowry, Jr., and No. 5,432,307 on Robert E. Lowry. All refunds may be made payable to Mr. Lucille W. Lowry.

Sincerely,

ROBERT E. LOWRY.

---

LEBANON, OHIO, *November 10, 1977.*

Mr. WILLIAM GRUBBS,
*General Counsel, Bankers Life and Casualty Co., Chicago, Ill.*

Dear Mr. GRUBBS: Due to my physical condition, I was unable to attend the meeting my son, Robert, had with you at the offices of the department of insurance, State of Ohio, Columbus, Ohio, last month. Robert was acting in my behalf under my authorization. He explained to me the details of the meeting. He promised that I would make a decision as to my requirements on or before November 14, 1977. Therefore, my decision is as follows:

I wish to cancel the following listed policies and request refund of all premiums paid on these policies from the issued dates:

Life policies: 5248470, issued January 3, 1975; 4854476, issued June 14, 1976; 5413376, issued March 2, 1977. Health policy: 770052917.

I trusted your salesmen to help me set up an insurance program that would benefit my children. I did not realize that I would not be able to pay all these premiums until I found myself financially strapped and unable to meet my current obligations out of my monthly income. So instead of helping my children, I find that sooner or later I will lose all the money I have paid in and I am on a dead-end street, so to speak. An audit of my financial affairs indicates that 68 percent of my income is owed to Bankers Life and Casualty Co., and I will not be able to help my children as represented by your salesmen. My son, Kenneth, has been here from Michigan and agrees with all of the above decisions.

I sincerely hope you will make the above adjustment in order to rectify my predicament.

Sincerely yours,

LUCILLE W. LOWRY.

"AVENUES OF ASSISTANCE EXHAUSTED"

Mr. LOWRY. In the days following the meeting I did not know where else to turn for assistance in resolving this problem. The company's attitude in refusing to recognize that insurance oversale had apparently taken place and their minimal concessions gave little hope that our decisions and requests would provoke a positive response. I was also aware that the Ohio Department of Insurance appeared to feel that their immediate responsibility had been satisfied simply by bringing about the meeting. Due to the structure of Ohio laws it seemed that I had exhausted both the avenues and the remedies available to the complaining consumer in Ohio.

The problems of insurance exploitation and the offensive sales tactics described in the Pennsylvania press releases were so similar to my mother's situation that I began to wonder if the problem practices had crossed the State line and were now flourishing in Ohio and elsewhere. The probability that my mother's problem was not unique or isolated suggested the necessity of alerting the appropriate authorities and assisting in the exposure of the condemned sales practices.

The attorney general's staff was again helpful in referring me to a former staff member of your committee who is presently directing an Ohio agency program concerned with problems of the elderly.

She strongly suggested that I contact the Washington office of Senator Glenn and the Committee on Aging in order to call the problem to their attention. I did so. Senator Glenn and his staff became immediately involved. Letters were written to the Federal Trade Commission, the Ohio Department of Insurance, and the Ohio attorney general's office expressing a great concern for my mother's specific problem and requesting some review of the possibility that insurance exploitation of the elderly might be taking place in Ohio and elsewhere. Senator Metzenbaum also directed letters urging investigation of the problem to those same Ohio agencies. I contacted Senator Stevenson's office which reported the problem to the Illinois Department of Insurance and they, in turn, made inquiry of Bankers Life & Casualty. We are most sincerely grateful for the interest and support received from these concerned Senators.

I finally received a letter from Bankers Life & Casualty on December 10, and a copy of their reply to Senator Stevenson's inquiry. The letter contained a justification of the company's position, the propriety of the insurance program written on my mother and two refund

checks. To my complete surprise, the refund was a blanket cancellation of all 13 policies. Referring again to the letters my mother and I sent to the company, we specifically requested only four policies be rescinded and refunded, that is, the three life policies which constituted, by far, the major share—$6,901.15—of her annual insurance premiums and one health policy.

The company's action in this total program cancellation was inexplicable. There had been no intention on our part to leave my mother without some insurance protection. Three of the health policies were to be maintained, at least for the time being. The accident policy and the grandchildren's policies were relatively inexpensive and we had decided to retain them—despite our conviction that they represented basically unnecessary purchases in an already oversold program. The company's treatment, in this unrequested blanket refund and cancellation, was interpreted by us as a vindictive act. One further offense had been committed against this elderly client and we were unable to understand the reasons.

The Pennsylvania press releases make a strong recommendation, a plea, for family members to dare to involve themselves in their aging parents' affairs in order to help assure that overinsurance or exploitation does not occur. As I indicated earlier, my own involvement was accidental and very tardy. Once a problem of insurance oversale does exist and is discovered, the avenues available for pursuit of its correction or remedy are, I feel, unnecessarily difficult and time consuming. Responsible public agencies at the local or State level are not always responsive or tend to view their roles as referees who stand back and say, "Let you and him fight." Washington, D.C., is a long distance for most people to travel and it should not be necessary to come here in order to obtain an insurance program correction.

I sincerely hope that this difficulty of corrective actions might become one of the concerns of this committee. Also, there should be an awareness that there is considerable apprehension and reluctance to come forward, to admit publicly what my mother has mentioned to me. "I have loved too much, lived too long, or trusted too much."

## Single Agent Selling Duplicate Policies

Senator Chiles. Thank you.

Mr. Lowry, looking at the listing here of the policies that she bought it appears that in one instance one agent was responsible for some of the sales of duplicate policies which were later refunded by the company on that basis. Is this your understanding?

Mr. Lowry. Yes. From the information I was able to gather, Mr. Walsh had sold the original health intensive care policy in April 1976 and 8 months later, he again sold her the same type of coverage which was subsequently refunded by the company as duplicative. This particular type of policy was very popular because other Bankers agents apparently sold it to her two more times in April 1977. I fail to understand this, but I do have the refund stubs. My mother is unable to recall the details of these transactions.

Senator Chiles. Do you know how these agents first contacted your mother? How did they become aware of her?

Mr. Lowry. I do not know, Senator. If I might dare to conjecture, it may have been through a Sunday supplement coupon or a mailed out brochure which could have piqued her curiosity. She does have certain anxieties and concerns and I think it very likely that she would have responded to these advertisements.

Senator Chiles. Do you know if these same agents sold insurance to anyone else in the Otterbein Home?

Mr. Lowry. I do.

Senator Chiles. They did?

Mr. Lowry. Yes, sir. I know of at least one other Otterbein Home resident who purchased two life policies from the same agent who had sold my mother her two largest policies. She has apparently contacted some trusted person who has advised her against the program she purchased. She would like to obtain a refund and yet, when I look at the figures on her insurance, the cash surrender values are minimal—approximately one-third—in comparison to the amount of premiums paid in over 2 or 3 years time.

The company had made quite a point of saying to us that there would be no refund because the policies had been well sold, that there was a true "need" which existed for my mother. Therefore, nothing out of place had occurred. Yet, I believe, with the spotlight focused on them and receiving expressions of interest from various Senators here as to their actions, they did decide that a refund should be made. This was a full refund.

I would like to believe that the company would not consider my mother a very special exception. She did receive a full refund, and I would hope that perhaps other dissatisfied senior citizens might be able to obtain their program corrections.

Senator Chiles. Senator Glenn.

Senator Glenn. Thank you, Mr. Chairman.

This struck a particular chord with me because of a family experience we had, I guess. My dad worked as a plumber all his life, had a small plumbing shop, saved a very modest amount for retirement. My mother and dad owned their own home. About 2 years after my dad retired, he got cancer and was on about a 6-year downhill slide and all the savings went.

After my dad died, my mother then had a number of calls in the next few months regarding her own health insurance. I suppose they assumed that all the money had gone to pay for my dad's medical bills and she would be especially concerned about her own health problems. Fortunately, she called me and I was able to advise her in these matters. However, where there is not someone immediately available like that, and with the fright that the elderly have with regard to their health, it becomes an increasing problem.

## "A Frightening, Frightening Prospect"

As people reach their senior years, health becomes the most important thing to them. When they have that concern, and when we know that medicare pays only about 38 percent of the medical costs of those over 65, you begin to see the extreme concern that people have of getting left stranded as paupers with nothing to take care of their

health needs. It is a frightening, frightening, prospect, and it places people like your mother, and others, in a situation where they are so very vulnerable to the pressures that can be exerted on them. That is something we absolutely have to take care of, either through the companies voluntarily or through law.

Let me add one other thing. I think those who have pushed for national health insurance with a comprehensive overall national health insurance have done a disservice in some respects. They have insisted on the whole national health package or nothing, and as a result we have got nothing. I think, a long time ago, we should have gone to the major area of concern—as I see it—that of covering the catastrophic illness. That is the one that just wipes people out overnight, wipes out family finances. It seems to me that we should get something in place that covers that most dangerous area, that of catastrophic illness, but we have not been able to split that off from comprehensive national health insurance. The proponents of national health insurance will not see anything except the full blown package, and as a result we have had nothing. I think we should be covering some of these areas of special concern.

Let me ask you specifically, in this area of false signatures, what was done on that? Now that is criminal. Was there any followup made on that?

Mr. LOWRY. The company had offered to refund those or honor the policies as we were to decide.

Senator GLENN. But I mean it is criminal for anything, not just with insurance. It is criminal to sign somebody else's name or falsify a signature. Did the attorney general or anyone follow up on that as to——

FALSE SIGNATURE NOT FOLLOWED UP

Mr. LOWRY. No, Senator. I appreciate your having raised this issue. I have been extremely disappointed at the lack of reaction in Ohio, to the maintenance of laws that I understood would exist for the protection of the citizens. Neither the attorney general's office found an avenue for acting in this area, nor the department of insurance. A local attorney I spoke to was unsure.

I had not requested, had not accepted the company's offer to refund these particular policies, because we were and still are considering possible legal action there in Ohio. This is an area about which I have felt a great deal of concern.

I might mention one other violation. In the blanket cancellation which the company accomplished of all of my mother's coverages, attached to every one of the health policies is a small rider called the Ohio statutory rider. I won't read the whole thing. It says, "Cancellation by the insured, noncancellation by the company." One of the sentences specifically says, "The company may not cancel this policy." Yet, the company did.

Now I plan to file a formal protest regarding this in Ohio. Even though the Lowry family feels that it wishes no further insurance involvement with Bankers Life & Casualty, we were willing to maintain these policies because we did not wish to leave my mother totally unprotected, but I protest the action of the company in violating yet one more Ohio statute.

Senator GLENN. Was one of the frauds that was also perpetrated—I guess it would be official fraud—that of using different names or using an applicant's initials one time, the first name another time, the first initial and middle name another time, so that perhaps they wouldn't show up on the computer runs that the company might make to follow up on individual agents? I don't think we are here today to castigate the whole insurance industry. That is far from my purpose here today because I think a lot of this comes from individual agents out there that need to be policed better by the companies. I don't fault everybody in all the companies, and I want to make that clear, but sometimes individual agents out there will use different names or sets of initials for the same person. Was that done in your mother's case? Was the name always the same?

Mr. LOWRY. This is one of the warning signals included in the Pennsylvania press releases, but I have not found that to be the case. Her name was spelled and misspelled with a passion, but this did not seem to result in a duplication.

Senator GLENN. Maybe this just was not a very bright agent in this case.

Mr. LOWRY. The company has made a great point in much of its correspondence to the North Carolina Department of Insurance in citing a number of rules which exist for the behavior of their agents. I found these extremely interesting due to the fact that they consistently managed to violate their own rules, so the recitation of such behavioral codes means very little to me. It may well be that these rules are a very recent creation and brought about through protests such as this.

Senator GLENN. Did you ever talk personally to the agents involved that sold these to your mother—Mr. Walsh, for instance—that sold five different policies in a reasonably short period of time, about 1½, 1¾ years?

Mr. LOWRY. No, Senator, I did not. I met with only one agent, Mr. Grooms, who came out to respond to some initial questions. He was also interested in insuring me during the visit. The subsequent contacts were all with Mr. Grubbs.

Senator GLENN. I know we do have other witnesses and our time is getting away, and we are going to have to move along, so I will curtail my questions. We might wish to send you questions that could be answered later on so the committee records will be complete. I would note though and want to make this comment to you, we are going to follow up on the record of today's hearings and your testimony. I have already asked my staff, Diane Lifsey on my personal staff, and I would ask the committee staff to go through this and make a copy of the day's hearings so that we can send it along with any comments on this from the staff here to the Ohio attorney general's office to see if there is any area of criminal prosecution that should be followed up.

The attorney general, Bill Brown, is a very good friend of mine. I know personally of his interest in following up where there has been fraud or where criminal activity would be involved against a particularly vulnerable group of people like this. I don't know at this point whether there is anything that can be done or not, but I know he would be interested in following through on it. We will make the

32-703 O - 78 - 4

record available to him, along with staff analysis of where they think there might be particular areas that warrant criminal prosecution.

Mr. LOWRY. I sincerely feel that the Ohio attorney general's office did wish to become involved, but they found themselves blocked from such involvement by existing legislation and reluctantly referred me to the insurance department. I would hope that necessary changes could be made in the Ohio law and the Ohio Consumer Fraud Act.

Senator CHILES. Thank you. You have done a service not only for your mother but for a lot of elderly people, too.

Mr. LOWRY. Thank you.

Senator CHILES. Mr. Klowden, you are next. Your statement in full will be placed in the record and if you could summarize that for us a little bit it might help us because we have a number of other witnesses.

## STATEMENT OF JULES L. KLOWDEN, VOLUNTEER INSURANCE COUNSELOR, SENIOR CITIZENS SERVICE CENTER, SAN DIEGO, CALIF.

Mr. KLOWDEN. I will try to be as brief as possible.

Senator CHILES. Thank you. We want to have time to ask you a few questions.

Mr. KLOWDEN. I am overwhelmed to be able to address these distinguished people.

My name is Jules Klowden, I am a volunteer insurance counselor with the city of San Diego Senior Citizens Service Center. My office is in the city administration building. A month after coming to live in the area, my services were enlisted as I came in to register to vote. The story given to me was that the seniors were being "ripped off" by insurance companies and since I was retired and formerly in the insurance field, would I help? Mrs. Evelyn Herrmann, chief of the senior citizen services, is in charge, and it was she who recruited me.

We analyze approximately 15 to 20 policies per week, or for that many people, I should say, and we have many telephone interviews as well. The city attorney has provided, in writing, permission for me to be able to recommend a number of insurance companies and our service is free of any charges to the public.

We find that people are inclined to buy more than one health policy for two reasons: (1) That medicare does not pay the entire bill and adheres to its famous phrase, "Reasonable fees and charges"; and (2) supplemental plans to medicare follow the same principle and offer to pay their share of what medicare allows as reasonable.

### GAPS REMAIN

This leaves a big gap in medical costs for the patients to pay, despite the fact that they have medicare supplemental plans.

There is a great fear in the elderly, especially women, who worry about whether they have enough coverage should they wind up in a hospital or nursing home. This fear impels them to buy from glib-tongued salesmen and from well-flowered ads they see in newspapers.

An interesting case that I am concerned with is for a retired Navy chaplain who felt that he and his wife needed a benefit for a nursing home facility. The salesman, working for an insurance agency, came to the chaplain's home and after telling him about this great plan that he had, indicated that it could only be sold to members of his senior citizens association. The fee for that is $12 per year. The policy was purchased for $120 per year for each of them, plus a $10 policy "fee," a one-time payment, plus of course the $12 per year.

A statement in the policy says the company will pay according to plan selected, for a period not to exceed 180 days, after excluding the first 100 days of covered nursing home confinement. The benefit it provides is $10 per day. At no time does it offer to pay at least part of the medicare deductible since it does not pay anything until the medicare benefit ends. Is this value?

One month later, upon delivery of the policy, the salesman told of a great investment plan that he had for the chaplain. This was with a savings and loan association from Los Angeles which was planning to build an establishment in San Diego within 6 months.

The chaplain fell for the idea and his investment was to be $1,176 per year. After the second payment was made and no building was put up by the investment company, he tried to reach the salesman by phone and then with repeated visits to the office. The man was never in, always out to see his doctor, but never returned the calls.

Our chaplain now came to me for help and we found that the great investment for this 77-year-old man—now 79—was a life insurance policy. We filed charges of fraud with the district attorney as he was working on other cases against this sales agency. He, in turn, contacted the department of insurance. We are still waiting for the investigation to be completed.

The owner of this insurance agency has been arrested on another case since then with the trial coming up soon. Two other men from this agency are now in jail. Several others are being investigated for shenanigans in the field, one for continuing to sell insurance after his license was canceled by the department of insurance, and working a funeral cost racket with seniors for this same agency.

Another case with that group was of a lady who had made purchase of a medicare supplement policy but had not yet received it. Reading the newspaper story about the owner of the agency, she became frightened and wanted out. I advised her against it as the problem was not with the insurance company. She was insistent. We showed her how to do it.

A few days later, two men came in with a tape recorder and "held an inquisition," as she described it. She was hysterical. Her money was refunded.

### Bombarded By Advertising

Another problem we have is selling medicare supplements with brochures that indicate benefits that are not provided by the policy.

We again have the problem of companies that advertise in the newspapers. Some of them have fair plans that could have some meaning to the elderly; however, they start a bombardment of mailings to add

riders or to sell additional coverages that bring them millions and empty the purses of the seniors. The extra plans they sell come under my description of "junk policies." Here is a case of a company who advertises in one of our local papers with a fairly good plan.

They supply this for only $1 for the first month. Not bad? Whether you continue with the plan or drop it, you are on the mailing list and ripe for their cancer policy. This was purchased by one of my ladies. The annual premium was $53.32 and was dated April 22, 1977. A rider was added for $23.44, dated October 22, 1977; then again another rider for $77, dated November 22, 1977. This makes a total of $153.76 per year.

Not too long ago, a cancer policy sold for $10 per year to cover an entire family and included many other dread diseases with it. These benefits are poor and the cost too high. It allows $60 per day for the first 12 days and $40 per day thereafter for a total of 90 days of coverage. It pays from $30 to $500 on a listed surgical benefit. This is for cancer. They allow up to $50 per day for intensive care, limited to 30 days. They allow up to $6 per day for drugs or medicines for the first 12 days and up to $4 per day thereafter until a total of $250 is paid.

We in San Diego are living in one of the highest medical cost areas in the world. People must not have such junk offered to them. The hospital nearest to my home charges $151 per day for general care—at least it was that last week. Our big problem is the bill presented by the doctors and most of the "junk policies" offer no benefits, just piddly ones that can bankrupt a family.

## Reluctance To Pay Benefits

We have case after case of insurance companies who do not like to pay even the benefits that they provide in their policies.

One lady came to me with medical bills of over $8,000 and begged for help. A girl in the doctor's office filed the claim for her. Upon my inquiry, they said no claim had been made. This was about 10 or 8 months later. Upon filing the claim we got $1,400 for her.

The same company, on another claim that I made for a man, resulted in a payoff. He tried for 10 months to get help to make them pay. However, they shorted him $40. It took several months more and filing with the department of insurance to do it before they paid. It is a nationally known group and very well known.

We have the problem of an 80-year-old widow with seven policies who came to me last week to see if she had proper coverage to help with medicare benefits. She left the policies with me as I could not evaluate all of them immediately. The next day she wrote a letter which I brought with me. I would like this entered into the record, if possible.

Senator Chiles. Without objection, it will be entered into the record.

[The letter referred to follows:]

San Diego, Calif., *May 6, 1978.*

Dear Mr. Klowden: As you probably recall I left some insurance policies with you Friday, May 5, for you to please look over and give your opinion of which ones are the better and/or if they are practical for me to keep.

I know I have too many, perhaps covering the same thing—and if so could I collect from both?

When I took them out, I knew that medicare does not call "reasonable" nearly the amount the hospital, doctors, and convalescent or skilled nursing homes cost and some of the policies maybe say they only pay $15 or $20 a day in hospital—or for $18 to $10 per shift for home nursing, but I thought that amount would help pay for the "unreasonable" part that medicare doesn't cover? But on the other hand—would it be cheaper or more advisable for me to put my money in the savings and loan to draw interest? I'd have to pay or file income tax then if my income was high enough. I don't like the idea of paying interest on interest, neither throwing money away.

I've heard a number of people say one only needs one good supplement to medicare, but what ones are good?

Also different ones speak of having Blue Cross-Blue Shield, whatever they are, but said BC-BS was quite expensive. Does or can one have medicare and Blue Cross and Blue Shield at the same time? And what do they pay that medicare doesn't?

I've been thinking the past few months of dropping one or two or three of these anyway, and if I could get some one policy if there is such a one, that would cover and pay for what the ones I now have do. I would not want to let them go where I wouldn't be covered, until the waiting period of a new policy has elapsed, I mean if I have to wait 6 months before I can collect on a policy. I should want to keep one I have until I have had a new one that long.

At the present I have too many to keep track of when premiums are due.

I think I read something a while back in "Senior World" about AARP and Colonial Penn, but I don't remember what. Isn't Colonial Penn a reliable company, one that pays and pays promptly, or are their premiums too high?

I was thinking a while back before I thought of coming to (you) for help of maybe dropping Bankers "Over 65 Skilled Care" since it has raised to $133.82 a year now and maybe keeping AARP recommended Colonial Penn Skilled Nursing and Home Nursing Policy No. 1152372, but also was about of the opinion that medicare or Bankers or Colonial Penn would not cover the costs or even 50 percent of costs for the majority of people that go to these places, for stays here require 24 hours a day skilled service, have to have registered nurse and doctor 24 hours per day. So maybe would not be able to get anything from medicare or any insurance company.

What do you think? I had thought the individual accident part of 1152372 might be good if the company will pay what the policy says, but they have never raised the price since I took it out, but maybe they aren't reliable and wouldn't even pay what they said. (It is $4.75 per month.)

My sister had Bankers' in-hospital like mine and it paid off as policy stated while she was in the hospital. But nothing while she was in Hillcrest Rehabilitation and Convalescent Hospital. Medicare didn't either except the H.R.C. had her charged for 20 percent of therapy. Said that medicare had paid them but she didn't get any reduction on any of colostomy supplies, medication for or drugs for bladder trouble, heart or lungs, but charged her almost twice as much for some of same kind of medicine, etc., that she took when she was home. Therapy, even 20 percent, was plenty high, I don't know of any only rubbed her back and helped her walk a few times.

Thanks for giving your time in looking at my policies and trying to read this. I appreciate it very much.

Sincerely,

(SIGNED.)

P.S. Sunday—

Someone gave me a folder to look at today called Coronet Senior from Blue Shield. I looked it over some but am not sure I understand it all or not, but I think if one takes out the Coronet Senior they have to pay $100 a year hospital care, and prescription drugs and private duty registered nurse, these things while in a hospital. Is that correct? And any medical and outpatient hospital services are provided by Blue Shield without a deductible. (What is outpatient hospital services?)

Under "payments" of this folder, what does this line, "Benefits of this plan may not be assigned without the written consent of Blue Shield," mean? Under part B—"Medical and Outpatient Hospital Services," what does outpatient hospital services mean? Does that mean that if one has this policy, even if they haven't been in the hospital, but if a doctor or even the holder of the policy thought they needed an X-ray, or had a chest pain, or some ailment and they

wanted to find out what was the cause, and got relief, they could go to the hospital and ask for such help without first contacting a doctor even if I had been doctoring with one? And if one's doctor had sent patient to have X-rays and tests, that medicare pays 80 percent of what they call reasonable, and Blue Shield pays the other 20 percent of what medicare calls reasonable? (And then the patient still pays about 40 percent of the bill that isn't reasonable.)

Do you think I would be better off and as adequately covered if I took Coronet Senior if I could get it with Blue Shield at $67.50 a quarter or $270 a year, and drop two or three of the ones I have? Which ones? Which do you advise? I have felt I had too many for hospital, but not ones that cover doctors and medicines, etc., but I guess none of them pay for nonprescription medicines or for chiropractor treatments, or adjustments, and heat when one has a wrenched or strained back, do they?

If you can read this and give me your honest opinion I will appreciate it.

I am 80 plus, have social security and a little savings but not much, but enough so far to not need welfare, but have not enough that would last long in a hospital or convalescent or rest home, or even if I had to have help. So far, have lived in studio apartment for quite a number of years so get rent cheaper than would if I hadn't been here so many years. If have to pay rent like most, then my savings wouldn't last and I have been making a little working a few hours at housework, so cut down on expenses too. I have no one to help me or to depend on if I get so I can't care for myself. So far, I only have to take one prescription regularly.

I don't understand "reimbursement of benefits for injury" paragraph.

Sincerely,

(SIGNED.)

Mr. KLOWDEN. It tells the story of one poor soul of many millions with the same problem. One of the policies indicated it was for persons over 65 and they had the audacity to put a maternity benefit in it.

## CALIFORNIA ACTIONS

California has become aware of the medi-gap problems and the department of insurance has taken a few more steps to help our seniors. We have established a loss ratio for medicare supplement policies at 55 percent. The commissioner will study the annual reports from insurance companies closely and see that they adhere to this regulation.

In order to be called a "medicare supplement policy" part A and part B will have to be included. However, the coverage could be limited to expenses incurred while hospital confined and may not need to include skilled nursing care services.

Preexisting conditions are now to contain a maximum of 6 months waiting period instead of 12 months for coverage of conditions treated during the 6 months prior to the effective date of a policy.

Policies designed to supplement medicare shall be indentified as such.

Readability is being stressed. All medicare policies are to be withdrawn as of December 31, 1978, and be replaced if they were issued prior to May 1, 1978. They are to be written in understandable English. Disclosure forms must be provided with each new policy delivered after January 1, describing the benefits and returned to the insurer to indicate understanding of the policy.

A catastrophic medicare supplement coverage will be permitted to be written starting in January. This could be designed to pay the difference between what medicare pays and the usual, customary, and reasonable expenses.

I am afraid, however, that if no control is placed on medical costs when this type of policy is issued, may God help us.

My most heartfelt thanks for listening.

Senator CHILES. Thank you, Mr. Klowden, for your comprehensive statement. You mention on page 2 of your statement that the insurance agency was selling insurance only to members of a senior citizens association and that they paid a $12 fee to belong to that association.

Mr. KLOWDEN. That is right.

Senator CHILES. Is that a local group?

Mr. KLOWDEN. Yes, sir, it is a local group. They did not actually seek out members and then sell them insurance. What they do is seek out most people to whom they sell their insurance and then tell them they must be members in order to get the insurance. In this way, they sell the membership also.

Senator CHILES. I see. The design was not just to sell insurance. You would be able to buy insurance if you were in that group but they were going to provide other services.

Mr. KLOWDEN. Yes.

Senator CHILES. What other services were there besides the prescription service?

Mr. KLOWDEN. They had meetings once a month. They had guest speakers. They did have some kind of travel setup to offer to the people but this——

Senator CHILES. This was looking like a nonprofit association designed to benefit the members by helping them with problems.

Mr. KLOWDEN. I would not say that it was nonprofit—$12 a year—I think they made themselves a good piece of change, because they didn't give anything for it—very little I would say.

Senator CHILES. Did they give counseling and advice to the seniors as well as help them with their prescriptions?

Mr. KLOWDEN. It is possible. It is possible.

Senator CHILES. How many members did they have, do you know?

Mr. KLOWDEN. I have no idea, sir. I never did check on that. I am sure that the district attorney has that information available to him.

Senator CHILES. Some of these people have been put in jail?

Mr. KLOWDEN. Yes, sir, that is right, and there are more going.

Senator CHILES. You indicate that the brochures advertising supplemental policies to be misleading. How much of that do you see in your position as counselor? Do people get a lot of these brochures through the mail?

Mr. KLOWDEN. Yes, sir, they do. In fact, I did bring a policy and a brochure that was used in which to sell it, although I have it downstairs in an office. It is in my briefcase.

Senator CHILES. We will keep the record open. We would like to see that.

### LIMITATIONS NOT EXPLAINED IN ADVERTISING

Mr. KLOWDEN. We find that many companies offer in their brochures various benefits. Just to give you an example, say they claim that they will pay X-ray charges, they will pay laboratory fees, and it is assumed by the individual who then buys it that the full amount is going to be paid. However, when the policy is received and you read these various benefits, they indicate the same benefits but then a few words after that "up to $10." In other words, they have a tight limitation on it, but it is not indicated as such in the brochure.

Senator CHILES. The step that California has taken in providing that they must pay out 55 percent of their premiums, do you think that is a good step?

Mr. KLOWDEN. I believe so, only there is one problem that we might be involved in in the future in that. If the company has to pay that much out in benefits, it is going to cut down on the cost of commissions to their salesmen, and if that happens we may have more problems with vultures.

Senator CHILES. Senator Glenn.

Senator GLENN. Yes, a couple brief questions.

Mr. Klowden, you indicated in your statement you were formerly in the insurance field. In what capacity was that?

Mr. KLOWDEN. As an insurance salesman, and I was an assistant manager with my agency for a while.

Senator GLENN. Did you in your experience with the companies follow up to see or make a real substantial effort to see that these kinds of practices did not occur when you were active yourself?

Mr. KLOWDEN. We had very, very few problems of that kind at the time that I was in the business. I got out of the insurance business in 1961 and it has been a while. We had a few companies that were rather rough on people, some of the cases that have been brought up to date, but there were very few like that. Most of the companies were quite dependable.

Senator GLENN. When you were active this was before medicare and before some of the fast rising costs that we have had.

Mr. KLOWDEN. Yes, sir.

Senator GLENN. Do you think State insurance laws in general are adequate now in this area?

Mr. KLOWDEN. I am not familiar with any outside of my State, or that of which I operated before, but I think they should be tightened up even more, to be more watchful.

Senator GLENN. What kind of cooperation have you had since you have become an advisor in this area in San Diego? What kind of cooperation have you had from the companies when you point out the problems?

Mr. KLOWDEN. Oh, some of them were very reluctant. I have attempted to get specimen policies, for example, from many companies and usually they will send brochures trying to advertise rather than to send specimens, because I know that the payoff on any claim is based on the policy itself, and for this reason I refuse to evaluate information on a company other than on the policy itself.

Senator GLENN. One obvious improvement that could be made immediately, of course, is that people do take the time to know what they are doing, and in that case a lot of people who do not have the expertise that you can provide for them, it is difficult for them to analyze what is best in their situation unless they have someone like you.

Mr. KLOWDEN. True.

### EXPERT ADVICE OFFERED

Senator GLENN. Has this been an expanding program in California and could you comment very briefly on the advice or role you have had

and whether you think it should be expanded? I personally think this is a great idea, having someone of your caliber and someone of your background who knows of the problems so they know somebody they can call so they have not a bipartisan but——

Mr. KLOWDEN. Unbiased.

Senator GLENN. An unbiased view of the people's real needs. Usually people don't have anyone to turn to, and so I think that your situation would be one we should try to foster in all States and arrange for people who do not have someone else to advise them.

Mr. KLOWDEN. Senator Glenn, I highly recommend it because as far as I know there is no one else in this country doing it as a volunteer. I don't get paid for it. It costs me money to do this but I am happy to do it. If any State or city in this country is willing to learn something about it, I will be very happy to train a staff for them, so long as they send them out to me for this help.

Senator GLENN. Well, you are to be commended for your activities and for taking this on and helping your colleagues out there who may not have your expertise. I commend you for it.

Thank you, Mr. Chairman.

Senator CHILES. Thank you, sir.

Thank you very much for your testimony, Mr. Klowden.

Mr. KLOWDEN. Thank you.

Senator CHILES. Our next witness will be William E. Grubbs, director of government relations, Bankers Life & Casualty Co., Chicago, Ill.

Mr. Grubbs, I understand you have a couple of people with you. You can bring them to the table with you if you like.

## STATEMENT OF WILLIAM E. GRUBBS, ASSOCIATE LEGAL COUNSEL AND DIRECTOR OF GOVERNMENT RELATIONS, BANKERS LIFE & CASUALTY CO., CHICAGO, ILL.; ACCOMPANIED BY DUANE CHAPMAN, ADMINISTRATIVE VICE PRESIDENT; RUSSELL VAN KAMPEN, MARKETING VICE PRESIDENT; AND MICHAEL DRESSENDORFER, ASSOCIATE

Mr. GRUBBS. Mr. Chairman, I have with me Duane Chapman, an administrative vice president; Russell Van Kampen, a marketing vice president; and Michael Dressendorfer, an associate in my division.

We are pleased to be here and we appreciate the courtesy of this committee in inviting us. We have been asked to comment in two general areas. First, the range and extent of purchase of private insurance policies by medicare beneficiaries. This includes comments upon the underwriting limits and practices involved in the offering and issuance of life insurance and accident and health insurance to persons over 65 years of age. Second, the issuance of life and accident and health policies to insure Mrs. Lucille Lowry, three of her grandchildren, and her two sons.

We have presented the committee and staff our prepared statement covering in some detail our view of the range and extent of the private insurance held by medicare beneficiaries.

Senator CHILES. Mr. Grubbs, that statement,[1] in full, will be included in the record and if you can summarize that for us it will be helpful.

Mr. GRUBBS. Yes, sir. That is exactly what we intend to do, Mr. Chairman. We were asked by staff to try to restrict our comments to 10 minutes. I went through this once and I made it in 10 minutes and I hope to do it again.

Senator CHILES. We will give you a little leeway there but we would appreciate it.

Mr. GRUBBS. Thank you.

## $120 MILLION IN HEALTH PREMIUMS FROM ELDERLY

Our insurance marketing is not limited to persons over 65. I will just take a moment here to issue for your information a little profile of our company business as of 1977 so that these matters can be put in the proper perspective.

In 1977, we had total premium income of $476 million roughly. We had individual and accident health insurance in force of $298,500,000. We had group accident and health insurance in force of $74 million. We had approximately $120 million or about 45 percent of our total accident and health in force on persons over 65.

Senator CHILES. I missed that figure.

Mr. GRUBBS. That is approximately $120 million out of the $476 million. The total premium income being $476 million, the income coming in from persons over 65 is $120 million.

Senator CHILES. Can you tell me the premium that you are collecting from people over 65?

Mr. GRUBBS. The $120 million is premium or 45 percent of the total accident and health roughly. That is between 40 and 45 percent somewhere.

Mr. Chairman, do you have those figures? We have individual life coverage in force of $62 million, annuity in force of $13,500,000, group life of $7,300,000, and group annuity of $800,000. I think that will perhaps help you keep this matter in its proper perspective.

In addition, our written report provides detail concerning the issuance of life and accident and health policies to insure Mr. Lowry, three of her grandchildren, and her two sons. I would like to comment at this time about the Lucille Lowry matter since it became the responsibility of my department to handle this matter after a complaint had been lodged with the Ohio Insurance Department on or about September 28, 1977, and subsequently with the Illinois, Virginia, and North Carolina Insurance Departments, to whom we were required to explain this matter.

I would like to add one additional factor here, and that is our company does not consider one over 65 to be prima facie an incompetent person. Our assumption is that a person over 65 is competent and able. As a matter of fact, in our hiring practices, from the very beginning, we have never had a mandatory retirement age for this reason. One of my leading secretaries happens to be 74 and is most competent and able. Consequently, just because an individual is over 65, we don't treat him any differently than we would a younger individual.

---

[1] See page 56.

My original review of the policyholder files indicated to me the health insurance in force upon Mrs. Lowry fell within reasonable parameters and also within our company rules limiting the maximum of premium to $50 a month. We have been informed——

"DON'T OVERSELL"

Senator CHILES. Excuse me just a minute but I am going back to your full statement where you talk about medicare coverage.

With few exceptions, everyone over age 65 has the benefit of medicare, both parts A and B. If for some reason they didn't apply for part B, advise them to do so. This in itself is excellent protection.

Then you go to a "Don't oversell, don't place a burden on the policyholder that he or she cannot afford."

Mr. GRUBBS. That is correct.

Senator CHILES. Then going on, I notice on page 5 that you say, "By putting the above actions into every presentation to people in the over-65 age market, you will not only help them but in the long run the company and yourself."

You were referring there to in-force coverage. "Regardless of how substantial the benefits of our policies are, very seldom is there an advantage to the policyholder to lapse one individual policy in favor of another. Usually, it is an injustice with a resultant misunderstanding on claims." So it looks like you have in your manual recognized the over-65 and you have put in certain kinds of conditions in regard to sales to that over-65.

Mr. GRUBBS. That is absolutely correct.

Senator CHILES. Why don't you recognize them as being incompetent? Under your own manual it seems that you are trying to instruct your agents as to something in sales restraint.

Mr. GRUBBS. That is correct.

Senator CHILES. Excuse me for interrupting.

Mr. GRUBBS. We have been informed. Mr. Lowry questioned whether his mother had received sufficient life or accident and health coverage to account for the amount of premium she had paid. It was my understanding Mr. Lowry felt his mother had more life insurance than she could pay for, as related to her income, and Mr. Lowry indicated neither he nor his brother had signed the applications for two life policies insuring their lives for which his mother was paying.

On October 13, 1977, Mr. Lowry and two persons to assist him, two representatives of the Ohio Insurance Department, the company's regional manager and I, met for an informal hearing in the Ohio Department. Since Mr. Lowry had indicated to us neither he nor his brother had signed the life applications, I requested a check be drawn from the company to Mrs. Lowry refunding the entire premium of these two policies in the event Mr. Lowry indicated his mother wished to have the policies rescinded.

At the hearing, the following occurred: First, I felt a satisfactory accounting of the crediting of premium paid to the company by Mrs. Lowry was provided. The accounting was later presented to Mr. Lowry in a written form by the company.

Second, we offered to either rescind or keep in force the two life policies with the challenged signatures upon the applications at the

discretion of Mr. Lowry and his brother. Mr. Lowry asked for an additional 30 days to think it over and we agreed to this request. We did previously give him an additional 30 days before this occurred from the time we were notified of the question by the Ohio department.

Third, at that time I felt that the two life policies on Mrs. Lowry's life had been in force for more than a year and since we had been on the risk for over $30,000 face coverage during that period it was my view at that time we could only return the nonforfeiture values, if any, which may have accrued. Although I had some concern about the amount of premium which Mrs. Lowry was paying, it was my misimpression at that time that Mrs. Lowry had a greater regular income and considerable estate for which life insurance would be an appropriate vehicle to provide liquidity in her estate upon her death. At the Ohio hearing, Mr. Lowry did not apparently know, or at least didn't mention, the existence of an approximately $60,000 face amount of life insurance Mrs. Lowry apparently had with New York Life Insurance Co. We had no knowledge of that either.

Fourth, it was my impression when the meeting adjourned in the Ohio department, their understanding concerning this case was the same as mine. Approximately 2 weeks after the hearing in the Ohio department, I received a copy of a letter written by Robert Lowry, which for the first time disclosed to me the existence of the New York Life policies. Since in my mind this placed the matter of the amount of premium being paid and the amount of coverage Mrs. Lowry possessed in a different light, consequently I asked that a complete refund of all premiums received from Mrs. Lowry be made and the company made the refund to Mrs. Lowry on December 13, 1977.

## Apology Offered

As to our company's position in the matter, we wish we had caught the excessive premium in its relationship to income at the time the applications came to us. Further, we would hope that our agents would have uncovered accurate information so that they would not have taken these life applications in the first place. The submission of forged applications is intolerable to us. We are embarrassed and we apologize to Mr. Lowry and his mother.

We will be happy to try to answer any questions you care to ask us. Since we were first notified about this hearing approximately 1 week ago, it is possible we might not have been anticipating some of your questions or be able to prepare some of the information you want. We will, of course, be happy to accumulate and submit to you any material which you want which we have not brought with us.

[The prepared statement of Mr. Grubbs follows:]

### Prepared Statement of William E. Grubbs

Mr. Chairman and members of the committee, I am William E. Grubbs, associate legal counsel and director of government relations of Bankers Life & Casualty Co. With me is Duane Chapman and Russell Van Kampen, both of whom are vice presidents of the company. Mr. Chapman is an administrative vice president, Mr. Van Kampen is a marketing vice president.

We are pleased to be here and we appreciate the courtesy of this committee in inviting us. We have been asked to comment in two general areas. First, the range and extent of purchase of private insurance policies by medicare bene-

ficiaries. This includes comments upon the underwriting limits and practices involved in the offering and issuance of life insurance and accident and health insurance to persons over 65 years of age. Second, the issuance of life and accident and health policies to insure Mrs. Lucille Lowry, three of her grandchildren, and her two sons.

The insurance products marketed by Bankers Life & Casualty Co. to persons over 65, who have medicare coverage fall into four general areas:

A. Medicare part A wraparound products.—These are insurance policies which are designed to pay the entire deductible and coinsurance features not covered by part A of medicare and to provide catastrophic hospital benefits when medicare stops paying.

B. Policies which pay medical-surgical and out-of-hospital expenses.—These are intended to provide reimbursement for doctor calls, surgery, miscellaneous expenses such as X-ray, laboratory and anesthetist fees.

C. Hospital confinement indemnity.—These policies pay at a fixed-guaranteed rate for each day of hospitalization, thus providing financial help to cover hospital, doctor or personal expenses.

D. Extended care facility policies.—These policies pay the coinsurance amounts of medicare in the first 100 days. In addition, they pay benefits for the next 300 days.

The committee may be interested in the underwriting rules which pertain to the sale of these products. The following is a section taken from our agents manual providing instructions pertaining to the offering of our products to the elderly:

C. COUNSELING OVER-AGE RISKS

When selling health insurance to prospects in the over 65 age market, the company and its agents incur legal, social, and moral responsibilities to help these people in identifying their proper insurance needs, and preventing situations that would constitute overinsurance or undue financial hardships.

Because of their age, their normal anxiety relating to the increased possibility of illness, and ever-increasing hospital and medical costs, this market is quite susceptible to being taken advantage of by some agents. This must be prevented if you as an agent and the company are to remain reputable. To assist you in counseling and delivering a proper sales presentation, keep the following points in mind:

1. Finances.—Generally speaking, most over-age prospects are no longer employed full-time. As a result, their income is derived from such things as pension and retirement benefits, social security benefits, and perhaps some investment income. It is unwise to judge an applicant's ability to pay by how much he has in the bank. Their ability to pay should be judged upon the actual income they have.

2. Medicare coverage.—With few exceptions, everyone over age 65 has the benefit of medicare, both parts A and B. If for some reason they didn't apply for part B, advise them to do so. This in itself is excellent protection. Maybe the premium for part B is all they can afford. Don't over-sell. Don't place a burden on the policyholder he or she cannot afford.

3. Wraparound or supplemental coverage.—The prime need for coverage supplementing medicare is a wraparound policy providing supplemental benefits for hospital expenses not covered by the Federal medicare program. No individual should be sold more than one of each type of policy, either hospital or medical, because the result is overinsurance, duplication of coverage and unnecessary and excessive costs to the policyholder.

4. Hospital confinement indemnity.—Hospital confinement indemnity provides excellent coverage but should be sold only where the policyholder can afford the premium, desires a private room and other special services, or realizes that he will incur additional extra expenses due to an extended hospital confinement.

5. In-force coverage.—Regardless of how substantial the benefits of our policies are, very seldom is there an advantage to the policyholder to lapse one individual policy in favor of another. Usually it's an injustice with resultant misunderstandings on claims and a real disservice to the policyholder. If someone has good coverage in force with another reputable company, suggest that he keep the coverage, ask for referrals, and all concerned will benefit in the long run. But putting the above actions into every presentation to people in the over-65 age market, you will not only help them, but in the long run, the company, and yourself.

In order to reinforce some of the rules regarding applications on persons age 65 and over, we are calling your attention to the rules listed below which must be followed:

1. Only one of the policy forms in each group listed below can be sold to an individual (this applies to policies in all companies, including the MacArthur Insurance Companies, except as noted):

(*a*) Medicare wraparound coverage such as the GR-730B, GR-764A, 1696 Rider, etc.

(*b*) Medical surgical policies such as the GR-716, GR-717, and GR-75J.

(*c*) Extended care facility policies such as the GR-747, GR-748, and GR-74B.

(*d*) Hospital confinement indemnity policies such as the GR-700, GR-780, and GR-74J.

Only $30 per day hospital confinement indemnity coverage is allowed per individual.

It is essentially important in dealing with senior citizens to assure that the policy sold does not duplicate other coverage and that the amount of premium is affordable based on the senior citizen's current income.

In addition to these instructions, we practice the following underwriting rules:

1. For individuals 65 or over, the maximum allowable premium including substandard charges for all accident and health policies for all companies insuring the individual is $50 monthly. To enforce this rule, we have established systems involving a computer alphabetized check of all accident and health in-force business when a new application is received.

2. A policy which has been lapsed less than 12 months must be reinstated, upgraded, or exchanged in order to inhibit "rolling" of a policyholder from one policy to another. An upgrade or exchange is limited to one in a 12-month period.

3. We will not allow any improper switching of an over-65 policy to another policy.

We have also been asked to comment on the range and extent of purchase of private insurance policies by medicare beneficiaries. We have obtained some information from the research division of the Health Insurance Association of America whom we would recommend as being a good source for further statistical data about the industry practices and the extent of coverage in this market.

We have attached their information as Appendix "A".[1]

You will note that there are about 23 million senior citizens. Of this group, Bankers Life & Casualty Co. provides coverage for about 750,000 people or about 3.5 percent of this population.

We would like to address the case brought to this committee by Mr. Robert Lowry. Mrs. Lucille Lowry applied for and was issued the following coverage:

(a) Life insurance coverage on her own life with annualized premiums of $6,651. These policies were issued between 6-3-75 and 3-12-77 and in the aggregate provided ultimate death benefits of $37,700.

(b) Accident and health insurance issued to Lucille Lowry amounted to annualized premium of $565.

(c) Life insurance policies covering Lucille Lowry's grandchildren were issued for an annual premium of $65 each (for a total $195 to provide coverage for each of them to age 23 and with guaranteed insurability options.

(d) Life insurance policies with a rider to provide annuity benefits for each of her two sons costing a total annual premium of $1,636.

For details of the above policies, see Appendix "B".[2]

As to the life insurance policies with annuity riders which Mrs. Lowry took out for the benefits of her sons, Robert and Kenneth, with the understanding that the signatures had been forged and they did not complete the applications, we rescinded these policies and refunded all premium. The agent involved left the company prior to our discovering the facts about this situation. His records with the company and with the Ohio Insurance Department have been marked to show he was "terminated for cause". There was no way for the company to know about these forgeries until Mr. Robert Lowry uncovered it and told us about it.

The life insurance policies issued to cover Mrs. Lowry's three grandchildren are not unusual purchases for grandparents. These are policies requiring a one-time premium payment of $65 to provide $1,000 of insurance to age 23. At age

[1] See page 60.
[2] See page 61.

23, the amount of insurance is $5,000 and premiums commence. In addition, they have guaranteed insurability options which allow the child upon reaching 23 and until age 31 to purchase insurance in $5,000 increments up to a total of $30,000 of life insurance without evidence of insurability. These premiums were refunded.

The health insurance policies (not life) written to cover Mrs. Lowry are within the limits of the annual premium allowed by the company. These were refunded as we understood Mr. Lowry wished them refunded because of the total premium being paid by his mother was excessive for her income. We also understand from subsequent correspondence on which we received copies, that Mr. Lowry objected to our refunding these premiums. If Mr. Lowry would like to continue any of the policies uninterrupted, we will be pleased to do so. It was not our intention to vindictively rescind and refund these policies as he suggested.

Subsequent to the hearing in the Ohio Insurance Department, we learned from copies of Mr. Lowry's correspondence to others on which we received copies that Mrs. Lowry had in excess of $50,000 of life insurance in force with the New York Life Insurance Co. This information is not reflected in any of our files or underwriting investigations. It apparently wasn't known by Mr. Lowry at the time of the hearing in the Ohio Insurance Department as it was not discussed at that time. Had we known of this insurance, the life policies which had been issued to Mrs. Lowry would not have been issued. In view of this fact and Mr. Lowry's request, the policies were rescinded and all premium was returned to Mrs. Lowry.

In view of the foregoing, you are no doubt interested in our position on the Lowry case. Frankly, we are embarrassed—we apologize to Mr. Robert Lowry and his mother, Mrs. Lucille Lowry. We wish we had caught the excessive premium and its relationship to her income at the time the applications came to us. Further, we would hope that our agents would have uncovered accurate information so that they would not have taken these life applications. Also, the agent's submission of the two forged applications on Mrs. Lowry's sons is intolerable. We wish we hadn't made an underwriting error in issuing the second Life policy (4,854,476) in June 1976.

We wish our impression of Mrs. Lowry's financial position had been more accurate at the time we visited with Mr. Lowry in the Ohio Insurance Department. The premium Mrs. Lowry was paying in relation to her income admittedly exceeded our own underwriting standards.

The medicare wraparound market came upon us rather rapidly in 1966. No one of us in the individual accident and health insurance business knew what the market would be—we barely knew what medicare was and we certainly didn't know what the insuring needs of the over-65 age group were or what they wanted, if anything. We did our best to provide riders to our existing policyholders to fill the gaps in medicare as we perceived them and to offer new policies to the insuring public over age 65. As we became more informed of their needs and desires, we developed updated coverages which were more comprehensive. It was in the process of providing broader and additional coverages that we created the products which were used by relatively few agents to take advantage of older individuals through twisting and rolling of previously issued policies. It should be noted that these agents were at the same time taking advantage not only of the insuring public but of the companies which contracted with them.

Each time abuses have been noted, they have led to new rules and new controls, both by our company and regulatory agencies. There have been areas where the abuses have been deemed serious by the company which resulted in stringent remedial action.

Mr. Lowry in several of his letters has referred to the situation which was investigated during the last part of 1974 in Pennsylvania by the Pennsylvania Insurance Department. We invite this committee to have its staff obtain the facts of the situation and the action taken from the deputy in charge of the investigation. Please contact Mr. Kimber A. Wald, deputy commissioner of the Pennsylvania Insurance Department, Harrisburg, Pa. We feel the situation has been remedied. The effectiveness of the remedial efforts of the company have been successful. See copies of letters from Mr. Wald—Appendix "C".[3]

Incidentally, market conduct surveillance examinations conducted by the State insurance departments cover all areas of an insurance company's operations;

[3] See page 62.

sales, advertising, underwriting, policy issue, claims, correspondence servicing, and complaint handling. The examiners either cover total activities in each area examined or when large volumes of work are analyzed they select significant samples based on statistically valid techniques.

To say there is no problem or there are not problems worthy of our attention is not correct. The principal area that continues to cause problems for our company and for the insurance industry lies in the area of how to identify the individual who is no longer capable of carrying on his or her own business transactions.

It is possible that even one policy consisting of a $10 or $20 monthly premium could be an excessive burden on an individual. From a company viewpoint, there is no absolute or practical way to know this. Also, for any of us who have dealt with older individuals, there are situations where the individual's incapacity is not immediately apparent to an outsider.

These individuals are not easily recognizable. They are prey to any one of the unscrupulous or unprincipled individuals in our society whether they are selling insurance or any other product. It could be noted here that there are people under 65 who because of their lack of sophistication are also susceptible to being taken advantage of.

Remedies for excess insurance and excess premium in relation to income are hard to find. It is difficult to obtain a statement of income and insurance from this group. However, the very people we're trying to protect will normally be easily led into giving an incorrect statement.

Is it possible that this market should not be sold any individual life or accident and health policies? It is inequitable to deprive the large majority of this population the same privileges when they are fully capable of handling their own business affairs.

We think the protection of those individuals is properly a concern of all. We have provided training, rules and controls to prevent and to uncover problems, but, while reduced, they continue to occur. We continue to look for new ways but we think this committee will find out it is very difficult to completely protect the incapacitated individuals in this group without removing some of the freedoms from the capable members of this group.

To what degree can we as a business, or we as a Nation, through our various governmental agencies, prevent abuse of these individuals? It is our observation that we cannot prevent all wrongful actions from taking place. We can provide inspections and controls and systems to uncover them. We also can provide remedial action to reverse improper transactions and identify those individuals involved in such activity and either help remove their licenses to transact business, fine them or prosecute them.

If we can provide any other information or answer any questions for the committee, it will be our privilege to do so.

## APPENDIX "A"

The Health Insurance Association of America, as of its last published survey covering reporting year 1976, indicates the following facts about senior citizens who are covered by private insurance:

(A) The U.S. Bureau of Census reported age 65+ population as of July 1, 1976, to be 22,934,000.

(B) The number of senior citizens covered by private insurance for hospital expenses was 12,554,000 (55 percent). Hospital expense insurance would be generally defined as one form or another of a "wraparound" or medicare supplement insurance. Primarily, it would be covering the deductible and coinsurance amounts of the in-hospital portion of medicare part A.

(C) The number of senior citizens covered by private insurance for surgical expenses by including Blue Cross/Blue Shield was 10,580,000 (46 percent). Surgical expense coverage would refer to the physician expenses involved with a surgical procedure.

(D) The number of senior citizens covered by private insurance for regular medical expense was 10,227,000 (45 percent). The regular medical expense insurance would include all other physician care, such as office visits, etc.

(E) The number of senior citizens covered by private insurance for catastrophic or major medical expenses was 1,913,000 (8.5 percent). The major medical and catastrophic insurance would include the providing for high limit coverage (in excess of $10,000) for hospital expense when medicare benefits are exhausted.

APPENDIX "B"

## Life Insurance Policies Issued Insuring Lucille Lowry

| Policy Number | Date of Issue | Annual Premium | Form |
|---|---|---|---|
| 5,248,470 | 6-3-75 | $ 3,000 | L-129 |
| 4,854,476 | 6-14-76 | $ 3,204 | L-129 |
| 5,413,376 | 3-2-77 | $ 447 | L-29A |
| | Total | $ 6,651 | |

## Accident and Health Insurance Issued Insuring Lucille Lowry

| Policy Number | Date of Issue | Annual Premium | Form |
|---|---|---|---|
| 730,576,561 | 11-9-73 | $ 221 | GR-780<br>GR-747<br>GR-717 |
| 760,175,115 | 4-19-76 | $ 73 | GR-774 |
| 760,392,452 | 12-16-76 | $ 77 | GR-764 |
| 770,052,917 | 1-9-77 ($285)<br>Upgrade benefits of GR-780 above - net increase in premium | $ 166 | GR-74J |
| 770,149,043 | 4-22-77 | $ 28 | 79L |
| | Total | $ 565 | |

## Life Insurance Policies Insuring Lucille Lowry's Grandchildren -- Form L623

| Policy Number | Name | Annual Premium | Amount of Coverage |
|---|---|---|---|
| 5,423,863 | Alisa Lowry | Single One Time $65 Premium | $1000 to age 23 |
| 5,423,861 | Robert Mark Lowry | | $1000 to age 23 |
| 5,423,862 | Cynthia Lynn Lowry | | $1000 to age 23 |

## Life Insurance Policies with Annuity Riders Issued To Cover Lucille Lowry's Sons -- Form 165 Rider 1401

| Policy Number | Name | Annual Premium | Issue Date |
|---|---|---|---|
| 5,432,307 | Robert Lowry | $ 818 | 4-22-77 |
| 5,432,306 | Kenneth Lowry | 818 | 4-22-77 |
| | Total | $ 1,636 | |

APPENDIX "C"
EXHIBIT 1

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG
17120

January 18, 1977

Duane Chapman, Vice President
Bankers Life & Casualty Company
4444 Lawrence Avenue
Chicago, Illinois 60630

Dear Duane:

I am attaching the MacArthur Group complaint printout for 1976. You will note a further decline to 161. Previous years are:

| | |
|---|---|
| 1975 | 204 |
| 1974 | 261 |
| 1973 | 263 |

It should be noted this was in the face of a 51.3 percent increase in our work load. A statistical analysis of our work is also enclosed.

Obviously, the reforms you sparked in 1974 are paying off in better consumer service.

Very truly yours,

Kimber A. Wald
Deputy Commissioner

KAW:mf
Attachments

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG
17120

APPENDIX "C"
EXHIBIT 2

September 8, 1977

Duane Chapman, Vice President
Bankers Life and Casualty Company
4444 Lawrence Avenue
Chicago, Illinois 60630

Dear Duane:

Confirming our discussion of today, I am attaching two copies of the MacArthur Group complaint printout for the first half of 1977. The record continues to improve.

Very truly yours,

Kimber A. Wald
Deputy Commissioner

KAW:mf
Attachment

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
HARRISBURG
17120

**APPENDIX "C"**
**EXHIBIT 3**

March 22, 1978

Rec'd 3/24/78

Duane Chapman, Vice President
Bankers Life and Casualty Insurance Company
4444 Lawrence Avenue
Chicago, Ill. 60630

Dear Duane:

I am attaching a copy of the 1977 MacArthur Group complaint printout. Once again you have had a sharp decline in the face of a rising complaints volume here. I continue to maintain this is due to the reforms you instituted in 1974, when your total was nearly double the 1977 figure.

I am also enclosing a comparison of all complaints by coverage and problem which may be of interest.

Very truly yours,

Ken

Kimber A. Wald
Deputy Commissioner

KAW:cb
Attachments

Senator CHILES. I note and I appreciate very much your digest of the statement for me. That is very helpful to us.

I note that you do say in your full statement on page 8:

> The health insurance policies (not life) written to cover Mrs. Lowry are within the limits of the annual premium allowed by the company. These were refunded as we understood Mr. Lowry wished them refunded because of the total premium being paid by his mother was excessive for her income. We also understand from subsequent correspondence on which we received copies that Mr. Lowry objected to our refunding these premiums. If Mr. Lowry would like to continue any of the policies uninterrupted, we will be pleased to do so. It was not our intention to vindictively rescind and refund these policies as he suggested.

Mr. GRUBBS. That is correct, Mr. Chairman.

Senator CHILES. I just wanted to make sure Mr. Lowry understood that because he had said from his statement today that he would like to have some of those policies or he felt that it might be helpful to his mother to have some of those policies in force. So it would be the company's position if he wanted to continue some of these policies noninterrupted you would do so.

Mr. GRUBBS. That is correct, Mr. Chairman.

## COMPANY POLICIES TO DETECT DUPLICATE SALES

Senator CHILES. Now, I am interested in reading your full statement to see that the company does have a policy. Part of these policies that were returned, as I understand they were returned because your computer picked them up as being duplicate, is that correct?

Mr. GRUBBS. That is correct, Mr. Chairman.

Senator CHILES. So this is a check that the company tries to have to send back a duplicate policy.

Mr. GRUBBS. Yes, sir.

Senator CHILES. When you do that, when you send that policy back or in this instance, can you tell me, do you contact the agent? Do you try to find out why a duplicate policy was written? We have at least one agent writing several duplicate policies.

Mr. GRUBBS. Perhaps Mr. Chapman can explain the operation of the computer as it relates——

Senator CHILES. We are trying to get at this here and other instances. I am delighted to see what you have in your policy handbook that you give your agents, but if it is just a policy and a handbook and it never gets translated out into the field other than being there, then it is nice for the company to say, "We have got this policy." But we see that your agents didn't exactly follow that policy in the Lowry case. They certainly sold her insurance beyond what she could pay for and that is against your policy. They gave her duplicate policies and that is against your policy. There are two or three other instances that they covered that are against the policy. I want to know, how does the policy get interpreted into the field?

Mr. GRUBBS. Mr. Chapman can answer that.

Mr. CHAPMAN. I will answer the part about the home office, Senator. The policy rules, as we have outlined them here, deal with the accident and health portion of our controls, and I think they are outlined there. The computer checks are people checks, too. You know, the computer is no smarter than the people who run it and input it and read the alphabets.

The total premium problem came about, as I reconstructed it when I first looked at it last week, was due to the excess life insurance. If you will notice the total premium that Mrs. Lowry was paying—better than $6,000 of that premium was for two life insurance policies. The first one was issued for approximately $3,000. At that time our underwriters passed that case because of the total amount of investments and income that they understood and our subsequent checks revealed that Mrs. Lowry had. Our files show that the statement made by Mrs. Lowry indicated an estate of somewhere over $100,000. The underwriter thought the policy should be issued.

The second policy which was issued 1 year later added up to $3,200 additional premium. So when we talk about 68 percent of her premium, some $6,200——

Senator CHILES. You mean 68 percent of her income?

Mr. CHAPMAN. Yes. Some $6,200 was represented in two life insurance policies. The second life insurance policy was taken—I cannot justify its being taken. When it came into the home office, it would not go through our A. & H. control because we have a different——

Senator CHILES. A. & H. is accident and health?

Mr. CHAPMAN. Yes. I am sorry, sir. Accident and health. I am used to using these terms.

The life insurance has not been recognized by us as needing to come under this premium control and the reason it has not is that these are reviewed by underwriters who should be reviewing the total income and the necessity for this insurance because there is a company problem here, too, and that is being overexposed on a risk just as a matter of self-interest, if you will. We don't want to be on a risk for more than we should be. How much insurance should you sell without any need for insurance to someone in this age group 75, 76 years old?

Senator CHILES. That is the prime link your underwriter is looking at.

Mr. CHAPMAN. Oh, absolutely. I am merely pointing out that we did not have a control on life insurance to protect Mrs. Lowry or someone like Mrs. Lowry. In our own self-interest we should be protecting ourselves and incidentally not collecting the additional premium. There was a mistake made. The basic underwriter approved it and it went through the system without a second supervisory underwriter's signature. It should not have been issued.

I would like to back up just a moment and make a few comments. I have heard what has been said here this morning.

## ENFORCEMENT OF POLICY

Senator CHILES. Just a minute now. I will be glad to give you that time. No one has told me yet how this transfer translates down to the agents. Specifically, in this case, when you sent back three policies as being duplicates, at least two of which were done by the same agent, it looks like maybe three were done by the same agent, does anybody ever say to that agent:

> You are not following the policy of this company because it is no good to have a policy and to come up and say we have a policy to protect people in this regard if no one is going to follow up on that.

Mr. CHAPMAN. We have a procedure which obviously in this case did not work and this is one of the problems. Frankly, we are embarrassed by this particular case, and there have been a few others. The procedure is that the underwriter recognizing the duplicate policies have been written does have a procedure to write out a complaint form against those agents. The complaint form is sent to the manager of the agent and asks him to answer the complaint, to interview the agent and file the answer. This goes back to our agency secretary and it is reviewed for completeness, for adequacy, and it becomes a part of his agent's file.

Senator CHILES. Can you tell me whether this was done in this case?

Mr. CHAPMAN. Yes, it was done in this case.

Senator CHILES. When? Do you know when?

Mr. CHAPMAN. I don't have the file with me, sir. I know the case of agent Montgomery's name was brought up this morning. I know that agent Montgomery terminated from the company prior to this case coming to our attention. I know that subsequent to our uncovering this and making refunds, that agent Montgomery's records were marked "terminate for cause" and the Ohio Department was notified of this.

Senator GLENN. Would the chairman yield?

Senator CHILES. Yes.

Senator GLENN. Is he still in the insurance business?

Mr. CHAPMAN. I do not have any personal knowledge. I would defer to Mr. Van Kampen, perhaps he knows. I would have no way to check that, Senator.

Mr. VAN KAMPEN. Senator, I am not sure whether he is in the insurance business. He will never be allowed to return to our company.

Senator GLENN. One of the problems is floating agents from company to company to company sometimes who may be violating every rule.

Mr. VAN KAMPEN. Senator, if I might add, when that happens where an agent is terminated for cause, as Mr. Chapman said, we do notify the insurance department that it is a termination for cause, giving all those facts, and hopefully that will prevent this agent from going on to work with other companies.

Senator CHILES. I interrupted you. You had some other thought.

## COMPANY CANNOT ALWAYS CATCH UNSCRUPULOUS AGENTS

Mr. CHAPMAN. I had just a general comment, having heard what we have heard this morning. Certainly there are people, and I don't want anyone to misunderstand me, in the older age group who cannot take care of their own affairs. They are victimized by agents. The company cannot always catch them.

Mr. Lowry referred in his testimony this morning to the news releases from Pennsylvania. He referred to the fact that we were one of the companies that was involved in sales to people over 65. Yes, that is true. Yes, there were a lot of the rules that you see in our testimony that were installed since that time. A number of people in the over-65 market need insurance, they want insurance. There is a proper market there. There is definitely a problem in trying to control the unscrupulous agent and there is a need on the part of home office

administration, I think, to get a little smarter and a little more sophisticated in doing so.

Senator CHILES. Can you tell me what percentage of the premium income, $120 million that your premium covers over 65—what part of that are you paying out in claims?

Mr. GRUBBS. Well, that gets into a loss ratio, Mr. Chairman, and what we are currently paying out overall. The company's overall loss ratio for both individual and group accident and health for 1977 was sixty-six sixty-sevenths percent as indicated on our annual statements.

Senator CHILES. Maybe I am asking you some questions that you don't have an answer for today.

Mr. GRUBBS. That is right.

Senator CHILES. Would you speak to that computer of yours and ask it if it can tell me what you would be paying out of that $120 million in the way of claims?

Mr. GRUBBS. We will be glad to do that and provide you with the information.[1]

Senator CHILES. Give me that for a couple of years if you will—1975, 1976, 1977.

Mr. GRUBBS. All right.

If I could add this, Mr. Chairman.

Senator CHILES. Yes, sir.

Mr. GRUBBS. Loss ratio figures should not be promiscuously used in that they are products of actuarial science.

Senator CHILES. I don't intend to be promiscuous about those figures, I cannot speak for Senator Glenn.

Senator GLENN. I will follow my chairman's leadership.

Mr. GRUBBS. I will be happy to provide you with those figures.

Senator CHILES. All right, sir. If you want to show me some other breakdowns in addition to the questions I will ask you, that will be satisfactory, too.

Mr. GRUBBS. What are the other——

Senator CHILES. I said if you have some other way you want to show it, in addition to the question I have asked, that will be satisfactory, too.

Mr. GRUBBS. Thank you.

LIFE INSURANCE PREMIUMS EXCEED UNDERWRITING STANDARDS?

Senator CHILES. You said that the premium Mrs. Lowry was paying for life insurance in relation to her income exceeded your underwriting standards. Can you tell me what that standard would be? I note she was paying life premiums of $8,586 with an income of $13,508.

Mr. GRUBBS. Mr. Chapman would be most knowledgeable about the underwriting area I believe.

Senator CHILES. Yes, sir.

Mr. CHAPMAN. The total amount of insurance that could have been written according to our rules on Mrs. Lowry would have been in the neighborhood of that first policy, $17,000 to $18,000 face amount.

Senator CHILES. What kind of commission does your company pay its agents on the sale of full life policies such as those purchased

[1] See page 70.

by Mrs. Lowry? Is that one and a half or what would be your commission?

Mr. GRUBBS. Mr. Van Kampen should be qualified to answer that.

Senator CHILES. I might note while he is looking for that, I used to have something to do with starting a little debit company at one time in the life insurance business and we had a great ratio. We paid out about 125 percent. [Laughter.] We don't have that company any longer.

AGENT'S COMMISSION: 25 TO 65 PERCENT OF 1-YEAR PREMIUM

Mr. VAN KAMPEN. Senator, each policy would vary in commission, but on our life policies we go all the way from approximately 25 to 65 percent of the first year's premium which would be the commission to our agent.

Senator CHILES. On the whole life policy, like what we are talking about here?

Mr. VAN KAMPEN. On the son's policies—in the neighborhood of 55 percent to 65 percent.

Senator CHILES. That is on your first-year premium.

Mr. VAN KAMPEN. Yes.

Senator CHILES. Then your retention is what after that?

Mr. VAN KAMPEN. Well, it would be based on the premium that stays in force with the second year, approximately 25 percent renewal on the Lowry boys' policies and then graded from the third to the tenth year at 20 percent. We will be glad to submit for the committee each of the policy forms [1] and the actual commission rates.

Senator CHILES. I think that might be helpful to us.

What kind of commission do you pay the agents who sell the health insurance policies?

Mr. VAN KAMPEN. That is more of a front commission and there again it would depend on the type of policy but generally speaking it is a premium or commission equal to possibly 300 percent of 1 month's premium over the first 6 months of the first year's premium.

Senator CHILES. Three hundred percent of one month for the first 6 months.

Mr. VAN KAMPEN. It would be spread over that period.

Senator CHILES. Oh, spread over that period.

Mr. VAN KAMPEN. Yes. If the policy was written and didn't renew and persisted for the entire year and it was a $10 monthly premium—we would collect 12 months at $10 premium per month, equalling $120. Our agent would receive 100 percent of the first month and then 40 percent of the next 5 months—which totals $30 that our agent would receive, which is 25 percent of the annual premium of $120. Now that again is a general basis and we would be glad to furnish you with the commission schedule for all of our health policies.

Senator CHILES. Would you also when you speak to the computer give us the loss ratios for each of the four medicare supplements that you listed on page 2 of your statement?

Mr. GRUBBS. Yes, sir, we will.

Senator CHILES. And then for all four combined.

Mr. GRUBBS. We will.

[1] Retained in committee files.

[Subsequent to the hearing, Mr. Grubbs supplied the following information:]

POLICY LOSS RATIOS

To illustrate the proportion of health insurance premiums paid in claims, State insurance departments require insurance companies to publish in their annual statements loss ratios for the calendar year preceding the date of the statement. Loss ratios are calculated by dividing incurred claims by premiums earned. For the year 1977, the loss ratio for Bankers Life & Casualty Co. policies sold to policyholders above age 65 was 55 percent. Loss ratios for senior citizens policies for 1976 and 1975 were 55 percent and 51 percent, respectively.

The better measure of fair return of premium in claim payments is the ultimate loss ratio, rather than the loss ratio for a particular calendar year. For various reasons, loss ratios tend to increase as a block of business ages. Thus, the appropriateness of using calendar year loss ratios to determine whether policyholders have received a fair return is highly dependent on the average age of the business for which the loss ratios are determined. The loss ratio for a very young block of business will be much lower than the average over the lifetime of that group of policies. The loss ratio for a very old block of business is generally somewhat higher than the average over its lifetime.

Loss ratios for calendar years 1975, 1976, and 1977 which were requested for each of the four categories of senior citizens business referred to on page 2 of our statement to the committee are for in-hospital benefits supplementing medicare part A which constitute 30 percent of our total senior citizens business, 66 percent, 75 percent, 69 percent respectively; for medical-surgical benefits, which constitute 22 percent of our total senior citizen business, 60 percent, 61 percent, 65 percent respectively; for daily hospital confinement indemnity benefits, which constitute 31 percent of our total senior citizens business, 41 percent 43 percent, 48 percent respectively; for extended care (skilled nursing) facility benefits, which constitute 14 percent of our total senior citizens business, 40 percent, 45 percent, 30 percent respectively. Policies for in-hospital benefits supplementing medicare part A and medical-surgical benefits were introduced when medicare became effective. Policies with daily hospital confinement benefits designed for senior citizens were first sold in 1967. Policies with extended care facility benefits were not sold until 1972.

We believe that the loss ratios stated above understate the ultimate percentage of premiums returned to policyholders in benefits. This ultimate percentage for all categories combined should be close to 60 percent. The premiums we developed for our current generation of senior citizens health products for the categories listed above are all calculated on anticipated loss ratios in excess of 60 percent.

"NAME SWITCHING"

Senator GLENN. You mention a computer alphabetized check when a new application is received. We have had letters and other suggestions that salesmen sometimes get around this by writing the policies in different forms of the name, using the initials on one policy and a full name on another policy, to avoid computer detection. Is that something that you all are aware of is happening, and what kinds of checks do you have on that?

Mr. CHAPMAN. Yes, Senator. That has been in the past a very common practice by an agent who wants to defeat an internal process. You will also find where there is a husband and wife, some policies are in the wife's name and some in the husband's name. We have installed an address check and hope to overcome this and we have found that it results in a considerable improvement over what we were able to uncover in the past.

Senator CHILES. I note that in the two life policies on Mr. Lowry's life and his brother's life that they were improperly executed. When were the forgeries discovered by the company?

Mr. GRUBBS. Our first information that they were not signed by Mr. Lowry came from Mr. Lowry in our October 13 meeting in 1977, at which time he said his brother did not sign his application either, so it was at that time we got firsthand knowledge. Earlier the general counsel for the Ohio Department of Insurance had called me on the phone and told me that Mr. Lowry had said that. Consequently, I was prepared, when I arrived there, to either give the money back, rescind the policies, or allow them to remain in force although it has been contrary to our interest, of course, to do so, because we had no representations as to their condition of health or anything else.

Senator CHILES. These were the policies that were written by the agent that was terminated for fraud?

Mr. GRUBBS. That is correct.

Senator CHILES. Senator Glenn.

Senator GLENN. I would like to followup on this signature thing for just a moment, Mr. Chairman.

This type of policy, is it not the law that you have to have the permission of the person being insured?

Mr. GRUBBS. There is such a thing as a signature not by the person being insured under some instances. It is our usual company rule that the signature of the insured must appear upon the policy application.

Senator GLENN. If this is illegal and if the signing was illegal, have steps been taken to internally prosecute those who did this?

Mr. GRUBBS. Senator, I think if you will examine the signature, we did not report Mrs. Lowry for signing her sons' names. I would not think that her sons would wish us to do this. Certainly we did not report that she had signed her sons' names.

Senator GLENN. Let me make a comment on your statement, pages 2 through 5. That is an excellent statement of your policies and what you expect your agents to live up to, and that is fine. I am sure that every insurance company in the business has a similar statement of policy that is excellent and sets the standard that you hope your agents try to adhere to. However, I would take some exception with your comment on page 11 that

> The principal area that continues to cause problems for our company and for the insurance industry lies in the area of how to identify the individual who is no longer capable of carrying on his or her own business transactions.

It seems to me that that is almost an impossible task. We cannot set a certain age deadline, nor would we try to, where people are beyond the use of their normal faculties. Some people are absolutely brilliant at age 100 and others phase out at my age—and maybe I already did, I don't know. Anyway you cannot set an age limit, so I don't think you can identify the individual who is no longer capable. I think that sets an impossible goal.

## "WEED OUT THE BAD APPLES"

I think there is a possible goal here, though, and that is sensitizing your own agents in this area and following up on what kind of policies they are writing and weeding these bad apples out. It may be a matter of business for the company, but where an individual is involved on the recipient end of this, it is absolutely a personal tragedy. I don't know what kind of followup you can do.

I am very much concerned about what you are doing to weed out the unscrupulous agent who is not including all of this information and is not doing the right job of analyzing and is just business as usual, take advantage of the elderly, write every policy you can, pass the name on to another agent who is a buddy in a different company who then comes back, and economically, at least, rapes this individual all over again. We wind up with a whole pattern here. There has to be some way of following this up in the industry or we will have stringent legislation on the industry.

I hope that you gentlemen in your expertise can come up with some method of self-policing here. I am not trying to lecture you, but I think you ought to come up with some method of self-policing so that we won't find Federal legislation necessary to, in turn, force State insurance commissions to in turn force you into methods of self-policing when you could have done this voluntarily to begin with. I would welcome a comment on this from any of you.

Mr. GRUBBS. Senator, to begin with, if the policyholder is taken advantage of because he is oversold insurance and if he is, to use your words, economically raped, so is the company at that time, may I remind you, sir.

Senator GLENN. I agree, and I am not trying to castigate any of the insurance companies here necessarily. You provide a vital function and it is great and I am glad you do the job you do, but we are trying to prevent abuses. You gentlemen are in the middle of it, you give us the advice.

Mr. GRUBBS. Well, we are, of course, entering new endeavors all the time in order to protect, frankly, our own economic interest, because when the policyholder is not treated properly it is a direct damage to the company when they are oversold. The policies lapse and that is expensive to the company when they are oversold life insurance and there is no insurable interest. The casebooks are filled with tragic things which occur.

Senator GLENN. Let me get to a specific here. On page 10, in the middle of the testimony, it says:

> It was in the process of providing broader and additional coverages that we created the products which were used by relatively few agents to take advantage of older individuals through twisting and rolling of previously issued policies. It should be noted that these agents were at the same time taking advantage not only of the insuring public but of the companies which contracted with them.
>
> Each time abuses have been noted, they have led to new rules and new controls, both by our company and regulatory agencies. There have been areas where the abuses have been deemed serious by the company which resulted in stringent remedial action.

Could you list some of those remedial actions you have taken on past abuses?

### 22 AGENTS TERMINATED IN PENNSYLVANIA

Mr. CHAPMAN. A previous case, Senator, that has come up here is the Pennsylvania situation. I believe that we terminated 1 regional manager, 2 or 3 district managers, and about 22 agents in that area. In addition, we put in some of the controls we have referred to previously. What can we do? I think we have got to do more of what we have started to do. Certainly the matter of policing agents on sales to

people over 65 has got to have more attention and more money put into it. When we think that we are going along with improvements, seeing the complaint ratios improving, we believe we are doing a pretty good job until we see a Lowry case. Frankly, that kind of case is shocking, it tells us that we have got to do something with the life insurance premium and look at the total premium by individual.

Senator GLENN. Do you require adequate financial status information on each individual to properly analyze it, as in the Lowry case?

Mr. CHAPMAN. We do on life insurance, Senator, because that is part of our underwriting. We have to know what the need for that insurance is. When we get over certain amounts, our self-interest and that of the individual. So we do ask for financial information. I don't think the Lowry case is typical. We missed the impact of that financial information and we did not have anything that totaled up all those policies until Mr. Lowry started looking into his mother's affairs.

Senator GLENN. With health insurance you can't require any general financial statement.

Mr. CHAPMAN. No, sir, we do not.

Senator GLENN. Do you think that is an area that should be included so you have a picture of whether they are getting overextended or not?

Mr. CHAPMAN. That is a possibility that we have considered. I personally have trouble with it because if you have an agent leading someone, they can lead them to sign this financial disclosure statement.

### "SELF-POLICING HAS GOT TO BE THE ANSWER"

Senator GLENN. I have trouble with the whole field because I don't want to determine the rights of people to determine their own lives, No. 1, and I don't want to limit people because of age, No. 2, and I don't want to limit the insurance, No. 3. I think you must put on a level of supervision that is far more stringent and far more definitive, as you have said. I make this as an industrywide statement, not just to your particular company. I think self-policing has got to be the answer. You gentlemen in the industry will know that something will be done when abuses are increasing and as people become more concerned about their health problems and their old age.

This is what we are faced with now, so it seems that your unscrupulous agents are going to have more of an opportunity to take advantage of people who perhaps are not as able to take care of their own affairs. So it means there is going to have to be more self-policing in this industry or we are going to have some kind of legislation to take care of it. I think it is that important.

If you need a new level of subdistrict manager, one for every five agents or whatever, there has to be some sort of policing mechanism that prevents cases like that. I am sure the committee and the staff would be most happy to work on this, and my office will certainly be happy to work with you in any way on ideas that you may have. I hope we don't have to come through with some big package of legislation and try to run the insurance business in this area, like we run too many things from Washington. If there is a need here and people are being taken and nothing is being done by the industry, then that is certainly what is going to happen. I am just stating the facts.

## Concern About Lists Being Passed Around

Senator Chiles. How do you think it did happen that you have all these different agents from Bankers Life & Casualty calling on Mrs. Lowry? How does that practice happen? We are concerned about lists being passed around and sometimes an agent leaves one company and carries his list with him. How would that many people get to see her to do the check?

Mr. Van Kampen. Senator, I am not sure how this one happened, but the way it could happen, and I am sure this was part of this situation, first of all you have the manager who is assigned to a certain number of agents in his office. Occasionally, when a manager will be training a new agent, the two people would call—both the manager and the agent in training.

From time to time, our agents are promoted to management in another area of the country and those in-force policyholders, the listings are then turned over to the office or to a new agent who goes out to either service or sell additional coverage, if the need warrants it, and this would mean that now a different agent would come by. Very possibly the manager has been promoted and the manager and the new agent in training would be out servicing a policyholder and would find out that there was some coverage that was missing or a policy that we had come out with filled still another gap. It would be offered if it did not exceed the maximum amount of $50 per month premium to be paid by any one insured who is 65 or over. In this way several agents could have called on her.

Hopefully, our agents are not passing on the names of these overage people to other people in the industry. We would react to that for both reasons, certainly the overager being taken advantage of and handing over our contracts to the competitor. So we would have a dual interest there.

Senator Chiles. Well, then it is part of your policy as such for your managers to try and get the agents to call routinely, or to make calls, on people that your company has already sold policies to.

Mr. Van Kampen. Yes, for several reasons. One would be service, another would be a copy of every claim that is paid by the company is sent to our local office and it is the responsibility of our local office to call on each one of these to make sure that the claim is properly handled, that all benefits were received, that all bills were submitted to make sure that they have received the full claim payment.

## Less Control Over Independent Contractors

Mr. Grubbs. Senator, if I may, I should point out that our agents happen to be independent contractors. This is not true with all companies in the industry, but ours are independent contractors. Consequently, although we can provide rules and terminate their contract and notify the insurance department, we don't have the extent of control over them that perhaps if they were employees we would.

Senator Chiles. These independent contractors, will they be writing with other companies?

Mr. Grubbs. In most cases not with this company. In most cases not, but they are still allowed to be.

Mr. VAN KAMPEN. Hopefully not, sir.

Senator GLENN. Do you have a termination of pages 2 through 6 here, or 2 through 5? If any of those things are violated, do you have——

Mr. GRUBBS. Yes. If they violate company rules, we can terminate them. Yes.

Mr. VAN KAMPEN. We terminate their contract because they are an independent contractor.

Senator CHILES. We thank you for your testimony and look forward to the submissions that you are going to provide us.

Mr. GRUBBS. Thank you, Senator.

Mr. VAN KAMPEN. On that, Senator, before we finish, you seemed a bit surprised when I mentioned the commission schedule and I mentioned 300 percent of 1 month. Maybe we better explain this. Because of the 6 months, I saw a quizzical look on your face. If the policy was written and did renew and persisted for the entire year and it was a $10 monthly premium—we would collect 12 months at $10 premium per month equaling $120. Our agent would receive 100 percent of the first month and then 40 percent of the next 5 months—which totals $30 that our agent would receive, which is 25 percent of the annual premium of $120.

Senator CHILES. I understand that.

Mr. VAN KAMPEN. All right.

Senator CHILES. Our next panel will be Harold R. Wilde, the commissioner of insurance for the State of Wisconsin; and W. W. Cooper, the administrator for health insurance, Florida State Insurance Department.

Mr. Wilde, we are going to call on you first to give us your statement. I understand you are going to talk about medicare and that you have done considerable work in this area. We are delighted to have your appearance here today.

Your statement in full will be included in the record and if you care to summarize in any way, that will be helpful.

## STATEMENT OF HAROLD R. WILDE, MADISON, WIS., COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

Mr. WILDE. Thank you, Senator. As I was sitting here this morning I have been gradually cutting that statement shorter and shorter.

Senator CHILES. As the hour gets shorter.

Mr. WILDE. I hope that you will ask me some questions concerning some of the testimony you have heard earlier; for example, phrases like "independent contractors" and "terminated for cause." You may want to have some clarification on those.

Senator CHILES. Good.

### MEDI-GAP SALES NO. 1 CONCERN

Mr. WILDE. I would like to thank you for the opportunity to speak here today about an issue which I think has been my No. 1 concern since I became commissioner of insurance in the State of Wisconsin.

Senator CHILES. When was that?

Mr. WILDE. Three years ago. There are about one-quarter million senior citizens in the State of Wisconsin who we believe supplement medicare with some form of private health insurance, and it is our belief that those senior citizens are probably wasting well into the millions of dollars.

Senator CHILES. There are still one-quarter of a million there that have not come to Florida?

Mr. WILDE. Oh, there are well over one-half million senior citizens. In fact, we are known as the star of the snowbelt. There are elderly people who move to northern Wisconsin because they like the winters. Different strokes for different folks.

The most basic waste in medicare relates to the product itself. Medicare returns 95 cents on the dollar as a benefit. Some private group insurance normally returns 85 to 95 cents in benefits on every dollar. Good private individual medicare supplement contracts return 70 to 75 cents on the dollar. What is the return in actual benefits on the high commission/low value medicare supplement, nursing home and indemnity contracts which are marketed most aggressively to the elderly? A good guess would be 40 percent, if that.

"INEFFICIENCY AND EXTRAVAGANCE IN MARKETING"

The inefficiencies and extravagances built into the marketing of these health insurance products to the elderly are obscured by the complexity of the products themselves and the marketing techniques utilized.

There is no insurance policy sold in our State—and I doubt that there is any policy sold in any State—which fills all of the gaps of medicare. None. But there are thousands of insurance policies purchased every week which are thought to fill all the gaps in medicare. Then another policy is purchased, and then another.

As we have heard this morning, it is not uncommon for us to find senior citizens in Wisconsin who are spending well over $1,000 a year on health insurance policies, each of which is duplicative of the other, and only one of which will pay off in the event of a loss.

How can this happen? Part of the answer lies in the nature of the "crime." The victims of one fast talking medi-scare peddler may, all together, have wasted $100,000 in a year on inadequate or duplicative coverage. But each victim lost only $200 or $300, so the size of the crime and the pattern of victimization is rarely recognized.

Many old people don't even realize they are victims; some are enfeebled or infirm and incapable of complaining. They make poor witnesses in court and in administrative proceedings. It is no surprise, therefore, that local prosecutors are wary of attemptng to pursue such white-collar crime. It is costly and difficult.

Nor should it be surprising that the ripoff artist himself frequently points to the approval of a policy form by the State commissioner of insurance as evidence of its acceptability.

"REGULATORS ACQUIESCE TO MORALLY INDEFENSIBLE PRACTICES"

Government has been and continues to be part of the problem. State regulators have too long acquiesced in practices which are morally

indefensible. I think it is time to call a halt to such acquiescence by both Government and the private insurance industry. A Government that creates a medicare program for its senior citizens ought to act to assure that the gaps and holes in that program are addressed responsibly.

In Wisconsin we have experienced success, failure, and much frustration over the past 3 years as we have attempted to cope with this problem in its many dimensions. We have greatly strengthened our enforcement efforts. We have increased the number of agent license revocations, suspensions, and forfeitures from a handful in 1974 to nearly 100 last year. We have fined one company $25,000 and suspended it from the market for over 1 year. We have conducted examinations of a number of the insurers with the worst records—and major disciplinary actions may now result. We have distributed directly or indirectly over 100,000 copies of a booklet we prepared for senior citizens outlining their health insurance needs and rights and I have submitted that booklet for the record.

Senator CHILES. A copy of that will be made part of our record.[1]

Mr. WILDE. But, at least until recently, the problem has not shown signs of lessening.

Here are just some of the examples of what we have come across in the past 3 years, and these are the kinds of things you heard this morning. We could go on all day with examples.

LISTS CIRCULATED

Agents tell us about lists of "mooches," or "cripples," or "marks," that have been circulated among the medi-scare peddlers—lists of infirm or senile old people who will take anything offered to them—who will "buy the whole load." We have a list like that in our office of 150 people, and I think that the example you gave this morning was an example taken off that list. I can't think of anything more disgusting in my experience as commissioner than that kind of practice.

We are aware of teams of agents switching from one company to another company and in the process thousands of people getting caught in a war as policies are switched from one company to another company.

We go into a company's files and we find dozens of medical applications from particular agents which have been "clean sheeted." There is a whole vocabulary. "Clean sheeting" means that you take an application from a person over age 65 and where you are supposed to indicate medical history, there is no medical history. Therefore, the person gets underwritten because he does not show up as having medical history. Of course, how many people over age 65 don't have a medical history? So when they have a claim, if it is a serious claim, the company goes back and searches out the medical history. If they find that the person had a medical history, they retract the claim and refund the premium. It is a horrible practice, "post-claim underwriting"; but the clean sheeting is only one part of the process. It is a process quite frequently engaged in unannounced to the purchaser.

---

[1] See appendix 2, item 1, page 110.

32-703 O - 78 - 6

The agent walks away, gets the purchaser's signature on the bottom line, has a whole history and holds it up to the window. That is the classic example. He forges the signature on a new application and hands this in clean sheeted. What kind of company gets applications of people age 65 with no prior health history and does not see something wrong?

"COMPANIES OUGHT TO CATCH ON"

We go into another company's files and find stacks of complaints on a particular agent 6 or 8 inches high—and that company I think was represented here today. Yet the agent had not been dismissed or was not dismissed. Stacks of complaints 6 or 8 inches high. How many complaints does it take before a company decides it is time to boot the guy out? The answer is, of course, that a guy who can generate that many complaints can also generate a hell of a lot of business. He is a good producer, he makes money for the company.

In the course of various investigations we come across evidence of systematic forgery and routine postdating of applications. This is an agent practice, but again, the companies ought to be catching on.

If there is some cause for optimism in Wisconsin, I guess it arises from our experience of the past few months. In January of this year, a new rule went into effect which required all new policies sold as "medicare supplements" to senior citizens in Wisconsin to provide minimum benefit levels and which mandated that whenever an elderly person in Wisconsin is solicited for health insurance he or she must receive a copy of the consumer booklet to which I referred earlier which is produced by our office.

One important byproduct of this rule has been that many of the inadequate policies previously on the market have been withdrawn. Another important result has been the creation of the possibility for elderly consumers to make meaningful pricing comparisons among health insurance policies such as they have always been able to make in buying auto and homeowners insurance. For the first time the senior citizen can see the difference in costs, because the benefits have been standardized in the various policies approved under our rule. The end result is that the policies with ridiculously high expense ratios cannot meet the minimum benefit requirements of the rule and still be offered at a competitive price.

Senator CHILES. What is your minimum benefit?

Mr. WILDE. Well, we have a minimum, not in terms of loss ratio, but in terms of various policies—medicare supplement 1, 2, 3, 4A, and 4B. Each one must have a certain amount of benefits which are specified quite explicitly in the rule. The end result is that we have a medicare supplement 2, for example, where at this point two or three of them have been filed at around $200 and we have a number of others which have been filed at around $400 to $450. Same policy.

Now how can that be? The answer is simple. The companies that are filing them at $200 are viewing them as basically public service policies, low commission, policies that they write because it is kind of their obligation in that marketplace in Wisconsin. Low expense, low administrative cost.

The companies at $400, $450, these are the "drummers," the guys who are out there who have the 50 percent, 60 percent commissions, et cetera, and as a result they have got products that are too expensive, and they come in and weep copious tears and we feel very sad.

Senator CHILES. You don't prevent them writing that policy, you just try to set forth the procedure wherein the person over 65——

Mr. WILDE. All policies have been filed on expense ratios of 55 percent or greater, but the expense ratio is a prospective filing. Somebody here earlier referred to actuarial science. Well, actuarial science is not always what it is cracked up to be. I mean one company comes in and estimates its experience one way and another company comes in and——

Senator CHILES. Do you have an underwriter who works for you?

Mr. WILDE. We have an actuary who reviews these things, but our actuary is often hesitant to second guess their judgments. As I say, one company comes in and says, "We need a $400 premium at an expense ratio of 55 percent." Another company comes in and says, "We need a $200 premium at an expense ratio of 70 percent." Our actuary accepts them both. Now what we then do is look to the actual experience.

Senator CHILES. You are trying to go back and postaudit then?

Mr. WILDE. Yes, but then you are talking about 5 years down the road, and that is a terrible problem with looking to loss ratios. We are now postauditing policies that were filed 5 years ago, and there are some with 10-percent loss ratios. There are some with 75-percent loss ratios, and they come from all over the place. Actuarial science is not a science.

STANDARDIZED POLICIES

What we like to see is not the department making the judgment on price, but the marketplace making the judgment on price by having standardized policies that the consumers can compare. We now have a circumstance where the consumer can see it is the same policy—it is $200 with this company and $400 with this company. That is in fact what is happening. The agents who are selling the $400 policies are going back to their own company and saying: "We cannot sell this. Either lower the price or we will get out of this." So, again, that is the marketplace making the judgment, and we have been publicizing the price differentials for just that reason.

Senator CHILES. Do you think you are really getting that message across to the people who are out there buying it?

Mr. WILDE. Yes, I do. I do. We have purchased public service advertisements and various things like that to get it across. Yet even this rule which provides a mechanism for greater standardization of policies, improved consumer information, elimination of many of the worst policies from the market, can easily be misused and our past experience gives us good reason for caution.

One fear, for example, has been that the medicare peddlers would use the new policies as a justification for people to replace perfectly good current policies and subject themselves to new waiting periods and exclusions, and we have seen examples of this taking place. Another problem has been the group policies, such as those offered by the

AARP—American Association of Retired Persons—policies which have not been subject to the rule and in fact have not been subject to State insurance regulation in most States, including Wisconsin.

Despite the problems at this point, we are guardedly optimistic that the medicare supplement marketplace in Wisconsin may be improving. We are seeing parallel initiatives in California.

Even if the States do finally do their job, even if they are generally effective in meeting that responsibility, I don't think that gets either the Federal Government or the insurance industry off the hook.

## Federal Government Obliged To Cope With Medicare Problems

The Federal Government, which created the medicare program and its gaps, has an obligation to cope with the problems left in its wake. At a minimum that coping should include:

Extensive information and counseling efforts through the Social Security Administration and its local offices.

Some sort of Federal initiative to target law enforcement funds to State attorneys general, local district attorneys, and State insurance commissioners, to encourage them to pursue and prosecute this type of insurance fraud, and it is a difficult kind of prosecution to make.

Senator Chiles. It is a difficult kind of targeting to make when the Governor says, "Don't tie things on your LEAA funds."

Mr. Wilde. What we have tried to do in Wisconsin is show some local district attorneys that it may be a political page 1 issue. That is the only way, sometimes, you can get them to pay attention. It is a painful issue because if you are going after this kind of fraud, if the guy is a very hard peddler, he is worth a lot and he can raise a very tough defense. It is a sophisticated kind of prosecution to make and most local district attorneys are not equipped to do it.

Finally, I think that the Federal Government could encourage the private insurance industry to offer a small number of standardized, comprehensive medicare supplement alternatives on an open enrollment basis countrywide. I think you can encourage that in a lot of ways: First of all, by setting up some proposed standards which might apply countrywide; and second, by using the market power of the Federal employees who are distributed throughout this country and who can—in effect—dictate terms at least to some of the major carriers; and finally, by using the media power of the Federal Government.

As a State insurance commissioner, while I must be wary of Federal regulatory incursion into areas of State jurisdiction, I believe that States have many effective options to pursue in combating the abuses I have identified. I nevertheless welcome your interest and involvement on this issue because I think there is a Federal moral responsibility involved, and also because I believe your involvement insures that the insurance industry and the insurance commissioners will take the issue seriously. In particular, I should say that it pleases me after having spent a number of years listening to tales such as Mr. Lowry's and seeing the victims and feeling quite often the frustration, it pleases me to see some attention at the Federal level to this issue.

Senator Chiles. Thank you, sir. Your prepared statement will be entered into the record at this time.

[The prepared statement of Mr. Wilde follows:]

PREPARED STATEMENT OF HAROLD R. WILDE

Eleven and one-half years ago, the Government of the United States put into effect a program designed to assure adequate health insurance for every elderly person in America. That program was medicare.

Today, elderly Americans pay far more out-of-pocket for medical attention, hospitals and drugs, than they did before medicare. In fact, of the $1,218 average yearly medical bill in 1975 for a person over age 65—medicare paid only $463, or 38 percent. And this percentage has decreased progressively since 1966, when medicare started.

It is not my purpose today to critique the Federal medicare program. Its deficiencies speak for themselves:

A program designed to assist the elderly pay hospital and doctor costs, end up setting off an unprecedented inflationary spiral in those costs, which hurts everyone (except providers), but most of all, senior citizens on fixed incomes.

Cost control mechanisms built into the program are "too little, too late" and end up penalizing patients in their pocketbooks, instead of restraining the bills of doctors and hospitals.

Medicare's deficiencies have been well documented. So too have been its successes, most notably, a broadening of health care availability to America's senior citizens and a consistent ability to deliver health insurance benefits at an administrative cost of 5 cents on the dollar, or less.

What hasn't been adequately documented, or graphically enough demonstrated, is the nature of the problems for the senior citizens left in medicare's wake in the private insurance system—problems which might be called the "medi-scare insurance racket."

Countrywide, these problems—which are the result of what amounts to an unholy alliance between the public and the private sectors to confuse and exasperate the elderly of America—add up to a multimillion dollar ripoff of our senior citizens. They are nothing less than a national disgrace.

I am convinced that the failure of the private sector to adequately and responsibly address this gouging of America's senior citizens by some insurers and their agents in the name of "medicare supplement," represents the Achilles' heel of the private insurance industry in the debate on national health insurance. In few areas is the record of private insurers less credible.

Paradoxically, because of Government's role in creating this problem, the conclusions Federal policymakers should draw from this sorry situation may be equally painful.

What exactly is the "mediscare insurance racket"?

It starts with the high cost of health care, and the (generally quite rational) fears of senior citizens about their future health needs and the gaps in medicare.

There are the obvious gaps:

The initial deductibles.

The 20 percent copayment for physicians services.

No money for out-of-hospital prescription drugs, eyeglasses, hearing aids. dentures.

No hospital days after the lifetime reserve is exhausted.

Then there are the less obvious holes:

The patient's responsibility to pick up the difference between what medicare calls "reasonable and necessary" (as a cost control measure) and what the physician wants to charge.

Nursing home care in a nonmedicare certified nursing home.

Custodial nursing home care.

When a person anticipates real risks which may drain his or her future resources, it is natural to turn to insurance, as a way of transferring those risks.

It is estimated that at least one-half of America's senior citizens, or over 11 million people, do just this—and that they may spend into the billions of dollars this year on private health insurance, to supplement medicare.

For the smart ones, or the lucky ones, who purchase one comprehensive medicare supplement policy from a reputable carrier (frequently one of the "Blue" plans) and no other health insurance—this insurance can be a relatively good deal. And they may feel reasonably secure.

But when you're dealing with a subject which causes you and your peers continuous and daily worry, when the terms of medicare and health insurance coverage in general are extremely confusing and nonstandardized, and when you've been identified as a target group by a class of hard-selling predator-agents and companies, it is difficult to be either smart or lucky. Millions make a good choice. Millions of others do not.

Think of yourself as a 65-year-old widow or widower.

Which of us would not succumb to the charms of an earnest young man at our door who tells us that the policy we currently have will not fill all the gaps in medicare, but his will?

What would we know about 100 percent first year commissions—yes, unbelievably, there is one policy which offers such a commission—or the more "routine" 65 percent commissions?

What would we know about the economics of an industry where 50 percent or 60 percent expense factors are routine for some companies—leaving 40 cents or less on the dollar for benefits? Would we understand the all-too-frequent need of the earnest young man to turn over, churn, or "twist" business, in order to hang onto the high first year commissions which he depends upon to make a decent living?

And then we're hit by the next appeal.

It may be for a cancer policy, in the newspaper. Or an "inexpensive" hospital indemnity policy, at "low group rates," from a national organization.

Or it may be from another door-to-door agent, telling us that we need a nursing home policy—after all, medicare doesn't pay for custodial nursing home care, and isn't that our number one fear.

Trouble is, she doesn't tell us that there is no insurance policy sold in our State that truly covers custodial nursing home care, and that her policy only pays off for nursing home stays after hospitalization and after medicare benefits are exhausted—which means, the policy is virtually useless.

But how are we to know this?

There are approximately one-quarter million senior ciitzens in Wisconsin who supplement medicare with some form of private health insurance (the figure may be significantly understated). We have no way of estimating the amount of money these citizens waste every year in seeking health insurance to fill the gaps in medicare—but we can guess it is well into the millions of dollars.

The most basic waste relates to the product itself. Medicare returns 95 cents of every dollar spent as a benefit. "Blue" plan group insurance (and some private group insurance) normally return 85 cents to 95 cents in benefits on every dollar. The highest value individually marketed medicare supplement insurance policies return 70 cents to 75 cents on the dollar in the form of benefits.

And what is the return in actual benefits on the high-commission, low-value medicare supplement, nursing home, and hospital indemnity contracts which are most aggressively sold to the elderly? A good guess would be 40 percent, if that.

A glance at the 1977 Wisconsin Insurance Commissioner's report and the loss ratios on Wisconsin business of some of the companies heavily into this market will confirm this dreary conclusion; and Wisconsin's experience is not in any way unique.

Ask yourself: How many senior citizens would spend $200 on a nursing home policy or a medicare supplement policy, if they knew that on the average the highest return they could expect back on that policy was $80?

The inefficiencies and extravagances built into the marketing of these health insurance products to the elderly are obscured by the complexity of the products themselves, and the marketing techniques utilized.

There is no insurance policy sold in our State—and I doubt that there is any policy sold in any State—which fills all of the gaps of medicare. None.

But there are thousands of insurance policies purchased every week which are thought to fill all the gaps—at least, until the next medi-scare salesman knocks on the door.

And then another policy is purchased. And another.

It is not uncommon for us to find senior citizens in Wisconsin who are spending well over $1.000 a year on health insurance policies, each of which is duplicative of the other, and only one of which will pay off in the event of a loss.

How can we allow such waste? How can we excuse it? Why is it allowed to go on?

Part of the answer lies in the nature of the victims: Older people, vulnerable, afraid for their health and their estates, more likely to blame themselves when their insurance proves inadequate than the company or its agent.

Part of the answer lies in the nature of the "crime." The victims of one fast-talking medi-scare peddler may, all together, have wasted $100,000 in a year on inadequate or duplicative coverage. But each victim lost only $200 or $300—so the size of the crime and the pattern of victimization is rarely recognized.

Many old people don't even realize they are victims; some are enfeebled or infirm, and incapable of complaining. They make poor witnesses, and they are reluctant to come forward—because they think it may expose their own ignorance and make them look foolish.

It is no surprise that local prosecutors are wary of attempting to pursue such white collar crime. It is costly and difficult.

Nor should it be surprising that the ripoff artist himself frequently points to the approval of a policy form by the State commissioner of insurance as evidence of its acceptability.

Government has been and continues to be part of the problem. State regulators have too long acquiesced in practices which are morally indefensible.

It is time to call a halt to such acquiescence, by both government and private insurance industry.

A government that creates a medicare program for its senior citizens ought to act to assure that the gaps and holes in that program are addressed responsibly.

For too many years, the attitude has been, "out-of-sight, out-of-mind"—which for the senior citizens usually means "out-of-pocket." Such an attitude cannot be accepted in a government which, out of a commitment to "compassion" and "competence," seeks our support for broader government health initiatives.

Nor can the arguments of the private sector against national health insurance be given much credence, when the performance of some of the insurers in the medicare supplement market is reviewed. If this is the best the private sector can do in working with a public program, then it is a powerful argument for a fully socialized health insurance system—at least for the elderly.

In Wisconsin, we have experienced success, failure, and much frustration over the past 3 years, as we have attempted to cope with this problem.

We have greatly strengthened our enforcement efforts. We have increased the number of agent license revocations, suspensions and forfeitures from a handful in 1974 to nearly 100 last year. We have fined one company $25,000 and suspended it from the market for over a year. We have conducted examinations of a number of the insurers with the worst record—and major disciplinary actions may now result.

We have distributed (directly or indirectly) over 100,000 copies of a booklet we prepared for senior citizens outlining their health insurance needs and rights. But, at least until recently, the problem has not shown signs of lessening.

Here are just some of the examples of what we have come across in the past 3 years:

Agents tell us about lists of "mooches," or "cripples," or "marks," that have been circulated among the medi-scare peddlers—lists of infirm or senile old people who will take anything offered to them—who will "buy the whole load"—and we have seen such lists.

Teams of hundreds of agents switch from one company to another, and thousands of people get caught in the ensuing "war."

We go into a company's files, and find dozens of medical applications from particular agents which have been "clean-sheeted." How many people over age 65 do you know with no prior health problems?

We go into another company's files, and find stacks of complaints 6 or 8 inches high on particular agents—yet these agents are still with the company. The unspoken reason: They're too heavy producers to be dismissed.

In the course of various investigations, we come across evidence of systematic forgery and routine post-dating of applications.

Agents tell us about the message they received from their company supervisor in training: "Don't worry about the replacement regulations, don't worry about the 'outline of coverage,' don't worry about the commissioner. The name of the game is to make a sale."

If there is cause for some optimism in Wisconsin, it arises from our experience of the past few months.

On January 1, 1978, a new rule went into effect, which required all new policies sold as "medicare supplements" to senior citizens in Wisconsin to provide minimum benefit levels; and which mandated that whenever an elderly person in Wisconsin is solicited for health insurance, he or she must receive a copy of the consumer booklet produced by this office concerning the health insurance needs of senior citizens.

One important by-product of this rule has been that many of the inadequate policies previously on the market have been withdrawn. Another important result has been the creation of the possibility for elderly consumers to make meaningful pricing comparisons among health insurance policies, such as they have always been able to make in buying auto and homeowner insurance. For the first time, the senior citizen can see the difference in costs (because the benefits have been held constant). Policies with ridiculously high expense ratios cannot meet the minimum benefit requirements of the rule and still be offered at a competitive price. Indeed, among the first policies approved under the rule were some at over $400, offering identical benefits to others priced at less than half that figure.

Yet, even this rule, which provides a mechanism for greater standardization of policies, improved consumer information, and elimination of many of the worst policies from the market, can easily be misused—and our past experience gives us good reason for caution.

One fear, for example, has been that medi-scare peddlers will use the new policies as a justification for people to replace perfectly good current policies—and subject themselves to new waiting periods and exclusions—and we have already seen examples of this taking place.

Another problem area has been the "group" policies, such as those offered by the American Association of Retired Persons, which have not been subject to the rule—and have therefore become a source of some confusion to the elderly.

But at this point, we are guardedly optimistic that the medicare supplement market place in Wisconsin may be improving. We are receiving strong support in our efforts from elderly groups, and from elements of the insurance industry itself (most notably, the State life insurance underwriters organization, which has set up a counseling program).

Even if our effort, and parallel initiatives by California's insurance department and other States, do show signs of working, I do not feel, however, that that gets either the Federal Government or the insurance industry "off the hook."

The Federal Government which created the medicare program—and its gaps—has an obligation to cope with the problems left in its wake. At a minimum, that "coping" should include:

Extensive information and counseling efforts through the Social Security Administration and its local offices.

The "targeting" of law enforcement funds to State attorney generals, local district attorneys and State insurance commissioners to "encourage" them to pursue and prosecute this type of insurance fraud.

"Encouragement" of the private insurance industry to offer a small number of standardized, comprehensive medicare supplement alternatives on an open enrollment basis country wide (e.g., through use of the market power of Federal employees and the media power of the Federal Government).

As a state insurance commissioner, I must be wary of Federal regulatory "incursion" into areas of State jurisdiction. And I believe that States have many effective options to pursue in combating the abuses I have identified.

Nevertheless, I welcome Federal interest and involvement on this issue—because I think there is a Federal moral responsibility involved; but also, for practical political reasons.

The insurance industry and State insurance regulators frequently do not seem to take an issue completely seriously until the Federal Government starts to rattle its "nuclear saber." In recent weeks, there have been signs, within the National Association of Insurance Commissioners and the Health Insurance Association of America—that this issue is finally being given the attention it deserves.

For that—and I am sure for the recommendations with which this committee comes up—you will deserve the gratitude of this nation's senior citizens.

Thank you.

Senator CHILES. Mr. Cooper, I am going to take your testimony and then I will question you both together.

## STATEMENT OF W. W. COOPER, TALLAHASSEE, FLA., ADMINISTRATOR, HEALTH INSURANCE SECTION, OFFICE OF FLORIDA INSURANCE COMMISSIONER

Mr. COOPER. Thank you, Senator.

Senator CHILES. We are pleased to have you here from our State. Your full statement will be made a part of the record [1] and you may summarize.

Mr. COOPER. We have problems in this area. We feel the Florida Insurance Department is setting the pace and controlling the situation in our State, protecting the hundreds of thousands of senior citizens that could be taken advantage of. I entered into the record a letter [2] that is a tragic situation. I think the Senator will note this was in 1976. We have not been confronted with such a flagrant situation of someone being taken advantage of, but we do have problems with it with some companies concerning advertising.

### 21 SERVICE OFFICES

We have one control center that we feel is a big tool in our area in the State of Florida. That is our 21 service offices. The commissioner for the State of Florida has instructed his staff that each Monday morning, after these big spreads have come out in the newspapers, to check into those and see if there is any violation of our rules and regulations in the State of Florida in controlling advertising. This we monitor constantly. We still have some violations.

Our biggest problem is one of general agents. Another thing that we have in Florida is that we check companies. We have a regulation in the State of Florida that companies have to file their training programs, as has been mentioned here today. A lot of training in the past has been poor, and poor training manuals put out by companies, but in the State of Florida they have to file annually their training programs. We have found that if we review these each year and find a situation as has been brought out here today, we see that this is corrected.

We verify loss ratios in the State of Florida. As the commissioner of Wisconsin says, he has a rule and regulation that I think has just been put in force. We do not have such a rule and regulation but we have Florida statutes that require that the premium be reasonable in relationship to benefits provided.

Since Bill Gunter has taken office he has instructed the staff to check and verify loss ratios. We have started this procedure since he has taken office and we go back 4 years. You mentioned this a moment ago. We feel like that is a credible experience and we check each year for the credibility of this contract to be sure that this loss ratio provides benefits above 50 cents on the dollar.

We have had several companies that we have found that their premium was not reasonable in relation to the benefit provided. We have had several of them to revise their complete portfolio to either reduce the premium or increase the benefits and give refunds to these people in the State of Florida.

---

[1] See page 86.
[2] See page 87.

We think in Florida that we are doing an excellent job. We know that Washington has its control and we hope that the other States will follow in behind Florida and will help control their situations such as Bill Gunter is doing in the State of Florida. We have revoked numerous agent's licenses. The word has gotten around in Florida that you cannot become a fat cat by fleecing the senior citizens or the younger ago group.

So we feel, Senator, that we are doing a pretty good job, but we still have complaints brought to our attention. We have regional investigators that Bill Gunter has assigned for central Florida, north, south, southwest Florida, et cetera. We don't sit back on our duff and wait until somebody has really been ripped off, we get on top of it immediately.

Senator CHILES. I will enter into the record at this time the prepared statement of Mr. Cooper.

[The prepared statement of Mr. Cooper follows:]

### PREPARED STATEMENT OF W. W. COOPER

#### SENIOR CITIZENS INSURANCE MARKET

(1) The biggest problem Florida has in the area of senior citizens coverage with respect to medicare supplement contracts, also known as medi-gap, is in the replacement of these type contracts during the first 12 months of coverage. Replacement during this initial period of coverage prohibits the insured from being able to receive benefits for pre-existing conditions. This is because the policy must be in force usually, from 1 to 2 years, before he is able to collect benefits for pre-existing conditions. This type of waiting period is common in most contracts, to prevent antiselection against the company, because of people purchasing insurance specifically to pay for expenses on a pre-existing condition. When a policy is replaced before a person satisfies this waiting period, he must pay for all the expenses incurred for a pre-existing condition which causes a further financial hardship on the senior citizens, which is not necessary. The reason agents replace this business, knowing the potential detriment to the insured, is that he will receive first year commission. A first year commission will average between 35 to 65 percent of the annual premium. When an agent makes a practice of replacing medicare supplement coverage, it is common to find that an unscrupulous agent will return to his own client at the time of renewal of a policy, and will sell the client a new policy instead of renewing the current policy.

Renewal commissions are approximately 5 to 10 percent of the annual premium. Therefore, it is more profitable for those agents who are dishonest to sell a new policy instead of collecting the renewal premium on the current policy. It is not uncommon for a dishonest agent to represent more than one company, and replace one of his client's policies with another policy issued by a different company.

(2) Another related problem is a dishonest agent using pressure tactics to sell the insured more coverage than he has a need for. This is called stacking of business. [See attachment, page 87.] This is a common occurrence in the medicare supplement insurance market. There are numerous companies that offer medicare supplement policies that provide sufficient benefits under one policy, to supplement their medicare parts A and B coverage. Therefore, in most cases, there is no need for coverage under several policies that can be provided under one policy.

(3) The third most common practice creating problems in the medicare supplement insurance market is the manner in which these policies are sold. Some dishonest agents, in order to replace a policy or to sell additional and unneeded coverage, will misrepresent a policy and use pressure sales pitches. This results in insureds being confused about what insurance benefits they need and what they are actually purchasing. We have received complaints from in-

sureds stating that they were scared into purchasing coverage and not knowing what they were actually buying.

(4) The Florida Insurance Department regulates advertising used in Florida through the use of guidelines under rule 4–6, which outline the manner in which advertising may be written. The rule requires that all insurance companies provide an annual certification that all of their advertising complies with rule 4–6. However, the problem that most often occurs is with a general agent. The agent will draft his own advertising without prior authorization from the insurance carrier. In the medicare supplement insurance market, the most common violation has been the use of advertising material which is written or designed so as to mislead the reader into thinking that the material is being distributed by the agent of the Federal medicare program. Rule 4–6.13(2), states "no advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color, or other characteristic are so similar to combination of words, symbols, or physical materials, used by agencies of the Federal Government or of this State, or otherwise appear to be of such a nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, State, or Federal Government".

The Florida Insurance Department has 21 service offices throughout the State that try to keep a close watch on advertising material being used in their area.

SOLUTIONS

(1) The department is reviewing the annual statements submitted by companies on their experience as to premiums earned and claims paid on each type policy sold. This review is made to find policy forms that reflect a premium which is not reasonable in relation to benefits provided. This indicates a policy that may be designed actuarily so as to provide too small a benefit to the insured, and too high a profit to the company. The recent investigation by the department of one such company resulted in the company, at the department's instructions, having to update and revise their entire policy portfolio in order to provide benefits that are reasonable in relation to the premiums charged. The department is also reviewing request for rate increases to be sure that the company's actual experience justifies the need for a premium increase. In the majority of such requests for rate increases, we have found that the actual experience for Florida policyholders, did not justify the amount of premium increase being requested.

(2) Bill Gunter, as a result of continual problems in the replacement of health insurance, has proposed a rule which would require that agents give full disclosure and comparison of contracts involved in a replacement. This should be a big help in stopping replacement of insurance which is sold for the sole purpose of profit to the agent.

(3) The Florida Insurance Department, in order to provide the citizens of Florida with a better understanding of health insurance, including what a person should be aware of in a policy, is in the process of publishing a booklet to be given to the public. This booklet will explain terms, provisions, definitions, exclusions, and benefits of insurance policies. The booklet will identify what the senior citizens should look for in a medicare supplement policy.

(4) Market conduct surveillance examinations.

[Attachment]

MARCH 11, 1976.

In Reply please refer to: Our file No. 14–76–663 (Oliver) or various policies.
Mrs. ———, ———, complainant.

DEAR MR. GREEN: Several recent complaints or inquiries have been brought to the attention of the Insurance Commissioner's Office of insurances where agents of your company have grossly and flagrantly oversold and exploited risks in this area and other areas of Florida.

The most recent is the case of Mr. and Mrs. ———. Mrs. ———, the daughter of this couple is visiting her parents and found that their cooking range, refrigerator, and television were not operating. She asked her parents why they had not had the appliances repaired and was told they could not afford the expense. When she inquired further her parents told her their insurance was such an expense they did not have money for other necessities. Copies of checks drawn on the ——— checking account payable to Insurance Company are attached

and indicate premium payments on December 5, 1975, $1,747.00, January 9, 1976, $354.00, January 1, 1976, $143.40, October 13, 1975, $380,00, January 3, 1974, $134.00, December 26, 1974, $124.00.

In a period of slightly more than a year, these people have paid to your company $2,882.00 for nineteen policies, which are identified on the attached pages.

Mr. ——— is 82 and Mrs. ——— is 78. In speaking to Mr. ——— on the telephone, his speech is halting and barely audible, which is the result of three strokes.

Senator CHILES. You mentioned in your written statement a number of practices that unscrupulous agents use. I suppose those practices, some of those still won't go?

Mr. COOPER. Senator, we still have some of those. They are not running as hard and as fast as they were in the past. We checked in general. We have the right to go in and check a general agent's record even if he is not licensed. Maybe he just sets up an agency and he has men under him. Any time he is transacting insurance in the State of Florida we check those records, and this is how we find stacking of policies.

Senator CHILES. I am delighted to hear that Florida is doing so well and I trust then I am not going to get any letters when the press writes about this hearing, that says there are not any problems in Florida.

Mr. COOPER. Senator, you will get letters. We get letters every day. When these ads hit the paper Sunday, Monday, Tuesday, Wednesday, and Thursday, we receive the letters that we check into, but it is not as rampant as it was in the past, sir.

## INDEPENDENT CONTRACTORS

Senator CHILES. Mr. Wilde, you were talking about independent contractors. You were going to comment on that and also on someone being fired "for cause."

Mr. WILDE. Yes. First of all, the phrase "independent contractor," for example, in Wisconsin, would not be an acceptable kind of approach. In Wisconsin, we have only one status of insurance salesman at the moment, which is an agent, and the company is legally responsible for the acts of the agent. Now some companies like to say that their agents are "independent contractors." I suspect in a similar fashion to the way that the guy who sells "numbers" somehow is an independent contractor when you try to trace up the whole chain to the top. I think that the phrase is misleading. Legally, the company is liable for the actions of those agents. They are the company's agents and the company is responsible for their deeds, pure and simple, and so the company has a responsibility to train them.

Senator CHILES. When you are talking about numbers, you are not talking about phone numbers?

Mr. WILDE. No, I am talking about an analogous structure to some elements of the so-called organized crime.

Senator CHILES. We call that bolita.

Mr. WILDE. Second, the "terminated for cause" comment. I am not going to comment on any particular company, but we have discovered, and I suspect most insurance departments would discover, that almost

no agent is ever "terminated for cause." When agents are terminated, they are terminated for "nonproduction."

Senator CHILES. When one gets in a U.S. Senate hearing he might be terminated for cause.

Mr. WILDE. That is not to say they are not terminated for cause, but I am saying from a departmental standpoint, one of the important controls we have is when a company has a bum agent and they know he is a bum agent, they want to get rid of him. I accept that fact. Good companies, bad companies, nobody wants a bum agent—he might steal from them. Generally, when they get rid of him they are afraid to say that they terminated him for cause, they are afraid he will sue them or whatever, so they indicate in their notice to the department that they terminated him for nonproduction.

Under our rules, if they do that, it is a violation by the company; and we are now finding dozens and dozens of these kinds of violations as we go into company records. When we examine their records we discover agent X has been dismissed for all kinds of horrible activities and complaints, yet in our records it shows he was dismissed for nonproduction.

Senator CHILES. Then you require, as part of your regulations, that they notify you?

Mr. WILDE. Absolutely.

Senator CHILES. And what the reasons are?

Mr. WILDE. Absolutely. As I say, that is a requirement that has been in place for years.

Senator CHILES. Do you license these agents?

Mr. WILDE. Yes. That is why it is so crucial that we get that kind of evidence, because, as Senator Glenn was referring earlier to the fact that these guys jump around from company to company; this is very, very true.

Senator CHILES. What kind of results have you had where you failed to license an agent? Have you been tested? Has anybody taken you to court for failure to grant a license?

Mr. WILDE No. We have refused licenses to a number of agents in recent years and we so far have gotten away with it.

Senator CHILES. Nothing has been overturned?

Mr. WILDE. That is right.

Senator CHILES. So it can be an effective means of getting these people out of writing insurance where you have this information?

Mr. WILDE. Yes. In fact, I would say that one of the most striking things is that just one general agent, with a team of a few hundred subagents, can generate hundreds of thousands of dollars of business and hundreds of complaints. If you go after that general agent, it is very hard to get him. They are insulated and protected. But if you go after them, if you can stop them, you see a literal drop-off in the number of complaints in the hundreds, just from the prosecution of a few key agents.

### AN AGENT GRAPEVINE

Senator CHILES. Word gets around fast.

Mr. WILDE. Yes.

Senator CHILES. There is a great grapevine out there among those agents, is there not?

Mr. WILDE. Yes, there certainly is.

Senator CHILES. You mention certain things you think the Federal Government can do, and you also mention that you see some more activity on the part of the National Association of Insurance Commissioners. Do you think that is really moving? Is there a possibility for some kind of model law and model regulations, or is the Federal Government going to have to get into this field, as we have gotten into so many areas when the job wasn't being done?

Mr. WILDE. I think that there are some National Association of Insurance Commissioners models of minimum standard things in place now, but in the medicare supplement area it is not very helpful. There may well be at this point in time some interest in the National Association of Insurance Commissioners in going to a much more detailed approach, such as California and Wisconsin have gone to, and it should be said California and Wisconsin have gone in somewhat different directions and that suggests the need for some form of uniformity.

I think that there are agencies of the Federal Government, perhaps the Federal Trade Commission, and others, who have some interest in this issue. I don't think at this point there is a need for a Federal law to establish minimum standards, but as I suggested in my testimony, it would be very appropriate for an agency of the Federal Government and the Congress to develop some guidelines as to what you think would be good and then take the Health Insurance Association of America at their word and walk back to them and say, "OK, you say there is a small number of sharks; what about the good guys?" What are you good guys going to do?

Are you going to offer, countrywide, a few good policies, on an open enrollment basis, so that anyone can get them—and that are offered on an accommodation basis—which means they are not high expense, high commission products? Maybe you can get the private health insurance industry to recognize what I think is its clear responsibility and if it does not recognize it then I think we may have to come back to the Federal Government and say what is the Federal Government's responsibility given the fact that a large part of the problem is created by medicare and the gaps in medicare.

Senator CHILES. Mr. Cooper, what kind of requirement does Florida have in regard to standardization of policies?

Mr. COOPER. In the accident and health field?

Senator CHILES. Yes.

Mr. COOPER. We have what was put into effect a couple years ago, Senator, minimum standards which the commissioner from Wisconsin mentioned, and they are pretty stringent. We have certain guidelines that companies have to comply with when they file policy forms, and if these do not comply with these guidelines then they are not permitted to sell them in our State. Every company had to revise their contracts to bring them into compliance within the State of Florida.

Senator CHILES. Do you have provisions that would require the contract to show what percentage, what is the cost of the accident and health for each coverage A and B and supplemental coverage?

Mr. COOPER. In all areas, Senator, we require in the State of Florida when a company submits a new policy that they have to give us a 10 year breakdown on their anticipated loss ratio and we have received

a little bit of flack from industry in this area because several of the companies did not want to reflect what they anticipated down the road. They might have a 10-percent loss ratio on the contract that is in force in Florida and if we knew it we would withdraw the form which we have statutory authority to do and we have done so. We feel that by requesting this anticipated loss ratio that it is going to correct some of the situations that have been brought out here today.

Mr. WILDE. Senator, if I could comment, I thought I heard your question differently. I thought you were asking what was required in terms of information on the policy.

Senator CHILES. That is what I am trying to find out. What do you require of the purchaser of the policy so that he will see on the face of that policy what the expense is for A coverage or B coverage, medicare A, medicare B?

Mr. COOPER. As far as specifics, Senator, we don't have anything of that nature. We have an outline that is required to be filed with medicare supplements and it tells what they get but it does not go into the cost of the contract.

Senator CHILES. Well, it sounds like to me from what Wisconsin is doing and California—is California doing that, too, what you are talking about?

Mr. WILDE. Well, I am not sure exactly what California requires. What we require is that on any of these medicare supplement contracts they must provide a chart in a very simple, readable form of medicare, what medicare covers, what the policy covers, and what neither covers, side by side, so that it is very simple for the policyholder to figure out what is not covered and what is covered. I don't know if California does that or not.

Mr. COOPER. That is included in our outline.

Senator CHILES. That is included?

Mr. COOPER. Yes, we include what you get and what you don't get on the medicare supplement. I didn't quite understand your question.

Senator CHILES. I am also trying to reach the provision that you are talking about where some companies would show their expense ratio was $400 and another would show that it was $200. That would be in your——

Mr. WILDE. That would be just the basic price of the policy, that would not be the expense ratio. That comparison, of course, every State would have. In States that did not have a standardized approach, company A and company B could both be offering a policy which they call medicare supplement. Company A could have huge exclusions in it and have a very high expense ratio and company B could have no exclusions and be a very comprehensive policy yet they could have the same price.

Senator CHILES. Standardized policy?

Mr. COOPER. Right, sir. Our actuary has told us that any contract written in the accident and health field, that when the company structured its rates and did not have a 55-percent loss ratio that it could cause a large increase in premiums down the road within a couple of years, and this we have found true in Florida after we began to check exhibits of loss ratios where companies would apply for a 200-percent premium increase, as the commissioner has mentioned.

Senator CHILES. How prevalent would either of you judge instances of insurance oversale to the elderly to be?

Mr. COOPER. There is quite a bit of it, Senator.

Senator CHILES. Can you give me a ballpark figure of what you would say it is in Florida?

Mr. COOPER. Most of these people that we have found, that have been brought out today, are very insurance minded. They realize what could happen to their life savings and a lot of them will buy unnecessary contracts such as these policies. So there are quite a few. As far as the numbers, it would be hard to say, Senator.

Senator CHILES. Mr. Wilde.

Mr. WILDE. One way of measuring that question would be to look at the number of people on the medicaid program, which is, after all, only available to people of moderate or low incomes, the number of people on the medicaid program who are insured improperly—since the medicaid program in Wisconsin, and I assume the rest of the country, has to get reimbursement from private insurance where a person in medicaid also has private insurance.

## 20 PERCENT OF MEDICAID RECIPIENTS WITH PRIVATE INSURANCE

Now the State of Wisconsin Department of Health and Social Services has done some survey work, and at this point I think it is something like 20 percent of the people on medicaid have been shown to have some form of private health insurance. Now there is very little rhyme or reason to people having that health insurance, since by law they really have to turn all the money they receive from insurance over to the State anyway, since they are taking the medicaid benefits and that is one of the prices of those medicaid benefits.

Some people have told us they think they are about to go off medicaid and that's why they want to hang on to insurance. But a lot of those people, particularly people with cancer policies and limited policies of various types, are holding insurance that they should not be holding, and this is an indication of how the marketing tactics have gotten through to the people who clearly can't afford it.

I would like to turn your question around a little bit and also say that the problem in this market is not just one of people being oversold too much insurance, it is also a problem of people being oversold a lot of inadequate insurance so that, for example, they get a stack of policies, such as you have heard today, rather than getting one comprehensive policy, let's say, to supplement medicare. They get four or five limited policies which end up costing $100 or $200 more, and when the crunch comes they find out that those policies are not worth very much.

Mr. COOPER. This is the reason, Senator, that we have withdrawn numerous contracts in the State of Florida because of companies that did not wish to comply with our request.

Senator CHILES. Some people have suggested to the committee that some companies, no matter what the training manual of the company policy says, unofficially encourage agents to disregard the rules as long as the high volume of sales will continue. Do you have any actual knowledge of this, either of you?

Mr. COOPER. Senator, as far as actual knowledge, we don't, but we have been told this and you are going to have some, but most of them

police their own self in this area because we come down on the company. As someone stated, we see that it is corrected. As the commissioner of Wisconsin said, contract or no contract.

Mr. WILDE. I think the answer to that question is that that is the case in this marketplace and has been the case. We have had agents tell us point blank that vice presidents or whatnot of the company have said to them, "Ignore the rules, ignore the commissioner, that is not what you are out there for." As I indicated before, we have come into company records where we could see a stack of complaints 6 inches high on the agent and the agent was still there. That tells us something; it tells us that the company values that agent's production more than their own credibility. We know that we have taken action against agents in Wisconsin and the companies have come in and said: "We agree with you completely. That guy is a bum; we don't want anything to do with him." Then they have licensed him in Illinois.

Senator CHILES. Both of you talked about agents. Do you know anything when you take this action? Do you send that to other States, neighboring States?

Mr. WILDE. Yes, we do and we distribute it. The National Association of Insurance Commissioners distributes a monthly or bimonthly list of agents whose licenses have been revoked or terminated, but it is a very inadequate procedure, because a lot of disciplinary actions don't necessarily result in revocations. They may result in forfeitures, they may result in voluntary withdrawals by the agent, and so on and so forth. I have no doubt that when a State really cracks down, that it may be exporting its problems to other States.

## POSING AS MEDICARE REPRESENTATIVES

Senator CHILES. Both of you have talked about agents misrepresenting themselves as agents of the Federal medicare program. I noticed in some of the material provided to the committee, for example, cards mailed to people asking them to return the cards if they want information or changes in medicare. Can you describe how this type of contract works?

Mr. WILDE. When we first started going after this problem 3 years ago, Senator, we used to see literally packets of 10,000 and 50,000 of these cards being mailed out of three or four different agencies. I don't know where they got the lists from, probably from some source that uses motor vehicle records, or some other records that are typed by date.

They would send out a card saying: "Medicare changes information. If you want to know about what is going on in medicare, write to us." Then they would systematically follow up on this. Now we have set up rules which don't allow that kind of misrepresentation and I think we have largely cut it out, but it seems to go on in various ways no matter what we do.

For example, when our new rule went into effect January 1, one of the first things that happened was that some kind of boilerroom agent operation was set up north where someone was calling up lists of senior citizens and saying: "Under the commissioner's new rule, all medicare supplement policies have been abolished; you have to buy

our new medicare supplement policy." The ingenuity of the people in this market is infinite.

Senator CHILES. Mr. Wilde, what has been the reaction of the insurance companies to your new rules and clarification system for medicare supplemental policies?

Mr. WILDE. I think I would say, generally, it has been a healthy reaction. A number of the companies have withdrawn from the market, which is probably healthy. Some companies have gone into the market and made what I would call a public service commitment. They have said that, "We are going to write these policies, not to make a lot of money, but because we think it is the need."

As I indicated in my prepared testimony, they have already distributed 100,000 copies of our booklet to elderly people in Wisconsin, so somebody is out there selling. We have seen the distribution of prices that I referred to, which is, some companies have come in at low prices, some at high, and I think that is important for the consumer.

We have had some problems and one of them, as I indicated in my prepared testimony, was with the American Association of Retired Persons group policy which does not come under the rule. There are something like 40,000 people in Wisconsin who have these policies and many of them are very confused about how they relate to the rule and what their needs are and how their policies relate. I would say we have not been too successful, up to now, in trying to get that situation resolved, but I trust that after "60 Minutes" went to work, maybe we can resolve it much quicker.

Senator CHILES. Mr. Cooper.

Mr. COOPER. Referring to the premium, Senator, some of these companies in the past, we have found some would come out with a gimmick contract and we would disapprove it due to the fact that the premium was not justifiable, it would be too low. We could see that it would create insolvency. We turned those down, we didn't try to have the premium too low for benefits provided. This would cause a problem. We watched both ends of it, whether it was too high or too low.

Senator CHILES. We thank you both very much for your testimony. You have been very helpful to the committee and we appreciate it.

This concludes our hearing.

The committee will be looking at this question further and we will probably be seeking additional information trying to determine what is the extent of the problem and how many States are adequately trying to police the problem.

[Whereupon, at 12:28 p.m., the hearing adjourned.]

# APPENDIXES

## Appendix 1

## ADDITIONAL MATERIAL SUBMITTED BY ROBERT E. LOWRY[1]

### ITEM 1. FURTHER COMMENTS OF ROBERT E. LOWRY

Several concerns exist on a highly personal and, I believe, relatively unselfish level. These are "awarenesses" which developed as I groped my way toward the original goal. The light manner in which the problem and complaint was handled in Ohio and the official indifference or unwillingness to initiate action (either in criminal charges for the inducement to forgery, or disciplinary for the company and agents) for behavior which the same officials found "reprehensible" in private conversations. Add to this the concerns which developed during the contacts and communications with company representatives; their insensitive reaction to the factor of financial hardship caused by overinsurance, their insults and insinuations.

I don't give up a fight easily, but I confess that these layers of resistance, to an appropriate resolution of the problem, were almost overwhelmingly discouraging. After 2 months of effort and having apparently exhausted the remedies available in Ohio, my only accomplishments were the company's grudging admission that two policies were refundable, having been "improperly written," and a suggestion that we lapse any other policies found financially burdensome. I tried to imagine my mother or some other "typical" gentle-mannered elderly person attempting to fight their own battles in pursuit of a correction to their grievance on problem along the same path I had traveled. The willingness to admit one has been deceived, the energy to knock on many doors and write innumerable letters, or the ability to endure bureaucractic delays and indifference may be lacking. It is not my intention to demean the spirit or capabilities which many senior citizens retain, but my observations suggest that these types of frustrations and confrontations are neither desired nor needed at this stage of their lives. In short, I became convinced that neither the systems designed to prevent insurance exploitation and abuse nor the systems designed to correct such abuses, after they occur, are adequate in meeting the needs of elderly consumers. This concern and its exposition became as important as resolution of the specific family problem.

I've still got a little fight left in me, but these factors were almost overwhelmingly discouraging. I tried to imagine my mother or some other "typical," gentle-mannered elderly person attempting to pursue a correction of their grievance or problem along the same path I had traveled. The system is neither fair nor adequate to meet their needs when a problem arises. I also learned a few facts of life about the insurance industry, how powerful it is, both economically and politically, and how aggressive they appear to be in their relationships with the various state agencies which regulate their activities. The relevance of these factors seemed to merit equal emphasis within any presentation of our insurance problem to the committee.

There is a direct correlation between our exposure of my mother's insurance problem and the company's willingness to take corrective actions in refunds and, 6 months later, to guardedly admit that insurance oversale did occur and tender an apology. The admissions that something had gone wrong within the company's sales and fiduciary relationship with my mother finally occurred under the bright lights of the committee hearing room with the close attention of

[1] See statement, page 30.

Senators and the media. I feel very strongly that the committee needs to be aware of the very different attitude which this company manifested and the formal stand it took, in reference to our specific problem and complaint, during the 8 months prior to the hearing date. This earlier attitude is relevant to the committee's interests since it represents exactly what we would have had to content ourselves with if the committee had not interceded with a closer examination. As recently as April 5, Mr. Grubbs wrote to the North Carolina Department of Insurance and reaffirmed the statements made in an earlier (January 13) letter concerning my complaint of mistreatment and insurance oversale. The change of heart and attitude occurred between April 5 and May 16. The committee's concern is, I am sure, directed toward the many elderly consumers whose legitimate complaints are not so publicly exposed or favored by Senatorial intervention and who, consequently, may not benefit from a changed attitude by this or other insurance companies.

For this reason, I would like to request that all correspondence between the company and the North Carolina Department of Insurance be included as information supplemental to my testimony. In these and other letters you will note that the company never recognized nor admitted the possibility of overinsurance, nor did it ever mention the New York Life policies as the factor which had motivated their refund in December, although this was the reason given to the committee. Neither the facts of the originating problem nor the information available to the company, from which their attitude and decisions were presumably derived, have altered since last fall. The investigation initiated by the North Carolina Department of Insurance is a positive and energetic response to the complaint I filed as a resident of that State. The correspondence stimulated by this continuing investigation provides both public record and documentary proof that statements made by Mr. Grubbs and other company representatives to a responsible State regulatory agency vary considerably from the company's testimony before the committee (in certain key areas including the issue of overinsurance). The point being made is now obvious. If insurance companies feel free to deal with the consumer in a callous, indifferent manner, and with State regulatory agencies in misleading, possibly deceptive statements, to whom do they respond with the truth? The committee cannot serve as a consumer's "court of last resort."

---

## ITEM. 2. EXCHANGE OF CORRESPONDENCE BETWEEN ROBERT LOWRY, THE NORTH CAROLINA COMMISSIONER OF INSURANCE, AND BANKERS LIFE & CASUALTY CO., CHICAGO, ILL.

RALEIGH, N.C., *November 30, 1977.*

Attn.: W. Kenneth Brown, deputy commissioner.

Hon. JOHN R. INGRAM,
*Commissioner of Insurance, Department of Insurance, State of North Carolina, Raleigh, N.C.*

DEAR COMMISSIONER INGRAM: As a resident of North Carolina since 1974, I have noted, with considerable satisfaction, your personal concern and the aggressive efforts of the department of insurance in the provision of guidance and protection for the consuming public against unfair insurance industry practices. Unfortunately, not all States enjoy such independent and effective regulatory controls against abusive sales tactics. I feel it is now my responsibility to inform you of a problem situation facing my family and myself which involves a company licensed to do business in North Carolina, Bankers Life & Casualty Co. of Chicago.

In August 1977, I visited my ailing mother, Lucille W. Lowry, age 75, at the Otterbein (retirement) Home in Lebanon, Ohio. Her financial affairs were in a state of chaos due to recent, extremely heavy (nearly $13,500) investments in unnecessary insurance coverage with the above company, as described in the enclosed documents. In examining her papers, I discovered a number of cancelled checks and bank drafts for premium payments on policies she did not have in her possession. Upon inquiry, a Banker's Life agent confirmed the existence of two identical whole life policies with a principal sum of $2,000, one on my life (No. 5,432.307) and another on my brother's life (No. 5.432.306), for which monthly premiums of $140.44 were being collected by bank drafts. During the phone conversation, the agent twice suggested that I might wish to cancel the policies and obtain a full refund. He also stated that the policies had apparently never been "placed" or delivered to my mother. The company's reluc-

tance to deliver the policies emphasized the need to know how life policies could be created on two adult sons without their knowledge, approval and signatures.

Together with other missing policies, the two subject policies were finally delivered on October 13 during a meeting with the Bankers Life chief counsel, Wm. Grubbs, in the offices of the Ohio insurance warden, Mr. R. Katz. The two subject policies had an issue date of April 22, 1977 and all missing policies were stamped "duplicate," an identification which I protested. The contract signatures were not in my brother's or my handwriting and may have been written by my mother, but they were witnessed or authenticated by the selling agent, R. M. Mr. Grubbs commented that these particular policies were "bad" and were not properly written, but that R. M. was no longer with the company. My mother's apparent participation in the creation of these questionable contracts was represented as a serious inconvenience to the company, but Mr. Grubbs said they would overlook her offense and we would be permitted to choose whether to continue the policies in force or rescind them for a full refund of premiums.

Subsequent to the meeting on October 13, the company supplied three other missing policies which my mother had purchased in March 1977 on the lives of her three grandchildren, two of whom are my children with residence in Raleigh. The policies have an issue date of April 6, 1977 and they had apparently never been delivered to my mother, but were stamped "duplicate" when received. I had requested that the company provide me with an accounting for all monies paid in as premiums on life policies. The accounting was sent along with the children's policies, but the dollar amounts do not correspond with the cancelled checks and bank drafts in my possession relating to items #2 and 4 of the enclosed list, the two major life policies.

Mr. Grubss had agreed to maintain all policies in force until November 14 so as to provide time for the family to study the recently supplied policies and determine which policies, of the entire insurance program with this company, should be maintained. Following consultations with my mother, my brother and other advisors, I wrote to the company on November 3 with the details of our decision (copy enclosed). The relatively small health, accident and childrens policies were not of major concern, although they certainly form a part of what is considered the oversale of insurance programs to an elderly woman. My letter requested rescission and refunds on three major life policies and one health policy representing exorbitantly expensive and totally unnecessary coverage in view of her pre-existing insurance program.

As indicated, the company has offered to rescind and refund the two highly questionable policies written on my brother's and my lives. While we regard them as undesirable and are offended by their manner of creation and existence, no decision has, as yet, been reached in reference to accepting the offer pending further legal consultations and your investigation of the matter. I do protest, most strongly, that a contract concerning my life or death, however well-meaning, was accomplished in another State without my knowledge and a financial commitment was created which I would have to assume upon my mother's death. I respectfully request your investigation of this situation and the general business practices of Bankers Life & Casualty Co. of Chicago as they may relate to the citizens of North Carolina.

Sincerely,

ROBERT E. LOWRY.

---

STATE OF NORTH CAROLINA,
DEPARTMENT OF INSURANCE,
*December 19, 1977.*

Re: Various Policies, Mrs. Lucille W. Lowry, Lebanon, Ohio.

DONALD CLARKE,
*Manager, Claim Review Department,*
*Bankers Life & Casualty Co.,*
*Chicago, Ill.*

DEAR MR. CLARKE: Your attention is directed to the attached letter, with enclosures, of November 30, 1977 from Robert E. Lowry.

After carefully reviewing the letter and enclosures and discussing this matter with Mr. Lowry, it is our observation that since a citizen of North Carolina has been involved in the manner alleged that we have an obligation to become concerned with his interests and with the sales practices which caused his involvement.

Because of this we request that you furnish this office with a complete report surrounding this matter and responding specifically in detail to each and every charge of Mr. Lowry.

If it is found that all or any of these charges are correct we also request that you inform this department what measures you have taken to determine that such practices will not occur in this State involving our citizens.

We are concerned with the welfare of all citizens with respect to sales practices and tactics but must necessarily be especially interested in any improper application of such practices with respect to our elderly population.

Your prompt reply is expected.

Very truly yours,

FRED L. SEAMAN,
*Assistant Deputy Commissioner,*
*Consumer Insurance Information Division.*

---

BANKERS LIFE & CASUALTY CO.,
*Chicago, Ill., January 13, 1978.*

Attn.: Mr. Fred L. Seaman, Assistant Deputy Commissioner, Consumer Insurance Information Division.

Re: Your December 19, 1977 letter concerning Lucille W. Lowry—my January 3, 1978 letter.

JOHN RANDOLPH INGRAM,
*Commissioner of Insurance,*
*State of North Carolina,*
*North Carolina Insurance Department, Raleigh, N.C.*

DEAR MR. SEAMAN: This is a followup to my January 3 letter concerning Mr. Robert E. Lowry—your letter of December 19, 1977.

I have reviewed the entire file and have completed a policyowner review of all coverages applied for by Mrs. Lowry.

1. Here's a review of the coverages that were issued for Mr. Lowry. On November 9, 1973, we issued a No. 717 Medical-Surgical Policy, No. 747 Extended Care Facility Policy and No. 780 Hospital Indemnity Policy, all of which were under Policy No. 730,576,561. We don't feel the sale of these policies would have been detrimental to Mrs. Lowry.

2. The Hospital Indemnity Policy, No. 780, was converted and replaced to a 74J Hospital Indemnity Policy, the current form essentially replacing the No. 780 form, under policy No. 730,576,561.

3. On April 19, 1976, the Company issued a No. 774 Intensive Care Policy to Mrs. Lowry under policy No. 760,175,115. This is supplemental insurance which provides a benefit of $50 per week for hospital confinement plus additional benefits of $100 a day for intensive care in the hospital.

4. On December 16, 1976, there was issued a No. 764 Hospital Medicare Supplement Policy to Mrs. Lowry, policy No. 760,392,452 which was a guaranteed issue. In retrospect, this Medicare Supplement probably should not have been issued because of the existence of other coverages. Apparently, since this particular product was a guaranteed issue, it did not become personally reviewed by an underwriter.

5. On April 22, 1977, a Traffic and Travel Accident Policy was issued to Mrs. Lowry.

6. On April 2, 1977, an Intensive Care Policy No. 770,150,792 was issued, but was voided as Mrs. Lowry already had a plan of this kind in force.

7. On April 22, 1977, the Company issued policies 5,432,306 and 5,432,307 which were life insurance policies for Kenneth and Robert Lowry. I am attaching photocopies of the applications which show the signatures of Mr. Kenneth Lowry and Mr. Robert Lowry. We have since learned that Mr. Robert Lowry and Mr. Kenneth Lowry may not sign the applications, but were signed by Mrs. Lowry. We refunded the entire amount of $842. This action was taken immediately when we did discover these were not properly signed.

8. On April 6, 1977, we issued three Juvenile Estate Life Policies on Mrs. Lowry's grandchildren; policies 5,423,861, 5,423,862 and 5,423,863.

9. Mrs. Lowry was also owner of four policies on her life: policy 5,393,843, issued December 15, 1976. That policy was voided as of the issue date. Policy 4,854,476 was issued June 14, 1976; policy 5,248,470 was issued on June 3, 1975; policy 5,413,376 was issued on March 2, 1977.

10. It did appear from our review, of the underwriting file for Mrs. Lowry, that the life policies could have had a definite need. The files would reflect that at the time of issue, Mrs. Lowry was in a strong financial position.

11. We are concerned with the abuse of the senior citizen in the sale of insurance. We have taken action to attempt to curb such abuse when we have it.

12. As a means of assuring fair treatment of senior citizens, Bankers Life and Casualty Company has established several rules concerning abuse in the sale of Accident & Health insurance to senior citizens.

13. The most important of the current rules are: (1) For individuals 65 or over, the maximum allowable premium, including substandard, for all Accident & Health policies for all companies, is $50 monthly. We have established extensive computer systems involving a computer check of all in-force business when a new application is received. Our agents are required to carefully review a prospective insured's current coverage and note such coverages on the application. (2) A policy for an age 65+ policyholder, which has been lapsed less than 12 months must be reinstated, upgraded or exchanged. Such a policy lapsing over a 12 month period can be rewritten, but such rewrites are limited to one in a 12-month period. (3) The Company will not allow any switching of an over-65 policy to another policy in Bankers or any affiliated Company regardless of any explanation given by the agency associate.

14. These rules have been adhered to by the Company. For example, to monitor the success of our rules, I reviewed the computer records on rejection of applications for the reason that a person over 65 has $50 per month in accident and health premiums.

| Month | Number of rejections | Percent of all A. & H. premiums |
|---|---|---|
| November 1977 | 130 | 6.6 |
| October 1977 | 98 | 4.1 |
| September 1977 | 83 | 3.4 |
| August 1977 | 70 | 2.7 |
| July 1977 | 64 | 3.0 |

15. We carefully train our agency associates to use common sense underwriting in the saie of insurance to the senior citizen. We tell our agents when selling health insurance to people in the over age 65 market, that we, the Company, and the agent incur legal, social and moral responsibilities to help these people identify their proper insurance needs and prevent situations that would constitute overinsurance or undue financial hardship. Our agents are made aware that because of the prospect's age, the normal anxiety relating to the increased possibility of illness, and ever increasing hospital and medical costs, that such a person is quite susceptible to being taken advantage of. We teach our agents to review the finances of a senior citizen prospect. We tell our agents to judge an applicant's ability to pay not by how much he has in the bank, but on the actual income they have from their pension or other retirement as well as social security.

16. The Life policies written by ex-agent R.M. on the lives of Robert and Kenneth Lowry appeared to have been signed by Mrs. Lowry rather than her two sons. The Company issued these policies on the assumption the applications were signed by Robert and Kenneth Lowry. When the purported applicants contended otherwise, we made refund and rescission as requested. Our attorney for Agents Licensing matters is also investigating the matter to determine if ex-agent R.M. should have his file in the Insurance Department and the Company indicate "termination for cause".

17. We issued the duplicate policies mentioned in Mr. Lowry's November 30, 1977 letter, since it was apparent Mrs. Lowry could not locate the original policies.

18. The Company has granted a full refund of all premiums we received for all applications of Mrs. Lowry. All policies issued were rescinded. This action was explained to Mr. Robert Lowry on December 5th.

19. On October 13th, Mr. William Grubbs of our Company met with Regional Sales Manager, William Tobin, Mr. Robert Katz and Mr. William White of the Ohio Insurance Department, along with Mr. Lowry. Our Company explained Mrs. Lowry's coverage to the Department and Mr. Lowry at that time, along with an accounting of all premiums for all of the policies she purchased.

20. It was agreed at that time, that Mr. Lowry would notify Mr. Grubbs before November 14th as to whether or not be wished rescission of the two policies issued for Kenneth and Robert Lowry. We did not hear from Mr. Lowry as to his decision.

21. The decision to grant the refund was not based on the Company's conclusion that Mrs. Lowry was overinsured or was mistreated in the sale of these policies. We made the refund as an accommodation for Mrs. Lowry, considering her apparent present circumstances.

If you have further questions, please feel free to write or call. Thank you for the time and attention you have given this matter.

Sincerely,

MICHAEL J. DRESSENDORFER,
*Government Relations Department.*

---

STATE OF NORTH CAROLINA,
DEPARTMENT OF INSURANCE,
*Raleigh, N.C., March 29, 1978.*

Re: Lucille W. Lowry and Robert Lowry.

MICHAEL J. DRESSENDORFER,
*Government Relations Department,*
*Bankers Life & Casualty Co., Chicago, Ill.*

DEAR MR. DRESSENDORFER: Your file will reveal that you furnished this office a report on January 13, 1978 with a supplemental letter on January 18, 1978 enclosing material omitted from the first letter.

In keeping with our normal practice we have supplied the complainant, Robert Lowry, with a copy of your report and we now have the attached response from him addressing the contents of your letter which he has numbered by paragraph for convenient reply.

We are aware that the refunds for all policies sold Mrs. Lowry have been made and that the agent reportedly making the sale of this life insurance on Mr. Lowry is under investigation. We also realize that all of these transactions occurred in another State, however, the nature of the charges brought against your company which is licensed in North Carolina are of sufficient scope to make it necessary that we interest this Department further in this matter on the premise that we monitor the conduct of all companies when charges of this nature arise regardless of where they occur.

We consider this a fundamental obligation to our citizens which we are required to protect by law.

In reviewing Mr. Lowry's comments we find interest in and request explanation of the following numbered items on the basis that if he is correct, we are entitled to further explanation.

These items are No. 7, No. 8, No. 10, No. 11, No. 12, No. 13, No. 14, No. 15, No. 16, No. 17, No. 18, No. 21.

We trust that you will furnish a complete response to the questions and observations of Mr. Lowry as promptly as possible.

Very truly yours,

FRED L. SEAMAN,
*Assistant Deputy Commissioner,*
*Consumer Insurance Information Division.*

---

Attn.: Mr. Fred L. Seaman, Assistant Deputy Commissioner, Consumer Insurance Information Division.

Re Analysis/Response to Bankers Life & Casualty Co. letter of January 13, 1978 to the North Carolina Department of Insurance.

Hon. JOHN R. INGRAM,
*Commissioner of Insurance, Department of Insurance, State of North Carolina, Raleigh, N.C.*

DEAR MR. SEAMAN: In order to facilitate an understandable discussion of the various issues touched on, I have numbered the paragraphs on the accompanying copy of the Company's letter. Please read each numbered paragraph in the Company letter and then refer to the corresponding item number in the analysis/response. Certain issues or subject areas not mentioned in the Company letter, but considered relevant to the overall problem, are discussed in my analysis. For convenience, Mr. Dressendorfer is referred to as Mr. "D".

1. This original, three-part Health policy No. 730,576,561 may have been the most reasonable policy of the entire program. (The annual premium was $220.91.) However, the later "conversion" of the Hospital Indemnity portion considerably increased the cost.

2. With the removal of the Hospital Indemnity portion, the premium on the old policy was reduced to $109.64. The Hospital Indemnity coverage paying benefits of $14.28 per day (per Mr. Grubbs and Mr. Tobin) had apparently cost $111.27 per year. The new, "converted" Hospital Indemnity policy No. 770,052,917 had an annual premium of $284.72 which resulted in a cost increase of $173.45 (256%), yet benefits only increased to $30.00 per day. The very high cost of this converted policy is felt to be disproportionate to the small increase in benefits and, for this reason, I requested rescission and refund on this policy in my November 3 letter to the Company. I suggest that possibly the real reason for the salesman's suggestion to convert was: a.) to accomplish a new policy sale or, b.) to remove Mrs. Lowry from a policy coverage not "cost efficient" to the Company (the rates for which could only be raised by class and throughout the state). Within some circles this sales tactic is considered a form of "twisting".

3. This Intensive Care coverage was certainly the favorite of the various Bankers agents in that at least two (and possibly three) duplicate policies were apparently sold to Mrs. Lowry and subsequently refunded. I had planned to maintain this coverage for the time being.

4. Mr. D. recognizes this policy as inappropriate in view of existing coverage. The selling agent who suggested it was quite familiar with the existing coverage. Thus far, this is the only admission of possible oversale or inappropriate coverage by the Company . . . out of the entire 16 sales accomplished within a period of two years.

5. This was a relatively inexpensive coverage and we had decided to maintain the policy. The policy was delivered seven months after its issue date.

6. As previously mentioned in Item No. 3, this was the *third* (and second duplicate) sale of this same Intensive Care coverage. The second sale was in December, 1976 by Agent Walsh. This is puzzling because Walsh was the same Agent who had sold the original coverage only nine months earlier, in April, 1976. The subsequent repeat sales were each increasingly expensive: No. 1 $73.09, No. 2 $109.64, No. 3 $129.82.

The excuse provided by the Company for such duplicate sales was an absence of records or client's file maintenance at the local offices. The fact that Agents from two separate Bankers offices in Dayton, Ohio were working (with) Mrs. Lowry was also tendered as a possible reason for confusion and duplicate sales. Mrs. Lowry had entrusted the planning of her insurance program to the Bankers "professionals" and obediently followed their guidance. She was, in fact, confused as to what coverage she had as were, apparently, the Agents who were intent on selling her still more policies. Her handwritten notes reveal that she was receiving conflicting guidance from the various Bankers Agents, including conflicting advice as to which of her health policies with other companies should be kept or dropped.

7. The Company is quite sensitive regarding the manner of creation of these policies and their subsequent handling of the resultant problem. A number of misleading statements which attempt to portray an openness and promptness of corrective action are contained in Company correspondence to myself and to investigating officials. In light of this, the key question becomes, "On or about what date did the Company *discover* that the policy applications were improperly or fraudulently completed?"

In mid August, I discovered the existence of two mysterious policies, which apparently concerned my brother and I, through the canceled premium checks in my mother's possession. Bankers Agent Paul Grooms was contacted and asked to provide information as to the nature of the policies since they were not in Mrs. Lowry's possession. On August 25, Mr. Grooms telephoned to inform me that the policies were on me and my brother's lives, that they had been issued on April 22, 1977, but had never been delivered to Mrs. Lowry. Twice during the conversation, Mr. Grooms suggested that the policies might not fit our needs and that he would be willing to order their cancellation and provide a full refund of all premium payments. The Company seemed curiously reluctant to make delivery of these policies. (At this time, I was still unaware that the Company had similarly failed to deliver four other policies issued in April.)

My suspicions aroused by the number of selling Agents involved, the appearance of oversell and the extremely high premium outlay to this one Company, I refused to sign a Company statement of "Lost Policy" and requested both the missing

policies and an accounting of all policies through Mr. R. Katz, Warden for the Ohio Department of Insurance. The two subject policies were finally delivered during the October 13 meeting with Mr. Grubbs and Mr. Tobin in Mr. Katz' office. At that time, I stated that the signatures on the application forms were not mine or my brothers and that both were possibly signed by Lucille Lowry. "Our" signatures were, however, witnessed or authenticated by selling Agent Ronald Montgomery. *If* the Company did not know that the applications were improperly signed by the time Mr. Grooms suggested cancellation in August, they were informed of such on October 13.

A check for $842.24 identified as an "Issue Date Refund" (copy enclosed), for the two subject policies, was subsequently received from the Company on December 12, 1977. Interestingly enough, this Company check No. 495917 was stamped with a date of issuance of October 7, 1977. While no request for a refund on these policies had been made, Mr. Katz had asked for copies of the original application forms in his letter of September 28 to the Company. It is reasonable to assume that the Company had some motive for issuing the check at that time, possibly in preparation for the scheduled meeting on October 13. Further, the check was probably in Mr. Grubbs' possession during the meeting, but no request for refund was made and the check was never shown nor offered. In view of the above described events which strongly suggest that the Company had prior knowledge of the improper creation of these policies, how can Mr. D. now claim that the refund "action was taken immediately when we did discover these were not properly signed."?

A number of reasonable questions arise which are relevant to any examination of this Company's business practices, controls against abusive sales tactics, promptness and adequate in taking necessary corrective action, and candor in dealing with investigating officials or regulatory agencies.

(a) When did the Company discover the policies were not properly created?

(b) Why were the policies withheld and not delivered until nearly six months after date of issue?

(c) Why were the policies stamped "Duplicate" when finally delivered: was this not a rather obvious method of covering up for the long delay in delivery?

(d) Why did Agent Grooms suggest that I might wish to cancel the undelivered policies on August 25 with the offer of a full refund?

(e) Was Mr. Grooms' suggestion not prompted by his or the Company's discovery of an improper, if not illegal, act by one of their agents?

(f) When was selling Agent Montgomery dismissed and on what grounds?

(g) If representatives of the Company had prior knowledge of the improper creation of these policies, why was there no one with the honesty, integrity and courage to bring this to the attention of the client and stop the collection of monthly premium payments?

8. These grandchildren policies were acceptable and no cancellation was requested. As with the policies described above, these were not delivered until six months after issue date and were incorrectly stamped "Duplicate".

9. This is correct.

10. The issues and subject matter touched on in this paragraph are worthy of a much more detailed statement of justification, particularly in view of my frequently expressed complaint regarding oversale. It would be most appropriate and interesting to learn what "definite needs" the life policies were intended to meet. Mrs. Lowry had the following life insurance coverage in force at the time of purchasing the various Bankers policies:

LIFE INSURANCE, LUCILLE W. LOWRY

| Company | Status | Year of issue | Death benefits |
|---|---|---|---|
| Midland Mutual | Paid up | 1924 | $1,000 |
| Union Central | do | 1960 | 2,000 |
| New York Life | do | 1932 | 5,000 |
| Do | do | 1954 | 5,000 |
| Do | Annual premium | 1968 | 25,000 |
| Do | do | 1968 | 25,000 |
| Total life insurance coverage in force plus accumulated dividends | | | 63,000 |

Mrs. Lowry has no one dependent upon her for support. Her two married sons, ages 43 and 46, are and have been independently self-supporting for many years. Who was dependent upon future death benefits from these policies? As one of the two designated beneficiaries to the policies listed above and to the more recently purchased Bankers Life policies, I am not unaware of the comforts which can be derived from receipt of "windfall income", but neither my brother nor I are dependent upon these future benefits. What constitutes the "definite need" described in the statement by Mr. D? I suggest the possibility that the "financial needs" of the selling agent were a much stronger factor in the creation of these life policies than any concern for Lowry heirs or sound estate planning, particularly in view of existing coverage.

"The files" referred to by Mr. D. appear to contain the key information which serves as the basis for the Company's interpretation of "definite need" and their determination that, "at the time of issue, Mrs. Lowry was in a strong financial position". During the October 13 meeting, I was denied access to these files by Mr. Grubbs. His position was that the Company's first obligation was to protect the "best interests" and privacy of their client, Lucille Lowry, and that revelation of the confidential, privileged information contained in these files would not be in keeping with this obligation.

Mr. D.'s reference to Mrs. Lowry's "strong financial position" at the time of issue and his much more pointed statement in paragraph No. 21 regarding "her apparent present circumstances" attempt to suggest an altered or deteriorated financial situation due to causes beyond the Company's knowledge. It has been my contention that the deteriorated "present circumstances" were *directly* attributable to the rapidly growing financial involvement with the Company which represented an unbearable drain on her income and resources for the payment of insurance premiums. The facts are that one of Mrs. Lowry's important income producing assets, her savings accounts, were being gradually reduced due to large withdrawals for the payment of annual and quarterly premiums. Fortunately, both her income as beneficiary of the trust account and her Federal benefits have increased somewhat.

In both Mr. Grubbs' letter of December 5 and in the present letter from Mr. D., the Company has conveniently portrayed itself as "accommodating" an unfortunate person who has fallen on hard times. They have consistenly avoided a direct and detailed response to the charges contained in my letter of November 3 to the Company:

(a) That an appropriate evaluation was *not* accomplished of Lucille Lowry's existing insurance covearge, her present residential circumstances and financial obligations, and, most importantly, her real need and ability to pay for so much additional insurance. The Company's vague references to a "review of the (secret) underwriting file" does not constitute an adequate justification of their actions nor an explanation of "definite need".

(b) That the accomplishment of *sixteen* separate sales of insurance policies (less four cancellations and refunds) *within a two year period* was an obvious abuse by Company representatives which clearly demonstrates an irresponsibility within the fiduciary relationship of advisor and client.

(c) That the resulting financial committment to annual premium payments amounting to *$9,158.61* represented approximately *68%* of Mrs. Lowry's annual income and thus constituted not only an unreasonable financial burden. but an indefensible abuse of her confidence and an unconscionable, possibly malicious, attack on her resources.

The circumstances and facts detailed above certainly betray the ineffectiveness of the Company's training program or code of behavior which is so eloquently described by Mr. D. in paragraph No. 15 of his letter.

11. It would be reasonable to ask how long the Company has seriously evidenced a concern for protecting senior citizens from abuse in the sale of insurance. I was informed, by a senior official of the Pennsylvania Department of Insurance, that Bankers Life and Casualty had been seriously involved in abusive practices of sales of unnecessary insurance to Pennsylvania senior citizens during 1973 and 1974. It would be relevant to know to what extent they were involved there and what corrective actions were required by the authorities.

If, for a moment, one could assume that an improper sales practice was called to the Company's attention in 1974, what excuse or justification now exists for agents of the same company to practice similar abusive sales tactics in the neighboring state of Ohio or elsewhere in 1975, 1976 or 1977? Can either agents or Company home office officials dare to claim they were unaware that such prac-

tices, as described in the enclosed Pennsylvania press release, were no longer to be tolerated? You will note that a majority of the condemned sales practices described in the press release checklist *were accomplished* in the Company's dealings with Mrs. Lowry. With the present evidence of the Company's behavior so readily apparent, can this company properly claim to be effectively self-regulating?

12. Mr. D. has now narrowed the scope of his explanation to the field of Accident and Health insurance. Some of the Health policies sold to Mrs. Lowry were considered excessive and of doubtful value, but the major strain on her financial resources was caused by the various expensive life policies. With reference to sales of life coverage, would not similar rules be equally appropriate "as a means of assuring fair treatment of senior citizens"?

13. Mr. D. has stressed the importance of the described rules designed to prevent abuse of senior citizens. Unfortunately, Mrs. Lowry was not a beneficiary of this "protection". The premiums for her Banker's Health and Accident policies averaged $47.68 per month *in addition* to her Blue Cross, Blue Shield and other previously existing Health coverages. (This amount is, of course, apart from the premiums Mrs. Lowry was paying the Company for her life insurance policies . . . averaging $715.53 *per month!*)

The establishment of "extensive computer systems and checks of all in-force business", as described by Mr. D., are worthless if the applications do not detail such other coverages. He states, "Our agents are required to carefully review a prospective insured's current coverage and note such coverages on the application." Why was this *not done* in the case of Mrs. Lowry? On most of the attached application forms there is simply the scrawled notation, "Medicare and BL&C". Only on the original application for Health policy #730,576,561, issued in November, 1973, was the Blue Cross mentioned, but no other coverages were described. No indications of monthly or annual premium amounts for existing coverages were included on the application forms despite a specific block which requests such information.

There seems to be little point to a recitation of "Company Rules", the "careful training programs" and good intents of the Company if its representatives ignore them. The existence of rules, mottos and codes of behavior may serve a practical purpose, however, in advertising and public relations. They can be referred to with pride or conveniently trotted out to stifle some complaint or defuse an investigation by a regulatory official. The defense strategy is all too obvious, "That (incident) could not have happened because the Company rules don't allow it." or, "If it did happen, that certainly was not the way those agents were trained or told to behave."

During the October 13 meeting, Mr. Grubbs mentioned that the Company had experienced a turnover of approximately 2,000 agents during the past year. His meaning, I assume, was to suggest that hard working, honest and faithful representatives were hard to find. With such a turnover, I would also assume that training programs are less effective than might be desired. This is a Company problem and I sincerely resent the fact that Mrs. Lowry was used as a training ground and that their problem has become our problem. The point is clear: rules may exist, but their usefulness to the consumer is minimal *if they are not enforced* and if agents are not checked by supervisors as to compliance. After having carefully "reviewed the entire file", Mr. D. decided to include a description of certain Company rules and training guidance. I am surprised, but pleased that he included these for *they have been ignored* in nearly every instance in the specific case of Mrs. Lowry. Are we expected to believe that she is a unique exception and that other senior citizen clients in North Carolina, Ohio, Pennsylvania and elsewhere will benefit from the protection afforded by these rules? The Company's past track record suggests otherwise.

14. Mr. D. says, "These rules have been adhered to by the Company." At the risk of appearing overly repetitious, I must again point out that this is *not* a truthful or accurate statement (see above). As I have mentioned previously, the Company's handling of our complaint has been deceptive rather than frank and their correspondence concerning the situation is riddled with statements which are intentionally misleading. Their decision to deal with me, the perceived antagonist, in this manner was not unexpected, but I am very much surprised that the responsible Company officials would risk jeopardizing their considerable business interest in this state by utilizing the same deceptive tactics in their official response to the inquiry made by the North Carolina Department of Insurance.

It is interesting to note the steady increase in both percentage and number of rejections from July through November, 1977 in the computer data provided. But, why is there no data prior to July? I suggest the strong possibility that this Company rule is a new one (i.e. as of May or June, 1977) and that compliance by agents is increasing as news of the rule spreads.

In recognition of the pride with which Mr. D. presents the Company rules established for the protection of senior citizens, perhaps if will be considered nitpicking if I point out what appears to be an area of serious omission in rule No. 1 if the rule is intended to avoid overloading or strain on the client's budget and resources. Average, necessary expenditures for housing, food, medications, transportation and, in some cases, life insurance premiums are factors whose relevance cannot be denied and which must figure in any equation designed to evaluate a client's capability to assume additional financial committments. Rather than setting some arbitrary dollar amount as a maximum allowable premium obligation, I suggest that a safer, more equitable premium maximum could be established as a percentage of average monthly income. For thousands of clients, the $50.00 maximum could represent 25% or more of average monthly income and would be excessive. When were these rules created and what circumstances prompted their creation? They may form a part of some corrective actions which were required by another state's regulatory agency.

15. The validity or truth of the first sentence in this paragraph is clearly disproved by a review of the correspondence and case history detailing Lucille Lowry's financial overinvolvement with the Company. The following, rather laudable, Company interpretation of appropriate business ethics and practices again appears to deal exclusively with the subject of Health insurance sales. Is this a safer ground for the Company's posturing of virtue and moral concern for the client's welfare? There is a definite avoidance of any mention of the ethics involved in life insurance planning and sales throughout the Company's correspondence. This ommission is puzzling and perhaps deliberately misleading within the context of a discussion or investigation concerning policies requiring an annual premium expenditure of $9,158.61, of which 94% is life insurance premiums. The Company's ploy seems rather transparent with their "Let's talk about what I want to talk about" attitude. Are we to assume, and be fairly warned, that the Company and the agents do not similarly "incur legal, social and moral responsibilities to help these people identify their proper insurance needs and prevent situations that would constitute overinsurance or undue financial hardship" in the sale of life insurance?

The paragraph's last sentence is particularly commendable, "We tell our agents to judge an applicant's ability to pay not by how much he has in the bank, but on the actual income they have from their pension or other retirement as well as social security". While this statement probably refers to premium outlay for Health coverage, it seems equally appropriate, with few exceptions, to the planning for a life insurance program. The Company obviously does not see the correlation or rejects the applicability of this judgemental factor to the sales of life insurance coverage. The "guidance" received by Mrs. Lowry resulted in the creation of a Bankers insurance program with an average monthly premium obligation of $763.21 representing 68% of her average monthly income. Of this amount, $715.53, or 63.5% of monthly income, applied to payment of premiums on expensive, unnecessary life insurance policies. The Company's assessment of this situation, as expressed by Mr. D. in paragraph No. 21, is that Mrs. Lowry was neither mistreated nor overinsured in the sale of these policies. We may conclude, therefore, that the history of sixteen policy sales within a two year time frame and the resulting financial committment to premium expenditures reaching 68% of a client's income is, in the Company's view, acceptable and perhaps even standard business practice. We have also established the apparent existence of a double standard within the Company rules and sales guidelines (Health vs. Life coverages) which were ostensibly designed to protect the elderly client from abusive practices.

16. Once again, either Mr. D. has not reviewed the files of correspondence carefully or the Company has experienced yet another communications "misunderstanding". He says, "we made refund and rescission as requested". As previously indicated, I clearly stated, at the Oct. 13 meeting in Columbus, Ohio and again in my letter of November 30 to Commissioner Ingram, that the signatures on the applications were not mine nor my brother's. *No* request for refund or rescission on these two highly improper policies was even made pending possible civil or

criminal prosecution. The decision to refund was made by the Company alone and was undoubtedly in recognition that a wrongful act had been committed, and to avoid possible legal action.

Under the circumstances, I feel it is appropriate to inquire the date on which Mr. Montgomery became "ex-agent Montgomery" and the reasons for his termination. Was there a connection between his sale of these policies to Mrs. Lowry and his termination? Is the act of encouraging and authenticating the improper signing of applications considered a "cause" for termination? Was his supervisor, Agent LaBovick, who generally accompanied him on the sales visits to Mrs. Lowry and co-brokered one sale with Montgomery, also held partly responsible for what transpired? In a company which claims to be so concerned about propriety of conduct with senior citizen clients, why would nearly six months have to elapse before an investigation is initiated to determine whether or not Montgomery's termination should be identified as "for cause"? To which Insurance Department would Mr. Montgomery's file be referred, Illinois or Ohio?

17. This paragraph is partially true, but the Company persists with the insinuation that Mrs. Lowry lost the original policies despite Agent Grooms' statement to me that the policies had never been delivered. The sentence is yet another example of the skillfully crafted phraseology which avoids an outright falsehood, but attempts to deceive through misleading the reader. In effect, it is true that "Mrs. Lowry could not locate the original policies", but this is because she never had them in her possession. I suggest it is now high time that the Company provide proof of an earlier, original policy delivery. At the same time, proof of earlier, timely delivery could be provided for Accident policy #770,149,043 issued April 22, 1977 and the three Juvenile policies #5,423,861; #5,423,862; and #5,423,863 issued on April 6, 1977. All of the above policies were finally delivered during or shortly following the October 13 meeting and were erroneously stamped "Duplicate".

The Company's "lost policy" insinuation is particularly hard to accept when all other Company policies were located in Mrs. Lowry's safe deposit box at the Lebanon bank. Rather neatly filed in her apartment was nearly every other document relating to her contacts with the Company; cancelled checks, refund check vouchers, sales brochures, envelopes and booklets with notes of decisions reached during meetings with agents from Bankers. It is unknown whether the non-delivery of these six policies was an act of oversight, negligence or embarrasment at the discovery of oversale and improper acts.

18. The Company has apparently "granted" a full refund of all premiums paid in by Lucille Lowry. This rescission and refund of all policies was *not* requested in my November 3 formal letter to the Company. The Company's decision to rescind all policies was very definitely not explained, nor was it even mentioned in Mr. Grubbs' letter of December 5. The heading of Mr. Grubbs' letter listed only the Life policies #4,834,476, #5,248,470, #5,413,376 for which rescission and refund had been requested, plus the policies #5,432,306 and #5,432,307 on Robert and Kenneth Lowry, for which rescission and refund was *not* requested. No other policies or coverages are described or referred to in the letter.

Mr. Grubbs' letter closes with, "we herewith enclose a full refund of the premium we have received. The policies issued herein are, as of this date, rescinded and are under no force and effect". No mention nor explanation was provided concerning the rescission of the eight other Health, Accident and Juvenile policies, only one of which, Health policy No. 770,052,917, it was our intention to rescind. The Company's actions in this regard came as a complete surprise. Were we to interpret this blanket cancellation as a petty act of revenge for having requested undelivered policies, adjustments and corrections in Mrs. Lowry's insurance program? Or, in view of our questioning the sales tactics, the frequency of visits and sales, and the number (two and three) of salesmen arriving together, was this a "closing of the books" on an elderly and troublesome client? While we were not enormously pleased with the Company's past handling of her insurance program, due to her advanced age, we had decided to maintain some of the Health and Accident coverage for the time being. Indeed, Mr. Katz' letter of December 14 (copy enclosed) indicates his interpretation of the Company's December 5 communication as encompassing refunds on Life policies only and he urges that we consider continuation of appropriate Health coverages.

Thus, we now have a situation wherein the original series of abuses involving improper documents and the oversale of insurance have been unnecessarily

complicated by intentionally misleading statements from Company officials and, finally, by the undesired cancellation of all coverage for this elderly woman. This behavior can scarcely be regarded as the corrective actions of a respectable business firm which proclaims a concern for protecting the interests of senior citizens and recognizes the Company's "legal, social and moral responsibilities to help these people". It seems appropriate that a company's image and reputation should be based on the realities of what it does rather than upon its artfully prepared statements of intentions.

During the meeting on October 13, Mr. Grubbs cited "clerical error" as the culprit in certain questionable practices involving altered signature blocks and unsigned application form copies within policies. The same excuse will probably be offered when the Company is reminded that each Health and Accident policy sold to Mrs. Lowry contains the clearly labeled statement, "The Company may *not* cancel this policy". Is this not simply one more "rule" or policy statement, designed to protect the best interests of the client and the public image of the Company, which is conveniently forgotten or set aside when necessary?

In the event of a serious complaint regarding the blanket cancellation of all policies, the Company's defense posture is already prepared. A break down of communications or a "misunderstanding" of Mr. Grubbs' instructions will have occurred in the office that issued the check. Certainly Mr. Grubbs' letter of December 5 makes no mention of cancellation of Health policies and very clearly spells out the policy numbers of the Life policies which were being cancelled. Aware that the unrequested cancellation of all Health policies would leave this elderly client without insurance protection and, aware also that such an action would be viewed negatively by others, the deed was accomplished unobtrusively simply by failing to mention the Health policies within the letter. Mr. Grubbs was mindful of the need to avoid stimulating a negative reaction among the distinguished and lengthy list of individuals who were scheduled to receive copies of his December 5 letter. I strongly suggest that it was the intent of that letter to confound and placate the readership while appearing to bring the entire matter to "an amicable conclusion". Again the question may reasonably be asked; can the above described handling of this problem situation be considered standard, proper or acceptable business practice?

19. Mr. Grubbs and Mr. Tobin did interpret much of Mrs. Lowry's insurance program during the October 13 meeting. The premium accounting explanation became overly complicated and time consuming so I requested a written accounting for all Life insurance premiums paid in. This accounting was received subsequently, but, as indicated previously, their figures do not tally with the cancelled checks in my possession.

20. This is essentially true. My formal response to the Company on November 3 did mention the two subject policies, but indicated that no decision had, as yet, been reached as to their disposition. This position was taken on the advice of legal counsel.

21. This paragraph is particularly significant in that it appears to represent the Company's overall assessment or evaluation of the quality of service provided to Mrs. Lucille Lowry within an extensive business relationship. The statement may reasonably be interpreted as Company conclusion that Mrs. Lowry was not mistreated and was not overinsured in the sale of these policies. In his letter of December 5 to Senator Adlai Stevenson, Mr. Grubbs stated, "We feel we have acted in good faith in regard to Mrs. Lowry's purchases". With these statements providing a frame of reference, we may deduce that the Company maintains an unusually liberal approach toward its definition of what constitutes acceptable or standard business practice.

The Company has concluded that no mistreatment took place in the sale of twelve separate, largely unnecessary, insurance policies within a two year period and the resultant creation of a financial burden in annual premiums amounting to $9,158.61 or approximately 68% of the elderly client's income. No mistreatment occurred in the preparation of applications and sale of two undesired policies on the lives of adult sons, nor in the non-delivery of these and other policies. The presence of two or three aggressive young Agents during a sales visit would not, from the Company's viewpoint, constitute inappropriate pressure tactics. Overinsurance with new Bankers policies did not occur, according to the Company, despite the existence of a variety of Health coverages and more than adequate Life coverage with other companies. Finally, within the same context, the Company possibly intended no mistreatment in its action of an abrupt, unrequested

cancellation of all Health insurance coverages for this client. It is fortunate, indeed, that most business firms have a much more conservative attitude in regard to acceptable business practices and factors which would represent mistreatment, particularly with respect to dealings with senior citizens.

Despite the Company's apparent conviction that no mistreatment occurred within its business relationship with Mrs. Lowry, a decision was reached to cancel and refund all thirteen policies then in force although cancellation had been requested only on four of the most expensive coverages. Mr. D. says, "We made the refund as an accommodation for Mrs. Lowry, considering her apparent present circumstances." For the record, Mrs. Lowry's "present circumstances," as of December 5, were no worse than they had been in September when the complaint alleging oversale was first filed with Ohio authorities and the Company was notified. This relatively minor point is mentioned only to show the time frame within which the Company apparently experienced a change of heart; a period wherein the Company became aware of the interest and concern, on the part of Federal officials and consumer oriented groups, for a satisfactory resolution of Mrs. Lowry's problem and complaint. The fact is that the only "accommodation" offered by the Company, during the October 13 meeting, involved the cancellation and refund of the two fraudulently created policies, a thirty day grace period for the family to consult and render a decision as to which policies of the program would be maintained, and a suggested "adjustment" to the program by lapsing the life policies.

While the two extremely expensive Life policies represented 70% ($6,455.00) of Mrs. Lowry's annual premium payments to the Company, the suggestion to lapse these was rejected. Though considered undesirable and unnecessary, it is common knowledge that Life policies which are lapsed within two or three years of their issue date provide a negligible return of the dollars invested due to their minimal cash value. Convinced that these policies represented the grossest example of overinsurance and exploitation, I requested rescission and full refund on these as a more appropriate and logical alternative or solution. In his December 5 letter, Mr. Grubbs chose to avoid mention of my alternative request and insinuated that my letter of November 3, containing the request, was never received. Surprisingly, he commented on my failure to "advise us if your mother wished to allow the two life policies on herself to lapse. We have not heard from you in this regard." After referring to the policies as fulfilling a "definite need", he said that, "a refund wouldn't be due under any rule or law". Yet, despite the various Company statements of righteous and correct behavior, of conviction that neither overinsurance nor mistreatment had occurred, a blanket cancellation and full refund for all policies was made, "as an accommodation for Mrs. Lowry, considering her apparent present circumstances".

This statement's suggestion of Company compassion and generosity is highly suspect in view of the earlier rigidity of their position. The "present circumstances" referred to were a direct result of Mrs. Lowry's deepening involvement with the Company and are a subject of discussion in paragraph #10. I submit that the Company's ultimate decision to "accommodate" and refund was motivated primarily by the desire to remove both itself and the problem issue from the focused attention of increasing numbers of concerned officials and observers. Certainly the Company was aware of the issue's appearance of: impropriety in the type and frequency of sales contacts with Mrs. Lowry; insurance oversale, in view of all prior existing coverage; and exploitation of a senior citizen's concerns and resources through the creation of a contractual burden equalling 68% of her annual income.

The "accommodation" made by the Company was offensive and petty in its seemingly vengeful cancellation of all coverage. It is imperfect in that the Company refuses to admit or recognize the occurrence of excesses in its sales contacts and contracts with Mrs. Lowry, to apologize to her for these excesses, and to provide assurances that the questionable practices will not be repeated with other elderly clients. The "accommodation" is incomplete due to its failure to address the issue of compensation for the anguish and actual expenses suffered by Mrs. Lowry in the effort to correct this problem situation, as detailed in Item #3 of my November 3 letter to the Coompany. Was this letter not received by the Company?

To prevent future abuses of the elderly in the sale of insurance programs, adequate safeguards must exist within the companies themselves and, in the

event of their failure, easily accessible and effective mechanisms for remedy are needed at the state and Federal level. Based upon our experience, effective safeguards are not utilized by this Company. I suggest that the mere refund of $14,100 will not serve as an adequate deterrent to future abuses, whereas a close monitoring and investigation of the Company's business practices would have a positive effect. Is this case history one of which the Company is proud?

Thank you for the opportunity to review the Company's letter of explanation. As has been repeatedly shown, the realities and facts of their business practices are very frequently at odds with their public relations pronouncements.

Sincerely,

ROBERT E. LOWRY.

---

BANKERS LIFE & CASUALTY CO.,
*Chicago, Ill., April 5, 1978.*

Attention: Mr. Fred L. Seaman, assistant deputy commissioner, consumer insurance information division.

Re: Lucille W. Lowry and Robert Lowry.

Hon. JOHN RANDOLPH INGRAM,
*Commissioner of Insurance, State of North Carolina, Raleigh, N.C.*

DEAR MR. SEAMAN: This will acknowledge your letter of March 29, 1978 with attachments concerning the captioned matter directed to Mr. Michael J. Dressendorfer, which has been handed to me for answer.

Please be advised that I have carefully reviewed your letter and attachments together with the file.

You have requested a response to 12 paragraphs of Mr. Lowry's undated letter to you, which is attached. I believe the answers to the questions posed by Mr. Lowry in his letter to you can be found in Mr. Dressendorfer's letter to you dated January 13, 1978.

Shortly after the advent of the federal legislation commonly lumped together and called Medicare, in 1966 Bankers Life and Casualty Company which as you know sells approximately 99% of its business through agents licensed in the state in which they operate, the Company decided to provide coverage of the initial deductible and co-insurance factors left uncovered by that legislation. As the Company gained experience in selling this coverage, rules were enacted governing the sale of products to those persons over the age of 65, in order to prevent abuses in the sale of insurance products to them. During the early 1970s, the company provided that the maximum allowable premium including substandard for all accident and health policies would be $35.00 monthly—since raised to $50.00.

We have established extensive computer systems involving a computer check of all in-force business' when a new application is received. Our agents are required to carefully review a prospective insured's current coverage and note such coverages on the application.

Incidentally, in the third paragraph of your above indicated letter, the statement that "agent R. M. is under investigation" is not correct; our records indicate he was terminated September 10, 1977.

As you point out in your letter, a refund for all policies sold to Mrs. Lowry has been made and the transactions herein occurred in another state, but in addition, I would like to emphasize that the State of Ohio in which the transactions occurred, made a complete investigation including a four-hour informal hearing, and found it unnecessary to take any disciplinary action against the Company.

It appears to me to be non-productive and inappropriate for either your Department or the Company to expend any further time and funds on this matter. I am certain that I don't need to remind you the administrative costs of answering correspondence and reviewing files becomes a factor in the computation of premium rates which the insurance-buying public of North Carolina must pay.

We have done our best to satisfy Mr. Lowry and to answer your questions, and regrettably no matter what we do, it doesn't appear to me that we will be able to satisfy Mr. Lowry.

Thank you for the time and attention you have given this matter.

Sincerely,

WILLIAM E. GRUBBS,
*Director of Government Relations.*

## Appendix 2

## ADDITIONAL MATERIAL SUBMITTED BY HAROLD R. WILDE [1]

ITEM 1. BOOKLET ENTITLED, "HEALTH INSURANCE ADVICE FOR SENIOR CITIZENS," PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

# HEALTH INSURANCE ADVICE
FOR
# SENIOR CITIZENS

THE PURPOSE OF THIS BOOKLET IS TO HELP SENIOR CITIZENS DECIDE WHETHER OR NOT TO PURCHASE PRIVATE HEALTH INSURANCE TO HELP SUPPLEMENT THE MEDICARE PROGRAM.

PLEASE READ IT CAREFULLY!

Prepared By

State of Wisconsin
Office of the Commissioner of Insurance
123 West Washington Avenue
Madison, Wisconsin 53702

1978

[1] See statement, page 75.

## INTRODUCTION

Medicare, and Medicare supplement insurance, are complicated. Don't be embarrassed if you have trouble understanding some items.

As you go through this booklet, jot down any questions that you may have. If the person trying to sell you a policy cannot answer those questions (and a good agent should be able to), feel free to contact the insurance company involved, your local Social Security office, or the Office of the Commissioner of Insurance.

IF YOU ALREADY HAVE INSURANCE TO SUPPLEMENT MEDICARE, PLEASE READ THE FOLLOWING VERY CAREFULLY!

* * * * *

### A WORD OF CAUTION ON REPLACING YOUR PRESENT POLICY.

A new state rule requires all Medicare Supplement policies to bear a special state-approved label and contain a minimum level of benefits. This rule is meant to make it easier for you to understand your health insurance needs and to compare health insurance policies you might purchase. But don't think that your old policy is inadequate or needs to be replaced, just because it isn't "up to date." Any decision to replace an old health insurance policy should be made extremely cautiously.

Replacing any health insurance policy with new insurance may subject you to new waiting periods and new exclusions for various health conditions.

## I. GENERAL INFORMATION ON MEDICARE SUPPLEMENT INSURANCE

Medicare supplement insurance is insurance sold by private insurance companies to fill in some of the "gaps" in the federal Medicare program. These "gaps" are outlined in detail on pages 7 to 9 of this booklet.

The following general information should be helpful to anyone who is considering the purchase of this type of insurance coverage.

### 1. MEDICARE SUPPLEMENT INSURANCE IS SOLD ONLY BY PRIVATE INSURANCE COMPANIES.

It is not sold or serviced by either the state or the federal government. Although the Office of the Commissioner of Insurance "approves" all policy forms used by insurance companies, it does not recommend particular companies or policies. Do not be confused by misleading advertising or by agents who suggest that Medicare supplement insurance is a government-sponsored program. If an insurance agent tells you he or she is from the government and later tries to sell you a policy, please report that agent's name to the Commissioner's office.

### 2. NOT EVERYONE NEEDS INDIVIDUAL MEDICARE SUPPLEMENT INSURANCE.

Anyone who is eligible for Medicaid (Title 19 - the federal medical assistance program for low-income people) does not need to purchase any private health insurance. This program pays almost all the health care costs for anyone who is eligible. To find out about your eligibility for Medicaid, contact your county social services department.

Many people have health insurance as part of a group while they are employed. If you are covered by a group plan, find out before you retire if this coverage can be continued or converted to suitable Medicare supplement coverage when you reach 65. If

your spouse is included in your group health plan, find out what happens if he or she reaches 65 before you do. Group insurance is usually less expensive and often provides more coverage than insurance purchased individually.

If you are eligible for Medicare (but not Medicaid) and do not have other insurance, you have two choices. The first is to rely entirely on Medicare and expect to pay any other health care costs yourself. These costs can be substantial for persons with long-term illnesses.

The second choice is to purchase an insurance policy to supplement Medicare. The types of policies which are currently available to supplement Medicare are described on pages 9 - 13. The coverage which is best for you depends primarily on the state of your health, and your ability to pay the necessary premiums.

3. NO INSURANCE POLICY WILL COVER EVERYTHING WHICH MEDICARE DOES NOT.

Medicare excludes certain types of medical expenses. So do Medicare supplement policies. Some items which are frequently excluded from Medicare supplement policies are: Private duty nursing, routine check-ups, eye glasses, hearing aids, dental work, cosmetic surgery, custodial care in nursing homes, psychiatric care and self-administered drugs. (An exception to this is a Medicare Supplement I policy - explained on page 10 - which offers some coverage for prescription drugs and psychiatric care.)

MEDICARE PAYS ONLY FOR CHARGES WHICH ARE CONSIDERED "USUAL AND CUSTOMARY" AND SERVICES WHICH ARE CONSIDERED "REASONABLE AND NECESSARY." MOST MEDICARE SUPPLEMENT POLICIES FOLLOW MEDICARE GUIDELINES.

This means that:

a. If you are charged more for a service than Medicare thinks is reasonable, neither Medicare nor your insurance policy will pay the difference. For example, if a surgeon charges you $400 for an operation and Medicare decides $300 is a reasonable charge, Medicare will pay 80% of $300, the insurance company will pay 20% of $300 -- You will be left with the difference. That is, you will have to pay the difference between the actual and the reasonable charge. (Before paying this amount, you may want to contact your doctor and see if he or she will reduce the charge.)

b. If you receive a service which is not considered medically necessary by Medicare (cosmetic surgery, for example) most insurance policies will not cover this expense.

4. TRY TO PURCHASE ONLY ONE MEDICARE SUPPLEMENT POLICY.

Purchasing the most complete Medicare supplement policy which you can afford is much better than purchasing several incomplete policies. Duplicating coverage is both costly and unnecessary.

5. SHOP AROUND.

Try to talk to several agents and companies before deciding which policy is best for you. The POLICY CHECKLIST on the inside back cover will help you keep track of the coverage and cost of each policy.

6. THE LAW REQUIRES AN AGENT TO LEAVE YOU AN OUTLINE OF COVERAGE WHEN SELLING YOU A POLICY.

The Outline of Coverage is very important. Read it carefully! It should contain the following information:

a. A clearly worded chart which summarizes the benefits provided by Medicare Parts A and B, and the Medicare supplement benefits provided by the policy -- and indicates what expenses are not covered by either.

b. The name and address of the company.

7. MANY MEDICARE SUPPLEMENT POLICIES ARE WRITTEN WITH WAITING PERIODS AND LIMITATIONS AND EXCLUSIONS.

Many health insurance policies have some waiting periods before coverage begins. This may apply to illnesses or physical disorders which are new or which existed prior to the purchase of the policy, or both.

Many policies exclude coverage for pre-existing conditions completely -- others for a limited period of time only. Sometimes if you have a medical history involving a particular health problem, the insurance company will not insure you for expenses connected with that problem. If that is the case, the insurance policy will have a separate page attached when you receive it. The condition which is to be excluded must be identified specifically on this page.

If the policy excludes pre-existing conditions for a limited period of time, this information must be clearly stated in the policy. The waiting period for coverage of pre-existing conditions cannot be longer than 12 months if the condition has not been explicitly excluded from coverage. General information on exclusions may also be included in the "definitions" and "limitations and exclusions" section of the policy.

* * * * * * * * *

REMEMBER

BE SURE TO ASK THE AGENT ABOUT THE LIMITATIONS AND EXCLUSIONS OF THE POLICY AS WELL AS ANY WAITING PERIODS BEFORE COVERAGE BEGINS.

8. OMITTING SPECIFIC MEDICAL INFORMATION REQUESTED ON YOUR APPLICATION CAN BE VERY COSTLY.

DO NOT BE MISLED BY AGENTS WHO INDICATE THAT YOUR MEDICAL HISTORY ON AN APPLICATION IS NOT IMPORTANT.

When you complete an application for individual health insurance which includes medical information, be sure that all medical questions are answered completely and accurately. If an agent helps you fill out the application, do not sign it unless you have had a chance to read it and make sure that all the medical information requested is included. If you omit medical information and the insurance company finds out about it later, the company may deny your claim and/or terminate the policy.

9. POLICIES WHICH CAN BE RENEWED AUTOMATICALLY OFFER AN ADDED PROTECTION.

Be sure and ask the agent or company about the "renewability" of the policy.

10. MAKE CHECKS PAYABLE ONLY TO THE INSURANCE COMPANY. DO NOT PAY CASH OR MAKE A CHECK OUT TO THE AGENT.

And be sure you have the agent's name, address and Wisconsin agent's license number and the name and address of the company from whom you are purchasing the policy.

11. EVERY INDIVIDUAL HEALTH INSURANCE POLICY PURCHASED IN THE STATE OF WISCONSIN COMES WITH A GUARANTEED 10-DAY FREE LOOK.

State law gives you 10 days after you actually receive a policy to make sure it's right for you. If you are at all dissatisfied with it, you can return it to the company and receive a full refund of your premium.

You should use these 10 days to:

a. Read the policy carefully and make sure it offers the benefits you expected, and

b. Check for any limitations, exclusions or waiting periods. If specific medical conditions are to be excluded from coverage, this is the time you will find out about it.

If the language is too difficult to understand, ask someone who understands insurance to help you figure out what the policy is offering.

If the application is part of the insurance contract, you will receive a copy of it with the policy. Read it carefully to make sure that it has not been changed in any way and that all the medical information is completely accurate.

12. POLICY DELIVERY, AND REFUNDS ON POLICIES SHOULD BE MADE PROMPTLY BY INSURANCE COMPANIES.

If you do not receive your policy within a month, or if there is a delay in receiving a refund, call or write the insurance company and inform them of your problem.

13. BE VERY CAREFUL WHEN PURCHASING INDIVIDUAL HEALTH INSURANCE FROM AGENTS OR COMPANIES WHOSE NAMES ARE UNFAMILIAR TO YOU.

14. KEEP A COPY OF YOUR HEALTH INSURANCE POLICY (and any other insurance policies) IN A SAFE PLACE.

It is a good idea to choose someone ahead of time who can take over your affairs in case of a long-term or serious illness. This person should know where all your records are kept.

## II. EXPLANATION OF MEDICARE AND MEDICARE "GAPS."

Medicare is the health insurance program administered by the Social Security Administration for people over 65 and some people who are disabled. It is designed to pay many, but not all, of the health care costs incurred by senior citizens and other eligible persons. The chart below gives a brief outline of those costs which Medicare does and does not pay.

A booklet entitled Your Medicare Handbook is available free from any Social Security office. It gives a detailed explanation of Medicare and how it works. Read it carefully before purchasing any supplemental insurance!

Medicare is divided into two types of coverage: Hospitalization Insurance (Part A) which pays hospital bills and Medical Insurance (Part B) which pays doctors' bills and some other charges. Compare the items Medicare will not pay with the supplemental insurance policy you are considering to see how many "gaps" are covered. The deductible figures are for 1978 only and are subject to change periodically.

REMEMBER: MEDICARE IS WRITTEN WITH INITIAL PAYMENTS (DEDUCTIBLES) FOR WHICH THE INDIVIDUAL IS RESPONSIBLE.

If you can afford to pay these deductibles out-of-pocket, the savings you will realize in paying for supplemental insurance policies may be considerable (i.e., having these deductibles covered by an insurance policy will result in a higher premium than for similar policies which do not cover deductibles). The policies discussed in Section III may or may not cover these deductibles.

## PART A - HOSPITAL INSURANCE BENEFITS

HOSPITAL IN-PATIENT (Semi-private Room and Board, General Nursing, and Miscellaneous Hospital Services)
FOR EACH BENEFIT PERIOD

| | |
|---|---|
| First 60 Days: | YOU PAY THE FIRST $144.00 IN EACH BENEFIT PERIOD. Medicare pays the balance. |
| 61st - 90th Day: | YOU PAY $36.00 PER DAY. Medicare pays the balance. |
| 91st - 150th Day: (60 Day Life Time Reserve Period): | YOU PAY $72.00 PER DAY DURING THE RESERVE PERIOD. Medicare pays the balance. |
| Beyond 150th Day (or when your reserve days are exhausted) | YOU PAY ALL COSTS. |

POST HOSPITAL CARE (In a facility approved by Medicare, provided you have been in the hospital for three days, go to the approved facility within 14 days and meet several other conditions.) MEDICARE DOES NOT PAY FOR CARE WHICH IS CUSTODIAL ONLY. VERY FEW PATIENTS IN NURSING HOMES QUALIFY FOR MEDICARE BENEFITS!

NURSING HOME CARE

| | |
|---|---|
| First 20 Days: | Medicare pays the entire cost. |
| Next 80 Days of Continuous Confinement | YOU PAY $18.00 PER DAY. Medicare pays the balance. |

HOME HEALTH CARE

| | |
|---|---|
| Home Health Care (after Hospital Confinement) | YOU PAY FOR VISITS BEYOND 100 AND ANY SERVICES NOT COVERED BY MEDICARE. Medicare pays for 100 visits per benefit period (if you qualify). |
| Blood | YOU PAY FOR FIRST 3 PINTS. Medicare pays the balance. |

PART B - MEDICAL INSURANCE BENEFITS

| | |
|---|---|
| Physicians Services<br><br>Inpatient Services<br><br>Outpatient Medical Services and Supplies at a hospital<br><br>Outpatient Physical and Speech Therapy<br><br>Ambulance | EACH CALENDAR YEAR YOU PAY A $60.00 DEDUCTIBLE AND 20% OF ALL REASONABLE CHARGES. Medicare pays the balance.<br><br>NOTE: YOU ARE FULLY RESPONSIBLE FOR THOSE CHARGES WHICH MEDICARE DECIDES ARE NOT REASONABLE AND NECESSARY. |
| Prescription Drugs | YOU PAY FOR SELF-ADMINISTERED PRESCRIPTION DRUGS AND NON-PRESCRIPTION DRUGS. Medicare pays for all drugs administered by trained professionals. |
| Home Health Care | YOU PAY FOR VISITS BEYOND 100 AND NON-COVERED SERVICES. Medicare pays for 100 visits per year (if you qualify). |
| Dental Care, Eye Care, Hearing Aids, Routine check-ups | YOU PAY FOR ALL THESE ITEMS. |
| Blood | YOU PAY FOR THE FIRST 3 PINTS AND 20% AFTER THAT. Medicare pays for 80% after first 3 pints. |

## III. MEDICARE SUPPLEMENT INSURANCE: CATEGORIES 1 THROUGH 4

The Office of the Commissioner of Insurance recently adopted a rule which establishes four categories of Medicare supplement insurance policies.

The purpose of this rule is to help senior citizens who are purchasing Medicare supplement insurance choose the policy which is most appropriate for their needs. The rule provides for easily understandable categories of Medicare supplement insurance and appropriate benefit standards for each of these categories.

All policies sold in Wisconsin for the purpose of supplementing Medicare must now fit into one of four categories and be appropriately labeled. NO POLICY SHOULD BE PURCHASED TO SUPPLEMENT MEDICARE WHICH IS NOT LABELED AS A MEDICARE SUPPLEMENT 1, 2, 3, 4a or 4b. A "1" policy is the most complete (and most expensive) policy. Policies numbered "2" and "3" are progressively less complete (and probably less costly). A "4a" policy supplements Part A of Medicare only. A "4b" policy supplements Part B of Medicare only.

REMEMBER:

1. The benefits provided in these policies will generally be tied to Medicare benefits. Few, if any, will pay expenses not considered "reasonable and necessary" or "usual and customary" by Medicare. The charts on pages 12 and 13 give detailed information on what is or is not covered by each policy. Keep in mind that these are minimum standards. Some policies may be sold with extra benefits.

2. Most of the policies are written with maximum dollar amounts or day limits. If these limits are reached, you are responsible for any additional costs.

3. Policies in any of the categories may or may not cover the initial deductibles under Medicare Part A and Part B. Keep in mind that including the initial deductible increases the cost of the policy by a substantial amount.

MEDICARE SUPPLEMENT I

A policy labeled "I" is the most complete Medicare supplement policy. It will pay most of your medically necessary health care expenses left unpaid by Medicare. In addition, these policies will cover most prescription drug expenses and some psychiatric treatment costs.

The minimum limits for a Medicare Supplement I are:

a. $22,500 per benefit period for both Part A and Part B; or

b. $15,000 per benefit period for Part A and $7,500 per year for Part B.

MEDICARE SUPPLEMENT 2

Policies in this category supply major, broad-based protection against catastrophic and less serious illnesses. Number "2" policies do not have to pay and usually do not pay for prescription drugs or psychiatric treatment.

The minimum limits for a "2" policy are:

a. $15,000 per benefit period for both Part A and Part B; or

b. $10,000 per benefit period for Part A and $5,000 per year for Part B.

"2" policies cover almost as wide a range of items as "I" policies, but the maximum you can collect will usually be lower for a "2" than a "I" policy. A "2" policy need not cover blood, prosthetic devices, durable medical equipment (home oxygen, wheelchairs, etc.), prescription drugs or extensive outpatient psychiatric care.

REMEMBER

* * * * * * * * * * * *

THESE ARE MINIMUM BENEFITS. INSURANCE COMPANIES MAY CHOOSE TO PROVIDE EXTRA BENEFITS ON SOME POLICIES.

MEDICARE SUPPLEMENT 3

The coverage for a category "3" policy is selective but substantial. A "3" policy will pay many of the most important expenses not covered by Medicare.

A "3" policy need not cover home health care without previous hospitalization, drugs which are not self-administered, outpatient speech therapy, certain diagnostic tests, independent lab tests, surgical dressings, prosthetic devices, durable medical equipment, blood, prescription drugs or extensive outpatient psychiatric care.
The minimum limits for a "3" policy are:

a. $6,500 per benefit period for both Part A and Part B; or

b. $5,000 per benefit period for Part A and $1,500 per year for Part B.

MEDICARE SUPPLEMENT 4

This category includes two types of limited or specialized policies.

"4a" policies provide payments for Medicare Part A (hospital) expenses only. A 4a policy will pay up to a maximum of $15,000 per benefit period for Part A expenses. There is no coverage for Part B expenses.

"4b" policies supply broad coverage of Medicare Part B (medical) expenses. There is no coverage for Part A expenses. Coverage extends to at least $7,500 per year. "4b" policies are not required to cover prescription drugs or extensive outpatient psychiatric care. There also may be a large deductible in "4b" coverage - up to $500 per year. This decreases the cost of the policy but makes the policyholder liable for most of the medical expense of a short illness.

## FOUR CATEGORIES OF MEDICARE SUPPLEMENTS COMPARED

Caution: This chart outlines <u>Minimum</u> Provisions. It does not show variations among policies in each category or the options, deductibles and exclusions which could affect your coverage.

| MEDICARE PART A LIMITS: | M.S. 1 $15,000 | M.S. 2 $10,000 | M.S. 3 $5,000 | M.S. 4a $15,000 | M.S. 4b |
|---|---|---|---|---|---|
| | YOU MAY HAVE TO PAY THE INITIAL DEDUCTIBLE FOR EACH BENEFIT PERIOD | | | | |
| 1. Hospitalization to 90th day | Yes | Yes | Yes | Yes | NO COVERAGE |
| 2. 60 Extra Hospital days-usable once | Yes | Yes | 30 days only | Yes | ↓ |
| 3. Skilled Nursing Facility after Hospital | Yes | Only to 100th day | Only to 100th day | Yes | ↓ |
| 4. Health care at Home after Hospital | Yes | Yes | No | Yes | ↓ |
| 5. Blood: First 3 pints | Yes | No | No | Yes | ↓ |
| 6. Custodial or rest care in nursing facility or at home | No | No | No | No | ↓ |

32-703 O - 78 - 9

| MEDICARE PART B | M.S. 1 | M.S. 2 | M.S. 3 | M.S. 4A | M.S. 4B |
|---|---|---|---|---|---|
| LIMITS: | $7,500<br>You may have to pay up to $60.00 deductible per year | $5,000 | $1,500 | | $7,500<br>Up to $500 deductible per yr |
| 1. Physicians Services, Hospital or Office (Excluding office routine exams) | Yes | Yes | Yes | NO COVERAGE | Yes |
| 2. Health Care at Home without previous hospitalization | Yes | Yes | No | | Yes |
| 3. Outpatient Services at Hospital: Emergency Room Lab Tests X-rays Medical Supplies | Yes | Yes | Yes | | Yes |
| Drugs (not self-administered) | Yes | Yes | No | | Yes |

| | | | | |
|---|---|---|---|---|
| 4. Outpatient Speech Therapy | Yes | Yes | No | Yes |
| 5. Other Services & Supplies: (Diagnostic, X-ray at home) | Yes | Yes | No | Yes |
| Ambulance (if Medicare approved) | Yes | Yes | Yes | Yes |
| Independent Lab Tests | Yes | Yes | No | Yes |
| Surgical Dressing | Yes | Yes | No | Yes |
| Prosthetic Devices (Organ substitutes) | Yes | No | No | Yes |
| Durable Medical Equipment (prescribed) | Yes | No | No | Yes |
| 6. Blood: First 3 pints + 20% | Yes | No | No | Yes |
| 7. Prescription Drugs | At least 75% | No | No | No |
| 8. Psychiatric Services (outpatient) | 50% up to Max. of $1,000 | 50% up to $500 | 50% up to $500 | 50% up to $500 |

## IV. LIMITED POLICIES: Nursing Home, Hospital Confinement Indemnity, and Specified Disease

THE POLICIES DISCUSSED BELOW ARE ALL LIMITED IN NATURE: They are not adequate substitutes for the broader health care protection provided in a Medicare supplement policy.

1. Nursing Home Coverage. Most coverage for confinement in a nursing facility which is included in a Medicare supplement policy is for Skilled Nursing Facilities approved by Medicare. Although the number is growing, there are few of these in Wisconsin at this time.

If you buy a separate policy for nursing home care (not a Medicare supplement policy), the coverage or reimbursement must be effective for any nursing home licensed by the State of Wisconsin which provides skilled nursing care. However, such policies are not related to Medicare in any way and you must be careful that the policy fits your overall needs. REMEMBER: LENGTHY CONFINEMENT IN A HOME WHICH INVOLVES REST CARE OR CUSTODIAL CARE (CARE THAT DOES NOT REQUIRE MEDICAL TREATMENT) RATHER THAN SKILLED NURSING CARE IS NOT COVERED UNDER ANY POLICY ON THE MARKET TODAY.

2. Hospital Confinement Indemnity Insurance. Hospital confinement indemnity insurance policies pay a fixed amount per day for a specific number of days and may not pay if you have Medicare or other coverage. Hospital confinement indemnity coverage frequently is not effective until after you have been hospitalized for a specified period of time. Such policies are not related to Medicare and may not be necessary if you have a good Medicare supplement policy.

3. Specified Disease Coverage: Policies which protect the insured person from a single disease or group of specified diseases are not Medicare supplements. The value of such coverage depends on the chance that you will contract the specific disease covered. Although some diseases covered by such policies are not rare (cancer or heart disease, for example), many are uncommon. These policies should not be purchased as an alternative to Medicare supplement insurance. Any specified disease policy should have the words "This is a Limited Policy - Read it Carefully" printed on the face of the policy.

## V. HOW TO FILE A CLAIM

In order to get the most from your Medicare supplement insurance policy after you purchase it, it is important to file a claim properly. The following checklist should be helpful.

1. Keep an accurate record of all your health care expenses. It is probably a good idea to keep the record with your health insurance policies.

2. Whenever you receive treatment, make sure to present both your Medicare card and any other insurance cards which you have.

3. File all claims promptly. With each claim payment from Medicare, you will receive an "Explanation of Benefits." If the insurance company requests this in order to figure out its share of the cost, make a copy of it to send to the insurance company. When you send in a claim, write down the date you mail it. Keep copies of any information you have concerning services received, the dates of services and the person or persons who provided the services.

4. Many large clinics will provide a special billing to be submitted to your insurance company. If your physician does not, make sure that you are provided with an itemized bill. This bill should include the date, type of service, and amount charged for each service performed. There must also be a diagnosis, or "symptoms and complaints," for each item of expense.

5. Insurance companies will not accept clinic or hospital statements which show only the "balance due." You can speed up claim handling if you make sure any required claim form is completed properly, that itemized bills are attached and that copies of the Medicare Explanation of Benefit forms are submitted, if required.

If you have a specific complaint, refer it <u>first</u> to the insurance company involved. If you do not receive satisfactory answers from the company, please contact:

Office of the Commissioner of Insurance
123 West Washington Avenue
Madison, Wisconsin 53702 (608) 266-0103

<u>NOTICE</u>: The Wisconsin Association of Life Underwriters conducts periodic counseling sessions for senior citizens. Please contact:

Wisconsin Association of Life Underwriters
4513 Vernon Boulevard
Madison, Wisconsin 53711 (608) 233-7085

for more information about this program.

Other sources of information are Social Security offices and county Social Services departments located throughout the state.

## POLICY CHECKLIST

Name of Company/Agent:

Type of Policy:

Cost of Policy:

Limits of Policy: Part A ________
Part B ________
Total ________

| Part A (Hospital) | | YES | NO |
|---|---|---|---|
| Hospitalization | | | |
| Initial Deductible | ($144) | | |
| 61 - 90th Day | ($36) | | |
| 60 Reserve Days | ($72) | | |
| Nursing Home 21 - 100th Day | ($18) | | |
| Home Health Care (after hospitalization) | | | |
| Blood | | | |
| **Part B (Medical)** | | | |
| Physicians Services | | | |
| Home Health Care (without hospitalization) | | | |
| Outpatient Services (which ones) | | | |
| Other Services & Supplies | | | |
| Ambulance | | | |
| Lab Tests | | | |
| Surgical Dressing | | | |
| Prosthetic Devices | | | |
| Durable Medical Equipment | | | |
| Blood | | | |
| Prescription Drugs | | | |
| Psychiatric Services | | | |
| Extra Benefits of policy | | | |

ITEM 2. "OUTLINE OF COVERAGE" LETTERS REQUIRED AND APPROVED BY THE WISCONSIN INSURANCE COMMISSIONER

## OUTLINE OF COVERAGE — POLICY FORM LIC-6030 W

Retain for your records

# MEDICARE SUPPLEMENT 3 POLICY

The Wisconsin Insurance Commissioner's Office has established four categories of Medicare Supplement Insurance and Minimum benefit standards for each. These range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review this Outline of Coverage provided you.

**READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!**

**This outline of coverage, including the following chart, provides a very brief description of some of the important provisions of Medicare as they apply for the calendar year 1978. We suggest that you get in touch with your local Social Security Office or obtain one of their publications to obtain more complete and current details of the coverage provided.**

**Neither ITT Life nor its representatives are in any way connected with the Federal Medicare Program or Social Security Administration.**

**ITT Life Insurance Corporation**

HOME OFFICE: THORP, WI 54771 (715) 669-5405
EXECUTIVE AND MARKETING OFFICE: MINNEAPOLIS, MN 55426 (612) 545-2100

APPROVED
JAN 13 1978
INDIVIDUAL A & H
INSURANCE DEPARTMENT
STATE OF WISCONSIN

Toll Free Customer Service Telephone 1-800/826-6941

OOC-6030-W 1/78

# GUARANTEED RENEWABLE-ADJUSTABLE PREMIUMS

Your policy is renewable for your entire lifetime by the payment of premiums in effect at the time of renewal.

There are two things that could cause your premium to be different than it was at the time your policy was issued. They are:

1. The dollar amounts shown in the chart on the following page are based upon Medicare regulations for the calendar year 1978. These amounts may vary from year to year, but your ITT Life policy is designed to adjust to these variations so that the amounts shown in the columns "% Covered" should always remain the same. Of course, your premium will also vary up or down to reflect such changes, but any future premium will be based on your age when your policy was issued and in direct proportion to the benefit adjustment.

2. ITT Life may also adjust premiums based upon the loss experience within your state but only if the identical adjustment is made on all policies in your state that bear form LIC-6030 W. Adjustment can never be made based upon your individual experience.

# MAXIMUM BENEFITS

PART A - The maximum benefit payable for Part A Expenses is $50,000. per benefit period. A benefit period begins on the first day you are hospitalized and ends when you have not been confined to a Hospital or Nursing Home for 60 consecutive days, at which time your full maximum benefit amount of $50,000. is restored.

PART B - The maximum benefit payable for Part B expenses is $5,000. per calendar year beginning on January 1st and ending on December 31st. Each calendar year stands on its own with a new $5,000. maximum benefit amount.

# PRE-EXISTING CONDITIONS

The following pre-existing conditions will not be covered for the first six months your policy is in force, but will be covered thereafter:

1. Conditions which have been diagnosed or treated in the 24 months prior to the policy effective date.

2. The presence of symptoms which ordinarily would cause a person to seek medical advice and which occur within 12 months of the policy date.

# NOT COVERED

Policy benefits payable will not duplicate any benefits payable by Medicare. Your policy also does not cover:

1. War or act of war, whether declared or not;
2. Dental care, unless required as the result of injury to sound natural teeth;
3. Cosmetic surgery unless required as the result of an accidental injury;
4. Routine physical examinations or immunizations, eye glasses or eye examinations for the purpose of prescribing eye glasses, hearing aids or examinations for prescribing hearing aids;
5. Orthopedic shoes or other supportive devices for the feet;
6. Personal comfort items;
7. Injury or sickness for which benefits are provided by Workers Compensation or Employer's Liability Laws;
8. Outpatient treatment for: mental disease or disorder as shown in Part VI, Paragraph 2, in your policy.

There may be instances where all costs of an Extended Care Facility (Skilled Nursing Home) will not be covered. The chart on the next page shows the conditions that must be met for Medicare participation.

EXTENDED CARE ALTERNATE BENEFIT. If your confinement to an Extended Care Facility (Skilled Nursing Home) does not qualify for Medicare participation, you may still be eligible to have your policy help pay for the first 30 days. The daily benefit payable will be that established by the Wisconsin Department of Health and Social Services. Your confinement must begin within 24 hours of hospital discharge and be certified as necessary by a physician.

ADDITIONAL BENEFITS. Your policy will have benefits for tuberculosis and kidney disease attached by rider in accordance with Wisconsin statutes.

THIS CHART IS ONLY A BRIEF DESCRIPTION OF MEDICARE AND YOUR POLICY.

For further details, conditions and limitations you may consult:

- for Medicare — your local Social Security Administration Office.
- for ITT Life's policy — the policy itself (Form LIC-6030-W).

| | ITEMS OF MEDICAL EXPENSE | MEDICARE | YOUR ITT LIFE POLICY | | combined % covered | REQUIREMENTS | NOT COVERED |
|---|---|---|---|---|---|---|---|
| HOSPITAL INSURANCE — PART A OF MEDICARE | Hospital Confinement Room, Board, Miscellaneous and general nursing care | | | ITT Life pays to maximum of $50,000 per benefit period | | | |
| | First 60 days | Medicare pays all but first $144 | ITT Life pays first $144 | | 100 | You must be eligible for Medicare. | |
| | 61st to 90th day | Medicare pays all but $36 per day | ITT Life pays $36 per day | | 100 | | |
| | 60 reserve days | Medicare pays all but $72 per day | ITT Life pays $72 per day | | 100 | | Medicare reserve once used not rep |
| | 151st day and thereafter | No Payment | ITT Life pays 100% (daily room and board limited to semi-private rate). | | 100 | | Portion of expense exceeds $50,000 one benefit period |
| | Extended Care Facility (Skilled Nursing Home) First 20 days | Medicare pays all | No Payment | | 100 | The facility must be Medicare participating and the 5 conditions below met. | Neither Medicare ITT Life will pay fo care which is cust or rest care. |
| | 21st to 100th day | Medicare pays all but $18 per day | ITT Life pays $18 per day | | 100 | ITT Life does not require Medicare participating facility. See alternate benefit. | |
| | Home Health Care (post-hospital nursing/therapy) | Pays full cost up to 100 eligible visits per benefit period. | No Payment | | 100 | | Visits over 100 pe benefit period |
| | Blood — 1st 3 pints | No Payment | ITT Life pays up to $35 per pint | | 100 | | Excess of $35 per |
| | After 3 pints | Medicare pays all | No Payment | | 100 | | |
| MEDICAL INSURANCE — PART B OF MEDICARE | Initial Deductible In Hospital | No Payment | ITT Life pays $60 | ITT Life pays to maximum of $5,000 per calendar year | 100 | Must be enrolled and pay premiums to Medicare. | |
| | Out Patient | No Payment | No Payment | | 0 | ITT Life does not require that you be enrolled in part B Medicare | |
| | Home Health Care Service (Nursing/Therapy) | Pays full cost up to 100 eligible visits per year | No Payment | | 100 | | Visits over 100 per year |
| | Outpatient Services (hospital, office, home) physicians, emergency room, lab, x-ray, radiology, splints, casts, dressings, etc., drugs not self-administered, ambulance | 80% of reasonable cost | 20% of reasonable cost | | 100 | | |
| | Speech and Physical Therapy | 80% of reasonable cost | No Payment | | 80 | | 20% of reasonable cost |
| | Prosthetic Devices | 80% of reasonable cost | No Payment | | 80 | | 20% of reasonable |
| | Durable Medical Equip. | 80% of reasonable cost | No Payment | | 80 | | 20% of reasonable |
| | Blood 1st 3 pints | No Payment | No Payment | | 0 | | No payment unless hospitalized. |
| | Blood after 3 pints | Pays All | No Payment | | 100 | | |
| | Prescription Drugs | No Payment | No Payment | | 0 | | Total Cost |
| | Psychiatric Services | Physicians limit of $250 per year | No Payment | | limited | | Excess of $250 per year |

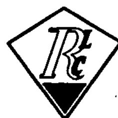
Both Medicare and ITT Life base payment on charges that are considered reasonable and necessary. The chart above is based on "reasonable and necessary charges. If Medicare or ITT Life were to disallow all or part of any charge as not being reasonable and necessary, then, of course, the percentage figures above would be different.

Conditions for Medicare payment in Skilled Nursing Facility.

1. Must follow 3 days of hospital confinement.
2. Must be for the same condition that required hospital confinement.
3. Must enter within 14 days of hospital discharge.
4. Your doctor must certify that you need and receive the daily care provided by the facility.
5. The facility's Utilization Review Committee or Professional Standards Review Organization approves of your stay.

APPROVED
JAN 4 1978
INDIVIDUAL A & H
INSURANCE DEPARTMENT
STATE OF WISCONSIN

**Reliable Life and Casualty Company**
**Madison, Wisconsin**



OUTLINE OF COVERAGE FOR RELIABLE'S

# MEDICARE SUPPLEMENT 3

The Wisconsin State Insurance Commissioner's Office has established four categories of Medicare Supplement insurance and minimum benefit standards for each. These categories range from the most comprehensive (Medicare Supplement 1) to the least comprehensive (Medicare Supplement 4). For an explanation of the differences between this "3" policy and policies in the other categories, consult the Commissioner's pamphlet "Health Insurance Advice for Senior Citizens" which you received with the application for this policy. Do not buy this policy if you did not get this pamphlet and were not given a chance to review the Outline of Coverage provided you.

Reliable is an insurance company offering insurance to supplement Medicare's hospital, medical, surgical and skilled nursing home benefits.

## NEITHER RELIABLE NOR ITS AGENTS ARE IN ANY MANNER CONNECTED WITH MEDICARE.

### THINGS YOU SHOULD KNOW ABOUT MEDICARE AND RELIABLE'S GR 645

**Unnecessary Charges**
Neither Medicare nor Reliable will pay for charges which Medicare considers unnecessary.

**Unreasonable Charges**
Medicare will not pay for charges it considers unreasonable. Reliable will pay its full share of the actual charges you incur.

**Expenses Not Covered by Medicare**
Certain types of expenses are not covered at all by Medicare, such as: routine physical examinations; eyeglasses or hearing aids or examinations for them; prescription or non-prescription drugs you buy yourself; self-administered injections; and others. Neither Medicare nor Reliable will pay benefits for these types of expenses.

**What is a Skilled Nursing Home?**
Under the Medicare program, a Skilled Nursing Home is an institution or a portion of an institution certified as a Skilled Nursing Facility by Medicare.

Under Reliable's GR 645, a Skilled Nursing Home is an institution or a portion of an institution which is licensed in your State to provide Skilled Nursing Care and which regularly engages in providing such care. Under Reliable's policy definition, the institution need not be certified by Medicare as a Skilled Nursing Facility.

Under both Medicare and Reliable, a Skilled Nursing Home does not include an institution or a portion of an institution which is licensed to provide a lesser degree of care such as intermediate, residential, personal, boarding, or custodial care.

To determine whether an institution is certified by Medicare as a Skilled Nursing Home, check with the Administrator of the institution or with the Social Security Administration. To determine whether a Skilled Nursing Home is licensed in your state to provide Skilled Nursing Care, check with the Administrator of the institution or with the State Department of Health and Social Services.

**What Skilled Nursing Care is covered by this Policy?**
Not all nursing home expenses are covered by this Policy. Neither Medicare nor this Policy will pay for custodial or rest care. To be covered by this Policy, Skilled Nursing Care must: (1) be care regularly and customarily given inpatients of a Skilled Nursing Home; (2) be under the supervision of a graduate registered nurse; (3) include the keeping of your medical records on a daily basis; (4) be based on a planned program of observation and treatment by a physician; (5) include a physical examination given to you at least once every 30 days by a physician; and (6) include certification by a physician (other than a podiatrist) that you need on a daily basis and actually receive services or care which as a practical matter can be provided only in a Skilled Nursing Home on an inpatient basis.

**Exceptions and Limitations under Reliable's GR 645**
Reliable's plan does not cover: (1) plastic surgical operations for cosmetic purposes, (2) dental care except surgery of the jaw or the setting of fractures of the jaw or facial bones, (3) simple rest or custodial care, (4) outpatient care for mental illness or disorders, (5) war, declared or undeclared, or (6) that part of any covered expense payable by Medicare or any other government health program, workmen's compensation law or any other law of the United States or a State.

**Pre-existing Conditions**
There is no coverage for a loss commencing during the first 365 days after the effective date of the policy if caused by a condition existing prior to the effective date of the policy.

**Renewability**

This policy is Guaranteed Renewable for your lifetime at the rates in force at the time of renewal. If the premium is paid on time, Reliable cannot reduce any benefit period or amount, or add any restrictive provision whatsoever.

**Tuberculosis and Kidney Disease Treatment**

Additional benefits may be payable under rider Form 246R attached to your policy.

**Maximum Stated Benefits**

Maximum Benefits payable by Reliable's GR 645:
To Supplement Medicare Part A: $25,000 per benefit period
To Supplement Medicare part B: $1,500.00 per calendar year

**Here is a summary of benefits paid by Medicare and Reliable's GR 645**

| | Not covered By Either Medicare or GR 645: | GR 645 Will Pay, To Stated Maximums: | Medicare Will Pay: |
|---|---|---|---|
| **MEDICARE PART A ELIGIBLE EXPENSES*** | | | |
| Hospitalization<br>First 60 Days (Initial Medicare Part A deductible of $144.00) | | $144.00 | the balance |
| 61st - 90th day | | $36.00 per day | the balance |
| 91st - 150th day (Lifetime Reserve Period) | | $72.00 per day | the balance |
| Beyond 150th Day (or when your Lifetime Reserve Days are exhausted) | 20% of hospital expense plus balance of daily Room and Board | 80% of Hospital Expense Other than Room & Board plus $50.00/day Room and Board | |
| Skilled Nursing Home (if confined in hospital 3 days in a row and within 14 days thereafter confined in a Skilled Nursing Home for covered Skilled Nursing Care of same sickness or injury) (If confinement is not covered by Medicare, first thirty days may be covered under Rider 288R.)<br>First 20 days | | | entire balance |
| 21st to 100th day | | $18.00 per day | the balance |
| Post-Hospital Home Health Care (per benefit period) | 100% beyond visits paid by Medicare Part A or B | | 100% of 100 visits per benefit period |
| Blood | First 3 Pints | | the balance after 1st 3 Pints |
| **MEDICARE PART B ELIGIBLE EXPENSES*** | | | |
| Yearly Deductible (1st $60.00) | $60.00 if incurred while not hospital confined | $60.00 if incurred while hospital confined | |
| Treatment by a Physician (other than by a member of your family)<br>Outpatient services billed by Hospital: Emergency Room and Outpatient Clinic (except physical therapy and speech pathology), Splints, Casts, Laboratory Tests, X-rays & Radiology<br>Ambulance | | 20% | 80% |
| Independent Lab Tests, X-Rays not Billed by Hospital, Outpatient drugs and biologicals which must be professionally administered, prosthetic devices, durable medical equipment used in your home, physical or speech therapy, surgical dressing. | 20% | | 80% |
| Blood (per year) | 1st 3 pints plus 20% of balance | | 80% after 1st 3 pints |
| Home Health Care | 100% beyond visits paid by Medicare Part A or B | | 100% of 100 visits per year (May pay in addition to Medicare Part A 100 visits.) |

***This chart, required by Wisconsin law, is only a brief description of Medicare. It assumes that: (1) the expenses stated are Medicare eligible expenses; (2) Medicare pays only reasonable and necessary charges; and (3) the Medicare Part B $60 yearly deductible is paid. This chart does not completely explain the details, conditions, or limitations of Medicare or the facts or circumstances under which Medicare benefits may or may not be payable. For further explanation of the details, conditions, and limitations of Medicare, do not rely on this chart but instead consult the U.S. Social Security Administration or its Medicare publications.**

This Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and the insurer.

## ITEM 3. EXCERPTS FROM PUBLIC TESTIMONY AT A HEARING OF NEW WISCONSIN INSURANCE RULES GOVERNING SALES OF MEDICARE SUPPLEMENTS, APRIL 20, 1976, BEFORE COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

### LT. GOV. MARTIN SCHREIBER

"Abuses have been reported to us on a regular basis and also reported to the State and other local consumer agencies. I don't think anything could be more revealing than the elderly person being sold supplemental coverage and then discovers its benefits do not cover medical costs of other major illness. Unfortunately, this kind of result has been the rule rather than the exception.

"Unfortunately (the elderly's), critical need for insurance protection has forced the elderly to seek and embrace almost any insurance policy that offers to fill in this medicare gap."

### STATE SENATOR TIM CULLEN, CHAIRMAN, WISCONSIN SENATE SPECIAL COMMITTEE ON AGING

"The unscrupulous agents and companies concentrate on the small towns and rural areas of Wisconsin where senior citizens are less likely to be active in senior citizen groups and be warned of potential abuses."

### JANE M. SADUSKY, INVESTIGATOR, CONSUMER FRAUD AGENCY, PORTAGE AND MARATHON COUNTY DISTRICT ATTORNEYS OFFICE

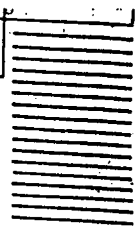
"Complaints reveal a pattern of sales practices characterized by misrepresentation, scare tactics, and pressure selling. These practices are common to certain firms that are the subject of recurring complaints.

"In the past month alone we have received 24 complaints and are in the process of interviewing complainants and obtaining statements.

"A salesman appeared unannounced and claims he had been referred to these people by their cousin. The complainants already had a supplemental policy and informed the salesman of this. He urged them to cancel it, claiming that the company was going to raise its rate without announcing it and it was in financial trouble and was likely to go broke within the year. . . . The salesman claimed that his company paid a $225 surgical deductible which medicare did not. When the complainant responded that she had never heard of such nor received any notice of it he insisted that the social security office was not telling people about it in order to 'rip them off.' When the complainant requested a brochure about the coverage he refused to provide anything on the grounds that insurance agents, like physicians, were not allowed to advertise."

ITEM 4. EXAMPLES OF MISLEADING MAILINGS AND SOLICITATIONS WHICH MISREPRESENT THE RELATIONSHIP BETWEEN PRIVATE HEALTH INSURANCE PLANS AND THE FEDERAL GOVERNMENT; SUBMITTED BY OFFICE OF COMMISSIONER OF INSURANCE, STATE OF WISCONSIN

BUSINESS REPLY MAIL
NO POSTAGE STAMP NECESSARY IF MAILED IN THE UNITED STATES



**Postage Will Be Paid By:**

WISCONSIN AGENCY
Senior Citizen Information
5225 West Center Street
Milwaukee, Wisconsin 53210

**SENIOR CITIZEN INFORMATION CARD**

**PLEASE COMPLETE EACH QUESTION**

Your replies will be a great help in evaluating your total coverage: So we may provide you with complete information on Health Insurance alternatives for senior citizens to help meet today's rising cost of Health and Medical Services.

*NO POSTAGE NECESSARY - - - - MAIL TODAY*

Yes ☐ No ☐ I AM COVERED BY MEDICARE ☐ Part A ☐ Part B

Yes ☐ No ☐ I HAVE SUPPLEMENTAL COVERAGE

Yes ☐ No ☐ I HAVE COVERAGE FOR A SKILLED NURSING FACILITY

My date of Birth:

Month________ Day________ Year________

WISCONSIN AGENCY - REPRESENTING OLD EQUITY LIFE - EVANSTON, ILLINOIS

NO PART OF THE STATE OR FEDERAL GOVERNMENT

WISCONSIN AGENCY
Senior Citizen Information
5225 West Center Street
Milwaukee, Wisconsin 53210

**QUESTIONNAIRE**

REPLY REQUESTED

*Insurance Advisory Services*
**P.O. BOX 4181**
**MADISON, WISCONSIN 53711**

# MEDICARE CHANGES INFORMATION

## EFFECTIVE JANUARY OF THIS YEAR NEW CHANGES IN MEDICARE WHICH AFFECT YOU

To The Senior Citizen Addressed:

In January of this year, certain changes were made concerning Medicare which you should know about as they personally affect you.

Many people do not fully understand what benefits are payable under Medicare and what expenses the Senior Citizen himself must pay.

Medicare was enacted to help our Senior Citizens pay the ever-rising cost of Hospital and Medical Services; however, Medicare does not pay the entire bill. As you know some expense is left for you to pay in addition to Medicare. Now, with these new changes effective this January there are more expenses left for the Senior Citizen to pay.

As it is very important that you know about these changes, complete and mail the enclosed postage-free card immediately, so that we may have our representative furnish you complete information concerning the new changes in Medicare. Of course, this is not sponsored by nor connected with the Federal Government, and there is no obligation.

Sincerely,

*Insurance Advisory Services*

**EFFECTIVE JANUARY 1, 1976**

**The cost of Medicare to people over 65**
**increased 13%**
**in addition to**

**JANUARY 1, 1975**

**when**
**The cost of Medicare to people over 65**
**increased 9.5%**
**Return enclosed card for complete information.**



## MAIL THIS CARD TODAY

NO POSTAGE STAMP REQUIRED

- ☐ I would like to have further information concerning the changes in Medicare.
- ☐ I would like further information concerning skilled nursing home and extended care insurance coverage.
- ☐ I would like to have further information concerning how the changes in Medicare affect my Supplemental Insurance.

MEDICO LIFE INSURANCE COMPANY

3860 LEVENWORTH STREET • OMAHA, NEBRASKA

# INFORMATION REGARDING CHANGES IN MEDICARE

To The Senior Citizen Addressed:

On January first, certain changes were made concerning Medicare which you should know about as they personally affect you.

Many people do not fully understand what benefits are payable under Medicare and what expenses the Senior Citizen himself must pay.

Medicare was enacted to help our Senior Citizens pay the ever-rising cost of Hospital and Medical Services; however, Medicare does not pay the entire bill. As you know, some expense is left for you to pay in addition to Medicare. Now, with these new changes effective January first there are more expenses left for the Senior Citizen to pay.

As it is very important that you know about these changes, complete and mail the enclosed postage-free card immediately, so that we may rush you complete information and give you a full explanation of the new changes in Medicare.

(Front)

**FIRST CLASS**
Permit No. 3205
Madison, Wis.

**BUSINESS REPLY MAIL**
No Postage Necessary if mailed in the United States

Postage will be paid by

**MEDICO LIFE INSURANCE COMPANY**
**INSURANCE ADVISORY SERVICES**
**P.O. BOX 4181**
**MADISON, WISCONSIN 53711**

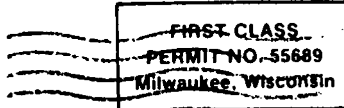
(Back)

☐ I would like to have further information concerning the changes in Medicare.

☐ I would like further information concerning "Medico," Medicare and Skilled Nursing Home Coverage.

My age is ______________

(Front)




BUSINESS REPLY MAIL

No postage stamp necessary if mailed in the United States

**MEDICARE CHANGES INFORMATION**

**SENIOR CITIZEN INFORMATION DIVISION**

**Philips Agency**
**P.O. Box 11544**
**Milwaukee, Wisconsin 53211**

(Back)

*I would like you to tell [illegible]*
*can get money I pay all you [illegible]*

**MAIL THIS CARD TODAY**
NO POSTAGE STAMP REQUIRED

☐ YES—I would like to have further information concerning the NEW Changes in MEDICARE.

*[illegible] don't go up only things we pay for*

☐ YES—I would like further information concerning skilled Nursing Home care

*How do I get a nurse to pay*

*Please Help*

[name and address redacted]

MC 6/76

# Appendix 3

## ADDITIONAL MATERIAL SUBMITTED BY BANKERS LIFE & CASUALTY CO.[1] OF ILLINOIS

### ITEM 1. LETTER FROM MICHAEL J. DRESSENDORFER, GOVERNMENT RELATIONS DEPARTMENT, TO KATHLEEN M. DEIGNAN, SENATE SPECIAL COMMITTEE ON AGING, DATED JUNE 23, 1978

DEAR MS. DEIGNAN: Enclosed is the information our company promised to furnish the committee at the June 13, 1978, meeting.

Here are our agent's contract form 710–1 and the commission schedules 1787–J, 7172C, and 7049C.

In addition, here are copies of policy forms GR–75J, GR–74B, GR–764A, and GR–74J. These policy forms represent our current portfolio of over-age 65 accident and health insurance policies. As you will note, the policy forms fit the four categories enumerated in our written statement to the committee on May 16. I am also enclosing copies of policy summaries; these summaries will enable you to determine the benefit levels for the policy forms. I have included our field office bulletin No. F–74–4 and manager's sales brief FOB F–74–4 which discuss our maximum premium rule.

I am furnishing you with copies of our agent complaint procedure.[2] I am including the June 1, 1978 version and the May 1, 1976 version. The differences involve changes to reflect additional routing copies of the form 1122 to our data processing department and incorporation of form 2428 which has been used for several years by our claim department in the complaint procedure.

We will be happy to answer any further questions you have.

Very truly yours,

MICHAEL J. DRESSENDORFER.

---

[1] See statement, page 53.
[2] Retained in committee files.

## ITEM 2. AGENT'S CONTRACT FORM

# BANKERS LIFE AND CASUALTY COMPANY
# AGENT'S CONTRACT

1. PARTIES

THIS CONTRACT is made in duplicate between BANKERS LIFE AND CASUALTY COMPANY of Chicago, Illinois, hereinafter called the "Company," and ______________________________

of ______________________________, hereinafter called the "Agent."

2. EFFECTIVE DATE

This contract shall take effect on ______________________________, 19____.

3. APPOINTMENT

The Company hereby appoints as its Agent the above named for the purpose of soliciting and procuring applications for policies of insurance sold by the Company. This appointment shall continue until terminated as provided in paragraph 20 hereof.

4. INDEPENDENT CONTRACTOR

It is the intent of the parties that the Agent is and shall be an independent contractor. Nothing herein contained nor any of the acts of the Agent pursuant hereto shall be construed as creating the relationship of employer and employee.

5. TERRITORY

This contract does not confer on the Agent exclusive representation of the Company in any territory, and the Company may appoint other Agents in the same territory.

6. COMPENSATION

As compensation in full for the performance of services of the Agent as authorized in this contract, the Company will pay commissions as set forth in the attached Schedules of Commissions. Said Schedules may be altered, decreased, modified or withdrawn at any time by the Company, and effective upon any business written by the Agent subsequent to the effective date of the change.

7. AUTHORITY

While this contract is in effect, the Agent has the authority to:

(a) procure applications for insurance issued by the Company and payments thereon, and to issue receipts for the monies so collected;

(b) deliver policies issued on applications so procured, provided the first premium has been paid;

(c) give service to policyholders of policies so written so as to maintain the policies in force;

(d) endeavor to procure applications for reinstatement of lapsed policies.

8. LIMITATIONS OF AUTHORITY

The authority given in this contract is subject to the provisions and limitations contained herein, and the Company's manuals, rate books, rules and regulations. The Company may, from time to time, prescribe rules concerning the conduct of the business covered herein and amend its manuals, rate books, rules and regulations. This contract does not give the Agent any authority to represent the Company, except as specifically set forth herein, nor any authority to alter, modify, waive or change the insurance contracts written by the Company, nor to commit the Company in any respect regarding liability or payment of claims, nor to commit nor incur liability on behalf of the Company in any respect. The authority herein granted shall end upon termination of this contract.

9. REPORTS, LICENSES AND TAXES

(a) The Agent agrees to advise the Company of any change of address of his regular place of business, and further agrees to furnish the Company with all information concerning business that he has written for the Company.

(b) The Agent shall prepare and file all reports and returns required of him by any municipal, state or federal statute or regulation, and shall pay all taxes levied against him by same. (This provision shall not be construed as requiring the Agent to pay premium taxes or any other taxes levied against the Company.) The Agent shall pay for the renewal state agent license fees, and any occupational license fee required under local ordinances. The Agent is to secure and maintain such other municipal and state licenses necessary for him to conduct business, and he shall not write insurance unless properly licensed.

10. COLLECTION OF PREMIUMS—SUBMITTAL OF APPLICATIONS—DELIVERY OF POLICIES

(a) The Agent will report and remit all Company monies received or collected in accordance with the Company's rules governing collections; and he hereby agrees that he receives and holds said funds in a fiduciary capacity as trustee until remitted to the Company, and further agrees not to commingle or divert them in any manner.

(b) The Agent shall immediately submit applications to the Company, make no alterations in the text nor the terms of the application, nor modify nor alter any representations made by or for the applicant therein without the written authority of said applicant.

(c) All policies sent to the Agent shall be delivered promptly to the applicant and, whenever such delivery cannot be made, the Agent agrees to return each such policy to the Company with a written report stating the specific reasons.

11. INDEBTEDNESS

The Company may deduct any indebtedness due or to become due at any time from the Agent to the Company from any commissions or other payments due hereunder without limitation of the Company's other legal or equitable remedies as regards indebtedness. Said indebtedness shall be a first lien on all payments due or to become due the Agent.

12. REFUNDS

Whenever a premium has been refunded to an applicant or policyholder in accordance with the rules and regulations of the Company, the Agent agrees to immediately return to the Company any commissions received as a result of that business.

13. BOOKS, SUPPLIES AND DATA

The Company will supply rate information, sales manuals and forms for the solicitation of applications for insurance. Upon termination of this contract, all rate books, manuals, records, policyholder cards, supplies, sample policies and other materials so furnished to the Agent shall concurrently be surrendered and delivered to the Company. The Agent agrees at any and all times to hold all names, policyholder cards or other contact data furnished him by the Company in a fiduciary capacity, and he agrees at all times not to divulge such names, policyholder cards or other contact data to any other company or agency and to return the same to the Company upon demand.

14. ADVERTISING

No promotional material, advertising circulars, radio or TV broadcasts or other advertising, in any form, shall be made, published or circulated by the Agent unless written approval of the Company shall have been obtained.

15. PROMOTE INTEREST

The Agent shall promote the interest of the Company as contemplated by this contract and shall conduct himself in a fair, honest, lawful and courteous manner so as not to adversely affect the business, good will, or reputation of the Company, nor shall he assist any competitive insurer by referral of Agents, materials or otherwise to the detriment of the Company.

16. NO WAIVER

No act of forbearance or toleration on the part of the Company in favor of the Agent in respect to provisions of the contract, either expressed or implied, shall be construed as a waiver by the Company of any of its rights hereunder.

17. SURETY BOND

The Agent agrees to furnish bond in amount and surety satisfactory to the Company for the faithful discharge and performance of all the duties and obligations of this contract.

18. NON-ASSIGNABILITY

No assignment of this contract nor of any benefit to accrue hereunder, in whole or in part, shall be valid or in any way binding on the Company without its prior written consent.

19. RIGHT TO REJECT APPLICATIONS AND REMOVE POLICIES FROM SALE

The Company reserves the right to reject any application for insurance submitted hereunder without specifying the reason therefor. It reserves the right to remove from sale any policy of insurance from the territory or parts thereof assigned to the Agent, and it may increase or decrease the premiums charged for any policy issued by it.

20. TERMINATION OF CONTRACT

(a) Either party may terminate this contract at will by giving notice to the other party of his intention to terminate this contract.

(b) Upon the termination of this contract commissions will be paid as set out in the attached Schedules. The Agent agrees that nothing herein gives, or is intended to give, the Agent any right, claim, title or interest of any kind in or to any special accounts or funds established by the Company including, but not limited to, any account which has as its purpose the promotion of the health, safety and welfare of its employees and agents, and that he has no right, title, claim or interest therein.

(c) The Company may terminate this contract immediately for cause. For cause means any violation by the Agent of the terms of this contract and includes, but is not limited to, fraud, failure to remit funds, or failure to secure and maintain necessary licenses.

(d) If this contract is terminated for cause as herein defined, no commissions or other compensation or allowances shall be payable.

(e) Upon termination of this contract for any reason, all liability to the Company hereunder shall immediately become due and payable.

21. CAPTIONS

The captions and sub-captions contained in this contract are for the purpose of convenience and shall not be construed as limiting or expanding the text.

22. ENTIRE CONTRACT

This contract and the Commission Schedules referred to herein supersede all previous contracts between the parties, if any, and constitute the entire contract between the parties. The contract can be changed or modified in behalf of the Company only by the written consent of the President or a Vice President of the Company.

IN WITNESS WHEREOF, this Contract was executed on this ______ day of __________, 19 ___, at Chicago, Illinois.

BANKERS LIFE AND CASUALTY COMPANY

By ______________________________
President

______________________________
Agent

Witness:

______________________________

710-I

ITEM 3

# CAREER AGENT'S HEALTH COMMISSION SCHEDULE

Subject to paragraphs 1 through 22 of the Career Agent's Contract, to which this Schedule is attached, and as long as the Career Agent is actively performing under the terms of the Career Agent's Contract, the Company will allow, and the Career Agent will accept as full and complete compensation, (less application fee, if any), commission in accordance with the following Schedule:

1. COMMISSION PERCENTAGES

| Type of Contract | Initial | Subsequent |
|---|---|---|
| (a) Renewable at Option Disability Income Policies | 100% of 1st and 2nd mo. premium | 30% of 3rd through 6th mo. premium as collected by Company |
| (b) Guaranteed Renewable and Collectively Renewable (Franchise & Association) Disability Income Policies | 100% of 1st and 2nd mo. premium | 40% of 3rd through 6th mo. premium as collected by Company |
| (c) All other Renewable at Option policies (including Collectively Renewable P-7 & P-7A Franchise Policies) | 100% of 1st mo. premium | 30% of 2nd through 6th mo. premium as collected by Company |
| (d) Guaranteed Renewable and Collectively Renewable (Franchise & Association) Hospital-Surgical, Medical or Surgical, & Hospital Indemnity Policies | 100% of 1st mo. premium | 40% of 2nd through 6th mo. premium as collected by Company |

(e) Commission percentages on Benefit Riders, for which premium is charged, is the same as the Policy to which the Rider is attached, unless otherwise indicated in other rules published by the Company.

(f) In addition, the Career Agent may retain additional commission computed as follows:

(1) In the case of Renewable at Option policies, the Career Agent may retain 10% of the difference between the Annual Premium and commission due on the first six (6) months, when the Annual Premium is collected at time of sale.

(2) In the case of Guaranteed and Collectively Renewable policies, the Career Agent may retain 10% of the difference between the Annual Premium and six (6) full monthly premiums in addition to the regular commission, when the Annual Premium is collected at time of sale.

(g) The Company may, from time to time, grant additional commission as a bonus, based upon the volume of business the Career Agent has in force at semi-annual intervals. The formula for such bonus will be at the sole discretion of the Company. Any such bonus shall become payable when so declared by the Company, and then only if and upon the express condition that the Career Agent is at that time actively performing under the provisions of the Career Agent's Contract. Nothing herein contained gives, or shall be construed to give, to the Career Agent any vested or earned interest or any claim in any such bonus, regardless of the date of termination of this Contract, and the same may or may not be paid solely at the option of the Company. It may be withheld, increased, decreased, or discontinued, at any time solely at the discretion of the Company.

2. COMMISSION WHEN BALANCE OF QUARTERLY, SEMI-ANNUAL, OR ANNUAL PREMIUM IS COLLECTED ON DELIVERY

If the writing Career Agent collects the balance of a quarterly, semi-annual, or annual premium on delivery, or within 30-days following date of issue, the Career Agent may retain, according to the above Schedule, the commission due on the balance of the first-year's premium collected. This applies to Health Policies issued on a monthly, quarterly, or semi-annual basis. (This does not apply to PPSP or Payroll Deduction.)

3. REINSTATEMENTS, UPGRADES, OR EXCHANGES

The commission paid to the Career Agent shall be in accordance with the Company's last published rules.

4. VESTED DISABILITY INCOME COMMISSION AFTER TERMINATION OF CONTRACT

Commission on Disability Income premiums shall be vested and paid subject to the following:

(a) Disability Income monthly premium in force is that premium in force under the Career Agent's number at time of termination.

(b) Reinstated Career Agents will be eligible for vested commission under their assigned Career Agent number on a "Reinstated Career Agent" basis.

(c) Commission will be five percent (5%) of all Disability Income monthly premium in force, less a service charge of one-half of one percent (½ of 1%).

(d) Commission may be vested and paid for a maximum of ten (10) years.

(e) The vested period shall begin only after the Career Agent has completed eighteen (18) consecutive months of active service, and shall be credited on a month-for-month basis after the eighteenth (18th) month through five (5) years of service, and on a year-for-year basis after five (5) years of service.

(f) Vested commission will be paid to the Career Agent monthly until such vested monthly commission (gross amount) due the Career Agent falls below $25.00.

(g) In the event of the Career Agent's death, Renewal Commission will be paid as set out above, subject to the service fee.

## ITEM 4

## CAREER AGENT'S LIFE COMMISSION SCHEDULE

Subject to paragraphs 1 through 22 of the Career Agent's Contract, to which this Schedule is attached, and as long as the Career Agent is actively performing under the terms of the Career Agent's Contract, the following Life commissions shall be allowed for Life policies and Life riders approved and issued by the Company. Such commissions shall be allowed on policies maintained in force by Waiver of Premium or Policy Loan provision, and to policy reinstatement, if the Career Agent collects the full premium in default. Commission on premiums paid in advance of the current policy year shall not be paid until the policy year the premiums are due.

1. LIFE INSURANCE PLANS AVAILABLE AND COMMISSION PERCENTAGES

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd Year Renew. Comm. | 3rd-10th Year Renew. Comm. |
|---|---|---|---|---|---|
| 12B | Joint Whole Life | 18-70 | 65% | 25% | 2% |
| 020 | 20 Pay Life - Return of Premium | 0-45 | 65% | 25% | 2% |
| 29A | Whole Life (Par) | 60-64 | 55% | 15% | 2% |
| | | 65-69 | 40% | 15% | 2% |
| | | 70-74 | 35% | 15% | 2% |
| | | 75-80 | 30% | 15% | 2% |
| 030 | 30 Pay Life - Return of Premium | 0-35 | 65% | 25% | 2% |
| 46J | Retirement | 0-40 | 65% | 25% | 2% |
| | Income At | 41-45 | 60% | 20% | 2% |
| | Age 65 (Par) | 46-50 | 45% | 15% | 2% |
| | | 51-55 | 30% | 15% | 2% |
| 52B | Single Life Decreasing Term | | | | |
| | 10 Year Term | 18-60 | 40% | 15% | 2% |
| | 15 Year Term | 18-60 | 40% | 15% | 2% |
| | 20 Year Term | 18-55 | 45% | 20% | 2% |
| | 25 Year Term | 18-50 | 45% | 20% | 2% |
| | 30 Year Term | 18-45 | 45% | 20% | 2% |
| 52N | Annual Renewable Term | 18-65 | 40% | 15% | 2% |
| 53A | Joint Decreasing Term | | | | |
| | 10 Year Term | 18-60 | 40% | 15% | 2% |
| | 15 Year Term | 18-60 | 40% | 15% | 2% |
| | 20 Year Term | 18-55 | 45% | 20% | 2% |
| | 25 Year Term | 18-50 | 45% | 20% | 2% |
| | 30 Year Term | 18-45 | 45% | 20% | 2% |
| 101 | Preferred Risk Whole Life | 15-65 | 65% | 25% | 2% |
| 105 | Whole Life - Par | 0-70 | 65% | 25% | 2% |
| 111 | Executive Ordinary Life | 10-70 | 65% | 25% | 2% |
| 120 | 20 Pay Life | 0-65 | 60% | 20% | 2% |
| | In Wisconsin and Connecticut only | 66-70 | 55% | 20% | 2% |
| | In Wisconsin and Connecticut only | 71-75 | 50% | 20% | 2% |
| | In Wisconsin and Connecticut only | 76-80 | 45% | 20% | 2% |
| •129 | 20 Pay Life-Par | 0-39 | 60% | 20% | 2% |
| | | 40-64 | 55% | 20% | 2% |
| | | 65-69 | 40% | 20% | 2% |
| | | 70-74 | 35% | 20% | 2% |
| | | 75-80 | 30% | 20% | 2% |
| •165 | Life Paid-Up at Age 65 | 0-40 | 65% | 25% | 2% |
| | | 41-45 | 60% | 20% | 2% |
| | | 46-50 | 50% | 15% | 2% |
| | | 51-55 | 40% | 15% | 2% |
| 168 | Juvenile Limited Payment Life | 0-14 | 55% | 25% | 2% |
| 170 | Life Modified at Attained Age 70 | 0-55 M/0-58F | 70% | 25% | 2% |
| 195 | Life Paid-Up at Age 95 | 0-70 | 60% | 15% | 2% |
| 198 | Life Paid-Up at Age 98 | 0-70 | 60% | 15% | 2% |

1787-J (Career Agent) 9-77

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd Year Renew. Comm. | 3rd-10th Year Renew. Comm. |
|---|---|---|---|---|---|
| 299 | Whole Life | 60-80 | 35% | 5% | 2% |
| 320 | 20-Year Endowment | 0-65 | 45% | 20% | 2% |
| 365 | Endowment at Age 65 | 0-30 | 65% | 25% | 2% |
| | | 31-35 | 60% | 25% | 2% |
| | | 36-40 | 55% | 25% | 2% |
| | | 41-45 | 45% | 20% | 2% |
| | | 46-50 | 35% | 15% | 2% |
| | | 51-55 | 25% | 15% | 2% |
| 385 | Endowment at Age 85 | 0-50 | 65% | 25% | 2% |
| | | 51-55 | 60% | 25% | 2% |
| | | 56-60 | 55% | 25% | 2% |
| | | 61-64 | 45% | 20% | 2% |
| 395 | Family Insurance | * | 60% | 25% | 2% |
| 418 | Endowment at Age 18 | 0-3 | 30% | 15% | 2% |
| | | 4-9 | 20% | 15% | 2% |
| 428 | 20 Pay Endowment at Age 65-Return of Premium-Par | 0-45 | 65% | 25% | 2% |
| 440 | Joint Life 20 Year Endowment | 0-60** | 45% | 20% | 2% |
| 504 | 5-Year Level Convertible Term | 15-60 | 35% | 10% | 2% |
| 505 | 5-Year Level Renew. & Convert. Term | 15-60 | 35% | 10% | *** |
| 507 | F&A 5 Year Renew. & Convert. Term | 0-65 | 35% | 15% | 2% |
| 510 | 10-Year Level Convertible Term | 15-55 | 40% | 10% | 2% |
| 511 | Executive Decreasing Term-Convertible | | | | |
| | 10-Year Term Period | 15-60 | 40% | 10% | 2% |
| | 15-Year Term Period | 15-60 | 40% | 15% | 2% |
| | 20-Year Term Period | 15-55 | 45% | 20% | 2% |
| | 25-Year Term Period | 15-50 | 45% | 20% | 2% |
| 515 | 15-Year Level Convertible Term | 15-50 | 50% | 15% | 2% |
| 551 | Joint Life-Last Survivor Term-Level | 18-50**** | 60% | 5% | 5% |
| 565 | Level Term to Age 65 | 15-40 | 60% | 25% | 2% |
| | | 41-45 | 55% | 20% | 2% |
| | | 46-49 | 50% | 15% | 2% |
| 623 | Juvenile Estate Builder | 0-4 | 20% | — | — |
| | | 5-14 | 25% | — | — |
| | Renewal at Age 23 (treat as new issue) | 23 | 65% | 25% | 2% |
| 698 | Single Premium Endowment | | | | |
| | Maturing in 20 Years or more | ***** | 3% | — | — |
| | Maturing in 10-19 Years | ***** | 2½% | — | — |
| | Maturing in less than 10 Years | ***** | 2% | — | — |
| 400 | Retirement Annuity | 0-65 | 25% | 20% | 2% |
| | In the state of Washington And Tennessee | 0-65 | 20% | 20% | 2% |
| 1401 | Retirement Income Rider | 0-65 | 60% | 15% | 2% |
| | In the State of Washington And Tennessee | 0-65 | 20% | 20% | 2% |

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd Year Ren. Comm. | 2nd Year Serv. Fee | 3rd-10th Year Ren. Comm. | 3rd-10th Year Serv. Fee | 11th & Thereafter Service Fee |
|---|---|---|---|---|---|---|---|---|
| 47J | Retirement Income at Age 70 - Par. | 15-19 | 55% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| | | 20-24 | 50% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| | | 25-29 | 45% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| | | 30-34 | 40% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| | | 35-44 | 35% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| 48J | Retirement Income at Age 70 - Non-Par | 45-49 | 30% | 10% | 5% | 1.5% | 1.5% | 1.5% |
| | | 50-54 | 25% | 7% | 3% | 1.5% | 1.5% | 1.5% |
| | | 55-59 | 20% | 7% | 3% | 1.0% | 0.5% | 1.5% |
| | | 60 | 15% | 5% | 2.5% | 1.0% | 0.5% | – |

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd-10th Year Renew. Comm. | Special Service Fees: 2nd-10th Year | Special Service Fees: 11th-20th Year | Special Service Fees: 21st Year and thereafter |
|---|---|---|---|---|---|---|---|
| 404 | Retirement Annuity at age 70 - Par. | 15-25 | 27% | 1.0% | 3.0% | 2.5% | 1.5% |
| | | 26-35 | 24% | 1.0% | 2.5% | 2.5% | 1.5% |
| | | 36-45 | 20% | 1.0% | 2.0% | 2.5% | 1.5% |
| | | 46-50 | 17% | 1.0% | 1.5% | 2.5% | 1.5% |
| | | 51-55 | 14% | 1.0% | 1.5% | 2.5% | – |
| | | 56-60 | 10% | 1.0% | 1.5% | 2.5% | – |
| | | 61-63 | 7% | 0.5% | 1.0% | – | – |
| | | 64-65 | 5% | 0.5% | 1.0% | – | – |
| | | 66-67 | 4% | 0.5% | 1.0% | – | – |
| | | 68-69 | 3% | 0.5% | 1.0% | – | – |

Special Service Fees are payable only to an active career agent who provides the necessary service as determined by the Company. Section 3 of the Career Agent's Life Commission Schedule does not apply to the 47J, 48J or 404 Policies.

| Plan No. | Policy Plan | Age At Issue | Single Premium Comm. |
|---|---|---|---|
| 04A | Single Premium Deferred Annuity | All Ages | 3% |
| 690 | Single Premium Immediate Annuity (Individual) | All Ages | 3% |
| 691 | Single Premium Immediate Annuity (Joint and Survivor) | All Ages | 3% |

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd Year Ren. Comm. | 2nd Year Serv. Fee | 3rd Year Ren. Comm. | 3rd Year Serv. Fee | 4th-5th Year Ren. Comm. | 4th-5th Year Serv. Fee | 6th-10th Year Service Fee | 11th & Thereafter Service Fee |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 02A | Flexible Premium Annuity | 18-60 | 20% | 5% | 5% | 2.5% | 5% | 2.5% | 2.5% | 2% | 1.5% |
| | | 61-69 | 6.5% | 2% | 3% | 2% | 2.5% | 2% | 2.5% | 2% | – |

Additional new money contributions for ages 18-60 is 20% for all years; for ages 61-69, 6.5% for all years.

Commissions/Service Fees are payable for the years shown or to the Policy Anniversary nearest age 70, if earlier.

NOTE: On Military Risks in the first 3 pay grades, reduce commission by 25% of that shown.

* Issue Ages: Applicant (Primary Insured) 18-45 } Provided Primary Insured is between 7 years younger and
Insured Spouse 17-52 } 12 years older than spouse
Insured Children 15 days - 18 birthday

** One of the applicants must be at least age 15 and neither may be over age 60. Any applicant under age 15 will be treated as age 15.

*** Renewal Commission as follows:

| | |
|---|---|
| 3rd to 5th Year | 2% |
| 6th Year | 20% |
| 7th to 10th Year | 2% |

**** The Average of both actual ages must be between 19-45.
***** Policy can be used for virtually any combination of Issue Age and Endowment Period.

2. COMMISSION ON BALANCE OF QUARTERLY, SEMI-ANNUAL, OR ANNUAL COLLECTIONS

If the balance of a quarterly, semi-annual or annual premium is collected on delivery, or within 30 days following date of issue, the commission due on the balance of the First Year's premium that is collected may be retained by the Writing Career Agent or split according to prior agreement according to the above Schedule. This applies to all Life policies issued on a monthly, quarterly, or semi-annual basis. (This does not apply to PPSP or Payroll Deduction.)

3. SERVICE FEE

From the 11th to the 20th year, inclusive, an active Career Agent will also receive 2% of the Renewal Premium collected as a Service Fee on all Life business in force on a premium paying basis, with the exception of L-507 and L-511 (10-Year Term) and those plans for which special service fees are indicated.

4. COMPENSATION PROVISIONS

(a) The Company may, from time to time, determine the right to commissions, the amount and the period of payment thereof, in the following cases: (1) policies and riders hereafter introduced; (2) reinstated, reissued, or changed policies; (3) policies where part or all of the risk is reinsured; (4) conversions of Term Life policies or riders, provided no commission is allowed on conversion of a Group policy; (5) renewals of Renewable Term policies; (6) policies issued with substandard or flat extra ratings.

(b) Commission on Life riders is the same percentage as the policy to which the rider is attached, unless otherwise indicated in other rules published by the Company.

5. VESTED COMMISSIONS AFTER TERMINATION OF CONTRACT

(a) If this contract is terminated after the Career Agent has ten (10) years continuous service, or upon reaching age 65, whichever comes first, or as a result of the Career Agent's death or total and permanent disability as defined in paragraph 5 (b) of this Schedule, renewal commissions shall be vested and paid as set out in paragraph 1 of this Schedule, as long as such commissions equal or exceed $200 in any calendar year.

(b) If the Career Agent, due to illness or injury, is unable to perform as a Career Agent of the Company in accordance with the terms of this contract for a period of six (6) months, and shall require the regular attendance of a licensed physician, and is certified to be in such a condition by such licensed physician, then the Career Agent shall be considered totally and permanently disabled.

(c) If this contract shall be terminated prior to the time the Career Agent shall qualify under any of the conditions set out in paragraph 5 (a) above, then only commissions on first-year premiums shall be paid.

SUPPLEMENT TO BANKERS LIFE AND CASUALTY COMPANY

CAREER AGENTS AND AGENTS LIFE COMMISSION SCHEDULE

| Plan No. | Policy Plan | Age At Issue | 1st Year Comm. | 2nd Year Renew. Comm. | 3rd-10th Year Renew. Comm. |
|---|---|---|---|---|---|
| 1579 | Annual Renew. Term | 0-65 | 50% | Same as policy to which attached. | |

ITEM 5

# CAREER AGENT'S GROUP COMMISSION SCHEDULE

Subject to paragraphs 1 through 22 of the Career Agent's Contract, to which this Schedule is attached, the Company shall pay commissions at the rates shown below, provided the Career Agent: (1) is continuously and actively performing under the terms of the Career Agent's Contract; (2) is continuously recognized by the policyholder as Career Agent for the Group Policy, and (3) services the Group Policy in a manner satisfactory to the Company.

| | Regular Scale | | Level Scale |
|---|---|---|---|
| Annual Premium | % 1st Year | Renewal % 2nd through 10th Yrs. | % 10 Yr. Level Graded |
| First $1,000* | 20% | 5% | 6.5% |
| Next 4,000* | 20% | 3% | 4.7% |
| Next 5,000* | 15% | 1.5% | 2.85% |
| Next 10,000* | 12.5% | 1.5% | 2.6% |
| Next 10,000* | 10% | 1.5% | 2.35% |

*Or any part thereof

ABOVE COMMISSIONS TO BE PAID AS FOLLOWS:

1. Group (over 25 lives):

   (a) Regular Scale

   (b) At option of Career Agent with Company approval—Level Scale

   (c) Upon election by the Company—Level Scale

   (d) Business previously in force, in whole or in part, in another insurance company, within six (6) months of effective date of the business placed with our Company—Level Scale

   (e) Group with Annual Premium in excess of $30,000, or on any case where a special agreement is required, commissions and overwrite to be determined by the Company.

ITEM 6. FIELD OFFICE BULLETIN

OVER-INSURANCE - SENIOR CITIZENS F.O.B. F-74-4

The attached bulletin establishes a new rule for writing Health Insurance in the Senior Citizen market.

The maximum allowable monthly premium for Health Insurance will be $30.00 per individual, based upon the standard premium for that person at age 65 for all Health Insurance policies in force and applied for in all companies.

This new rule is a necessary reinforcement of our senior citizen "common sense underwriting" guidelines as spelled out in F.O.B. No. F-71-41, which bulletin remains in full force and effect.

Along with your Company, many State Insurance Departments are becoming concerned about the problem of over-insuring persons over 65. The Company's attitude toward Senior Citizens is that they should own adequate Health Insurance. However, with few exceptions, everyone over age 65 is covered by both Part A and Part B of Medicare. Therefore, their primary Health Insurance needs can be adequately covered by Medicare Supplement Policies, Extended Care Facility Policies and/or Hospital Indemnity Policies, if there is a need and they can afford them. Excessive coverage must be avoided.

It is the responsibility of every sales manager to see that his agents fully understand the new rule governing sales of Health Insurance to this market, along with the importance of using "common sense underwriting." Please review this bulletin very carefully with your agents using the examples shown, and also review with your agents F.O.B. No. F-71-41, "Common Sense Underwriting."

Place this bulletin in your Bulletin file.

BANKERS LIFE AND CASUALTY COMPANY

FIELD OFFICE BULLETIN NO. F-74-4
DATE: 1/28/74
RE: OVER-INSURANCE -- SENIOR CITIZENS

TO: ALL SALES MANAGERS AND AGENTS

Recently, there have been indications that many policyholders in the over-65 age market have been sold excessive amounts of health insurance; amounts that would constitute over-insurance far beyond their means. In addition, in some cases, the amounts of premium involved are inconsistent with the incomes of the applicants. Remember, it is not in the best interest of the policyholder to be paying premiums on policies which he or she does not really need.

Effective immediately, for individuals age 65 or over, the maximum allowable monthly premium for all health insurance policies in force or applied for with all MacArthur Insurance Companies and other companies is $30. This includes 1441 Business. This does not include premiums paid for Part B of Medicare. Remember, $30 is the maximum allowable premiums; individual financial circumstances may indicate that an even lower premium would be prudent.

The $30 per month limit is based upon a standard premium at age 65 and not on the dollar amount actually being paid. With a prospect over age 65, the agent must therefore:

1. Determine existing in-force coverage.
2. Based on similar MacArthur Insurance Companies coverage sold, find standard monthly rate at age 65 for all policies.
3. Total all monthly rates.
4. Subtract from $30.00.
5. If answer is greater than 0, that is the "available monthly premium" which can be written using the following formula:

   For plan of coverage desired, find standard monthly rate at age 65. If this exceeds amount obtained in #4, reduce coverage to point where it doesn't exceed amount in #4.

   NOTE: If after reducing to the minimum benefits of plan desired, the rate still exceeds the "available monthly premium" that plan may not be written. The only plan that may be written at that point, is one that does not exceed the "available monthly premium."

   If that is the case - only that plan/benefit can be sold at the actual age/rate.

For example, assume Sam Smythe is 75 years old and has cirrhosis of the liver (Qualified Risk Point Value of 75). He is paying $15 in standard monthly health insurance premiums on policies purchased at age 65. He recently purchased a 717 on which he pays a rated premium of $11.70 monthly. In determining the standard monthly rate at age 65, the $15 would remain unchanged. The $11.70 paid for the 717 would be adjusted downward to $5, altogether the

total being (15 + 5) $20. Subtracting $20 from $30 leaves $10 which is the amount of standard monthly premium (at age 65) which may be written on Sam Smythe. For instance, a 774 with an actual premium (age 75 with Qualified Risk Point Value of 75 for cirrhosis) of $16.15 can be written since the standard rate at age 65 for this policy is $6.

For a second example John Jones is age 65. He purchased a 780 policy last year when he was 64 for $7.70. Since the premium at age 65 is $8.80 for this policy, the premium must be adjusted upward. In addition he has purchased other policies since he turned 65, with monthly premiums of $15. Mr. Jones is now applying for a 764A with a premium of $4.00. Since $4.00 + $8.80 + $15 equals $27.80 the 764A can be written.

Finally, with the implementation of the $30 monthly health premium limit, increased emphasis is placed on listing all information concerning insurance now in force or applied for with this or other companies on the application. An accurate and thorough job of reporting this data will serve to speed Home Office handling of all Senior Citizen health insurance applications.

## ITEM 7. MEDICARE SUPPLEMENTAL POLICY FORMS, OUTLINES OF COVERAGE[1]

BANKERS LIFE AND CASUALTY COMPANY
4444 West Lawrence Avenue, Chicago, Illinois 60630

### OUTLINE OF COVERAGE

For Medical-Surgical Policy GR-75J
(Retain this for your records)

#### BENEFITS

The Medical-Surgical Policy provides for each insured family member:

For Doctor Calls

Up to $10 for each treatment at home:

Up to $5 for each treatment in the hospital, nursing home, convalescent home, rest home, extended care facility, or in a doctor's office.

Doctor calls start with the first treatment for accident, third treatment for sickness, and are limited to one treatment per day.

Total payments for each insured family member shall not exceed $600 for any one accident or any one sickness.

For Surgery

From $6 up to $600 based on the nature of the operation as set forth in the surgery schedule.

Benefits will be paid for both doctor calls and surgery if each service is performed by a different doctor. If the same doctor provides the doctor calls and the surgery, then benefits either for the doctor calls or surgery, whichever is greater, but not both, will be payable.

Miscellaneous Expense Benefits

Up to $25 for Radiologist's services;

Up to $15 for Pathologist's services;

For Anesthetist's services; 15% of the Surgical Benefits payable, or $10, whichever is greater.

The above benefits are not available when the services are performed by hospital employees.

#### EXCEPTIONS

The Medical-Surgical Policy does not cover loss due to:

Mental disturbance without demonstrable organic disease; dental operations or dental treatment; any act of war; services rendered by any agency of the Federal Government, including Veterans Administration; services rendered by any agency of a State Government, unless the Insured is legally obligated to pay for such services; any injury or sickness covered by any Workmen's Compensation or Occupational Disease Law.

Conditions commencing within the six months prior to the effective date of coverage are not covered for a period of six months after the effective date of coverage.

#### RENEWAL CONDITIONS

The Medical-Surgical Policy is renewable for life as long as premiums are paid on time. The Company may change premium rates only on a class basis.

You have a ten day right to examine the policy and return it for any reason for a full refund.

This is an outline of coverage for the Medical-Surgical Policy Form GR-75J and is not a contract. The policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY carefully.

[1] Complete policy forms retained in committee files.

BANKERS LIFE AND CASUALTY COMPANY
4444 West Lawrence Avenue, Chicago, IL 60630

# OUTLINE OF COVERAGE

For Skilled Nursing Facilty Policy Form GR-74B
(Retain this for your records)

The policy provides Skilled Nursing Facility Benefits only, which are supplemental to Part A of Medicare.

## BENEFITS

The Skilled Nursing Facility Policy provides for each insured Family member the following:

If a Family member is confined in a Skilled Nursing Facility within 28 days after a confinement of 3 or more consecutive days in a hospital due to injury or sickness, the Company will pay during the 21st through the 100th day of confinement, the following:

The room and board expense incurred (not to exceed the reasonable and customary charge for semi-private accommodations); the expense incurred for services and supplies including regular nursing services; medicines and drugs; medical supplies such as splints and casts; use of appliances and equipment such as a wheelchair, crutches and braces; physical occupational and speech therapy; and other medically necessary services and supplies, but not to exceed the amount of Medicare Deductible for which the Family member is responsible. At the time of application, this amount is $18.00 per day.

Expenses due to medical or surgical services provided by a physician, surgeon on intern; services of a private duty nurse or other private duty attendant; blood of blood transfusion; custodial care; and personal comfort or convenience items such as telephone, radio or television furnished at the Family members request, are not covered.

During the 101st through the 400th day of confinement in a Skilled Nursing Facility, the Company will pay the above benefits, but not to exceed $15 per day.

If the insured Family member is not eligible or does not qualify to receive payments under any Federal Medicare Legislation or plan, the benefits provided by the policy will be paid as though the insured Family member was eligible or qualified to receive such payments.

If changes are made in Medicare benefits which effect the benefits provided by the policy, an appropriate adjustment in benefits will automatically be made with an appropriate adjustment in premium, if necessary.

## EXCEPTIONS

The Skilled Nursing Facility Policy does not cover loss incurred while under the influence of any drug not administered by a physician.

Conditions commencing within the six months prior to the effective date of coverage are not covered for a period of six months after the effective date of coverage.

Other Insurance in this Company — Only one of these policies can be effective for the family at any one time. If more than one is effective, the Company will return all premiums paid for all other such policies.

## RENEWAL CONDITIONS

The Skilled Nursing Facility Policy is renewable for life. The Company may change premium rates on a class basis.

You have a ten day right to examine the policy and return it for any reason for a full refund.

This is an outline of coverage for Skilled Nursing Facility Policy Form GR-74B and is not a contract. The policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY carefully.

3862A-G

BANKERS LIFE AND CASUALTY COMPANY
4444 West Lawrence Avenue, Chicago, Illinois 60630

# OUTLINE OF COVERAGE

For Guaranteed Renewable For Life Hospital Confinement Indemnity Policy Form GR-74J
(Retain this for your records)

## BENEFITS

The policy provides the following Hospital Indemnity for an insured family member for each day of hospital confinement, beginning after the applicable Elimination Period, if any, but not to exceed the Benefit Period for any one accident or any one sickness.

| | Hospital Confinement Indemnity | Benefit Period | Elimination Period |
|---|---|---|---|
| Insured | $ 10 or $20 or$30 Daily | 365 | 0 days |
| Insured's spouse | $10 or $20 or$30 Daily | 365 | 0 days |

## EXCEPTIONS

The policy does not cover loss due to: Mental disturbance without demonstrable organic disease.
Conditions commencing within the six months prior to the effective date of coverage are not covered for a period of six months after the effective date of coverage.

## RENEWAL CONDITIONS

The policy is renewable for life as long as premiums are paid on time. The Company may change the premium rates on a class basis.

You have a ten day right to examine the policy and return it for any reason for a full refund.

This is an outline of coverage and is not a contract. The policy itself sets forth the rights and obligations of both you and the insurance company. It is therefore imperative that you READ YOUR POLICY carefully.

4476-G

BANKERS LIFE AND CASUALTY COMPANY
4444 W. Lawrence Ave., Chicago, Illinois 60630

# OVER-65 HOSPITAL EXPENSE POLICY REQUIRED DISCLOSURE STATEMENT

Form GR-764A

(1) *Read Your Policy Carefully*—This disclosure statement provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) *Medicare Supplement In-Hospital Expense Coverage*—Policies of this category are designed to provide, to persons insured, coverage for in-hospital expense incurred, as a result of a covered accident or sickness, which are not covered under Part A of Medicare subject to any limitations set forth in the policy. Coverage is *not* provided for physicians or surgeon fees. *Basic* hospital or *basic* medical insurance coverage is not provided.

(3) The Over-65 Hospital Expense policy provides Supplementary Hospital Benefits which are based upon the Federal Medicare Program. As of *January 1, 1978* the GR-764A provides the following supplementary benefits, during each benefit period, when you are confined in a hospital as a result of injury or sickness.

The initial Medicare deductible—$ 144.00

$ 36 per day from the 61st through the 90th day of hospital confinement.

$ 72 per day from the 91st through the 150th day of hospital confinement (or as long as Lifetime Reserve under Medicare is available).

From the 151st day (or when Lifetime Reserve is exhausted), 100% of all usual and customary expense for hospital services and medical supplies, including semi-private room and board (or Private, if such facility was medically necessary and used during the period of Medicare coverage). However, this would NOT cover medical or surgical services provided by a physician or surgeon. Nor would it cover the services of a Private Duty Nurse except as provided below.

After the 60th day of hospital confinement, the GR-764A pays the expense incurred for the services of a Private Duty Nurse (other than a member of your family) up to $20.00 per day as long as you are hospitalized—UP TO A MAXIMUM OF 100 DAYS.

AUTOMATIC BENEFIT EXTENSION—If the hospital benefits provided by the Federal Medicare Program change, then the benefits provided by the GR-764A policy shall also change to supplement the new hospital benefits provided by Medicare. Any premium adjustment that may be necessary will be explained on the first premium notice following such change.

(4) The GR-764A does not cover you during the first 60 days from date of issue, for any hospital confinement caused by a condition for which you've been medically treated or advised prior to policy issue. It does not cover loss due to mental illness, without organic disease; services rendered by any agency of Federal Government, including Veterans Administration; services rendered by a State Government agency, unless you are legally obligated to pay for the service.

(5) The Over-65 Hospital Expense Policy is renewable for life or until the aggregate benefits paid or payable equal $25,000 as long as premiums are paid on time. The Company may change premium rates on a class basis.

# Appendix 4

# STATEMENTS AND LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

## ITEM 1. STATEMENT OF MARY M. BACH, STAFF ATTORNEY, CENTER FOR PUBLIC REPRESENTATION, MADISON, WIS.

The Center for Public Representation is a public interest law firm engaged in issues impacting on the elderly. For the past several years, the Center has been actively involved in the Medicare supplement area. In addition to conducting advocacy training on the problems of Medicare and private health insurance, the Center has pushed for more administrative control over sales and advertising practices, greater disclosure to consumers and minimum standards.

Access for Senior Citizens, a project of the Center for Public Representation, is a new direct services program providing advocacy for the elderly in ten Wisconsin counties. The project is staffed by benefit specialists working under attorney supervision who provide assistance in the broad area of government benefits. ASC has found, to its surprise, that after six months of operation, private health insurance problems constitute the largest single issue affecting our clients and account for almost one-fourth of the total caseload. Related issues in the Medicare and Medical Assistance program bring the total to well over one-half. Attached is a Service Summary which provides a breakdown of the ASC caseload from September 15, 1977 through February 28, 1978.[1]

Also attached is a comment written by the ASC benefit specialist in Grant County which describes in some detail the types of issues we are encountering.

The Center for Public Representation and Access for Senior Citizens are particularly concerned about the sale of limited insurance such as cancer insurance and the sale of Medicare supplement and other health insurance to Medical Assistance-eligible people. Attached are copies of correspondence related to these two issues.

We are most pleased that the Committee is beginning to investigate this matter of grave concern to the elderly, and we would welcome the opportunity to provide the Committee with additional information.

---

## ITEM 2. STATEMENT OF JO PEBWORTH, BENEFIT SPECIALIST, ACCESS FOR SENIOR CITIZENS PROJECT, CENTER FOR PUBLIC REPRESENTATION, MADISON, WIS.

The majority of people over 65 and on Medicare have different requirements for private health insurance than the rest of the population. Because they are on a fixed income, usually Social Security benefits—often supplemented with interest or dividends on their "life's savings"—their biggest concern is the possible reduction of income or assets. Adequate health insurance is essential in case of a catastrophic illness or accident to protect income and assets and the income assets produce. However, because a retired person's income is not affected by illness or injury beyond hospital, medical and nursing home expenses, indemnity plans are not necessary.

Medicare is a tremendous help for the elderly. Part A insures a person against the average hospitalization with only $144 deductible. Part B covers a major part of surgical and medical expenses. However, expenses incurred for catastrophic illness and accident will not be adequately covered by Medicare alone. Additional insurance is essential for most elderly people. Even adequately insured persons face many extra charges not covered by either Medicare or by private health insurance.

[1] Retained in committee files.

In the past seven months, in my work as Benefit Specialist in Grant County, I've worked with 191 individuals over 60. One hundred three of these clients had problems concerning insurance. All 103 were confused about how Medicare and private health and nursing home insurance pay. Some of my clients simply wanted their coverage reviewed and explained to them. Others needed advice on what to buy. Some had too much insurance. Some had inadequate coverage. Many needed help submitting claims. In the following report I'll explain the problems I've encountered in each area.

TOO MUCH INSURANCE—24 CLIENTS

People over 65 often have too much insurance because they:

(1) Don't understand Medicare.

(2) Don't know what they need, but know Medicare won't pay everything.

(3) Are afraid of cancer and accidents.

(4) Are worried about going to a nursing home some day.

(5) Are disoriented, forgetful and confused. Some don't realize that they have existing policies in force. Others won't show an agent what policies they do already have.

(6) Have run into sales people who neglected to explain coverage adequately or who sold more coverage than a person needed, or who didn't check to see if a person was on Medical Assistance (but some elderly people I've met didn't realize they were on Medical Assistance or how it paid).

(7) Often find it very hard to turn down a salesman.

The clients I have worked with who had too much insurance usually have at least one adequate Medicare supplement and perhaps a skilled nursing home policy. Their additional coverage usually includes two to five accident indemnities and a cancer plan. A few have had two or three Medicare supplements and some have been sold intensive care plans. They are often paying $200 to $600 or more annually for unnecessary coverage. Through explaining and listing a client's policies and premiums, the policy holder realizes how much he actually is spending on insurance and that he or she can cut down his or her insurance costs drastically and still maintain very adequate coverage. The amount people spend on insurance for simply adequate comprehensive coverage is very high. Medicare Part B costs $89.40 and a Medicare supplement from $200 to $500. Add a skilled nursing home plan and the cost per individual can run over $800 a year for health insurance. Counseling is essential to explain how private insurance works with Medicare and to show how a person can reduce their insurance costs.

HELP WITH INSURANCE CLAIMS—17 CLIENTS

Once an elderly person has been in the hospital, even with adequate insurance and Medicare, coping with Medicare and private insurance claims can be a nightmare.

(1) Often one hospitalization results in bills from four of five doctors each having different "rules" for the patient to follow in submitting claims to Medicare and private insurance.

(2) After claims are submitted many people don't understand how the benefits are determined. The confusion usually arises over the difference in the amount billed and the amount allowed by Medicare.

(3) Many people don't submit claims when they are eligible for benefits. One client with insurance covering prescription drugs had never submitted a claim. She is eighty-six and has been on set medication for years. Other clients have stopped submitting claims when the process became too lengthy and confusing.

(4) A few clients were completely confused by the claims processes and couldn't submit a claim without help.

(5) Once a hospital would not take the extra step necessary to resubmit claims for eligible benefits.

(6) Some insurance companies send classic letters of confusing information, understandable only if a person has a complete past record of correspondence and billing at their disposal, i.e. the insurance company knows what they are talking about; the client has no idea.

(7) Elderly people often lose Explanation of Medicare Benefits, riders to policies, and sometimes even checks.

For many of the 17 people I've helped with insurance claims, an explanation of how their claims were paid—checking amounts against bills—was all that was necessary. We pore over Explanation of Medicare Benefits, the Medicare Handbook, insurance policies, explanation of benefit letters, and usually it all

comes clear and no mistakes have been made. This is a confusing, frustrating experience, even for me, and I've seen lot of bills, Explanation of Medicare Benefits and insurance settlements. It is a frightening thing for an elderly person to think that (s)he may have been cheated, or that (s)he may have not made a claim correctly, or (s)he should have gotten more money and (s)he can't understand why or what or who or how. Medicare and one Medicare supplement paying on a single hospital stay can be a nightmare of confusion for an elderly person. A few cases have been very complicated. The client and I just cry together and keep on trying.

### INADEQUATE INSURANCE COVERAGE—8 CLIENTS

Clients who have inadequate coverave may:

(1) Believe Medicare is sufficient. Since Medicare alone pays as well or better than lots of insurance people may have had before reaching 65, they believe they don't need further coverage. Usually they are not prepared financially to co-insure with Medicare.

(2) Think an indemnity plan or disease plan is sufficient. Unfortunately insurance agents often sell a policy with a daily hospital indemnity and a surgery schedule and imply (or mistakenly think themselves) that this is all a person needs to supplement Medicare.

(3) Have purchased packages of insurance which may be incomplete. The AARP plans are an example of this, and there are others sold in Grant County.

I've had eight clients with private insurance that did not adequately supplement Medicare. Most of these had indemnity plans, some with surgical schedules. Sometimes the plans were limited, i.e. accident or cancer policies. It requires a knowledge of all the health plans available to residents of Grant County to be able to counsel people on how to supplement existing insurance. Fortunately with the new rules for Medicare supplements in Wisconsin, a lot of the "guess work" is taken care of in this area.

### NEED ADVICE ON WHAT TO PURCHASE—16 CLIENTS

Shopping for a Medicare supplement is somewhat easier now in Wisconsin with the new state rules enacted by the Commissioner of Insurance. However:

(1) There are presently problems with prices of qualifying plans. As of today only one plan can be honestly recommended.

(2) Because most companies don't have a qualifying Medicare supplement to market right now—many people will buy indemnities and surgery schedules to supplement Medicare.

(3) People approaching eligibility for Medicare don't understand how it pays. The Medicare Handbook is excellent but still confusing to some elderly people.

(4) People with existing coverage don't realize they can often convert to a Medicare supplement with the same company for a lower premium.

(5) Some people refuse to purchase Medicare Part B.

(6) People don't understand pre-existing condition clauses.

I've advised 16 people on what to purchase. As of May 1, there was only one Medicare supplement in Wisconsin I could advise a client to purchase, because of its rating (2) and cost ($17 less than any other plan regardless of rating). I use the Insurance Commissioner's booklet, "Health Insurance Advice for Senator Citizens" 1978, to explain Medicare supplements and find it a valuable tool.

### NURSING HOME COVERAGE—EVERY CLIENT

Because one out of five elderly people in the U.S. will spend some time in a nursing home during a lifetime, nursing home bills pose a real threat to a person with a limited income and assets to protect. In Wisconsin at this time there is no adequate insurance for all types of nursing home care. There is "Nursing Home" insurance available and it is marketed widely in Grant County. The policies themselves are adequate for two to four years of skilled nursing care in a state-approved nursing home. As nursing homes are used more and more as a recuperative step between the hospital and final recovery at home, skilled nursing home policies can be an important part of an elderly person's total insurance coverage (depending on a person's asset level and possible eligibility for Medical Assistance). These policies, the nursing home coverage in many Medicare supplements, and the coverage Medicare provides are often confusing to elderly people because:

(1) They don't understand the difference between Skilled and Custodial Care, and therefore don't realize a nursing home plan won't pay on all nursing home bills.

(2) Most nursing homes are not covered by Medicare.

(3) They don't realize that Medicare rarely pays for nursing home care because of strict regulations in Medicare-approved homes for care to meet Medicare standards for payment.

(4) Many Medicare supplements and nursing home riders and policies only pay when Medicare pays in a Medicare-approved home.

(5) Strict requirements must be met before any skilled nursing home will pay.

I spend time with each client explaining custodial and skilled care and where and how Medicare pays for care in Grant County nursing homes. Recently I've developed a speech to give to senior citizen groups on nursing home coverage—it takes a good 15 to 20 minutes to explain nursing home insurance. Emphasis must be placed on the inadequacies of Medicare in this area and also how a person should examine his or her own financial situation to determine whether a nursing home policy is advisable in his or her case. A nursing home stay is often devastating financially because often income-producing assets must be dispersed to pay for care. The tragic situations are: a wife or husband outside the nursing home depleting life's savings until the nursing home resident is eligible for Medical Assistance, or the single person, returning home to a reduced income after depleting income-producing assets to pay for a lengthy nursing home stay.

SUMMARY

The problems I've encountered concerning insurance to supplement Medicare are caused by ignorance on the part of people selling insurance and of people buying insurance and of people collecting insurance claims. Ignorance on the part of elderly consumers is understandable because this is a very confusing area. Unfortunately published statements often add to the confusion.

"Insurance to supplement Medicare and Medicaid" when Medicaid needs no supplement.

"Medicare pays for the first 20 days in the nursing home" when very few nursing homes are Medicare approved. Medicare, in fact, pays for only around 3% of the nation's nursing home bill.

There is a lot of education necessary in all segments of the health care system from consumers, to insurance salespeople, to doctors, to Medicare clerks, to hospital social workers, to Social Security Claims Representatives. Many of these people are excellent in their ability to counsel on Medicare and insurance; some aren't. Unfortunately for the person 65 or older it's difficult to become knowledgeable on all the facets of health care and insurance. Getting advice from someone not well acquainted with the health care financing picture in his or her town or county can be disastrous.

The answer to most complaints is education and someone to call for help RIGHT NOW when things are going wrong. I want to see more health care financial management counseling done on a local level. The health insurance counseling and help with claims that I provide is inadequate for the number of elderly people in the area I serve. From my work so far I believe the great majority of people over 60 in Grant County need information and/or advice on insurance. Many need help submitting and understanding insurance claims.

Presently I provide group counseling through speaking on Medicare and Medicare supplements and nursing home insurance at senior citizen clubs or on the radio. I provide individual counseling at a client's home or other location (office, nutrition site, senior citizen club). This counseling includes an explanation of existing policies and Medicare, and discussion of the client's unique problems (including financial situation if necessary). If help with claims is necessary, this is provided. In all cases the client is encouraged to take necessary action once (s)he understands what must be done. Otherwise I help with claims. In all cases follow-up is provided.

The attached letter describes a case I'm working on with a couple which has become a short course on insurance counseling and filing claims. I'm not only concerned with this couple's latest hospitalization, but with past medical care as well. They had too many policies: a group health plan, AARP plans, three Medicare supplements, a nursing home plan, cancer plan, and accident plans.

They had no knowledge of which policies were in force. Before I started working with them they had many doctors and hospitals submit claims on policies that were not in force at the time. Even now when they receive benefits, they are reluctant to apply them to their medical bills, and they are reluctant to drop any policies that are in force. They have no family in the immediate area to assist them in filing claims. I have been able to recover about $475 for this couple so far. They illustrate practically all the problems elderly are apt to encounter with Medicare and private insurance. And because of their nursing home bill (in a Medicare-approved skilled nursing home no less!) all the money I can collect from every one of their policies still won't come close to paying for their health care in 1977.

---

ITEM 3. LETTER TO RICHARD AUDETAT, GRANT COUNTY COMMISSION ON AGING, LANCASTER, WIS., FROM DENISE HILL, PLATTEVLLE MUNICIPAL NURSING HOME, PLATTEVILLE, WIS., DATED MAY 1, 1978

DEAR MR. AUDETAT: I would like to comment on the recently developed position of Benefit Specialist for Grant County. I am the social worker at the Platteville Municipal Hospital and Nursing Home, and I am approached often by patients, residents, and families with questions regarding Medicare and insurance. My knowledge of such matters is limited, and in one case in particular I called upon Jo Pebworth for help. The case involved a married couple who had been in our nursing home for several months. They were about 90 years old, and had been handling their own financial affairs. Their children lived out of town, and they were not willing to let their friends and neighbors get very involved in their business. During their stay in the nursing home, I had many discussions with them regarding their financial resources, Medicare, and their insurance coverage. They were not eligible for Title XIX, and had minimal coverage in the nursing home by Medicare Extended Care. They had limited financial resources, and were very concerned about the cost of their nursing home care. During the course of our discussions I discovered that they had numerous insurance policies, (at least 8 or 9 each), some of which they thought covered nursing home care. Unfortunately, they had no copies of the policies with them, and their records at home were incomplete and disorganized. I worked closely with the couple and with our nursing home insurance clerk to try to uncover the facts about their insurance coverage. It was quite time-consuming for the insurance clerk and myself, and very frustrating and worrisome for the couple. When the couple was discharged to their home in October 1977, we were still awaiting replies from several insurance companies, and their bills were still pending. At this point, I explained the situation to Jo Pebworth, and asked her to help us. Since I have neither the time nor the expertise to do the amount of follow-up that would have been necessary after their discharge, the availability of a Benefit Specialist proved to be an invaluable resource. I have spoken with this couple several times since their discharge, as well as with Jo. It has been a very time-consuming case for her, also, and they have told me how grateful and relieved they are for her assistance. By corresponding with insurance companies, identifying overlapping policies, and advising them as to which policies are necessary, she has enabled them to significantly reduce their premiums. By working with me and with our insurance clerk, she is gradually straightening out their nursing home bills. In addition to saving them money, Jo has been able to save them countless hours of worry and frustration. Had there been no Benefit Specialist to call on, I honestly do not think the outcome would have been nearly as favorable.

This rather lengthy narrative is just one example of an instance in which a Benefit Specialist was a valuable resource. I hope that such an involved case won't come up again, but I have learned that the lack of information regarding Medicare and insurance is widespread, especially among the elderly. The accessibility of knowledge and skilled intervention in this area is a necessity for Grant County.

Sincerely,

DENISE HILL.

# Appendix 5

## "WHAT YOU SHOULD KNOW ABOUT HEALTH INSURANCE WHEN YOU RETIRE," PUBLICATION OF HEALTH INSURANCE INSTITUTE, WASHINGTON, D.C.

---

## Introduction

This short booklet is designed to give you the practical information you need to know about Medicare and about the use of private insurance after you retire to help you avoid the costly expenses associated with periods of illness requiring hospitalization and surgery.

Because the gaps in Medicare can add up to considerable expense, private insurance companies have developed a number of gap-filling coverages.

In the following pages, we will introduce you to the meaning of some common health insurance practices; we'll analyze how Medicare works in practical terms and we'll show you how supplementary policies can fill in the gaps.

Obviously this little booklet won't turn you into a health insurance expert. But we hope we can give you enough understanding of these important government and private health programs to enable you to deal more confidently with the choices available to you.

On the next few pages are plain language definitions of health insurance terms. Once you have read through them, the rest of the booklet should be easy to understand.

## Some common health insurance practices

Health insurance policies can appear confusing. Because they are legal contracts, they employ precise legal language. We won't try to tell you what all the terms mean. But we can describe in everyday language the concepts those words spell out legally. The concepts employed by both the Medicare program and by private insurers are marked with an asterisk.

***Deductible:** An initial amount of health expenses for which you are not compensated.

***Co-insurance:** A percentage of a health expense for which you are responsible after paying the deductible amount. A policy that uses co-insurance typically would pay up to 80 percent of a given expense, and you would pay the remaining 20 percent.

**Pre-existing Condition:** A current health problem which you had prior to becoming insured.

*Exclusion* — In connection with a pre-existing condition, it means that the policy will not pay benefits for illness arising from that condition.

*Waiting Period* — It means benefits will not be paid for a pre-existing condition until after you have had the policy for a specified period of time.

**Elimination Period:** This applies to a certain type of plan called a "hospital income policy", in which benefits may not be paid under the elimination period for the first several days of hospitalization. Elimination periods vary from policy to policy and from company to company. The result is their length can be selected: the longer the elimination period, the lower the cost of insurance. But you are less likely to receive benefits for a short period of illness.

***Benefit Maximum:** The limit a policy will pay for a given benefit. A benefit can be expressed either as a length of time (for example, 60 days of semi-private hospital room charges), or as a dollar amount (for example, $350 for a certain procedure).

**Lifetime Maximum:** Most plans have an upper limit on the total benefits they will ever pay. This lifetime maximum is commonly quite high.

**Reinstated Benefits:** Some policies will restore the lifetime maximum according to a specified schedule during periods when you are not drawing benefits.

**Entrance Age:** The age up to which the company will sell you a policy. Entrance ages vary considerably from company to company and some policies can be bought at any age.

**Guaranteed Renewable:** The company agrees to continue insuring you up to a certain age as long as you pay the premium; and it cannot raise your premium unless it raises premiums for a particular class, such as everyone in your geographical area with the same kind of policy. Some policies are guaranteed renewable for life.

**Conditionally Renewable:** The company will continue insuring you as long as it continues to insure people in your state with the same kind of policy.

**Renewable at Company Option:** The company reserves the right to stop insuring you as an individual. However, you cannot be cut off from receiving benefits under the policy in the midst of an illness.

# Medicare

Medicare was never meant to be an all-inclusive health insurance program. It is designed mainly to relieve people aged 65 and older of the major part of medical costs associated with hospitalization, surgery and lengthy periods of recovery.

Local Social Security offices keep a booklet on hand which describes in detail how it all works. Deductibles and co-payments are periodically changed and it is sound practice to keep a current copy handy.

The summary that follows shows how Medicare works and what it does not cover.

**Medicare Part A** *(Hospital Insurance)*

The first part of Medicare (Part A) is primarily a hospital insurance program. After you pay a deductible amount of $144,* Medicare pays for 60 days of full hospital care for each spell of illness, including all of the charges customarily associated with a hospital bill, such as the semi-private room rate, meals, regular nursing services, laboratory and X-ray fees, intensive care costs, operating and recovery room, drugs, casts, dressings, splints and in-hospital therapy services.

If a spell of illness goes beyond 60 hospital days, you become responsible for a $36* daily co-payment, up through the 90th day.

In effect, the program provides for most of the cost of 90 days of hospitalization each spell of illness.

In addition, the program provides a 60-day "lifetime reserve" of hospital days against which you can draw, should any spell of illness extend beyond 90 days. You must pay $72* for each day you use the "reserve."

Medicare Part A also pays toward extended care in a skilled nursing home, as well as part-time skilled nursing care at home. It works this way:

After a hospital stay of at least three consecutive days, Medicare helps pay for up to 100 days of extended care in a skilled

nursing facility, provided the nursing is certified as being connected with the illness that put you in the hospital. As with the hospital coverage, the nursing home benefit pays the charges normally associated with these facilities. The first 20 days of nursing home care are paid in full; the next 80 days of care requires an $18* daily co-payment from you. Your eligibility depends upon your need for skilled medical services. The program does not cover custodial care in a nursing home.

Medicare Part A also provides for 100 home nursing visits by skilled paramedical personnel. These benefits can include therapy, skilled medical services, and supplies and equipment provided by home health care agencies.

**Medicare Part B** *(Medical Insurance)*

The second part of Medicare, the one you pay premiums for, helps pay for physician and surgeon services both in and out of a hospital.

It works this way:

After you have paid a $60 deductible amount, the program will pay for 80 percent of reasonable medical charges; you are responsible for 20 percent of those charges.

The key word here is "reasonable" and Medicare determines what is a reasonable charge. It could be considerably below a physician's normal fee. Some physicians accept that figure but others do not.

So the basic question to ask when seeking medical services is: Will your physician or surgeon accept Medicare "assignment" — that is, accept only what Medicare will pay the doctor?

If so, your out-of-pocket expenses are limited to the deductible amount of $60, plus 20 percent of the doctor's charges. If not, your out-of-pocket expense will be (1) the deductible amount, (2) the 20 percent co-insurance and (3) that part of the doctor's charges in excess of Medicare's definition of a "reasonable" charge.

Aside from physician and surgeon benefits, Medicare Part B has a number of other benefits — most of them subject to the

*Deductibles and co-payments cited were those in effect as of January 1, 1978.

deductible and 20 percent co-insurance features. Remember, you do not pay the deductible every time you use one of these services. Once it is paid for — it is done with for the calendar year.

Other Medicare Part B benefits pay toward diagnostic tests, prosthetic devices, medical supplies, independent laboratory tests, certain ambulance services, radiology and pathology services, and administration of drugs that you cannot administer yourself, physical and speech therapy services and limited out-patient psychiatric, chiropractic and dental surgical care. Emergency room and out-patient clinical benefits are also included.

The Part B program, like Part A, includes 100 home visits by skilled paramedical personnel. These can be used after the 100 visits of the Part A program are exhausted, or independent of a stay in a hospital, provided your illness is covered under Part B of Medicare.

## A close look at the gaps

Medicare Part A (the hospital part) does not provide for all costs, but the gaps usually do not create big out-of-pocket hospital costs if you are ill for only a short while. The $144 deductible, which you pay, can usually be met by people living on a retirement income and the co-payments do not start until the 61st day.

However, a long illness and recovery period could mean some sizable costs. Your co-payments of $36 a day from the 61st to 90th day could run up your part of a hospital bill to more than $1,000. And if you had to use the "lifetime reserve" each day would cost you $72 in co-payments.

A working knowledge of Medicare can sometimes reduce this potential expense. If your illness looks as if it may last a long time, you and your physician should discuss whether the latter part of your treatment can be managed in a skilled nursing facility

instead of the hospital. From a cost point of view, this transfer should be made before you would have to begin co-payments. If you are eligible, the first 20 days in a nursing facility are paid by Medicare and the remaining 80 require daily co-payments by you of $18—substantially smaller than the $36 hospital co-payments.

And if the remainder of your recovery can be managed at home, you can also cut costs. Part A provides for 100 home health care visits per benefit period in connection with an illness that required hospitalization, while Part B provides another 100 visits.

This brings us to the gaps in the Part B program (the professional service part). These are less well-defined in dollar terms. You will recall that with Part B you would have to pay a $60 yearly deductible amount. But the rest of the gaps are expressed not in dollars, but in percentages of the bills. Since Part B pays for 80 percent of reasonable charges, bear in mind that important word "reasonable." If, for example, your doctor bills are higher than Medicare allows as reasonable, you become responsible for not only the 20 percent co-payment, but for everything over the allowable charge as well.

Furthermore, private duty nursing, which is sometimes required, is not covered. Nor are prescription drugs that you might require after you leave the hospital.

So, taken together, there is a sizable risk of incurring some substantial out-of-pocket costs under Medicare.

## Closing the gaps

First let's face the uncomfortable realities. As people age and become more prone to illness, the cost of insuring against illness goes up. Also, the longer you put things off, your choices of insurance policies become fewer.

So, assuming you've got several years before you reach age 65, let's examine what's available beforehand.

**Before age 65 . . . Group insurance**

The first thing to do is to check your group health insurance plan where you work, or in your professional or fraternal organization.

There has been a trend among new group plans to continue some coverage after retirement, with some employers paying part or all of the costs.

If that's the case with your plan, examine the benefits with your employee benefit personnel to see if those benefits cover the gaps we've discussed. If they do, take advantage of the privilege of continuing your health insurance when you retire, because group insurance benefits are often less expensive than what you can buy as an individual. You still may find it advantageous to continue a group plan that doesn't fill in all the Medicare gaps, and purchase an individual plan for those that remain.

Another point on your group insurance: Find out if there is a Health Maintenance Organization (HMO) in your area which accepts Medicare enrollees. If there is, your group health insurance in most cases automatically gives you the option of joining it.

An HMO is a community medical service plan. Its annual fee entitles you to its health facilities, professional services and supplies. HMOs which accept Medicare members compute the dollar-value of your Medicare benefits, plus the value of your supplementary group coverage, and charge you in dollars what it takes to meet their annual fee.

There is a reasonable chance your current group insurance, if it can be carried over into retirement, will serve as an adequate supplement to Medicare. There's also a chance that you don't have a group plan, or that your present plan is either inadequate or won't carry over. In that case you must then consider . . .

**. . . Individual insurance**

Let's next explore a couple of approaches you can consider prior to retirement.

*Major Medical.* This is a policy which individuals sometimes add to their basic group health insurance coverage, if it's not

provided by the group. It carries a deductible amount, which you pay, but which often can be met by the basic group plan. Major medical insurance has a co-insurance feature, for example 20 percent of expenses, which you pay; the insurance company pays 80 percent. Lifetime maximums under major medical insurance are quite high.

If your individual major medical policy is guaranteed renewable for life, it can extend the range of Medicare for you (since you can continue it into retirement) and it may cover hospital co-payments and some of your out-of-hospital, out-of-pocket costs. But you must check with the insurance company that issued it to determine precisely what benefits are available when you reach age 65.

It may be worthwhile to continue your policy into retirement, because almost all individual policies bought after age 65 include a waiting period, during which a prior health problem is not covered by the insurance. Here you would be vulnerable to out-of-pocket expenses from an ailment you were treated for beforehand.

There is another type of policy which you may want to consider buying prior to age 65.

*Hospital Income Policy.* This is a limited policy but has wide uses. Its benefits are paid only when you are hospitalized, but these benefits are in cash, which can be used for any purpose — filling Medicare gaps, extending Medicare's range, paying for anything that Medicare and other supplementary insurance doesn't pay for, including prescriptions at home, private duty nursing, out-of-pocket physician's charges and for building up a health cost reserve against future illness.

There are many types of hospital income policies. They are available either through agents or directly from insurance companies by mail. Like any product line that offers many choices, these policies require care in matching the plan to the need. They will also require periodic updating because their benefits are in dollars and health care costs continue to rise. And, as in the case of most individual major medical policies, hospital income policies contain a waiting period if you are presently ill, or have been recently ill, which is a reason for making your purchase before age 65.

If you are carrying over some health insurance into retirement, a hospital income policy can be useful in filling small gaps in an overall health insurance plan before age 65. How this type of policy can be used after age 65 will be discussed in the next section of this booklet.

**After retirement . . .**

If you've carried no private health insurance over into your retirement, there are choices available to you when you become eligible for Medicare. Two basic types of policies are available — the aforementioned hospital income policy, and the so-called wrap-around policy. And there are different ways to buy them — through agents, directly from companies by mail or through associations of retired individuals.

The big difference between the "wrap-around policy" and the hospital income policy is the type of benefits they pay. Each can serve as a satisfactory way to fill in the gaps that Medicare does not pay.

*The wrap-around policy . . .* This policy typically pays a high proportion of health expenditures Medicare doesn't pay for: First-day hospital deductible amount of Medicare Part A and the co-payments that begin on the 61st hospital day. Such a policy may also pay the $60 deductible amount associated with Medicare Part B and the 20 percent co-payment on physician and medical services you would ordinarily be responsible for.

Wrap-around policies typically will pay for a substantial part of a number of other health services not fully covered or not covered at all by Medicare, such as out-of-hospital prescription drugs, medical appliances and equipment.

Often these policies in effect, extend the number of hospital days covered under Medicare and they may also pay for the co-payments involved in a skilled nursing home stay.

Wrap-around policies vary somewhat from one another, but generally they fulfill their definition — that is, they wrap around and fill in the gaps of Medicare.

Wrap-around policies are available through agents of a number of insurance companies; through Blue Cross-Blue Shield organizations; and through at least two major retirement associations.

*The hospital income policy* . . . As noted, this kind of policy pays its benefits in cash on a daily basis when you are hospitalized. Because Medicare covers most of the cost of up to two months of hospitalization, many people set aside the early benefits of these policies against out-of-pocket costs that develop later in a spell of illness.

If a hospital stay doesn't generate big out-of-pocket costs, the benefits that are paid in cash under a hospital income policy can be banked to establish a health cost reserve against future illness.

To review, these plans deliver cash. It's up to you to pay the out-of-pocket costs as they arise.

In purchasing one or more of these policies, these are the elements to take note of as you match plan to need:

*Pre-existing condition clause:* This clause varies from policy to policy. Such a condition may delay the start of coverage for the condition from one to two years, or for as little as three months. The longer the period, usually the lower the premium — but also the longer your vulnerability to out-of-pocket costs if a pre-existing health condition requires treatment.

*Daily benefit amount:* Hospital income plans provide benefits ranging from a low of $10 a day to $80 a day. Some plans increase the daily cash benefit when hospitalization goes beyond a stated length of time.

*Elimination period* (sometimes called benefit waiting period): Some policies begin paying on the first day of hospitalization; others have different waiting periods. The longer the waiting period, generally, the lower the premium, and the likelier you will receive no benefits during a short illness.

*Duration of benefits:* Most of these policies pay their cash benefits from one to two years, as long as you are hospitalized. Some pay for less than one year; some for an unlimited duration of

a hospital stay. Some include benefits — usually at half the hospitalization benefit rate — for skilled nursing home stays which follow a period of hospitalization.

*Entrance age:* Many of these policies are written for retirees and can be purchased by people in their middle 60s, or 70s, and 80s. Some have no entrance age limit.

*Renewability:* It comes in three forms:

- Guaranteed renewable for life.
- Conditionally renewable, which means the company can't drop you as an individual policyholder, but it can cease to renew that particular policy in a given geographical area.
- Optionally renewable, which means the company has the option of ending your policy, at the end of a policy year, or when a premium falls due. You cannot, however, be cut off from benefits that are already begun during a covered hospitalization period.

*Licensing:* If the company is licensed to sell insurance in your state you will have recourse to your state insurance commissioner should a dispute arise.

*Retirement associations* . . . There are several associations of retired individuals that offer supplementary insurance. Membership fees in these associations are nominal and, in addition to offering insurance plans, they provide other programs of interest to retirees.

Typically, the health insurance plans they offer are wide ranging, permit enrollment regardless of previous health history and have fairly short waiting periods for pre-existing conditions.

## Talking it out

The following hypothetical conversation was developed from questions people frequently ask about supplementing Medicare.

**Q.** What is the first contact I should make?

**A.** Your local Social Security office. And do this at least several months *before* you reach 65. At work, contact your employee benefits person to find out if your group health insurance can be continued after 65 as a supplement to Medicare.

**Q.** What if it can be continued?

**A.** Check the benefits carefully to be sure there are no big gaps in insurance protection left between your plan and Medicare. If there aren't, most of the problem is non-existent.

**Q.** Most of the problem?

**A.** Remember that even with the major health protection gaps covered, there will be out-of-pocket expenditures. Sometimes these can be financed from current income or savings. But if it looks like these may be a burden, you should consider an individual policy to cover the extras.

**Q.** What if I can't continue my group coverage — or if continuing it doesn't seem advantageous?

**A.** There are basically two kinds of individual supplementary insurance plans you can buy: A "wrap-around policy" (described on Page 12) and a hospital income policy (described on Page 13).

**Q.** Where are they available?

**A.** Wrap-around policies are available through agents of some insurance companies; through at least two retirement associations; and at several of the area Blue Cross-Blue Shield organizations. Hospital income policies are available from insurance companies, either through agents or directly by mail, and from retirement associations.

**Q.** Hospital income policies pay only when you are hospitalized. Wouldn't this duplicate Medicare coverage?

**A.** True, they pay benefits only upon hospitalization. But they pay their benefits in cash, which you in turn can use to pay for any out-of-pocket costs that develop.

**Q.** Which is better?

**A.** Each has its strengths. Wrap-around policies generally try to do the job for you by covering the obvious gaps in Medicare, and by extending benefits beyond Medicare levels. Also because they pay their benefits as a percentage of the actual costs, these policies tend to respond automatically to inflation with higher benefits. This, in turn, is naturally reflected in periodic premium rises.

Hospital income policies pay their benefits in the cash you need to pay what Medicare does not, but you have to keep an eye on rising health costs. If they outrun your coverage, you might have to buy an additional policy — supplementing the supplement, so to speak.

**Q.** If that happens should I drop one policy for another with higher benefits?

**A.** Not necessarily. Often it's more advantageous to buy another policy for its additional cash benefits. A new policy will probably not cover a pre-existing health condition for a time, but this is usually not the case with a policy you already own.

**Q.** What about the "elimination period" where benefits are not payable immediately? Is it best to get first day coverage in the policy I buy?

**A.** Again, not necessarily. Decide if you can balance the benefits you want against the premiums you can afford. You may, for example, be able to pay for a short stay in a hospital out of your own pocket. If you think you can weather the first week without supplementary health insurance benefits, you could buy a policy with an eight-day elimination period and cut your premium by half. Also, some policies are specifically written to pay costs associated with Medicare co-insurance, which begins on the 61st day of a hospital stay and rises only after the 90th day. While premiums for such a policy are relatively low, the plan might not provide any cash for you to put aside against co-payments under Medicare Part B, or for health expenses you might have after leaving the hospital. A policy with a shorter elimination period would do this. For this reason, many retired people use the less expensive, long-elimination period policies as an extra supplement.

**Q.** If I've got ample supplementary coverage, should I consider dropping the Part B section of Medicare?

**A.** Never. Part B Medicare premiums are subsidized by the government, which means you get more for your dollar than through any other approach. Private health insurance is designed to dovetail with the Medicare program, not compete with it.

**Q.** Are nursing home benefits included in supplementary health insurance policies?

**A.** *Skilled* nursing home benefits may be. Custodial nursing home benefits, no. The general rule is if the patient requires professional nursing services in connection with an illness, it's covered. If it is custodial, it's not covered.

**Q.** What about nursing care at home?

**A.** Medicare provides for specified types of home nursing care. Some private health insurance policies also do this.

**Q.** Is private duty nursing in the hospital included in any policies I might buy?

**A.** Yes.

**Q.** Can I buy more than one such policy and have them both pay me?

**A.** That depends. Two hospital income policies will each pay their benefits, but generally, it's in your own interest to avoid over-insurance. A "wrap-around policy", and a hospital income policy often will both pay. But two wrap-around policies could cause problems, because the benefits likely would exceed the actual charges. It doesn't make sense to profit from an illness, and insurance companies usually follow this rule.

## Some final tips

• As you can see, both the Medicare program and many private supplementary health insurance plans are designed to keep you from going broke because of medical bills. So you have a continuing stake in not over using expensive health facilities.

32-703 O - 78 - 12

• Start a health emergency fund of your own. There will always be some out-of-pocket expenses associated with a period of illness, even with Medicare and a sound supplementary health insurance plan. If possible keep your emergency fund in a joint savings account so someone else can get to it when it's needed, if you can't.

• Skilled nursing services, either in a nursing facility or at home are made available — if you meet the qualifications — to help you avoid the higher costs of long periods of hospitalization.

• Your choice of physicians and surgeons should depend on your confidence in their skills. But don't hesitate to ask them about their fees and how they are to be paid.

• Your choice of supplementary health insurance should be made very carefully. Investigate, weigh benefits, compare, ask questions and don't be satisfied until you get plain-language answers.

• Claim forms should be made out carefully and fully. If they're not, delays may result, costing you money and concern.

• Check your bills and watch for deductible amounts which you must pay first.

• Don't overinsure. There are a lot better things to do with money in retirement than to pay premiums that duplicate or overlap other insurance coverage.

• Keep your health insurance up to date. Some policies adjust to inflation better than others. But health cost inflation is particularly virulent. So make sure the benefits of your policies have not been outdistanced. Review them annually.

• Don't drop one policy and buy another with similar benefits merely because the second one looks a little better, or is a little less expensive. You could delay benefits under a brand new policy.

• Use your health emergency fund to cover small expenses.

• Keep your health insurance policies in one place that is readily accessible and tell those close to you where they are. Then make a list of the policy numbers and the companies that issued them in case the originals are lost or misplaced.

## Appendix 6

# DECISION BY CALIFORNIA DEPARTMENT OF INSURANCE REGARDING AMENDMENTS AND ADDITIONS TO REGULATIONS RELATING TO INDIVIDUAL DISABILITY POLICIES DESIGNED TO SUPPLEMENT MEDICARE, DATED MARCH 21, 1978

STATE OF CALIFORNIA,
DEPARTMENT OF INSURANCE,
*San Francisco, Calif.*

In the Matter of the Proposed Amendments and Additions to the Regulations of the Insurance Commissioner Relating to Individual Disability Policies Designed To Supplement Medicare

**Ruling No. 221; File No. RH–191**

### DECISION

The attached Proposed Decision of Peter Groom, Deputy Insurance Commissioner, is hereby adopted by the Insurance Commissioner of the State of California as his Decision in the above-entitled matter.

IT IS SO ORDERED this 21st day of March, 1978.

ROGER L. MCNITT,
*Chief Deputy Insurance Commissioner.*

### PROPOSED DECISION

The above-entitled matter came on regularly for hearing in accordance with Notice published and disseminated pursuant to law before Peter Groom, Deputy Insurance Commissioner, in San Francisco, California, on November 1, 1977, in Los Angeles, California, on November 2, 1977, and in San Diego, California, on November 3, 1977, at which times exhibits, statements, arguments and contentions, both written and oral, were received. At the conclusion of the hearing the matter was submitted for decision, subject to the record being continued open until the close of business on December 7, 1977, to allow the filing of further statements and exhibits with respect to the matters covered by the hearing.

The matter having been duly heard and considered, the following PROPOSED DECISION and ORDER are hereby made.

### HISTORY

California Insurance Code § 10293(a) authorizes the Insurance Commissioner to withdraw his authorization for issue of individual hospital, medical and surgical policies if he finds that the benefits such policies provide are unreasonable in relation to the premiums charged therefor. The regulations promulgated pursuant to the cited section (Title 10, California Administrative Code, Chapter 5, Subchapter 2, Article 1.9) establish a 50 percent "benchmark" loss ratio (subject to certain corrections) as the minimum which a policy may attain and still be deemed to provide reasonable benefits relative to premiums. The regulations require that loss ratios for policies subject thereto be separately reported in a supplemental exhibit attached to insurers' Annual Statements.

Late in 1976, this Department's attention was drawn to the fact that a number of individual Medicare supplement policies issued in California did not appear to be attaining loss ratios of at least 50 percent. A list was then developed of all

such policies and the loss ratios therefor, pursuant to Title 10, California Administrative Code § 2222.13, which provides that the Commissioner may review the loss ratios of any policy ". . . at any time that he determines such review to be advisable or necessary". This list confirmed that numerous individual Medicare supplement policies were attaining loss ratios below 50 percent.

Medicare supplement policies differ from other types of hospital, medical and surgical policies in several respects. Basic benefits payable under such policies have changed almost annually since the inception of Medicare because of increases in Medicare deductible and co-payment amounts. Although claim amounts are usually modest, claim frequencies are high, which suggests high claims expense ratios. However, Medicare fiscal intermediaries perform the basic claims adjustment, which tends to balance the high claim frequencies when determining final expense ratios. In view of these and other factors, it was decided to hold public Investigative Hearings to gather information about the economics of Medicare supplement insurance, with a view toward determining whether the 50% benchmark loss ratio, established before the advent of Medicare, was appropriate for Medicare supplement policies. These Investigative Hearings were conducted on January 4, 5 and 6, 1977, in San Francisco, Los Angeles and San Diego respectively, before Joseph P. Powers, Deputy Insurance Commissioner. A representative group of insurers active in the marketing of Medicare supplement policies was requested to attend the hearing and present pertinent data. Members of the public were also invited to testify.

No information received during the Investigative Hearings suggested that individual Medicare supplement policies should be subject to any less stringent loss ratio requirements than any other type of hospital, medical or surgical coverage. Indeed, the "High Level" individual Medicare supplement plans offered by Northern California Blue Cross and Southern California Blue Cross attained loss ratios in the range of 75% to 90%, and representatives of these organizations felt comfortable with loss ratios in that range.

Generally, public witnesses were less concerned about the cost of Medicare supplement policies than with their design and solicitation. Many witnesses told of purchasing policies which they thought provided broad protection and then finding, at time of claim, that they were covered for only a small portion of the expenses not paid by Medicare. Others complained that the policies were so complicated that they were unable to determine what was covered. Finally, numerous instances of questionable solicitation practices were brought to light. The new and amended regulations proposed in the Notice of Hearing in this matter, dated September 29, 1977, addressed these problems.

## EXPLANATION

The testimony and the statements received at the hearings on the proposed regulations having been considered, the following actions are taken regarding the numbered items in the Exhibit attached to the Notice of Hearing in this matter dated September 29, 1977. The amended regulations appear in the Exhibit attached to this Proposed Decision.

(1) The "follow-up form", set forth in the proposed Article 8, was intended to enable insurers to monitor the actions of their producers more effectively so as to reduce the incidence of misrepresentation, replacement of existing policies with new ones upon which higher commissions are paid, and "loading-up" of insureds with many duplicating policies. The forms were also intended to provide a direct line of communication between the insured and the insurer independent of the producer soliciting the policy. The proposed Article 8 of Subchapter 1 is not adopted.

The proposed "follow-up form" received little support from public witnesses or industry representatives. Several witnesses criticized the form as adding to the proliferation of pieces of paper which accompanies the delivery of most insurance policies today and noted that the form overlapped the already required Supplemental Disclosure Form, thus contributing to possible confusion of insureds. It was also stated that insurers have difficulty in getting insureds to respond to mail communications, even where a response is to the insured's personal advantage. One witness stated that a response ratio of 50 percent was seldom achieved in the best of circumstances. With such a low probable response, the usefulness of the form in monitoring producers' activities would be doubtful. Also, most industry representatives objected to the additional administrative

expense which use of the forms would entail, which expense would be passed along to insureds in increased premiums. It should be noted that although several of these representatives were requested to submit expense projections after the hearings, no such information was ever received. Finally, several industry representatives felt that the required offer of rescission was inconsistent with Insurance Code § 10276 and that the proposed article provided insurers with too little guidance as to what was to be done with the information which would be collected from the returned follow-up forms.

Several witnesses stated that the Supplemental Disclosure Forms, use of which had become mandatory only six months before the Investigative Hearings in this matter, appeared to be working well. Indeed, most of the public testimony concerning insureds who were confused about what they had purchased involved policies issued before use of such Forms had become mandatory. There was considerable agreement among the witnesses that establishment of independent lines of communication between insurers and insureds had some merit and it was suggested that the Disclosure Forms could be modified to provide for it. This suggestion has been incorporated in the amended Disclosure Forms Regulations discussed below.

(2) The amendments proposed to § 2220.29 were to increase the minimum hospital indemnity benefit to $15 per day and to prohibit the labeling of policies subject to that Section as Medicare Supplement Policies. The proposed amendments are adopted. (See Item 1 in the attached Exhibit.)

The increased hospital indemnity benefit was opposed by industry on the grounds that the necessary increased premium might prevent some less-affluent prospective insureds from purchasing any type of coverage. Although this is a primary consideration whenever a minimum benefit is increased, it seems unlikely that an appreciable number of persons would be prevented from buying this product. On the other hand, the expenses for which such coverage is generally purchased have increased substantially in the five years since the previous $10 per day minimum benefit was established. Also, the $15 per day minimum benefit is consistent with Insurance Code § 10291.5(b)(9), which prohibits reductions on account of age exceeding 50% and the minimum $30 per day minimum benefit for those under 65.

There was no opposition to the proscription against labeling a hospital indemnity policy as being supplemental to Medicare, it being accepted that this type of policy is not a true Medicare supplement coverage.

(3) The principal amendments proposed to § 2220.30 were to require that both Parts of Medicare be supplemented by any "Medicare Supplement Policy", but with a proviso that coverage could be limited to expenses incurred while hospital confined. The proposed amendments also posited a "Catastrophic Medicare Supplement" policy which would provide supplemental benefits on a "blanket" basis subject to a "corridor deductible." The proposed amendments, further modified as discussed below, are ADOPTED. (See Item 2 in the attached Exhibit.)

Several witnesses pointed out that requiring coverage of the Part A Medicare deductible perpetuated the "dollar trading" situation that the proposed subparagraph (c) was intended to eliminate. Therefore, coverage of the Part A deductible will remain optional with the insurer, as provided in the prior regulations.

Industry representatives expressed considerable opposition to the requirement that both Parts of Medicare be supplemented by a Medicare supplement policy. Several insurers stated that their Part A-only supplemental policies were their best sellers and were concerned that the addition of Part B coverage would increase premiums to the extent that fewer persons would purchase supplemental policies. Some insurers seemed to believe that, so long as the premium-benefit ratio was reasonable for a policy, the philosophy of the Minimum Benefit Law was respected, even though the benefits provided were quite modest. However, Insurance Code § 10291.5(b)(7), pursuant to which Minimum Benefit Standards are promulgated, specifically excepts consideration of premium from the determination of what constitutes a benefit of "real economic value". The principal benefits provided by most Part A-only supplemental policies are for the initial deductible and for the co-payments for days of hospitalization after the 60th day of confinement during a Medicare benefit period. As the average hospital stay for a person over 65 years of age is approximately 12 days (American Hospital Association, 1974), the principal benefit payable under most Part A coverages will be that for the initial deductible. Since the premium for that benefit is in the

range of one-third of the deductible amount, there is some doubt that the initial deductible should be insured at all. In 1974, Medicare paid less than 40% of the overall health costs of Medicare beneficiaries, but Part A of Medicare covered over 60% of all the expenses covered by it. (Private Health Insurance Supplementary to Medicare—A Working Paper—Special Committee on Aging, U.S. Senate, December, 1974.) Therefore, it is concluded that, for most persons, the need is greater to supplement Part B of Medicare than to supplement Part A, and Part B coverage is made mandatory in the amended regulation. Much of the concern over the high premiums which would be required to supplement both Parts of Medicare was in the context of the initial proposal that Part A initial deductibles be covered. The deletion of required coverage for the Part A deductible should ameliorate to some extent the premium impact of the mandatory Part B coverage.

There was no testimony opposing the restrictions on coverage for the Part B annual deductible as the annual premium for unrestricted coverage of said deductible exceeds one-half of the deductible amount itself. Such "dollar-trading" is not economic insurance, since it amounts to the insured and the insurer merely exchanging dollars with one another to cover a type of loss which most insureds will incur with considerable regularity. Furthermore, it is an unequal exchange because of the relatively high proportion of expense to the benefit paid.

Considerable public testimony was received objecting to permitting any restriction on coverage for pre-existing conditions, as Medicare covers all pre-existing conditions. Industry representatives were quite concerned about "anti-selection", since the coverage in question is voluntary. In recognition of the public concern over coverage for pre-existing conditions and the existence of many policies which contain six-month pre-existing conditions provisions, the proposed regulation has been amended to provide a six-month waiting period for coverage of conditions treated during the six months preceding the policy date.

It was pointed out that Part B of Medicare pays benefits on a calendar year basis, rather than a "per cause" basis, and subparagraph (b) has been amended accordingly. No testimony was received concerning the $1,000 minimum benefit per calendar year for Part B.

"*Grading of Policies*". At the Investigative Hearing of January, 1977, considerable support was expressed for a system by which Medicare supplement policies would be categorized or "graded" depending upon the coverage they provided. This Department carefully considered such an approach and examined the regulations then being proposed in Wisconsin, which established five different types of policies, ranging from a Part A-only supplement to one which covered virtually all expenses not paid by Medicare. However, such a system necessarily assumes something akin to a set of standardized forms, as relative grades would mean little if one policy provided more ancillary benefits (such as extensive nursing benefits) than another, but did not provide one of the required basic coverages for a particular grade. Furthermore, there is such a vast range of possible supplemental benefits to Medicare that it would be difficult to consider them all properly in a comprehensive grading system. Finally, Insurance Code § 10291.5(g) prohibits the Commissioner from prescribing standard forms of disability policies, while his authority under Insurance Code § 10291.5(b)(7) is limited to the setting of *minimum* benefit levels.

Nevertheless, the amended Supplemental Disclosure Form regulations (discussed below), recognize three basic categories of Medicare supplement policies, which categories are named descriptively, rather than by "grade", so as to avoid implications that one category is necessarily inferior to another relative to the needs of the prospective insured. These categories are "in-hospital", "in-and-out-of-hospital" and "catastrophic" Medicare supplement policies and are reflected in the amended § 2220.30.

"*Catastrophic Coverage*". There was call from some public witnesses for a policy which would "cover everything", but those witnesses gave little consideration to the premium consequences of requiring such coverage. Related to this was the consistent complaint that Medicare characteristically underpays its portion of coverages under Part B, on grounds that the charges made by providers of services are excessive. As traditional Medicare supplement policies provide benefits based upon Medicare's determination of proper charges (e.g., pay 25% of what Medicare pays under Part B for a particular service), the insured may still be faced with a substantial liability after exhausting Medicare

and supplemental policy benefits. In response to this problem and the call for broadly based supplemental coverage, the amended regulations establish guidelines for "Catastrophic Medicare Supplement Coverage", which, in essence, would be administered in much the same way as a comprehensive group major medical plan. Based upon the *insurer's* latest standards of what constitutes "usual, customary and reasonable" charges for the services rendered, such a policy would pay the difference between such charges and what Medicare pays. An annual "corridor deductible" is permitted to enable premiums to be kept at a reasonable level. Of course, the Commissioner has no authority to require that such a coverage be made available, although we understand that some group supplemental plans are set up along these lines. It is hoped that carriers will offer coverage of this type on an individual basis, thereby filling most of the gaps in Medicare coverage.

"*Special Medicare Supplement Policies*". The final paragraph of § 2220.30 recognizes the Commissioner's authority to approve limited Medicare supplement policies such as those providing nursing home benefits. However, the Commissioner does not contemplate approving Part A-only or Part B-only Medicare supplement policies under this exception.

"*Skilled Nursing Benefits*". Meaningful testimony was received concerning the value of and the need for substantial supplementation of Medicare's skilled nursing facility coverage. One insurer representative testified that almost one-half of the benefits paid under his company's broad coverage Medicare supplement policy were under the private duty nurse and nurse-at-home benefit. As considerable reservations were expressed concerning the impact on premiums of requiring that Part B of Medicare be supplemented in all policies, it was decided not to require at this time that extended care facility and home health visits be supplemented. However, the amended Standard Supplemental Disclosure Forms for in-hospital and in-and-out-of-hospital policies now specifically reflect whether such coverage is provided.

(4) The amendment proposed to § 2222.12 was to establish a separate loss ratio category for Medicare supplement policies and to set a minimum "benchmark" loss ratio for that category at 60%. The amendment, modified to require a 55% loss ratio, is ADOPTED. (See Item 3 in the attached Exhibit.)

Strong insurer opposition was encountered to any increase in the present "benchmark" loss ratio of 50%. Insurers made the point that, to be assured of attaining a 60% loss ratio, they would have to aim for a 65% or a 70% loss ratio, which might make such coverages unprofitable, especially for agency companies. This argument was urged, however, in the context of the now withdrawn proposal that loss ratios be based upon California-only experience, which would not be credible for many companies.

A producer complained that agents would perhaps bear an unfair portion of the burden imposed by the proposal because an increase in the loss ratio benchmark would result in a reduction in commissions, which are already modest because of the relatively low premiums charged for most Medicare supplement policies. This was corroborated by several insurer representatives. Although it was generally admitted that sales through individual agents may not be the most economical method by which to market Medicare supplement coverages, it was accepted that the personal contact and service provided by individual agents is very important to many consumers.

Those opposing the increased loss ratio requirement did not believe that any jurisdiction required more than a 50% loss ratio. However, several states including Nevada and Florida, have regulations or guidelines requiring loss ratios in excess of 50%. Florida, like California, has a large number of senior citizens, and we understand that the Insurance Commissioner of that State is reviewing the loss ratios being attained by individual Medicare supplement policies issued to citizens of his state. (Florida has the highest percentage of persons 65 and over of any state. Administration on Aging, U.S. Department of Health, Education, and Welfare, 1973.)

Most senior citizens are on fixed, low incomes. In 1975, the average income of those over age 65 was $4,800, compared to an average income for the age group of 18–64 of $12,400. Additionally, one out of every six seniors is existing at the poverty level, versus one out of every ten persons in all other age groups. (U.S. Department of Commerce statistics quoted in Lamb and Duffy, *The Retirement Threat*, J. P. Tarcker, Inc., Los Angeles, CA 1977). In view of the characteristically low and shrinking disposable income of the elderly, we find that they

constitute a proper separate class for the purposes of determining appropriate loss ratios. However, because of the concern expressed by many about the impact of a 60% benchmark loss ratio on the availability of individually solicited policies, the required loss ratio is hereby set at 55%. This Department will not monitor the reaction of the insurance industry to the increased loss ratio "benchmark" to see if it affects the number of companies marketing Medicare supplement coverage.

(5) The amendment proposed to § 2222.19 was to require that the loss ratio requirement of § 2222.12 be based upon California loss experience and to require explicitly that experience for Medicare supplement policies be reported in the supplement to the Annual Statement. The proposed amendment is ADOPTED, amended to delete the requirement for California-only experience and to require that individual Medicare supplement policies be specifically identified in the supplement to the Annual Statement. (See Item 4 in the attached Exhibit.)

Most industry representatives opposed the requirement that loss ratios, for the purpose of Article 1.9 of Subchapter 2, be based on California experience only, because the resulting premium volume for many insurers would be so small as to lack actuarial credibility. They pointed out that loss ratios on small premium volumes tend to vary widely from year to year, so that, to be sure of exceeding the benchmark loss ratio, higher target loss ratios must be established, thereby compounding the reduction in the margin for profit and expenses resulting from the increased loss ratio requirements of § 2222.12, as amended. No testimony was received regarding the explicit requirement that Medicare supplement policy loss ratio experience be reported.

The industry's opposition to requiring California-only experience is well-taken. No regulatory purpose is served by acting upon statistics which may not be credible and the amendment, as adopted, leaves it to the discretion of the insurer whether to report California or nation-wide experience.

This Department's review of loss ratios in conjunction with our Investigative Hearings of January, 1977, was considerably complicated by the failure of many Annual Statement Supplemental Exhibits to identify those policies providing Medicare supplement coverage. The new requirement that such policies be identified is consistent with the establishment of a separate loss ratio class for them in § 2222.12.

(6) The proposed amendment to § 2536.8 was intended to draw prospective insureds' attention to the fact that out-of-state group plans might not be subject to California laws. However, several witnesses pointed out that the proposed requirement would tend to suggest to California consumers that complaints concerning such plans be referred to the Insurance Commissioner of the state in which the master policy was delivered, whereas this Department has a strong interest in receiving all complaints about insurers doing business in this State. Also, this requirement would have impacted many legitimate group insurance plans based on out-of-state master policies and would have tended to place them at a competitive disadvantage compared to domestic group plans. For these reasons, the proposed amendment is NOT ADOPTED.

(7) The proposed amendment to § 2540.4(b) makes it consistent with the requirement stated in § 2540.5(k) that paragraph [2] be included in Supplemental Disclosure Forms for use with Medicare supplement policies and is ADOPTED. (See Item 5 in the attached Exhibit.)

(8 and 9) The proposed amendments correct an ambiguity in Ruling No. 200A of November 24, 1975, are technical in nature and are ADOPTED. (See Items 6 and 7 of the attached Exhibit.)

(10, 11, and 12) The amendments proposed to the Standard Supplemental Disclosure Forms for use with Medicare supplement policies responded to the interest expressed by many public witnesses in some means to categorize or "grade" such policies. (See "Grading of Policies", in paragraph 3, above.) The proposed amendments also reflected the amended minimum benefit requirements. Those amendments, further modified as discussed below, are ADOPTED. (See Items 8 through 11 in the attached Exhibit.)

Although the follow-up form discussed in paragraph 1, above, was not adopted, several witnesses expressed their belief that opening up a line of communication directly between insureds and insurers was a valuable concept. It was suggested that this could be accomplished by incorporating the effect of the originally proposed § 2192.3(e) in the Disclosure Forms for Medicare supplement policies, and this has been done in the adopted amendment, along with appropriate in-

structions. To make doubly sure that Disclosure Forms are properly delivered, so that this direct line of communication will be established, the regulation is further amended to require that insurers establish affirmative procedures for ensuring such delivery. Although the modified amendment describes, by example, several acceptable affirmative procedures for ensuring such delivery, insurers are allowed discretion to develop other reasonable procedures.

As discussed previously (paragraph 1, "Skilled Nursing Benefits"), considerable testimony regarding the importance of skilled nursing facility coverage was received. Although such coverage is not required at this time, the amended Disclosure Forms state whether or not it is provided.

Several witnesses pointed out that paragraph [2] for the "in-hospital" and the "in-and-out-of-hospital" policy Disclosure Forms was much less readable than the same paragraph in the "catastrophic" policy Disclosure Form. Those paragraphs have been re-drafted to make them more readable. The statement of the computation of the co-payment benefit for Part B was modified to recognize that some insurers provide benefits therefor in different ways.

READABILITY

Many complaints were received concerning the difficulty of understanding Medicare supplement policies. Most are complicated in design and abstruse and legalistic in text. Complicated design will always be a problem with Medicare supplement policies because of the complexity of Medicare, but it is obvious that most insurers have made little effort to simplify the text of such policies. Although Insurance Code § 10291.5(a) (2) (added in 1974) directs the Commissioner to ensure ". . . that the language of all (individual disability) insurance policies can be readily understood and interpreted", the Commissioner is given no authority to promulgate standards for evaluating the readability of policies. However, pursuant to this Bulletin No. 78–7, dated March 1, 1978, the Commissioner now requires that Flesch Readability Test Scores accompany all submissions of individual disability policies and benefit riders. It is hoped that this requirement will draw insurers' attention to the lack of readability of many of their products. One major insurer has already submitted an "easy-to-read" in-and-out-of-hospital Medicare supplement policy to this Department for approval. Using the "sampling" approach of Flesch Test scoring, the policy achieved a score of 73, which is considered to be a sixth grade reading level which would be attained by approximately 90% of the United States population. By contrast, another widely marketed broad-coverage Medicare supplement policy attained a score of 40, which is considered to be a "high school or some college" reading level which would be attained by approximately 33% of the United States population. (Flesch, Rudolph. *How to Test Readability*; Harper & Brothers, New York, N.Y. 1951.)

Some insurers have stated that they have not attempted to improve the readability of their disability policies because of required and hard-to-read statutory language, primarily the Compulsory Uniform Policy Provisions (Insurance Code § 10350, *et seq.*). Indeed, one of these provisions attains a Flesch Test score of 16, which is considered to be "very difficult" and which is typical of scientific or professional writing. However, Insurance Code §§ 10350 and 10369.1 permit the Commissioner to approve language in lieu of the statutory Uniform Provisions so long as such language is not less favorable in effect to the insurance than the statutory language.

EFFECTIVE DATES

In order that insurers will have adequate "lead time" in which to comply with these amendments and in order that new policies and disclosure forms may be introduced coincidentally with the expected revision of Medicare benefits, the amendments set forth in the attached Exhibit will be effective on January 1, 1979, except for those pertaining to Minimum Benefits Standards (§§ 2220.29 and 2220.30) which shall be effective on May 1, 1978. However, insurers are encouraged to comply with the amended Standard Supplemental Disclosure Forms set forth in the attached Exhibit (Subchapter 3, Article 12.2, §§ 2540.5(k) through (n)) for policies complying with the amended Minimum Benefit Standards as soon as possible.

Insurers should note that, pursuant to Insurance Code § 10291.5(d), this Department intends to withdraw authorization of all Medicare supplement policies

authorized prior to May 1, 1978, to be effective December 31, 1978. Formal notification of such withdrawal of authorization will be sent to insurers later this year.

ORDER

Wherefore, It Is Hereby Ordered, by virtue of the authority vested in the Insurance Commissioner by §§ 790.10, 10291.5(c), 10293(a) and 10608 of the Insurance Code of the State of California that the proposed additions and amendments to Chapter 5 of Title 10 of the California Administrative Code be hereby made a part thereof.

CERTIFICATION

I hereby certify that the foregoing constitutes my Proposed Decision in the above-entitled matter as a result of the Hearings held before me, as the duly authorized Deputy of the Insurance Commissioner on November 1, 1977, at San Francisco, California, November 2, 1977, at Los Angeles, California, and November 3, 1977, at San Diego, California, and I hereby recommend its adoption as the Decision of the Insurance Commissioner.

Dated: March 6, 1978.

PETER GROOM,
*Deputy Insurance Commissioner.*

EXHIBIT.—CALIFORNIA ADMINISTRATIVE CODE, TITLE 10, CHAPTER 5

1. Amend Subchapter 2, Article 1.5, Section 2220.29 to read: "Insurance Issued to Persons Eligible for Benefits Under Medicare."

2220.29. *Hospital Indemnity Policies.* A daily hospital benefit, provided on other than an expense incurred basis and issued to a person eligible for benefits under Medicare, shall be deemed not sufficient to be of real economic value to the person insured if:

(a) It provides a daily hospital benefit of less than $15, payable for less than 60 days, or if it is a hospital benefit for mental disorders, and the period of time the benefit is payable is less than 30 days; or

(b) The elimination period, if any, exceeds one day for sickness benefits and one day for accident benefits; or

(c) The benefit is subject to any waiting period other than a waiting period for conditions specified in § 2220.10(b); or

(d) It excludes coverages or provides reduced benefits for exceptions, limitations or reductions other than those specified in § 2220.8; or

(e) It contains a pre-existing condition provision other than as specified in § 2220.30(d).

A hospital indemnity policy conforming to this Section may not be labeled or described as a Medicare Supplement Policy.

2. Amend Subchapter 2, Article 1.5, Section 2220.30 to read:

2220.30. *Medicare Supplement Expense Policies.* A policy designed to supplement Medicare shall be deemed not sufficient to be of real economic value to the person insured if:

(a) It fails to provide supplemental benefits to Part A of Medicare in the amounts of the co-insurance payment required for the 61st through the 90th day of hospital confinement and the co-insurance payment required for the lifetime reserve; and

(b) It fails to provide a supplemental benefit in the amount of the co-insurance payment required by Part B of Medicare of at least $1,000 per calendar year payable either while the insured is hospital confined, or payable regardless of whether the insured is hospital confined; or

(c) It provides a supplemental benefit to the Part B deductible for a calendar year during which the insured is not hospital confined; or

(d) It contains a pre-existing condition provision less favorable to the insured than one which excludes coverage for more than six months after the effective date of the policy for a condition for which medical advice or treatment was recommended by a physician or received from a physician within six months before the effective date of the policy; or

(e) It is subject to any exceptions, limitations or reductions (other than as specified in this Section) which are not consistent with the exceptions, limitations or reductions permissible under Medicare, other than a provision which

provides that coverage is not provided for any expenses to the extent that any benefit is available to the insured person under Medicare ; or

(f) It indemnifies losses resulting from sickness on a different basis than losses resulting from accident ; or

(g) It is designed in such a manner that the benefits will not be increased automatically to coincide with any changes in the deductible amounts and co-insurance percentage factors of Medicare coverage.

(h) This Section does not prohibit "Catastrophic Medicare Supplement Coverage" which provides benefits on a "blanket basis" for all expenses deemed by the insurer to be usual, customary and reasonable in the treatment of conditions covered in whole or in part by Medicare and which provides a maximum lifetime benefit of at least $25,000, subject to a deductible amount not to exceed $1,000. Such coverage may be subject to reasonable internal limits relating to psychiatric treatment and prescription drugs.

A policy issued to provide coverage for persons not eligible for benefits under Medicare which continues in force and provides coverage on a reduced basis for such persons when they become eligible for benefits under Medicare and provides benefits not less than the benefits required by this section, shall be deemed to meet the requirements of this section if the reductions relate to reducing or eliminating coverages to the extent that such coverages are provided or are available to the insured persons under either Part A or Part B of Medicare.

The Commissioner shall not approve any policy or rider benefit under this section when the payment of any item of expense or any benefit are subject to unreasonable conditions precedent to eligibility for and payment of such benefits. The Commissioner shall apply all applicable sections of the Insurance Code and this Article when making a determination pursuant to Section 2220.7 of this Article, that a policy or rider designed to supplement Medicare benefits will be of real economic value to persons insured thereunder. This section shall be construed to provide regulatory protection to the residents of California eligible for Federal Medicare benefits.

3. Amend Subchapter 2, Article 1.9, Section 2222.12, to read: . . . (ii) 35 per cent if the premium is at a lesser rate or (iii) 55 percent if the policy is designed to supplement Medicare.

4. Add a new paragraph to Subchapter 2, Article 1.9. Section 2222.19 to read: Policies designed to supplement Medicare shall be identified as such.

5. Amend Subchapter 3, Article 12.2, Section 25540.4(b) to read as follows: (b) *Drafting Instructions for Paragraph* [2]. Each benefit enumerated in the prototype description of the category of coverage shall be stated, regardless of whether the policy with which the disclosure form is to be used provides that benefit. Unless provided otherwise, this paragraph may be omitted if the optional text appearing in parentheses in Paragraph [4] is used in that paragraph. This paragraph may also be omitted if no such optional text appears in Paragraph [4] of the appropriate prototype form.

6. Amend Subchapter 3, Article 12.2, Section 2540.5(e)[4] to read as follows: [4] *Exceptions, Reductions and Limitations of This (Policy)*. (Benefits are not provided for physicians' or surgeons' fees nor for miscellaneous hospital services.) [The foregoing sentence may be modified to reflect the benefits provided by the policy.]

7. Amend Subchapter 3, Article 12.2, Section 2540.5(h) [4] to read as follows: [4] *Exceptions, Reductions and Limitations of This (Policy)*. (No benefits are provided for any loss resulting from sickness.) [The foregoing sentence may be modified to reflect the benefits provided by the policy.]

8. Repeal Subchapter 3. Article 12.2, Section 2540.5(k) and add a new Section 2540.5(k) to read as follows:

(k) *Disclosure Forms for Medicare Supplement Policies: Additional Instructions.* The following Prototype Standard Supplemental Disclosure Forms shall not be used with policies issued to persons eligible for Medicare which do not supplement Medicare on an expense-incurred basis.

Paragraph [2] shall not be omitted from the following Prototype Standard Supplemental Disclosure Forms. The name, address and telephone number of a representative of the insurer or the General Agent shall be inserted in the blank in the sentence following Paragraph [6]. (Such representative may not be the agent, if any, who solicited or delivered the policy.) Such representative shall be located in this State unless a toll-free "800" telephone number is specified.

Insurers shall establish affirmative procedures for ensuring that Medicare Supplement Policy Disclosure Forms are properly delivered pursuant to Insur-

ance Code § 10601(e) and 10605, where solicitation is made on an other-than-direct response basis. Such procedures could include physically attaching disclosure forms to field-issued policies; requiring return to the insurer of copies of disclosure forms signed by prospective insureds; or requiring separately signed acknowledgements of receipts on applications for insurance when such applications are returned to the insurer. (This requirement shall not be interpreted to mean that insurers need not establish reasonable procedures for ensuring that other categories of disclosure forms are properly delivered to prospective insureds.)

9. Add Subsection (1) to Subchapter 3, Article 12.2, Section 2540.5, to read as follows:

(1) *Prototype Standard Supplemental Disclosure Form for Policies Providing In-Hospital Medicare Supplement Coverage.* "In-Hospital Medicare Supplement Coverage" provides benefits, principally on an expense-incurred basis, to supplement the coverage provided under both Parts of Medicare for hospital-confined beneficiaries.

[COMPANY NAME]

IN-HOSPITAL MEDICARE SUPPLEMENT COVERAGE

OUTLINE OF COVERAGE

For (Policies) Issued in [insert year]

[1] *Read Your (Policy) Carefully.* This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] *In-Hospital Medicare Supplement Coverage.* This type of coverage is mainly designed to supplement your Medicare coverage while you are in the hospital. It will pay some of the dollar deductibles and percentage co-payment charges which you would have to pay without it. In general, it will not help pay your share of expenses for treatment outside the hospital.

[3] *Benefits of This (Policy).* [Alternate text in parentheses in this paragraph shall be selected depending upon the coverage provided by the policy. The Medicare deductible and co-payment charges for the year of policy issue shall be inserted in the blanks.]

To Supplement Medicare Part A Hospital Insurance, this (policy)

(a) (Pays) (Does not pay) the initial deductible amount for hospitalization during a Medicare Benefit Period. This year that amount is $——.[1] [The preceding sentence may be omitted where the initial deductible is not paid.]

(b) (Pays) (Does not pay) benefits for the first sixty days of hospitalization during a Medicare Benefit Period. [Disclose benefit, if any].

(c) Pays the co-payment charges for the 61st through the 90th day of hospitalization during a Medicare Benefit Period. This year, that charge is $—— per day of hospitalization.[1]

(d) Pays the co-payment charges for the "lifetime reserve" of 60 days of hospitalization. This year, that charge is $—— per day of hospitalization.[1]

(e) (Pays) (Does not pay) the co-payment charges for the 21st through the 100th day of confinement in a skilled nursing facility. This year, that charge is $—— per day of confinement.[1] [The preceding sentence may be omitted where skilled nursing facility confinement is not covered.]

[(f) Other benefits to supplement Medicare Part A Hospital Insurance.]

To supplement Medicare Part B Medical Insurance, this (policy):

(a) (Pays the calendar year deductible amount for any year during which you are hospitalized. This year, that amount is $——.[1])

(Does not pay the calendar year deductible amount.)

(b) Pays the co-payment charges for medical services provided while you are hospitalized. These charges are 25% of the benefits paid by Medicare Part B Medical Insurance. This (policy) will not pay more than $—— per calendar year for these co-payment charges. [If co-payment charges for medical services are

---

Footnotes at end of article.

computed on some basis other than the benefits paid by Medicare, the preceding sentence shall be replaced by a brief explanation of that basis.]

[(c) Other benefits to supplement Medicare Part B Medical Insurance.]

[4] *Exceptions, Reductions and Limitations of This (Policy).* This (policy) does not pay benefits if you are not confined in a hospital or a skilled nursing facility. [The preceding sentence may be modified to reflect the coverage provided by the policy. In addition to the requirements of Section 2540.4(d), this paragraph shall state that benefits are not payable for custodial care, for expenses deemed by Medicare not to be reasonable or necessary nor for convenience items. Other items excluded from coverage by Medicare need not be stated unless they relate directly to benefits provided by the policy.]

[5] *Renewability of This (Policy).*

[6] *Premium for This (Policy).*

If you have questions about this (policy), please write or call ——————.

10. Add Subsection (m) to Subchapter 3, Article 12.2, Section 2540.5, to read as follows:

(m) *Prototype Standard Supplemental Disclosure Form for Policies Providing In-Hospital and Out-of-Hospital Medicare Supplement Coverage.* "In-Hospital and Out-of-Hospital Medicare Supplement Coverage" provides benefits, principally on an expense-incurred basis, to supplement the coverage provided under Medicare, whether or not treatment is received while hospitalized.

[COMPANY NAME]

IN-HOSPITAL AND OUT-OF-HOSPITAL MEDICARE SUPPLEMENT COVERAGE

OUTLINE OF COVERAGE

For (Policies) Issued in [insert year]

[1] *Read your (Policy) Carefully.* This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is, therefore, important that you Read Your (Policy) Carefully!

[2] *In-Hospital and Out-of-Hospital Medicare Supplement Coverage.* This type of coverage is designed to supplement your Medicare coverage regardless of whether you are in the hospital. It will pay some of the dollar deductibles and percentage co-payment charges which you would have to pay without it. However, it may not pay all your share of expenses for treatment.

[3] *Benefits of This (Policy).* [Alternate text is parenthesis in this paragraph shall be selected depending upon the coverage provided by the policy. The Medicare deductible and co-payment charges for the year of policy issue shall be inserted in the blanks.]

To Supplement Medicare Part A Hospital Insurance, this (policy):

(a) (Pays) (Does not pay) the initial deductible amount for hospitalization during a Medicare Benefit Period. This year that amount is $——.[1] [The preceding sentence may be omitted where the initial deductible is not paid.]

(b) (Pays) (Does not pay) benefits for the first sixty days of hospitalization during a Medicare Benefit Period. [Disclose benefit, if any.]

(c) Pays the co-payment charges for the 61st through the 90th day of hospitalization during a Medicare Benefit Period. This year, that charge is $—— per day of hospitalization.[1]

(d) Pays the co-payment charges for the "lifetime reserve" of 60 days of hospitalization. This year, that charge is $—— per day of hospitalization.[1]

(e) (Pays) (Does not pay) the co-payment charges for the 21st through the 100th day of confinement in a skilled nursing facility. This year, that charge is $—— per day of confinement.[1] [The preceding sentence may be omitted where skilled nursing facility confinement is not covered.]

[(f) Other benefits to supplement Medicare Part A Hospital Insurance.]

Footnotes at end of article.

To supplement Medicare Part B Medical Insurance this (policy):

(a) (Pays the calendar year deductible amount for any year that you are hospitalized. This year that amount is $——[1])

(Does not pay the calendar year deductible amount.)

(b) Pays the co-payment charges which are 25 percent of the benefits paid by Medicare Part B Medical Insurance. This (policy) will not pay more than $2 per calendar year for these co-payment charges. [If co-payment charges for medical services are computed on some basis other than the benefits paid by Medicare, the preceding sentence shall be replaced by a brief explanation of that basis.]

[(c) Other benefits to supplement Medicare Part B Medical Insurance.]

(4) *Exceptions, Reductions and Limitations of This (Policy).* [In addition to the requirements of Section 2540.4(d), this paragraph shall state that benefits are not payable for custodial care, for expenses deemed by Medicare not to be reasonable or necessary nor for convenience items. Other items excluded from coverage by Medicare need not be stated unless they relate directly to benefits provided by the policy.]

(5) *Renewability of This (Policy).*

(6) *Premium for This (Policy).*

If you have questions about this policy, please write or call ————

11. Add Subsection (n) to Subchapter 3, Article 12.2, Section 2540.5, to read as follows:

(n) *Prototype Standard Supplemental Disclosure Form for Policies Providing Catastrophic Medicare Supplement Coverage.* "Catastrophic Medicare Supplement Coverage" provides benefits to supplement Medicare on a "blanket" basis for all expenses deemed by the insurer to be usual, customary and reasonable in the treatment of conditions covered in whole or in part by Medicare. Benefits may be subject to lifetime maximum of no less than $25,000. Coverage for psychiatric treatment and prescription drugs may be subject to reasonable internal limits.

[COMPANY NAME]

CATASTROPHIC MEDICARE SUPPLEMENT COVERAGE

OUTLINE OF COVERAGE

(1) *Read Your (Policy) Carefully.* This outline of coverage provides a very brief description of some important features of your (policy). This is not the insurance contract and only the actual (policy) provisions will control. The (policy) itself sets forth, in detail, the rights and obligations of both you and (your insurance company). It is therefore, important that you Read Your (Policy) Carefully!

(2) *Catastrophic Medicare Supplement Coverage.* This type of coverage is designed to pay the difference between what Medicare pays and the usual, customary and reasonable expenses of treatment of any medical condition covered at least partly by Medicare. However, benefits may be reduced by a deductible amount and only limited benefits may be payable for psychiatric treatment and prescription drugs.

(3) *Benefits of This (Policy).* [This paragraph shall briefly describe the operation of the policy in accord with Section 2540.4(c), above.]

(4) *Exceptions, Reductions and Limitations of This (Policy).* [In addition to the requirements of Section 2540.4(d), this paragraph shall state that benefits are not payable for custodial care, for conditions not covered at least in part by Medicare, nor for convenience items. Other items excluded from coverage by Medicare need not be stated unless they relate directly to benefits provided by this policy.]

(5) *Renewability of This (Policy).*

(6) *Premium for This (Policy).*

You should not purchase this policy unless you can afford to pay the deductible of $ [insert deductible amount] before receiving benefits under this (policy). [The preceding sentence may be omitted if the policy does not provide for a deductible amount.]

If you have questions about this policy, please write or call ————

[1] These benefits will be increased to match any increases in Medicare deductible amounts or co-payment charges.

# Appendix 7

## ITEM 1. "PUBLIC REGULATION OF PRIVATE SUPPLEMENTS TO MEDICARE AND MEDICAID IN OREGON," BY RON WYDEN,* EXCERPT FROM CONNECTICUT LAW REVIEW, VOL. 9, NO. 3, SPRING 1977

The rise of "consumer power," while transforming political life in many states, has largely bypassed the elderly, one of America's most vulnerable and exploited consumer groups. Even in Oregon, whose citizens have shown great enthusiasm for innovative legislation in many fields,[1] entrenched business groups and state agencies refused, until recently, to recognize the special problems of the elderly. The difficulties of the elderly have been particularly acute in the field of health insurance.[2] Older consumers, ill informed about medicare and medicaid often make poor decisions about private supplemental insurance. Many insurance salesmen take unfair advantage. Yet the Oregon Insurance Department failed to act.

But in 1976 a coalition of senior citizens' rights activists confronted Oregon's insurance commissioner. After a state-wide publicity campaign, the coalition secured the adoption of administrative rules which require insurance agents to distribute forms outlining medicare-medicaid benefits to prospective purchasers of supplemental policies. The senior citizen husbanding a fixed income no longer has

---

* J. D. University of Oregon School of Law; Member Iowa State Bar, Ron Wyden is now the Legal Services Developer for the Elderly for the State of Oregon. Title III of the Older Americans Act provides federal funds for this position, which involves statewide coordination of public legal services for the elderly. Title III, Older Americans Act of 1965, 42 U.S.C. §§ 3001-3055 (Supp. 1975).

1. Oregon has traditionally been regarded as a state receptive to political change. M. BARONE, D. MATTHEWS, G. UJIFUSA, THE ALMANAC OF AMERICAN POLITICS, 706-08 (1975). The Oregon legislature has passed innovative laws dealing with subjects such as land use planning (*see, e.g.*, Fuller, *Oregon's New State Land Use Planning Act—Two Views*, 54 ORE. L. REV. 203 (1974); *Symposium: Land Use Planning in Washington and Oregon*, 10 WILLAMETTE L.J. 320 (1974)), nondisposable bottles (*see Note*, *The Oregon Bottle Bill*, 54 ORE. L. REV. 175 (1974)), and aerosol sprays (*see* Kadera, *Oregon Asks Nationwide Ban on Aerosol Sprays*, The Oregonian, Dec. 24, 1975, at A9, col. 3 (Portland, Oregon); *Straub Signs Bill Banning Cans Using Fluorocarbon Propellant*, The Oregonian, June 17, 1975, at A16, col. 6 (Portland, Oregon).

2. The Oregon insurance industry has been described as slow to take the reform spirit. *See generally* M. DOTTEN, OREGON HEALTH INSURANCE POLICIES: SOME FINDINGS AND RECOMMENDATIONS (1973) (available from the Consumer Research Center, University of Oregon, Eugene, Oregon).

to guess the value of each extra dollar spent on insurance. The successful campaign to change Oregon's regulation of supplementary health insurance has shown that the elderly can effectively pressure state agencies. Positive results may follow in other areas subject to state regulation.

For millions of Americans who are no longer covered by employer-paid health insurance plans and cannot afford complete private coverage, health care is only possible through medicare and/or medicaid. However, medicare pays for only a share of the health costs of the elderly, and this share has steadily diminished since the inception of the program.[3] For this reason, a significant proportion of the elderly purchase one or more private health insurance policies, dubbed "medigaps," in the hope that they will cover those health care expenses not covered by medicare.[4] Elderly persons who purchase these policies take a calculated risk. Medigap premiums take a significant bite out of a fixed income; paying them can be a hardship. Yet a large medical bill not covered by insurance is a disaster which can wipe out the lifetime savings of those unprotected by insurance.

Before the adoption of the new regulation in Oregon, the purchase of medigap policies was made even more risky by poor drafting and unprofessional salesmanship. Fine print and 150 word sentences were common.[5] The unstandardized policies often proved of little value because they were so filled with contractual "gobbledygook"[6] that many elderly could not comprehend them.[7] Many insurance agents employed scare tactics[8] to persuade some seniors[9] to

---

3. The Chairman of the Senate Special Committee on Aging, Senator Frank Church of Idaho, has stated that medicare now covers only about 38 percent of the average medical costs of persons 65 and up. *Future Directions in Social Security: Hearings Before the Senate Special Comm. on Aging*, 94th Cong., 1st Sess. 1814 (November 24, 1975).

4. The elderly spend over half a billion dollars on premiums for private health insurance policies each year. SENATE SPECIAL COMM. ON AGING, 93D CONG., 2D SESS., A WORKING PAPER, PRIVATE HEALTH INSURANCE SUPPLEMENTARY TO MEDICARE, 1 (1974) [hereinafter cited as SENATE SPECIAL COMM. ON AGING, WORKING PAPER].

5. M. DOTTEN, *supra* note 2, at 7-10.

6. H. SHAPIRO, HOW TO KEEP THEM HONEST 126 (1974).

7. R. GUARINO & R. TRUBO, THE GREAT AMERICAN INSURANCE HOAX 88 (1974); *Health Insurance for Older People: Filling the Gaps in Medicare*, 41 CONSUMER REP. 27-34 (Jan. 1976).

8. *Deceptive or Misleading Methods in Health Insurance Sales: Hearing Before the Subcomm. on Frauds and Misrepresentations Affecting the Elderly of the Senate Special Comm. on Aging*, 88th Cong., 2d Sess. (May 4, 1964).

9. The term "seniors," referring to the group variously called "the elderly," or "senior citizens," is not a word of art, but seniors prefer it to other forms.

purchase as many as four or five supplemental policies that extended the same basic coverage.[10]

This situation cried out for regulation, and a statutory framework existed to provide it. Since Congress, under the McCarran Act,[11] has firmly committed insurance regulation to the states, every state has an insurance department, an insurance code, and a system of regulation for the sales practices of private health insurance companies.[12] State legislatures normally delegate vast discretion to their insurance commissions to govern insurance transactions "in the public interest."[13] In practice the commissions may rubberstamp the whims and wishes of the insurance industry.[14] Like most state regulatory agencies, these commissions invariably have small budgets and smaller staffs, and a reputation of sympathy toward the industry they are supposed to be regulating.[15] Nevertheless, in some states, such as Massachusetts and Pennsylvania, the insurance commissioners have used their discretionary power to publish educational forms—"buyer guides"—that offer informational tools to help consumers make more intelligent choices about health insurance.[16]

The passivity of the Oregon Insurance Commission, which had never published any buyer guides, had always disturbed consumer activists. Several public interest groups and their lawyers decided that their clients needed educational information on health insurance and on May 14, 1976, they petitioned the Insurance Commissioner to adopt new administrative rules to cure the deficiency.[17] The pro-

10. Medigap policies often either fail to cover what the purchaser assumed was being covered, or duplicate existing benefits. *See* SENATE SPECIAL COMM. ON AGING, WORKING PAPER, *supra* note 4, at 24-27. Insurance agents can sell such policies by taking advantage of the seniors' legitimate fear that illness means financial ruin. R. BUTLER, WHY SURVIVE? BEING OLD IN AMERICA 312-13 (1975); *see* Bernard, *Why People Become the Victims of Medical Quackery*, 55 AM. J. OF PUB. HEALTH 1142 (1965).

11. 15 U.S.C. §§ 1011-1012 (1971).

12. Hanson, *The Private Insurance Industry and State Regulatory Activities as Alternatives to Federally Enacted Comprehensive National Health Insurance Legislation*, 6 TOL. L. REV. 677, 696 (1975).

13. J. GREGG, THE HEALTH INSURANCE RACKET AND HOW TO BEAT IT 140 (1973).

14. Shapiro, *supra* note 6, at 2.

15. K. DAVIS, ADMINISTRATIVE LAW 37 (3d ed. 1972).

16. Letter from Roy V. Proctor, Deputy Commissioner, Oregon Department of Commerce, Insurance Division, to Sandra Blischke, Legal Intern and Assistant to Steve Goldberg, Marion-Polk Legal Aid Service, Inc. (June 8, 1976) (on file at the Marion-Polk Legal Aid Service, Inc., Salem, Oregon).

17. The petition was filed on behalf of five organizations (the Marion County Home Health Agency, the Mid-Willamette Valley Council of Governments, the Area Agency on Aging, the Gray Panthers, and the Salem Area Seniors) and two individuals. The

32-703 O - 78 - 13

posed rules required insurance agents selling or attempting to sell health insurance supplementing medicare to hand out a form outlining the senior's medicare coverage, and to inquire of the prospective policyholder whether he or she is, or is about to be, eligible for medicaid.[18] In cases of such eligibility, the proposed rules required the agent to give out a second form outlining the coverage available under medicaid before accepting any application for insurance supplementing medicaid.[19] These handouts were not intended to be abstract explanations of federal health insurance. Instead, each form was to contain blank spaces which the insurance agent would be required to fill in with information showing how the policy to be sold covered one or more of the gaps in medicare or medicaid.[20]

The petitioners asserted that the Insurance Commissioner had ample authority to promulgate the rules under existing Oregon law. One Oregon statute gives the Commissioner general rulemaking authority,[21] and a second statute provides that "[t]he Commissioner, by rule, may require any agent who sells, or attempts to sell insurance to provide each prospective insured such information as the Commissioner considers necessary to adequately inform the prospective insured regarding the insurance transaction. . . ."[22] The petitioners requested a hearing so they could present these views orally. In written testimony they argued that the adoption of the rules would allow elderly consumers to understand their medicare and/or medicaid coverage, to detect any gaps in that coverage, and to select the proper supplemental insurance, thus avoiding duplication of benefits afforded by the medicare and medicaid statutes.[23]

---

individuals, elderly clients of Marion-Polk Legal Aid Service, Inc., had had bad experiences with medigap insurance salesmen.

18. Described as Form A, this one-page factsheet outlined the senior's medicare benefits.

19. Described as Form B, this one-page factsheet outlined the senior's medicaid benefits.

20. Written Testimony in Support of Petition to Propose Rule (May, 1976) (on file at the office of the Oregon Insurance Commissioner, Salem, Oregon). (The proposed rule required health insurance companies to disclose certain information to purchasers of health insurance policies supplemental to medicare and medicaid, and was codified as ORE. ADMIN. RULES 836-52-105, 836-52-110) (Insurance Division).

21. "In accordance with the applicable provisions of ORS 183.310 to ORS 183.500 the Commissioner may make reasonable rules necessary for or as an aid to the effectuation of the Insurance Code. . . ." ORE. REV. STAT. § 731.244 (1975).

22. ORE. REV. STAT. § 743.021 (1973).

23. *See Petition to Propose Rule* (June 25, 1976). This is the rule referred to in note 20 *supra*.

When the petition to propose the rules was filed, the petitioners informed the state's major newspapers of their action, expecting a news feature that would publicize their proposals.[24] Initially, all of the papers declined to write stories. Perhaps they thought that health insurance for the elderly was a topic of little interest to their readers, but some senior activists have suggested that the press rated the petition's chance of success against the Oregon insurance companies as too low to justify press coverage.[25]

On June 8, 1976, the request for a hearing was denied and thus legal channels for the activist groups were blocked. But Deputy Commissioner Roy V. Proctor's letter on behalf of Insurance Commissioner Lester Rawls unlocked a more effective approach—publicity. Proctor wrote that "we do not feel that conducting a hearing on the subject [of supplementary medical insurance] will accomplish your objective."[26] He made it clear that the Insurance Commissioner felt that the elderly did not need additional assistance with their supplementary medical insurance by stating that "[existing rules give us the authority to] restrict policy forms . . . and analyze the difficulties of senior citizens in clearly understanding the policies they intend to purchase."[27] This objection could not counter the petitioners' arguments, for regardless of the potential of existing rules, they were ineffective as applied. Furthermore, by concluding his letter with the assertion that "these [existing] rules do not permit us . . . to advise each purchaser as to the need for advisability of purchasing a specific policy,"[28] Proctor showed either that he failed to understand the thrust of the petition, or that he wished to avoid the entire provision by misreading the proposals.

The seniors coalition quickly responded. They informed the media, the Governor and the Insurance Commissioner that the function of regulatory agencies was not to give advice to individuals.[29] They

---

24. Among the papers contacted were *The Oregonian*, of Portland, *The Oregon Statesman*, of Salem, and *The Eugene Register-Guard*, affiliated with the University of Oregon in Eugene. The seniors coalition issued a standard press release, which they expected the newspapers to pick up as a matter of course.

25. Interview with Gray Panther member Elizabeth Fink, Eugene, Oregon (June 2, 1976).

26. *See* letter from Roy V. Proctor, *supra* note 16.

27. *Id.*

28. *Id.*

29. Letter from Hugh M. Hanna, Program Chairman, Mid-Willamette Valley Council on Governments, Area Agency on Aging, Salem, Oregon, to the Honorable Robert Straub, Governor, State of Oregon (June 24, 1976) (on file at the Marion-Polk Legal Aid Service, Inc., Salem, Oregon).

repeated again that they only wished the Commissioner to give generalized informational resources to the elderly to permit them to make intelligent choices about private health insurance coverage.[30] This time they found that their advocacy paid off. Proctor's letter received extensive publicity; the Portland *Oregonian*, the state's largest paper, covered their story,[31] and the wire services and other newspapers soon followed. On July 8, 1976, the petitioners received a letter from Governor Robert Staub stating that he had been "in touch" with the Insurance Commissioner [whom Staub had the legal authority to replace] and that the rulemaking hearing so doggedly sought by the petitioners would be scheduled soon.[32]

On July 20, 1976, notice was filed with the Secretary of State of a public hearing to be held September 1, 1976, to consider proposed administrative rules 836-52-105 and 836-52-110.[33] The notice declared that the purpose of the rules "is to prescribe information that any agent, who sells or attempts to sell health insurance providing benefits that supplement Medicare and Medicaid, must furnish to inform such persons adequately regarding the insurance transaction."[34] From July until September 1, 1976, senior citizen groups around the state publicized the upcoming hearing at food distribution centers, churches, senior citizen centers, and other places frequented by elderly persons.[35] The results of their efforts were stunning: on September 1st between four and five hundred seniors journeyed to the state capital in Salem and overflowed the largest hearing room.[36] Those who could not sit on a table or on the floor inside listened to the proceedings from loudspeakers in the hallway.

The seniors coalition carefully staged the hearing as a theatrical

30. *Senior Citizens Win Hearing on Health Insurance*, The Oregonian, July 17, 1975, at A12., col. 5 (Portland, Oregon).

31. *Id. The Oregonian* has the widest circulation of any paper in the state: 200,000 daily. The state's other major newspapers and both major wire services also filed stories at this point.

32. Letter from The Honorable Robert Straub, Governor, State of Oregon, to Hugh M. Hanna, Program Chairman, Mid-Willamette Valley Council On Governments, Area Agency on Aging, Salem, Oregon (July 19, 1976) (on file at the Marion-Polk Legal Aid Service, Inc., Salem, Oregon).

33. ORE. REV. STAT. § 183.335 (1975) lists the prerequisites for the adoption of administrative rules.

34. ORE. ADMIN. RULES 836-52-105 (Insurance Division).

35. *See* Press Release, Marion-Polk Legal Aid Service, Inc. (Aug. 20, 1976) (on file at that office in Salem, Oregon).

36. *Senior Citizens Want Plain-Talk Insurance*, The Oregon Statesman, Sept. 2, 1976, at 1, col. 2.

event, with dramatic testimony and appropriate props. Several seniors were supplied with magnifying glasses symbolizing their opposition to the tiny print in medigap policies. Thirty seniors testified in favor of the proposed rule at the all-day hearing.[37] Grace Lepray, eighty-six years old, testified that she had purchased four policies with identical coverage from the same agency:[38]

> I said to him [the agent who came to her door], "why are you writing out that policy?" and he said, "Never mind; it will help you." He kept coming back and selling me policies.
>
> "The same agent?" she was asked.
>
> No, . . . The first agent came twice, then he got a heart attack and another guy took his place and wrote another couple policies. . . .

Mrs. Lepray concluded her testimony by saying that although she was confused, she felt that the two agents who dealt with her had her best interests in mind: "They just said, 'Trust me.' "[39]

After the seniors had spoken, opponents of the proposed rules testified. Most of the nation's biggest insurance companies sent representatives to the hearing or transmitted written testimony on the proposed rules.[40] But not every representative testified, and few of those who did spoke against the proposed rules. Most sought to calm the sea of seniors which surrounded them by telling stories about their own aged parents living on fixed incomes back home in Middle America.[41] No one seemed willing to challenge the general concept of the proposed rules. As one company spokesman said of the hearing, "It seems inappropriate to attack any proposal which seeks to better inform prospective insureds about their coverage. . . ."[42] Only

37. *Oldsters Ask for Help in Buying Medical Insurance*, The Eugene Register-Guard, Sept. 2, 1976, at 11, col. 3. Those testifying included Chet Arterburn, spokesman for several retired insurance salesmen.

38. *Insurance Gobbledygook Scored*, The Oregonian, Sept. 2, 1976, at B1, col. 4.

39. *Elderly Jam Capitol, Ask Simple Form*, The Oregon Journal, Sept. 1, 1976, at 3, col. 4.

40. Written testimony on the proposed rules is on file in the office of the Oregon Insurance Commissioner, Salem, Oregon.

41. *Insurance Gobbledygook Scored*, *supra* note 38.

42. Letter from Gerald F. Bevan, Vice President, National Home Life Assurance Company, Liberty Park, Pennsylvania, to the Honorable Lester L. Rawls, Commissioner

John P. Hanna, a lawyer with the Health Insurance Association of America, a Chicago-based organization of the nation's largest health carriers, dared to mention caveat emptor. In his view, "[T]he burden is on the buyer to decide what he or she wants."[43]

More substantial criticisms were made in written testimony submitted after the public hearing.[44] Pacific Northwest Life of Portland, Oregon, argued that the responsibility for informing elderly citizens of their medicare and medicaid positions properly rested with the Department of Health, Education, and Welfare, not with private insurers: "You are imposing requirements on agents that should be imposed on the Social Security Administration. . . ."[45] Other insurers thought that the rules would be ineffective, or even counterproductive. Wabash Life Insurance Company of Indianapolis, Indiana, wrote: "The only persons who will comply with the spirit and intent of this proposed regulation are those who are already serving the public in a conscientious manner."[46] Mutual of Omaha of Omaha, Nebraska, stated that with "a signed disclosure statement of the type proposed . . . it will be almost impossible to successfully prosecute an agent charged with misrepresentation if he can produce an applicant's signature acknowledging [that the proper information had been supplied]."[47] Nationwide Mutual Insurance Company of Columbus, Ohio, admitted that the proposed rules had some merit, but argued that group, blanket, franchise, and group conversion policies should be exempt from the requirements, because these policies are usually sold to groups that are more insurance conscious.[48]

---

of Insurance, State of Oregon, Salem, Oregon (Aug. 9, 1976) (on file at the Commissioner's office).

43. *Insurance Gobbledygook Scored, supra* note 38.

44. Many insurance companies wrote to the Commissioner. The statements cited in the text are representative.

45. This letter is on file at the Office of the Insurance Commissioner, Salem, Oregon.

46. This letter is on file at the Office of the Insurance Commissioner, Salem, Oregon.

47. This letter is on file at the Office of the Insurance Commissioner, Salem, Oregon.

48. This letter is on file at the Office of the Insurance Commissioner, Salem, Oregon. The theory that groups are wise insurance shoppers seems to have been shattered by recent reports showing that the seven million members of the American Association of Retired People have not been well served by their health insurer, Colonial Penn Group of Philadelphia. *See generally Health Insurance for Older People: Filling the Gaps in Medicare, supra* note 7; *Colonial Penn Alleges Errors in CU report*, 41 CONSUMER REP. 185 (April 1976); *Colonial Penn Group and the American Association*

After the seniors' impressive showing at the hearing, and Governor Straub's message, the battle for adoption of new rules was as good as won. Another important struggle, involving the ultimate shape of the regulations, took place behind the scenes. After the hearing the senior citizen groups heard rumors that the Commissioner's staff had prepared alternate responses for the Commissioner to adopt on the disclosure issue—and had shown them to the insurance carriers, but not to the petitioners.[49] The seniors thought this unfair and wanted to protest publicly until one of their attorneys introduced them to the facts of life in the regulatory arena: agency staff has the power to make ex parte contacts with those on one side of a disputed issue, without affording the same privilege to other parties—even those who introduced the proposal.[50] The seniors concluded that protest might tip the hidden power struggle against them.

On December 21st—over three and a half months after the hearing—Insurance Commissioner Rawls announced at a press conference that he had filed Administrative Rules 836-52-105 and 836-52-110 with the Oregon Secretary of State. Since March 1, 1977, all insurance companies selling medigap supplementary coverage have had to comply with the disclosure requirements set forth in these rules.[51] Though senior rights groups generally praised Commissioner Rawls for his decision,[52] the forms required by the new administrative rules were a watered-down version of those originally drafted by the elderly petitioners. First, the adopted forms are not printed in large type, as the seniors repeatedly urged at the public hearing.[53] Second, they do not include information about the average

---

*for Retired Persons Have an Unusual Relationship: You Might Even Call it Incestuous*, FORBES, April 1976 at 185.

49. Interview with Steven Goldberg, Attorney for the Petitioners, in Salem, Oregon (Dec. 3, 1976).

50. F. COOPER, 1 STATE ADMINISTRATIVE LAW 198-99 (1965).

51. *See Supplemental Policies Clarified*, The Oregonian, Dec. 22, 1976, at 1, col. 5 (Portland, Oregon).

The proposed forms were designed by Attorney Goldberg and the author. Forms issued by Herbert Devenberg, former Pennsylvania Insurance Commissioner, were used as models. In our view no consumer pamphlet could have solved the medigap problem in Oregon. An effective solution had to involve requiring the insurance companies, through state regulation of sales practices, to be responsible for providing customers with more information.

52. *See Elderly's Insurance Forms Clarified*, The Oregon Journal, Dec. 21, 1976, at 2, col. 2.

53. The public hearing was taped, and this tape can be heard in the Office of the Insurance Commissioner, Salem, Oregon.

length of an elderly person's stay in an Oregon hospital, data the petitioners had argued was necessary for low-income seniors attempting to balance a policy's cost against the likelihood that it would be needed.[54]

Commissioner Rawls' rejection of the proposed enforcement provision is a third major weakness of the new rules. The clause proposed by the seniors provided for rescission at the option of the insured, at any time, if the informational forms were not distributed. Within fifteen days of notice of rescission, the insurance company would have been required to return all money paid by the insured, regardless of whether the company had made payments on the policy.[55] This stringent clause would have given enforcement power to the seniors themselves. In practice, enforcement may be difficult without such a provision.[56]

The most important failure of the rules adopted by the Commissioner, and one which has drawn vocal and organized criticism from Oregon seniors groups,[57] is their misleading statement of a crucial distinction in medicare coverage. For the first twenty days of the medicare benefit period the older person in a *skilled nursing facility* pays nothing. Medicare pays for the whole cost. However, the same person in an *intermediate care facility*, providing less intensive care than the skilled nursing facility, pays the entire expense. While Ad-

---

54. The material sought to be included by the petitioners was provided by the Professional Activities Studies Group at the University of Michigan. The material stated that for individuals 65 years of age or older, the average length of stay in a hospital was 9.2 days in 1974.

55. The enforcement provision proposed by the petitioners contained a "penalty" clause:

> If an insurance agent fails to fully complete the prescribed disclosure form at the time of the sale of the policy the insured may rescind his or her purchase of the policy at any time. The letter of rescission shall be in writing and mailed to the insurance agent. Within fifteen (15) days of the mailing of the letter, all money paid by the insured shall be returned, irregardless of whether any payments were made by the company under the policy. Disputes as to whether or not the disclosure form was fully complete should be resolved by the Insurance Commissioner.

Letter from Steven Goldberg, Attorney for the Petitioners, to Ruth Shepherd, Executive Officer, Governor's Commission on Aging (Dec. 13, 1976) (on file at Ms. Shepherd's office, 315 Public Service Bldg., Salem, Oregon).

56. Interview with Steven Goldberg, Attorney for the Petitioners, in Salem, Oregon (Dec. 15, 1976).

57. Letter from Hugh M. Hanna, Program Chairman, Mid-Willamette Valley Council On Governments, Area Agency on Aging, Salem, Oregon, to Lester Rawls, Insurance Commissioner, State of Oregon (Jan. 10, 1977) (on file at the Marion-Polk Legal Aid Service, Inc., Salem, Oregon).

ministrative Rule 836-52-110 gives the rule for skilled nursing facilities, it does not mention intermediate care facilities.[58] The form only hints at the differences with a small print caveat: "Caution: You should check whether nursing facility qualifies for Medicare." Elderly consumers, ignorant of the distinction, often purchase supplementary policies that do not fill the crucial gap. One Salem, Oregon, social worker has stated, "I spend about 50 percent of my day trying to explain it . . . . [T]heir policies do not cover what Medicare does not cover—intermediate care."[59] Of course, a careful insurance purchaser would buy both kinds of coverage, but elderly consumers are not provided with information to aid them in making that choice.

Whatever the value of the rules actually adopted when compared to those proposed, they will mean little if they are not used. Though some newspapers printed stories, the Insurance Department has never publicized the rules. Senior activists, who have long understood how hard it is to communicate with the hard-to-reach elderly,[60] believe that without extensive publicity Oregon seniors will have little awareness of their newly won rights.

On balance, however, Oregon's senior activists have achieved a meaningful reform. No other state has provided the elderly with such a valuable source of information to aid in the purchase of health insurance. The efforts of the citizens paid off—the Commissioner had little choice but to act when confronted with such a showing of senior political muscle.

The Oregon experience with supplementary medical insurance demonstrates that state regulatory agencies can be fertile ground for seniors and their advocates interested in government reform. While the federal government operates many significant programs for the aged, such as social security and medicare, many other services important to seniors such as insurance,[61] nursing homes,[62] and utili-

---

58. *See Form Aims to Cut Confusion on Health Policies*, The Oregon Statesman, Dec. 22, 1976, at 7A, col. 1 (Salem, Oregon). Although most patients are placed in intermediate care facilities, medicare pays none of the cost. *See* Letter from Hugh M. Hanna, *supra* note 57; *see generally* SOC. SEC. ADMIN., YOUR MEDICARE HANDBOOK; HEALTH INSURANCE UNDER SOCIAL SECURITY (1970) (available free from the Social Security Administration, Washington, D.C.).

59. *Form Aims to Cut Confusion on Health Policies*, The Oregon Statesman, Dec. 22, 1976, at 7A, col. 1 (Salem, Oregon).

60. *See generally* Zborowski & Eyde, *Aging and Social Participation*, 17 J. GERONTOLOGY 424 (1962).

61. *See* note 11 and accompanying text *supra*.

62. *See, e.g.*, Brown, *An Appraisal of the Nursing Home Enforcement Process*, 17 ARIZ. L. REV. 304, 321-22 (1975); *Staff Report, What To Do About Nursing Homes*, 6

ties,[63] are dominated by the states. Most state regulatory agencies are created by enabling statutes that vest them with wide discretion to act in the public interest—discretion that can be used, as it was by Commissioner Rawls, to implement new methods of serving the elderly. The political support necessary for the enactment and enforcement of administrative rules is often easier to generate at the state level than at the federal level. Many seniors have time to visit the state capital for agency meetings, but they do not have the health and finances to travel to Washington, D.C. Greater participation by seniors and their advocates might also be a valuable antidote to industry lobbyists, and might possibly reduce agency favoritism to industries that serve the elderly, such as hearing aid and prescription drug manufacturers. There can be no doubt, after the Oregon experience with supplementary health insurance, that senior citizens have the power to bring "buyers guides," "hotlines," and consumer complaint centers into existence.

---

JURIS DOCTOR 30 (1976). See Hackler, *Expansion of Health Care Providers' Liability: An Application of Darling to Long-Term Health Care Facilities*, 9 CONN. L. REV. 462 (1977) for discussion of *federal* regulation of nursing homes.

63. *See, e.g.*, Mello, *Public Utility Raté Increases: A Practice Manual for Administrative Litigation*, 8 CLEARINGHOUSE REV. 411 (1974).

## ITEM 2. DECISION BY OREGON DIVISION OF INSURANCE REGARDING INFORMATION INSURERS MUST DISCLOSE TO PROSPECTIVE PURCHASERS OF HEALTH INSURANCE TO SUPPLEMENT MEDICARE AND MEDICAID, DATED DECEMBER 21, 1976

| | | |
|---|---|---|
| In the Matter of the Adoption of Oregon Administrative Rules chapter 836, section 52-105 and 52-110, relating to information insurers must disclose to prospective purchasers of health insurance to supplement Medicare and Medicaid. | ) | ORDER OF ADOPTION<br>IC-72 |

ORDER

The attached Proposed Decision of Wilfred W. Fritz, Executive Assistant, is hereby adopted by the Insurance Commissioner of the State of Oregon as his Decision in the above-entitled matter.

IT IS SO ORDERED this 21st day of December, 1976.

Lester L. Rawls
Insurance Commissioner

* Proposed Decision not attached

ORDER OF ADOPTION

OREGON ADMINISTRATIVE RULES
Chapter 836. Insurance Division

INSURANCE POLICIES

Division 52. Health Insurance

---

836-52-105 STATUTORY AUTHORITY; PURPOSE; EFFECTIVE DATE.

(1) OAR 836-52-105 to 836-52-110 are adopted pursuant to the general rulemaking authority of the Commissioner in ORS 731.244 and the specific authority in ORS 743.021 for the Commissioner to issue rules regarding information that must be furnished to prospective insureds.

(2) The purpose of the rules is to prescribe the information that an agent or insurer who effects a sale of health insurance that is supplemental to federal Medicare insurance must furnish to adequately inform the prospective insured regarding the insurance transaction.

(3) The effective date of OAR 836-52-105 to 836-52-110 is March 1, 1977.

836-52-110 INFORMATION TO BE FURNISHED PROSPECTIVE INSURED. An agent or insurer effecting a sale of health insurance providing benefits that supplement federal Medicare insurance benefits shall deliver the form set forth as Exhibit I to OAR 836-52-105 to 836-52-110 to the insured not later than the time of delivery of the policy. The agent or insurer shall complete and sign the prescribed form.

SUMMARY OF MEDICARE BENEFITS AND INSURANCE

The State of Oregon requires an insurance company selling health insurance to an individual covered by Medicare to provide the following information. Future changes in federal law may change Medicare benefits, with resulting changes in the insurance policy benefits.

| | MEDICARE | INSURANCE POLICY PAYS |
|---|---|---|
| **In-patient Hospital Benefits** | | |
| First 60 days of Medicare benefit period | You pay 1st $______. Medicare pays balance. | ______ |
| Next 30 days of continuous confinement (61st - 90th day) | You pay 1st $______ per day. Medicare pays balance. | ______ |
| Next 60 days, while one-time reserve lasts (91st - 150th day) | You pay $______ per day. Medicare pays balance. | ______ |
| After 150 days of continuous confinement | You pay full amount. Medicare pays nothing. | ______ |
| **Skilled Nursing Facility Benefits*** | | |
| (*Caution - you should check whether nursing facility qualified for Medicare.) | | |
| First 20 days of Medicare benefit period | You pay nothing. Medicare pays 100% | ______ |
| Next 30 days of continuous confinement (21st - 100th day) | You pay $______ per day. Medicare pays balance. | ______ |
| **Medical Service Benefits** | | |
| Physician services, medical supplies, ambulance, prosthetic devises and other covered services | You pay 1st $______ each calendar year. Medicare then pays 80% of further Medicare approved charges and you pay the balance of charges. | ______ |

(The space below may be used to describe insurance benefits not related to Medicare.)

More information:

1. This policy has been approved for sale in Oregon as required by law. Such approval is in no way a recommendation or endorsement.

2. Physician fees and other medical service charges may exceed charges approved by Medicare. In such instances, you are obligated for the difference.

3. (a) If the policy is labeled "Guaranteed Renewable" the insurance company must continue the policy as long as you pay the premium. The company has the right to increase the premium, but not to make any changes in the policy.

   (b) If the policy is labeled "Renewable at the Option of the Company," the insurance company may terminate the policy on any premium due date. (Check your policy for details.)

4. Generally speaking, if the application you completed for your policy asks medical questions, pre-existing conditions are covered from the date the policy is issued. If no medical questions are asked, medical conditions you had prior to the application are not covered until the policy has been in force for the time required by the policy. (Check your policy for details.)

5. Generally, neither Medicare nor private insurance will pay for convenience items not necessary in the treatment of your medical condition.

The Insurance Commissioner makes the following recommendations:

1. That you check with your local Social Security office to obtain more specific details of your Medicare benefits, if you have further questions about Medicare. The other side shows only a summary of the basic Medicare benefits. Some Medicare benefits are available that are not shown.

2. That you buy one policy for your health insurance needs. You will generally save money by doing this rather than buying several limited policies.

3. If you are eligible for Medicaid, insurance to supplement Medicaid is not recommended.

4. After you receive your policy, make sure you have the coverage you thought you bought. If not satisfied, return the policy to the company within 10 days for a full refund of premium directly from the company. Companies are required to make immediate refunds directly and not through their agents.

This form is required by the Insurance Commissioner of the State of Oregon to be delivered with any health insurance policy designed to supplement Medicare benefits.

Date Summary Prepared:______________________________
Policy Form NO.:______________________________
Insurance Company Issuing Policy:______________________________
Summary Delivered by:______________________________
(Agent of Above Company)