United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

November 3, 2008

Via Electronic Transmission

Jim L. Ridling
Commissioner
Alabama Department of Insurance
PO Box 303351
Montgomery, Alabama 36130-3351

Dear Mr. Ridling:

The United States Senate Committee on Finance ("Committee") has exclusive jurisdiction over the Medicare and Medicaid programs and, accordingly, the duty to ensure that these programs are fiscally sound. As a senior member of the United States Senate and Ranking Member of the Committee, I have a special responsibility to conduct oversight of these programs and the effects that health insurance policies have on them. As part of ongoing work related to these programs, the uninsured, and health care reform, I have been looking into certain supplemental indemnity plans and how they are marketed to Americans. As the primary Alabama official responsible for protecting the interest of insurance consumers, I wanted to share the following issues with you and invite your perspective on this important matter.

An April 28, 2008, *Wall Street Journal* article, "Cash Before Chemo: Hospitals Get Tough," chronicled the challenges faced by a patient at M.D. Anderson Cancer Center in Houston, Texas (M.D. Anderson). The patient, Lisa Kelly, also described her experience to the Finance Committee at a hearing on health reform held on June 10, 2008. *The Wall Street Journal* story reported, and Ms. Kelly's subsequent Congressional testimony confirmed, that she was initially diagnosed with leukemia by her personal physician in Lake Jackson, Texas. She was then immediately referred to M.D. Anderson due to its superior facilities in treating patients with leukemia. When scheduling her first appointment, Ms. Kelly was instructed to bring a cashier's check for $45,000 to the appointment because M.D. Anderson would not honor her health insurance policy. The article went on to illustrate some disturbing practices that reportedly occurred, including an instance in which the hospital staff refused to change Ms. Kelly's chemotherapy IV until her husband demonstrated clear proof of payment.

During the course of my inquiry, I learned that Ms. Kelly had purchased an AARP Medical Advantage Plan (MAP) policy. It was this policy that M.D. Anderson refused to accept. The MAP policy as I understand it is a supplemental indemnity plan that pays a flat amount to plan holders for out-of-pocket health care costs, rather than a "major medical" health insurance policy that covers significant percentages or portions of

health care costs. With supplemental indemnity plans, the plan holder is responsible for the difference between the flat amount and the costs charged by the healthcare provider. So, in the case of Ms. Kelly, she was required by M.D. Anderson to pay most of her medical costs up front and then AARP would pay her directly a maximum of $7,500 per procedure – a far cry from the hundreds of thousands of dollars that her chemotherapy and other treatment would cost.

It is apparent from interviews conducted with Ms. Kelly, and her congressional testimony, that she believed that, while the policy did not provide comprehensive coverage, it would cover much more than it ended up covering. Instead, when she was diagnosed with cancer, she discovered her policy was so inadequate that M.D. Anderson would not even accept assignment for any of the minimal cash payments that the plan would apparently provide.

AARP's website, http://aarpmedadvantage.com, describes MAP as a "smart option for the health care insurance you need." In a smaller font that could be illegible for an elderly individual, the MAP policy is described as "an indemnity plan that pays you fixed cash benefits for covered doctor's appointments, prescriptions, hospital stays, surgeries, outpatient lab tests, emergency room visits and more – *even though it's not a major medical plan*" (emphasis added). The website goes on to instruct individuals to apply for MAP if they "don't have health coverage," need "a 'bridge' to Medicare or until other coverage is available," or "need to lower [their] medical expenses." The website directs potential customers to call a toll-free number if they have additional questions.

Committee staff also reviewed AARP's promotional materials for these plans and had a lengthy meeting with AARP representatives. During that meeting AARP representatives emphasized that indemnity plans like the one purchased by Lisa Kelly for nearly $200 per month were designed to be purchased *in addition to* other health insurance. They also stated that the MAP policy was, at least, "better than nothing." Additionally, they went on to say that they believed that these fixed indemnity plans, which are targeted to people between 50 and 65 years of age, are purchased mostly by those who have no other health insurance.

To learn more about AARP's insurance products, Committee staff also called the website's toll-free number on September 10 and 12, 2008. After asking AARP representatives about insurance options for older parents, Committee staff was twice directed toward purchasing the indemnity plan. One AARP representative told Committee staff that the plan, which is substantially similar to that purchased by Ms. Kelly, was an "excellent choice" for someone seeking a "less expensive option" to "major medical." Asked twice, the AARP representative reiterated to the caller that the plan was indeed "health insurance" and went on to explain that the plan would be accepted at most hospitals, and only after direct questioning did the representative say that the caller would be responsible for any difference between the fixed amount and the charges. Explaining the range of benefits, the representative only informed the caller of payment amounts for "Level 3," the highest amount, even though the caller was later told that he would probably be approved for Level 1. Another representative insisted that the

plan was "good health insurance," and that AARP "consider[s] this an excellent option as a bridge between retirement and Medicare." The representative also told Committee staff that the plan "covers cancer," as long as it was diagnosed after the coverage was in effect. Again, the representative informed the caller only of the highest possible "Level 3" benefits, and not the two other lower tiers of benefits.

To summarize, it appears that indemnity plans such as MAP may be marketed in ways that would lead consumers to believe they are purchasing conventional insurance plans. If this is the case, consumers could be left with less coverage than expected when they need it most or placed into situations where they cannot get the medical care they need.

I am also aware of the numerous investigations that took place in many states of HealthMarkets, Inc, and the related 29-state settlement agreement. Like the policies sold by the Mega Life and Health Insurance Company and its affiliates, the AARP policies are limited benefit policies. Accordingly, I am interested in learning more about whether states are continuing to see.

In light of this, I am interested in whether insurance consumers nationwide are continuing to experience problems with Mega Life and if they are seeing similar problems with AARP policies or other limited benefit policies and their marketing practices, and if so, what is happening on the state level to address them. As Alabama's insurance commissioner, you have insight into what is happening in your state and I look forward to hearing your perspective on this matter. I would be grateful if you could answer the following questions and any additional comments on experiences in your state with respect to fixed indemnity insurance products that are related to health care events. These questions are for the period of January 1, 2005 to September 30, 2008.

1. Has your office continued to receive complaints regarding limited benefit and/or fixed indemnity plans? If so, can you please quantify the number of complaints received in your state?

2. If so, what were the subjects of the complaints? Were there complaints about the plans' coverage limits?

3. Did complaints address the manner in which these products were marketed, and if so what is the nature of the complaints?

4. Were consumers confused about the products they had purchased? Did they think they had been misled about these products?

5. Aside from the market conduct exam of the Mega Life And Health Insurance Company, has your office undertaken any market conduct exams, or any other official investigation(s), based on complaints about limited benefit and/or fixed indemnity products? If so, what was the outcome?

6. Do you know the sales incidence of these products? Are they supplanting more comprehensive coverage in the individual health insurance market or policies that

have stop-loss coverage? Have the sales of these products continued at the same rate since the consent agreement was executed as prior to the execution of the agreement?

7. Do you know the incidence of cancellations, non-renewals, and discontinuances of limited benefit policies in your state? If the information is available, please provide the duration of the policies prior to their discontinuation, cancellation, or non-renewal, and the reason the policy was discontinued, cancelled, or not renewed.

I look forward to your thoughts and thank you in advance for taking the time to share them with me. Of course we are also available to speak by telephone.

If possible, please respond to this letter by no later than November 24, 2008. If you have any questions, please direct them to Christopher Armstrong or Kristin Bass of my Committee staff at (202) 224-4515. All correspondence responsive to this request should be sent electronically in searchable PDF format to Brian_Downey@finance-rep.senate.gov or delivered to the Committee's main office on compact disc. All deliveries should be coordinated with Brian Downey at (202) 224-6447, and delivered in accordance with his instructions.

Sincerely,

Charles E. Grassley
Ranking Member