MEDI-GAP: PRIVATE HEALTH INSURANCE SUPPLEMENTS TO MEDICARE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-FIFTH CONGRESS

SECOND SESSION

PART 2—WASHINGTON, D.C.

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THURSDAY, JUNE 29, 1978

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

The committee met, pursuant to call, at 9:40 a.m., in room 457, Russell Senate Office Building, Hon. Lawton Chiles presiding.

Present: Senators Chiles and Domenici.

Also present: William E. Oriol, staff director; Kathleen M. Deignan, professional staff; Garry V. Wenske, assistant counsel for operations; Letitia Chambers, minority staff director; David A. Rust, minority professional staff; Theresa M. Forster, fiscal assistant; Madonna S. Pettit, research assistant; and Pam Klepec, clerical assistant.

OPENING STATEMENT BY SENATOR LAWTON CHILES, PRESIDING

Senator CHILES. We will convene our hearing.

A few weeks ago, when this committee opened hearings on the sale of private insurance policies to the elderly, I was distressed to hear from consumers and State insurance commissioners that many older Americans were clearly being taken advantage of by unscrupulous insurance agents eager to make high commissions.

We were also distressed to hear that in some cases insurance company policies encourage oversale and misrepresentation of health insurance policies to the elderly—while the insurance company at the same time does not take the responsibility for its own agents.

RESPONSE TO FIRST HEARING

As one result of that hearing, additional refunds have been made to some consumers, and inquiries are being made about agents who figured in earlier high-pressure sales.

We also received much mail—from consumers, from insurance commissioners, and from insurance salesmen. Their letters show that these problems are not limited to the situations described in the earlier testimony.

We have heard of insurance salesmen offering door prizes at senior centers and other programs for older Americans to obtain membership lists—lists which are then routinely used to sell insurance policies.

Sales agents have described company directives requiring them to sell new policies on every service visit, to write new policies rather

than to renew current ones, and to delete medical histories on new policy forms.

We have also had reports of companies routinely denying claims when they first come in—taking the better-than-average chance that the elderly policyholder will not challenge their judgment and resubmit a claim.

Relatives have written who were outraged when they discovered an elderly parent with many insurance policies and large accumulations of canceled checks to insurance companies. One from Marathon, Fla., said:

> Last spring, I learned that my 88-year-old aunt * * * whose income is less than $5,000 per year * * * had been sold more than $10,400 of health insurance in approximately a 1-year period.

Several expressed great frustration at knowing how to find good supplemental health coverage for their parents. Some related long stories of visits and letters to State insurance commission offices and to State consumer protection offices—only to be told that there was nothing that could be done about getting refunds on policies they felt had been sold under false pretenses.

Another of these letters came from Mr. Wiley Cheatham, a district attorney in Cuero, Tex., who told us that he had seen, and prosecuted, many cases much more aggravated than those the committee heard at our earlier hearing. We will be hearing from Mr. Cheatham this morning, as well as Mr. C. L. Woodard, a U.S. Postal Inspector from Houston, Tex., who assisted Mr. Cheatham in prosecution of agents preying on the elderly in Texas.

I would like also to welcome Elizabeth Hanford Dole, Commissioner, Federal Trade Commission. Commissioner Dole has taken a special interest in consumer problems of older Americans ever since her appointment, and she has been instrumental in turning the Federal Trade Commission's attention to the difficulties elderly consumers have in purchasing medicare supplemental insurance.

We are also pleased to take testimony from Mr. Joseph Mike, commissioner of insurance in the State of Connecticut, representing the National Association of Insurance Commissioners. We look forward to the National Commission's recommendations and to working further with all State insurance regulatory commissions to find solutions to these problems. Commissioner Garcia, from New Mexico, is also here, and I am sure we will have many good suggestions from him.

Senator Domenici, we are delighted to have you here and we would be delighted to have an opening statement.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator DOMENICI. Thank you very much, Mr. Chairman.

I would like my written statement to be made part of the record, with your concurrence, and just make a couple of remarks and an explanation to the witnesses and to you about my schedule.

Mr. Chairman, I don't think there is an easy answer to this problem. Obviously, we are here to find out what we can do as the National Government. One suggestion is that we broaden the base of counseling that is available to senior citizens so that they can be

better informed. However, any such effort will not solve the entire problem.

MINIMUM STANDARDS

While I do not want to usurp the State's role, I am looking forward to hearing from the experts here as to what our Federal Government's role ought to be. Perhaps some national minimal standard should be in place if the States do not adopt some kind of disclosure or minimum compliance standards. Basically, we have got to get a handle on the sale of insurance, the type we have recently heard about. I hope that the experts we hear from today will address the issue forthrightly and give us some ideas as to what we might do.

I am most appreciative that Mr. Garcia is with us today. I am fully aware that his agency in New Mexico is taking very constructive steps, and I think we will learn from his experience and his suggestions today along with the other experts whom you have welcomed to the hearing.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Domenici follows:]

PREPARED STATEMENT OF SENATOR PETE V. DOMENICI

In an age of rapidly rising health care costs, all of our citizens are afraid that the insurance they carry will not be sufficient to meet their health care needs. Our elderly, who are so much more vulnerable to long-term illness than the rest of the population, are especially aware of the deficiencies in many health insurance policies. Also, as we all well know, medicare has its limitations, and coverage is frequently inadequate. We are now learning that medi-gap policies, sold to "fill the gap" in medicare benefits, also have some serious drawbacks.

To protect what assets they may have, many elderly persons seek additional insurance coverage. Medicare now covers only about 38 percent of total health care costs for those age 65 and over. In addition, there is often confusion over what is covered by medicare. For 1976, out-of-pocket costs for health care of medicare members was $562 million.

"SHOCKING TESTIMONY"

During the hearing held on this subject on May 16, this committee received some very shocking testimony. A case in point was that of Mrs. Lucille W. Lowry. By June of 1977, Mrs. Lowry's contractual obligations for premium payments to one insurance company amounted to $9,158.61 per year, or approximately 68 percent of her annual income. At that hearing we were led to believe that abuses of this type are not so uncommon as we might like to think.

It is easy to see why our elderly fall prey to unscrupulous insurance agents. Seniors are often unsophisticated and unknowledgeable about the terms and conditions of insurance policies, many of which are quite complex. Further, as age progresses, they realize that their health is more likely to fail, and they do not want to burden themselves or their families with exorbitant medical bills. Catastrophic

illness can wipe out anyone's income, and our elderly are especially prone to catastrophic or, at least, long term illness.

Reforms are needed to protect the elderly from overlapping and inadequate medi-gap coverage. Many reforms will have to be made at the State level and insurance companies will have to institute safeguards of their own. In addition, I have proposed—and I hope that the committee will take an in-depth look at my suggestion—a program of insurance counseling for the elderly. If we can devise and implement a comprehensive and easily understandable insurance counseling program, our elderly will be better informed and can then purchase medi-gap coverage wisely at premiums they can afford.

I hope that some very important questions will be answered by the witnesses testifying today. In particular, I would like to know what you feel the role of the Federal Government should be in the area of medi-gap abuse. Naturally, I do not want to see the authority of the States usurped in any manner, but it is very possible that limited Federal involvement is necessary. Perhaps it should be the responsibility of the Federal Government to develop a set of minimum standards. In any event, I hope that Commissioner Dole and the other witnesses we hear today will be able to provide their thoughts on the responsibility of the Federal Government in this area.

I am very pleased that Manny Garcia, superintendent of insurance, State of New Mexico, is here to testify today. Manny and his predecessor, Mr. Kenneth Moore, have involved themselves extensively in this problem, and have taken affirmative action to uncover and eliminate medi-gap abuse in my State of New Mexico. Both Mr. Garcia and Mr. Moore deserve praise and commendation for their fine efforts to eradicate medi-gap abuse. I look forward to hearing from Mr. Garcia about the details of New Mexico's reform program.

Mr. Chairman, thank you for your time. I look forward to working with those testifying today and with the committee members toward a solution to a very perplexing and serious problem which faces our senior citizens.

Senator CHILES. Thank you.

Senator DOMENICI. I would want to say to the witnesses that at 10 o'clock I have to appear with a nominee for the Federal pension in the State of New Mexico. Mr. Chairman, I will go there and reappear as quickly as possible if you wish.

Senator CHILES. Our first witnesses will be Mr. Cheatham and Mr. Woodard. We will ask you if you will come up, please.

Mr. Woodard, you may proceed in any way you desire.

STATEMENT OF CURTIS L. WOODARD, U.S. POSTAL INSPECTOR, HOUSTON, TEX.

Mr. WOODARD. Mr. Chairman and members of the committee, my name is Curtis L. Woodard. I am a postal inspector stationed at Houston, Tex.

This is Wiley Cheatham, district attorney from the 24th Judicial District of Texas.

I appreciate the opportunity to appear before you today to discuss investigations the inspection service has made regarding the defrauding of elderly citizens of Texas and Oklahoma by unscrupulous insurance agents and exinsurance agents.

I have been assigned the investigation of mail fraud cases at Austin and Houston, Tex., for approximately the last 7 years. The type of fraud investigated and prosecuted under the mail fraud statute, title 18 United States Code, section 1341, is very broad and includes any type of business which is operated fraudulently and uses the U.S. mails to further its scheme. It need not be a mail order business.

TEXAS INVESTIGATIONS

The postal inspection service investigates alleged violations of the mail fraud statute among its many responsibilities. Normally, the results of a mail fraud investigation are presented to the U.S. attorney for consideration of filing charges in the U.S. district courts. However, in these investigations, the U.S. attorney's office in Fort Worth, Tex., determined that it would be advantageous to cooperate with Mr. Wiley Cheatham, the district attorney in the 24th Judicial District of Texas. This decision was based partially on the fact that State investigations were underway and some indictments had been returned in State court. The fact that all of the victim witnesses were aged and some were in poor health was also considered.

Beginning in January 1974, the inspection service was asked to investigate a series of offenses involving the defrauding of elderly people in Texas by unscrupulous insurance agents and exinsurance agents, usually working in pairs. Mr. Wiley L. Cheatham, district attorney, 24th Judicial District of Cuero, Tex., who had noticed some of these crimes occurring in his district, which consists of four counties in south Texas, was also investigating violations of State statutes. Indictments were ultimately returned in six other State judicial districts and overlapping convictions were obtained in three of those districts. The State board of insurance assisted and assigned Investigator Howard L. McRae who also worked with us on these investigations.

Senator DOMENICI. May I ask a question, Mr. Chairman?

Senator CHILES. Yes.

Senator DOMENICI. What is the crime? Would you state it for us again?

Mr. CHEATHAM. Yes. It would actually be theft by false pretext or theft by fraud, as someone indicated in their prestatement. It is theft, but theft by misleading and defrauding of people as to what they are getting. Legally we call it theft by fraud.

Does that clarify it for you?

Senator CHILES. Yes, sir.

Senator DOMENICI. Yes, sir.

Mr. WOODARD. A mail fraud case would be a combination of many such thefts drawn into one indictment.

The series of investigations involved aged victims, usually women, age 65–92 years, living alone. Also elderly couples were fraudulently solicited, but usually one of them was senile or incapacitated, and the fraudulent pitch would be directed toward the one who handled the checkbook and financial affairs. Elderly people tend to be concerned with their health and their need for extra hospitalization which is generally motivated by a desire to remain independent and to be able to financially survive an expensive illness.

The elderly citizen is frequently lonely, and a well dressed, youthful, and confident salesman has an easy time gaining entry to the victim's home and gaining his or her confidence. We noticed that the elderly people usually do not understand the fast talking, double talking sales pitches that these agents use. These factors make the elderly an easy mark for unscrupulous insurance salesmen.

"Goose Lists"

The first investigation in which I participated involved two men. One was a licensed insurance agent and one had lost his Texas insurance agent's license. They sold accident and health policies by "hard-sell" tactics to elderly women commonly called "gooses" by these agents.

Senator Chiles. Tell me, what does that term mean? That was a term of art that the agents used?

Mr. Woodard. Mr. Cheatham.

Mr. Cheatham. This is the slang word that they use for these elderly people who are easy prey.

Senator Chiles. Easy marks.

Mr. Cheatham. Easy marks, yes.

In fact, when we got down the line we were able to capture one of the goose lists [1] and we will give you a couple of examples of what it pretty well portrays, the feeling that these agents have for these old people in their description of them, how easy they are to sell. We will cover that if you like.

Senator Chiles. Thank you.

Mr. Woodard. These insurance sales were intermingled with the selling of worthless, desolate west Texas land or lots at grossly inflated prices. The term "gooses" relates to aged people who can be sold hospitalization, insurance, or almost anything else on an insurance pitch, whether or not it is needed. Most of the west Texas lots were sold on a "paid-up" hospitalization pitch, when in fact no such paid-up insurance was available, nor was any insurance furnished. The salesmen perpetrated their fraudulent scheme by substituting deeds for virtually worthless lots; however, these deeds were generally not furnished to the victims unless a complaint arose or an enforcement agency became involved. Some insurance policies were put in force but were sold by the same tactics that we found—misleading. Some lots were deeded to more than one victim. The scheme involved the mailing of checks for collection between banks and the mailing of the deeds of the worthless and unwanted lots. Approximately $200,000 was obtained from elderly people in Texas on this flim-flam.

Overloading Accident and Health Insurance

The two principal operators received 7- and 8-year prison sentences from the DeWitt County Texas District Court. That is Mr. Cheatham's district. The investigation further disclosed numerous instances of overloading and defrauding elderly citizens of Texas and Oklahoma in accident and health insurance solicitations.

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[1] See p. 227.

Several separate but similar investigations were made in 1974 and 1975 involving a loose-knit group of insurance agents and exagents primarily operating out of Fort Worth, Tex. Generally, one agent who held an insurance license was recruited to "front" or sign the papers and receive a percentage of the commission for very little effort on his part. Unlicensed salesmen fraudulently solicited business from the aged and sometimes senile citizens susceptible to high pressure tactics. These schemes usually worked for relatively short periods of time because the Texas insurance companies, and in a few instances Oklahoma or other out-of-State insurance companies, were eager to obtain the new business which had virtually no claim liability during the first 1 or 2 years. Underwriting safeguards were not adequate to detect and reject the fraudulently solicited business.

The high pressure and fraudulent sale of accident and health policies to the aged almost always resulted in the "twisting" or replacing, or the dropping of existing policies which had outlived some or all of their waiting periods.

Senator CHILES. That term "twisting," is that another term of art?

Mr. WOODARD. Yes, sir.

Mr. CHEATHAM. Yes, sir, that is correct. The way they work it—you touched on it slightly a while ago—an agent presents a policy and collects the annual premium. Usually nearly all the policies have waiting periods from 1 to 2 years before the purchaser is covered as far as hospitalization. As that policy comes near to the time it will expire, the agent will come in and usually tell the victim that there are a number of ways to renew which we can touch on later if you like.

Senator CHILES. Yes.

Mr. CHEATHAM. The agents will tell people, for example, "It is time to renew your policy; we need your annual premium." The agents will say, "We didn't have time to get it out of the computer so you will be getting a bill on this, but just disregard the bill and you can go ahead and pay us now." They collect the money and of course the insured will follow the instructions of the agent and will disregard the notice and not make the payment, so their policy that is in force will lapse and they will lose what time coverage they had. They will be sent a new policy which will have a new waiting period and actually many of those old people were never insured although they would pay premiums each year supposedly for renewal and it would actually be for a new policy which would begin anew.

Senator CHILES. Regardless of their claim, they would always be in the waiting period.

Mr. CHEATHAM. Always be in the waiting period. The company will say: "I am sorry but you have not had the policy long enough. We regret very much not being able to pay your hospital claim."

Mr. WOODARD. We will cite you an example in just a moment, Mr. Chairman.

This replacing or twisting of policies of course resulted in a high rate of denials of claims. Some instances of twisting within the same company were noted. In one such instance, an agent was convicted in the 24th Judicial District of Texas in a case prosecuted by Mr. Cheatham. In that case the aged victim's claim was denied after the

agent had fraudulently replaced a good policy that had been in force with a new policy. The more common type of twisting noted during these investigations involved the transferring of aged customers between two or three companies. This usually resulted in the expiration of policies which were in force, in favor of newly acquired policies with new waiting periods.

Tactics Used

Some examples of fraudulent and deceptive tactics used by salesmen in obtaining money from the aged citizens are as follows:

One: The seeking out of elderly people who are known to be susceptible to repeated insurance sales.

Two: The use of "goose lists" in identifying and locating aged victims, and in disseminating information from one agent or ex-agent to another on the pitch or technique to be used.

We have an actual goose list [1] that we would like to show you and we have made copies. The names we would like to protect for the reason of not embarrassing those people.

Senator Chiles. Thank you.

Mr. Woodard. Some of the comments are very interesting in that they show the salesman's attitude toward the old people.

Three: Salesmen claiming to be there to collect on accident and health premiums due on existing policies while actually soliciting new business.

Four: Salesmen claiming to represent the victim's accident and health companies.

Five: Salesman claiming to be combining their insurance and sometimes getting money back.

Six: Unlicensed agents soliciting insurance sales to be "fronted" by licensed agents.

Seven: Licensed and unlicensed agents claiming to represent companies that were familiar to the aged victims, such as American Insurance Co.—anything with "American" in it is good to use on an old person—and tricking them into signing new applications for insurance with other companies.

Eight: Salesmen representing that "Our company has bought out your company" and that "The company has sent us out here to collect for your insurance and get these new papers signed," while actually soliciting new hospitalization business.

Nine: Salesmen's representations such as "No waiting periods," "This policy will pay everything" or "Everything that medicare does not pay," "This is a paid-up hospitalization policy," and "You will start getting so many dollars per month back on this paid-up policy."

Incidentally, I don't know of any paid-up policies. We didn't run across any in our investigations.

Ten: Salesmen represented that they would reinstate expired accident and health policies which in some cases had been expired for 2 or 3 years and had been issued by companies they did not represent.

Eleven: Some solicitations were as simple as "Get your checkbook; your insurance is due."

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[1] See p. 227.

Twelve: Salesmen claiming that they were there to help the aged victims with their social security while actually soliciting accident and health business.

Thirteen: The use of familiar sounding and appealing agency trade styles such as the American Agency, Senior Citizens Agency, and First Continental Agency—these names were actually used in Texas—to induce aged people to listen to the sales pitches.

Fourteen: Falsification of applications for new accident and health policies by clean sheeting—omitting unfavorable information such as age, health conditions, and additional policies in force; forging signatures of applicants; and fence-post policies—completing applications in the name of relatives or others, unknown to the victims. This is done to bypass underwriting rules when it is known the victims already have the maximum coverage in effect with a company.

SIXTEEN INDIVIDUALS CONVICTED

The results of prosecutions—Mr. Cheatham's prosecutions. As a result of the investigations, 16 individuals were indicted and convicted on insurance-related offenses which were prosecuted by Mr. Cheatham in the 24th Judicial District of Texas. Some individuals were convicted of more than one offense. One was convicted of perjury in connection with a grand jury investigation and another on bail jumping when he failed to commence his sentence, and that was an additional offense. Prison sentences ranged up to 9 years in addition to probated sentences and an additional 5-year prison sentence was assessed to the bail jumper after a 9-year sentence on swindling old people. All defendants indicted in Mr. Cheatham's district were ultimately convicted.

I don't think that is intended to mean that everyone that did something bad to old people was indicted. Some of the cases could not be made, but he did convict all of the ones he indicted.

Mr. Chairman, I have prepared five specific examples which demonstrate the hardship these insurance frauds have worked upon the elderly. With your permission, I offer them for the record.

Senator CHILES. Without objection, they will be made a part of the record.

[The material follows:]

EXAMPLES OF FRAUDULENT ACCIDENT AND HEALTH INSURANCE SOLICITATIONS

An 84-year-old woman at Helotes, Tex., paid at least $15,303 on approximately 23 accident and health solicitations from November 1972 to April 1974. She paid $3,200 on a paid-up insurance pitch, but later was delivered a deed to near worthless and unwanted lots in west Texas (she owned a 10,000-acre ranch in Texas plus three farms in New Mexico). She was solicited three times during March and April 1974 and issued checks totaling $6,720.50, payable to Senior Citizens Agency, VWC Agency on Nursing Care, and accident and health pitches. The money was diverted to purchase worthless vehicle warranty contracts. Among the policies issued to her, nine were issued on forged or unsigned applications and seven were issued on "fence post" or unauthorized names.

One victim at Dallas, Tex., age 92, was solicited for insurance 13 times between April 1972 and July 1974. She paid $3,440 in checks plus $1,000 cash, and received nothing. On April 16, 1974, she paid $975 on an insurance pitch that would allegedly combine and pay up her accident and health policies. She alledgedly was to begin receiving $100 per month from the paid-up insurance. However, the money went to purchase worthless vehicle warranty. She owned no automobile.

An aged couple at Victoria, Tex., was solicited for 16 checks, totaling $3,220, for accident and health-type insurance between October 1973 and May 1974. The husband was unable to handle financial affairs and the wife, age 74 and confined to a wheelchair, looked after these matters. Of the money paid for hospitalization, $633 was diverted to a vehicle warranty contract. Salesmen claimed they were collecting premiums on insurance that was due.

Two sisters living together at Victoria, Tex., ages 85 and 91, were solicited six times between January and May 1974 for a total of $3,071 on accident and health pitches. The 91-year-old sister unwittingly paid $1,656 in two installments for a vehicle warranty contract. She had no automobile, but her sister did have a 20-year-old car.

An 83-year-old victim at Lockhart, Tex., gave an agent a check for about $7,200 to pay up her insurance, but overheard the agents conversing as they left her home and thus learned that they did not intend to do as they had agreed. Later testimony by one of the agents disclosed that the money had been solicited for insurance, but was to be converted to worthless west Texas lots. She was again solicited in March and April 1974 for $1,975 and $1,860. The first solicitation was to reinstate a lapsed policy and to pay up two life policies, plus one annual hospitalization policy. She received no insurance coverage for this money. The $1,860 was paid on an accident and health pitch, but included a $50,000 life policy. She received no insurance, but did receive a worthless vehicle warranty contract in the mail for her $3,835 paid to Senior Citizens Agency.

Mr. WOODARD. This concludes my statement. I will be glad to answer any questions you may have.

Senator CHILES. Thank you, sir.

Mr. Cheatham, we will put you on next and then we will question both of you.

STATEMENT OF WILEY L. CHEATHAM, DISTRICT ATTORNEY, 24TH JUDICIAL DISTRICT, CUERO, TEX.

Mr. CHEATHAM. Thank you, sir.

I believe what I might do is to cover this in a little more depth.

Senator CHILES. Fine. If you want to relate to any of these examples, fine. I want to ask you some questions about this.

Mr. CHEATHAM. Any time that you like, feel free to interrupt me.

Senator CHILES. Why don't you list them?

Mr. CHEATHAM. We photocopied part of the list and I will be glad to leave a copy with you. We have the original in case you would like to see it.

RICH AND POOR VICTIMS

I would like to mention that in this regard both the rich and poor alike are victims of these schemes. We had an ex-Governor's close relative who was victimized regularly, not in my district, however, but it came to my attention. In our investigation in our district we have a district judge's elderly mother and aunt who were regularly taken each year for considerable sums of money, unbeknown to the judge. This is one area that the younger relatives might want to take note, because these elderly people like to feel that they are handling their business; that they are getting insurance and won't have to fall back on their children; so very often they don't tell their closest relatives of the business transactions they have had.

We were able to recover quite a bit of the judge's mother's and aunt's money that they had expended on these fraudulent sales and policies. We had several wealthy widows, one of them who has a ranch in excess of 10,000 acres in Texas, and much more land in New Mexico. She was one of the regular customers. They would

more or less vie for who would go in there and write her a big policy.

We have another elderly lady in one of the adjoining counties where one set of salesmen would go in and write in excess of 10,000 dollars' worth of policies at one time, come back the next year and write her again. Since it was not in my district, we could not follow up on it, but one of these agents who we convicted, as part of his sentence, made full disclosure of his knowledge of the violations that had gone on in Texas, New Mexico, and Oklahoma. He indicated that in a period of 14 months this one wealthy lady, through about four companies and a larger number of agents, spent between $45,000 and $50,000.

Then, of course, you have many of the poorer senior citizens living in low-cost housing units. We have found quite often that the agents would have to time their visits so that they would get there after the social security checks came in so they could take advantage of the social security checks.

"Clean Sheeting"

With reference to their tactics, they have a language all of their own, and this I guess makes it a little difficult to understand the jargon, but Mr. Woodard touched on the "clean sheeting." When the agents go into a house and write the victim, they will write it up as if there were no prior illnesses, thus indicating to the company that if they get sick, anything would be covered. This is sort of a two-edged sword, if you will, because when the person gets sick and goes to the hospital, the doctor makes the report. When the company gets it they write back and say, "Well, you defrauded us, you didn't tell us about all your prior illnesses, so therefore we have to deny your claim." We had a number of the companies that were doing that.

I guess one of the best examples that we have had is an old couple that lived right behind the jail in Cuero, Tex. The husband had had a stroke and had been in a wheelchair since 1967. His wife was the sole breadwinner and she worked at a little hamburger stand making hamburgers and selling soft drinks. We recovered something over $3,000 for them, a lot of others we didn't, but the point being that the husband had been in a wheelchair since 1967 and when the agent went in to sell, the husband was sitting there in the wheelchair. Yet, the agent wrote up the policy indicating that he had had no prior illnesses.

Some of the companies had had insurance policies on these people before and had claims before and, of course, knew what sort of shape the old man was in, yet they would accept these new policies each time. She thought she was renewing and she was getting a new policy every time so that very seldom did the waiting period run out. If it did run out—the waiting period—then the company still would refuse to pay because they said the people had not related to them that they had had the prior illnesses in their application for the insuring policy.

They would hit the old people with the "Pay it all proposition"; in other words, you are paying up all of your insurance. Also, for example, they went in on one couple, indicating that the company would pay up to $25,000 no matter what the bills were. Well, of

course, the policy itself did not read that way. The agents used an outlaw pitch sheet, a printed form which they would show the people and, of course, the people felt that they were legitimate agents.

Senator CHILES. Were, in fact, some of the agents legitimate and working with companies?

Mr. CHEATHAM. Yes, very definitely so. Some of them were agents with the companies, and I will touch on this just momentarily. Many of them were prior agents who had lost their license and then kept on selling these old people through another licensed agent. I might add—and I think this is important—that when these agents go in these old people's homes they come up in a $500 suit and a Lincoln Continental or a Cadillac. They come in there and they know everything about that old couple or the old person. They will know what policies they have, when their policy will be coming due. They will know the name of their cat or their dog, whether or not the sister lives with them. When they go in on those old people like that it is very disarming; in other words, they feel that they are bound to be legitimate agents and a legitimate company, otherwise they would not have all the information.

Many times these people hardly ever have company; they don't see people very often. When you have an agent coming in and being that aware of everything about their prior life and visiting with them, they are very easy prey.

"LOADING UP"

Mr. Woodard touched on this matter of "loading up," or collecting for many policies. Very often we found where the agents would go in and find out how much the victims had in the bank and leave the victims $50 or $100 to live on for the next month and write out a check for whatever amount the older person had, and then left the victim just short of going on starvation wages. They would sign these forms up in blank and then go back in the company offices and select various policies that would fit the amount of money that they had collected. Very often these policies would be of very little value or no benefit to the person. They would probably sell them two or three hospital policies and maybe a cancer policy on the side to try to fit the amount of money they had collected. Very often, the cost of the policies furnished did not match the exact amount of money collected from the victim.

One of these agents, incidentally, indicated that his net take for his part per year was approximately $85,000. The other agents of course got like amounts.

NONLICENSED AGENTS

Mr. Woodard touched on this matter of "fronting." This is where you have one or more licensed agents and maybe a half dozen nonlicensed agents or agents that have lost their license. The nonlicensed agents go in and make the pitch to the old lady. They meet at the end of the day or the end of the week and have the licensed agent sign the application forms before submitting them to the company.

In Texas, this form requires that the agent be present with the

old lady when the application was taken, so he signs the form indicating that he was present in Cuero, Tex., or Victoria, Tex., when the victim signed the application. This also has some problems as far as the prosecution of these men, because when we get a description from a little old lady that said, "There was a nice tall dark headed man who came in and sold me this policy," and we think it is "so and so" insurance company, we check with that company and get a copy of the application and it will have an agent's signature on there. They will get a picture of the agent and it will turn out to be a short blond. So we have a little old lady that they say, "Well, she is just completely confused." It does not even fit the same description of the signing agent. It also helps the agents to have a defense when you catch up with them, unless you are able, as Mr. Woodard helped us, to find and check the other nonlicensed agents that were working with the licensed agent.

But in one of these little rural districts when you have one little old lady and she gives a description of a man that does not fit the description of the man who wrote the insurance, you can realize the difficulty in trying to make a case to catch the man who defrauded her because she does not even have the right description. She describes the person who was there, but the person who was there is not the one who signed the policy.

Mr. WOODARD. You convicted the signing agent.

Mr. CHEATHAM. Yes. I might add that under Texas law a person is guilty as a principal if he does anything to aid another person in committing the offense, and in several instances we were able to indict not only the person who went in the house after we found out who he was, but also the signing agent acting as a principal, although he didn't actually, physically, go in the house where the little old lady was. But he took part in the scheme by signing the application in which he was confirming he was there at the time.

"PAID-UP POLICY PITCH"

Touching on this "paid-up policy pitch" that they have, they go in and tell them, "We want to finalize your policies." They will get some little old lady that has a suitcase full of policies who has been paying $300 or $400 to the companies for the last 3 or 4 years on each of many policies. She may have a big paper sack or suitcase full of policies that are duplicated and they come in and tell her, "These other companies are not treating you right: you are paying too much money. We want to fix it up so we will finalize or combine all of your policies. You pay us another $700 or $800 and we will put them all together and they will be completely paid up and then you will start drawing"—usually they will tell them $100 to $200 a month. Of course that sounds like Christmas, you know, a good thing, so the little old lady pays that up and of course she never gets the several hundred dollars a month and she also does not keep the policies alive that she already has.

Mr. Woodard touched briefly on what they call "fence posting" in the business. This is where they sell so many policies that the company can't legally insure them on any more policies and they have more money that they collected from the little old lady. This $45,000 one, and several of the others—they would start writing up

policies on her relatives or even her friends. They would ask, "Who is your beneficiary?" and they would write up several policies on her. We convicted several of these.

One of the little old ladies, when she got the policy back, was still alert enough to realize that they were sending her a hospitalization policy back on her sister and brother who lived some 300 miles away in Forth Worth. She wrote them. Fortunately for us, she wrote a little letter to the company and indicated she did not do that, and of course the company just avoided it, and did not answer the letter at that time as I recall, so she had her lawyer write a letter.

When you get instruments like this, it helps you very much with the little old ladies, because if they have become senile in the meantime it is very difficult to make a case on their testimony, but where you have evidence in black and white and written complaints that come from the victim or principal to show what their understanding of what they were being sold at the time, it helps very much in prosecuting these people. Because, you can realize the problem of having a one-witness case with a little old lady that can't remember the color of the agent's hair or remembers the man as being a brunette and he turns out to be a blond. Here comes a smooth talker who could sell an Eskimo a refrigerator, if you pardon the expression, and he comes into court and is a smooth operator. When you are successful in getting these other instruments, it does help tremendously in convicting these people.

I would like to touch a little more on this matter of "twisting" policies. This is, as Mr. Woodard explained, where the victims have a policy and the agents come in and cause a lapse of that policy. The policy coverage is lost and the agent sells a new policy to the victim. There are several facets of that. We ran into a situation where one man owned three companies. The agent would run in and sell the woman a policy and all the companies had similar names—usually all of them had similar names—and one of the names would be the same, and then they would vary it a little. They would come in and sell the little old lady one policy for whatever they could get, $300 or $400 or more.

Company Switches

Thirty days before that policy ran out, they would come in and say, "I am here to collect your insurance," and instead of renewing the old policy, they would write it on the second company, all owned by the same man, and then they would come in later and sell them this third policy on the same company owned by the same man. The old person would actually never have insurance that would cover them because the waiting period had not run out.

Then you have a situation—it is not always the companies and the agents working together in each situation—we learned about where one company had sold out to a new purchaser. Then the exowner got the agents to go out in the field to twist off all the policies that they had sold to the new company. They put the policies back into another company that the person owned that had sold out the first company. So the new company wound up with a shortage of customers and the little old lady has suffered because she was not covered by the insurance because of the waiting period. So it was a fight

with the companies; in effect, but the little old ladies are the ones who really suffered.

I think he touched pretty well on the similar name pitch, where they come in and say, "Well, we are from American" or "We are from Southwest" and so forth, and that convinced most of the elderly policyholders. That meant some prominent well-recognized company to the victims. We are not saying that all of the companies are that way. Companywise, there are a small minority of these companies that I think, as far as I can see, were doing this, but these unlawful practices do hurt a lot of the companies that are legitimate.

Senator CHILES. Did you find companies that were trying to police their agents?

Mr. CHEATHAM. In some areas and in some of these new companies; in some of the companies, if once we caught them, yes, they would come in and they would come down and testify for us. We would issue a subpena and they would produce the records, but without exception each one of these people, as we convict them and before they were sent to the penitentiary—we talked to them; they always told us: "We could not have done what we did had the company not known. In other words, the company had to approve it. The company officials had to be approving it or we could not have accomplished this, other than maybe on a very short term basis." If the company checks their records properly, it does not take them long to recognize these repeaters.

Another one of the schemes we ran into was where one agent would come in and sell the hospitalization policy to the little old lady. We had one who had to have an eye operation that was not paid for because of this. She bought the policy and she kept it long enough to where she was covered, fortunately. The second agent came in and told her that, "No, I am terribly sorry, but one of our agents sold you a policy on the wrong form and you are really not covered like you should be and we are going to sell you this new policy. The waiting periods will be waived and you will be covered." She bought the new policy and the old policy lapsed.

Incidentally, she was telling the agent all the time: "I have to have this eye operation. I have a cataract operation coming up and I want to be sure I am covered." He assured her that she was covered, and, of course, when it reached the company they complained and he came back and said, "I am sorry, you have not had this policy long enough to be covered." So she lost her coverage for her cataract operation.

We have touched on the "no waiting period" and this, to me, is one of the real problem areas with these senior citizens. I am not an insurance man and there may be problems there, but if there were any way that these elderly people, buying policies—if the company were required to not insure them until they could get by this waiting period or, once they accepted the business, that they would not have the waiting period, not all of it but a lot of this type of fraud would probably be eliminated.

We had another pitch that sold a lot of policies. The agent would take a husband or a daughter or a close friend and, in trying to sell the policy, they would tell them, "Well, you know, my husband here or my daughter had an illness last year and the company paid more than the whole hospital, and doctor bill too—we have actually made

money on it," and of course the husband and daughter didn't even have insurance with the company. You would be surprised how that causes people to buy insurance. They want to be sure that they are completely covered and, of course, they are not.

We had some agents who would sign up a group of elderly people. If they were not able to place it with one company, they would then forge the signatures on new applications. We had old people who wound up with insurance with companies that they had never even heard of before. We had a number of instances of that.

Basically, that is all.

Senator CHILES. Tell me something, on the goose list. How did that work and where did you get that?

"GOOSE LIST" EXCERPTS

Mr. CHEATHAM. This was recovered from a group of these people who we caught. The man who made this particular list up had lost his license in Texas and his presence in Texas was not very—in other words, they were looking for him and he left to go to Oklahoma, as I recall. Before he left, he prepared the list and gave them this list to use in Texas. If you would like, I can show you this.

Senator CHILES. Yes, sir, if you would.

Mr. CHEATHAM. This will show you how "benevolently" some of these agents feel toward some of these old people.

Without using the name, he says: "This one is a good deal, but she likes Reserve Life, so handle with ease. Sell on idea of lowering rates that she now pays."

Here is another one. "This lady is as goosey as two young skunks. Cinch sale—$200, $250."

Here is another one. "There are two sisters here and another one that lives somewhere else. They pay for her, too. Good for $2,000, $3.000. Cinch."

Here is another one. "This woman is easy. Go in and sell her for her sister that don't live with her. She likes to hear a pitch. Also likes insurance that covers cancer and preexisting conditions."

Here is another one. "Everybody knows this one so don't take a check for more than $200, $300." In other words, otherwise you might get a hot check for your premium, because some of them have gone in there and got money from her already.

"This is just a plain old goose. Check bank balance."

Here is another. "This lady has a sister that lives with her. They are goosey, but they like Reserve Life. Real good, so you need to put a story on them. They are not stupid, so handle with care."

Here is another one. "This lady is goosey, but she is a younger one. Also, she has about five to six policies with Reserve Life."

Here is another one. "This one is a younger woman and goosey as hell. Has a husband, but she takes care of all insurance. Sell preexisting policy. She's sick. Not a big deal, but a cash sale. Don't 100 percent."

Now I guess I better touch on that slightly. Most of these agents on a new policy will receive anywhere from 60 percent to 90 percent, and we found a few, I don't think any more, that would even get 100 percent of the first year's annual premium. If they go in and sell a policy and don't turn it in at all and keep all of the money, then they are more likely to get caught. But if they go ahead and

put the policy in with the company, even though it does not pay, then if somebody complains they can claim that the little old lady misunderstood them in what they told her because there is the policy that they sold. But they are cautioning them on this one, "Don't 100 percent her"; don't keep all the money, or otherwise you might get caught.

Then we have them, for example, where we had one little old lady in one of the other towns in my district who had been sold so much that she had a great big suitcase full of policies. Every time some of these agents go in and sell her some more, they would ask to look at her policies and then they would carry an armful of those policies out and throw them out down the road, so if relatives came and found the suitcase they would not find all this mass of duplicate policies.

Back to the goose list.

Here is another. "This lady has always bought good. She wants a policy that pays for rest home; she won't have anything else. Go to back door."

Here is one. "This is the goosiest thing you ever saw. Run check through regular channels, no more than $500 at a time. This one is pretty well known by all the high rollers."

A lot of these agents refer to themselves as "high rollers."

So again—well, it is self-explanatory, I think.

This one says: "This one is a cinch. Make like you are lowering her premium."

In other words, she is paying too much for a premium so we are going to sell you a policy that won't cost you as much.

There are a lot of other examples in here, some of which are not fit to read in mixed public. The committee is welcome to have a copy and read them if you like.

[The list follows:]

"GOOSE LIST" SUBMITTED BY MESSRS. CHEATHAM AND WOODARD

[ADDRESSES AND TELEPHONE NUMBERS DELETED]

MAGGIE. This is a *cinch* sale, easy to talk to.

MYRTLE. This one is a good deal but she likes Reserve Life, so handle with ease—sell on idea of lowering rates she now pays.

JEWELL. This is a man and wife. They like Reserve Life, but I think they can be sold on anything because they are paying a lot for this insurance; however, the rate's about $50 less than they are paying.

HARRIET. This woman is a good deal but you have to sell—so set in tough so you can close.

WILMA. This one is tough but has always been sold heavy, but you have to stroke it on her ———.

EULA. This lady is as goosy as two young skunks. Clinch sales, $200—$250.

EFFIE. Don't know this one but she is a buyer. I never could get her at home.

LUCILLE. This is a sale. not too big, but a cinch.

NOVA. This is a cinch sale good for $150–$200—silly as ———.

GLADYS. This one is a cinch for all she has—check bank account. I sold $350. Check good.

AUDIE. This is a woman (Audie) good deal.

EVA. This is a jam-up good one for anyone.

LOTTIE. E. J. has sold this deal four or five times. He can't write nothing but goosies. Try her.

BESS. You ought to know this one, but don't fail to call on—she is a dandy.

WILLYNE. These are two sisters here and another one that lives somewhere else; they buy for her too—good for $2,000 or $3,000. Cinch.

LONNIE. This is a good deal.

ADDIE. This is a small deal, but is a sale.

ZELA. This lady is a goose. Talk to her about her quilts that she makes. Buy one from her—pay her half and stroke it on her ———.

OLGA. This woman is easy. Go in and sell her for her sister—that don't live with her—she likes to hear a pitch; also likes insurance that covers cancer and preexisting conditions.

RUTH. This one is a younger woman and goosy as hell—has a husband, but she takes care of all insurance. Sell preexisting policy. She is sick; not a big deal but a cash sale. Don't 100 percent.

PAULINE. This is a goose, but watch out for her daughter. This is not a hot one, but her daughter is a smart ———.

MARY. Everybody knows this one, so don't take a check for more than $200–$300.

IRENE. This is a good deal, but sure likes Reserve Life, so handle with care.

BESSIE. This is just a plain old goose—check bank balance.

ADDIE. This is a good deal but not too big—$150 or so.

CORA. This lady has a sister that lives with her—they are goosy, but they like Reserve Life real good, so you need to put a story on them—they are not stupid, so handle with care.

VERA. This one has bought a lot of insurance but I don't remember anything about her. I am kinda slack this morning.

INEZ. This is one of E. J.'s old deals.

EUNICE. I don't know about this one for sure, but she pays quite a bit for insurance.

MABEL. This lady is goosy, but she is a younger one. Also, she has about five or six policies with Reserve Life.

IRMA. This one is just a plain old goose; not too big, but sale inevitable.

RUTH. This is a good one; handle easy, nice to talk to.

LEONA. This is a good deal; pays cash, but she has a sister that lives in FTW who also has Reserve Life. But be sure, don't call on her; she is a great letter writer.

ZULA. This one will buy, but not a big deal. Everything counts in love and war.

EDITH. This one is a cinch sale; goosy as ———.

ZORA. This one is goosy for a policy that pays everything for home and office calls.

DELSIE. I sold this lady a couple of times. She is good, but not too big.

RUBY. This one is a good deal, but not too big.

ULYSSIS. This is an old man and is a good deal. Go in and talk about playing guitar; he likes that kind of ———. Has daughter, but she don't mess with his business.

LAURIA. This is a sale, but don't have very much money (sorry about that).

FLORENCE. This is a lady that pays a lot for insurance with E. J., so put a story on this one.

FLANNIE. This is an old time buyer, goosy as ———. Be sure and call her before going in because of the law up there—they will strap it on your ———.

ROY. This man has been missed, but he wasn't handled right. You can't rush him; he likes to hear preexisting condition.

ISA. This is a good one.

MOLLIE. This lady has always bought good. She wants a policy that pays for rest home. She won't have anything else. Go to back door.

MONDRE. This is a good deal. Her nephew works in bank; go through channels; have no trouble with check.

JANIE. This is a goose (get it on).

MINNIE. This one is a good deal. No address; lives west on MWC Highway. Sweet deal.

ALICE. This one looks like a good deal. I didn't find her at home. Has been very big for years.

MARGARET. Good deal; not too big—cinch.

INEZ. Small deal, but go sell.

MARTHA. This is a good deal. She talks about getting struck by lightning out by the clothesline. You have to put it on her ———, but never no trouble with business.

AL. This is a man with money and will buy. I know another one that you would like to know about up here.

RUBY. This one is hot as a three dollar bill, so send someone on this.

DORA. This is the goosiest thing you ever saw. Run check through regular channel, no more than $500 at a time. This one is pretty well known by all the high rollers, so don't go ape ———.

FRANCES This one has always bought from me, but is sure not a cinch for everybody. You have to stroke it on her ———. See how tough you are.
THELMA. This one might not be very good, but I had a big bunch of ——— over it, but I ——— her around pretty bad; sorry about that.
EILA. This one I sold, but no comments. Can't think.
MYRTLE. This one is a cinch. Make like you are lowering her principle.
VERA. Goose.
MAGGIE. Can sure be sold (I did).
VELMA. Not too big, but sold.

Mr. CHEATHAM. That is about as much as I can cover in a brief list. I am sure you might have questions and we would be glad to answer any of them.

Senator CHILES. Thank you, Mr. Cheatham.

I understand you convicted everybody you indicted out there.

Mr. CHEATHAM. Yes, sir. I will say we had to take a second run on several of them because of the technical problems.

Senator CHILES. But you took another run at it.

Mr. CHEATHAM. We took another run.

We had one we got the maximum conviction from the jury on, only to find that one of our jurors had been an exconvict. I messed up there, I will be frank. If I had known he was an exconvict, I would not have taken him, but apparently he didn't like little old ladies being defrauded either. In Texas one of the qualifications to sit on a jury is that you not be an exconvict. The defense found out that he had been placed on probation for an offense in one of the other counties, and that county had not sent the conviction in, so it was not on the NCIC or TCIC records, so we were not aware of it. They found it out and, of course, the judge had to give him a new trial because of that. There were several instances like that, but we backed up and started over.

Senator CHILES. Mr. Cheatham, based on your experience and what you found out in this case, do you think this kind of action is taking place just in Texas?

Mr. CHEATHAM. No, sir.

Senator CHILES. Does it lap over into New Mexico?

Mr. CHEATHAM. Well, let me explain it this way. I can only speak for the counties that I cover, but our evidence indicates that it is taking place over in New Mexico and in many other States.

Senator CHILES. Yes, sir.

Mr. CHEATHAM. But as we convict these people, usually part of my plea bargaining with them was that they make full disclosure of theirs and other activities all over Texas and anywhere else. We had some rather startling information from people going into New Mexico and Oklahoma. One agent had a bad record in both Texas, Oklahoma, and Arkansas, as I recall.

THICK COMPLAINT FILES

Incidentally, the State board has the files on these agents from the time that they have first filed an application to be appointed as an agent. They get complaint letters from little old ladies, and very few of them know to write in—only a small percentage—but it would shock you to see the thickness of some of these agents' files which were full of complaint letters from little old ladies.

We had one we convicted and, unfortunately, the judge saw fit to

give him probation rather than the penitentiary. By contacting Oklahoma and Arkansas authorities, we got massive amounts of complaint letters from each one of those States that the little old ladies or the elderly citizens had written in to the various State boards of insurance complaining of this person. I can only speak for Texas, and to a limited extent there, because I don't run the State board of insurance, but they don't have the authority themselves to prosecute a case criminally. They can take a license and that sort of thing, but we have found just a massive number of these complaint letters from the little old ladies. As I say, for each little lady who is able to write in, there are many hundreds who either would not know where to write or, because of their aging conditions, could not write; so it is pretty indicative.

Senator CHILES. Did anything happen to the companies?

Mr. CHEATHAM. I will have to speak to that with mixed emotions, I suppose, and of course I realize I am touching on a little gray area. The State board of insurance set up a task force when this was brought out in the newspapers. They did some investigation. I understand they intend to take some corrective action.

This man, Mr. McRae, who worked with us, I might add, has done an outstanding job. Unfortunately—and I could not say why—he has not been promoted up in the way that he should. In years past, he has been bringing these cases to me, but we didn't have anyone like Mr. Woodard who could take it over a statewide basis. We had to handle them all on a single-case basis. He did an outstanding job on it.

Senator CHILES. Who did he work for?

Mr. CHEATHAM. The State Board of Insurance of Texas.

I understand there were a number of companies examined by the State board and Mr. McRae indicates to me that he feels that they have made good strides toward correcting some of the problems. I think you get into the question of what type of correction you want. Is it sufficient just to take licenses and that sort of thing, or is it necessary to send people to the penitentiary?

I guess I kind of lean to the side that if you send them down to the penitentiary for a while they have less likelihood to repeat, but maybe I am too tough, I don't know. Some of them have indicated I am. There are others inclined to feel that if they correct it or take their licenses, that will be sufficient. I have my own feelings on it, but I realize that there are other feelings, and those who feel otherwise have their points. Every question has two sides.

Senator DOMENICI. Mr. Cheatham, has the State of Texas, in your opinion, made substantial changes in the way of insurance commission?

Mr. CHEATHAM. I think they have made some changes for the good. I could not say that they have gone as far as I personally feel they could, and I don't mean this as criticism. I think they have taken steps and made strides toward correcting this problem.

Senator DOMENICI. You lead me to conclude that we ought to take a look at the national criminal statutes to see if we cannot make the job a bit easier in terms of prosecuting. It seems like we have got to strain some statutes here to get prosecution.

Mr. CHEATHAM. You hit the point perfectly, Senator.

Senator DOMENICI. Well, do you have any suggestions in that regard, either of you?

Mr. CHEATHAM. That covers a lot of territory.

Senator CHILES. Well, you certainly raised points that we are going to look at as to whether there should be.

FAMILIARITY WITH COMPANIES HELPS

Mr. CHEATHAM. Let me say, and I don't want to take too much of your time, but before Mr. Woodard came in and helped us or was able to, Mr. McRae—I cannot commend him highly enough for his work. Frankly I would rather have him than 50 others on the State board of insurance. He has a knack about him. He is a handwriting expert, for example; he knows these companies; through the years he has become familiar with them. He knows what companies are borderline; he knows what companies are fudging on some of their policies.

He can take a bunch of these applications and pull them out and say, "This one and this one and this one I don't believe are going to be good ones," and I have not seen him miss yet, he is that good. What I am saying is that in the past years he would call me up and say, "Wiley, I believe I have a couple of cases down in your district," and he and I would work together and we got convictions on all of those, but they were single-shot deals; they were one little old lady.

Very often when we convicted that agent, he would tell us of others whom he had defrauded. We would try to get their money back, and this is another problem. If I might bring it in, there are many of these little old ladies who don't want their relatives or friends to know they have been duped. We have several who said, "Well, I would rather lose the money than have to go up and testify and have my friends find out that I got talked into this thing."

Back to the main point, we were able to convict these people on a single-shot basis, but we didn't have the needed area coverage. We could not bring in, for example, the help when you have one little old lady competing in her testimony with a smooth insurance agent. It is very difficult if you don't have the supportive documentary evidence to get a conviction. But when you have help from someone like Mr. Woodard, as he is able to do, he could go out and get the other 20 who were sold, say in the same week out of my district, and we can bring as many of those little old ladies as we can. Some of them are too sick to travel, that is the problem, but if we can bring in extraneous offenses, we can bring those 20 little old ladies in and say they were told the same thing. As a result, the jury knows that little old lady they are trying the case for is telling the truth and, in that respect, it has aided us immensely to have the assistance of Mr. Woodard who has a broader scope of coverage than they have.

Senator CHILES. If some of these cases could have been prosecuted in the Federal courts when you were talking about Oklahoma, Texas, and New Mexico, could you have brought those all together in a major conspiracy case?

Mr. CHEATHAM. I would like to bite into one like that, but my State office is not——

Senator CHILES. I am just asking, would that have helped resolve the kind of problem when they were getting beyond your jurisdiction?

Mr. CHEATHAM. Very definitely. One of the problems he has touched on here—if you have an 85- or 90-year-old woman, it is a little difficult to bring her 150 or 200 or 300 miles to Fort Worth, for example, to testify. It creates a problem, and this is one of the reasons I think that they elected to have us prosecute them at a local level where it was a shorter distance for little old ladies to travel.

Senator DOMENICI. Let me ask you one other question. You mentioned that on a number of occasions, after you started prosecution, you found a number of complaints on file with the insurance commission in your State. You indicated those complaints would come from only a small percentage because a lot of people won't complain. Did you find that the insurance commission followed up on the complaints?

Mr. CHEATHAM. They would send an investigator out and take a statement from the little old lady, almost without exception, and then, depending on what they found, they would contact the insurance company and probably ask them to send them copies of their records, and that sort of thing. They have provision for hearings for the taking of agents' licenses. They have that; they do that.

Senator CHILES. What kind of crime is it in Texas for selling insurance after your license has been taken?

Mr. CHEATHAM. There is a statute, but my recollection is, and I could be wrong, but I think it is a misdemeanor. When you get into that area, if these fellows are netting $85,000 a year, as one man admitted to me, it does not hurt him to pay a $500 fine or something like that.

Senator CHILES. I agree if it is simply a misdemeanor.

MAIL FRAUD STATUTE APPLIES

Senator DOMENICI. Mr. Woodard, you have adequacy on the Federal statutes to address this issue?

Mr. WOODARD. Well, the mail fraud law covers any scheme, and the fact that an insurance policy is sold on a fraudulent pitch would satisfy that part of the statute. The other element is, of course, the use of the mails. Fortunately, all these schemes or agencies or insurance companies use the mail, so these cases could have been prosecuted at Fort Worth. The problem is the gathering together of those 70-, 80-, 90-year-old women, who are generally unwilling to go a long distance to participate in a week-long trial or even a 3- or 4-day trial. They can come in to their county seat, and that, I think, is the main reason that the U.S. attorney in Fort Worth felt that the local prosecutions were the best resolution. I think the law covers this type of scheme. This is commonly used, especially in the younger victims' situations.

Senator CHILES. The goose list—this is not the only list of this kind?

Mr. CHEATHAM. Oh, no. They collect what we call lapse cards from the companies. I have another man that, when he finally got convicted and capitulated, he turned over his entire files to us. I have one, for example, that is a steel filing cabinet with four drawers about so long and a fifth steel cabinet, and they are com-

pletely full of index cards like this. They will index them alphabetically by name and by area so that they know when they go to Livingston, Tex., they will have a list of all the little people there and their addresses. When their policies expire, what type of insurance they have, the name of their sister, of a dog or whatever it might be, they have there.

If I could touch on answering part of the question that you asked him, and I don't mean this as criticism or anything like that, but in both Federal and State courts now we all have such full dockets; we have so many cases that they have to eliminate some by whether they are stronger or weaker cases. We have to do this to a certain extent. I think, in addition, these type of cases are not like a simple burglary, or they are not the easiest cases to try; they tax your wits and your efforts and it takes a lot of preparation to try these cases. We are all human beings with human frailties and I think there is a tendency not to take this type of case because, for one reason, many elderly people are sick and senile. They don't always make good witnesses, so you may have to interview 50 victims before you find one that is still alert enough to be able to withstand the rigid cross examination of a defense lawyer. So this is part of the problem.

Senator DOMENICI. Let me ask both of you one last question from my end. In this area that you work, would you be able to assess for the committee whether or not this is a major problem in terms of scope, of selling this kind of policy to the elderly?

Mr. CHEATHAM. I would consider it so, and also for the whole State of Texas; it is amazing. I mean, when you talk to these people and then go back and get the rest of their scheme on one particular deal, it will run—well, we have one here from 50-some-odd victims. What we did in that case, we found out that there was no insurance company to refund these victims. We have sent each one of them to the penitentiary in one case; given them a probation in another, so that when they get out they have to be supervised and make restitution.

We have on their probation—I have one of them here if the staff or you would like to see it as an example. We have all the elderly people's names and their towns and the amount of money they paid in and didn't get anything for. It runs from south Texas where we live all the way up through Texas and into Oklahoma. As I recall, we have four to six victims in Oklahoma. They may have been all old and passed away by the time they get the money paid back, but the probation office is due to collect money to pay back to them if they live long enough, and of course when these people get out, it takes them a long time to make the payments. We are requiring, where we can, duplicate convictions; we sent them to the penitentiary, which helps to keep them from doing it again, and we can probably give them probation in another case and require restitution. This requires some doing, but it works.

STANDARDIZATION WOULD HELP

Senator CHILES. Do you think it would help if we had standardized policies so that it would be clear to these older people what is in a policy, what kinds of benefits are available to be paid?

Mr. CHEATHAM. Yes, this would help. The prior Commissioner had a program to try to simplify the policy, but I would point out again that many of these people are not capable, at their age and degree of health, to comprehend. I am not a senior citizen yet but there are a lot of these problems I have extreme difficulty understanding. In fact, when we get ready to try a case I will get a man from the State board of insurance to come down and testify just what that policy will or will not do, in comparison with what the agent advised it would do. It is a difficult area.

Senator CHILES. I want to thank you both again for your testimony and for the job that you did here. I think you made the old adage "What is sauce for the goose is sauce for the gander," and I think you could compile a little book on the 16 ganders that you all worked on.

Mr. CHEATHAM. It is very heartbreaking, Senator, to go in and talk to these elderly people and see what little they have left, and to realize that they are being bilked out of that.

Senator CHILES. I think the information that is on this goose list gives you an idea of the type of people who are preying on the elderly, and their total and complete lack of any kind of feeling whatsoever. I can't think of anything much more heinous than people who would run this kind of scheme.

Mr. CHEATHAM. They better not do my mother and father that way, that is all I can say.

Let me say this. We do have a lot of other files that might or might not be helpful to your staff. I have indicated to your staff that if they need them, I can make them available.

Senator CHILES. We will be in touch with you.

Mr. CHEATHAM. Thank you, sir. I enjoyed coming before you. I hope I have been helpful.

Senator CHILES. Our next witness will be the Honorable Elizabeth Hanford Dole, Commissioner, Federal Trade Commission.

Mrs. Dole, I again thank you very much for the work that you have been doing in trying to protect the elderly in consumer affairs.

STATEMENT OF HON. ELIZABETH HANFORD DOLE, COMMISSIONER, FEDERAL TRADE COMMISSION; ACCOMPANIED BY JEFFREY EDELSTEIN, ATTORNEY-ADVISER; ANNE DENOVO AND GAIL SHEARER, OFFICE OF POLICY PLANNING; AND MARK ROSENBERG, OFFICE OF GENERAL COUNSEL

Mrs. DOLE. Thank you, sir.

I am pleased to be with you today and I would like to introduce several people who are with me.

Anne Denovo, on my left, is the author of the staff report [1] which I will be discussing a little later in my presentation.

Jeffrey Edelstein is an attorney-adviser to me at the Commission.

Gail Shearer is right behind me and is with our Office of Policy Planning.

Mark Rosenberg is here as well, from the FTC, from our General Counsel's Office.

[1] See appendix 1, p. 275.

I want to thank you for inviting me to testify here today on behalf of the Federal Trade Commission. I welcome this opportunity, for I share with you a deep personal concern about the problems of the elderly. I am pleased that, thanks to your efforts, the issue of medicare supplement, or medi-gap, insurance is beginning to receive the attention it so urgently needs.

More than half the people in this country aged 65 and over have private health insurance in addition to medicare. They purchase it because they worry about meeting the medical expenses which medicare does not cover, and with good reason. On the average, elderly individuals spend $1,360 per year on health care—three times as much as the rest of the adult population. In 1976, medicare paid only 38 percent of their health care costs.

At this committee's hearing on May 16, both State officials and consumers told of the abuses associated with the marketing of medicare supplement insurance and, of course, we have heard more about it this morning. There was testimony that some dishonest agents take advantage of the isolation or physical disability of many older people. Some agents engage in "stacking" or selling several policies with overlapping coverages to the same person.

Another common marketing abuse as we have heard this morning is "twisting" or persuading people to cancel their policies and buy new ones which subject them to new exclusions and waiting periods. Some agents also misrepresent that they are from medicare or Social Security or that the policies they sell have been approved or sponsored by the Federal Government. The Federal Trade Commission commends those State insurance commissioners who have increased their enforcement efforts in order to put an end to misconduct by agents.

"Impossible To Make Rational Purchase Decisions"

It is also important to recognize that there is such a dearth of consumer information in the medicare supplement market that it is almost impossible for consumers to make rational purchase decisions; agent misconduct is thus facilitated. A great variety of differing policies effectively precludes buyers from comparing benefits or premiums, resulting in lack of price competition and the sale of duplicate coverage to hundreds of thousands of people who are under the impression that they are filling all the gaps in medicare. Other areas of widespread misunderstanding are the limited nature of medicare supplement coverage, the relatively high cost of coverage for the initial deductibles compared to insurance against catastrophic medical expenses, and exclusions for preexisting medical conditions.

This morning, Mr. Chairman, I would like to describe some of the common informational problems in the medicare supplement area, and then review briefly the public policy alternatives and some recent State initiatives. These subjects are discussed at length in a staff report[1] which is nearing completion and which we hope to release to you next month. Finally, I would like to discuss the possibility of an impact evaluation of various state approaches—con-

[1] See appendix 1, p. 275.

ducted, perhaps, as a cooperative Federal-State effort—to determine the most effective method of making medi-gap supplement insurance policies comprehensible to everyone.

Reasons for Federal Attention

Why should the Federal Government become involved in this area?

First, the medicare supplement market is a by-product of the Federal medicare program. Supplemental insurance is confusing because medicare's benefit structure is complicated. Commissioner Harold Wilde of Wisconsin has observed that the Federal Government has a moral responsibility to cope with the problems medicare has caused.

Second, there are arguments for a uniform approach to medicare supplement regulation, which Federal study could facilitate. Continuing variation in State standardization regulations carries the spectre of insurers having to market different medi-gap policies in every State, with obvious increasing costs. In addition, it would appear that uniformity would benefit consumers by insuring that the categories for medi-gap insurance will be the same should they move to another State. These and other issues should be assessed in the impact evaluation to determine if there are particular reasons why uniformity is desirable in this segment of the insurance market.

Third, most States would not be able to enforce their medicare supplement regulations against mail order insurers not licensed in their States. Many supplement and indemnity plans are sold by mail.

As you know, the McCarran-Ferguson Act generally immunizes the "business of insurance" from the Sherman-Clayton and FTC Acts to the extent that such business is regulated by State law. However, Federal agencies can make valuable contributions to the deliberations in this important area by undertaking studies such as the impact evaluation that I have mentioned and making recommendations to Congress and to the States.

Let me discuss just for a moment the complexity of the market.

Three types of health insurance policies are commonly sold to the elderly. Medi-gap or medicare supplement policies pay service benefits to fill some of the gaps in medicare; generally, they pay some or all of medicare's initial and daily deductibles and coinsurance.

The second and third types—hospital indemnity and dread disease policies—may be sold to adults of any age, but many companies emphasize sales to the elderly. Unlike medi-gap policies, indemnity policies pay a certain dollar amount per day of hospitalization, typically $20 to $50, to offset daily hospital costs which usually run up to $150 or more. Finally, dread disease contracts cover only some of the expenses incurred for care of a particular illness, such as cancer.

No Standardization

Even in the medi-gap category alone there is virtually no standardization. Let me give you just a few examples. Some medi-gap policies cover only the part A initial and daily hospital deductibles; some place low dollar limits on coverage for the 20 percent coinsurance under part B; some cover virtually the full 20 percent part B coinsurance, but others only for those medical services rendered in a

hospital setting and not for the same procedures performed outside a hospital. Some sell several policies with piecemeal, but overlapping, coverages. Some mix service and indemnity benefits.

It is difficult enough for anyone to have a thorough understanding of medicare's complex benefit structure and its gaps. Now add to that the bewildering variety of ways each different insurer fills some of those gaps. Then, when hospital and nursing home indemnity plans and dread disease contracts complicate the picture, comprehension and comparison become almost impossible for consumers.

Confusion caused by the multiplicity of policies often leads consumers to buy two or more policies in an effort to obtain complete coverage. It has been estimated that 23 percent of the people over 65 who have private insurance have two or more policies covering hospital costs, resulting in some degree of overlapping coverage. Medigap policies generally include coordination of benefits clauses. This means that in the areas of overlap, only one policy will pay for each gap. For instance, a person who buys three policies which cover the $144 part A deductible will not receive $432 in the event of hospitalization. Only the first policy will pay $144 in benefits. The buyer has wasted the portion of the second and third premiums which paid for the duplicate coverage of the initial deductible. Those elderly persons who live on fixed incomes can ill afford to spend their money on such worthless duplication.

Both indemnity and dread disease plans will pay benefits in addition to medicare and any other private insurance, giving "extra cash." However, these policies often produce few benefits in relation to the amount of money invested; they typically have very low loss ratios.

Even the elderly person with only one medi-gap policy may have a low value product. Since comparison shopping is foreclosed, many medicare supplement insurers are not obliged to price or operate competitively. Recently the outgoing chairman of the board of the Health Insurance Association of America criticized those companies whose loss ratios are "far too low," saying they "give a bad name to the whole industry."

Incomplete Benefits

Many people purchase supplemental coverage in the belief that their private insurance will take care of all of the medical expenses medicare will not pay. Often agents tell their prospects: "This policy will cover everything that medicare doesn't cover." In reality, many medi-gap policies exclude from coverage the very same areas which medicare will never cover: Out-of-hospital prescription drugs, most nursing home care, routine physical examinations, eyeglasses, hearing aids, and dental care. Medicare will not pay for the portion of physicians' fees which exceed a "reasonable charge," as determined by the medicare carrier. We are not aware, either, of any medicare supplement insurer who will pay those excess charges.

Of course, medicare's determination of reasonable charges is a measure designed to control costs. We are not suggesting that medigap insurers should provide reimbursement for excess physicians' charges. Nor do we mean to say that supplemental policies should fill every gap in medicare. The problem is the common misperception that medicare supplemental coverage is comprehensive. Actually its

role is limited; private health insurance accounts for only 5 percent of the health care expenses of the elderly. How many people would buy medi-gap policies if they knew how incomplete their coverage might prove to be?

Consumers may not realize that some kinds of medicare supplement coverage are more expensive than others. For example, they pay more for coverage for the initial deductibles than for insurance covering those catastropic medical expenses which could mean financial disaster. The California Department of Insurance estimates that it costs, on the average, $30 per year to buy insurance for the $60 annual part B deductible.

It is important that consumers know how much first-dollar insurance coverage really costs them, as well as which medi-gap policies provide it and which do not. Some people, however, want first-dollar coverage for health care expenses because it gives them a sense of security, and they may not realize that not all medi-gap policies cover the initial deductibles. Once again, the problem is lack of information. And if consumers knew the true cost of first-dollar coverage, perhaps they would not choose it.

Many medi-gap policies exclude coverage or require waiting periods before they will cover preexisting conditions as you have already heard this morning. Under "pre-X" clauses, an insurance company can deny coverage for conditions which existed before the policy went into effect. Since many elderly people have multiple health problems, a policy may lose much of its value if the insurer interprets a pre-X clause strictly to deny claims for any illness which developed out of preexisting conditions. Some companies insure all applicants regardless of medical history, then deny their claims citing preexisting conditions. Because pre-X clauses are not uniform, it may be extremely difficult for the consumer to anticipate what his premium dollar is buying.

In attempting to solve the consumer information problems in the medicare supplement area, the States have developed three possible approaches. The first of these is the establishment of minimum standards. California has set a benchmark minimum loss ratio of 55 percent for medicare supplement policies. An Illinois statute requires that all such policies delivered in that State must fill certain gaps, including the initial part A deductible, part A copayments, and part B coinsurance.

New Rule Sets Up Four Benefit Levels

A second approach is to bring about standardization by establishing categories for policies and requiring that each policy carry an appropriate label. Wisconsin's new rule sets up four benefit levels for medi-gap policies, which must now bear the corresponding number. Categories 1 to 3 range from most to least comprehensive. Policies in category 4A supplement only part A of medicare; those in category 4B supplement only part B. California has also established, in a different way, three categories for medicare supplement policies, labeling them "in-hospital only," "in-and-out-of-hospital," and "catastrophic."

The third type of public policy initiative involves efforts to provide information to consumers in order to permit the market to

function more effectively. The most common method is a disclosure requirement. Wisconsin requires agents to give out an 18-page booklet and California mandates the use of general one-page disclosure forms.

Senator CHILES. I am going to have to interrupt you right here to answer the rollcall.

Is your time requirement all right now?

Mrs. DOLE. Yes. Thank you.

[Whereupon, at 11:07 a.m., the committee recessed until 11:25 a.m.]

Senator CHILES. Please go on.

Mrs. DOLE. OK. I believe I was just discussing the third type of public policy initiative which involves efforts to provide information to consumers in order to permit the market to function more effectively. In Oregon, insurers or agents must fill in the blanks on a disclosure chart showing medicare benefits, gaps, and policy benefits. New Mexico requires a slightly different disclosure chart. In my opinion, a chart would be particularly useful if it could show not only medicare's coverage and gaps and the policy's benefits and costs, but also the expenses the consumer would still have to pay out-of-pocket.

I should emphasize that these State approaches—minimum standards, standardization combined with labeling, and disclosure requirements—are not mutually exclusive. It may well be that a combination of these regulatory measures would be most effective.

At present when an agent or an advertisement exaggerates the worth of a medi-gap policy, the prospective buyer typically has nowhere else to turn for impartial information to correct the misunderstanding. Other methods have been suggested besides mandatory written disclosures to assure that buyers get the information they need, such as individualized insurance counseling and consumer education measures to furnish facts which insurers do not generally provide: For example, medicare coverage and gaps; eligibility for medicaid; health risk information—for example, average length of hospital stay for the over 65 age group—and rating of companies' records in handling claims. In addition, nontraditional avenues for increasing consumer awareness, such as the use of television spots, should be explored.

EVALUATION OF STATE APPROACHES NEEDED

What is needed to ferret out the problems and evaluate the public policy implications of alternative solutions? We believe the answer is an impact evaluation of existing State regulations of medicare supplement insurance with central focus on the effectiveness of different regulatory systems in facilitating the purchase of medicare supplement insurance which meets consumers' needs and expectations.

Considerable groundwork would be necessary to narrow the focus of such a study. Basic facts about the medicare supplement industry, such as total premium volume, are presently unavailable. It is evident that duplicate coverage is a serious problem but no one knows its precise nature or extent. It would be important to learn from

consumers what information they feel is essential to make wise purchasing decisions.

A full scale impact evaluation would help to answer the complex and important policy questions which abound in the medicare supplement area: Is it possible to provide complete yet comprehensible explanations of medicare and the multitude of ways private insurers fill some of its gaps? Is standardization necessary to make the market's offerings understandable? Should public policy try to influence the consumer's choice between costly first-dollar coverage and what economists might call more rational insurance for catastrophic medical expenses? What are the arguments for and against the sale of dread disease or indemnity policies?

An impact evaluation would be timely because several States' regulations have become effective within the past year. As I have already indicated, Wisconsin and California have established totally different systems of standardization and labeling. Oregon and New Mexico have different disclosure requirements, but no regulations involving standards. Illinois sets minimum standards but does not prescribe any particular disclosures. An evaluation should point up the strengths and weaknesses of each State's system and should assess the desirability of a model regulation.

An impact evaluation could also provide information about the effectiveness of various disclosures and recommend followup consumer education and counseling measures. And if current debates lead to the establishment of some form of national health insurance, it appears that the results of such a study would be valuable to policymakers, since a similar supplemental market might well develop under any system providing a less than comprehensive benefit package. The results of the impact evaluation would be available, of course, for the use of State regulators and legislators, Congress, and the public.

Cooperative Federal/State Approach

How should this impact evaluation be performed? Perhaps a cooperative Federal/State approach would be best, with participation by the National Association of Insurance Commissioners, the Federal Trade Commission, and the Department of Health, Education, and Welfare. A joint HEW–FTC–NAIC project would bring together different types of expertise, each of which would contribute greatly to such a study. The NAIC and State insurance departments have firsthand experience with insurance regulation and access to data. In fact, on June 12 the accident and health subcommittee of the National Association of Insurance Commissioners voted to create a task force to investigate regulation of health insurance sold to the elderly and identification of other health insurance products "which do not fulfill the public's interest." HEW would contribute knowledge about the medicare program and the FTC's expertise in the areas of consumer protection, information disclosure, and competition would be pertinent. We would welcome the opportunity to work with the NAIC and HEW in such an undertaking.

In conclusion, Mr. Chairman, I am convinced that inappropriate medicare supplement insurance purchased at this point can impose severe hardships on the elderly. We must begin now to determine

the best approaches for resolving these problems, and I hope that my testimony this morning will make some contribution to that endeavor.

Senator CHILES. We thank you very much for your comprehensive statement, and I think you have certainly contributed to what we are trying to do here. We would like to have you make the staff report[1] you mention a part of our hearing record. Would that be made available to us as soon as possible?

Mrs. DOLE. Yes.

Senator CHILES. When do you expect to have that?

Mrs. DOLE. During the month of July that will be available.

Senator CHILES. We will leave the record open until that time because I think it would be valuable to have.

Mrs. DOLE. We will certainly send it down as soon as it is ready.

Senator CHILES. You say what is needed is an impact evaluation of existing State regulations of medicare supplement insurance. Will the Federal Trade Commission undertake this study?

Mrs. DOLE. The Commission has expressed an interest in such an impact evaluation, Mr. Chairman. At this point the Commission has not actually set aside the funds for this study or assigned personnel to it, but we will be engaging in budget determinations fairly soon now. Our staff is looking into this and, I am sure, will have some recommendations for the Commission to focus upon as far as personnel and funding.

Senator DOMENICI. Will the Senator yield?

Is there anyone else to your knowledge, Commissioner, that is undertaking the study—any other institution?

Mrs. DOLE. No, sir, I don't believe so. This study might analyze all of the State regulations. The breadth of the study would be one of the considerations. Should each State regulation be evaluated or should just certain ones be chosen and a more selective approach taken? As far as I know there has been no across-the-board approach of this sort.

Senator CHILES. Senator Domenici and I both think that the information to be derived from such a study would be most helpful, not only to the States themselves but to all of the parties concerned. I like very much your approach of having that be a cooperative study with the State commissioners and others that you pointed out in your study. I think so many times they tend to feel that anything the Federal Trade Commission is doing is perhaps to step on their turf.

"A NATIONAL PROBLEM"

I think it has been pointed out that regulation of insurance is a State problem, but what we are dealing with here is very much a national problem stemming from the gaps in medicare coverage. Having the State insurance commissioners participating as we look at standards and possible model legislation will be very important so that improvements in regulations can eventually result.

What would the evaluation cover and how long do you think it would take?

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[1] See appendix 1, p. 275.

Mrs. DOLE. The best estimate at this point would be 15 to 17 months. This would involve a period of establishing a design for the impact evaluation with perhaps a pilot study during that phase; we estimate the first phase would take about 9 months. An impact evaluation is a very complex matter. It is not an easy undertaking.

Senator CHILES. I am sure is isn't. I want to ask you about a few parts which the study could include.

Mrs. DOLE. All right.

Senator CHILES. We have taken testimony suggesting that perhaps the commission structure set by the insurance companies could encourage policy sales by the setting of high commissions on first-year policies. Would a study like this be able to examine this area?

Mrs. DOLE. I think that such a study would focus on what information is in the market—is there a dearth of information, what misinformation exists at this point. Certainly to the extent that the commission structure is causing misinformation in the market and to the extent that a dearth of information is making it possible for abusive practices to take place, that would be encompassed in the study. I don't know if you want me to elaborate further. I didn't complete my answer on what the impact evaluation would entail.

Senator CHILES. Excuse me.

Mrs. DOLE. Just to give a little more information on that point, the impact evaluation would involve, during the first phase when the design is being established, deciding how to approach the matter; whether it should focus on all of the States or certain selected States; matching the States so that those with regulations are compared with similar States which have no regulations. Where a State already has a regulation in effect, there may be base line data which was accumulated before the regulation took effect. If not, I think by comparing similar States with and without regulations, we can get the equivalent of base line data. Decisions would have to be made in that area, and we would try to obtain from insurance companies and from the State commissioners data that would be useful.

Surveys of consumers would take place in phase 2—finding out when they purchased their medi-gap policies, what sort of information they relied on, what the source of that information was. Did the policy actually meet their expectations? How much overlapping coverage was there? We know there is certainly a problem of overlapping coverage, but we don't know the extent. To summarize, there would be a number of various issues which would be focused upon in the design phase and then, in phase 2, there would be actual surveys of consumers. Phase 2 would also involve analyzing the data and writing the report. Ultimately, perhaps, we might work with the States to develop some sort of uniform regulatory model.

Senator CHILES. Do you favor the use of minimum loss ratios as a way to solve the problem?

Mrs. DOLE. The loss ratio would certainly be a focus of the study because some of the States which have recently adopted regulations do have loss ratios. For example, California has a loss ratio of 55 percent; I believe Michigan has a 65 percent loss ratio. This regulatory approach would certainly be a part of the study.

INFORMATION LIMITED

At this point data is limited because, for example, the premium volume and the sales volume is not available for medi-gap or medicare supplement insurance. The reason is that the companies report data to the State insurance commissioners under the heading of health insurance, but they don't break it out into medicare supplement insurance. Data is not broken out now except in several States where there is a minimum loss ratio.

Senator CHILES. The States would have to get that information.

Mrs. DOLE. It would be important in any sort of undertaking to understand the volume of sales and the volume of premiums. This type of information would certainly be needed.

Senator CHILES. Do we have information now on how many dread disease policies are sold?

Mrs. DOLE. No, we don't. It is the same problem. It is in aggregate form under the heading of health insurance. That is the way it is reported generally to the State commissioners. It is not broken out according to dread disease or indemnity policies or medicare supplement policies.

Senator CHILES. Do you envision that our senior citizens could help in that survey effort that you are talking about?

Mrs. DOLE. I certainly would anticipate that.

Senator CHILES. That is to say their national organizations.

Mrs. DOLE. I certainly think so. Consumer surveys would be a very important part of an evaluation.

Senator DOMENICI. Commissioner, let me ask you this. As the chairman has indicated, I certainly join with him in an effort to do what we can to expedite the kind of evaluation you are speaking of. Would there, in your opinion, be any congressional action necessary to expedite this kind of evaluation?

Mrs. DOLE. I don't foresee any particular action at this moment. I can't think of anything specific at this point to suggest. I certainly think that we should follow closely what you do in the committee. You may decide to have additional hearings and to collect and disseminate additional information. I would encourage you to continue to do that. This would certainly be helpful as the impact evaluation gets underway.

Senator DOMENICI. What if we were to communicate as a special committee to the Commission, indicating that we are holding these hearings, that we are already convinced that it is a major problem, that we don't have enough information to address the problem properly and that we encourage the Federal Trade Commission system to assist in getting information. Would that be helpful?

Mrs. DOLE. At this point, we must determine what information is needed. The impact evaluation will pinpoint exactly where we should go, and at this point I don't think we could say just what is going to be necessary. Then, of course, there will hopefully be the opportunity to get a lot of the data from other sources, perhaps the State insurance commissioners. There will hopefully be voluntary cooperation on the part of the companies and ultimately, if we have to use a compulsory process, it is my view that the Commission has authority to obtain the necessary data. I don't

think that we really know now just what specifically would be needed until we pinpoint the areas that will be focused on.

Senator DOMENICI. Let me ask you one other question. I am fully aware of your genuine interest in this area and I commend you for it. It has got to be one of the most difficult to address, yet obviously one that is peculiar and different in terms of insurance in this country—in fact, so different in my opinion that it would ultimately require a significant departure, regulatorywise, from other insurance selling. It is obvious that we have a victim sphere here that is very vulnerable and very different because of the nature of being old and alone.

Mrs. DOLE. Yes, I agree.

"INSURANCE COMPANIES MUST BE MORE CONCERNED"

Senator DOMENICI. What I am most impressed with after two hearings, participating as much as I can, is that somehow or another we are able to get the so-called fly-by-night agents, be they criminals or operating without a license, or the like. However, it seems that ultimately the companies that insure have to do the policing. If they end up writing a policy, they are the ones that are going to have to have more stringent rules and more stringent evaluation before they issue the policies and the like to catch their own malfeasance in the field. We cannot get at the company. When called in before a Commission, the companies state that a refund has been made, et cetera. When companies such as New York Life Insurance and General Life Insurance—unscrupulous agents like these would have been caught. They just don't go around defrauding people like this, selling them 15 policies, and the like, or 20.

It does appear to me that some way or another we have got to get every insurance company that sells this kind of insurance and issues the basic policy more concerned about policing what is going on in the field.

Mrs. DOLE. I think that what you are doing by holding these hearings should assist a great deal in that effort. I would say that in addition to the agent abuses we certainly have to keep in mind the great dearth of information in this area and, of course, that is one of the reasons that agent abuses can take place. By means of the impact evaluation, we can take a good hard look at whether it is going to be possible to remedy the problems here through provision of information or whether perhaps we will have to move to some form of standardization. We do not know at this time what the answer is going to be, because the problem is so extremely complex.

As a prospective medicare supplement purchaser, you have to understand the medicare system. You have to understand what medicare does and does not cover. You have to be able to compare between the many combinations of policies that are offered. You have to understand the difference in dread disease and indemnity policies as well as medicare supplement policies.

On top of that, there is a body of general information which is important to understand. For example, when an elderly person is considering whether a medicare supplement policy is needed, it is helpful to know what the average length of stay in the hospital is for a person over 65, and it is very important to know that if you

are eligible for medicaid, you probably should not be purchasing additional policies.

Various Remedies Possible

There are many different pieces of information which are most important to an intelligent decision, and we will have to explore whether or not it is possible to remedy problems through disclosures and through information as some of the States are trying to do, or whether standardization is the right approach, or perhaps even a cost index. There are various options, and at this point I think we need to know more about the industry to understand how these various remedies would impact on the market.

Senator Domenici. There might even be some prohibitions. We might end up where certain kinds of policies are useless and cannot be written, is that not correct?

Mrs. Dole. That would be one focus, I would think, as you explore all of the various options.

Senator Domenici. Thank you, Mr. Chairman.

Senator Chiles. On page 3 you speak about a dearth of consumer information in the market. Since these policies are, as you say, a product of Federal action, should the Social Security Administration make greater efforts to supply such information?

Mrs. Dole. Mr. Chairman, that has occurred to me as one possible means of providing information; through that channel to the persons who are in need of the additional insurance data could be pinpointed directly. I would think that if HEW is interested in being a part of this impact evaluation—and I hope that they are because of their expertise in medicare—this idea could be explored.

Senator Chiles. Again, we want to thank you very much for your statement and the efforts that you have made in this area. We look forward to working with you.

Mrs. Dole. Thank you. I appreciate the opportunity to appear this morning.

Senator Chiles. Our next witness will be Mr. Joseph C. Mike, insurance commissioner of the State of Connecticut, and chairman of the National Association of Insurance Commissioners Accident and Health Subcommittee.

Mr. Mike, we appreciate your appearance here today and note that you have a lengthy statement on this subject. We would like to put that in the record[1] in full and, if you could summarize that for us in some way, we can have a chance to ask you some questions.

STATEMENT OF JOSEPH C. MIKE, INSURANCE COMMISSIONER, STATE OF CONNECTICUT, AND CHAIRMAN, NAIC ACCIDENT AND HEALTH INSURANCE SUBCOMMITTEE; ACCOMPANIED BY RICHARD HEMINGS, NAIC COUNSEL

Mr. Mike. Thank you very much, Senator.

My name is Joseph C. Mike and I am the insurance commissioner of the State of Connecticut and the chairman of the Accident and Health Insurance Subcommittee of the National Association of Insurance Commissioners.

[1] See p. 252.

Accompanying me this morning is Richard Hemings, the NAIC counsel.

The NAIC is a voluntary association of the chief insurance regulatory officials of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. It is a pleasure to be with you this morning to relate the concerns and activities of the NAIC with respect to sales of so-called medicare supplement health insurance coverages.

We share your concern over confusion accompanying the medicare program and marketing practices, and the inappropriate and duplicate private health insurance coverages being purchased by medicare eligible persons. We trust that constructive and cooperative efforts of the Federal Government and the States will minimize the problems and confusion of the medicare population. Several States have already acted individually to set medicare supplement standards, and the NAIC will now prepare recommendations for all States. In addition, all States do act on consumer complaints regarding misrepresentation, false advertising, and other unfair marketing practices that may accompany sales of medicare supplemental coverages.

Medi-Gap Task Force

At its June 12, 1978, meeting, the NAIC's Accident and Health Insurance Subcommittee resolved to examine the need for, and draft in accordance with perceived needs, rules governing the sale of medicare supplement health insurance, and we established a task force that has been charged with that responsibility. It is my expectation as chairman of the subcommittee that within 6 or probably 12 months that task force will have prepared for our subcommittee a recommendation. We would be most receptive to input and advice from your committee. You and your staff are invited to participate in our proceedings and, in the meanwhile, we do recommend or suggest or urge that any complaints that you have that you feel warrant further individual investigation be referred to the regulatory agencies in the State from which the complaint came and give us a chance to do something with it.

Senator Chiles. We will certainly do that. I appreciate very much that you have asked our committee and our staff to participate and I can tell you that we will look forward to taking you up on that. If you let us know when your first meeting is going to be held, we would like to have somebody there covering that.

Mr. Mike. We will be very glad to do that.

Let me turn now to our current understanding of the problems and our respective roles in resolving outstanding problems. The problems that we see are divisible into two categories: First is the question of whether and how to fill medicare gaps and limitations and, second, is how to control the unfair trade practices of medicare supplement insurers and agents.

Medicare supplement insurance is, as suggested by the term, designed to fill residual gaps and limitations not covered by medicare. One obvious option open to the Federal Government is to broaden the scope and extent of medicare benefits to lessen the apparent need for supplemental private insurance.

Senator CHILES. If you note, we are dealing with a $51 billion deficit in the Federal Government.

Mr. MIKE. Yes.

Senator CHILES. I don't think that you are going to find, as much as a lot of us would like to see it, all those gaps covered. So you are right, that would be a very nice way to cover the problem, just not to have any gaps, but each one of those gaps, of course, involves millions of dollars and our biggest problem right now is the cost of medical bills. We are now seeking the development of reasonable costs and guidelines.

We have not found any device that puts any downward pressure on rising health costs. So to say that we are going to cover those gaps right now is impossible. In other words, our biggest problem is to stay level to where we are and not create some more gaps. I foresee that that is going to be the problem with the current state of the economy. Proposition 13 has some effect here as well as it does in California. So I think that we have got to talk about the alternative No. 2, because I don't see that there would be any possibility in dealing with alternative No. 1.

Mr. MIKE. Absolutely.

The next statement I had was a deferral to the Senate. Obviously there are additional problems involved with attempting to address the gaps of medicare.

Senator CHILES. Yes.

Mr. MIKE. Two initial questions that appear though are: (1) Do those over age 65 need a private insurance supplement; and (2) should the Federal Government broaden the medicare benefits?

As far as the marketplace is concerned, the answer to the first question is yes, absolutely. As far as the people who purchase medicare supplements are concerned, there is no doubt in their minds that they need private supplements.

Most medicare eligible Americans have private health insurance. There are, nevertheless, some serious doubts in our minds that the public fully understands the workings of the health care system, the functions of medicare, and the value or the benefits of the private health insurance they have. I will explain those concerns in a moment in answer to the second question.

Senator CHILES. They need the coverage, but do they need the coverage that they are now getting if they knew what it, in fact, was and what they were paying for?

"NOT AN OPEN AND FREE MARKET"

Mr. MIKE. The ideal solution is for most of the beneficiaries to understand what they are now getting and what they are now purchasing. We would not have a fraction of the problems we have now if the market functioned the way theoretically an open and free market does function. I am sure it does not in this case.

People are moved by emotion, by fear, and by a great lack of understanding of the product that they are buying to protect them from all those fears. We defer to you and your ability to balance the need of the elderly with the national capacity to underwrite such coverage.

In general, medicare cost sharing serves the dual purpose of cost

containment of health services and limiting the program's financial strain on the Federal Government. Although the health care cost containment objective is, in our view, socially desirable, both for the medicare population and the general public, the public has become accustomed to first dollar coverages.

One of the major benefit provisions of most supplement policies is coverage of the deductible and coinsurance amounts. We do not intend to prohibit insurance for medicare cost sharing amounts. However, the value of such insurance is open to question.

If first dollar coverage is economically inappropriate, then the insurance industry, State and Federal Governments, unions, and employers are to blame for allowing or encouraging its prevalence. The NAIC is on record in encouraging the use of consumer cost sharing as a device to assure use of the restraining influence of household budgets to minimize the inflationary propensity of the health care system.

I would like to stress that point just a little bit because within my role as insurance commissioner in Connecticut I am also a member of the Connecticut Commission on Hospitals and Health Care, and one of the problems we constantly run into is the fact that the public is insulated very heavily from the cost of the health care he is provided. It is very difficult for them to see the flow-through between the health care system which needs to be controlled very badly and the insurance coverage.

We get a great many complaints every year over the increases in Blue Cross/Blue Shield coverage and most of the people who complain to our department are unable to make the transition to the budget of their own hospital or the questions of duplication in the health care system itself.

We think it is essential that we avoid, in all cases, 100 percent comprehensive coverage. There has to be a responsible feeling on the decision to purchase the health care that his insurance is helping to pay for. If we can return to a more basic principle of insurance that protects you from a severe economic loss—not any economic payment—then I think the system is going to be much better off. Unfortunately, that is not a very popular idea. The theoretical ideas of cost sharing are not accepted by the market.

I think perhaps some education as to the relative cost of first dollar coverage might be very illuminating to the public. That is something we think ought to be attempted.

The population that is being treated with medicare supplemental coverage is extremely vulnerable. Many of them remember quite readily a time prior to medicare when a senior citizen could not obtain medicare to protect him from any loss, and many of them are very much afraid of being a drain on the family and loved ones and afraid of catastrophic health losses. They also become a population that will respond readily to any kind of marketing attempt to provide health insurance, and they are a fertile ground for any kind of slippery operation that may be in place.

We in Connecticut have prohibited specified disease policies. This is not necessarily a unanimous position. There are some people who feel that as long as the public is desirous of making a certain purchase, it should be available. I would note, in 1969 and 1972, Connecticut also prohibited senior citizens supplemental medical indem-

nity-type policies, but the pressure from the population to drop that prohibition was enormous.

Senator CHILES. But you don't have the dread disease policies now.

Mr. MIKE. No, we do not. I think myself that the best thing we can do is attempt to prohibit them countrywide. I really believe the best answer to the concerns addressed by the person to purchase dread disease is to purchase full comprehensive coverage. It is marketed by emotional appeal and scare tactics.

SUBSTANDARD POLICIES

Senator CHILES. Does the association have any position on that?

Mr. MIKE. It has been to identify dread disease as nonstandard, substandard insurance policies. The task force I referred to has been given a twofold charge. The first is to take on the question of medicare supplemental coverages. The second question that will dovetail and follow the first one is to take on the broader question of those insurance policies that are not in the public interest. They are going to examine questions, I hope, like indemnity contracts, specified or dread disease policies, minimal benefit policies, the $10 a day hospital policy—that kind of coverage.

There is a great question now whether the public does benefit by it, regardless of how strong the desire to purchase it is. In keeping with my positions on the cost of the health care system, I see a real problem with indemnity policies. Indemnity policies, unfortunately in many cases, are often an incentive to consume a greater portion of the health care system and it is the kind of coverage that someone could very easily develop into a profitable operation. Somebody could make money by being in the hospital an extra day or two. That kind of economic situation lies in the face of any attempt at cost containment. That is a very difficult question.

In order for the consumer to intelligently decide whether to buy insurance coverage of the medicare cost sharing amounts, the consumer must understand what medicare provides. We agree with the chairman of this committee who, in 1974, acknowledged that "One of the most compelling points for the Congress to consider is the great need for more intensive educational efforts upon the part of the Federal Government to inform older persons about medicare itself."

A peculiar aspect of the medicare program is that the basic benefits payable have changed almost annually, due to rising deductibles and coinsurance. since the inception of medicare. This results in a great problem. We not only have an element of the population that every year must learn about medicare as they reach the age where they qualify for it, and that previously were probably not as well aware as they should be of what medicare provides, but we also have a problem where the instruction may change from year to year. There is a constant need to inform.

I am an individual who believes that too much emphasis is placed only on the simplification of insurance. The unfortunate fact is insurance is, by and large, not a simple proposition. It is very easy to say we are going to simplify the language of this policy and leave it at that. More is needed. Simplification is desirable and necessary,

but I think, especially in the situation of the senior citizen, an ongoing counseling service is going to have to be provided. I don't see any way around it.

Our department has been discussing the situation with the Commission on Aging in Connecticut and we feel that that kind of educational function is valid and it must be encountered. Once that happens, we are also going to find greater exposure of the practices of agents and companies in the market. I will get to that in 1 minute because we have an enforcement difficulty that I don't think will go away at any level.

The other thing that bothers me a great deal is the ability of the physician to take or leave assignments and the reimbursement formula that leaves gaps between the allowable charges and actual fees. It seems to me that the system is aggravated when you allow the physician to accept a charge for one particular service and not for another. It becomes difficult for the patient to be able to determine whether medicare will pay his full bill or whether he is going to be hit with an additional charge that even an additional supplemental carrier won't provide. I hope that is a question that is taken up further. I think a physician ought to make a determination whether he will participate in the program or not, not on a case-by-case basis, whether he feels it is advantageous for this individual or this procedure, to take the assignment.

The consumer does not adequately understand the impact of nonassignment on the part of the physician. He does not understand the ability of the physician to charge him extra; the inability of most supplemental insurance to cover that.

Some possibilities for State regulators' consideration are mandatory disclosure of premiums allocable to the cost sharing amounts under any private supplement and controls on policy replacement procedures. These are some of the topics that we expect the task force is going to be undertaking.

In addition to medicare "gaps" attributable to purposeful cost sharing requirements, there are other gaps and limitations such as the maximum 90 inpatient days per episode of illness covered by part A; or the gaps caused by "reasonable and necessary care" payment limitations; or the numerous health care services not covered and not intended to be covered by medicare such as drugs, dental services, and full nursing home services.

"Market Can Be Influenced by Public Demand"

Given the existing set of medicare benefits, we believe the proper role of the States to be that of assisting the consumer in determining what gaps are suitable for private insurance coverage. So long as the public understands the benefits and limitations of the medicare program, the nature of private health insurance, and need to contain health care costs, the market for sensible and appropriate medicare supplements can be positively influenced by public demand. Public understanding should be a primary objective of both the Federal and State Governments with respect to medicare and sales of private insurance supplements.

When it comes to enforcement, there is an additional problem. Now we have the authority to enforce not only the insurance stat-

utes, but to seek enforcement of the criminal statutes over the marketing practices specifically of the agent force.

I should note that in Connecticut the Blue Cross program writes the vast majority—I would say almost 90 percent—of the supplemental coverage. They don't have a waiting period and they are not encountering any of the problems with not having preexisting conditions and with open enrollment. Because of that, a great many of the insureds are with the Blue Cross program. Their rates are reviewed annually. They are costly and our marketing problems are less than many.

That is not to say they don't exist. They exist primarily with special operations. We find that a particular company may become active in some approach that we don't care for or believe to be illegal or some particular agency may undertake an approach that we find it necessary to enforce our laws against.

We have a significant investigation going on right now that involves the State's attorney's office and the State police. It is a problem much like all of the other episodes that have been outlined here and in the previous testimony. We feel the situation is obviously illegal, but it is an enforcement difficulty, it is a crime, and I don't see any good way to avoid the commission of a crime. The best we can do is to attempt to enforce the statutes as fully as possible and detect problems as quickly as possible.

I would be a fool to sit here and maintain that we could prevent the situation from ever occurring again. What we feel is necessary is for the population to understand what their rights are and what their rights should be; to understand what kinds of coverages they should be obtaining and what they should not be expected to do. To the extent that we can make the population, if nothing else, very cynical and provide for them counseling services, we can expose the marketing practices to our scrutiny and be even more effective in enforcement.

"Not Aware of Victimization"

Many senior citizens are not aware of the fact that they are being victimized, pure and simple. A lot of the situations where the individual had all those insurance policies stashed away in a trunk were the same as people we found in our cases. We had to go in and explain to the persons, once we found the operation and started to track down its victims, why they were being victimized and show them exactly what was wrong with what they had and where the problem was. In many cases the persons became so embarrassed about it that they would be reluctant at best to participate in the investigation further.

So there has been a special problem. We cannot look at the figures and say it is a small problem. Most of the figures don't come to light. Most of the problems are difficult to detect and we have to ferret them out. That is why I think to the extent the public is more well educated everyone will benefit.

At least six States have promulgated regulations specifically dealing with the matter of medicare supplement insurance and, in my lengthier testimony, I have submitted outlines of what those States have done and also submitted examples in an addendum of the kinds of regulations that are already in force, are already adapted by the

NAIC, and enforced by most of the States affecting the behavior of agencies and companies.

It is premature to suggest which, if any, of these specific State regulatory approaches may be followed by the NAIC. A fair conclusion is that each attempts to summarize what medicare provides and to enhance the consumer's ability to determine what is appropriate to supplement medicare. This general objective will undoubtedly be shared by any model regulation proposed by the NAIC.

Thank you.

[The prepared statement of Joseph C. Mike follows:]

PREPARED STATEMENT OF JOSEPH C. MIKE

Mr. Chairman and members of the committee, my name is Joseph C. Mike, Connecticut Insurance Commissioner, and chairman of the Accident and Health Insurance Subcommittee of the National Association of Insurance Commissioners (NAIC). The NAIC is a voluntary association of the chief insurance regulatory officials of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. It is a pleasure to be with you this morning to relate the concerns and activities of the NAIC with respect to sales of so-called medicare supplement health insurance coverages.

We share your concern over confusion accompanying the medicare program and the inappropriate and duplicate private health insurance coverages being purchased by medicare eligible persons. We trust that constructive and cooperative efforts of the Federal Government and the States will minimize the problems and confusion of the medicare population. The marketing abuses and purchaser confusion accompanying medicare supplement health insurance sales appear to have ripened into problems appropriate for State regulatory action. Several states have already acted individually to set medicare supplement standards and the NAIC will now prepare recommendations for all states. All states actively regulate trade practices to deal with unfair marketing methods, unfair advertising, unfair claims settlement practices, and improper agent conduct.

As you may already know, the NAIC conducted its 1978 annual meeting in Washington during the second week of June. At its June 12, 1978, meeting, the NAIC's Accident and Health Insurance Subcommittee resolved to examine the need for, and draft in accordance with perceived needs, rules governing the sale of medicare supplement health insurance. It is my expectation that within 6 to 12 months the NAIC will be in a position to recommend a model regulation to individual States. During the public hearings to be held on this subject in future months, we would be most receptive to the recommendations and advice of the Senate Special Committee on Aging. We cordially invite members of the committee or your staff to participate in NAIC proceedings on formulating State regulatory initiatives in response to problems associated with medicare supplement sales. In the meantime, the NAIC recommends and respectfully requests that you refer individual medicare supplement complaints that come to your attention to the States for appropriate consumer assistance.

The States currently have in effect broad and detailed authority to regulate advertising, unfair trade practices, and other aspects of insurance company marketing. To the extent that fraud, abuse, and other unfair marketing practices are at the heart of problems with medicare supplement sales, individual states already have regulatory tools in place that are adequate to the task of addressing marketing abuses. When consumer complaints are filed with the State insurance departments, or when unfair market conduct is otherwise brought to our attention, we can and do deal effectively with individual instances of company or agent marketing abuse. However, on the basis of our regulatory experience, it has become clear that one of the best means to accomplish consumer protection is to arm the consumer with adequate knowledge of insurance products and educate him to appropriately identify his needs. Medicare is a complex Government health insurance program. It has become apparent that beneficiaries do not adequately understand what benefits they have much less what they need in the way of private supplements. Confusion in the minds of medicare supplement purchasers, inability to determine one's insurance needs, and inappropriate selection of health care may be aspects of

the problem that the Congress and the States can constructively address, but perhaps not entirely solve. However, we see the need for educational and consumer assistance programs as a major element of the medicare supplement problem. We will develop recommendations for State action. Let me turn now to our current understanding of the problems and the appropriate roles of the State and Federal Governments in resolving the significant problems.

The problems that we see are divisible into two categories—whether and how to fill medicare gaps and limitations; and controlling unfair trade practices of medicare supplement insurers. I have attached to this statement a brief review highlighting state regulatory measures applicable to the marketing of health insurance in general. The focus of my statement to you today will be what additional positive steps may now be taken on medicare supplement problems.

Medicare Gaps and Limitations

Medicare supplement insurance is, as suggested by the term, designed to fill residual gaps and limitations not covered by medicare. If complete, comprehensive coverage were provided to the elderly under medicare, there would be no market for private medicare supplement coverages. Therefore, one obvious option open to the Congress is to broaden the scope and extent of medicare benefits.

It may be interesting as a historical footnote to relate the insurance industry's expectations expressed in 1965 on the role of private health insurance under medicare. In commenting on the NAIC on the then-proposed medicare program offering both hospital and optional medical coverages, the industry suggested that "there will be little, if any, room left for private health insurance for those over 65 and coverage now in force would be eliminated." [1] Credit either the ingenuity of the suppliers of private health insurance or the demands of the elderly for first dollar comprehensive health insurance, or both, there is clearly a market for medicare supplement policies despite the bleak predictions of health insurers in 1965. According to the Health Insurance Institute, at the end of 1975 some 12.6 million older people, six-tenths of the over-age-65 population, had private health insurance to supplement medicare.[2]

Two initial questions that are woven through all of the issues now before you are: (1) Is there a real need for private medicare supplement insurance; and (2) should the Federal Government broaden medicare benefit structures? As far as the marketplace is concerned, the answer to the first question apparently is a resounding yes. Most medicare eligible Americans have private health insurance. There are, nevertheless, some serious doubts in our minds that the public fully appreciates the workings of the health care system, medicare, and private health insurance. I will explain our concerns in a moment. The second question, the appropriateness of broadening medicare coverage, is a matter for congressional discretion. For reasons that are undoubtedly well known by you, we cannot in general recommend expansion of the medicare system. We defer to the ability of Congress to balance the needs of the elderly with the capacity of the government to fulfill those needs.

The intent of the medicare legislation was to provide a broad program of hospital insurance protecting the over-65 population against the costs of inpatient hospital services, posthospital extended care, posthospital home health services and outpatient hospital diagnostic services. The hospital insurance plan was to be supplemented by a voluntary medical service plan to protect against the costs of physician services, home health services, and numerous other medical and health services. According to the 1965 House report on medicare legislation:

"The combined coverage of the two insurance plans would result in protection for the elderly of a quality that only a few older people can now afford. Most elderly people could be expected to have the protection of both of these insurance programs. The provision of insurance against the covered costs could encourage participating institutions, agencies and individuals to make the best of modern medicine more readily available to the aged." [3]

In spite of the fact that medicare was intended to be relatively complete and adequate, a high proportion of medicare eligibles supplement the program with private insurance.

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[1] 1965 NAIC proceedings II at 333.
[2] Health Insurance Institute. "Source Book of Health Insurance Data," 1976-77, at 21.
[3] H. Rept. No. 213, Mar. 29, 1965, p. 2.

COST SHARING GAPS

In general, medicare cost sharing serves the dual purpose of cost containment of health services and limiting the financial strain on the Federal Government in providing medicare benefits. We believe the health care cost containment objective is socially desirable both for the medicare population and the general public. However, the public has become accustomed to first dollar coverages.

As noted by one of the foremost authorities on social insurance, Robert J. Meyers, in his 1970 book entitled "Medicare":

"The high rate of continuance of supplementary private health insurance of all types is a vivid testimonial to the belief of a large segment of the population that relatively full insurance coverage is desirable if it can be afforded. This support is also noteworthy in view of the facts that much of the supplementary coverage represents first-dollar costs that are readily budgetable and that the ratio of the value of the benefit protection to the premium paid is now relatively low as compared with what it was under some full-coverage policies and plans in existence prior to medicare." [4]

This committee has been made fully aware of the fact that one of the major benefit provisions, if not the major benefit, of most supplement policies is coverage of the deductible and coinsurance amounts.[5]

If first dollar coverage is economically inappropriate, the insurance industry, State and Federal Governments, unions, and employers are to blame for allowing or encouraging its prevalence. The NAIC is on record in encouraging the use of consumer cost sharing as a device to assure use of the restraining influence of household budgets to minimize the inflationary propensity of health insurance.[6] If the Congress can be entirely convinced of the need for medicare deductibles and coinsurance, private insurance coverage of such cost sharing measures could be prohibited.

However, whatever the theoretical virtues of mandatory cost sharing, the public is not likely to accept prohibition of first dollar coverages absent a convincing and prolonged public education program accompanied by repeal of the tax subsidies of employer and individually purchased health insurance. The problem is further complicated by the fixed income of retired persons coupled to rising cost sharing requirements of medicare. Therefore, we conclude that a sizable market will continue to exist for first dollar medicare supplements whether they are appropriate or not. Nevertheless, a public campaign to persuade and educate the medicare population on the economics of health insurance we believe is in the public interest.

In order for medicare eligibles to be able to evaluate their needs for medicare supplements, perhaps the most pressing deficiency of the medicare program is public misunderstanding. The chairman of this committee, Senator Frank Church, in 1974 acknowledged in unmistakable terms that—

"One of the most compelling points for the Congress to consider is the great need for more intensive educational efforts upon the part of the Federal Government to inform older persons *about medicare itself* (original emphasis)." [7]

A peculiar aspect of the medicare program, one that distinguishes medicare from other forms of hospital, medical, and surgical policies, is that the basic benefits payable have changed almost annually due to rising deductibles and coinsurance since the inception of medicare. Given changing benefits, the ability of physicians to take or leave assignments for medicare patients, and the reimbursement formula that leaves gaps between the allowable charges under medicare and actual health care provider fees, one can easily understand the confusion in the minds of medicare eligible patients. Moderating the increases in cost sharing amounts under medicare, and setting easily understood deductible and coinsurance requirements would go far in our opinion to ameliorate present misunderstanding and to improve the ability of the medicare population to select desired supplements. We recommend congressional review of the cost sharing provisions of medicare.

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[4] Robert J. Meyers, "Medicare," (1970) at 308.

[5] Ellenbogen, "Private Health Insurance Supplementary to Medicare," (1974), prepared for the Senate Special Committee on Aging at 5.

[6] See NAIC Model Comprehensive Health Insurance Bill, Sec. 6C, "Proceedings of the NAIC II." 407–437.

[7] Ellenbogen. "Private Health Insurance Supplementary to Medicare," Special Committee on Aging, U.S. Senate, (1974) at iv.

Disclosure of what medicare pays and what private supplements pay is a major objective of virtually all of the State medicare supplement regulations now in place in six States. These State plans will be discussed in greater detail later in my statement.

GAPS AND LIMITATIONS OTHER THAN COST SHARING

In addition to medicare "gaps" attributable to purposeful cost sharing requirements, there are other gaps and limitations such as the maximum 90 inpatient days per episode of illness covered by part A; or the gaps caused by "reasonable and necessary care" payment limitations; or the numerous health care services not covered and not intended to be covered by medicare such as drugs, dental services, and full nursing home services. Are these additional gaps suitable for private insurance supplements? Should there be broader medicare coverage of both existing and additional benefits? The answers to these questions, as you well know, are not easy.

On the issue of broadening medicare coverages, we are aware of the remarkable rate at which costs of existing medicare and medicaid programs are increasing. Combined medicare and medicaid expenditures by the Federal Government have risen from $9.9 billion in 1970 to an estimated $32.2 billion in 1977.[8] Within only a few short years after the enactment of medicare legislation, future cost projections were being revised markedly upwards because of soaring costs attributable to provide cost increases and greater than anticipated utilization.[9] The problems created by health care cost increases are directly related to public and private, third-party reimbursement. Obviously, congressional interest in increasing medicare benefits must take account not only of the needs of the elderly but also the ability of the Government to support broadened coverages and contain health care costs.

If private insurance is feasible for services not already covered by medicare, the individual need for services must necessarily be of an insurable nature. Insurance deals with pooling similar risks of loss. The individual risk is the occurrence of a fortuitous event. If individual needs for dental services, drugs, or custodial care are either predictable or within the control of the patient, such services are by definition not insurable. While there are developing in the private market insurance programs for dental and drug services, the existence of such programs is largely attributable to the tax subsidies available in employer-paid benefit programs rather than a natural market for insurable services. Since many of most medicare patients are no longer employed, private insurance to supplement medicare with dental, drug, or custodial care services may simply be uneconomical. Premiums for such insurance may tend to match or exceed the individuals direct payment costs for such services.

In a similar vein are hospital and medical costs determined under medicare to be unreasonable and/or unnecessary. It is questionable both as a matter of public policy and economics to encourage private insurance for care, sought not for medical necessity but for convenience of the patient. In short, which total health care expenses of our medicare population may substantially exceed the amounts paid by medicare, it does not necessarily follow that the remaining expenses not paid by medicare can or should be privately or publicly insured.

However, there are gaps within medicare that are suitable for private insurance coverage. For example, the occurrence of a catastrophic illness or accident may lead to hospitalization beyond the period of coverage provided by medicare part A. This kind of risk is perfectly insurable, and private supplements to cover this kind of risk are undoubtedly beneficial. So long as the public understands the benefits and limitations of the medicare program, the nature of private health insurance, and need to contain health care costs, the market for sensible and appropriate medicare supplements will be shaped by public demand. Public understanding should be a primary objective of both the Federal and State Governments with respect to medicare and sales of private insurance supplements.

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[8] U.S. Department of Commerce, Bureau of the Census, "1977 Statistical Abstract" at 249.

[9] Staff of the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, "Data on the Medicaid Program: Eligibility, Services, Expenditures, Fiscal Years 1966–76," 94th Cong. 1st sess. 3 (1976).

REGULATORY ACTION TO ASSURE A PROPER PRIVATE INSURANCE MARKET FOR FILLING THE GAPS AND LIMITATIONS OF MEDICARE

At least six States have promulgated regulations specifically dealing with the matter of medicare supplement insurance: California, Colorado, New Mexico, Oregon, Washington, and Wisconsin. As noted at the outset, it is the intention of the NAIC to consider the need for a similar model medicare supplement regulation.

Let me briefly summarize the existing State regulations:

(a) *California.* The California regulation basically sets benefit standards and calls for disclosure. The standards for "medicare supplement" coverages in California require:

(i) Application of a 55 percent loss ratio requirement for policy approval; and

(ii) Coverage of the coinsurance amounts applicable to both parts A and B which are automatically adjusted to medicare changes.

The standards prohibit:

(i) Coverage of the part B deductible if the insured is not hospital confined in the year;

(ii) Preexisting condition exclusions less favorable to the insured than a definition limited to conditions apparent 6 months before coverage and then excludable only for 6 months;

(iii) Exceptions, limitations, or reductions in coverage in a manner inconsistent with medicare;

(iv) Coverage of accidents on a different basis than sickness.

The disclosure requirements of the California regulation call for three categories of coverage: (i) in-hospital; (ii) in and out-of-hospital; and (iii) catastrophic coverage. Insurers in California are not required to make the catastrophic coverage available. A basic purpose of the California regulation is to require both parts of medicare be supplemented by any policy permitted to be sold as a "medicare supplement," subject to the proviso that coverage can be limited to expenses incurred as an inpatient. The catastrophic category is to provide blanket coverage after a "corridor deductible." In each category, prescribed statements clearly identify what is and what is not covered by the supplement.

(b) *Colorado.* The approach taken in Colorado is to require delivery of a prescribed notice form to medicare eligible applicants for any accident or health insurance that may replace or be added to existing insurance. The selling insurer is required to determine when a replacement or supplement may occur and then provide the notice form. The form cautions the applicant on benefits that may be lost on replacement and calls for a disclosure by the insurer of "any duplication or overlapping of coverages and deductions by reason of coordination of benefits."

(c) *New Mexico.* New Mexico has taken a straightforward disclosure approach in its medicare supplement regulation. In order to sell "medicare supplement" insurance, the insurer must provide a summary of Federal medicare benefits and applied-for policy benefits.

(d) *Oregon.* Oregon similarly requires delivery of a prescribed disclosure form that details medicare benefits, supplement policy benefits, and provides general purchase advice.

(e) *Washington.* In a manner similar to New Mexico and Oregon, Washington requires delivery of a prescribed disclosure form providing general consumer information and disclosure of medicare benefits with a continguous supplement policy benefit disclosure.

(f) *Wisconsin.* Wisconsin has set standards for medicare supplement rules that divide policies into four classes. The defined categories of coverage are designed to enhance consumer understanding and promote comparison. The first and most complete category of coverage under the Wisconsin regulation is medicare supplement 1. The category 1 coverage must provide a policy limit of at least $22,500 of supplemental coverage for specified medicare parts A and B eligible expenses. In addition, coverage of 75 percent of prescription drug expenses and 50 percent of psychiatric treatment expenses (up to $1,000) is required. Policies qualifying under the designation medicare supplement 2, medicare supplement 3, and medicare supplement 4 must provide specified but less complete benefits than the first category. Medicare supplement 4 may be issued in an A or B variety providing part A supplemental benefits or part B benefits. Wisconsin further defines permissible exclusions and limitations, requires de-

livery of outlines of coverage and consumer booklets, and prohibits sale of hospital confinement indemnity policies under the designation medicare supplements.

It is premature to suggest which, if any, of these specific State regulatory approaches may be followed by the NAIC. A fair conclusion is that each attempts to summarize what medicare provides and to enhance the consumer's ability to determine what is needed to supplement medicare. This general objective will undoubtedly be shared by any model regulation proposed by the NAIC.

SUMMARY

The perceived inadequacy of medicare benefits by our Nation's senior citizens is evident in the numbers of medicare supplement policies sold by the private insurance industry. A major question facing the Congress is whether to broaden medicare benefits to more completely provide the health insurance security sought by the elderly. Inextricably linked to the question of how comprehensive public benefits should be is the issue of how to assure that medicare beneficiaries are able to determine their medicare supplement needs and to select the appropriate private insurance supplement.

The apparent problems giving rise to these hearings on medicare supplement insurance are, in our view, attributable to confusion over what medicare provides, a lack of understanding of the economics of health care delivery, and difficulties with the private insurance mechanism. The members of the NAIC stand ready to assist you and the Nation's elderly in resolving each of these problems. In particular, State regulatory attention is being given to the need for medicare supplement standards and more adequate disclosure. To facilitate this effort, it is obviously desirable that the Congress clarify to the extent practicable what gaps and limitations are intended to exist under medicare and why. Broad regulatory authority is already in place in the States to control fraudulent, abusive, or misrepresentative marketing practices of insurance companies and their agents. We are hopeful that our collective efforts will substantially eradicate the conditions that have given rise to problems of our elder citizens in purchasing appropriate supplements to medicare.

Attachment.

SUPPLEMENTAL STATEMENT OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

A. HIGHLIGHTS OF MARKET CONDUCT REGULATORY AUTHORITY OF STATE INSURANCE DEPARTMENTS, RELATED HEALTH INSURANCE SALES

Where unfair trade practices by agents or insurers occur in the marketing of medicare supplement insurance and are brought to the regulator's attention, the States have ample regulatory authority already in place to address the problems. Even though only six States have acted to implement medicare supplement regulations, the remaining States can and do act under existing regulatory authority to revoke licenses, to impose fines and penalties, to issue cease and desist orders, and take other appropriate remedial action. In order to convey the nature and scope of State regulatory authority, there follows a brief description of several State insurance regulatory developments related to health insurance marketing.

(1) Unfair trade practices

Every State has enacted an Unfair Trade Practices Act in some form applicable to the business of insurance. Typically, these acts are patterned after the NAIC Model Unfair Trade Practices Act adopted in 1947.[1] In recent years, it was determined that the model law needed updating so as to more specifically address current problems of the insurance consuming public. After an extensive review in 1972, the NAIC substantially revised the model law. As currently recommended to the States, the model act speaks specifically to the fair treatment of policyholders and defines unfair claim settlement practices in considerable detail. The unfair trade practices act is clearly a consumer oriented legislative act. Regulatory procedures are authorized to determine the existence of unfair or deceptive practices in the business of insurance along with strong enforcement procedures. Cease and desist orders, license revocation, and sub-

[1] Reprinted in "Proceedings of the NAIC II," 509–15 (1960).

stantial fines and penalties are authorized by the model act. The unfair methods of competition, or unfair or deceptive acts and practices specifically defined in the act fall in these eleven general areas:

(a) Misrepresentation and false advertising of insurance policies;
(b) False information and advertising generally;
(c) Defamation;
(d) Boycott, coercion, and intimidation;
(e) False statement and entries;
(f) Stock operations and advisory board contracts;
(g) Unfair discrimination;
(h) Rebates;
(i) Unfair claim settlement practices;
(j) Failure to maintain complaint handling procedures; and
(k) Misrepresentation in insurance applications.

In addition, the NAIC model act authorizes the insurance commissioner to examine and investigate other practices which may be determined to be unfair or deceptive whether or not they are specifically defined as such in the act. This comprehensive authority to regulate insurance trade practices is second to none in terms of its broad scope and enforcement authority. In short, we have substantial authority to deal with unfair or deceptive insurance sales practices involving medicare supplement sales or any other line of insurance. If particular complaints are brought to your attention, the appropriate member of the NAIC will certainly provide its regulatory assistance on request.

(2) Health insurance advertising

In recent years the bulk of the problems associated with health insurance advertising have related to mass marketing activity through the mails, newspapers, radio, and television. Until fairly recently when an insurer entered a State through these techniques, as distinguished from personal solicitation by agents within the jurisdictional boundaries of the State, there had been serious questions as to the State's constitutional authority to reach such insurers. However, two court decisions in the middle 1960's have been favorable to the State regulatory position and have eliminated most of the questions related to the States' regulatory authority over mail order insurers.[2]

Health insurance advertising became increasingly important in the years after the NAIC 1956 rules governing advertisement of accident and sickness insurance were adopted. The expanding availability of group coverage, the advent of governmental programs, and the growth in sales of individual policies not only offer the public the diversity of choice, but also serves to complicate the consumer's decisional process. The consequent need for better information led to the disclosure requirements established by the 1972 NAIC advertising rules. As the volume of health insurance marketed through direct response techniques mushroomed, such advertising evolved from a sales aid for the agent to a major marketing effort. This led to the amending of the NAIC model rules governing advertisements of accident and sickness insurance (with interpretive guidelines) in 1974 to reflect specific requirements for direct response advertisements.[3]

The rules seek "to assure truthful and adequate disclosure" through the establishment of minimum standards and guidelines in the conduct of advertising. Certain information is required to be disclosed in a nonmisleading manner, and certain words, phrases, and illustrations are prohibited. Specific practices are also governed by the rules. For example, each insurer is required to maintain a file containing its various advertisements, and each file is subject to insurance department examination. An authorized officer is required to certify the insurer's compliance with the advertising rules. Furthermore, the rules contain an optional provision which would enable the commissioner to require that direct response advertising material must be filed for review 30 days prior to use.[4]

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[2] See *Ministers Life and Casualty Union* v. *Haase*, 30 Wis. 2d 339, 141 N.W.2d 287, appeal dismissed for want of a substantial Federal question, 385 U.S. 205 (1966); and *People* v. *United National Life Insurance Co.*, 56 Cal. 2d 577, 427 P.2d 199, 58 Cal. Rptr. 599, appeal dismissed for want of Federal question, 389 U.S. 330 (1967). For a detailed discussion of the constitutional issues, see Hanson and Ohenberger, "Mail Order Insurers: A Case Study in the Ability of the States to Regulate the Insurance Business," 50 Marq. L. Rev. 178, 215 *et seq.* (1966).

[3] 2. "Proceedings of the NAIC" 420 *et seq.* (1974).

[4] *Id.*

Thus, with the removal of the constitutional doubt as to the State insurance regulatory authority, the NAIC and the individual States have moved quite aggressively to improve health insurance advertising. The adoption of the NAIC rules in 1972, as amended in 1974, marked the culmination of an extensive and successful effort by the NAIC to improve the quality of the existing insurance market. Most States have promulgated advertising regulations, typically patterned on the NAIC model rules, which have contributed to a more informed buyer and have deterred sellers' advertising abuses.

(3) Complaints

Closely related to the Unfair Trade Practice Act and the advertising rules and regulations is the assumption of responsibility by State insurance departments for establishment of a mechanism for handling policyholders' complaints. State complaint services in recent years have been expanded and emphasized. Among other things, State insurance departments have implemented toll free telephone lines and more efficient complaint handling procedures in order to make their policyholder service units more accessible to citizens. Processing complaints not only serves to assist individuals with their particular problems but also provides a means to monitor an insurer's conduct in a more efficient fashion.

Two NAIC developments in this area are noteworthy. First, under the authority of the revised Unfair Trade Practices Act, a model regulation has been developed and adopted which requires an insurer to maintain records of policyholder complaints made to the insurer.[5] Such records are subject to insurance department review. Second, the NAIC has developed a uniform complaint handling system that is in widespread use throughout the States. Complaints which are received by an insurance department are in many States compiled in a uniform format[6] by company, type, line, reason, disposition, etc., so that data can be reviewed for regulatory purposes.[7]

B. GENERAL BACKGROUND ON HEALTH INSURANCE POLICY APPROVAL STANDARDS AND NAIC ACTIVITIES

(1) Premium rate controls

As a general matter, States do not regulate rates of life, health, and accident insurance in a manner similar to that of property and liability insurance. In most States, property and liability insurers must file insurance rates for prior approval by the insurance department, although there is a trend toward open competition rating in those lines. Blue Cross and Blue Shield rates are directly regulated in many States, in contrast to commercial health insurance, because of their tax exempt status, the service benefit nature of coverage, and their leverage over providers of health care.

Although health insurance rates are not regulated directly by the States as a general matter, most States require rates to be filed with the insurance department. As part of the policy form approval procedure, many States provide that forms will be disapproved if the benefits provided are unreasonable in relation to the premiums charged. All States require the filing of actual loss experience on policies. The requirements of a reasonable relation between premiums and benefits in many States has led to the development by the NAIC of loss ratio benchmarks that, as advisory guidelines, are recommended to the states for consideration in reviewing health insurance policy filings.

The NAIC currently has a technical task force that is reviewing the NAIC loss ratio guidelines in effect since 1953. New guidelines for premium increases on individual health insurance forms are being prepared which would, if adopted, require submission of an actuarial memorandum specifying the anticipated loss ratios, an actuarial certification that policy filings comply with State law and provide benefits that are reasonable in relation to premiums. Furthermore, the new guidelines would provide specific loss ratio benchmarks ranging from 50 to 65 percent depending upon the type of coverage and renewability features.

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[5] The model regulation as amended is reprinted in 1 "Proceedings of the NAIC" 282–310 (1974).

[6] 1 "Proceedings of the NAIC" 287 (1974).

[7] Such a program can focus attention upon particular patterns of complaints and can identify policyholder problems that may be rectified by contract modification or marketing technique changes. It is also possible to note those insurers that are creating more policyholder complaints than their volume of business would anticipate and react as need be. *Hearings*—NAIC, *supra* note 67, at 2653.

(2) Minimum standards requirements

Another area of recent State insurance regulatory activity, focusing specifically on health insurance, relates to development of minimum standards for health insurance policies. In this regard, during its December 1973 meetings, the NAIC adopted the Model Individual Accident and Sickness Minimum Standards Act.[8] The essence of the Minimum Standards Act is found in section 4 which requires the commissioner to establish minimum standards in relation to benefits for seven specified categories of coverage: (1) Basic hospital expense coverage; (2) basic medical, surgical expense coverage; (3) hospital confinement indemnity coverage; (4) major medical expense coverage; (5) disability income protection coverage; (6) accident only coverage; and (7) specified disease or accident coverage.

No policy or contract can be issued or delivered in the State which fails to meet the minimum standards for the categories of coverage into which it falls.[9] Other pertinent sections of the Minimum Standards Act include section 3, which directs the commissioner to promulgate regulations to establish standards that "set forth the manner, content, and required disclosure for the sale of individual policies" and Blue Cross and Blue Shield contracts,[10] and section 5, which provides that no policy or contract shall be issued or delivered in the State unless an outline of coverage is provided to the applicant.[11] Following the adoption of the model act, the NAIC immediately began work on a model regulation to implement the Minimum Standards Act. After a series of public hearings, a minimum standards regulation was adopted during the December 1974 meeting of the NAIC.[12]

In essence, the model act and the implementing model regulation establish the framework to: (1) enable the standardization of the definition of policy terms, (2) compel policies to meet minimum standards for the category into which they fall, and (3) compel disclosure to the consumer to better enable him to know what he is purchasing.

The minimum standards act and regulation does apply to individual medicare supplement policies despite the fact that a separate category for medicare supplements is not provided. In accordance with the current recommended draft of the minimum standards regulation, medicare supplements generally would be required to be sold as "limited benefit health insurance" coverages with and outline of coverage disclosing principal policy benefits and limitations.

In the event the NAIC resolves to provide specific rules for medicare supplements, the existing minimum standards act and regulation could be amended to include the new rules. The NAIC will give deliberate consideration to this option. The minimum standards regulation already includes provisions governing use of preexisting condition limitations, waiting periods, cancellation and renewal provisions, and other policy terms and conditions relevant to medicare supplement issues.

(3) Policy readability

A final regulatory development that is notable is the adoption earlier this month by the NAIC of a model Life and Health Insurance Policy Language Simplification Act. In response to the difficulties of policyholders in reading and comprehending life and health insurance policies, the NAIC has adopted a model law that sets new standards for policy drafting. The standards include, for example, a requirement that policies achieve a minimum Flesch test readability score, and the act sets standards for type face, inclusion of tables of contents, and avoidance of undue prominance given to policy text or riders. The purpose of the new act is to improve policy language in order to facilitate the insured's understanding of the coverages provided. It is our hope that regulatory developments such as the readability model will enrich the ability of all insurance policyholders, including medicare supplement purchasers, to choose the correct coverage for their needs and better understand their insurance benefits.

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[8] The model act is reprinted in 1 "Proceedings of the NAIC" 414 (1974).

[9] *Id.* at 416–17.

[10] This authority extends to, but is not limited by, several enumerated provisions and terms found in health insurance policies. Through this provision the commissioner can standardize definitions for particular terms, and specifically prohibit policy provisions which are "unjust, unfair, or unfairly discriminatory to the policyholder, any person insured under the policy, or beneficiary." *Id.* at 415–16.

[11] The commissioner shall prescribe the format and content of the outline of coverage including the category of the policy, a description of the principal benefits and coverage, a statement of exceptions and limitations, etc.

[12] The model regulation is reprinted in 1 "Proceedings of the NAIC" 54–77 (1977).

Senator CHILES. Thank you very much for your statement.

We have another rollcall in process so we are going to have to leave in just a few minutes.

Senator Domenici will leave now and maybe by the time he gets back I can go over.

How long do you anticipate the study of your task force to be?

Mr. MIKE. We had hoped 6 to 12 months would be sufficient time for the task force to bring its recommendations back. The NAIC meets twice a year and the task force is bringing their results to the subcommittee meetings. We had frankly hoped that by next summer we would have the recommendations and the subcommittee could begin action.

Senator CHILES. I just want to point out to you I tried at the last meeting that we had, and before you had your meeting—and I think I speak for Senator Domenici, too; I am sure I do—we strongly feel that the regulation of insurance has been and should continue to be a State question. I am the product of the State legislature myself, having spent 12 years there before I got sent up here, and I think the States are best able to do that.

NATIONAL PROBLEM

When you get a problem like this and we see the extent of the problem, it is clear that it is a national problem that we are dealing with. I think that those of us who want to see the States continue to regulate insurance have to be for action that you are talking about like your task force where we can see model laws develop and see the States move in unison to taking care of the problem like this. It has always been in an area like this where States often fail in their responsibility, that someone decides, well, that is something that the Federal Government has got to get into.

When I was in the State I used to talk about intrusion, but the longer I looked at it the more I saw it was, in many instances, where the States failed that the Federal Government moved into a vacuum, and moving into that vacuum we had more power come up here. I think we have got more now than we can say grace over. I would like the States to do more, but I think this would be one of those areas that, if the problems continue, it could well bring the regulation of insurance into the Federal Government arena.

I think that would be very important, so I want to tell you I am delighted to see that you have appointed a task force. I think your statement here today is certainly strong in the efforts you want to see that task force take. I just hope that that message will go to all of the insurance commissioners in all of the States.

This is a problem that you do have to work on. We do have to come up with solutions to it. We are talking about sooner or later having some kind of a national health insurance. We must get our house in order before the national health insurance comes down the pike.

I think it is awfully important that we do get some good work out of your task force. As I said, we do look forward to trying to work with you in any way that we can.

You were here and had an opportunity to hear Commissioner Dole and her testimony this morning. I would like to know just what

your feeling is in regard to what she was talking about in having a joint study in which the FTC would seek participation from the States and from the insurance commissioners of the State in trying to do an impact study.

Mr. MIKE. Obviously, I cannot speak officially for the organization.

Senator CHILES. I understand.

Mr. MIKE. We welcome anything that is going to provide further information to this task force to enable it to do its job better. We are recognizing that if we take the narrow view of attempting to jealously guard the States' rights to guard insurance to the exclusion of all other considerations, we are going to be overlooking a great many problems here and we are not fearful with involvement with the Federal Government. We think the public can benefit greatly by it and we would honestly welcome anything.

Senator CHILES. I think that is a very healthy attitude and I hope that you would circulate to the other States this kind of offer that she is talking about, because it seems to me that there are certain resources that are available to the Federal Trade Commission and certain resources that are available to us through certain powers that we have. By the same token, the States have much of the information. The basis of the information and by putting all of those parties together, I think we can come up with a much better and rational plan. Again, it would be up to the States to implement that plan.

Mr. MIKE. I intend to invite Commissioner Dole to submit to the NAIC a proposal with some detailed information for the organization to consider—that is, the executive staff. I am not an officer of the organization, but merely a subcommittee chairman. We can begin to discuss and implement something as quickly as possible.

Senator CHILES. I think that would be very, very helpful.

I want to thank you very much for your appearance and for your testimony. We will certainly look forward to working with you.

Mr. MIKE. Thank you very much.

Senator CHILES. I am going to go and vote. Senator Domenici will be coming back shortly.

Mr. Garcia, we will be taking your testimony.

[Whereupon, the committee took a short recess.]

Senator DOMENICI [presiding]. Senator Chiles will vote and, if he can, he will return. We are going to proceed with our last witness for the day.

As our last witness for the day, it is our privilege to have Manuel A. Garcia, Jr., superintendent of insurance, New Mexico.

If you are ready, Mr. Garcia, you may proceed.

STATEMENT OF MANUEL A. GARCIA, JR., SANTA FE, N. MEX., SUPERINTENDENT, DEPARTMENT OF INSURANCE, STATE OF NEW MEXICO

Mr. GARCIA. Mr. Acting Chairman, it is a real privilege for me to be here and to present to this committee some of the problems that we have in New Mexico and also to present to this committee some of the solutions we have had with some of these problems.

Sometime during the latter part of 1976 and during 1977, the problems and abuses began to come to our attention in the form of complaints from some of the elderly citizens of New Mexico. The complaints that we received involved two areas of abuse: First, policies were being sold which did not fill the gaps left open by the Social Security Act, and these provided a vast area for misrepresentation by sales persons. Second, the overselling of insurance policies to the elderly.

I would like to proceed to present to this honorable committee the case histories, and you have already heard case histories from other witnesses involving the elderly. I would like to summarize the three cases we just picked at random. We had others, of course, but we thought these were significant.

The first case we had in the complaint, I might add, was received in our department by an officer of a life underwriting association in that part of the State. Our investigation proceeded and we found that this elderly person had purchased, in a period of 2 years, over 30 policies of various types. The total premium involved was $3,843.18.

After the department took over the investigation, we determined the information we needed to proceed. We summoned the representatives of various insurance companies to come to our department and discuss the matter. I might add that this not only involved one company, it involved nine separate companies. After presenting these companies with the problems and what our desires were, we were able to get a refund of $3,369.16 for that person. There was a balance of the premium that was not returned because these were some of the policies that the party decided to keep.

The second case we were involved in was an elderly gentleman in the northern part of the State of New Mexico. The complaint in this instance came from the Department of Health, Education, and Welfare of the Dallas, Tex., office, and the complaint recited that there was an agent identifying himself as a social security representative collecting medicare premiums.

"Soliciting Funds To Support Medicare Program"

We undertook an investigation immediately and discovered that there were 157 individuals who had purchased this medicare supplement plan from this particular agent. The information and copies of the applications were solicited and received from the insurance company represented by this particular agent. Of course, part of his deception was to indicate to these people that the medicare program was on the verge of bankruptcy and that he was soliciting funds to maintain the medicare program until the Congress could appropriate more funds.

Our representative out of the department worked with the different county welfare offices and counsel. We suggested that the letter be sent to all the people involved who purchased these plans; however, on the advice of their legal counsel, it was decided that instead of a written letter, we would issue a radio and newspaper release[1] that would be circulated through the northern counties and

[1] See p. 267.

throughout the State, warning people to take precautions against purchasing these plans from individuals passing themselves as social security representatives.

After discussions with the insurance companies, the company was willing to make refunds to all these purchasers, but we only had 22 formal requests for refunds. Those refunds were made. The agent's license was suspended. We offered him a hearing. We had no response from him at all as to his cancellation or as to his interest in a hearing. This agent is no longer doing business in the State of New Mexico so far as we are concerned.

The third case involved, again, an elderly lady in the southern part of the State who, over a 2-year period, had purchased 16 various policies, for a total of $7,431. We again conducted a full investigation, discussed the problems with the companies involved, and were able to secure a $7,171 refund; $260 was not recovered due to a company insolvency.

Senator DOMENICI. Commissioner, are those 16 policies all from the same company?

Mr. GARCIA. There were various companies involved. I don't have a breakdown as to how many.

Senator DOMENICI. How did you find out about that one?

Mr. GARCIA. We got a call from a friend of the lady involved.

These three examples as well as many of the others that you have heard this morning are from other sources. These examples are the ones that were encountered in New Mexico in the area of supplemental plans and the resolutions that were completed by the Department of Insurance for the State of New Mexico. These cases don't represent all of the problems. We have many other cases where we have been successful in terms of returning refunds on premiums.

We have done other things to proceed to try to eliminate some of these problems in the medicare gap and medicare supplemental plans. First, we published in the news media cautions and warnings of the pitfalls of purchasing medicare supplements. Although we felt that this type of release is not the most effective, we did feel it would reach certain segments of the public that would be involved in this and would bring to light some of the problems they may encounter by overzealous sales persons for this type of plan.

Second, we oriented all of the personnel who worked in the government service offices or service centers on how to identify the problems and how to aid in getting this information to the department of insurance as soon as possible. Three members of our department were sent to many population centers to explain problems to assembled groups and to make this information available to radio and the press.

FULL-TIME INVESTIGATOR

During these meetings it was encouraged that citizens bring their complaints and questions to the department of insurance as soon as possible, and I can report that these efforts have been successful in the use of these facilities. We added to our staff in the department a fulltime investigator who is now readily available to us so he can go out and investigate these problems. Prior to this we had to rely on telephone contacts et cetera.

We have also published, along with our regulation we promulgated to the different companies and agents, that any time we find an agent or a company who is guilty of this behavior, we will proceed immediately to either suspend or cancel their license to do business in the State. There is a suspension revocation. We have means through the National Association of Insurance Commissioners by which we can pass that information on to other people, especially neighboring States.

Information also received by this department would indicate that a company also involved in pursuing this type of practice would immediately be investigated and a hearing brought forth.

I mentioned previously that the department had promulgated the regulation in November 1977. We have attached this to my statement. The purpose of this regulation is to let the buyer of medicare supplements in the exhibit attached physically see this graphic form the benefits of such medicare supplemental plans and in addition how it compares to what coverage is provided for under medicare.

We feel in New Mexico that medicare supplements, when they are properly sold and controlled, are very essential to the health and welfare of the elderly citizens of the State. We do intend to continue our efforts in other areas to control and oversee these programs to the benefit of a very important segment of our society in New Mexico.

I would like to field any questions that you might have Senator.

[The prepared statement and attachments of Manuel A. Garcia, Jr., follow:]

PREPARED STATEMENT OF MANUEL A. GARCIA, JR.

Mr. Chairman and members of the Senate Special Committee on Aging, I welcome this opportunity to come before you and present some testimony involving medicare and medicare supplement plans and the problems that some of the elderly in New Mexico have encountered in this area. We will testify on the actions which the State of New Mexico, through its insurance department, has taken to protect the elderly medicare policyholders in New Mexico.

Sometime during the latter part of 1976 and during 1977, the problems and abuses began to come to our attention in the form of complaints from some of the elderly citizens of New Mexico. The complaints that we received involved two areas of abuse; first, policies were being sold which did not fill the gaps left open by the Social Security Act, and these provided a vast area for misrepresentation by sales persons. Second, the overselling of insurance policies to the elderly.

I will proceed to present to this honorable committee the case histories, the problems encountered, the abuses that were involved, the action that the State Department of Insurance for the State of New Mexico took, the resolution to these problems, and how we proceeded to take care of regulating this area of the private health insurance business. In addition to that, we will proceed to show you the regulation adopted by the State of New Mexico and the control that we have with the insurance industry in the area of medicare supplemental coverages.

The first case that we will refer to was C. P. of Carlsbad, N. Mex. Mrs. P. was involved in a very severe case of overselling in the area of medicare supplements. A formal complaint was received by the department from the vice president of the Life Underwriters Association in Roswell, N. Mex., a city north of Carlsbad. N. Mex., where Mrs. C. P. lived. There was no question after reviewing the grievance that Mrs. P. in a period of over 2 years. had over 30 policies of various types. The total involved premium was $3,843.18. A complete investigation was undertaken by the department investigator and, after determining the factual information necessary, several home office representatives were summoned to the department of insurance for dis-

cussion of this matter. Every insurance company involved was informed of the obvious abuses of agency practices regarding the duplication of coverage to Mrs. P: and a full refund of premiums to Mrs. P. was requested. We were successful in having $3,369.16 recovered for the insured from the various companies. The balance of the premium was in policies retained by the insured, and we closed our case.

The second case involved an elderly gentleman in the northern part of the State. The formal complaint was received from the Department of Health, Education, and Welfare, Dallas, Tex., office.

The complaint recited the following: The agent was identifying himself as a Social Security representative collecting medicare premiums. An investigation was undertaken by our department investigator and it was discovered that a total of 157 individuals had purchased this medicare supplement plan from this agent. This information and copies of the applications were solicited and received from the insurance company represented by this particular agent. A part of his deception was to indicate to these people that the medicare program was on the verge of bankruptcy and that he was soliciting funds to maintain the medicare program until the Congress could appropriate more funds. Our representative worked with the different county welfare offices and the State welfare office and their legal counsel. It was suggested by our department that a letter be sent out to all of the purchasers of these plans. Instead of a written letter, however, it was then decided that, for legal reasons, a general news release via radio and newspaper would be circulated in those northern counties warning people to take precautions against purchasing medicare supplement coverages from individuals passing themselves off as Social Security representatives. Although the insurance company was willing to make refunds to all purchasers, only 22 made formal requests for refunds. All of these refunds were made. The agent's license was canceled and an offer of a hearing was afforded the agent, although there was no response from him as to his cancellation or to his hearing. This agent is no longer doing business in the State of New Mexico.

The third case involved, again, an elderly lady in the southern part of the State who, in a 2-year period, had purchased 16 various policies. The total premium paid out was $7,431. After a full investigation by our department and contact with the proper company representatives, a refund was recovered for that insured totaling $7,171. The $260 not recovered was due to a company insolvency. The case was closed on April 19, 1978.

These are but three examples of the problems encountered by New Mexico elderly citizens in the area of medicare supplemental plans and the investigation and resolution as attempted and completed by the Department of Insurance for the State of New Mexico. These cases, of course, do not represent our only efforts; we have many cases which are as successful as the ones aforementioned and a few cases that will be resolved in the very near future. The efforts made by this department did not really stop there; we did several other things:

(1) We published in the news media cautions and warnings[1] of the pitfalls of over purchasing medicare supplements. We feel that this type of release is not the most effective; however, it will reach a particular segment of the insuring public and we are in hopes that it will at least bring to light some of the problems that they may encounter by over-zealous salesmen of these type of plans.

(2) We have oriented all of the personnel who work in the Governor's service centers how to identify the problems at hand and how to aid in getting this information to the department of insurance as soon as possible.

(3) Members of our department have been sent to many population centers to explain the problem to assembled groups and to make this information available to radio and the press. During these meetings, we have encouraged citizens to bring their complaints and questions to the department of insurance and I can report that this effort has been successful and that use of these facilities will be utilized further in the future.

(4) With a staff investigator readily available to this department, we can now accumulate detailed factual information necessary to curb these types of abuses on any of the insuring public of the State of New Mexico.

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[1] See p. 267.

(5) At any time that we find an agent or agents guilty of behavior of this fashion we will immediately suspend or cancel their licenses to do business in the State. The suspension or revocation of the license is then passed to all States involved through the facilities of the National Association of Insurance Commissioners.

(6) Information received by this department that would indicate that a company is involved in such practices, will immediately be investigated and brought to task.

Additionally, the department of insurance promulgated the attached regulation.[1] You will note that this regulation became effective on November 28, 1977. The purpose of this regulation is to let the buyer of medicare supplements physically see, in a graphic form, the possible benefits of such medicare supplements.

We feel that medicare supplements which are properly sold and controlled are essential to the health and welfare of the elderly citizens of the State of New Mexico.

We intend to continue our efforts in controlling and overseeing these programs to the benefit of a very important segment of our society in New Mexico.

Attachment.

STATE OF NEW MEXICO,
DEPARTMENT OF INSURANCE.
Santa Fe, N. Mex., November 18, 1977.

NEWS RELEASE

Within recent days the department of insurance has received a large number of reports that persons over age 65, and others have purchased or reported to have purchased health insurance and have not received policies of insurance.

These or reported agents have:

(1) Not properly identified themselves.

(2) Secured personal checks drawn to themselves. These checks have been cashed, and no policies delivered.

(3) Persons posing as agents in a number of cases have no license, nor can they be located, and the department of insurance has no record of them.

(4) Other purported agents are operating with material either stolen from a licensed company, or the material has been reproduced from copies of forms secured.

(5) Other purported agents are signing and forging the names of licensed agents.

(6) Other purported agents are offering policies of insurance in companies not licensed to do business in New Mexico.

(7) Other agents or purported agents are representing themselves as being from the Social Security Administration. No agent may do this.

The department of insurance recommends that if any client is unsure of the person presenting themselves as agents that they should:

(1) Ask for positive identification, and retain evidence of identification.

(2) Call the company being represented to affirm that the agent is as represented.

(3) If a policy is purchased, *always* make the check payable to the insurance company and put on the check what is being purchased.

(4) Secure in writing or in printing the benefits being offered.

(5) If there are any doubts concerning either the agent or the company, call or write to: Superinfendent of Insurance. P.O. Box 1269. Santa Fe, N. Mex. 87501, Telephone No. (505) 827-2451; or the Governors Service Center nearest your home.

The department of insurance is earnestly attempting to stamp out abuses and fraud, and to protect the interests of the buying public.

The department of insurance is equally interested in protecting the licensed and legitimate agents and companies who are offering the necessary insurance coverages.

KENNETH C. MOORE,
Superintendent of Insurance.

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[1] See p. 268.

ARTICLE 11, CHAPTER 58, RULE 4

DEPARTMENT OF INSURANCE REGULATIONS GOVERNING ACCIDENT AND HEALTH INSURANCE MEDICARE SUPPLEMENTS.

11-4-1. Authority.—This rule is promulgated pursuant to section 58-2-13, NMSA, 1953.

11-4-2. Scope.—This rule applies to any insurer which delivers or issues for delivery in this State an individual policy of sickness and accident insurance which is a medicare supplement. It also applies to any nonprofit health care plan which delivers or issues for delivery in this State an individual subscriber contract which is a medicare supplement.

11-4-3. Definition.—"Medicare supplement" means a policy or subscriber contract which relates its coverage to eligibility for medicare or medicare benefits, substantially or in part, to fill the gaps in the coverage supplied by medicare, part A and/or part B.

11-4-4. Disclosure requirements.—

(A) After 150 days following the effective date of this rule, no insurer and no nonprofit health care plan shall deliver or issue for delivery in this State an individual policy of sickness and accident insurance, or an individual subscriber contract, which is specifically designed as a medicare supplement unless a summary of Federal medicare benefits and policy (or subscriber contract) benefits is furnished to the applicant or subscriber at the time the application is made, or to the policyholder or contract-holder at the time the policy or subscriber contract is delivered.

(B) Such summary shall contain in substance the information shown or called for in attachment A, which is attached hereto and made a part hereof. The summary may include other information which the insurer desires to include, but such other information may not be presented in such a way as to obscure the comparison of medicare benefits and policy benefits.

(C) Federal medicare benefits are not stable and do fluctuate in accordance with congressional action. It is, therefore, necessary that any company or plan writing medicare supplements revise the form from time to time so that it does not furnish a form which is out of date.

(D) The policyholder of a medicare supplement which is subject to this rule shall be permitted to return the policy or subscriber contract within ten (10) days after its delivery if such person is not satisfied with it for any reason. If it is so returned to any office or agent specified by the insurer or plan (such as the insurer's or plan's home office or branch office or the soliciting agent) with written request for surrender, it shall be void from the beginning and any premium paid for it shall be refunded. A notice of such right to return the policy or subscriber contract and receive a refund of any premium paid shall be included in or printed on or attached to the policy or subscriber contract or included in the summary.

(E) The details on the disclosure form as outlined in attachment "A" shall be of a size of not less than ten (10) point type.

11-4-5. Effective date.—This rule shall take effect on November 28, 1977.

I, Kenneth C. Moore, superintendent of insurance of the State of New Mexico, pursuant to the authority granted me under section 58-2-13, NMSA, 1953, do hereby promulgate the following rule (article 11, chapter 58, rule 4) of the official compilation of rules and regulations, to take effect on November 28, 1977, after filing with the record center as provided by the provisions of State Rules Act (71-6-23, 71-6-24, 71-7-1 to 71-7-10, NMSA, 1953).

I, Kenneth C. Moore, superintendent of insurance of the State of New Mexico, do hereby certify that the foregoing initial rule has been issued and entered in the office of the Superintendent of Insurance in an indexed, permanent book which is a public record.

In Witness Whereof, I have hereunto set my hand and caused my official seal to be affixed at the city of Santa Fe, N. Mex., this 26th day of October, A.D. 1977.

KENNETH C. MOORE.
Superintendent of Insurance.

Certificate of Filing: I, Kenneth C. Moore, superintendent of insurance, State of New Mexico, do hereby certify that the foregoing initial rule (11-4-1 to 11-4-5) has been filed on October 26, 1977, with the records center.

KENNETH C. MOORE,
Superintendent of Insurance.

ATTACHMENT A.—SUMMARY OF MEDICARE BENEFITS AND POLICY BENEFITS

(1) *Inpatient hospital benefits (Part A of Medicare)*. Benefits are paid for covered hospital charges for hospital room and board and miscellaneous services during each "benefit period" as follows:

Day of confinement	Medicare now pays	Policy pays
Days 1–60 each benefit period	Covered charges, but not the first $144	
Days 61–90 each benefit period	Covered charges except $36 a day	
Days 91–150 while lifetime reserve remains	Covered charges except $72 a day	

(2) *Skilled nursing facility confinement benefits (part A of medicare)*. Benefits are paid for covered skilled nursing facility charges, if the patient is an inpatient in an approved skilled nursing facility and confinement begins within 14 days of a hospital stay of at least 3 days for the same injury or sickness, as follows:

Day of confinement	Medicare now pays	Policy pays
Days 1–20 each benefit period	All covered charges	
Days 21–100 each benefit period	Covered charges except $18 a day	

(3) *Medical benefits (part B of medicare)*. Benefits are provided for "reasonable charges" for covered physician's services, medical supplies, and other covered services, each calendar year.

Medicare now pays 80 percent of the "reasonable charges" but not the first $60 each year.

The summary shall also contain:

(a) A description of any other benefits provided by the policy or subscriber contract.

(b) A description of the exceptions, reductions and limitations contained in the policy or subscriber contract.

(c) A statement that the summary is only a brief summary of certain policy or subscriber contract provisions, and is not a part of the contract of insurance. The policy (or subscriber contract) itself sets forth the rights and obligations of the insured (or subscriber) and the insurer (or plan).

(d) A statement that medicare benefits change from time to time, according to Federal law and with rules and regulations of the Social Security Administration.

(e) The name of the insurer or health care plan and address must appear on the summary of benefits.

Senator DOMENICI. Let me just ask now on the disclosure part of your new rule, does the company that desires to sell and is making the disclosure submit the disclosure statement to the insurance commissioner's office or the superintendent's office for his approval?

Mr. GARCIA. Every one of these companies that is now selling these plans must provide us with a disclosure statement that is very similar, but that would cover specifically these items required in this disclosure.

Senator DOMENICI. You cited three cases that were rather severe and told us about the disposition of them. You have heard the testimony here today about how rampant this kind of misconduct is, downright criminal behavior in the State of Texas. Would you have an opinion as to whether or not abuse is still widespread in the State of New Mexico or not?

CANNOT MONITOR WITHOUT FORMAL COMPLAINT

Mr. GARCIA. Well, we don't have any way to monitor it in our department unless we get a formal complaint. I would answer the

question this way, and that is that the number of complaints has diminished since this regulation was promulgated. I am not going to be naive enough to think that there are not additional problems; I am sure there are. We don't think that there are many of this magnitude. I think there may be isolated problems, perhaps one agent has taken or perhaps two agents have oversold. We have no way of knowing until we get a complaint in the department.

Senator DOMENICI. You have been present and heard testimony regarding the difficulty of trying to police this kind of activity. Do you have any opinions as to whether or not some kind of standardization would be in the public interest and, if so, should it be national and, if not, how do we get it out there?

Mr. GARCIA. As I see our position in the State of New Mexico and with the regulation in the disclosure statement we have, we appear to be treating the symptoms rather than the disease. I really think that the standardization, perhaps on a Federal level or through the NAIC—the type of plans that are being sold throughout the country—is probably related. My feeling, however, is that the vast area of problems is not that one company is involved in all of this; there are several companies involved. I think we have to proceed to educate the consumers further and I think this should be a joint effort between the Federal Government and the State government to publish, in laymen's terms, the kinds of coverages they have under medicare, and also under the different plans. Yes, I would think that the standardization of some type to be very desirable.

Senator DOMENICI. Do you have any suggestions as to ways that this cooperative effort on educating or advising the people might be implemented? Do you have any examples of what might be done that is not being done?

Mr. GARCIA. One of the things I believe has made our approach to these problems successful is that traditionally in New Mexico—the people of the State have always been able to go very directly to the department of insurance with their complaints. The Governor's service centers have also certainly been in that position. If we had a joint effort to provide an easy avenue to report these problems to the proper authorities or to the proper departments, I think it would be worthwhile. I think this is the solution.

Senator DOMENICI. With reference to the authority that you have as superintendent, is your jurisdiction limited to taking action against the agents or companies in terms of their permission to sell, or are there some criminal statutes that you enforce?

Mr. GARCIA. No. Basically our jurisdiction and our authority would be to either suspend or revoke licenses and impose fines and ask that they be continued. However, I might add that in many cases the suspension of the license should not be taken lightly because, after all, these people are making a living in this and if they suspend the license, they are out of business until they have a hearing.

Senator DOMENICI. You indicated that in three examples you were able to get the cooperation of the companies and in two instances refunds were made—rather significant refunds. Now the companies that actually insured as contrasted with the agents out in the field, did the companies indicate that they were totally un-

aware of the kind of conduct that their agents were pursuing, or did they take part of the blame for their own procedures, or lack of them?

NEED MORE AGENT CONTROLS

Mr. GARCIA. Well, we were very quick to point out that the actions of their agents were the actions of the company. They were not aware in many cases that this was going on. You see, when you spread the problem out among, say, nine companies as I indicated in the first example, you don't have repeaters of the same company. There may have been one or two cases where maybe two different agents of the same company were involved that was not isolated to one company, which makes the regulation or the control of this problem difficult because you have several companies. Even when you standardize, you still would have agents representing different companies over-selling. I really think that more stringent regulations with reference to the agent himself may be the solution so that he is aware that he can't go out and repeat this type of thing.

Another solution might be to some way formulate some kind of an information pooling system between companies so as to cross-index—perhaps the same person would come up with the same type of coverages. If that would be so, then the companies would index it and if there is repetition they can do something with it.

Senator DOMENICI. Do you have authority to do that under your present laws?

Mr. GARCIA. I think we could extend our authority on that point. It is a little complex and we are doing some studies on it now. I don't know how it will come out.

Senator CHILES. I was just interested in what Senator Domenici was asking you. Part of the problem seems to be that there is no real down-hill risk for the companies themselves. They say, "Well, the agent did that, we didn't know, and as soon as we found out we took some kind of action against him." Yet you heard from the testimony—especially our district attorney from Texas today said when he started questioning these agents they said: "There was no way we could do this. If they were paying any attention at all, they would know what we were doing."

Mr. GARCIA. I might answer that this way, if a company in our State were to continue with this type of practice, we do have available to us the authority to convene a hearing to explain why they are continuing these types of practices. The Insurance Unfair Practices Act, which is our statute law—we do have that authority.

Senator CHILES. I think something like that is very necessary to require that the companies exercise some policing power themselves because obviously they really could do it better because they know these fellows.

Mr. GARCIA. The only problem with that, it takes a little time because you have to develop a pattern of practices with the company.

Senator CHILES. Right.

Mr. GARCIA. So far we have not been successful in establishing that kind of a pattern with any one particular company. Several companies have been involved.

Senator DOMENICI. Can you pull the insurance company's license instead of the agent's license?

Mr. GARCIA. Obviously we have to provide them with due process and provide them with a hearing, but that is within our authority.

Senator DOMENICI. You have not had to do this to this point?

Mr. GARCIA. No. I think the meetings that we have had with the companies and the agents have been really informal conferences to discuss the problems and to set forth our desires. In these cases it has been to get refunds from people. I might add that in one or two cases the companies discharged their agents because of these practices and no longer wanted them on the payroll.

Senator DOMENICI. I have one last question with reference to information available to help us arrive at some conclusion as to the dimension of the problem. Do you have, within the recordkeeping capacity of the insurance commission or insurance superintendent's office, knowledge as to how many policies in the area of medi-gap coverage, and what type coverage for cancer and the like are issued in the State of New Mexico?

Mr. GARCIA. That information is available. We would probably have to program the State computer systems or the data processing people to get some help on it. I believe we could get most of that information.

HOW RAMPANT ARE ABUSES?

Senator DOMENICI. I think what we know at this point would indicate that the malfeasance and abuse is going to be directly related to the number of senior citizens who are buying this kind of insurance. It just strikes me that the problem is so difficult that if we could know how many people are buying a typical kind of senior citizen health coverage it would aid us in determining how rampant the abuses are apt to be. Do you think you might request that of the computer system and see if you could get it to us?

Mr. GARCIA. I will sure give it a try.

Senator DOMENICI. I personally would like to have it because I think it would be almost directly related to the kinds of abuses that are out there.

Let me ask you one other question. Do you have any way of assessing how effective your disclosure procedure is? Are you monitoring it in some way? It sounds great and I compliment you for it, as I have publicly in the State, but do you know whether it is having a real impact?

Mr. GARCIA. Well, the only way we know that it is having some impact is in the reduction of the number of complaints. We have no way of really monitoring the results. We do know for a fact that companies that are writing these plans in New Mexico are providing each person who they sell this plan to with this disclosure form. If you will note, the disclosure form is very simple and we wanted to keep it that way so it would be easily understood. We don't purport that it covers all of the problems and answers all the questions, but at least a person has some idea of what they are buying but no way of monitoring the results.

Senator DOMENICI. One last question. Do you prohibit, at this point, any kinds of coverage? You have previously heard the insurance commissioner say that in Connecticut they prohibit several

kinds because they conclude, as a matter of public policy, they are useless, I assume.

Mr. GARCIA. No, we don't prohibit any of them. However, that is under study in the department now and we would like to consider that further.

Senator CHILES. We thank you very much for your appearance here and for the work that you have done in New Mexico. We look forward to continuing to work with you on this problem.

Mr. GARCIA. Thank you very much.

Senator DOMENICI. Thank you very much.

Mr. GARCIA. I might add that being last has some advantages. I have the committee almost to my self, it looks like. And some disadvantages. Everybody has already talked about some of the things I was going to talk about.

I thank you very much.

Senator DOMENICI. Yes, sir.

Senator CHILES. This will conclude our hearings in this area, but we will keep the record open for approximately 30 days.

Senator DOMENICI. Thank you, Mr. Chairman.

[Whereupon, at 12:45 p.m., the committee adjourned.]

APPENDIXES

Appendix 1

POLICY PLANNING ISSUES PAPER: PRIVATE HEALTH INSURANCE TO SUPPLEMENT MEDICARE, PREPARED BY THE FEDERAL TRADE COMMISSION

(By Anne DeNovo and Gail Shearer, July 1978)

This issues paper expressed only the views of the authors, staff members of the Office of Policy Planning. It does not represent the position of the Federal Trade Commission or any Commissioner. The authors would like to thank Joanne Riley, Dhylia Hughes, and Sharon Lawson for their invaluable assistance in completing this project.

Executive Summary

I. *Description of problems in the market for health insurance for the elderly.*—Health care costs are a major expense item and source of concern for the elderly. Medicare covers only 38 percent of their health care costs. People over 65 must pay for medicare's deductibles and coinsurance and for many kinds of care which medicare will never cover, including drugs, dental care, eyeglasses, hearing aids, routine examinations and most nursing home care. Even after medicare and private insurance, the average per capita health care expenditure for the over-65 age group was $403—much more than they paid out-of-pocket before medicare.

Because of the gaps in medicare, the Nation's elderly have turned to private health insurance; more than 50 percent have at least one policy. The annual premium volume of this medicare supplement or "medi-gap" business is unknown, but it has been estimated at $1 billion. In addition, large numbers of policies are sold to the elderly which are not true medicare supplements, such as hospital indemnity plans and dread disease policies.

The lack of consumer information in the medicare supplement market is so great that it is almost impossible to make rational purchase decisions. Very few people understand the complexities of medicare and its gaps. There is no standardization of private insurance policies, so buyers cannot comparison shop. As a result, supplemental policies often do not compete on price and offer only a low rate of return.

In an effort to get complete protection, many people over 65 buy two or more policies which overlap. An estimated 23 percent of those who do buy private health insurance have some unnecessary duplication in coverage. Unscrupulous agents selling door-to-door or mail order advertisements often mislead or frighten them into "loading up" on two or more policies or replacing policies each year, a practice known as "twisting." When they file claims, many of them find that the coverage they thought would fill all the gaps in medicare falls far short of their expectations. Most supplemental policies will not pay for pre-existing conditions or the major gaps in medicare, such as nursing home care, excess provider charges and prescription drugs.

II. *State regulatory initiatives.*—In response to complaints, several States have tried very different regulatory solutions to the medicare supplement problem. A recent Wisconsin rule requires that all policies marketed as supplements to medicare meet the standards for one of four benefit levels and bear a number one through four (from most to least comprehensive coverage). At the time of their initial contact with a prospect, insurers and agents must distribute an 18-page booklet prepared by the insurance commissioner's office,

which gives advice about medicare, its gaps, the four categories and insurance buying in general.

California has established three descriptive categories for supplemental policies: in-hospital only, in- and out-of-hospital and catastrophic. The California Insurance Department has also set a benchmark minimum loss ratio of 55 percent. Insurers must deliver a one-page form with very general disclosures along with their policies.

In Illinois, a statute prescribes minimum standards for supplemental policies but does not provide for any special disclosures. Oregon, New Mexico, and Washington require delivery of a two-page disclosure form with medicare supplement policies. Each agent or insurer is supposed to fill in the blanks on a chart to show which medicare gaps the policy will fill. Unlike Wisconsin and California, they do not have any regulation which sets minimum standards or tends to standardize coverages.

In Colorado, agents and insurers must furnish a warning notice when the sale would involve an addition or a replacement.

III. *Policy questions surrounding regulation of health insurance for the elderly.*—It may be appropriate for the Federal Government to play a major role in this area because its own medicare program created the problem and because a uniform system of standardization is necessary to reduce buyers' confusion. The medicare supplement market also furnishes an opportunity to study and plan for the supplemental market which will develop under national health insurance.

Governmental initiatives could address medi-gap or true medicare supplement policies only, all health insurance policies sold to the elderly or all individual health insurance. The second approach would be most likely to eliminate the purchase of "unnecessary" duplicate coverage by the elderly.

Policymakers must also decide whether they should seek to provide a great deal of information for the sake of accuracy or simple disclosures, whether they should attempt to standardize coverages or permit unlimited variety and whether they should distinguish between "good" Medigap filling, such as catastrophic coverage, and "bad" coverage such as reimbursement of the initial deductibles.

IV. *Policy objectives and criteria for assessing options.*—In order to promote competition, any initiative with respect to supplemental insurance should provide complete information in a usable form, ensure access to that information, standardize coverage and eliminate duplication. To correct market failures, an action should also assure a reasonable return, minimize the opportunity for marketing abuses, ensure prompt and fair claims handling and minimize undesirable side effects. Alternatives should also be politically feasible, easy to enforce, inexpensive to administer and complementary with national health insurance.

V. *Public policy alternatives.*—Governmental action with respect to health insurance for the elderly could take three principal forms: minimum standards; a system of standardization combined with disclosures or labels; or provision of information to consumers.

In the minimum standards category, minimum loss ratios could eliminate low-value policies from the market. Uniform language in clauses which include pre-existing conditions could reduce buyers' confusion and companies' unjustified denials of claims. Other options are a requirement that policies supplement both parts A and B of medicare, minimum dollar limits and mandated benefits.

Options for standardization combined with disclosures include prohibiting references to indemnity and limited polices as medicare supplements, establishing descriptive categories (the California model), setting up benefit levels (the Wisconsin model), or using a system of unit pricing. Another method, a cost index, could provide a more accurate measure of a policy's value than the first three options, but it would be an extremely complex task to devise one.

In the third category, many forms of mandatory written disclosures are possible, but they may be ineffective because health insurance to supplement medicare is such a complex subject. Alternative consumer education measures are a buyer's guide, providing information which is not now available, use of non-traditional media such as television and individualized insurance counseling.

Other options which do not fit in any one of the three categories include regulation of advertising, requiring direct contact between the insurance company and its customer, and imposing a fiduciary duty on agents and claims

handling requirements on insurers. The last possibility, Federal Government sponsorship of optional medicare supplement insurance, would permit the Government to realize certain cost advantages, although the extent of coverage and the subsidy element required would be subjects of debate.

VI. *Policy recommendations.*—The writers of this issues paper recommend that an impact evaluation be conducted to determine the effectiveness of existing State regulations of insurance sold to supplement medicare. Such an impact evaluation would yield information about whether and how standardization might bring about competition in this market, and might also lead to recommendations for other consumer protection measures. If possible, the study should be a joint project with the participation of HEW, the NAIC, and the FTC; each has special expertise to contribute in this area.

I. DESCRIPTION OF PROBLEMS IN THE MARKET FOR HEALTH INSURANCE FOR THE ELDERLY

Because medicare does not provide complete coverage for their health care expenses, more than 50 percent of people over 65 purchase private insurance in an effort to fill medicare's gaps. At the end of 1975, 12.6 million held at least one supplemental policy.[1] Estimates of the premium volume of this medicare supplement business run from $0.5 to $1.0 billion per year.[2] Total expenditures for health insurance by the elderly may be considerably more than $1 billion, since this estimate probably does not include hospital indemnity or dread disease coverage, and is based on figures from 1974. No official information exists about total premium volume because insurance companies are not required to separate medicare supplement figures when they file individual accident and health data with State insurance commissioners.

A Background: Health Care Expenses of the Elderly and Sources of Funds

1. Health Care Expenditures

The elderly have to spend much more on health care than the rest of the population, due to their more frequent illnesses and the greater expenses of their care, which often involves hospitalization. In fiscal 1976, the average per capita expenditure for health care by people over 65 was $1,521—almost three times as much as adults aged 19–64 ($547) and nearly six times as much as young people under 19 ($249).[3]

Medicare, medical assistance, and other government programs paid 67.6 percent of those expenses. Private health insurance, the subject of this paper, covered only 5.4 percent. Elderly patients and their families were left to pay

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[1] The Health Insurance Institute of America states that in 1975 12.6 million people aged 65 and over had some hospital expense coverage to supplement medicare benefits. HIAA data also shows that 10.4 million had some surgical expense coverage, 9.7 million had some regular medical expense coverage, and 2 million had some major medical expense coverage. HIAA's tables eliminate duplication occurring where more than one insurer or more than one policy affords the same kind of coverage. Health Insurance Institute of America, *Source Book of Health Insurance, 1976–77* 10, 21–31. The 1974 national health survey of 40,000 households reported that an estimated 53.8 percent of those 65 and older had private hospital insurance coverage in addition to medicare. See 52 *Hospitals* (Journal of the American Hospital Association) 20 (May 16, 1978).

[2] The author of a working paper prepared in 1974 for the use of the Senate Special Committee on Aging estimated the annual premium volume at $0.5 billion by assuming that all elderly paid the same rates for non-Blue Cross policies as they did for Blue Cross coverage and that they all chose low cost options. Therefore her estimate was almost certainly low. See G. Ellenbogen, *Private Health Insurance Supplementary to Medicare* (a working paper prepared for the Senate Special Committee on Aging) 1, n.2 (1974) [hereinafter Senate Committee print]. Consumer Reports repeated the $0.5 billion figure in 1976. See Health Insurance for Older People: Filling the gaps in Medicare, *Consumer Reports* 27 (January 1976) [hereinafter *Consumer Reports*]. Insurance Commissioner Harold Wilde of Wisconsin estimates that senior citizens spend somewhere between $0.5 billion and $1 billion each year on private insurance to supplement medicare. H. Wilde, "Medicare and Medi-scare: The Responsibility of Government and the Insurance Industry," speech to the Milwaukee Association of Life Underwriters (December 15, 1977) [hereinafter "Mediscare"]. In September 1977, slightly more than 50 percent of the companies then writing medicare supplement policies in Wisconsin responded to a survey conducted by Commissioner Wilde's office. They reported premiums totalling $22 million.

[3] Gibson, Mueller and Fisher, Age Differences in Health Care Spending; Fiscal Year 1976, 40 *Social Security Bulletin* 1, 5 (August 1977) [hereinafter Age Differences]. Elderly Americans, who make up slightly more than 10 percent of the population, accounted for 28.9 percent of all personal health expenditures.

26.5 percent of the bills themselves. Their out-of-pocket expenditures averaged $403 per person—much more than they paid before medicare.[4]

2. *Medicare Gaps*

Medicare, the Federal Government's health insurance program for the elderly,[5] paid only 38 percent of health care expenses in 1976.[6] Although the medicare program was enacted to assure that senior citizens would have access to basic health care, especially in hospitals, it was never intended to cover all their expenses. At hearings held in 1965 on a proposal for medicare, the Secretary of HEW stated:

"The proposed program will serve as a foundation on which people can build greater protection through private health insurance and employer retirement plans, just as the present social security cash benefit system is serving as a base on which people build additional protection through private means."[7]

Medicare has never covered certain types of care. Furthermore, the medicare deductibles which patients must pay have been constantly increasing, and in general, medicare patients have borne a large portion of the inflation of medical costs. One commentator has characterized the result as "a cutback implemented without legislative or administrative action."[8]

Some explanation of Medicare is helpful in understanding exactly what it does not cover. The program has two parts. The first, part A hospital insurance (HI) helps to pay for in-patient hospital care, care in a medicare-approved skilled nursing facility or SNF, and some home health care.[9] Most people over 65 also enroll in the second part of the program, part B supplementary medical insurance (SMI), which covers physicians' services, outpatient and other non-hospital care.[10]

A chart showing medicare benefits and gaps appears as appendix A to this report.

(a) PART A GAPS

Hospital care accounted for 45 percent of the health care expenditures of the elderly in 1976. Medicare paid for 71 percent of their hospitalization expenses,[11] but medicare patients must pay the following expenses themselves:

(1) An initial deductible set to correspond to one day's hospital stay—$144 in 1978. Medicare then pays all charges until the 60th day of the hospital stay.

(2) From the 61st through 90th days, the patient must pay a daily deductible of $36 in 1978.

(3) After the 90th day the patient has 60 "lifetime reserve days" which can be used only once in her life. For each reserve day she pays a $72 deductible in 1978.

(4) After a patient has used up her 60 lifetime reserve days, medicare part A coverage ends. But only 0.03 percent of hospitalized medicare beneficiaries

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[4] *Id.* at 9. Philanthropy and industry paid 9.4 percent of the elderly's health care expenses. The $403.53 average out-of-pocket per capita expenditure does not include medicare part B premiums or private health insurance premiums. In 1966, before the institution of medicare coverage, the average per capita out-of-pocket expenditures for the over-65 age group was $236.72. This article includes figures for 1974, 1975, and 1976. For similar compilations for the fiscal years 1966-1974, see U.S. Department of Health, Education, and Welfare, *Compendium of National Health Expenditures Data* at 110-111 (1976).

[5] Title XVIII of the Social Security Act, 42 U.S.C. Sec. 1395. Medicare also covers people under 65 who have been disabled (as defined by the Social Security Administration) for at least 24 months and those with chronic renal disease. SSA estimates that in fiscal 1978 23.6 million aged, 2.4 million disabled and 24,000 renal disease patients will be enrolled in part A of the medicare program. Congressional Budget Office, Congress of the U.S., *Catastrophic Health Insurance* 25 (January 1977) [hereinafter *Catastrophic Health Insurance*].

[6] Age Differences at 10. Medicare's share would be 43 percent but for the part B premiums paid by beneficiaries.

[7] *Medicare Gaps and Limitations*: Hearing before the Subcommittee on Health and Long-Term Care of the House Select Comm. on Aging, 95th Cong., 1st Sess. 36 (1977) (appendix I: "The Aged and their Health Expenditures").

[8] Schneider, Medicare: Beneficiaries, Cutbacks and Supplements, 9 *Clearinghouse Rev.* 552, 553 (December 1975).

[9] See generally Department of Health, Education, and Welfare, Social Security Administration, *Your Medicare Handbook* 10–19 (January 1977) [hereinafter *Your Medicare Handbook*]. Part A is financed largely through social security employer and employee taxes. People over 65 who were in the social security or railroad retirement programs are automatically enrolled in part A. Others may purchase part A hospital insurance for a monthly premium—$54 until July 1, 1978.

[10] In 1975 97.4 percent of the elderly people covered under part A were also enrolled in part B.

[11] Age Differences at 11, 13.

ever reach that point.[12] Many of the hospitalization expenses not covered by medicare are due to the following gaps in part A coverage.

(5) Nursing home care. While 23 percent of the health expenditures of people over 65 goes for nursing home care, medicare only pays for a small percentage of those expenses—3.6 percent in 1976.[13] The medicare program places the following limitations on nursing home coverage:

(i) The patient must be in a skilled nursing facility (SNF) approved by the medicare program. State licensure of a nursing home is not sufficient for medicare reimbursement. Care in SNF's or intermediate care facilities (ICF's) which are certified by medicaid but not medicare is not covered. Availability of medicare-approved SNF care varies widely from State to State; in some regions it is almost impossible to obtain.[14]

(ii) Five conditions must be met, including physician's certification of need for skilled services.[15] If a utilization review committee or PSRO decides that skilled care is no longer necessary, medicare will not provide any further coverage.

(iii) Assuming that the patient is in a medicare-certified SNF and has met medicare's five requirements, medicare will pay for the first 20 days of her stay. (However, medicare will not pay for custodial care even if all the other conditions are satisfied. See 8 below.) From the 21st through 100th days, she must pay an $18 daily deductible. Part A coverage for "extended care" ends after the 100th day.

(6) Medicare places a 190 day limit on part A coverage for in-patient treatment in a psychiatric hospital.

(7) Part A will cover up to 100 home health care visits for skilled nursing care, physical therapy or speech therapy visits if six conditions are met (including prior hospitalization, physician certification, and participation in the medicare program by the home health agency).[16]

(8) Neither part A nor part B of medicare will ever provide any coverage for "custodial care," whether it is rendered at home, in a hospital, in a SNF or in some other facility. Custodial care has been interpreted to mean personal care which does not require the attention of skilled or specially trained medical personnel, such as help with walking, bathing, eating, and dressing.[17]

(b) PART B GAPS

Part B covers physicians' services both in and out of hospitals, as well as some diagnostic services by independent medicare-certified laboratories and some medical supplies, equipment and devices.[18] In 1976 medicare paid for only 55 percent of physicians' services, which account for 17 percent of the health care expenses of the elderly.[19] Medicare part B enrollees must pay:

(1) An initial deductible of $60 per calendar year.

(2) 20 percent of all charges (after meeting the initial deductible).

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[12] *Catastrophic Health Insurance* at 25 (estimated figure for 1966–71 period).

[13] Age Differences at 10, 11. It is common for institutionalized patients to spend their own resources for their care until they become eligible for medical assistance, which paid 48.4 percent of nursing home costs in 1976. Sometimes their families also pay many of the bills.

[14] As of July 1975, the number of certified SNF beds per 1,000 medicare enrollees varied from 1.4 in Oklahoma, 2.2 in Arkansas and 2.6 in Louisiana to 22.9 in New York, 37.9 in Connecticut and 40.8 in California. In Arizona (the State with the fastest-growing elderly population), there were only 19 medicare-certified SNF's. Staff of the Subcommittee on Health, House Committee on Ways and Means. *National Health Insurance Resource Book* 105 (1976) [hereinafter *National Health Insurance Resource Book*].

[15] The five conditions for part A SNF coverage are: (1) The patient must have been in a hospital for at least 3 consecutive days before her transfer to a SNF. (2) The patient must have been transferred because she needed care for a condition which was treated in the hospital. (3) The patient must be admitted to the SNF within 14 days of leaving the hospital (with certain limited exceptions). (4) A physician must certify that the patient needs and actually receives skilled nursing or rehabilitation services on a daily basis. (5) The SNF's UR committee or PSRO must not disapprove the patient's stay. See *Your Medicare Handbook* at 17–19.

[16] See *Your Medicare Handbook* at 36.

[17] See *Your Medicare Handbook* at 8–9. Since there is no general definition of the term "custodial care" in the statute or regulations, its meaning has been the subject of much litigation. Seen generally CCH *Medicare and Medicaid Guide* paras. 4105, 4110 and 4115 (1976).

[18] See generally *Your Medicare Handbook* at 20–33. Part B also covers some home health care services under specified conditions which are different from the requirements for part A coverage of home health care. *Id.* at 37.

[19] Age Differences at 11, 13.

(3) Any "excess charges" over the level the medicare carrier determines to be reasonable. (Blue Shield plans or other private health insurers, called intermediaries under part A and carriers under part B, administer the program under contract with HEW.) The Social Security Act provides that no payment shall be made under either part A or part B for services or items which are not reasonable and necessary for the diagnosis or treatment of illness or injury.[20] If the part B carrier determines that a physician's charge exceeds the reasonable level, medicare will not pay the excess. In general, the carrier will pay only the lowest of: (i) The physician's actual charge; (ii) the customary charge (usually the median of her past charges); or (iii) the prevailing charge, which is defined as the 75th percentile of the customary charges made in the area for the same service.[21]

Whether the patient bears the cost of any charges which medicare determines to be excessive depends on whether the provider exercised an option to accept assignment of medicare benefits. Under such an assignment, the patient transfers her right to medicare reimbursement to her physician; the physician agrees to accept the reasonable charge determined by the carrier as full payment for her services. When the physician accepts assignment, she cannot bill the patient for any amount the Medicare carrier determines to be excessive.[22]

The number of physicians who will accept assignment has been declining steadily to its present level of 50.5 percent.[23] At the same time, the excess physician charges on unassigned claims have been on the rise. In 1976, they accounted for 9.6 percent of expenditures for physicians' services to the elderly, up from 4.5 percent in 1970.[24] During the second quarter of 1977, carriers reduced the total dollar amount of unassigned part B claims filed with them by 20.7 percent.[25] This means that medicare patients can expect to pay on the average 36 percent of their physicians' bills themselves (20 percent coinsurance plus an average of 20 percent of the remaining 80 percent).

(c) ITEMS AND SERVICES NEVER COVERED BY MEDICARE

Neither part A nor part B ever reimburses for:

—Drugs which can be self-administered (drugs and drug sundries account for 8 percent of the health care expenditures of people 65 and over);
—Dental care (except jaw surgery) (dentists' services account for 2 percent);
—Eye or hearing examinations;
—Eyeglasses, hearing aids, dentures, and many other medical appliances (eyeglasses and appliances account for 1 percent of the elderly's health care expenses);
—Routine physical examinations and routine diagnostic tests performed in connection with such examinations;
—Immunizations;

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[20] Of course the statutory provision is longer than this paraphrase. See 42 U.S.C. Sec. 1862(a). Reasonable charge reductions occur under part A as well as part B, but usually the provider of services cannot bill the patient for excess charges. The "waiver of beneficiary liability" provision states that the patient cannot be held liable for payment for services she did not know or could not be reasonably expected to know were not covered by medicare. 42 U.S.C. Sec. 1395 pp. This waiver provision applies whenever medicare denies or reduces payment for a claim on the grounds that the care was custodial or that it was not reasonable and necessary. What happens when a hospital or nursing home patient gets "PSRO'd out" is beyond the scope of this paper, but generally she and any advocates she may have get at least a few days to make some other arrangements before medicare coverage ends.

[21] This is a gross oversimplification. See CCH *Medicare and Medicaid Guide* Secs. 3190 *et seq.* (1977).

[22] To be more exact, the waiver of beneficiary liability provision operates in the case of assigned part B claims.

[23] In 1969, more than 60 percent of medicare claims were assigned. *Washington Post*, February 11, 1978, at 1. Assignment rates show great variation between regions, from lows of 24.6 percent in Wyoming and 27.2 percent in Oklahoma to levels above 70 percent in the industrial northeastern States. Department of Health, Education, and Welfare, Health Care Financing Administration, *Part B Carrier Workload Report* (October 1977). In general physicians are unwilling to accept assignment if they believe they can collect excess fees from their patients. In addition to possible reductions of their charges, they face delays of up to 9 months in obtaining reimbursement if they accept assignment.

[24] Age Differences at 13–14.

[25] Department of Health, Education, and Welfare, Health Care Financing Administration, *Quarterly Report on SMI* Carrier Reasonable Charge and Denial Activity (April–June 1977). Part B carriers made some reduction of 79.9 percent of the unassigned claims filed, for an average reduction of $18.31 per claim. They reduced 76.4 percent of all assigned claims files by an average of $16.51. Excess charges are expected to reach $0.8 billion in fiscal 1978. *Catastrophic Health Insurance* at 25.

—Most foot care;
—Most chiropractors' services;
—Full-time nursing care at home;
—Homemakers' services or meals at home.[26]

B. Health Insurance to Supplement Medicare—Areas of Market Failure

1. Description of Private Health Insurance Available to Supplement Medicare

Health insurance policies marketed to the elderly are not standardized at all. They fall into three general categories: (a) Medicare supplement or medigap, (b) indemnity, and (c) limited policies.

(a) MEDIGAP OR MEDICARE SUPPLEMENT POLICIES

These terms usually refer to policies whose coverage is designed to fill the gaps in the benefit structure of the medicare program and which pay service rather than indemnity benefits. Sometimes the health insurance industry refers to this gap-filling as "wraparound" coverage.

(1) *No Standardization of coverage.*—Within this category the variations in benefits are almost infinite. Some retiring workers can convert their group coverage to a plan with reduced benefits calculated to supplement medicare. (Usually they have to pay the entire premium themselves on retirement.) In addition, most Blue Cross-Blue Shield plans offer medicare supplement policies, both on an individual basis and as conversion contracts offering continued coverage (at a higher premium) to retirees who had Blues coverage with their employment group. Each of the 77 Blues plans has a different medicare supplement for its State or region, and some have low and high cost options.[27] In 1974, 50.9 percent of the people over 65 with hospitalization insurance had individual or group Blue Cross or Blue Shield policies. An additional 13.9 percent had some other form of group coverage and the remaining 35.3 percent had other individual hospital expense policies.[28]

Many health insurers besides the Blues have marketed medicare supplement policies, and no two are alike. Some policies are available in all States; some only in certain regions or only to members of certain groups. Some mix service and indemnity benefits. Some cover only the part A deductibles without any benefits to supplement part B; some place low dollar ceilings on coverage of the 20 percent coinsurance under part B. At least one company offers catastrophic coverage only, but *Consumer Reports* could only find one company which would write new major medical coverage for people over 65.[29] *Consumer Reports'* charts and the brochure published by the Wisconsin Governor's Council on Consumer Affairs, reproduced as appendixes B and C, show a sampling of the bewildering variety of coverages on the market.[30]

(2) *Inadequate coverage.*—Although the definition of "inadequate" coverage is open to debate,[31] it is indisputable that medicare supplement policies often fail to cover the most important gaps in medicare. None covers physician's charges above the level medicare determines to be reasonable. None covers the items and services medicare will never pay for, such as routine physicals, eyeglasses, and medical appliances. Like the rest of the population, few older people have insurance coverage for prescription drugs or dental care—two important gaps in Medicare. As of January 1, 1975, only 16.9 percent of the population 65 and over had any coverage for out-of-hospital prescription drugs and only 1.9 percent had any coverage for dental care. 15.8 percent had some nursing home coverage,[32] but medi-gap policies usually cover at most the medicare

[26] See generally 42 U.S.C. Sec. 1862(a), 42 C.F.R. Sec. 405.310 and *Your Medicare Handbook* at 42–43. The percentages of total health care spending for the over-64 age group are from Age Differences at 11.

[27] See Senate Committee print at 1, n.1 and *Consumer Reports* at 28.

[28] Percentages derived from table 4, National Health Insurance Resource Book at 235, which also includes data on the number of people over 65 enrolled in different types of plans covering various kinds of physicians' services and other care.

[29] *Consumer Reports* at 27. Illinois Mutual Life & Casualty offers major medical. Guardian Life sells a "catastrophic" Medi-gap policy which does not cover the initial deductibles.

[30] The Wisconsin brochure attempts to compare only 11 of the policies most commonly sold in the State *by agents* in 1977; it does not include policies sold by mail. Forty companies sold medicare supplement policies there last year.

[31] It is possible to argue that any third party reimbursement of providers' charges above a reasonable level is undesirable because it would diminish their incentives to keep costs down. In any event, medi-gap coverages are incomplete in that they do not fill all the gaps. Therefore they are "inadequate" in the sense that they often do not live up to consumers' expectations that their supplemental insurance will pay for all expenses medicare does not cover. See section I.B. 4(d)—coverage not in conformity with expectations.

[32] *National Health Insurance Resource Book* at 232.

deductibles for SNF care. A few offer some non-SNF nursing home benefits (usually indemnity) by rider. None covers custodial care.

Appendix A summarizes in chart form medicare's benefits and its gaps and the medi-gaps which supplemental policies usually will not fill.

(b) INDEMNITY POLICIES

Indemnity policies pay a certain number of dollars per day of hospitalization, regardless of actual charges, whether or not medicare and/or some other insurance actually pays the hospital bills. Often the amounts are so low that they would pay only a small fraction of a day's hospitalization cost. Benefits of $20 to $50 per day are typical, while the average hospital cost per patient per day is now over $150.[33] Although owners of indemnity policies could use the dollars they receive to pay medicare deductibles and copayments, the rate of return on these policies is so low that they would do better to place their money in another form of investment. (See sec. 4(b) below.)

Adults of any age can purchase hospital indemnity policies. However, the companies selling indemnity policies make a special appeal to older people—especially elderly women with low incomes.[34] In the profile of its policyholders prepared for internal use, one company stated:

"* * * future ad copy should emphasize the necessity of coverage, especially when not immediately supported by a spouse * * *. Upper age bracket policyowners are more heavily female than male * * * females at this age may feel more insecure than males concerning health costs and hence purchase the coverage * * *. Ad copy should accentuate that coverage is excellent supplemental coverage to Medicare to the older female who has a lower income." [35]

In their pitch to the medicare eligible, indemnity insurers also point out that their policies have no complicated limitations, exclusions and exceptions, unlike medicare supplement policies, which are geared to medicare and sometimes repeat the statutory exclusions from medicare verbatim. Their advertisements emphasize the fact that medicare was never intended to afford comprehensive coverage and that medicare deductibles go up each year.

They repeat that their policies will pay benefits in addition to Medicare. They even attempt to present duplicate coverage as an advantage. One company included the following in its mail-order solicitation:

"Q. Then, with Magna-Medicare I can be sure I'm completely protected?

"A. Yes. It is the only plan in the Nation that after the first deductible, pays all medicare-covered in-hospital expenses whenever medicare does not * * *. So to be completely protected you must have Magna-Medicare even if you have other plans.

"Q. But then won't I have duplicate insurance?

"A. Magna-Medicare does not duplicate government medicare and pays you in addition to any other insurance you may have now or ever get in the future. If part of your expenses are paid by another plan, you can spend the extra money any way you want * * *." [36]

(c) LIMITED POLICIES

The most commonly sold kind of limited policy is the dread disease policy. It pays benefits, often indemnity, only in the event the insured contracts a certain named disease—most commonly cancer. People of any age may buy dread disease policies, but like indemnity insurers, sellers of cancer policies market them to older people, particularly women.[37] Their advertising plays on the fear, common among the elderly, of burdening family members with astronomical medical bills because of a long illness. Dread disease coverage also overlaps with medicare and any other supplemental coverage a policyholder may have.

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[33] In 1975 the average total expense per patient day was $151.42. U.S. Department of Health, Education, and Welfare, Public Health Service, *Health, United States*, 1976–1977 381 (1977).

[34] *Commercial Health and Accident Industry*, Hearings before the Subcommittee on Antitrust and Monopoly of the Senate Committee on the Judiciary, 92nd Cong., 2d Sess. 591, 829 (1972) [hereinafter 1972 Hearings].

[35] *Id.* at 829. (National Liberty Group.)

[36] *Id.* at 382 (Bankers Life & Casualty Co. of Chicago). This advertisement might well violate many if not all State regulations applicable to all insurance advertising, since it is clearly deceptive to state that the policy pays all in-hospital expenses whenever medicare does not and probably also misleading to say that no duplicate coverage is involved.

[37] *Id.* at 1150. (American Family Life Assurance Co. of Columbus, Ga.)

Consumers Union recommends against purchasing any cancer insurance policies, warning that the ones it had analyzed "offer only fragmentary protection against the cost of treatment." CU also cautioned that "they offer no coverage at all for numerous other diseases that can also be expensive to treat." [38]

2. Marketing

Most medicare supplement insurance is sold by mail or by agents. Both marketing methods are the subject of widespread abuse.

(a) AGENT PRACTICES

State insurance departments receive many reports about door-to-door sales of insurance to the elderly. The most frequent complaints are:

Taking advantage of the physical or mental impairments of the elderly. Some agents circulate lists of the names and addresses of old people who are physically ill or mentally confused, who will buy any policies offered to them.[39] At a hearing held on June 29 by the Senate Special Committee on Aging, District Attorney Wiley L. Cheatham of the 24th Judicial District of Texas, read from such a "goose" list where agents described the approaches they had used to defraud each victim. Some companies list policy exclusions in very fine print or pale gray lettering, both especially difficult for anyone with limited eyesight to read.

Agents like to visit old people who live alone and have no family or friends nearby. It is easier for agents to make people who live in isolation believe that the agents have their best interests at heart when they advise the purchase of several insurance policies.[40]

Twisting or roll over. Often an agent can persuade older people that they need to cancel the insurance they now have and replace it with whatever the agent is selling. Agents have every incentive to do this because medicare supplement policies typically have high first year commissions—65 percent is routine, 100 percent is not unheard of.[41] Some agents try to "roll over" their entire clientele each year.

This practice is particularly unfair because the new policies usually exclude pre-existing conditions from coverage for the first 6 months, sometimes longer.[42] Insurance Commissioner Harold Wilde of Wisconsin has expressed the fear that agents will use Wisconsin's new medicare supplement regulation as a pretext to persuade people to replace their policies, by telling them the old ones are "no good" now that the new rule is in effect.[43]

Loading up. Agents tell people that their present coverage is inadequate and sell an extra policy or two to fill the gaps, which usually results in wasteful duplication.[44] This pitch is especially effective in selling nursing home policies and riders, especially in States where people over 65 are acutely aware that there are few medicare-certified SNF beds.[45]

"Clean-Sheeting." Agents sometimes submit an application for insurance, after obtaining the elderly applicants' signature, which does not mention that the applicant has any pre-existing health problems, although she may have tried to tell the agent about them. The company accepts the risk, then delves

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[38] Cashing In On Fear: The Selling of Cancer Insurance, *Consumer Reports* 336, 338 (June 1978).

[39] "Mediscare" at 8.

[40] Wyden, Oregon Elderly Win Insurance Fight, *Aging* 13, 15 (Nov.–Dec. 1977).

[41] "Mediscare" at 4. Agents commonly tell policyholders that their insurance company is in financial trouble or has already gone out of business.

[42] See *Consumer Reports* at 29 and Senate committee print at 17.

[43] "Mediscare" at 10.

[44] If an agent talks an individual who already has a Medi-gap policy into buying an additional indemnity contract, the second policy will pay indemnity benefits in addition to the other insurance. Indemnity insurers would argue that people could use the "extra cash" they receive to pay medical bills not covered by medicare or other medi-gap insurance. However, the indemnity plans are structured to pay a certain amount per day of hospitalization, not to pay the types of expenses both medicare and supplemental insurance leave uncovered: drugs, nursing home care, many kinds of preventive care. Since people are more likely to incur such expenses when they are not hospitalized, indemnity-type insurance does not meet the need people may perceive to supplement medi-gap insurance they already have.

[45] Medicare and "regular" medicare supplement insurance policies cover only care in a certified SNF, not in any intermediate care facilities or nursing home licensed by the State. Sometimes the nursing home policies which unscrupulous agents sell limit their coverage to medicare-approved SNF's, in which case the purchaser is often paying for unnecessary duplicate coverage.

into the policyholder's past to find the pre-existing condition and deny coverage on the basis of a general exclusion in the policy. This unfair practice is a variation of, and facilitates, post-claims underwriting, discussed in section I.B.4.(d)(i) below.

Other fraudulent practices. Some agents have elderly buyers pay cash or make checks out to the agent instead of the company, then abscond with the money. Sometimes the same agents simply switch companies and repeat the same tactic.

Often agents do not identify themselves as insurance agents; sometimes they try to make people believe that they are "from medicare" or some other service agency or organization. Sometimes they make fraudulent representations that the policy is approved, sponsored or recommended by the medicare program, that the premiums will never go up, or that the policy will cover everything medicare doesn't. They fail to explain or even mention waiting periods and exclusions for pre-existing conditions, leading purchasers to think that their policies will provide 100 percent coverage immediately.[46]

Unscrupulous agents can revise their sales pitches to get around almost any regulation requiring certain disclosures or prohibiting certain representations. They can dilute, discount or disparage mandatory written disclosures in an oral presentation. Often they can turn a newly enacted standard-setting regulation to their advantage by telling people they must buy new policies which conform to the new law's requirements. Thus monitoring agents' conduct is a continuing necessity for effective enforcement of any regulation in the medicare supplement area.

(b) MAIL ORDER INSURERS

Most advertisements and personal solicitations for medicare supplement insurance play to some extent on fear. Mail order companies' advertisements are notorious for their use of scare tactics. Herbert Denenberg, former insurance commissioner of Pennsylvania, has testified:

"Everyone, of course, is terrified at the prospect of major illness, but none more than the elderly. They have finished their work years and have to depend on pensions and social security. A sudden sickness requiring prolonged hospital care will break many budgets.

The mail-order companies prey on the fear of these old people. They suggest to them, in the biggest headlines, that they must have health insurance or they will die in the paupers ward. Or the company reminds them that they certainly don't want to be a burden to their children or relatives. * * * Another effective scare tactic is to push the idea that present coverage is not enough, whatever it is. Hospital costs are skyrocketing, therefore your coverage must be insufficient. * * * This is an effective technique in promoting policies to supplement medicare. * * * Some companies use frightening photographs. Continental Casualty Company likes to illustrate its ads with a picture of a hospital bed. United Fire Insurance Company is fond of wheelchairs. * * *"[47]

A technique commonly used in mail order advertisements is the warning that enrollment will only be possible for a limited time, whereas in fact the company may offer the same coverage in another mass mailing shortly thereafter.

Many of the policies sold by mail are not true medicare supplements tailored to fill the gaps in medicare's coverage; often they pay only indemnity benefits which are unrelated to the gaps in medicare.

The largest mail-order company, Colonial Penn, sells its insurance through the American Association of Retired Persons (AARP) and the National Retired Teachers Association (NRTA). Through AARP, Colonial Penn markets several hospital indemnity policies with limited benefits, encouraging overlapping coverage.[48] The U.S. Postal Service has begun an investigation of AARP's non-profit status, which entitles it to special mailing rates.

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[46] See generally "Mediscare" and Fact Sheet on Medicare and Medicare Supplements (November 1977) (available from the Office of the Wisconsin Commissioner of Insurance).

[47] 1972 hearings at 447. See also Senate committee print at 19–23.

[48] Some of AARP's policies do not cover any of the gaps in medicare part B coverage. Some do not begin to pay benefits until the insured has been hospitalized for 8 days. Any Colonial Penn policy sold through AARP is virtually certain to duplicate some of the coverage of any other health policy a person over 65 may have. Anyone who holds more than one of Colonial Penn's hospitalization plans for AARP members has at least some duplicate coverage. See *Consumer Reports* at 32–34 and Colonial Penn Alleges Errors in CU Report, *Consumer Reports* (April 1976).

In a private lawsuit, a former executive director of AARP has also challenged its relationship with Colonial Penn, alleging a "scheme to persuade and delude the public that the associations (AARP and NRTA) are not insurance marketing devices * * * but rather are democratically organized and independently operated organizations." The complaint also charges that the defendants, including founder Leonard Davis and his close associates, caused AARP and NRTA to "recommend the purchase of insurance policies so as to benefit CPG (the Colonial Penn Group) regardless of the welfare, interests and needs of the associations' members," principally through advertisements in AARP publications and newsletters which appeared to be articles by AARP or NRTA staff members endorsing Colonial Penn's insurance.[49]

3. Inadequate Information

It is very difficult for senior citizens to make rational decisions about their health insurance needs and purchases because they lack the requisite information.

(a) IGNORANCE ABOUT MEDICARE

Most older people know little or nothing about the medicare program. Although they may be aware that medicare does not cover everything, they do not know enough about its gaps to evaluate their supplemental insurance needs. In 1974 the Senate Special Committee on Aging noted "the great need for more intensive educational efforts upon the part of the Federal Government to inform older persons about medicare itself."[50] There is no indication that these efforts have taken place; indeed, some older people may not even file claims for medicare benefits they do not realize they are entitled to.

(b) IGNORANCE ABOUT RISKS

Like the rest of the population, older people generally do not know the extent to which they are at risk for various types of health care expenditures. They lack easy access to information about average hospital cost per day, average hospital length of stay, average annual per capita expenditures for physician charges, or likelihood and length of a nursing home stay for their particular age group. Thus they have no basis for deciding whether they want insurance coverage for each kind of expense. Some low-income elderly may not know that they are eligible for medicaid, which would eliminate or generally reduce their need for private health insurance. In many States, medicaid programs cover all or almost all the health care expenses of eligible individuals. Even in States which require medicaid recipients to pay some of their medical bills, there may not be any coverage available to fill those gaps, because medicaid programs usually cut back on the same services that neither medicare nor supplemental insurance covers (dental care and dentures, hearing aids, eyeglasses, small copayments for prescription drugs).[51]

(c) NON-STANDARDIZED COVERAGES

Since medicare supplements and other insurance policies commonly sold to the elderly are not standardized, it is often impossible to compare coverages.

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[49] *Miller* v. *Davis et al.*, complaint filed May 2, 1978 in the Superior Court of the District of Columbia, paras. 12 and 47. See also Two Non-Profit Organizations Accused as a 'Cover', *Washington Post*, May 3, 1978 at A2, col. 1.

[50] Senate committee print at iv; see also 24.

[51] The kind of care covered by medicaid or medical assistance programs varies from State to State. Federal law mandates that all State programs pay for certain types of services, but States may elect to offer a higher level of benefits. For an illustrative list of State medicaid cutbacks instituted during the period from January 1 through October 1, 1975, see *Medicare Gaps and Limitations*: hearing before the Subcommitte on Health and Long-Term Care of the House Select Comm. on Aging, 95th Cong., 1st Sess. 45–50 (1977) (appendix I: "The Aged and their Health Care Expenditures," sec. II. D: "Experience of the aged with Medicaid."). Some cutbacks involve services which would be covered by medicare anyway for elderly individuals, such as in-patient hospital care; they would not affect the need for supplemental insurance. In States where medicaid pays all health care expenses, an eligible person obviously needs no health insurance. Even where a State medicaid program is limited to the statutorily required benefits, supplemental medi-gap coverage necessarily involves a high degree of overlap, which is particularly unjustifiable for people living on very low incomes. Indemnity policies will, of course, pay benefits even to medicaid recipients who have not had to make any out-of-pocket expenditure for their health care. But State medicaid programs may consider indemnity benefits as income to the recipients, possibly endangering their eligibility status or subjecting them to penalties for fraud if they neglect to report the indemnity payments as income.

Even where two of the available policies have roughly comparable benefit structures, they may be so complex that comparing them may not be cost-justified.

(d) SPECIAL LIMITATIONS OF THE ELDERLY

Some older people may have vision or hearing limitations which make it more difficult to get information. Some may have reduced attention spans or impaired memories. Many do not even realize that they have been victimized until the time comes to make a claim. Even then many are reluctant to complain and some of those who do make poor witnesses.[52]

(e) NO SOURCES OF INFORMATION

Very few people outside the insurance industry are at all knowledgeable about insurance matters. In addition, the elderly, especially in rural areas, often lack advisers and advocates. As a result, the insurance agent or mass mailing may be the only source of information about supplemental insurance available to an older person. Although family members offer assistance when they can, their knowledge about insurance and medicare is usually far from complete. And some old people have no family to turn to.

4. Consequences of Inadequate Information

Because they do not have sufficient information about insurance to supplement medicare, senior citizens end up wasting a large portion of the $0.5 to more than $1 billion they spend on it each year. The following characteristics of the market indicate its failures.

(a) NO PRICE COMPETITION

The lack of standardization and the complexity of the coverages available make comparison-shopping almost impossible. Therefore supplemental insurers do not compete on price. In Wisconsin in 1977, for example, Blue Cross' relatively comprehensive medicare extended policy sold for $95.40/year. The premium for Reliable's much more restricted elder care series III plan was $200/year for people under 75, $236/year for those 75 and over.[53]

(b) LOW RETURN

Medicare supplement insurance policies pay back in benefits only a relatively low percentage of dollars paid in premiums. Loss ratios for hospital indemnity, nursing home and low-value medicare supplement policies run around 40 percent. Expense factors of 50–60 percent are not uncommon. The highest loss ratios for individual medicare supplement policies are between 70 and 80 percent. In contrast, Blue Cross-Blue Shield group health insurance plans usually have loss ratios of 85–90 percent.[54]

Not only do medicare supplement premiums return relatively little value; they also take a large share of the fixed incomes of the elderly, typically between 5 and 10 percent for those people who choose to buy them.[55]

(c) DUPLICATE COVERAGE

Lack of standardization, consumer ignorance about medicare and insurance and agent incentives combine to produce unnecessary overlaps in coverage. The extent of this duplication is unknown. However, the Social Security Administration has estimated that in 1972, 2.6 million of the 11.2 million people who had some hospitalization coverage to supplement medicare held more

[52] "Mediscare" at 7.

[53] In some cases differences in underwriting criteria might explain price differences. The two insurers cited in the example do not refuse coverage to poor health risks, although they may exclude coverage for certain existing conditions or some applicants. See appendix C to compare benefits available under the two policies.

[54] "Mediscare" at 4–6.

[55] This estimate was calculated as follows: The national median income for unrelated individuals over 65 was $3,495 in 1976. In 1977, 1 year later, the annual premium for the most comprehensive medi-gap policy in Wisconsin (WPS medicare plus $22,500) was $342. Most other annual premiums were in the $200–300 range while the cheapest widely sold medicare supplement (nonindemnity) policy was Blue Cross' medicare extended at $95.40/year. Since many people had duplicative coverage, an estimate of 5–10 percent is not unreasonable. In addition they must pay a medicare part B premium of $92.40/year.

than one policy covering hospital costs, so that at least 23 percent had duplicate coverage.[56]

Confusion may lead consumers to buy two or more policies in an effort to obtain complete coverage. But medi-gap policies generally include coordination of benefits clauses. This means that in the areas of overlap, only one policy will pay for each gap. For instance, a person who buys three policies which cover the $144 part A deductible will not receive a windfall of $432 in the event of hospitalization. Only one of the policies will pay $144. The buyer has wasted the portion of the other two premiums which paid for the duplicate coverage of the initial deductible. Those elderly persons who live on fixed incomes can ill afford to spend their money on such worthless duplication.[57] Indemnity policies will, of course, pay benefits without regard to any other insurance a policyholder may have.

Cases have been reported where a single individual held six or more policies and paid over $1,000 annually in premiums.[58] At a hearing held May 16 by the Senate Special Committee on Aging, a witness testified that agents from a single company sold his 67-year-old mother 17 insurance policies in a 2-year period, so that she was paying 68 percent of her income in premiums when he discovered her predicament.[59]

(d) COVERAGE NOT IN CONFORMITY WITH EXPECTATIONS

Contrary to policyholders' expectations, even the better medicare supplement policies leave some major gaps uncovered (See sec. I.B.1(a)(ii)—Inadequate Coverage). As a consequence of the way medicare supplement insurance is marketed, many older people think they have much more extensive coverage than they actually do. Advertisements and agents tell them a policy will cover everything medicare doesn't.[60] They believe it because no other mechanism exists to provide them with usable information about what benefits it really will pay. Common areas of misunderstanding are:

(1) *Preexisting conditions.*—A clause excluding coverage for pre-existing conditions gives the insurer the right to refuse to pay any expenses for conditions or illnesses which began before the effective date of the policy. A strict interpretation of these clauses can lead to denials of claims for any illnesses developing out of conditions (such as hypertension) which existed before the policy went into effect. Since many elderly people have multiple health problems, "pre-X" clauses can make coverage so limited as to be meaningless for some of them. Insurance companies often use "pre-existing conditions" as a pretext for rejecting claims in a totally arbitrary manner.[61] Since people cannot know in advance to what lengths a company will go to deny claims because of pre-existing conditions, they can never be certain of what their coverage is worth.

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[56] Senate committee print at 7–8. Apparently the Social Security Administration stopped estimating duplication after 1972. See National Health Insurance Resource Book at 239. In 1974 the National Health Survey of 40,000 households yielded an estimate that 53.8 percent of those 65 and older had private health insurance in addition to medicare and that 12.1 percent of them had two or more plans. See 52 *Hospitals* (Journal of the American Hospital Association) 20 (May 16, 1978).

[57] Senate committee print at 16–17.

[58] See "Mediscare" at 6 and Wyden, Public Regulation of Private Supplements to Medicare and Medicaid in Oregon, 9 Conn. L. Rev. 450, 452, 456 (1977) [hereinafter Wyden].

[59] Statement of Robert E. Lowry from Raleigh, N.C., before the U.S. Senate Special Committee on Aging at a hearing on Medi-Gap: Private Health Insurance Supplements to Medicare, May 16, 1978. Senator Lawton Chiles, who presided at the hearing, also read a letter from an 87-year-old woman who had been sold 19 health insurance policies in 1 year's time, by six different agents.

[60] See, e.g. *International Security Life Ins. Co.* v. *Finck,* 475 S.W. 3d 363 (Tex. Civ. App. 1971). The court held that a representation that the policy in question would cover everything not covered by medicare was not mere "touting," "in making a sales pitch to an elderly person who does not have and needs hospitalization insurance," but rather an assertion of material fact which the plaintiff relied upon and which entitled him to damages when it proved to be false. 475 S.W. 2d at 369. However, the Texas Supreme Court reversed on the ground that the agent's representations were beyond his authority to make; therefore the plaintiff could not recover actual or exemplary (punitive) damages from the insurance company. He was limited to recovery of benefits due under the insurance policy, plus interest and a 12 percent statutory penalty—$378.19, instead of the $6,596.07 the jury awarded him. *International Security Life Ins. Co.* v. *Finck,* 496 S.W. 2d 544 (Tex. 1973).

[61] See 1972 hearings at 597 and 644–758 for some examples of arbitrary denials. In the *Finck* case, *supra* note 60, the defendant insurance company apparently denied every claim filed, citing a prior existing condition or some other technicality, so that policyholders had to enlist an attorney's assistance in order to collect.

Diversity among pre-X clauses reduces still further the older insurance buyer's chance of comparing policies. Many medicare supplement policies will not cover pre-existing conditions for a waiting period of 6 months or 1 year after the policy has been in force. Some companies exclude coverage for certain conditions by means of riders; the policy will not cover those named conditions even after any waiting period is over. Mail order insurers often accept all applicants without any medical underwriting, then shock policyholders by citing pre-existing conditions as a ground for denial of claims.[62] The language of their pre-X clauses is particularly impenetrable.[63] The practice of denying large numbers of claims from policyholders with pre-existing health problems is known as "post-claims underwriting." Some companies add complications which are almost impossible to ascertain in advance. One Wisconsin policy will never afford any coverage for a pre-existing condition if it was treated during the first 6 months after issuance of the policy.[64]

(2) *Nursing some coverage.*—Purchasers usually assume that nursing home coverage applies to care in any nursing home facility, not just in medicare certified SNF's. One Salem, Ore., 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." [65]

(3) *Excess over reasonable charges.*—People who purchase a policy to supplement medicare expect that when medicare refuses reimbursement for part of a physician's charges, the supplemental insurance will take care of it. When the private insurer denies payment as well, they are surprised and confused.

(e) CLAIMS HANDLING

Elderly policyholders often complain, to state insurance departments and others, that their supplemental health insurance claims were unfairly denied. One cause of this problem is widespread misunderstanding about policy coverage. For example, in one 26-month period, one hospital indemnity insurer paid nothing at all on 30,291 or 38.5 percent of the 78,577 claims received. 12,213 or 15.5 percent were rejected because of a pre-existing condition and 5,660 or 7.2 percent because there was no hospital confinement or surgery as required by the terms of the policy.[66] Where such a large number of claims clearly not within policy coverage were filed, it is evident that many policyholders were completely misinformed (or totally uninformed) about the extent of their insurance coverage.

Claims denials are often simply the events which make older people aware that the insurance they purchased does not meet their needs. But some denials (especially for pre-existing conditions) are surely questionable. Incomprehensible policy provisions and lack of the most basic knowledge about supplemental insurance make it very difficult for older policyholders to challenge arbitrary treatment.

Another source of frequent complaints is delay in settling claims. For unassigned part B claims insureds must file a claim with the medicare part B carrier, wait as long as 6 months for payment or denial, then file a claim

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[62] Senate committee print at 14–15.

[63] In 1972, National Home Life Insurance Company used the following pre-X clause in one of its indemnity policies: "After 2 years from the date of this policy becomes effective for a covered member, hospital confinement commencing thereafter while the policy is in force for such covered member, and as a result of any such condition for which such covered member was medically treated, or advised prior to the effective date, shall be covered hereunder." The president of National Liberty Group explained its effect as follows: "* * * if you had been treated for a heart condition, and you take out one of our policies, for the first 2 years you will not be covered for any heart condition if you go in the hospital." 1972 hearings at 592 (testimony of Robert E. Slater).

[64] WPS medicare plus $22,500, sold by Wisconsin Physicians Service, a Blue Shield plan. In 1977, this policy offered the most complete medicare supplement coverage available; its big selling point was its coverage of out-of-hospital prescription drugs. Many health insurance policies issued to people under 65 require that policyholders go without treatment for a pre-existing condition during the first 6 months the policy is in force in order for that pre-existing condition to be covered. However, WPS considers taking medication for a pre-existing condition during the first 6 months a policy is in force to be "treatment" which would bar any coverage for that condition. For elderly policyholders with conditions which require regular medication (such as hypertension), WPS' coverage diminishes in value when they discover such limitations. (People who enroll in WPS' plan within 3 months of their 65th birthday are not subject to this particularly restrictive pre-X exclusion. Their pre-existing conditions are covered after 1 year even if they are treated during the first 6 months.)

[65] Wyden at 459–460.

[66] 1972 hearings at 598. (National Liberty) More than half the claims paid were less than $100.

with the supplemental insurance company and wait again.[67] Since medicare supplement insurers have little incentive to be responsive to their policyholders,[68] they can and often do pay claims very slowly.

II. STATE REGULATORY INITIATIVES

This section presents an overview of selected State approaches to the regulation of medicare supplement insurance.

A. Types of State Regulation

1. Traditional Approaches

Most States have statutes and regulations of general applicability which could be used in the medicare supplement area. All States have adopted some form of statute governing unfair methods of competition and unfair or deceptive practices in the business of insurance, naming misrepresentation, false advertising, boycott, coercion or intimidation, and unfair discrimination, among others.[69] Most States have more detailed regulations applicable to all advertising of health insurance, and some even specifically prohibit certain kinds of claims in advertising of medicare supplements.[70] However, most courts which have considered the question have declined to imply from such statutes a private right of action for unfair trade practices.[71] At least one court has noted such a state statute's expression of the public policy against misleading or deceptive advertising, in order to support the plaintiff's claim for misrepresentation in an insurer's advertisements for its indemnity plan. However, in such an action the plaintiff is limited to recovery of the benefits due under the policy.[72]

State insurance commissioners have the power the revoke licenses of agents who engage in fraudulent practices.[73] They are also empowered to license insurers to do business in their States and to deny or revoke licenses for failure to comply with requirements for minimum capitalization or reserves or for the reporting or other data.[74]

In addition, some States have the authority to disapprove policy forms which are inequitable, unfairly discriminatory, or misleading—because the benefits are too restricted to achieve the purposes for which the policy is sold, because the language is unnecessarily complex or for other reasons.[75] Some State statutes empower the commissioner to withdraw authorization of policies on a finding that permiums charged are unreasonable in relation to the benefits provided.[76] Some States interpret their statutes as requiring time-consuming individual evaluation of each policy and issuance of a written statement of reasons for disapproval.[77] For that reason this approach has not yet been widely used to ban low-value medi-gap policies.

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[67] When a provider accepts assignment, the claimant has to wait until the carrier issues an "Explanation of Medicare Benefits" form in order to send it along with an insurance claim. Even where the part B carrier and the supplemental insurer are one and the same, federal regulations require separate processing of medicare and private insurance claims.

[68] Elderly people are sometimes reluctant to cancel even when they learn that the policy is not what they thought they were buying or when they are dissatisfied with claims service. They are afraid that they will not be able to obtain any other health insurance because of advanced age or existing health problems.

[69] These statutes are similar or identical to the Model Unfair Trade Practices Act drafted by the National Association of Insurance Commissioners. See 2 *Proceedings of the NAIC* 509 (1960). The model act also provides a means for defining unfair practices in addition to those specifically listed.

[70] See, e.g. Calif. Admin. Code, Title 10, Ch. 5 (Rules and Regulations of the Insurance Commissioner), Secs. 2535 *et seq.*, especially Secs. 2536.2(a) 1 and guidelines 38–40, 2536.2(b)(2) and 2536.9.

[71] See the cases cited in *Crawford* v. *American Title Ins. Co.*, 518 F.2d 217, 229, fn. 32 (5th Cir. 1975) (Godbold, J., dissenting). Judge Godbold noted that in the cases where courts had implied a private right of action, the practice complained of was specifically enumerated in the state's unfair practices act. (He apparently views the *Craver* case, note 72 *infra*, as one supporting the implication of a private right of action only by analogy.)

[72] *Craver* v. *Union Fidelity Life Ins. Co.*, 307 N.E. 2d 265 (Ohio App. 1973).

[73] See, e.g. McKinney's Consolidated Laws of New York, Insurance Law, Secs. 113, 114, 117 and 119.

[74] See Lamel, State Regulation of the Insurance Industry (paper prepared for the U.S. Commission on Civil Rights) 12–13 (April 14, 1978).

[75] See, e.g. Wis. Stat. Sec. 631.20 (1975).

[76] See, e.g. Deering's Calif. Ins. Code Ann. Sec. 10293(a), (1969) (individual hospital, medical or surgical policies).

[77] Conversations with personnel of the Office of the Wisconsin Commissioner of Insurance concerning the requirements of Wis. Stat. Secs. 631.20(a) and (4), where the policy form has already been approved and is on file with the commissioner's office.

2. Standard-Setting: Minimum Loss Ratios

Some States require that individual accident and health insurance policies in general and/or individual medi-gap policies in particular return a certain percentage of dollars paid in premiums to policyholders in benefits. In Michigan the anticipated loss ratio for policies issued to individuals 65 and over must be at least 65 percent.[78] California is raising its "benchmark minimum loss ratio" for policies designed to supplement medicare to 55 percent effective January 1, 1979. Policies with lower loss ratios are deemed not to provide reasonable benefits relative to the premiums charged.[79] Recently, New Jersey Insurance Commissioner Sheeran banned the sale of 133 kinds of individual health and accident policies with loss ratios of less than 50 percent.[80] Many were limited policies which covered only specific dread diseases or certain accidents, a type of insurance marketed especially to elderly buyers. Reportedly, Florida and Nevada also have regulations or guidelines requiring that individual policies have loss ratios of more than 50 percent.[81]

3. Regulations Specifically Applicable to Medicare Supplement Insurance

In response to the volume of complaints from individuals and senior citizen's groups, some insurance commissioners (and State legislatures) have recently begun to devise new solutions specifically for the medicare supplement market. They have taken very different approaches. In general, State regulations which target medicare supplement insurance use one or a combination of three methods: (i) Setting standards or minimum benefit levels; (ii) promoting standardization through labeling; or (iii) requiring disclosures or provision of information by other means.[82]

B. Wisconsin: Four Grades Plus Extensive Disclosure

Wisconsin's new medicare supplement rule, Ins. 3.39, combines a labeling system with a requirement of extensive disclosure. The insurance commissioner's office hoped that it would result in "greater standardization of policies, improved consumer information and elimination of many of the worst policies from the market."[83]

Other States such as Michigan and New Jersey are considering adoption of the Wisconsin model.[84]

1. Standardization: Four Categories

Ins. 3.39 sets up four distinct categories of medicare supplement coverage. As of January 1, 1978, any policy "designed or structured to supplement medicare" must meet the standards for one of four classes of coverage in order to be approved for sale in Wisconsin. Approved policies must then bear a label (called a "designation") such as "medicare supplement 1."[85] Representatives of the insurance industry criticized Ins. 3.39 on the ground that it establishes minimum benefit levels and curtails individual choice. However, the rule does not impose a ban; it provides that no non-conforming policy "shall relate its coverage to medicare or be structured, advertised or marketed as a supplement to Medicare. . . ."[86] Technically, insurers could continue to sell policies which did not meet the prescribed standards as long as they did not present them as supplements to medicare.

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[78] Official Mich. Insurance Rules and Regulations R500.803 (1974).
[79] See appendix J, State of California, Department of Insurance, Decision in the Matter of of the Proposed Amendments and Additions to the Regulations of the Insurance Commissioner Relating to Individual Disability Policies to Supplement Medicare 1–2, 7–8 (March 21, 1978).
[80] See Sheeran Halts Sale of Health Policies, *National Underwriter–Life & Health Insurance Edition*, March 25, 1978, at 1, Col. 1.
[81] Appendix J at 7.
[82] Cf. Colantoni, Davis and Swaminuthan, Imperfect Consumers and Welfare Comparisons of Policies Concerning Information and Regulation, 7 *Bell Journal of Economics* 602 (1976).
[83] "Mediscare" at 10.
[84] Telephone interviews with Patience Drake, Michigan Insurance Department, and with Sharon Szabo, New Jersey Department of Insurance, February 13, 1978.
[85] See appendix D, Wis. Admin. Code Ins. 3.39(1)(a) (July 1977).
[86] Appendix D, Ins. 3.39(4).

(a) BENEFIT STRUCTURE

All four categories of medicare supplement policies are required to cover only "medicare-eligible" expenses. "Medicare eligible" means the same kind of expense that medicare would cover.[87] In other words, insurers need not provide for custodial long-term care, nursing home care outside a medicare-certified SNF, physicians' charges above the amount medicare determines to be reasonable, or any of the less obvious but more sizeable gaps left by medicare.

Policies do not have to include coverage for either part A or part B initial deductibles under any of the four categories. The Wisconsin regulators felt that high premium costs imposed by a first-dollar coverage requirement would outweigh any potential increases in clarification for prospective buyers.[88] Companies may cover the initial deductibles if they choose.

No medicare supplement policy may exclude coverage for pre-existing conditions for a period longer than 12 months after its effective date, unless the condition is specifically described.[89]

A medicare supplement 1, the most comprehensive policy, must cover "medicare-eligible" expenses under both parts A and B, including at least 75 percent of prescription drug expenditures, up to either (i) $22,500 for both parts A and B or (ii) $15,000 for part A and $7,500 for part B.[90] A medicare supplement 2 is similar, except that the minimum dollar ceilings are lower and the policy need not afford any coverage for prescription drugs, psychiatric care, or certain other benefits of limited significance.[91] The standards for a "medicare supplement 3" set still lower dollar limits and remove the requirements for coverage of part B-type home health care, some diagnostic tests and a few other benefits.[92]

The first three categories do not differ markedly except in their dollar limits. It remains to be seen whether companies and consumers will find them sufficiently distinguishable to bring about price competition within each category.

The fourth category is divided into two parts. A "medicare supplement 4A" provides coverage for hospitalization and other part A expenses only, up to a maximum of $15,000. A "medicare supplement 4B" offers coverage for part B-type medical expenses only, up to at least $7,500 per year. A medicare supplement 4B policy may provide catastrophic coverage by including a "corridor deductible" of up to $500, which means that a policyholder would have to pay $500 out-of-pocket before the policy would provide any coverage.[93]

The rule's drafters were persuaded by the industry's argument that a product with high deductibles could supplement part A only or part B only at a low price. They believed that the concept of catastrophic coverage only should be encouraged. They also thought that permitting a policy to supplement part A but not part B and vice versa would not necessarily result in consumer confusion. In an effort to prevent further fragmentation of coverage and reduce the possibility of duplication, a medicare supplement 4A may not include any coverage to supplement part B. Nor may 4B policies supplement part A in any way.

Because of a prior statutory requirement, medicare supplement policies (except 4B) must offer coverage for 30 days of skilled nursing care. This mandated benefit has been the subject of great controversy, because the insurance commissioner has interpreted it to mean that all medicare supplement policies must cover 30 days of skilled nursing care, whether it is rendered in a medicare SNF or any other nursing home.[94]

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[87] Appendix D, Ins. 3.39(3)(c).

[88] One of the authors of this paper, Anne DeNovo, became familiar with the viewpoints of the office of the Wisconsin Commissioner of Insurance during her participation in the hearing and meetings during the drafting process of Ins. 3.39 (as a law student intern with the Center for Public Representation, Madison, Wis.).

[89] Appendix D, Ins. 3.39(4)(a)(2).

[90] Appendix D, Ins. 3.39(5)(a).

[91] Appendix D, Ins. 3.39(5)(b).

[92] Appendix D, Ins. 3.39(5)(c).

[93] Appendix D, Ins. 3.39(5)(d). For a medicare beneficiary to be personally liable for $500 in medical expenses, she would have incurred $2,500 in total bills, because medicare would have paid 80 percent of the total.

[94] See, Warns on Insurance (letter from Harold R. Wilde, commissioner of insurance), *Wisconsin State Journal*, Madison, Wis., Feb. 25, 1978, Sec. 1 at 8, Col. 3; Wilde: Beware cut-rate insurance, *Capital Times*, Madison, Wis., Feb. 27, 1978, and Bruno's Rebuttal to Wilde, *Capital Times*, Mar. 3, 1978. Of the 45,500 skilled nursing home beds in Wisconsin, only 3,400, or 7.7 percent, are medicare-certified. Thus this interpretation of the mandated benefit for 30 days of skilled nursing care, Wis. Stat. Sec. 207.04, represents a very great increase in coverage.

(b) IMPACT

At the end of January 1978, only four of the 40 companies which had sold medicare supplement policies in Wisconsin in 1977 had medicare supplement policies approved for sale in the State in 1978. All five approved policies were in categories 2 or 3 (one company had both a 2 and 3); there were no 1's or 4's. Some insurers had expressed their intention to stay out of the Wisconsin market for a year to see what the effect of the new regulation would be, but by June, five more companies had had their policies approved, including one in category 4A. Eight more had filed policy forms and were awaiting approval.

Price dispersion is evident from the table of policies approved for sale in Wisconsin as of June 12, 1978 which appears as appendex E. Rural Security Life, Blue Cross of Wisconsin, and WPS (Wisconsin Physicians Service, the Madison area Blue Shield plan) sell the cheapest medicare supplement "2" policies, for $185.83, $210 and $211.20 per year respectively. The premium for the only other "2," sold by Reliable Life & Casualty, is $446.00 for ages 65–72, $502 for ages 73–79, and $646 for ages 80 and up. The least expensive policy in category 3 cost $230.28 for all age groups, whereas the two most expensive 3's cost $396 for ages 65–72, $438 or $442 for ages 73–79 and $586 or $594 for ages 80 and over. In general, anticipated loss ratios show a rough inverse relationship to price. In contrast, annual premium amounts increase with first-year agents' commissions.

Reportedly Blue Cross withdrew the medicare supplement 2 policy it had filed for approval upon learning that WPS' "2" policy would be selling for much less than Blue Cross had planned to charge, and came back with a premium about equal to WPS'. In 1977, WPS had sold a medi-gap policy whose coverage almost qualified it for a "1" rating, but in 1978 the company reduced its premium and eliminated some benefits to enter at the "2" level. Some companies doubled their 1977 premiums, blaming the price increase on the new medicare supplement regulation and the mandated benefit for skilled nursing care. The industry maintains that the mandated benefit raises premium costs by $55 per year on the average.[95]

2. Disclosure

Ins. 3.39 also requires the provision of a great deal of useful information about its four categories and medicare supplement insurance in general. Agents must give all prospective purchasers a copy of an 18-page booklet called "Health Insurance Advice for Senior Citizens" at the time they provide them with applications. This booklet is reproduced as appendix F.

The pamphlet, prepared by the office of the commissioner of insurance, explains the four new categories for medicare supplement policies. It includes general information about medicare gaps and insurance to fill them, emphasizing the fact that policies will exclude the same type of expenses that medicare excludes. The pamphlet also warns its readers about common frauds. It also cautions readers not to purchase any private insurance if they are eligible for medicaid and not to replace old policies simply because of the new medicare supplement rule. Commissioner Wilde has made the point that unscrupulous agents can and do use the new policies as a "reason" to persuade people to cancel the ones they have in force—perhaps subjecting themselves to new waiting periods for coverage for conditions they already have or even losing it entirely.[96] The back cover of the booklet is a policy checklist.

In addition to the pamphlet, agents must leave an outline of coverage with people who purchase a policy. The outline of coverage for medicare supplement policies must contain a clearly organized chart summarizing medicare benefits, the benefits the policy provides and the expenses which remain uncovered.[97]

All policies and outlines of coverage are supposed to include a "medicare supplement" label and a short, general caption. The caption should tell consumers to consult the pamphlet and say: "Do not buy this policy if you did not get this pamphlet and were not given a chance to review the outline of

[95] See "Warns on Insurance," note 94 *supra*.
[96] Testimony by Wisconsin Insurance Commissioner Harold R. Wilde, U.S. Senate Special Committee on Aging, hearing on "medi-gap" insurance 10 (May 16, 1978).
[97] Appendix D, Ins. 3.39(4)(b).

coverage provided you." However, the rule does not require that the outline of coverage be signed and returned. Nor does it accord individual consumers any remedy for failure to comply with the disclosure provisions.

3. Limited Scope in Ins. 3.39

The regulation applies only to individual medicare supplement policies, not group coverage or conversion contracts. The commissioner's office feels that it could not apply the rule to group mail order insurers not authorized to do business in Wisconsin without holding a hearing and making certain statutorily required findings of fact.[98]

The standardization provisions of the rule do not apply to hospital indemnity, dread disease or nursing home policies. Each of those policies must make certain written disclosures, including the fact that it is not a medicare supplement,[99] but their sale remains unaffected.

C. California: Minimum Standards, Three Descriptive Categories and Simple Disclosure Forms

Since 1974, California has prescribed minimum coverage standards and the use of one-page disclosure forms for each different type of individual health insurance. The regulations established separate categories for specified disease, hospital indemnity and medicare supplement expense policies. These minimum standards for medicare supplement, dread disease and hospital indemnity policies appear as appendix G, and the original text of the regulations requiring disclosures for those types of policies is in appendix H. California regulations also set a benchmark loss ratio of 50 percent for medicare supplement insurance. The department could presume that policies with lower loss ratios did not afford reasonable benefits in relation to premiums charged and withdraw its authorization for those policies.[100]

In late 1976, the department became aware that some individual supplemental policies were showing loss ratios of less than 50 percent, which was the "benchmark" minimum loss ratio at that time.[101] The department held investigative hearings on medicare supplement insurance in January 1977 and proposed revisions in its regulations in September. The notice of the proposed regulations and additions, dated September 29, 1977, is included as appendix I. The department held further hearings on the proposals in November, and issued final amendments on March 21, 1978, to become effective on January 1, 1979. The text of the revised regulations and the decision of the California Insurance Commissioner which accompanied them may be found in appendix J.

Public witnesses at the hearings were less concerned about the price of policies than their design and solicitation. Many testified that they found their policies incomprehensible and that they had purchased what they thought was complete supplemental coverage, only to discover when they filed claims that it filled only a few medicare gaps.[102]

1. Minimum Standards

(a) MEDICARE SUPPLEMENT POLICIES

The 1972 standards for supplemental policies paying benefits on an expense incurred basis set forth general requirements such as prohibitions of any de-

[98] Appendix D, Ins. 3.39(2). Also, Wis. Stat. 600.91(1)(6) makes the Wisconsin insurance code inapplicable to group or blanket insurance covering risks in the State if: (a) The policyholder exists primarily for purposes other than to procure insurance; (b) the policyholder is not a Wisconsin corporation or other resident and does not have its principal office in Wisconsin; (c) no more than 25 percent of the certificate holders of insureds are resident in this State; (d) on request of the commissioner, the insurer files with the commissioner a copy of the policy and a copy of each form of certificate; and (e) the insurer agrees to pay taxes on the Wisconsin portion of the business on the same basis it would do if authorized to do business in this State. . . . Under Wis. Stat. Sec. 600.01(2), the commissioner may subject such group insurance to the State insurance code, upon making a finding that the foregoing conditions are not satisfied or that circumstances require that the transactions be subject to the code in order to provide adequate protection to Wisconsin insureds and the public.

[99] Appendix D, Ins. 3.39(7), (8) and (9).

[100] See appendix J, State of California Department of Insurance, Decision 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 at 1–2, 7–8, (March 21, 1978).

[101] See appendix D at 1–2.

[102] Appendix J at 2.

ductibles (other than the initial medicare part A and part B deductibles, which did not need to be covered) and any exceptions inconsistent with medicare's exceptions.[103] Any coverage of medicare deductibles and part B coinsurance had to increase automatically whenever medicare raised those amounts.[104] The only permissible exclusions of coverage of pre-existing conditions were for: (i) conditions treated 12 months before the policy's effective date; or (ii) conditions treated 6 months before or 6 months after the effective date.[105] The regulations did allow policies to supplement part A only or part B only.[106]

The 1978 amendments require all medicare supplement policies to fill some of the gaps in both part A and part B of medicare. Insurers need not cover the initial part A deductible, but they must cover the initial part B deductible for any year in which the insured is hospitalized. All medi-gap policies must pay the part A copayments for the 60th through 90th day and the 60 lifetime reserve days of hospitalization.[107] They need not include benefits for skilled nursing care or home health visits, but the amended disclosure forms provide a space for showing those optional benefits.[108] Policies must reimburse part B coinsurance expenditures up to at least $1,000. Although some part B gap-filling is required, coverage of out-of-hospital medical expenses is not mandatory. Nor are companies required to cover physicians' charges in excess of the amount medicare determines to be reasonable, though they may offer a "catastrophic medicare supplement." (See sec. II.C.2(b) below.)

Some insurance company representatives testified that supplements for part A expenses only were their best sellers and that requiring all policies to supplement both parts A and B would make their policies prohibitively expensive. However, the California regulators noted that medicare covers a lesser percentage of medical expenses than hospital expenses and concluded that there is a greater need for supplementation of part B than part A. The final version of the minimum standards reflects their view that some mandatory part B coverage would not necessarily result in excessively high premiums, because insurers may omit expensive coverage of the initial hospital deductible if they choose.[109]

Public witnesses called for a ban on pre-existing conditions clauses on the ground that Medicare does not exclude such conditions from coverage, while industry representatives voiced concerns about adverse selection which would drive up premiums.[110] The department noted that many policies had 6-month pre-X clauses and adopted an amendment permitting only a 6-month waiting period before covering conditions treated 6 months before the policy's effective date.[111]

The department also raised its minimum "benchmark" loss ratio for medicare supplement policies to 55 percent, based on a finding that people over 65 properly constitute a separate class for the purpose of considering reasonable loss ratios, because many of them live on low fixed incomes. The department rejected the proposal that insurers be required to furnish loss experience data for California only, since some policies with small premium volumes in the state might have widely varying loss ratios from year to year.[112]

The amended regulations also require separate identification of medicare supplement policies in reporting loss experience.[113]

(b) HOSPITAL INDEMNITY POLICIES

The 1972 standards set general standards for hospital indemnity policies issued to people eligible for medicare, relating to pre-X clauses and waiting periods.[114] The 1978 amendments increased the minimum daily benefit from $10 to $15.[115]

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[103] Appendix G, Calif. Admin. Code, Title 10, Ch. 5, Art. 5, Secs. 2220.30 (b) and (c).
[104] Appendix G, Sec. 2220.30(f).
[105] Appendix G, Sec. 2220.30(a).
[106] Appendix G, Sec. 2220.30.
[107] Appendix J, exhibit, item 2, amended secs. 2220.30(a), (b) and (c).
[108] Appendix J at 6–7.
[109] Appendix J at 5.
[110] *Id.*
[111] Appendix J, exhibit, item 2, amended Sec. 2220.30(d).
[112] Appendix J at 8.
[113] Appendix J, Exhibit, item 4, amendment to Sec. 2222.12.
[114] Appendix G, Sec. 2220.29.
[115] Appendix J, Exhibit, item 1, amended Sec. 2220.29(a).

(c) DREAD DISEASE POLICIES

California's regulations set special minimum standards for dread disease insurance, although there are no requirements specially applicable to dread disease policies sold to the medicare-eligible. They establish a minimum benefit ceiling of $10,000 or alternative piecemeal minimum benefit ceilings for cancer only policies.[116]

2. Standardization through Labeling: Three Descriptive Categories

(a) THREE UNGRADED CLASSES

Although there was considerable public testimony at the hearings in favor of a grading system for supplemental policies, the California department explicitly rejected the Wisconsin model for two reasons. First, they felt that "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." [117] Furthermore, they believed that a provision of the California insurance code prohibiting the commissioner from prescribing policy forms presented a legal barrier to the creation of a grading system for different levels of coverage.[118]

The final 1978 rules set up three kinds of medicare supplement policies, each with its own special mandatory disclosure form. (See sec. II.C.3 below.) They are: (i) in-hospital expenses only; (ii) in-and-out-of-hospital expenses; and (iii) catastrophic medicare supplement coverage.[119] Apparently the department did not consider the possibility that permitting insurers to limit their coverage to treatment in a hospital (as they may do in category (i)) might not be desirable where the same treatment could be provided at a lower cost on an outpatient basis. There is no mention of this subject in the opinion accompanying the new regulations.

(b) CATASTROPHIC MEDICARE SUPPLEMENT COVERAGE

The department noted the great demand for a supplemental policy which would provide complete coverage, but rejected the idea as unworkable because premiums would be too high.[120] The department believed that in California, medicare beneficiaries bear a greater share of physicians' charges than elderly people in the rest of the country, because fees are higher and part B carriers' reasonable charge reductions are greater.[121] To address this problem, the 1978 regulations include guidelines for a new type of catastrophic medicare supplement coverage, to be administered like a major medical plan. Upon receiving a claim, the insurance company would reach its own reasonable charge determination using its own "UCR" data, just as it would for claims under any major medical plan. Then it would subtract any amounts paid to the insured by medicare and the amount of the "corridor" deductible, which could be up to $1,000. The minimum lifetime benefit ceiling would have to be at least $25,000.[122]

A catastrophic medicare supplement would only be required to cover those reasonable expenses incurred "in the treatment of conditions covered in whole or in part by medicare." [123] Such a policy would not have to pay any benefits for the kind of health care expenses medicare would never cover, such as out-of-hospital prescription drugs, eyeglasses or routine physicals.

As the department admits, it has no authority to require any insurer to offer catastrophic medicare supplement coverage. Nothing in the earlier version of the regulations would have prevented an insurer from offering such a policy if it had wished to do so. The department has expressed the hope that some companies will now begin to offer catastrophic medi-gap policies on an indi-

[116] Appendix G, sec. 2220.24. The recent revisions did not modify the minimum standards for dread disease policies.
[117] Appendix J at 5.
[118] Calif. Ins. Code Sec. 10291.5(g); see appendix J at 6.
[119] Appendix J, exhibit, item 8, amendments to sec. 2540.5(k).
[120] Appendix J at 6.
[121] Telephone interview with Deputy Insurance Commissioner Peter Groom, February 14, 1978.
[122] Appendix J at 6 and exhibit, item 2, amended sec. 2220.30(h).
[123] *Id.*

vidual basis, since apparently some group medicare supplement coverage is now written in a similar manner.[124]

At present policies which supplement medicare part B will pay the coinsurance percentage of the amount medicare determines to be reasonable. The fact that medicare (through its part B carriers) performs part of the claims adjustment process by making the determination of reasonableness first reduces claims adjustment expenses. Requiring duplication of part of the claims adjustment function by the catastrophic medicare supplement insurer might be inefficient.

A representative of the department has also recognized that even if insurers do offer catastrophic medicare supplements, it would be extremely difficult to enforce their obligation to make their own reasonableness determination instead of using medicare's reasonable charge determination.[125] Even if insurers did make an independent decision using their own UCR data, there is no guarantee that the result would differ from the present system or that policyholders would have to pay a small share of provider charges. Medicare part B carriers usually deny charges above the 75th percentile of the customary charge (of all physicians' charges in the area); private insurers generally allow claims up to the 90th percentile.[126] However, for procedures which are not commonly performed, insurers have little data about usual or customary charges and tend to reimburse the same amount that medicare would.

3. Disclosure

(a) PROTOTYPE STANDARD SUPPLEMENTAL DISCLOSURE FORMS

California's Health Insurance Disclosure Act of 1974 established mandatory one- or two-page diclosure forms for different types of disability insurance, included in appendix H. The state legislature declared that "[t]he availability of certain minimum information relative to the benefits, limitations and costs of health insurance coverages in a standard, readily comparable form would assist consumers in making the best choices among such insurance coverages commensurate with their respective incomes."[127]

The regulations promulgated established mandatory "prototype standard supplemental disclosure forms" for use with each kind of health or disability insurance policy.[128] Each disclosure form briefly describes the policy type, the specific benefits available, exceptions and limitations, conditions of renewability and premium.

The original 1974 regulations included disclosure forms for hospital indemnity policies and specified disease policies.[129] Amendments which became effective in February 1976 added mandatory disclosure forms for use with medicare supplement policies.[130] These forms had only been in use for less than a year when the first hearings on medicare supplement insurance were held. At the hearings several witnesses did state that the forms appeared to be working well.[131] The regulations were amended to provide separate disclosure forms for the three classes of medicare supplement coverage: in-hospital, in-and-out-of-hospital and catastrophic.[132] Each form must include the prescribed sentence about each medicare gap, whether or not the policy fills it. The 1978 versions include a section for disclosure of any skilled nursing facility copayment benefit, but it may be omitted entirely if the policy does not cover any SNF care at all.

(b) NEED FOR DIRECT COMMUNICATION BETWEEN INSURER AND INSUREDS

Last September, the California Insurance Department proposed requiring insurance companies to send their policyholders a "followup form" along with new policies. The followup questionnaire was intended to permit insurance

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[124] *Id.*

[125] Telephone conversation with Deputy Insurance Commissioner Peter Groom, *supra* note 121.

[126] See testimony of Michael Pertschuk, Chairman, Federal Trade Commission, Before the Subcommittee on Oversight and Investigations, Committee on Interstate and Foreign Commerce, U.S. House of Representatives 7, 8 (March 21, 1978) (discussing Blue Shield plans' choice of UCR as a payment mechanism and its effect on prices charged by physicians).

[127] Appendix H, title 10, Ch. 5, Sec. 2540.1.

[128] Appendix H, sec. 2540.3.

[129] Appendix H, secs. 2540.5(e) and (i).

[130] Appendix H, sec. 2540.5(k).

[131] Appendix J at 3.

[132] Appendix J. exhibit, item 8, amended sec. 2540.5(k).

companies to set up a direct line of communication with their policyholders and to monitor the selling activities of agents. Insurers would have been required to summarize the coverage provisions, to ask about replacement and the agent who sold the policy, and to extend an offer of rescission to dissatisfied buyers.[133]

The department eliminated the followup inquiry from the final 1978 amendments because of unfavorable testimony at the hearings. Industry representatives objected that the response rate of policyholders to written communications is always low (usually below 50 percent), that the followup form would overlap with their required disclosure form and confuse insureds, and that insurers were not given any guidance about what to do with the information they would collect.[134] The department therefore rejected the idea of a mandatory followup form, but recognized that purchasers of medicare supplement policies need to be able to bypass agents and contact their insurance companies directly. To that end the 1978 amendments require that the standard disclosure forms give the name, address and telephone number of the insurer's representative or general agent (other than the agent who sold the policy). The insurer must specify a toll-free 800 number unless its representative is located in California.

In addition, the new regulations impose the duty on insurers to set up affirmative procedures to ensure that the required disclosure forms are delivered. Acceptable procedures include attaching them to policies issued in the field, requiring return of copies signed by prospective purchasers or requiring return of separate signed acknowledgments of receipt in cases where the prospect sends the application directly to the insurer. Insurers are free to develop other reasonable procedures.[135]

(c) READABILITY

The department's general objective was to make the required disclosure forms complete yet short and readable. Complaints about complex and incomprehensible medi-gap policies were also a matter of concern. The opinion accompanying the 1978 regulations concluded: "Complicated design will always be a problem with medicare supplement policies because of the complexity of medicare, but it is obvious that insurers have made little effort to simplify the text of such policies." [136] Although the California commissioner lacks statutory authority to set readability standards for policies by rule, he does require that Flesch Readability Test scores accompany all new submissions of individual health policies and riders, in the hope that this requirement will at least call insurers' attention to the problem. One company has submitted for approval an easy-to-read in-and-out-of-hospital medicare supplement policy. According to Flesch test scoring, it would be understood by the 90 percent of the U.S. population who have attained a sixth grade reading level.

4. Scope

Unlike Wisconsin's Ins. 3.39, the California regulations apply to all individual health insurance policies issued to the elderly.[137] In addition to policies issued to individuals over 65, they govern conversion contracts by which some employees may convert their employment group coverage to individual policies when they retire. (Although the premiums are often much higher, conversion permits people to keep the same level of benefits and avoid exclusions or waiting periods for pre-existing conditions.)[138] However, the California department's disclosure requirements and minimum standards do not seem to apply to out-of-State mail order group health insurance policies. The department does not believe that it could make those regulations applicable to group mail order or other group insurers where the master policy is issued in another jurisdic-

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[133] Appendix I, proposed art. 8 (medicare supplement followup form), secs. 2192 and 2192.1-2192.5.

[134] Appendix J at 3.

[135] Appendix J at 9 and exhibit, item 8, amended sec. 2540.5(k).

[136] Appendix J at 10.

[137] Calif. Admin. Code, title 10, ch. 5, secs. 2219 and 2220.1. The requirement that Standard Supplemental Disclosure Forms be used applies to both individual and group policies, see appendix M, secs. 2540.1 and 2540.2(a), but not group policies not issued in the State of California. See note 139 *infra* and accompanying text.

[138] For the medicare-eligible, there is no duplication between a conversion contract and medicare. By the operation of coordination-of-benefits clauses, the conversion contract would function as a medi-gap policy, paying only those covered expenses which medicare did not cover.

tion. It views this legal constraint as a serious problem because of the inadequacy of some of the products sold by mail to California residents.[139]

A proposed amendment would have warned consumers on the disclosure forms that out-of-state group insurance plans might not be subject to California laws.[140] The department dropped this requirement after witnesses pointed out that it might lead Californians to report complaints about mail order policies to the insurance commissioner of the State where the master policy was delivered.[141] The California regulators apparently decided that their interest in receiving all complaints about insurers doing business in their State outweighed whatever beneficial effect the warning might have had in discouraging the purchase of policies by mail.

Different regulations apply to medi-gap, hospital indemnity and dread disease policies. Under the 1978 regulations, hospital indemnity policies may not be labelled or described as medicare supplements, "it being accepted that this type of policy is not a true medicare supplement coverage." [142] As in Wisconsin, the sale of indemnity and dread disease policies to the elderly may continue, though insurers must deliver the disclosure forms with those kinds of policies.

D. Illinois: Minimum Standards Only

The Illinois legislature has enacted a statute which briefly sets forth minimum standards for health insurance policies which "purport to supplement medicare," effective October 1, 1977.[143] The text of the statute is included as appendix K. All medicare supplement policies delivered in Illinois must cover: The initial part A deductible; the part A copayment for the 60th through 90th days of hospitalization; the part A copayment for 60 lifetime reserve days of hospitalization; the part A copayment for the 21st through 100th days of SNF care; 20 percent of the amount of physicians' charges medicare determines to be reasonable if the insured is a bed patient in a hospital (with a maximum deductible of $200 and a minimum benefit limit of $1,000).

The medicare supplement benefit structure mandated by the Illinois law leaves a great deal to be desired. Apparently the State legislature either failed to consider or rejected the view that it is undesirable to require expensive coverage of the initial part A deductible. In addition, requiring coverage of the 20 percent coinsurance under part B only for in-hospital care might be inappropriate. Third party reimbursement for inpatient services removes incentives to provide cheaper outpatient care for medicare beneficiaries. By its terms, the Illinois statute applies only to policies issued in that State,[144] so it would not cover the sale of policies to Illinois residents by mail order insurers not licensed to do business there. The statute has a loophole for *new* medicare supplement products. The insurance department may approve a policy for sale as a medicare supplement upon a determination that its benefits "when viewed as a whole, actuarially exceed the standards for this section." [145] Actuarial equivalence, of course, will not eliminate and may increase the confusion of older people faced with varying policy provisions. The Illinois department is currently reviewing each medicare supplement policy it already has on file in order to determine whether it conforms to the provisions of the new law.[146]

Illinois did not attempt to address the information problem by statute or regulation by requiring any special written disclosures in connection with the sale of medicare supplement insurance. Other statutory provisions prohibit

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[139] Telephone interview with Deputy Commissioner Peter Groom, note 121 *supra*. Deering's Calif. Ins. Code Ann. Sec. 41 states: "All insurance in this State is governed by the provisions of this code." The Department feels that the laws of the jurisdiction where a policy is issued are controlling. But see Deering's Calif. Ins. Code Ann. Secs. 1620.1 *et seq.* (Unauthorized Insurance False Advertising Process Act), which gives the commissioner and State courts jurisdiction over unauthorized insurers which advertise to State residents in a way which violates the Unfair Trade Practices Act, Deering's Calif. Ins. Code Ann. Secs. 790 *et seq.*

[140] Appendix I, item 6, proposed subch. 3, art. 12, sec. 2536.8(c).

[141] Appendix J at 8–9.

[142] Appendix J at 4.

[143] P.A. 80-435 (1977), new secs. 363 and 363a of the Illinois Ins. Code. (Smith-Hurd Ann. Ch. 73, secs. 975 and 975a).

[144] Appendix K, sec. 363.

[145] Appendix K, sec. 363(b).

[146] Illinois Department of Insurance, summary of regulatory initiatives, June 1977-June 1978 at 13 (paper distributed at the convention of the National Association of Insurance Commissioners, June 12-16, 1978).

certain representations by advertisements or agents in the sale of medicare supplements and "any other health insurance policy sold to individuals eligible for medicare because of age," which would presumably include indemnity and dread disease policies. For instance, they must make it clear that they are not connected with the medicare program and that they are soliciting the purchase of insurance.[147] However, the statute does not prescribe use of any specific language.

Apparently the Illinois department is now in the process of preparing a pamphlet describing the provisions of the new legislation, targeted for distribution to Illinois senior citizens some time during 1978.[148]

E. Oregon: Disclosure Requirement Only

Oregon has a disclosure rule applicable to the "sale of health insurance providing benefits that supplement Federal medicare insurance benefits," but does not prescribe any minimum standards or standardized categories for medicare supplement policies. The disclosure rule and prescribed disclosure forms are reproduced in appendix L. As of March 1, 1977 every agent or insurer must deliver a two-page disclosure form to the insured not later than delivery of a medi-gap policy, fill in the blanks and sign the form.[149]

(1) Two-Page Disclosure Forms

The first page of the form consists of a chart with three columns. The first column lists medicare benefits and the second tells what portion of each medicare will pay. In the third column, headed "Insurance Policy Pays," the insurer or agent is supposed to fill in blanks describing the policy's benefits.

The second page supplies general information about insurance to supplement medicare, including conditions of renewability. Among other things the second page warns prospects that they will still be obligated for the amounts of physicians' charges and other charges for medical services which exceed the level approved by medicare. It also states that if the policy application contains medical questions, it will cover pre-existing conditions from the date of issue, "generally speaking."

Apparently this sentence refers to the situation where the insurer does apply medical underwriting standards to applicants and may deny an application or issue a policy with specific exclusions (sometimes by rider) if it finds that the applicant has pre-existing health problems. This paragraph may be misleading since it creates the impression that an insurance company which asks medical questions will always consent to cover pre-existing conditions when it accepts an application. More often, such companies will have exclusions or waiting periods for pre-existing conditions in their medicare supplement coverage. This paragraph might lead consumers to neglect to question an agent or check the policy on receipt.

On the second page of disclosures, the Oregon Insurance Commissioner also recommends that buyers check with their social security office about benefits not described in the chart and that they buy only one health insurance policy instead of several limited ones. The second page also says that supplemental insurance is "not recommended" for the medicaid-eligible; many would think the wording of this warning should be much stronger.[150]

The form urges consumers to check to make sure that they have the coverage they thought they bought and if not, to return the policy directly to the company (not the agent) within 10 days for a full refund. This last warning is extremely important, though perhaps insufficient. Agents may, but are not required, to furnish the disclosure forms at the time of their initial contact with prospective buyers. It would be quite possible for an agent to induce a person to apply and pay for insurance by means of misrepresentation or fraud.

The disclosure forms would only arrive in the mail later with the insurance policy itself. In order for the buyer to take advantage of the "10-day free look" privilege, she would have to notice the warning buried at the end of two pages of disclosures, read the policy and discover that she had been the victim of a deceptive or misleading sales presentation.

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[147] Appendix K, secs. 363a(2), (3) and (4).
[148] See note 146 *supra*.
[149] Appendix L, Oregon Admin. Rules-Insurance Division, OAR 836-52-110.
[150] See note 51 *supra* and accompanying text.

(2) Shortcomings

Oregon's disclosure requirement could serve only (at best) "to adequately inform the prospective insured regarding the insurance transaction,"[151] not to standardize or upgrade medicare supplement offerings. It may not even be effective in forcing the provision of sufficient information to prevent Oregon's senior citizens from wasting the money they spend in supplemental insurance premiums.

In May 1976, a coalition of senior citizens' groups and community organizers petitioned Oregon's Insurance Commissioner for rule-making in the medicare supplement area. At first the insurance department refused to hold a rule-making hearing, but changed its mind after the activists' coalition launched a successful drive for statewide publicity of their cause.[152] At the hearing held in September 1976, one insurance industry representative actually admitted that it seemed "inappropriate to attack any proposal which seeks to better inform prospective insureds about their coverage * * *."[153] However, several did attack the rule, and the final version failed to respond to several of the Oregon senior citizens' concerns.

(1) The rule as proposed in their original petition would have required agents selling or attempting to sell supplemental insurance to inquire whether the prospect was eligible for medicaid. If so, the agent would have had to give her a second form describing the benefits available under the medicaid program.[154] The department dropped this requirement. One insurer commented that the Social Security Administration, not insurance agents, should bear the responsibility for informing the elderly about the benefits available from medicare and medicaid.[155]

(2) The disclosure form does not provide any figures about the average length of stay in Oregon hospitals for people over 65. The petitioners had argued that this information was necessary for old people with low incomes to balance a policy's cost against the likelihood of any payoff.[156]

(3) The regulation does not require that the forms be printed in large type, as many witnesses had asked at the hearing.[157]

(4) The section of the chart on the first page which lists the gaps in medicare coverage of care in a skilled nursing facility is misleading. It tells readers to check whether a nursing home "qualifies for medicare," but does not inform them that medicare will never cover a stay in an intermediate care facility.[158]

(5) The insurance department rejected the petitioners' proposed enforcement provision, which would have granted insureds the remedy of rescission for failure to provide the required disclosure statement. The buyer could have opted for rescission of the policy at any time. Within 15 days of the notice of rescission, the company would have had to return all the premiums paid, whether or not it had paid out any benefits.[159]

(6) Enforcement of the disclosure requirement is all the more problematic because of the Oregon Insurance Department's attitude. The coalition has complained that the department has never published any buyers' guides, either before or after the disclosure rule, or publicized it in any way.[160]

(7) Apparently the rule applies both to group and to individual insurance, but it does not clearly state whether it governs the sale of policies by mail to Oregon residents.[161] Nor does it require the provision of any information along with indemnity, nursing home and dread disease policies sold to the elderly.

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[151] Appendix L, OAR 836-105(2).
[152] See generally Wyden, note 58, *supra*, and Wyden, Oregon Elderly Win Insurance Fight. *Aging* 13-15 (Nov.-Dec. 1977).
[153] Wyden, 9 *Conn. L. Rev.* at 456.
[154] *Id.* at 453.
[155] *Id.* at 457.
[156] *Id.* at 458-459.
[157] *Id.* at 458.
[158] *Id.* at 459-460.
[159] *Id.* at 459.
[160] *Id.* at 452, 460.
[161] *Id.* at 457. The Nationwide Mutual Insurance Company of Columbus, Ohio, assumed in its comments to the Oregon Insurance Commissioner that the disclosure regulation would apply to both individual and group, including conversion, policies. However, it appears that the rule might only govern only policies insured in Oregon, since the agent or insurer is not required to supply the prescribed forms at any time before the delivery of the policy. See appendix L, OAR 836-52-110. Hence it probably would not cover mail order sales to Oregon residents by insurers not licensed in Oregon.

F. New Mexico: Disclosure Requirement Only

New Mexico also requires delivery of a two-page disclosure form with medicare supplement policies. As Superintendent of Insurance Manuel A. Garcia has described, in late 1976 and in 1977, the New Mexico department began to receive a large number of complaints about over-selling and inadequate supplemental products.[102] On November 28, 1977, the department sent out the text of its regulation, which became effective on that date, and the prescribed disclosure form, to all insurance companies writing health and accident insurance in the State of New Mexico. In an accompanying letter, Kenneth P. Moore, then superintendent, warned that both companies and agents who engaged in selling over an individual's needs would be subjected to a hearing. This letter, the regulation and disclosure form appear in appendix M. In his statement Superintendent Garcia described other measures the Department was taking to curb abuses in the sale of medicare supplement insurance, such as warnings in the news media and settlement of individuals' complaints.[103]

The New Mexico disclosure forms are similar to those required in Oregon. The first page consists of a chart with either two or three columns. For inpatient hospital and skilled nursing facility benefits under part A of medicare, the first two columns are headed "Day of Confinement" and "Medicare Now Pays." For part B medical benefits, there is a single column headed "Medicare Now Pays." For both parts A and B the third column is headed "Policy Pays." It consists of blanks which the agent or insurer is supposed to complete.

The summary disclosure form must also contain a description of other benefits, exceptions, reductions and limitations contained in the policy, statements that the policy (not the summary) controls and that medicare benefits are subject to change, and the name and address of the insurer. The regulation does not specifically state that these disclosures are to appear on a second page, but there probably would not be room on the first page with the chart.

Like Oregon, New Mexico does not require any mention of the kinds of health care expenses medicare never covers or the expenses a person would still have to pay even if she bought the policy. Unlike Oregon's, the New Mexico form does not contain any warnings about the purchase of supplemental insurance by people eligible for medicaid or about pre-X clauses.

As in Oregon, agents and insurers are permitted to furnish the mandated disclosures at the time of delivery of the policy.[104] If a purchaser discovers that the policy mailed to her does not conform to the oral promises an agent made when he visited her, she has the burden of returning the policy within the ten day period permitted by law to obtain a refund.

The disclosure regulation applies only to individual medicare supplements, not group policies.[105] It does not affect in any way the sale of hospital indemnity or dread disease policies to people who are eligible for medicare. Since the rule provides that it is applicable only to policies delivered in the State of New Mexico,[106] it does not cover mail order sales to New Mexico residents by unlicensed out-of-State insurers. New Mexico does not have any standard-setting or standardization regulation for medicare supplement insurance.

G. Washington: Disclosure Requirement Only

Like Oregon and New Mexico, Washington requires the provision of certain disclosures to purchasers of medicare supplement policies, without making any attempt to set minimum standards or standardize policy offerings. The text of its medicare supplement disclosure regulation and the three-page disclosure form are included as appendix N. The regulation will go into effect on August 1, 1978, though the insurance commissioner encouraged all those subject to its terms to begin using it when he issued it on April 20, 1978.[107] The disclosure form has a chart with two columns like those in use in the other two

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[102] See memorandum to members of the Senate Special Committee on Aging, from Manual A. Garcia, Jr., superintendent of insurance for the State of New Mexico, Medi-Gap: Private Health Insurance Supplements to Medicare at 1 (June 29, 1978).

[103] *Id.* at 4-5.

[104] Appendix M, Department of Insurance Regulations Governing Accident and Health Insurance Medicare Supplements, art. 11, ch. 58, rule 4, sec. 11-4-4.

[105] *Id.*

[106] Appendix M, sec. 11-4-2.

[107] See Appendix N.

States. The first column shows what medicare pays and the second leaves blanks to show what the policy will pay. But Washington's approach has some significant new aspects. First, the insurance commissioner's suggestions precede the chart. He cautions people about renewability, waiting periods and exclusions for pre-existing conditions, in simple language; he states that "one policy that meets your needs is usually less expensive than several limited policies"; and he advises people not to buy medicare supplement insurance if they are eligible for medicaid. The disclosure form also suggests that people use the information on the form to compare a policy's benefits with any policies they already have. The list of suggestions ends with a reminder about the State's "10-day free look" law, which may be helpful, since Washington (like Oregon and New Mexico) does not require that a prospect see the disclosure form before delivery of the policy.[168]

Second, the chart has several innovations. The section on the medicare part A skilled nursing facility benefit makes it clear that medicare provides no benefits beyond the 100th day of a patient's stay and no benefits for custodial care. Custodial care is defined in simple language as "care which is primarily for the purpose of meeting personal needs which could be provided by a non-professional person."[169] Perhaps these additions will make the common inadequacies in private health insurance coverage more apparent to elderly people concerned about the possibility of having to go into a nursing home, although the disclosure regulation apparently would not apply to nursing home indemnity policies.[170] The disclosure chart also includes a section for "miscellaneous services or benefits," which lists some areas medicare never covers: private duty nursing, outpatient prescription drugs, routine eye and hearing examinations, the first three pints of blood per year. There is an additional question about whether a policy's coverage of deductibles and coinsurance will increase automatically as medicare changes its copayment requirements. Surprisingly, Washington's form is the only one which requires disclosure of the premium amount and whether it rises when the insured reaches a certain age.

The regulation does not impose any requirements on sellers of dread disease and hospital indemnity plans. Although the disclosure form does state that a single policy, presumably a true medicare supplement, may be cheaper than several limited policies, older consumers will not have any opportunity to see how limited indemnity-type coverage is through the use of uniform disclosure forms. Washington's disclosure requirement applies only to individual health insurance policies, not group plans. Thus group mail order insurers would not be governed by it.[171] However, in Washington health maintenance organizations and health care service contractors must supply the disclosure form to prospects who are eligible for medicare, with appropriate modifications in language.[172]

H. Colorado: Disclosure Requirement Only for Replacement or Addition

Colorado's disclosure regulation for medicare supplements has a different objective than those of the other three States with disclosure requirements only. It does not attempt to give consumers a graphic means of comparison of medicare benefits and what a policy will pay. Rather it seeks to warn elderly people on the verge of purchasing a new medicare supplement policy about the dangers of cancelling the coverage they have in force and to inform them about areas of overlapping coverage if they have more than one policy.

Colorado's regulation 76-6 became effective on July 1, 1977; its text appears as appendix O. It differs from other States' disclosure requirements in that it applies to the sale of hospital indemnity insurance to the medicare-eligible as well as policies specifically designed to supplement medicare.[173] It is silent about dread disease policies, however. It applies only to individual policies, not to group plans.[174] Unlike the disclosure requirements in Oregon, New Mexico and Washington, it is specifically applicable to mail order or "direct response" insurers.[175]

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[168] Appendix N, WAC 284-50-455(1).
[169] Appendix N. Disclosure Form, Item 9.
[170] Appendix N, WAC-284-50-450; see also the following paragraph in the text.
[171] Appendix N, WAC 284-50-455(1). It is not clear from the regulation itself whether it is applicable to insurers not licensed to do business in Washington who sell individual medi-gap policies to Washington residents by mail—if such a situation exists.
[172] Appendix N, WAC 284-50-450 and WAC 284-50-455(3).
[173] Appendix O, Colorado rules and regulations, regulation 76-6, sec. III.
[174] *Id.*
[175] Appendix O, sec. IV(c).

An insurer or agent must make the required disclosures upon becoming aware that the sale of a policy would involve replacement or addition; in other words, upon learning that a prospect already has one or more medi-gap or hospital indemnity policies.[176] Application forms must include a question designed to ascertain whether the policy to be issued would be a replacement or an addition.[177] If an agent is making the sale, he must furnish the disclosure notice to the applicant at the time he takes the application. A company soliciting direct response insurance must provide the required disclosures by mail *before* the policy is issued. In either case, a copy must be signed by the insured and the insurer must retain it for 2 years.[178]

These provisions are evidently intended to assure that a person has time to consider the message in the disclosures and to contact her present insurer if she wishes, before a new policy is issued. The requirement that a copy of the notice be signed by the insured and returned to the company is meant to ensure compliance by giving companies a means for monitoring agents' conduct and by creating a written record for enforcement purposes. However, in the case of sales by agents, it is difficult to enforce the requirement that the disclosures be given before the policy is issued. It would be fairly easy for an unscrupulous agent to obtain a prospect's signature on the disclosure notice, without giving her a chance to consider it carefully, at the time he took the application, either by minimizing its importance or presenting it as "just another paper to sign."

The prescribed disclosure notice warns applicants about possible exclusions or waiting periods for pre-existing conditions, less favorable conditions of renewability and the possibility that the cost of a new policy will be higher because of older age at the time of issue. One paragraph cautions applicants that if they do not answer all the questions in the application truthfully and completely, the policy may be void. Perhaps this provision is intended to help buyers assert themselves to prevent agents from "clean-sheeting" them. The form also suggests that it may be advantageous for people considering replacement or addition to contact their present insurer or agent. The last paragraph simply instructs the agent or insurer to compare the applicants' existing medicare and private insurance benefits with those which the new policy would afford and to show any duplication, overlap or deduction because of coordination of benefits.[179] Of course, enforcement of this last requirement would be very difficult. If an insurer or agent failed to give an accurate picture of the extent of duplicate coverage which would result from an additive sale, the insured might not discover it until she filed a claim.

III. POLICY QUESTIONS SURROUNDING REGULATION OF HEALTH INSURANCE FOR THE ELDERLY

A. Need for Federal Involvement

Tradition, and since 1945 the McCarran-Ferguson Act, have left regulation of the business of insurance largely to the States. Yet there are several reasons why it may be appropriate for the Federal Government to take on a major role in the formulation and even the implementation of public policy with respect to insurance to supplement medicare.

1. Problem Created by Federal Program

The Federal medicare program created the medicare supplement market. At least one State insurance commissioner and members of the public have expressed the view that the Federal Government should step in and regulate the medicare supplement market.[180]

2. Need for Uniformity

Consumers and insurance companies would benefit from a uniform nationwide approach to regulation of supplemental insurance. If each State used a different system for standardizing medicare supplement policies, buyers' confu-

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[176] For the definitions of the terms "replacement" and "addition", see appendix O, secs. IV(a) and (b).
[177] Appendix O, sec. V.
[178] Appendix O, sec. VI.
[179] Appendix O, sec. VII.
[180] See Testimony by Wisconsin Insurance Commissioner Harold R. Wilde, U.S. Senate Special Committee on Aging, Hearing on "Medi-Gap" Insurance at 11-12 (May 16, 1978).

sion would continue. Many people move from one State to another at the time they retire, or afterwards. A uniform approach to standardization would reduce opportunities for "twisting" and "stacking" by ensuring that these people would not have to confront a different way of categorizing medi-gap policies.

Some insurers now subject to conflicting State regulations might not object to uniform requirements. At present a company could not simultaneously comply with the disclosure regulations of Wisconsin, California, Oregon, New Mexico, Washington, and Colorado by using a single form. In some instances a company could not sell the same policy as a supplement to medicare in Wisconsin, California, and Illinois. Continuing variation in State standardization regulations would carry the danger that insurers might have to market different supplemental policies in every State, at obvious increased cost.

3. Prototype for National Health Insurance (NHI)

The medicare supplement market provides an opportunity to study and plan for the supplemental market which will develop under national health insurance. It now seems likely that any national health insurance plan to be adopted in the near future will involve some form of cost-sharing by patients. The private sector would then develop policies to fill various NHI gaps. Problems in that market would affect the entire population, not just people over 65.

The benefit structure of national health insurance could be planned to minimize the potential for the kinds of confusion and misinformation which have grown up in the medi-gap market. In addition, any regulatory initiatives which proved successful in solving the competition and consumer protection problems in the medicare supplement market could be adapted for use in the NHI supplement area.

4. Mail Order Group Supplemental Policies: A Possible Gap in State Regulation

A substantial number of medicare supplement and indemnity plans are sold to the elderly by mail. It is common for a direct response or mail order insurance company to be licensed in only one State and send its advertisements and solicitations to residents of other States. When an applicant responds, the company issues a policy in the State where it is licensed and sends it to the insured.

It now appears that State insurance departments are experiencing some difficulties in regulating the sale of group policies to supplement medicare by an unlicensed out-of-State mail order insurer.[181] Some medicare supplement

[181] Whether or not the States could subject unauthorized mail order insurers to regulations specifically governing medicare supplement insurance is a complicated legal question beyond the scope of this report. The answer might well be different for each State, for each insurance company and for each situation. The point is that some companies do appear to be going unregulated because the States with medicare supplement regulations do not apply them to unlicensed group mail order insurers. At present, it seems that a State can generally enforce its unfair trade practices act, including the prohibition of false or misleading advertising, against an insurance company not licensed to do business there which advertises to its residents. See generally Hanson and Obenberger, Mail Order Insurers: A Case Study in the ability of the States to Regulate the Insurance Business, 50 *Marquette L. Rev.* 175 (1966). In *FTC* v. *Travelers Health Asso.*, 362 U.S. 293 (1960), an insurance company licensed only in Nebraska sent out allegedly deceptive advertisements to the residents of States where it had neither offices nor agents. The Supreme Court held that the FTC had jurisdiction over such false advertising practices, despite the McCarran Act, because Nebraska could not regulate the insurer's extraterritorial activities. In order for regulation to displace the FTC act, it must be "regulation by the State in which the deception is practiced and has its impact." 362 U.S. at 721. On remand, the Eighth Circuit found that the States whose residents received the advertising could not regulate the unfair practices effectively, because they could not constitutionally enforce a judgment against the mail order insurer which had no property within their boundaries. *Travelers Health Asso.* v. *FTC* 298 F. 2d 820 (8th Cir. 1962). After the *Travelers Health* decision, all States adopted the NAIC's model Unauthorized Insurers Process Act, which permits State commissioners to proceed against unauthorized mail order insurers for false advertising in violation of the State's unfair trade practices act. However, the FTC would still have jurisdiction, where the same constitutional infirmity of State regulation existed as in the *Travelers Health* case, or, logically, if the State where the advertising had its impact could not regulate effectively for some other reason. See Hanson and Obenberger, 50 *Marq. L. Rev.* at 200-211. Also, group insurance may be exempt from State jurisdiction where the master policy is lawfully issued and delivered in a State in which the insurer is authorized to do business. See, e.g. Md. Code Art. 48A, Sec. 203(b)(6). The above discussion of advertising says nothing about a State's ability to regulate an unauthorized mail order insurer's activity which does not violate the State's unfair practices act.

regulations govern only individual policies.[182] Some, by their terms, apply only to policies issued in the State, and thus exempt many individual as well as group policies sold by mail.[183] None of the States' standardization measures applies to unlicensed group mail order insurers. Policies can be a source of confusion for the elderly if they are not subject to their States' regulation.[184] Federal involvement could ensure that all policies sold to supplement medicare are subject to regulation.

B. Scope of Governmental Action

Should regulatory initiatives address true medicare supplement or medi-gap policies only, all health insurance policies sold to the elderly, or all individual health insurance policies?

On the basis of the following analysis, it seems best to consider all health insurance problems of the elderly as an integral unit, in order to attempt to eliminate the purchase of unnecessary duplicate coverage by people in that age group. It is important to note, though, that any remedy applicable only to medicare supplement insurance or even to all health insurance policies sold to the elderly would not address the fundamental problems experienced by older people in obtaining and paying for health care. Specifically, no such regulation would affect the situation of the near-poor and middle-income elderly who are ineligible for medicaid but cannot afford private insurance.

1. Alternative 1: Medigap Policies Only

It would be easier to devise a standardization/disclosure system for policies which supplement only the more obvious gaps in medicare (deductibles, coinsurance and perhaps some catastrophic expenses) than for all health insurance policies sold to the elderly. Some form of regulation could be implemented quickly and evaluation of its effectiveness would provide guidance in expanding it to other health insurance policies.

However, any initiative limited to medi-gap policies would exempt the dread disease, hospital indemnity, nursing home and other piecemeal policies commonly sold to people over 65. Agents could easily continue to sell overlapping coverage. Furthermore, such a limited approach would not address the problem of health care expenses, such as nursing home expenses, which neither medicare nor medicare supplement policies cover. It might even increase the potential for duplication in coverage, since dishonest agents could point to the narrow scope of regulated medi-gap policies as a reason for buying additional supplemental coverage.

2. Alternative 2: All health insurance sold to people over 65

Considering all health insurance policies sold to the elderly as a discrete problem area would permit regulators to address in a meaningful way the problems of duplicate coverage and lack of consumer information.

On the other hand, dread disease and hospital indemnity policies are sold to people of all ages. Their benefit structure is not designed around the medicare program. Minimum standards might have to be made applicable to all such policies in order to be sure of reaching all insurance sold to the elderly. In contrast, the applicability of disclosure regulations could be made to depend on a mandatory inquiry about the prospect's eligibility for medicare. For instance, agents might have to ask people about medicare eligibility, and companies might have to ascertain the ages of addressees of direct mail appeals.

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[182] Washington's medicare supplement disclosure regulation applies only to individual policies. See note 171 *supra* and accompanying text. Colorado's rule covers replacements of and additions to individual mail order policies, but not group. See note 175 and accompanying text. Wisconsin's standardization regulation, Ins. 3.39, applies only to coverage on an individual basis. See note 98 *supra* and accompanying text.

[183] The Illinois statute and the New Mexico disclosure regulation apply only to policies issued or delivered in those States. See notes 144 and 166 *supra* and accompanying text. In Oregon it is not clear whether the disclosure rule would apply to an unlicensed mail order medi-gap insurer. See note 161 and accompanying text. In California, the department of insurance cannot apply its standards, standardization or disclosure regulations of medicare supplement policies to unlicensed group insurers where the master policy is issued in another jurisdiction.

[184] Commissioner Wilde testified that confusion is already occurring in Wisconsin because AARP's group policies have not been subject to the medicare supplement rule. See testimony, note 180 *supra*, at 12.

3. Alternative 3: All individual health insurance policies

A uniform set of minimum standards and/or disclosure requirements for policies sold to people of all ages would be useful to all insurance purchasers. A system which would carry over after retirement would aid in pre-retirement planning.

However, it would take much longer to devise a regulatory scheme for all health insurance. Complications introduced by the medicare program might even make a uniform approach impossible. The accepted categories of health coverage such as basic hospital expenses, major medical, etc., lose their meaning when medicare's benefit structure is superimposed on them.

C. Important Policy Questions

1. Adequacy v. Simplicity of Information

The need to provide complete information about medicare and supplemental coverage may conflict with the need for simplicity and brevity in order to make sure that information is assimilated. At the point where it becomes inefficient (or even impossible) to give older people comprehensive information about coverage alternatives, efforts should be redirected to standardization to make the market's offerings understandable. It is important to evaluate the options in this area in terms of their effectiveness in getting information across to consumers.

2. Standardization v. Availability of Coverages

Insurance industry representatives insist that they should be left free to offer an unlimited variety of coverages to respond to different personal needs and income levels. But it may be undesirable to permit endless proliferation of products. Standardization or limitation of medicare supplement coverages may be necessary in order to further price competition between comparable policies.

3. "Good" v. "Bad" Medicare Supplement Coverage

Should regulation attempt to distinguish between the two?

(a) "dollar trading"

It is questionable whether medicare supplement policies should be required—or even permitted—to cover the initial deductibles. Consumers pay much more for coverage for the initial deductibles than for insurance covering catastrophic medical expenses which could mean financial disasters. The currently prevalent type of "shallow" health insurance which covers initial expenses but not very large medical bills has been criticized as affording only inadequate coverage while inducing substantial cost inflation.[185]

Since medicare beneficiaries have a very high chance of incurring the modest part A and part B initial deductibles, they may not be appropriate expenses for insurance coverage. Processing a high volume of small claims results in high claims expense ratios. The California Department of Insurance, among others, calls such coverage "dollar-trading," "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." The department estimates that in California annual premiums average about one third of the $144 part A deductible and one-half the $60 part B deductible.[186] On the other hand, first-dollar coverage seems to impart a sense of psychological security to which many people attribute great value. Some people may continue to use first-dollar coverage as a kind of prepayment mechanism for health care, as long as the premium does not exceed the deductible they would have to pay.[187] Informational issues are involved as well. People may not realize that not all medi-gap policies cover the initial deductibles. They may not understand the advantages of self-insurance for relatively small sums and for risks which are almost certain to occur.

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[185] See, e.g. Feldstein, A New Approach to National Health Insurance, 23 *The Public Interest* 93 (1971).

[186] Appendix J at 4-5.

[187] Deductibles may prevent some people from obtaining needed care; see note 190 *infra* and accompanying text.

(b) IMPACT ON HEALTH CARE COSTS

Is it appropriate to take action to promote or require medicare supplement coverage which may remove incentives to keep costs down? In general, requiring copayment clearly reduces utilization of physicians' services,[188] although the effects of deductibles and coinsurance differ.[189] This consideration alone might seem to argue against third-party reimbursement of initial health expenditures, but several factors may complicate the picture. It is possible that decreased utilization simply represents unmet demand for medical care by people with low (but not low enough to qualify for medicaid) incomes.[190] It is also possible that providers make the decisions about whether to provide care, especially the relatively low-cost services represented by the medicare deductibles, and that they deliver some services whether or not an individual patient can afford them.[191] People over 65 may also have less control over initial provider contact than other age groups if a higher percentage of their visits to physicians are due to serious illnesses.

Conversely, promoting competition on benefits among medicare supplement insurers could serve to decrease aggregate health care costs. At present there is often no third-party payment available for less costly health care alternatives.[192] Some policies which supplement part B cover only in-hospital medical services, not less costly outpatient charges, whereas it is possible that complete, first-dollar coverage for people over 65 could result in a shift from inpatient to outpatient care.

The trend is for supplemental insurance to cover hospitalization, perhaps some skilled nursing care, but not home health care. Neither medicare nor medicare supplements cover many routine diagnostic services which could reduce the catastrophic costs of serious but preventable conditions. Encouraging insurers to compete by offering to cover cheaper alternatives might result in beneficial alterations in the health care delivery system.

(c) LONG-TERM CARE

The problems of financing long-term care are far beyond the scope of this paper. The consequences of requiring policies to cover nursing home costs should be briefly noted, though. Mandating those benefits would transfer to insurers (and their policyholders) the long-term care expenses of those elderly who could afford the premiums and incurred nursing home expenses. Since the costs of long-term care are the most rapidly rising component of health care costs and since the phenomenon of adverse selection might well operate, those premiums could quickly become prohibitive.

IV. POLICY OBJECTIVES AND CRITERIA FOR ASSESSING OPTIONS

A. OBJECTIVE: PROMOTE COMPETITION IN THE MARKET FOR HEALTH INSURANCE FOR THE ELDERLY

There is a well-established relationship between availability of information about products and services and the competitiveness of an industry. Therefore any governmental initiative should:

1. Provide Complete Information

Any option should provide people over 65 with sufficient information to make a rational choice about purchasing health insurance in addition to medicare. Prospective purchasers should understand what medicare covers, what kinds of

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[188] Scitovsky and McCall, Coinsurance and the Demand for Physician Services: Four Years Later, *Social Security Bulletin* 19 (May 1977).

[189] See Phelps, Insurance Benefits and their Impact on Health Care Costs, Rand Corporation Paper P-5844 at 6-7 (April 1977). Phelps characterizes a uniform coinsurance rate such as medicare part B's 20 percent coinsurance as "neutral." In contrast, a fixed dollar deductible to be paid by the patient for each visit to a physician might discourage inappropriate recourse to physicians for nonserious conditions, but there would be no incentive not to choose the most expensive doctor, because once the patient has paid the initial deductible "luxurious" care costs her no more.

[190] See generally Hopkins, Roemer, et al., Cost-Sharing and Prior Authorization Effects on Medicaid Services in California, Part I. The Beneficiaries' Reactions, 13 *Medical Care* 582 (July 1975).

[191] *Catastrophic Health Insurance*, note 5 *supra*, at 34 (January 1977).

[192] Cf. Feldstein, note 185 *supra*, at 95. The same problem exists with medicare supplement coverages, as in Illinois, where coverage for in-hospital medical services is required by statute but coverage for the same services entered on an outpatient basis is not.

expenses medicare does not cover, the types of supplemental private insurance available and their cost. Each individual should be aware of factors affecting his or her insurance needs such as possible eligibility for medical assistance. Ideally people should also know about alternatives to the purchase of private insurance to supplement medicare, such as self-insurance and health maintenance organizations.

2. Provide Information in a Usable Form

It is difficult for people of any age to understand the complexities of medicare and supplemental insurance. Explanations must be simple enough so that they do not exceed consumers' capabilities for processing highly technical information. In addition, the information must be presented in a form adapted to the special needs of the elderly, who may have hearing or reading problems or live in isolation.

3. Ensure Access to Information

Because of medicare's complexity and the lack of standardization of supplemental policies, traditional methods, such as printed disclosure forms, may be ineffective in conveying the information necessary to a decision about appropriate coverage to supplement medicare. Search costs involved in obtaining information may be so great that senior citizens simply give up. Any governmental initiative should provide easy access to impartial and complete explanations.

4. Standardize Coverage

Standardization of available coverages may be necessary to make price competition possible, so that consumers can compare similar products. At the same time a regulatory system should permit a sufficient variety of coverages to meet differing individual needs.

5. Eliminate Duplicate Coverage

Any restructuring of the market should aim to reduce the potential for confusion which leads to the purchase of overlapping coverage. No one over 65 should have to pay more than once to supplement the same gap in medicare in an effort to obtain comprehensive coverage.

B. Objective: Correct Failures of the Market for Health Insurance for the Elderly

To improve market function in the areas where competition has broken down, an option should:

1. Assure Reasonable Return

Because consumers cannot obtain the information they need about supplemental insurance, competitive forces will not reward those insurers who provide their policyholders with the best return. All health insurance policies sold to the elderly should pay back a reasonable amount in benefits in relation to premium dollars. One way to assure better value may be to promote coverage only for appropriate insurable events, by discouraging or banning first dollar coverage, "dollar trading," and coverage for "risks" which are almost certain to occur.

2. Minimize Opportunity for Marketing Abuses

State insurance departments have primary responsibility for monitoring the conduct of individual agents. However, any program undertaken should be carefully designed to cut down opportunities for agent misrepresentation. Policy standardization and simplification could make it much more difficult to convince people that they need more or different policies. At the same time consumer education measures could give them the means to question agents more assertively and completely. Regulation should also facilitate, and perhaps require, insurance companies' policing of their agents' conduct.

3. Ensure Prompt and Fair Claims Handling

Policyholders who submit claims should not have to suffer long delays and arbitrary treatment. Decisions about claims should be reached in accordance with ascertainable standards and procedures. Better information will help here

too. If consumers understand what a policy does and does not cover at the time they purchase it, there will be less disputes about coverage at the time they submit claims. A larger problem is that insurance consumers cannot obtain reliable information about a company's claims handling practices before purchasing insurance.

4. Minimize Undesirable Side Effects

Regulation to remedy market failures should avoid undesirable distributional consequences and features which would contribute to the inflation of aggregate health care costs.

C. Objective: Implement Regulation Effectively and Efficiently

Priority should be accorded to alternatives which will be:

1. Politically Feasible

An option should raise relatively few questions about the proper role of government intervention.

2. Easily Enforceable and Inexpensive to Administer

3. Complementary With NHI

A regulatory initiative should be designed for easy adaptation while national health insurance is being phased in and afterwards.

V. PUBLIC POLICY ALTERNATIVES

Governmental action with respect to health insurance for the elderly could take three principal forms: (A) minimum standards, (B) a system of standardization combined with disclosures or labels, or (C) provision of information to consumers. In addition, several novel approaches are possible. The numbers in parenthesis refer to the criteria described in part IV.

A. Minimum Standards

1. Minimum Loss Ratios

Would require that at least a certain percentage of premium dollars be returned in benefits.

Advantages:

Would eliminate low-value policies from the market. (B.1)

Could help to improve quality coverage. (B.1, A.4)

Could induce companies to operate more efficiently. In particular, minimum loss ratios might bring about reform of commission structure and hence reduce agents' incentive to "roll over" their clientele. (B.2)

Relatively easy to implement. The studies and analysis which would be required to determine the appropriate level for an initial minimum loss ratio would not be as time-consuming as evaluating and implementing standardization measures. (C.1)

Disadvantages:

Would necessarily involve prohibiting the sale of some policies and thus some curtailment of choice. (C.1)

Could be expensive to police. Evaluation of anticipated loss ratios reported by companies could be expensive and time-consuming, since such figures may be subject to manipulation. (C.2)

2. Restriction on Exclusions of Preexisting (Pre-X) Conditions

Pre-X clauses could be banned or their provisions could be limited. For example, insurers could be permitted to exclude (i) only conditions which were treated or diagnosed 6 months or a year before the policy's effective date; and/or (ii) only for 6 months or a year after the policy's effective date. Insurers could be required to use a uniform definition of "pre-existing conditions" in policies and in handling claims.

Advantages:

Uniform pre-X clauses would:

Reduce buyers' confusion about coverage at the time of purchase. (A.2)

Help to prevent unjustified denials of coverage, especially by companies which accept all applicants regardless of their medical history ("post-claims underwriting"). (B.1, B.3)

Standardize one aspect of available policies. (A.4)

Provide guidance in planning for the NHI supplement market which is likely to develop with a less than comprehensive NHI system. Pre-X would continue to be a problem under NHI which, like medicare, would cover all previous conditions, whereas supplemental insurers would not wish to do so. (C.3)

Disadvantages:

Requiring coverage of pre-existing conditions could lead to adverse selection. People with health problems would purchase insurance, driving the premiums up. (B.4)

Policies with only very limited pre-X coverage may be the only protection available to high-risk elderly. Any restriction on availability raises political concerns. (C.1)

Detection and case-by-case adjudication of arbitrary denials of claims would be costly. (C.2)

3. Requirement That Medigap Policies Supplement Both Parts A and B

Advantages:

Would reduce confusion by increasing standardization. (A.2, A.4)

Would reduce potential for duplicate coverage and "loading up." Agents would not be able to persuade people they needed one policy to fill part A gaps, one for part B gaps, etc. (A.5, B.2)

Disadvantages:

If all medi-gap policies were required to cover both part A and part B initial deductibles, then increased dollar-trading might make coverage more expensive.[193]

Coverage of both deductibles might result in unnecessary health expenditures. (B.4)

4. Minimum Dollar Limits

Medi-gap policies would have to pay benefits to supplement medicare up to at least a certain amount. Wisconsin's rule is structured this way, e.g., a medicare supplement must pay at least $7,500 to supplement part B, or $22,500 to supplement both.

Hospital indemnity policies could be required to pay a minimum daily benefit which would represent a certain percentage of average daily hospital costs.

Advantages:

Setting high minimum limits for medi-gap policies increases coverage of catastrophic losses, which should result in only a small increase in premiums. (A.1)

Minimum benefits for hospital indemnity insurance would result in higher premiums and discourage its purchase by the medicare-eligible, who do not need it in order to meet medical expenses as they arise. (A.5)

Disadvantages:

Emphasis on limits does not give consumers any information about the need for catastrophic coverage or likelihood of incurring expenses above the dollar ceiling. (A.1)

A system for rating policies which relies on minimum dollar limits may not differentiate categories sufficiently to bring about standardization, since only a small percentage of claims involve high dollar amounts. (A.4)

The concept of a minimum maximum is inherently confusing. (A.2)

Hospital indemnity insurers would object that their policies are not meant to provide basic hospital coverage, but to supplement it. (C.1)

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[193] The requirement could be structured to eliminate mandatory coverage of the deductibles. However, many people would expect governmental intervention to assure "full" (i.e., first dollar) coverage.

5. Mandated Benefits

Any policy which covered a certain kind of care would also have to cover the same care rendered in a less expensive manner. For example, a policy which supplemented part B might have to reimburse outpatient as well as inpatient expenditures. Insurers could also be required to pay for the services of home health aides, nurse practitioners, etc.

Advantages:

Could help to reduce aggregate health care costs and reform health care delivery systems, to the extent that less costly services are substitutable for more expensive care. (B.4)

Might reduce consumer confusion about policies which "cover everything medicare doesn't." (A.1)

Disadvantages:

Open to criticism as unjustifiable interference with insurance industry decisions about risk and reimbursement and an attempt to accomplish aims which should be the object of a comprehensive government health policy. (C.1)

B. STANDARDIZATION/DISCLOSURE

1. Prohibition of references to indemnity, nursing home, dread disease and other limited policies as Medicare supplements

Advantages:

Would eliminate opportunities for misleading consumers in advertising and sales presentations. (A.1, B.2)

Noncontroversial; the idea that limited policies are not medicare supplements is widely accepted. (C.1)

Disadvantages:

Difficulty of policing oral representation by agents, whose presence can weaken the force of written statements or printed disclosures. (A.3, B.2)

Possibility that agents could use requirement to sell duplicate coverage. They could emphasize the difference between medi-gap and other kinds of policies to persuade individuals that they need more than one. (A.5)

2. Descriptive Categories (California Model)

Labels or captions on policies would reflect the nature or scope of the supplemental coverage without rating or comparing them. California provides for three categories: in-hospital only, in- and out-of hospital and catastrophic. Other possibilities are part A only and part B only.

Advantages:

Descriptive labels do not imply a governmental judgment that one policy is better than another. (C.1)

It would be easy to modify California's system to make clear the difference between true medicare supplement policies on one hand and indemnity or limited policies on the other, using additional capsule descriptions. (A.1, A.5)

Disadvantages:

Descriptive labels do not give specific information about which gaps in medicare are covered; they may be so vague as to be useless. (A.1)

They allow too much variation within each category, so prospective buyers cannot make meaningful price comparisons. (A.4)

They permit the sale of duplicate coverage to continue, unless the categories are carefully structured so that no one may include any element of another. (A.5)

Permitting in-hospital coverage only may cause distortion and increase health care costs. (B.4)

3. Benefit Levels (Wisconsin Model)

Wisconsin has established four benefit levels for medicare supplement policies, with mandated benefits and minimum dollar limits for each. Policies bear the numbers 1 through 4.

Advantages:

The labels "1" through "4" are easy to understand and use; they facilitate price comparisons within each category. (A.2)

The lowest level sets a floor for medi-gap coverage; policies which do not even meet the standards for the lowest category cannot represent themselves as medicare supplements. (The system could be modified to ban the sale of non-conforming policies if insurers proved able to circumvent such a provision.) Thus policies with very limited benefits can be eliminated from the market. (B.1)

Since the benefit levels are cumulative, they should reduce purchases of duplicate medicare coverage (A.5)

Disadvantages:

This model does not address the problem of indemnity and limited policies. (A.1) Even with knowledge of a policy's rating, a consumer could still purchase one of those policies which would overlap completely or partially with her medi-gap coverage. (A.5)

Different minimum limits may not differentiate categories enough to distinguish their value to the buyer. If not, then benefit levels are misleading. (A.4)

4. Unit Pricing

Supplemental insurers could be required to disclose, in a uniform format, the premium cost of filling each gap in medicare. Unit pricing could be combined with any other system of standardization or categorization.

Advantages:

Consumers would be able to see the high cost of insurance for the initial deductibles and the relatively low price of catastrophic coverage. (A.1)

By choosing more economical coverage packages, buyers could reduce their supplemental insurance expenditures. (B.1)

Fragmenting benefits could highlight possible areas of overlap and might reduce the likelihood that agents could "load up" buyers with policies. (A.5, B.2)

Disadvantages:

A unit pricing system could not take into account indemnity and dread disease policies, because it would be impossible to compare service and indemnity benefits in a uniform format. The problem of duplicate coverage would continue (A.5). Indemnity plans with lower premiums but limited benefits might appear to be better buys. (B.1)

Unit medi-gap pricing might well be too complicated for anyone to use. (A.2)

There would be no yardstick to allow consumers to compare the costs of different policies (unless unit pricing were combined with standardization regulation). (A.1)

5. New Method: Cost Index

It may be that neither the California nor the Wisconsin model is effective in bringing about sufficient standardization for price competition to take place. The States' experiences could be analyzed in order to pinpoint each regulations' shortcomings and to devise a new method to permit price comparison: a cost index.

Advantages:

The cost index would provide a more accurate measure of a policy's value than loss ratios, so that consumers could avoid policies with a low rate of return. (B.1)

The index could be comprehensive; it should reflect all factors which determine a policy's value to its holders. (A.1) At present little or no reliable information is available to consumers about:

An insurance company's claims service, especially time required for payment (B.3).

A company's record in handling complaints and denying claims without justification (B.3).

A company's underwriting standards and practices.

The policy's coverage of health care expenses the over-65 age group is most likely to incur.

Purchasers and persons planning for their insurance needs after retirement could use the cost index themselves, without interference from an agent or the need to seek advice from experts. (A.3)

The cost index system could be extended, with appropriate modifications, to insurance to supplement national health insurance. (C.3)

Disadvantages:

The cost index would be helpful only to a buyer who had the opportunity to compare policies. When alone with an individual prospect, an agent could still misrepresent a low index figure as "good" since it would be meaningless in absolute terms. (B.2)

Devising a complete cost index would be an extremely difficult and complex task. Companies have different standards for underwriting risks and settling claims. It might prove impossible to obtain information about some variables. For example, determining the number of unreasonable denials of claims presupposes an adjudication mechanism which does not now exist. (C.2)

It is now impossible to compare medi-gap policies which pay service benefits with indemnity and limited policies. Like term and whole life insurance, they have totally different purposes. If they are widely perceived as meeting different needs, then the opportunity to sell duplicate coverage still exists. (A.5, B.2)

Even among medicare supplement coverages, it might be impossible to estimate and compare the values of different combinations of health benefits, especially given individuals' varying needs. (A.1)

C. Provision of Information

1. Mandatory Written Disclosures

Insurers or agents could be required to present such disclosures as part of a sales talk, with a direct mail solicitation, or with delivery of the policy. Several variations are possible:

(a) Disclosure of loss ratios for medi-gap policies. A prerequisite would be separate reporting of loss experience for medicare supplement policies, which most States do not now require.

(b) Disclosure of loss ratios for all individual health insurance policies sold to the elderly including dread disease and indemnity contracts. They could be combined with a strongly worded warning that purchasing such insurance is like gambling.

(c) A one-page disclosure sheet with general information about benefits, renewability, etc. (California, Oregon's second page, New Mexico's second page, Washington's list of suggestions.)

(d) A one-page disclosure sheet in the form of a chart with columns for medicare benefits, medicare gaps and policy coverage (Oregon's first page, New Mexico's first page, Washington). The prospective purchaser could fill in the blanks in the last column herself, or with the assistance of an agent or an advocate.

(e) A cost index. (See B.4 above)

Advantages:

It is relatively easy to establish and enforce disclosure requirements. (C.2)

Disclosure and a strong cautionary statement are more politically acceptable than a ban on the sale of dread disease and similar policies. (C.1)

Disadvantages:

Written disclosures or warnings are not as forceful as an agent's oral statements. Face to face, an agent can gain a prospects's confidence and discount printed disclosures or persuade her to ignore them. (A.2, B.2)

Even on their own, people may not believe that disclosure statements have any importance for them; they seem to be especially indifferent to loss ratio figures. (A.2)

Brief disclosure messages are necessarily incomplete. They do not include some of the facts which would be necessary for a truly rational decision, such as risk information or disclosures about the "unfillable" gaps in both medicare and supplemental coverage. (A.1)

Loss ratios tell nothing about the particular benefits afforded by each policy and very little about a company's claims performance or underwriting practices. (See V.C. 2(b) below.)

If insurers are permitted to make mandatory disclosures at the time of delivery of the policy, the purchaser will have the burden of returning a policy for a refund within a short time (usually 10 days) if she discovers it does not cover what she thought it did. Perhaps some such errors could be prevented by requiring disclosures at an earlier point in time. (A.2, B.2)

2. Consumer Education Measures

Possible initiatives include:

(a) A buyer's guide with complete information about medicare and medicaid, supplemental coverage and the standardization/labeling system in use. Wisconsin's booklet *Health Insurance Advice for Senior Citizens* is an example.

(b) Providing, or requiring insurers to provide, information which is not now furnished. People cannot judge their need for an insurance product unless they have some perception of the risk involved. Some kinds of helpful information are:

Company ratings on the basis of complaints per premium dollar, percentage of claims denied, time for paying claims and complaint resolution record.

Risk information: hospital costs per day, length of stay, frequency of physician visits, etc., for the over 65 age group.

More education about medicare, especially expenses neither medicare nor private insurance will cover: physicians' excess charges, most stays in nursing homes which are not medicare-certified, custodial care.

Medical assistance benefits and eligibility requirements.

Provider information: whether a physician ever accepts assignment, physicians' average and median charges for certain procedures. (Medicare collects and must disclose customary charge data by provider name).

(c) Exploration of non-traditional avenues for increasing consumer awareness, such as the use of television and radio spots and videotapes for use in nutrition and other sites which receive government funds.

(d) One-in-one insurance counseling, integrated with pre-retirement financial counseling.

Each consumer education option has fairly obvious advantages and drawbacks. The first step in this area should be determining what information consumers use or would like to have before making a medicare supplement purchase decision. The next would be evaluation of each option's effectiveness in getting that information across to the people who need it and in narrowing the gap between the coverage they expect and the coverage they actually get. For example, individuals can study buyer's guides on their own, but their length may make them useless in the face of high-pressure sales tactics. Their success might depend on wide dissemination for reading before contacts with agents or advertising. Some initiatives would be very expensive. Placing on insurers the costs of collecting and communicating information about everything except policy coverage raises additional political questions.

Counseling in particular deserves more attention, although it would evidently require a sizeable commitment of resources to training, establishing and maintaining a network of counselors. Counseling may be the best way to assure that the information provided is actually used. It may be the only way to counter agents' oral presentations and provide an alternative to industry expertise.

D. Other Initiatives

There are a number of other approaches, some untried, to solving part or all of the medicare supplement insurance problem. This paper will list several of them but analyze only the last one, federally sponsored medicare supplement insurance.

1. Regulation of Advertising

State or Federal regulators could commence proceedings and increase enforcement of existing advertising standards. Advertising by mail order insurers would seem to warrant special scrutiny because it employs scare tactics and other misleading techniques and because, for the most part, it escapes regulation by State insurance departments.

2. Company-Customer Contact

Various suggestions have been made to establish direct contact between the insurance company and the insured, in order to permit the company to police the behavior of the agents who sell its policies. These include: A requirement that each company's promotional materials, advertisements and outlines of coverage give a toll-free number the customer can call for more information; a followup questionnaire about agent practices; a reaffirmation requirement which would effectively prevent sale of a policy on the first contact and give the buyer time to reflect. In order for a policy to become effective, the buyer

would have to reaffirm her wish to purchase it after a certain amount of time has elapsed.

3. Company Responsibility for Agent Conduct

State commissioners and others believe that insurance companies must take on a more active role in monitoring the activities of their agents to prevent abuses. Companies could set up procedures to detect overselling and twisting. They could also set up a reporting network among themselves, so that it would not be easy for an agent to find employment with another company after he had been terminated by one for misconduct.

4. Agents' Fiduciary Duty

Statute or common law could establish the principle that an agent has a fiduciary duty to sell only the insurance suited to each individual's needs. As a fiduciary an agent could not sell duplicate coverage or coverage inappropriate for the buyer's income level—which would necessitate some inquiries about a buyer's particular situation. Imposition of a fiduciary duty could be combined with a self-enforcing mechanism such as voidability at the buyer's option or a private right of action, perhaps coupled with provisions to facilitate access to legal services and promote its use, such as attorney's fees and treble or punitive damages.

5. Claims Handling Requirements

Insurance companies could be required to pay claims within a certain time limit or give a written statement of reasons for denials. Provisions for attorneys' fees and generous damages awards could be added to facilitate private enforcement and challenges to arbitrary refusals to pay claims. An alternative dispute resolution mechanism might be helpful.

6. Federal Government Sponsorship of Optional Medicare Supplement Insurance

Many elderly people now believe that medicare supplement insurance is approved or sold by the Federal Government, perhaps because of widespread fraudulent marketing practices. In any event, the proposal merits thorough evaluation of feasibility and costs for various design options.

One way to fill medi-gaps would be to extend medicare coverage, analysis of which is beyond the scope of this paper. The Federal Government's medicare supplement insurance would differ from mere expansion of the existing medicare program in that there would be less subsidization. Of course, it could be optional, like part B. The degree to which the government's medi-gap policy could be priced to risk would have to be the subject of intensive study. The extent to which it should be would of course be controversial. The underlying policy question is simply whether all of society should bear the costs of health care associated with aging.

Some possible advantages of a federal government medicare supplement insurance program are:

Ability to provide coverage only for the kinds of risks appropriate for insurance, such as the costs of major illnesses. There is no reason why private insurers could not offer such supplemental coverage, but few now do.

Ability to fill the gaps which neither medicare nor supplemental insurance now covers, such as prescription drugs, medical appliances and even excess provider charges, perhaps through partial subsidies. Such a policy would meet more of older people's expectations for complete coverage, but the objective obviously conflicts to some extent with the preceding one.

Cost advantages. Some medicare supplement insurers do not deny coverage to poor health risks. Although some have open enrollment periods and some do not do any medical underwriting at all, many of these companies have better loss ratios, perhaps because they usually have more policyholders. Similarly, the Federal Government could spread the risk over a very large group. Other economies are available to the government: use of the existing social security network of offices and employees with knowledge about medicare for sale of policies and handling claims, partial integration of claims processing with medicare, etc.

Better consumer information. Explanations of medicare and supplemental

insurance could be combined and given at the time or before a person becomes eligible for medicare, perhaps through retirement counseling.

Sale by social security employees would eliminate incentives for deceptive marketing and reduce opportunities for fraud by agents selling private insurance.

Opportunity to obtain valuable information for use in planning benefit structure and setting up the administration of national health insurance.

Possible disadvantages are:

Criticism by insurance industry and others who would object that the Federal Government has no business acting as an insurer.

Even if the program were voluntary, any move to curtail first dollar coverage or increase copayments would meet great resistance from the medicare-eligible and perhaps discourage many from participating in the program.

High cost, both in premiums and in inflation of health care costs, if the government's policy were to attempt to fill some of the gaps which are currently unfillable—especially long-term care. As noted above, this paper cannot attempt to answer the difficult policy questions involved in financing long stays in nursing homes.

VI. POLICY RECOMMENDATIONS

The recommendations which follow are of a general policy nature, based on the foregoing analysis of the market for private health insurance to supplement medicare. They represent only the opinions of the writers of this paper, not those of the Federal Trade Commission.

A. Impact Evaluation

An impact evaluation should be conducted to determine the effectiveness of existing State regulations of insurance sold to supplement medicare.

1. Purpose

The purpose of the impact evaluation would be to provide the information needed to prepare a recommendation for a uniform approach to the regulation of this supplemental market. Its end products would be a report for Congress, State regulators, and other policymakers, and the public.

2. Scope

The study should consider all health insurance policies sold to the elderly as a unit. In accordance with the analysis in section III., any initiatives should attempt to address problems arising from all the types of policies sold to the over-65 age groups, not only those which fill specific gaps in medicaid. Unnecessary duplication of coverage is often due to overlapping policies which are not true medicare supplements.

3. Objectives

The central inquiry of the impact evaluation should be to determine how elderly consumers can get the best coverage possible for each dollar they spend to supplement medicare—coverage which meets their needs and their expectations.

(a) initial groundwork

Considerable groundwork would be necessary in order to narrow the focus of the project. First, basic facts about the supplemental insurance industry, even total premium volume, are presently unavailable. More data should be gathered about this industry: a survey of the number and kinds of coverages available, premium and sales volume, benefits paid and loss experience. The project could also look into companies' complaint records and ascertain whether they make efforts to control or check on agents' activities to prevent overselling and other abuses.

Another initial stage could be a pilot consumer survey of elderly people who had recently purchased insurance to supplement medicare. Individual interviews could be conducted to determine the extent and nature of duplicate and overlapping coverage, whether the coverage they purchased met their expectations and whether those policies or others actually did serve to fill the gaps in medicare. Questions could also be asked about policyholders' experience with delay in settling claims, denial of claims which they felt were unjustified and

denials on the grounds of pre-existing conditions. Interviews could also include questions about how buyers obtained and used information before buying insurance and about marketing techniques they encountered.

Analysis of the results of two such preliminary projects would help to design a full-scale evaluation of the effectiveness of each State's regulatory approach. Careful design would be essential, in order for such a complex undertaking to be manageable.

(b) SUBJECTS OF INVESTIGATION

The impact evaluation should yield data about the ability of a standardization approach to bring down price competition among medicare supplement insurers. The impact evaluation should devote particular attention to determining the effectiveness of:

Minimum loss ratios (V.A.1.);

Uniform exclusions of pre-existing conditions (V.A.2.);

Various means of differentiating categories of coverage for consumers, such as minimum dollar limits (V.A.4. and V.B.3.);

The effectiveness of labels, numerical ratings or disclosure sheets in helping older people to compare policies (V.B.2., V.B.3 and V.C.1.).

The report resulting from the study should make recommendations about traditional forms of disclosure such as buyer's guides and mandatory disclosure sheets only if the impact evaluation shows that:

Consumers need kinds of information they cannot readily obtain now. (V.C.2(b)) If there are widespread misunderstandings about certain aspects of medicare, such a physicians' charges, the report could make recommendations as to how the Social Security Administration could help to correct them.

Consumers may not be able to use written information about this extraordinarily complex subject. If it is not possible to reach people with the printed word, then the report could consider alternatives, such as televised consumer education (V.C.2)

The final report could also include recommendations about consumer protection measures which seemed appropriate in light of the results of the study. These topics might include:

Arguments for banning or limiting the sale of dread disease and other indemnity policies;

Methods of curbing agent misconduct in selling policies;

The need for and costs of individualized health insurance counseling for the elderly; and

Possible imposition of claims handling requirements.

Demand for a possible optional medicare supplement insurance program sponsored by the federal government.

B. JOINT HEW/NAIC/FTC PROJECT

If possible, the impact evaluation should involve joint participation by HEW, the NAIC, and the FTC. On June 29, FTC Commissioner Dole testified to the Senate Special Committee on Aging that the FTC would welcome the opportunity to work with the NAIC and HEW in such an undertaking.

1. HEW

HEW staff could make a valuable contribution to the project because of their knowledge about medicare and its provisions. They could pinpoint areas of consumer misunderstanding and ignorance about Medicare, and therefore about supplemental coverage as well. The Department is taking an interest in supplemental insurance issues. Recently the Health Care Financing Administration published a request for proposals to study the purchase of supplemental insurance by medicaid recipients.[194]

[194] See 43 *Fed. Reg.* 15594 (April 13, 1978). One of the priority areas for health financing research and demonstration grants was "analysis of the extent of private health insurance coverage for medicaid eligibles." As a cost control measure, State agencies administering the medicaid program are required by law to try to recover payments from any third-party insurance held by medicaid recipients. Medicaid is supposed to be the payor of last resort, so medicaid agencies are directed to recover any third-party payments for medical expenses which a recipient receives or has the right to receive. These payments could be workers' compensation or family group coverage on another family member. Or they could be medicare supplement, indemnity and other policies sold to the elderly poor and disabled. State agencies would therefore collect information about policies held by medicaid recipients or applicants who are also eligible for medicare, but not about policies held by those elderly who are neither poor nor disabled.

Medicare supplement insurance also raises important policy questions about the supplemental insurance market which would be developed under any system of national health insurance with less than comprehensive coverage. HEW might wish to participate in and use the results of the medicare supplement impact evaluation to plan for NHI. Consumer confusion and the other market malfunctions observed in the medicare supplement area could affect a larger segment of the population under NHI, particularly if the benefit structure of any NHI system adopted is as complicated as medicare's. Moreover, the sale of insurance to cover deductibles and coinsurance might undermine the cost control purpose of copayment provisions (though it might allow beneficiaries to obtain needed care). Since cost-sharing is under serious consideration, planners might want to draw all the lessons they can from study of the medicare supplement experience.

2. The NAIC

On June 12, 1978, the Accident and Health Subcommittee of the NAIC voted to create a task force to investigate regulation of health insurance sold to the elderly and identification of other health insurance products "which do not fulfill the public's interest."[195] The NAIC would bring to the study State insurance commissioners' first-hand experience with insurance regulation and their access to relevant data. Barring new legal developments, the State commissioners will be primarily responsible for the regulation of medicare supplement insurance for some time to come. The NAIC's participation in a joint impact evaluation could provide a model for Federal-State cooperation and technical assistance to State regulators in the insurance area.

3. FTC

The need for a uniform approach to medicare supplement insurance and the widespread feeling that the Federal Government should cope with the problems the medicare program has caused point to an increased Federal role. FTC has an important contribution to make. The staff of the Bureaus of Economics and the Bureau of Consumer Protection have experience in evaluating the impact of proposed and present regulations, devising disclosure and standardization measures and determining the effectiveness of various means of conveying information to consumers. These are the skills necessary to address the complex issues raised by medicare supplement insurance.

[195] Statement of the National Association of Insurance Commissioners, submitted to the Senate Special Committee on Aging at a hearing on Private Health Insurance Supplements to Medicare, by Joseph C. Mike, insurance commissioner of the State of Connecticut and chairman of the NAIC Accident and Health Insurance Subcommittee 1-2 (June 29, 1978).

Appendix 2

STATEMENT OF MILT SMEDSRUD, PRESIDENT, COMMUNICATING FOR AGRICULTURE, FERGUS FALLS, MINN.

Mr. chairman and members of the committee, on behalf of the members of Communicating for Agriculture, I thank you for the privilege and opportunity of presenting this written testimony before you. CA is a relatively young organization that was incorporated in 1972 under the Non-Profit Corporation Act in Minnesota. The organization, now active in 44 Midwestern, Southeastern, and Rocky Mountain States, consists of members roughly 40 percent of whom are farmers and 60 percent of whom are small town agri-business people, such as bankers, lawyers, independent implement dealers, grocers, etc.

Our purpose is to promote the health, well-being and advancement of people in agriculture and agri-business. This purpose has generated involvement in legislation to protect the family farm, overcome inequities in social security and reform estate tax laws. We also provide scholarships for young people who are interested in pursuing careers in agriculture and agri-business.

In the area of health care delivery, CA supports initiatives to encourage physicians to practice in rural areas and promotes better utilization of rural hospital bedspace. In order to assure that people get the quality health insurance they seek, CA has become involved in promoting comprehensive health insurance laws in Minnesota, Wisconsin, Georgia, South Dakota, Iowa, and Missouri. While I am presently devoting all of my time to responsibilities with CA, I have a background in health insurance that spans more than 20 years.

During the last 20 years, we have seen the cost of medical care increase dramatically, far outpacing the rate of inflation. In 1956, Americans were spending about 15 million dollars annually to cover their health care needs. At present, we are spending eight times that amount.[1] In the last decade, the average annual medical expense per family has risen from $830 per family to $2,200.[2] On the average, it is estimated an elderly person spends $1,360 per year or three times as much as the rest of the adult population.[3]

To help cover the increasing costs of vital health care services, Americans have by-in-large turned to private health insurance. It is estimated that 90 percent of the American people have health insurance of some kind. Insurance companies have attempted to meet a vital need, and by-in-large they have succeeded. Their success is most evident in the quality group insurance plans offered to employees of large corporations, public institutions, and Federal and State governments.

The farmer, people in small business, and the self-employed cannot be assured that the health insurance policies they hold are similarly comprehensive or of low cost. In short, that is why an agricultural organization has become involved in the issue of comprehensive health insurance. CA has advocated a systematic expansion of health insurance opportunities for people in need.

CA believes that a most prominent need rests in the inability of people with preexisting health conditions to obtain comprehensive coverage in the private sector. CA lobbied to help establish a "pool" in Minnesota, where people who had been previously uninsurable would have an opportunity to gain coverage. The pool, operated and funded by an association of insurers and self-insurers, experienced a minimal deficit during its first year of operation. A total of $261 for every $1 million of health insurance premiums was assessed associa-

[1] Expenditures in 1975 totaled $118.5 billion. Data is from the Office of Research and Statistics of the Social Security Administration.

[2] "Current History," July-August 1977, p. 17. K. Leffler, "National Health Insurance: A Social Placebo?"

[3] "Medi-gap: Private Health Insurance Supplements to Medicare," Federal Trade Commissioner Elizabeth Hanford Dole. June, 1978, p. 1.

tion members (Minnesota had $500 million of health insurance premium). An effective, yet relatively inexpensive means to provide health care coverage for people with preexisting medical conditions appears to have been accomplished without massive government intervention.

Soaring health care costs have also created a great deal of anxiety for senior citizens, especially those who live on fixed incomes. It is estimated that medicare pays for an average of 38 percent of the medical expenses of senior citizens. But $418 of an annual medical bill of $1,360 is not adequate for most. Large numbers of senior citizens have turned to private insurance companies to fill the gap. The result has been that 63 percent of senior citizens have purchased coverage for physician services.[4]

Some of the policies are very good and provide an effective supplement to medicare. The record of the insurance industry, however, has been tarnished by some companies which take an exorbitantly large portion of premium payments for commissions, and fail to instill in their agents an honest commitment to client service.

In some cases 60 to 75 percent of first-year premiums have been allocated for commissions. A mere 25 to 40 cents per dollar has been retained for client benefits.

In one case, 100 percent of the first-year premium was allocated for commission. How can it be done that a company can allocate so much of its premium income and leave so little for client benefits? Inordinate commissions have been made possible by the sale of policies which do not pay benefits in relationship to their high cost. At present, an individual has no way of knowing how much the company keeps to pay salesman, administrative costs, and profits. CA believes that the people should know so that the loss ratio on all insurance claims can be limited to at least 65 to 70 percent.

Differing medicare supplement policies have been designed to provide different ways to fill the gaps in medicare coverage. The advent of indemnity and dreaded disease plans, many of dubious quality, has added further confusion to the already unnecessarily complicated medicare benefit structure. The result has been that senior citizens are not able to evaluate the nature and completeness of the policies which they purchase.

When these elements of confusion are coupled with a salesman who is not committed to honest client service, the results are tragic. This committee has been provided testimony regarding a Wisconsin woman who was sold over 17 policies amounting to over $4,000 of annual premium payments, and of a California senior citizen who purchased health and life insurance policies with contractual obligations of $9,158.61, or roughly 68 percent of the individual's annual income.

These examples indicate the extreme to which abuse of medicare supplement insurance can be taken. The message is clear, we must provide help for senior citizens so they can understand the kinds of services which medicare covers and can be assured of the quality and completeness of medicare supplements. In order to provide this committee with first-person testimony from people with whom CA is involved, a hearing of senior citizens was conducted at a meeting in Elbow Lake, Minn.

CA was invited to attend a seven-county organizational meeting of the Minnesota Federation of Seniors. Approximately 90 senior citizens attended the meeting. In order to gain needed consumer input, CA asked a number of questions regarding individuals involvement with and understanding of medicare and medicare supplement insurance.

In total, 53 percent of the people surveyed indicated that they did not have a very clear understanding of the health care costs for which medicare will pay, while 35 percent indicated that they were somewhat clear. Only 12 percent of the people surveyed suggested that they had a clear understanding of the health care costs for which medicare will pay.

The lack of understanding about the benefits of medicare was reflected in the answers of people when asked "what percentage of your medical costs will medicare reimburse?" Over 70 percent of those responding estimated that medicare would pay between 62 percent and 75 percent of their health care costs. The remainder of the people surveyed did not know or did not answer.

While CA's survey results cannot be viewed as precise statistical indicators, these prominent trends are important in understanding the difficulties senior citizens have with medicare and supplement insurance.

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[4] "Medi-gap—Private Health Insurance Supplement to Medicare," Senator Lawton Chiles, May 1978.

Confusion and misunderstanding about the benefits of medicare is an important factor in the susceptibility of senior citizens to the purchase of medicare supplements of poor quality. Clarification of medicare benefits and education for senior citizens regarding those benefits is necessary. It is interesting to note the comment of one man who suggested that seeking information about medicare from the social security office was intimidating because of "aloof bureaucrats who act as if you are interrupting them from something more important."

When questioned about their understanding of the coverage provided under medicare supplement insurance policies, confusion and lack of understanding was equally evident. Consistent with national estimates, the survey indicated that slightly more than 63 percent of these senior citizens held private insurance policies to supplement medicare. Roughly 20 percent had purchased more than one policy, and they attributed it to dissatisfaction with the insurance company with which they had previously held policies.

There were no reports of insurance agents misrepresenting the policies which they offered by suggesting they were government sponsored or recommended by the insurance commissioner. Several individuals did indicate that insurance agents had told them a statement of one's medical history was not necessary when applying for medicare supplement insurance.

Despite the lack of apparent widespread fraud, people expressed a great deal of anxiety about medicare and supplement insurance. Roughly one-third of the people surveyed questioned why medicare could not pay more and if medicare could be simplified.

Considerable dissatisfaction with the supplement policies which individuals held at present was expressed. Complaints included: (1) The frequency of restrictive riders for preexisting medical conditions, (2) limitations on coverage after 160 days of hospitalization, (3) nursing home coverage limited to just a few approved nursing homes, (4) the high cost of supplement insurance.

A senior citizen from a small west central Minnesota community also complained about the refusal of medicare to pay for treatment of an ear problem which she was having. The doctor in her community did not believe he had the needed expertise, and referred her to a specialist about 60 miles away. Medicare, suggesting that a specialist was not required for treatment, refused to reimburse the expenses.

The rural doctor recognized his limitations and sought proper care. A more highly trained urban doctor may not have needed to make the referral. Because of this, an individual in need was penalized. The example illustrates an instance where guidelines and health planning did not recognize the legitimate differences between the practice of medicine in a rural setting and that of an urban area.

In general, the high cost of medical care was frequently cited by people with whom we spoke. Bruno Aijala, State president of the federation, suggested that young doctors have demonstrated a greater tendency to comply with medicare guidelines for "reasonable and necessary charges." With medical costs inflating and the price of supplements growing out of reach, a more general compliance with medicare cost guidelines needs to be encouraged.

In January 1977, the Minnesota Comprehensive Health Insurance Act was enacted (the plan will be discussed in some detail later). The law prescribes a qualified medicare supplement which must be outlined to all prospective clients by insurance agents. From the testimony of people with whom we spoke, it did not appear that the nature and implications of the law are being clearly explained by all agents.

One man, very well versed in insurance costs and coverage, indicated that an agent had not told him about the qualified medicare supplement saying, "Perhaps he thought I already knew about it." Clearly, a more aggressive advocacy in behalf of clients by the divisions of insurance in our State governments is needed. The client orientation which CA advocated is best represented by Wisconsin's insurance commissioner, Harold Wilde, who fined an agent who had not provided required informational material to a client. With aggressiveness of this kind, laws designed to protect people will not go unheeded.

The problems associated with medicare are not restricted to people over 65 years of age. A 55-year-old Georgia man recently contacted CA seeking advice. His persistent heart tremor had necessitated release from work. The termination of his employment also resulted in the cancellation of the group health insurance policy which had been offered by his employer. The conversion policy offered by the insurance company provided extremely limited coverage.

Medicare would be available after the 2-year waiting period. As the situation now stands, this man will not have an opportunity for health insurance coverage of any kind during the next 2 years. The example illustrates a medigap for which no supplement is available. Even after gaining medicare coverage, preexisting medical conditions are likely to prevent obtaining needed supplemental coverage.

An even greater difficulty confronts a disabled homemaker who has not paid into social security. If one's spouse, who was several years older than the homemaker, retired, a group health insurance policy which covered both would be terminated. While the spouse would be eligible for medicare, the more youthful homemaker would have to seek coverage in the private sector. Again, preexisting medical conditions and poor conversion policies would prevent obtaining the needed coverage.

The plight of a disabled homemaker could be longstanding. Because one had not paid into social security, eligibility for medicare would not be possible. Both of the examples illustrate a need for legislation which makes it necessary for insurers to provide conversion policies of comparable coverage to individuals who have been under group health care plans of that insurance company.

With the passage of the Comprehensive Health Insurance Act in Minnesota, a requirement of comparable conversion policies was made into law. CA believes that the tenets of the Minnesota Comprehensive Health Insurance Act provide the substance for change so that senior citizens and all Americans can be assured of quality health care coverage. The law requires that all companies selling health insurance or medicare supplement in Minnesota offer a qualified plan to residents.

To be qualified, a plan must provide $250,000 of major medical coverage. with a choice of three deductibles and a maximum loss of $3,000. Qualified medicare supplements must provide $100,000 of major medical coverage, 50 percent coinsurance on the original deductibles, and a maximum loss of $1,000. A qualified plan would include coverage for all doctor and hospital fees, outpatient drugs, nursing home care, routine physical examinations, durable medical equipment, and dental care.

People may elect to purchase a level of coverage which is less than the benefits of a qualified plan. That fact may make it necessary to outline minimum standards for policies on a number of levels, so that people are best able to purchase the amount of coverage they need and can afford. A plan similar to Wisconsin's supplement guidelines can help to assure people that the policies they purchase are worth the money, though the policy may not include first dollar coverage on all medi-gaps.

Other prominent features of the law include a requirement that insurance companies state the percentage of the premiums which will be paid out in claims and offer conversion policies of comparable coverage. As mentioned, an insurance pool where people with preexisting medical conditions can obtain coverage has been created. Qualified health insurance plans and medicare supplements are outlined. And, the law requires that hospital care cost reports be filed with the State for review by the health department and the commissioner of insurance.

CA believes that with steps of this kind and a stronger client orientation by the insurance divisions of our State governments. insurance companies will be forced to provide adequate coverage. The act is strong enough to protect the public from companies who issue extremely limited policies or use excessive portions of premium payments to cover administrative costs. yet fair enough that legitimate insurers will have no trouble operating within the confines of the law. I am enclosing a copy of the law for your review.

When seeking solutions for the problems of medicare and medicare supplement insurance, CA believes that it is important to bear in mind the original intent of the law. Allow me to quote the testimony which Federal Trade Commissioner Elizabeth Hanford Dole has cited. "The medicare program was never designed to provide complete coverage. Instead, it was meant to serve as a base on which people could build by means of private health insurance plans." [5]

CA believes that legislation enacted on the State level, similar to the Comprehensive Health Insurance Act of Minnesota, can serve to provide the as-

[5] Loc. cit., p. 1, footnote.

surances that senior citizens need when purchasing supplement insurance, without a massive government intervention. In developing our position on health insurance issues CA has been guided by a philosophy aptly stated by a Sioux Falls, S. Dak., retired elementary school principal whose wife could not qualify for insurance. "I do not believe that we should have socialized medicine, but I do believe that the government should legislate so every person is eligible for a private plan * * * any help you could give would be appreciated. I am not asking for free insurance for my wife, I am just asking for an opportunity to carry insurance on her."

CA advocates an expansion of health insurance opportunities, and laws which assure people that the insurance they purchase is sound. We believe that the emphasis of these initiatives should rest in state governments and the private sector.

By serving to gather and refine available information, and by providing technical expertise to State governments, the Federal Government can act as a valuable facilitator of needed change. If CA can be of continued assistance, please contact us. Thank you very much.

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