REPORT TO GOVERNOR BRENDAN T. BYRNE

INQUIRY INTO THE BUSINESS PRACTICES OF INTERCONTINENTAL LIFE INSURANCE COMPANY IN THE STATE OF NEW JERSEY

MARCH 23, 1979

FINAL REPORT

DEPARTMENT OF LAW AND PUBLIC SAFETY
ATTORNEY GENERAL JOHN J. DEGNAN

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INTRODUCTION

This is a final public report on the investigation conducted by my office into the business practices of Intercontinental Life Insurance Company (Intercontinental) in New Jersey. It has been prepared for Governor Brendan T. Byrne in response to his directive issued on December 12, 1978. The investigation has been conducted under the direction of First Assistant Attorney General Judith Yaskin by a task force of attorneys and investigators from three divisions of my department -- the Divisions of Criminal Justice, Consumer Affairs and Law. The investigation has also been made in cooperation with Mr. Robert Del Tufo, United States Attorney for New Jersey.

While the main focus of the investigation concentrated on Intercontinental, it must be stated that many of the problems and practices of that company are not isolated. During the course of our investigation it has been made abundantly clear that new legislative and regulatory initiatives must be adopted to protect the elderly from unconscionable commercial practices in the sale of health and life insurance to New Jersey's senior citizens. My office has made such recommendations in the section entitled SUGGESTED LEGISLATIVE AND REGULATORY CHANGES.

There are a number of areas which, as the text of this report will reflect, require further, less public forms of investigation. Specifically, analysis is now ongoing with respect to

whether consumer fraud actions ought to be initiated against Intercontinental agents, its wholly owned subsidiaries or the company itself. In addition, the possibility of criminal proceedings, based both on information we expect now to receive from the House Select Committee on Aging and information we have developed independently, is the subject of active and ongoing consideration. However, investigations of that nature cannot be the subject of continued public comment lest the process be prejudicial to those involved and inimical to our interest in securing relevant and usuable data. At a time when final decisions have been made to proceed or not to proceed, that determination can be made public.

As a final note, the intensity of this inquiry into one insurance company has been quite out of the ordinary. While certain conclusions have been drawn herein which reflect adversely on the sale practices used to sell Intercontinental policies, we suggest that the problem is probably indicative of substantial industry-wide abuse. Without an analysis of other companies to the same degree to which Intercontinental has been subjected, we are unable to draw any conclusions, or to confirm those which have been made publicly elsewhere, with respect to where Intercontinental stands in relation to other companies doing similar business.

I. HOUSE SELECT COMMITTEE ON AGING

As stated in our February 1, 1979 interim report to Governor Byrne, my office has been conducting an inquiry into the allegations which have recently been made public regarding Intercontinental. In order to expedite this probe, minimize duplication, and conduct the investigation as thoroughly as possible, it was determined that, in addition to normal independent investigative procedures, an effort would be made to contact the House Select Committee on Aging. The Committee had previously held a hearing and was conducting its own investigation of Intercontinental.

On February 9, 1979 representatives from my office and the office of the United States Attorney for the District of New Jersey met with staff members of the House Select Committee on Aging. At that meeting, we requested any and all documentation that would pertain to the allegations which had been made public. In response, the Committee staff explained that no evidence would, or could, be released to New Jersey law enforcement authorities because of House of Representatives secrecy requirements. An attempt was then made to determine whether the Committee was aware of any information in its files that would be evidence of criminal acts committed in the State of New Jersey. At this point, the Committee staff stated that there was no specific evidence of criminality, but indicated that if any were uncovered,

it would be sent to my office. On Friday, March 16, 1979 we received from the Committee staff a telegram indicating that they had evidence of four possible forgeries that would be forwarded to my office "in due course." We intend to pursue any such charges immediately upon receipt of that information.

At the Committee's hearing on November 28, 1978, Mr. Herb Jaffe, the reporter from the Newark Star Ledger who had provided the Committee with leads for its field investigation in New Jersey, testified that he had previously turned over to the Committee his research notes and other materials, including the names of persons victimized by Intercontinental. When Mr. Jaffe was subsequently interviewed by my representatives and asked whether he could provide information that might assist my office in its inquiry, he explained that he was anxious to cooperate but that he had retained nothing that pertained to his investigation and had turned over his entire file to the Committee. In addition, while he could discuss the general areas of his investigation, he could not recall specific names or details. Accordingly, Mr. Jaffe sent a letter to the Committee requesting that all of his materials, or copies thereof, be made available to my office.

By letter dated March 14, 1979 from David Holton, Chief Investigator of the House Select Committee on Aging, addressed to Mr. Jaffe, the Committee expressed its wish to cooperate with my office and stated that it had done so "as far as we are permitted under House Rules and the U. S. Constitution." Mr. Holton

further stated that much of the Committee's information was the result of confidential interviews conducted by Committee staff and that the identity of these individuals had to be protected. Regarding Mr. Jaffe's file, which the Committee had in its possession, Mr. Holton stated that "as a professional investigator, I can think of no reason for these individuals to have or need copies of the materials you provided to us," although he did concede that it was "more accurate" for him to assume that "in [my office's] efforts to conduct a thorough examination of Intercontinental issues [my office is] zealously working to leave no stone unturned."

The resolution of this matter as to whether the Jaffe materials will be released to this office lies between Mr. Jaffe and the Committee. If the parties involved deem it appropriate to turn over those documents to my office, the documents will be reviewed in the context of our investigation.

Recent news articles have indicated that the House Select Committee has issued a confidential report on Intercontinental and has distributed that report to various New Jersey Congressmen. Several of those articles listed portions of that memorandum and reported that all of the statements were conclusions drawn by the Committee. While it is clear from the memo that the Committee has reached conclusions that there were widespread abuses by Intercontinental agents and that those abusive sales practices were the result of company policy, the Committee did not reach

any other conclusions, but rather listed a series of "allegations" which it indicated it was continuing to examine. Among those allegations were:

(1) "allegations of abuses in the sale of credit health and life insurance." We have examined that issue in this report in the section entitled SALE OF LIFE AND HEALTH INSURANCE IN CONNECTION WITH EXTENSION OF CONSUMER CREDIT.

(2) "allegations that Intercontinental has ties with or owns a Bahamian insurance company and has interests in Bally Manufacturing and Resorts International." We have discussed that issue in our section entitled HISTORY AND CORPORATE STRUCTURE OF INTERCONTINENTAL LIFE INSURANCE COMPANY.

(3) "allegations the insurance company received preferential treatment from State regulatory authorities because prominent public officials either were or are on its board." We have discussed that issue in our sections entitled INTERCONTINENTAL'S PURCHASE OF A BOND OF ILLINOIS GULF CENTRAL RAILROAD and ALLEGATIONS OF POSSIBLE IMPROPRIETIES.

(4) "allegations that Intercontinental engaged in particular acts of fraud in group solicitation of customers and other allegations of unconscionable commercial practices." We have discussed that issue in our section entitled CONSUMER COMPLAINT ANALYSIS.

(5) "allegations that the State Attorney General's Office ignored complaints about Intercontinental turned over to them by the State Insurance Commissioner." This allegation is discussed in our section entitled ALLEGATIONS OF POSSIBLE IMPROPRIETIES.

Shortly after the publication of those articles, a clarifying statement was released by the Committee stating that the memorandum was drafted for the limited purpose of informing its New Jersey members of the past course of events, as well as "allegations" still under investigation [Exhibit A].

Meanwhile, my office has conducted an independent investigation of Intercontinental. The direction of that investigation is fully explained in the following sections of this report.

II. CONTACT WITH INSURANCE AND LAW ENFORCEMENT OFFICIALS FROM OTHER STATES

In my previous report, I indicated that members of my staff would confer with insurance officials and law enforcement authorities from the other states which we had found to be actively investigating either the practices of agents who sell Intercontinental health insurance policies or the conduct of the company itself.

Representatives of my office have consulted with insurance and law enforcement officials from Massachusetts, Connecticut, Rhode Island, Georgia, Oregon, and California.

Both the Massachusetts Division of Insurance and the Massachusetts Attorney General's Office have commenced formal legal actions against the C.T. Marquis Agency of West Springfield, Massachusetts, an independent insurance agency whose agents sell Intercontinental Medicare supplemental policies among other kinds of Medicare supplemental policies. (Intercontinental is not licensed in Massachusetts and Intercontinental policies cannot be lawfully sold in Massachusetts.) The Marquis Agency had been recruited to sell Medicare supplemental policies for Intercontinental by the Major Insurance Service (MIS) of Santa Ana, California. Intercontinental has a contract with MIS whereby MIS receives a certain percentage of the premium for each Intercontinental Medicare supplemental policy sold and renewed by Marquis agents. Inquiries have been made to the California Insurance Department about MIS. Intercontinental

has informed my office that MIS has contracted with Intercontinental to provide national marketing consulting services and to recruit agents to sell Intercontinental's Medicare supplemental policies in all states where Intercontinental is licensed, including New Jersey. Documents have recently been obtained relating to this relationship. My investigation of MIS's role will continue.

The Massachusetts Division of Insurance has filed administrative charges against the Marquis Agency itself and ten of its agents for a variety of unfair or deceptive practices including making misrepresentations to prospective senior citizen insureds, "twisting" policies already held by insureds into policies with another company, "loading" insureds with duplicative policies, forging signatures, falsifying applications, and selling the policies of an unlicensed company (i.e. Intercontinental). The Division of Insurance seeks to revoke all of the agency's and agents' licenses and to assess fines. The administrative hearings on these charges will be held some time in late spring or early summer.

The Massachusetts Attorney General's Office has recently filed a consumer fraud complaint in Massachusetts Superior Court against the Marquis Agency and six of its agents. The basis of the Attorney General's suit is essentially the same as that of the Insurance Division's administrative filings. The Attorney General's Office anticipates a long discovery period in this consumer fraud litigation.

At this time, the Massachusetts authorities have taken formal action only against agents selling Intercontinental policies and not against Intercontinental itself.

The Connecticut Department of Insurance has recently filed administrative charges against two agents of the C.T. Marquis Agency on grounds similar to those of the Massachusetts Division of Insurance. The hearing on these administrative complaints will be held some time later this month. The investigative findings of the Connecticut Insurance Department regarding the activities of the C.T. Marquis Agency were forwarded to the Economic Crime Unit of the Connecticut State's Attorney. The State's Attorney is already prosecuting one of the C.T. Marquis Agents for larceny, criminal impersonation, and selling insurance without a license and the State's Attorney's investigation of the Marquis Agency and its other agents continues.

Although the Rhode Island Department of Business Regulation has not yet initiated any formal proceedings against the Marquis Agency or Intercontinental itself, the Department is investigating the activities of the Marquis Agency in Massachusetts, Connecticut, and Rhode Island as well as Intercontinental's conduct in allowing the alleged abuses of the Marquis Agency to occur. As I pointed out in the interim report, several hundred applications for Intercontinental health insurance policies were purportedly signed and executed in Rhode Island for Massachusetts and Connecticut residents.

The Georgia Department of Insurance is continuing its investigation of complaints made by Georgia senior citizens against one particular agent who sells Intercontinental health policies among other kinds of health policies.

The Insurance Commissioner of Oregon has informed me that the main problem which Oregon has had with Intercontinental occured in 1977 when a Portland-based agent marketing Intercontinental policies was placed on a two-year probation for the conversion of funds paid to the agent by consumers. The Commissioner also pointed out that there was a marked reduction in the number of consumer complaints about Intercontinental policies in 1978.

My staff has identified a contact person in each of these government agencies from other states who are investigating alleged abuses in the sale of Intercontinental policies. All of these contact persons have been most cooperative and have agreed to keep us apprised of the results of their investigations.

III. HISTORY AND CORPORATE STRUCTURE OF INTERCONTINENTAL LIFE INSURANCE COMPANY

Intercontinental was incorporated on December 1, 1964. It became operational on December 9, 1965. The original corporate officers and capital stock structure was:

President, Lawrence E. Stern	65,000 share at $.20 per share
Secretary, Brendan T. Byrne	65,000 share at $.20 per share
Treasurer, Harold R. Teltser	65,000 share at $.20 per share
Chairman/Board, Martin L. Greenberg	65,000 share at $.20 per share

The stockholders were given the option to purchase an additional 35,000 shares each at the price of $1.00 per share. All members exercised their options.

Lawrence E. Stern is now the Executive Vice President of the Integrity Insurance Company. He stated that he left the then Department of Banking and Insurance where he was Deputy Commissioner in charge of the Bureau of Insurance on January 1, 1965 and became President of the newly formed Intercontinental. It was strictly a life insurance company then and Stern's initial responsibilities included recruitment of agents and sale of the corporate stock. Stock was sold to a number of agents as part of the original offering.

Ephraim Weiniger recalled that on or about August, 1965, Stern approached Wallace Weiniger (Ephraim's brother) regarding a possible association between Weiniger's Insurance Agency and Intercontinental. At this time, three Weiniger brothers and their father had a large, long-established health, life and casualty business

in operation in Essex County. Their agencies were known as:

1. First National Health Agency
2. National Health Protective Agency

The Weinigers were general agents for CNA financial corporation (hereinafter CNA). Negotiations continued until December 1966, when, according to Ephraim Weiniger, an agreement was reached whereby Intercontinental purchased the building which housed the Weiniger agencies in exchange for 100,000 shares of Intercontinental stock, and 900,000 options exercisable over a five-year period. The options were contingent upon their producing a certain amount of business for Intercontinental.

From this point on the Weiniger's agencies sold both Intercontinental and CNA policies.

In 1969 Stern left Intercontinental. Ephraim Weiniger, who had become Vice President in charge of health insurance in 1967, took over as President. Prior to Stern's leaving, Intercontinental acquired Paramount Mutual Insurance Company from the Weinigers by way of a bulk purchase of assets and liabilities.

Brendan T. Byrne was Chairman of the Board from 1966 until 1969. He resigned as a member of the Board on December 28, 1970 prior to appointment to the bench and thereafter placed his company stock in a blind trust prior to taking office as Governor of this State.

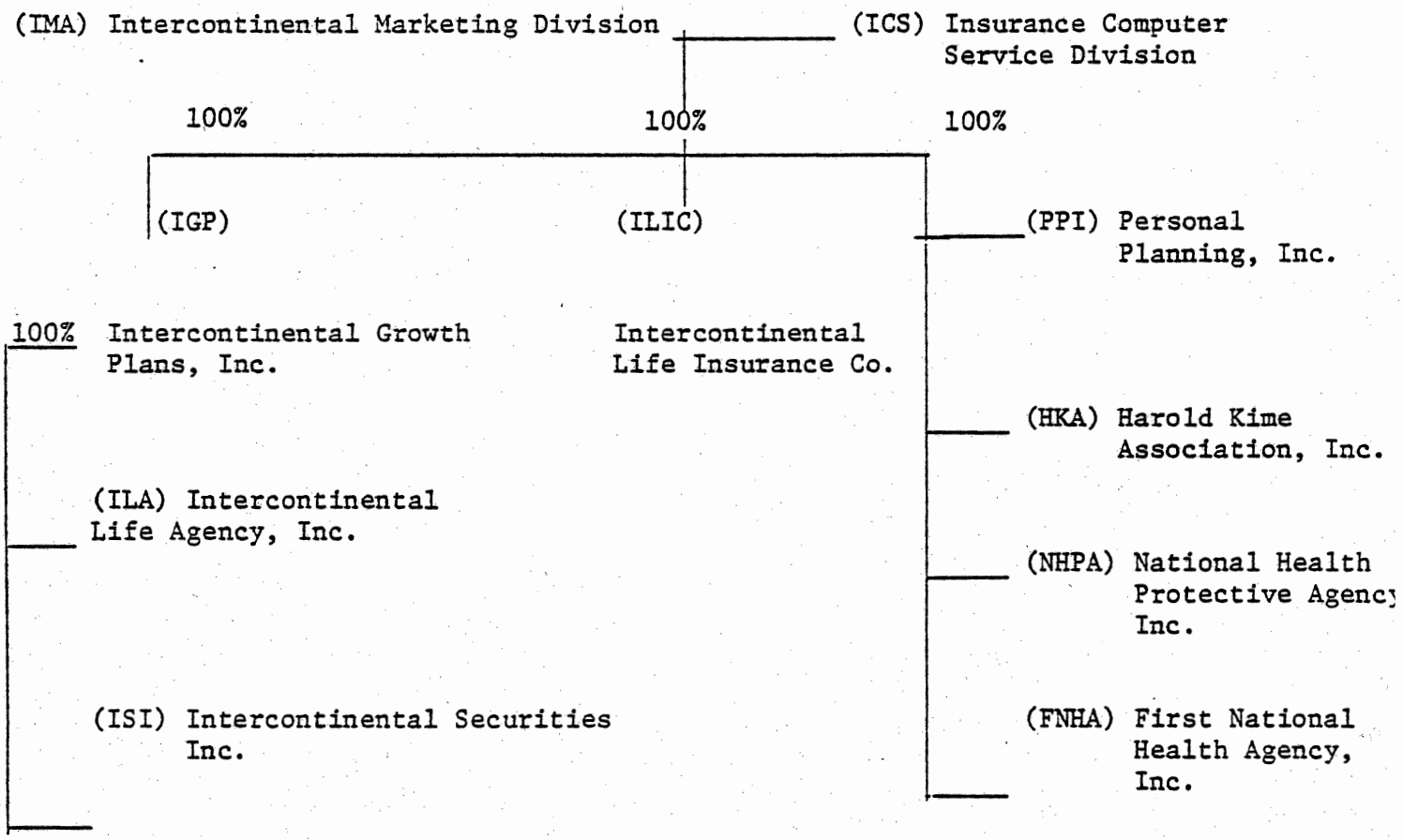
In 1970 Ephraim Weiniger became Chairman of the Board as well as President.

In 1971 a formal merger occurred between the Weiniger agencies and Intercontinental. Five companies were acquired from the Weiniger family on December 12, 1971. Consideration for acquisition was 1,665,000 shares of Intercontinental common stock. The companies were:

1. First National Health Agency, Inc.
2. National Health Protective Agency, Inc.
3. Professional Retirement & Pension Plans, Inc.
4. Eastern States Promotional Agency, Inc.
5. Insurance Computer Services, Inc.

A five to one reverse stock split occurred on July 16, 1973 whereby 4,500,000 shares outstanding were reduced to 1,100,000 shares. Thereafter, various structural changes occurred leading to its present form:

CORPORATE STRUCTURE
1977 & 1978
INTERCONTINENTAL LIFE INSURANCE COMPANY



The House Select Committee has received an allegation that Intercontinental might control a Bahamanian insurance company. We await the results of the House Committee examination for further details. Our own general inquiry reveals the following facts. There were at least two insurance companies operating in the Caribbean bearing the name of Intercontinental; one corporation was organized in Panama, while another was chartered in the British Virgin Islands. We have obtained the names of the principals of these companies. Based on our research into Intercontinental's corporate history and structure, none of the individuals or companies have any apparent connection with Intercontinental nor has our investigation disclosed that Intercontinental has a connection with any other Bahamanian insurance company. Mr. Ephraim Weiniger stated that Intercontinental did not own or have any interest in any insurance company located in the Bahamas. We have raised this question with the Weinigers, Lawrence Stern and others who might have some knowledge and all have denied that any exists. In addition, an issue has been raised as to the relationship between CNA Financial Corporation and Intercontinental.

Our investigation disclosed that CNA is the fourteenth largest multiple life insurance group in the nation. It has approximately 34 million common shares outstanding, a majority of which were acquired by Loews Corporation in November 1974. See Exhibit B, CNA Corporate Chart Structure.

The executive officers of CNA include Lawrence A. Tish, Chairman of the Board, Dennis Chookaszian, Vice President and

Comptroller and Thomas R. Ieloski, Vice President and Secretary. The present Board of Directors consists of eleven individuals, none of whom appear to have any relationship to Intercontinental principals. Mr. Tish also serves as Chairman of the Board and Chief Executive Officer of the Loews Corporation and Loews Hotels, Inc.

As noted earlier in this report, the Weiniger family since the 1930's acted as general agent for CNA insurance and particularly the Continental Casualty Company which is a wholly owned subsidiary of CNA. That business relationship is still maintained today by Intercontinental agents, many of whom were with the Weinigers prior to the merger with Intercontinental.

Sheldon and Ephraim Weiniger stated that they do not own any stock in CNA nor did that company or any of its principals have any interest in Intercontinental. They also stated, however, that Intercontinental Life Company benefited indirectly from the sale of CNA policies by agents of National Health Protective Agency and First National Health Agency, its two wholly owned subsidiaries, in that the profits of the wholly owned agencies reflect income from such sales. Although records reveal corporations related to CNA did have an interest in property in Atlantic City and also operate a hotel in the Bahamas for Resorts International, we have found no evidence of corporate ownership between CNA and Intercontinental aside from the fact that two subsidiary corporations of Intercontinental are licensed to sell CNA policies and profit thereby.

The investments of domestic life and health insurers in New Jersey are restricted by statute, N.J.S.A. 17B:20. As in most states, there is a "basket clause" provision, N.J.S.A. 17B:2-1(h), which allows insurers to invest a certain percentage of their assets in any way they see fit. In this State, the unrestricted percentage is 5%. The Department of Insurance monitors an insurer's complaince with the statute regulating investments on the basis of the annual statement which is filed. In this instance, Intercontinental's investments in Resorts and Bally are well within 5% of its 1978 assets if such investments are considered unrestricted. They are reflected in Intercontinental's 1978 annual report. Of course, the Department of Insurance, as a matter of its routine function, will evaluate whether Intercontinental has complied with N.J.S.A. 17B:20-1(h) as to its total unrestricted investments.

SALE OF LIFE AND HEALTH INSURANCE IN CONNECTION WITH EXTENSION OF CONSUMER CREDIT

We have been informed by the Department of Insurance that it has been investigating the sale of life and health insurance in connection with the extension of consumer credit by banks, small loan companies, other financial institutions, and automobile dealers. Thus far, the investigation has revealed that several companies may be selling insurance in connection with the extension of consumer credit through unlicensed individuals and entities, that certain single premium life and health policies which are unfair and unreasonable are being offered to debtors, that such policies may be marketed deceptively and fraudulently, and that the laws regulating the sale of credit life and health insurance may be violated by these sales.*

Intercontinental entered the market of creditor sales of insurance in 1967. The Department of Insurance's investigation

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* A creditor may require a debtor to purchase credit insurance, but the choice of insurance is the debtor's. N.J.S.A. 17B:29-11. A creditor selling insurance must be a licensed agent of the Department of Insurance. N.J.S.A. 17B:22-8; 17B:29-9. Insurance sold in connection with a loan or other credit transaction of less than ten years duration must be approved by the Department of Insurance pursuant to the laws regulating credit insurance. N.J.S.A. 17B:29-1 et seq. It is unlawful for any person to engage in unfair trade practices in the sale of insurance, which include misrepresentation, false advertising, and false information. N.J.S.A. 17B:30-1 et seq.

of Intercontinental's sales through creditors has concentrated on the sale of Intercontinental credit life and disability and auto accident policies by automobile dealers. There are three aspects to this investigation.

The first aspect concerns the sale of Intercontinental policies by unlicensed automobile dealers. New Jersey law requires that individuals or corporations acting as insurance agents be licensed by the Department of Insurance.* The Department of Insurance has learned that several automobile dealers who are not licensed agents are selling Intercontinental credit and non-credit policies to their customers.

The second aspect of the Department's investigation concerns whether automobile dealers selling Intercontinental policies are misrepresenting to their customers the nature of, and need for, these policies. In some cases, customers have informed the Department of Insurance that they were not made aware at the time of purchase of a vehicle that they had bought an Intercontinental policy. The Department has requested the staff of the Attorney General to aid it in preparing for administrative action against these dealers for violations of the licensing and unfair trade practices laws.

The final aspect of the Department's inquiry relates to

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* N.J.S.A. 17B:22-8; N.J.S.A. 17B:29-9.

the sale of an Intercontinental single premium auto accident policy by auto dealers to their customers. The Department determined that this policy was essentially duplicative of existing automobile insurance and that its benefits were unreasonably low in relation to the premium charged. The Department asked Intercontinental to voluntarily give up its right to make future sales of this policy. The company agreed to do so on January 10, 1979, after having sold only 800 such policies.

The Attorney General's staff will provide any necessary legal assistance to the Department of Insurance in taking administrative actions as a result of these continuing investigations.

INTERCONTINENTAL'S PURCHASE OF A BOND OF ILLINOIS GULF CENTRAL RAILROAD AND THE AWARD OF A STATE CONTRACT TO ILLINOIS GULF FOR REFURBISHING RAILROAD LOCOMOTIVES

On December 10, 1978, the Star-Ledger carried a news article entitled "State Rail Contract Follows Insurance Firm's Investment". Since interference in a State purchasing contract might be a criminal violation, we pursued this allegation in depth.

During the course of our inquiry, we reviewed all of the documents within the Department of Transportation which are relevant to the contract. In addition, we spoke with the following individuals:

1. G. W. Herkner, Jr., Assistant Director, Division of Consumer Services, Department of Transportation
2. Raymond Theriault, Chief, Bureau of Rail Equipment Department of Transportation
3. Martin Garrity, Vice President and Assistant Treasurer of Intercontinental
4. Joel Danishefsky, Merrill Lynch Investments
5. Richard Anderson, Director, Division of Consumer Services, Department of Transportation
6. Russell Mullen, Assistant Commissioner, Department of Transportation
7. Congressman James Howard
8. Theodore Labrecque, Chairman, Monmouth County Transportation Coordinating Committee
9. Ephraim Weiniger
10. Sheldon Weiniger

We found no evidence to support any allegations of improper conduct. All of the interviews and documents indicate that the transaction occurred in the following manner:

a. Intercontinental purchased the bond on October 13, 1977 at the recommendation of Intercontinental's investment broker, Joel Danishefsky of Merrill Lynch.

b. The purchase was made routinely without any knowledge on anyone's part of any potential dealings between Illinois Gulf and the State of New Jersey. This particular bond represented only 1/2 of 1% of Intercontinental's total investment of bonds.

c. The Department of Transportation was well aware that Illinois was one of the leading remanufacturers of Diesel locomotives and had discussions with Illinois on this subject as early as February 1977.

d. Lack of funds for this specific purpose had stymied any significant effort by the State to improve the rail transportation on the shore line.

e. In February 1978, Congressman Howard contacted Governor Byrne who referred him to Acting Commissioner Mullen about the deteriorating service on the shore line. Howard guaranteed a federal grant of monies to the State (80% of cost) for improvement of the line and specifically recommended to Mullen that Illinois be be contracted with because it was a reliable firm which could move quickly.

f. Congressman Howard learned of the existence of Illinois and its reputation through conversations between his staff and people in the Commuter Services Division in DOT. His interest was a result of continued complaints from shore commuters who were in Howard's district.

It appears that there is absolutely no connection between the purchase of the bond by Intercontinental and the contract with DOT.

VI. ALLEGATIONS OF POSSIBLE IMPROPRIETIES

In our interim report we stated that we would inquire into the quality of the response forthcoming from the Department of Insurance about Intercontinental Life Insurance Company (see page 37 of Interim Report, February 1, 1979).

We were aware that individuals who were associated with Intercontinental when it was founded had achieved prominence in public service. This fact has apparently raised a question in some peoples' minds as to whether Intercontinental was sheltered or given special favor by government agencies. We have, therefore, inquired in depth as to whether an improper relationship may have existed between Intercontinental or persons associated with it and the Department of Insurance.

During the course of our inquiry we spoke with Investigative Reporter Herb Jaffe, reviewed news articles printed on the subject and studied all the public testimony taken by the House Select Committee. We requested from the Counsel to that Committee any information that it might have that would in any way indicate that a corrupt relationship may have existed. These sources indicated only two (2) concrete leads:

1. A January 21, 1979 news report of a statement by April Auerbach, a former Consumer Services Investigator in the Department of Insurance, that her findings as to abuses

by Intercontinental agents "got buried" and that Commissioner Sheeran "cold watered" her when, on one occasion, she told him about evidence she had received of questionable practices by Intercontinental's agents.

2. A December 26, 1978 news report of a statement made by Elaine Goldin, Somerset County Consumer Services Director that a "formal investigation" of Intercontinental's health insurance practices by the Department of Insurance was "halted" and never publicly disclosed. Goldin seemed to infer that Director Eleanor Lewis of the Department was mistaken about a questionnaire that was allegedly sent to consumers who filed complaints and that April Auerbach may have been fired or forced out of the Department because she was "deeply involved" in the investigation of charges against Intercontinental.

THE INQUIRY

The attorneys and investigators assigned to this area decided to concentrate their efforts in five general areas:

1. Thoroughly examine those specific leads which April Auerbach and Elaine Goldin might provide.

2. Interview everyone in the Department of Insurance who handled complaints against health and life agents and companies with particular emphasis on Intercontinental and its agents.

3. Interview persons no longer connected with the Department or Intercontinental who might have information concerning an improper connection.

4. Interview the principal officers in Intercontinental and the upper level of the Department of Insurance.

5. Review records of the Department of Insurance concerning the manner in which complaints against Intercontinental and its agents were processed within the Department.

APRIL AUERBACH INTERVIEW

We interviewed Ms. Auerbach on January 24, 1979. A complete interview report is contained in the investigative file. Among other things Ms. Auerbach stated that she was employed by the Department during three (3) separate time periods:

1. Between May, 1973 and October, 1974 she was employed as an Actuarial Assistant in the Division of Actuarial Services and, during last six months of this period, as an Investigator in the Consumer Services Division under Dr. Eleanor Lewis. She resigned in October of 1974 to bear a child.

2. Between March of 1975 and October of 1975 she was employed on a part-time basis in the Division of Consumer Services. She worked on minimum standard regulations for the health industry. She resigned in October of 1975 for personal reasons wholly unconnected with any investigation by the Department of Insurance.

3. Between July of 1976 and December, 1977, she was employed as an Actuarial Assistant and later a Consumer Analyst in the Consumer Services Division. During this period of her employment, she conducted Market Conduct Studies of five separate insurance companies, handled general complaints against insurance companies including telephone complaints and worked with legal interns who were hired by

> the Department to draft regulations. Ms. Auerbach terminated her employment with the Department in December, 1977. She left the Department for personal reasons and was not in any manner forced or pressured to resign.

We gave her a copy of the article which appeared in the Sunday Star Ledger of January 21, 1979. She read the article in our presence and indicated that for the most part it was accurate. However, to the extent that someone reading the article could infer that there had been improper motives or activities on the part of people in the Department of Insurance, Ms. Auerbach stated that she never intended that such conclusions be drawn and she denies that any such improprieties existed.

She was questioned with regard to the procedure which the Department utilized in addressing consumer complaints. She indicated that Helen Thompson, an Actuarial Assistant, was actually in charge of all consumer complaints dealing with health and life insurance. Some of these complaints were given to Helen Thompson and some of the complaints were given to her or other consumer analysts. She said that she could discern no particular reason why one complaint was sent to her as opposed to Helen Thompson, nor was any explanation ever given to her as to any reason for such distribution of complaints. According to her the standard technique for dealing with complaints in the Consumer Services Section and the Actuarial Division was as follows:

When the complaint was received, a synopsis of that complaint was sent to the company that was complained of. The company would then reply to the complaint presenting whatever evidence was requested by the Department of Insurance. Based on the complaint made by the consumer and the company's explanation, a decision was made by the investigator assigned to that complaint as to whether the complaint was valid or whether the insurance company had properly acted under the circumstances. When such decision was made, both the complainant and sometimes the insurance company were notified of the Department's position in the matter.

In the case of agent complaints, a sworn statement from the agent would be requested to be forwarded to the Department of Insurance by the insurance company involved. In cases where it was felt that some action should be taken against the agent, the file was then transferred to the Division of Investigation and Complaints for disciplinary action. In those instances where a complaint involved some agent's misconduct but the insurance company had reached an agreeable solution to the problem with the complaining party, it was basically up to the investigator assigned to the file as to whether the file should be closed or forwarded to the Division of Investigation and Complaints for further action against the agent for whatever misconduct was

involved. She indicated that more often than not, such complaints were simply closed because the complaining parties were more interested in obtaining some sort of monetary satisfaction than they were in pursuing any disciplinary action.

With regard to the Market Conduct Studies, Ms. Auerbach said that she conducted Market Conduct Studies of five separate insurance companies. The second Market Study which Ms. Auerbach began was that concerning Intercontinental. She indicated that there was nothing done differently in the market study with regard to Intercontinental than was done in any of the other Market Conduct Studies. She did mention that she was concerned because she wanted to add some portions to the market conduct study on Intercontinental concerning the problem with agent misconduct. However, it was explained to her that such matters could not be included within this particular Market Conduct Study because it was beyond the scope of the study.

Ms. Auerbach indicated that Intercontinental had a highly disproportionate number of complaints regarding agent conduct compared to other insurance companies. She recalled that shortly after Commissioner Sheeran took office, he conferred with her regarding some kind of consumer oriented activity that the Department could undertake. The Commissioner had not yet formulated a definite plan but he was interested in the kind of problems that occurred and who the worse offenders were. She mentioned Intercontinental as being one of the worse in the industry in her opinion;

however, Commissioner Sheeran made no reply. She did not infer any corrupt motive from this.

Ms. Auerbach also received complaints which were forwarded to the Department of Insurance by Elaine Goldin, the Director of the Somerset County Consumer Services Office. Ms. Goldin forwarded approximately a dozen or so complaints over a period of time to the Department. The bulk of these complaints concerned high pressure sales techniques involving misrepresentation to elderly people. She indicated that most of the time Intercontinental simply gave the money back to the complaining party in these instances and the file would then be closed.

Ms. Auerbach indicated that to her knowledge, there was no purposeful secreting of any files in the Department of Insurance. She said that she did send various communications to Dr. Eleanor Lewis but did not receive a response. Ms. Auerbach felt that Dr. Lewis was unable to give enough time to her job since she was attending law school at night. Ms. Auerbach emphatically stated she does not feel that corruption or politics had anything to do with the Department's failure to take any punitive action toward Intercontinental or its agents. She attributes this failure to the general policy of the Department as it affected all such insurers, the lack of manpower and, to a certain extent, lack of initiative.

ELAINE GOLDIN INTERVIEW

We interviewed Elaine Goldin, Director of the Somerset County Department of Consumer Services on March 5, 1979. A com-

plete interview report is contained in the investigative file.

Among other things, Ms. Goldin stated that she never intended to imply from her statements as quoted in the December 26, 1978 news article that she (Goldin) believed that Director Lewis did not send out a questionnaire to consumers or that Ms. Auerbach was fired or forced out of the Department because of her investigation of Intercontinental and its agents. Ms. Goldin did state that she simply knew nothing about the questionnaire other than what Lewis told her and did not know why Ms. Auerbach left. Subsequent inquiry has demonstrated that Dr. Lewis did send questionnaires to 60 consumers that were chosen on a random basis from a complete list of policyholders of Intercontinental and that Ms. Auerbach's reason for leaving in December, 1977 was totally unconnected with Intercontinental.

Ms. Goldin stated that her office had forwarded fifteen complaints to the Department of Insurance over a period of three years. According to Ms. Goldin, she was unaware of any action taken by the Department of Insurance on these specific complaints. Ms. Goldin stated that in addition to the fifteen formal complaints which were forwarded to the Department of Insurance, the Somerset County Office of Consumer Services received numerous phone calls concerning Intercontinental and/or its agents. She stated these phone calls are not documented because the complainants refused to file a formal complaint.

Ms. Goldin said that she was present at two meetings at the Department of Insurance involving Intercontinental. The first

eeting occurred in June, 1975. The purpose of this meeting was to iscuss a mail solicitation to senior citizens in Somerset County hich Elaine Goldin felt had deceptively suggested, by its layout, hat it had originated from a government agency. Present at the eeting were Ephraim Weiniger and an attorney whose name Ms. Goldin id not remember. (Department of Insurance records indicate that the ttorney representing Intercontinental was Mr. Harold Teltser.) Also present were April Auerbach and Dr. Eleanor Lewis, both from the Department of Insurance. Ms. Goldin remembered that at the conclusion of the meeting, Dr. Lewis told Mr. Weiniger that all future direct mail solicitations of this type would have to be submitted to the Department of Insurance for review before mailing.

The second meeting concerning Intercontinental at the Department of Insurance took place approximately one year ago at Dr. Lewis' office. Besides Ms. Goldin, present were Ephraim and Sheldon Weiniger, Dr. Lewis and three sales agents from Intercontinental, one of whom Ms. Goldin identified as Evelyn Whiteman. Ms. Goldin thought that one of the other two agents was Ira Gurney and she could not remember the third. This meeting was called by Eleanor Lewis and Elaine Goldin because Ms. Goldin had been receiving complaints from retired teachers regarding the solicitation practices of these three agents. At the conclusion of this meeting, Dr. Lewis told Ms. Goldin that the Department of Insurance would send questionnaires to people solicited by the Intercontinental agents involved.

On the general topic of Intercontinental, Ms. Goldin stated that that company solicits heavily in Somerset County. Many people contact the Consumer Services office but are reluctant

to file formal complaints. Not all of the consumer contracts are in the nature of a complaint. Many contacts are merely inquiries regarding policy terms which apparently the selling agent did not adequately explain. When Ms. Goldin first began referring complaints to the Department of Insurance, Dr. Lewis assigned April Auerbach as a liaison between the Department and Elaine Goldin. When Ms. Auerbach left the Department of Insurance, Ms. Goldin dealt with Sima Silver. Ms. Goldin continues to deal with Ms. Silver up to the present.

Ms. Goldin stated that she had no direct knowledge of any improper activities. She stated that she did not know why Ms. Auerbach left the Department and did not intend to imply that Ms. Auerbach was fired or forced out. Ms. Goldin did offer that when she went to one of the meetings mentioned above, she noticed a Lincoln Continental parked in Commissioner Sheeran's parking place and was told by someone that it belonged to Mr. Weiniger. Ms. Goldin also recalls that after one of the meetings she observed Mr. Weiniger and his attorney enter the Commissioner's office and thereafter heard some laughter.

ANALYSIS OF THE APRIL AUERBACH AND ELAINE GOLDIN INTERVIEWS

Neither person indicated any knowledge of an improper relationship between Intercontinental and the Department of Insurance. Since they could not offer any new investigative leads, we decided to follow the path of complaints against Intercontinental through the Department and interview the personnel who handled them.

HELEN THOMPSON AND THE COMPLAINT SECTION WITHIN THE DIVISION OF ACTUARIAL SERVICES

Helen Thompson is in charge of the complaint section within the Division of Actuarial Services. She has held this position since 1969. It is one of four sections within that Division and the only one that handles complaints. This section receives 95% of all complaints received by the Department of Insurance that deal with life and health insurance companies and agents. There are only two investigators assigned to the unit which averages 300 new complaints received each month.

Ms. Thompson described the operation of her section in the following manner. All complaint matters are given a chronological file number in addition to a code indicating the insurance carrier. Most of the complaints received pertain to Blue Cross/Blue Shield coverages. Many complaints are closed with a reply and explanation to the complainant by her personnel. If the complaint reveals some substance, a copy of the complaint is sent to the insurance company or its agent for reply. Further action on a case depends on the reply received from the carrier or its agent. If she is satisfied, the complainant is so advised and the case closed. If dissatisfied with the response of the insurance company or its agents, she will forward the case with her recommendation to the Division of Investigation. Her section since 1977, now maintains an alphabetical file of all complaints filed against agents. In any case, when the matter is referred to the Division of Investigations, her basic function is completed.

She stated that she has never been asked or instructed to give preferential or special treatment to complaints lodged against Intercontinental or its agents nor has she every been asked or instructed to give such treatment to any other insurance company.

We interviewed Paul DeAngelo and Richard Danley who are the two investigators assigned to this section. Their precise title is Actuarial Assistant. Each one corroborated Ms. Thompson's description of the activities of this section. Paul DeAngelo, who has been in this section since 1975, has been assigned (since November, 1978) to all matters concerning Intercontinental on a priority basis. Mr. Danley, who has been in this section since 1973, is particularly interested in complaints alleging "replacement" or "twisting" by agents. Both Danley and DeAngelo stated that they have never been asked to give special treatment to Intercontinental or any other company or agent.

DR. ELEANOR LEWIS AND THE DIVISION OF CONSUMER SERVICES

Dr. Lewis became employed at the Department of Insurance, as Director of this Division, on March 8, 1974. Later she received the additional title of Assistant Commissioner. The Division of Consumer Services was formed by Commissioner Sheeran within the Department to protect insurance consumers. They intended that this Unit inquire into patterns of abuse, with an eye toward recommending new regulations or laws that would correct such patterns affecting whole classes of consumers.

The Division is comprised of:

1. Director
2. Seven (7) Analysts (two of which are now working for Deputy Commissioner Bliss)
3. One (1) Part-time Clerical
4. Three (3) Secretaries

Dr. Lewis explained that the Division would receive information of patterns of abuse from Helen Thompson's section, John Dirk (Chief, Division of Investigations & Complaints), letters to the Commissioner and Market Conduct Studies that would be conducted by the Consumer Services Division.

The Market Conduct Study approach was the most important aspect of the Division's activities. While April Auerbach was employed there, she specialized in life and health studies while Richard N.Wenng handled the casualty matters. Between 1975 and 1978 this Division conducted seven (7) market conduct studies of life-health companies and fourteen (14) market conduct studies of

property liability companies. The records further reflect that a Market Conduct Study of Intercontinental was initiated August 23, 1976 and a final report submitted on January 24, 1978.

We interviewed six of the consumer analysts assigned to the Division of Consumer Services. They are:

1. Richard N. Wenng, employed as an analyst since February 2, 1976.

2. Sharon Szabo, employed as an analyst since June 12, 1976.

3. Ruth Cunningham, employed by the Department since 1956 and is an Analyst since February 1976.

4. Sima S. Silver, employed as an Analyst since June 1977.

5. Eugene F. Gerry, employed as an Analyst since February 1978. Prior thereto he was an investigator in the Department for four years under John Dirk.

6. Philip S. Gray, employed as an Analyst since December 18, 1978. Prior thereto he was an investigator in the Department for four years under John Dirk.

Each stated that they had never given preferential treatment to Intercontinental or any other insurance company and had never been asked to do so.

JOHN J. DIRK AND THE DIVISION OF INVESTIGATION AND COMPLAINT

Mr. Dirk and his Chief Investigator, Arthur M. Keefe, were interviewed on March 14, 1979. Mr. Dirk has been Chief of the Division since January 1, 1969 and has been in the investigative

section of the Department since July 1959. For about the past two years, his Division has been under the supervision of Assistant Commissioner Dr. Eleanor Lewis. He is in charge of ten investigators and ten supporting clerical personnel. His unit handles approximately 13,000 complaints a year almost exclusively dealing with casualty-property insurance companies and their agents. Should this Unit receive an initial complaint regarding life/health insurance companies or their agents, it would be referred to the Division of Actuarial Services (Helen Thompson). His Unit will assist the personnel in Actuarial Services when requested and in some (but rare) instances, a complaint matter is referred to his Unit for further action. His investigators would then take additional investigative steps and they may recommend a letter of censure; a fine; or suspension or revocation of the agent's license. In the latter cases, the complaint matter is heard before the Hearing Officer, Ms. Naomi Labastille, and the Department is represented by a deputy attorney general. Before such a hearing is scheduled, substantial evidence and corroborated testimony must be secured. It was his recollection that only rarely was a complaint matter in the life/health area heard before a Hearing Officer. Mr. Dirk reviewed his files and indicated that between the years 1970 and 1978 there were only two actions taken against Intercontinental agents. Both matters were resolved by consent order. Stanley Siegel was fined $750 in 1972 and Mr. Alan

Lister was fined $1,000 in 1978. He also indicated that between the years 1970 and 1978, 22 licenses of agents selling life and health insurance were revoked by the Department of Insurance, 17 in the past five years. Two agents had their licenses suspended, one in 1976 and the other in 1978.

Mr. Dirk and Mr. Keefe both stated that they have never given preferential or special treatment to complaint matters concerning Intercontinental or its agents or any other insurance company or its agents. They have never been instructed to treat matters concerning Intercontinental or its agents differently than any other company.

WILLIAM WHITE, FORMER CHIEF ACTUARY OF LIFE AND HEALTH INSURANCE IN THE DEPARTMENT OF INSURANCE IS INTERVIEWED

Mr. White stated that he joined the Department of Insurance in approximately May 1969 as an Assistant Actuary to W. Harold Bittel who was the Chief Actuary at that time. Mr. Bittel served in that capacity until September 1972 and was therefore the Chief Actuary during the time when Intercontinental was formed. Mr. White became the Chief Actuary shortly after Mr. Bittel retired.

The Chief Actuary is in charge of the Division of Actuarial Services. The Division is comprised of four units:

1. Statistical Section
2. Examinations of Domestic Companies Section
3. Review of Policy Forms Section
4. Complaint Section

Mr. White stated that when he became the Chief Actuary, he noted an unusual number of complaints about the conduct of Intercontinental agents. The quantity of complaints was noteworthy in relation to the size of the company rather than in relation to the total number of complaints received by the Department of Insurance for all agents dealing in the life and health field.

Mr. White stated that complaints against Intercontinental first came to his attention from Mrs. Thompson's section. Those complaints dealt with the policy forms being utilized by Intercontinental. White stated that in approximately 1973, Intercontinental contracted with specialists in the field to improve their policy forms and that there was a steady improvement thereafter.

Mr. White stated that during the time he was at the Department of Insurance, the traditional approach to complaints about life and health insurers and their agents was to "prevent abuse rather than punish it." The employees of the Department of Insurance who received complaints were told that most complaints were probably the result of a misunderstanding. They were further instructed to contact the insurance company and the consumer and attempt to mediate the matter. Mr. White explained that the main reason complaints went to the Actuarial Division was to give that Division feedback on policy forms. This information might demonstrate factual patterns where the insured person "ought to"

collect but the contract, which had been approved by the Department of Insurance, allowed the company to resist any claim. In short, the Department of Insurance and the Division of Actuarial Services were more concerned with keeping tabs on what was going on in the industry and in correcting particular injustices to insurance consumers rather than prosecuting complaints against companies or agents.

Mr. White stated that in March or April of 1974, Dr. Eleanor Lewis was employed by the Department of Insurance as Director of the newly established Division of Consumer Services. The Division of Consumer Services was not exclusively concerned with life and health insurance companies but also considered casualty companies. It was Dr. Lewis' group which accomplished most of the market surveys of individual companies.

Mr. White stated that after 1974, consumer complaints dealing with the selling practices of agents were sent to both Divisions. Routine technical problems were usually referred to the Actuarial Services Division while consumer oriented complaints were referred to Dr. Lewis.

Mr. White stated that when his particular Division received complaints about an agent's conduct and those complaints were contradicted by statements received by the Department from the accused agent, the matter was then usually terminated. He stated that it was the Department's policy that such "factual disputes"

should be settled by a court rather than by a regulatory agency. He also stated that when a pattern of complaints against a particular agent emerged that the insurance company would then be contacted and a suggestion made to it that the agent be fired.

Mr. White stated that around 1972-73 he formed a low opinion of Intercontinental based on the volume and nature of the complaints, and he communicated this opinion to former Commissioner McDonough and Dr. Lewis when she came aboard. He suggested to Dr. Lewis that Intercontinental would be a good starting place among the domestic companies for a market conduct survey.

We asked Mr. White whether he had any conversations with April Auerbach in which Ms. Auerbach indicated to him any feeling on her part that Commissioner Sheeran or anyone else was unreceptive to complaints about Intercontinental. He replied that April Auerbach did not make any such comments to him and further that such a comment would be the opposite of White's own opinion. Mr. White added that to his recollection, Commissioner Sheeran never indicated any reluctance to investigate or "get after" Intercontinental, nor did he appear to be callous or unconcerned to the problem of abuses in the life and health insurance company field.

Mr. White specifically identified Medicare Supplementary policies as being particularly bad ones that are allowed under New Jersey law and are being sold by Intercontinental, as well as many

other companies. He stated that the Department of Insurance could not forbid the sale of such policies and that corrective legislation was needed.

Mr. White also stated that no one ever requested that he give any special attention to Intercontinental or that he fail to pursue any investigation of them.

COMMISSIONER JAMES SHEERAN INTERVIEW

We interviewed the Commissioner on March 14, 1979. He was appointed to his position on January 15, 1974. He stated that he considered individual health regulations to be a priority matter for the Department and had initiated the new Division of Consumer Services under Dr. Lewis to come to grips with abuses in this area. Commissioner Sheeran stated that in his opinion the best available method of identifying abusive patterns and practices on health insurance activities was the Market Conduct Study. Once the problem areas were known, an educational program aimed at making health insurance consumers better shoppers would be more effective in the long run than dealing with individual cases. Commissioner Sheeran cited a recent Department publication (September 1978) entitled "A Shopper's Guide to Life & Health Insurance for Senior Citizens" as an example of this program.

Commissioner Sheeran stated that he had no interest whatsoever in Intercontinental or in any other insurance company. No public

officers, including Governor Byrne, had ever approached him concerning complaints received by the Department against Intercontinental and no one suggested that he go easy on the company.

Commissioner Sheeran explained that there were severe manpower and budgetary limitations on the Department in addition to a lack of adequate statutes that would prohibit certain kinds of abuses. These deficiencies are commented on in the Section of this report entitled Suggested Legislative And Regulatory Changes.

Commissioner Sheeran had no recollection of discussing Intercontinental with April Auerbach and never intended to give anyone the impression that he was not interested in hearing about abusive practices. Sheeran stated that he never met with any of the Weinigers regarding complaints against Intercontinental agents and did not give them permission to park their automobile in his parking space.

SHELDON AND EPHRAIM WEINIGER INTERVIEWS

Ephraim Weiniger is President of Intercontinental and Chairman of the Board. He stated that his family became involved in the insurance business in the 1930's and that he personally became active in the First National Health Agency in 1946. His father and Uncle (Mr. Schleifer) had joined First National and

and the National Health Protective Agency as general agencies for the sale of CNA Life, Health and Casualty Insurance.

In August of 1965, Lawrence Stern, on behalf of Intercontinental, approached Wallace Weiniger regarding the possibility of the two joining forces. An agreement was reached in December 1966. Both Weinigers stated that they did not know Governor Byrne, Senator Greenberg or Mr. Teltser prior to these events. Both Weinigers also stated that they did not know Commissioner Sheeran prior to his appointment to office in 1973 except that Ephraim did recall meeting Sheeran at a breakfast meeting in 1970 or 1971.

Both Weinigers denied being politically involved in Governor Byrne's campaigns and stated that they did not make any significant contribution (more than $100) to them. Likewise they stated that none of the business entities in which they had an interest made contributions to those campaigns.

Both Weinigers denied asking for or receiving any assistance from any public officer in their dealings with the Department of Insurance.

DEPARTMENT OF LAW AND PUBLIC SAFETY

During the course of this inquiry, it has been alleged that "the State Attorney General's office ignored complaints about Intercontinental turned over to them by the State Insurance Commissioner." This particular language first appeared in a confidential memorandum dated March 6, 1979 from the Chairman of the Select Committee on Aging to the New Jersey Delegation under a section of that memorandum which listed allegations for further investigation.

We have searched for any and all evidence that might be the basis for such an allegation. In the January 21, 1979 Star Ledger article it was reported that April Auerbach "explained how she tried to take serious complaints against Intercontinental agents to the Deputy Attorney General assigned to the Insurance Department." The news article went on to quote April Auerbach as stating:

> "The deputy attorney general never furthered the investigations or urged me to continue with it. They never thought it was that important."

In our interview of April Auerbach, she did not express this opinion. Specifically, she never indicated that the State Attorney General's Office or any member of it "ignored complaints about Intercontinental." Auerbach did state that she would often confer with the Deputy Attorney General concerning the market

conduct study which Auerbach was then undertaking of Intercontinental Life Insurance Company. Auerbach indicated that the deputy attorney general frequently advised her to relate specific factual allegations to specific regulations or prohibitions that may have been violated. Auerbach also stated that the deputy attorney general advised her on the need for sufficient legal proof to carry the burden imposed by the State in any revocation or suspension hearing. Auerbach indicated to us that she did not feel the Deputy Attorney General was giving "special" treatment to Intercontinental or trying to cover-up allegations made against Intercontinental agents. Apparently the deputy attorney general's advice with regards to market conduct study of Intercontinental was the same advice that she gave to April Auerbach and others on all other similar matters.

The deputy attorney general assigned to the Department of Insurance stated to us that she had conversations with April Auerbach in October 1977 about the market conduct study that Auerbach was then undertaking. The deputy reviewed her file and specifically a memorandum to the file concerning her conversations with Auerbach on this topic. That memorandum and the deputy attorney general's own recollection demonstrate that the deputy attorney general advised Auerbach that it was necessary to have more than two or three cases before the Department of Insurance

could conclude that a particular business practice by the company was unfair. In addition, the deputy attorney general advised Auerbach that each case should be tied into a specific substantive legal requirement.

The records of the Division of Criminal Justice within the Department of Insurance indicate that one referral regarding Intercontinental was made to the Division of Criminal Justice by the Department of Insurance in October of 1975. The matter was properly reviewed by the Division of Criminal Justice and referred back to the Department of Insurance for administrative action in November of 1975. Administrative action was taken against the agent by the Department.

CONCLUSION

After following all available leads, we have not found any credible evidence to support the allegation that an improper relationship may have existed between Intercontinental and the Department of Insurance. Complaints against Intercontinental's agents were processed in the same manner as any others. If the regulatory scheme was deficient, it was the same for everyone. Please note that practices of the Department in regards to such complaints are commented on in the section entitled, "Analysis of Consumer Complaints."

VII. ANALYSIS OF CONSUMER COMPLAINTS

In our interim report, we indicated that the consumer complaint files of the Department of Insurance had been obtained for analysis. These consumer complaint files included current files and the files for the years 1973 through 1978. In addition, approximately 100 consumer complaint files involving Intercontinental sent to the Better Business Bureau of Newark were reviewed and those complaints not appearing in the Department of Insurance files were abstracted. The files of the New Jersey Office of Consumer Protection were searched where we found that all complaints against Intercontinental had been forwarded to the Department of Insurance.

Investigators from the Division of Criminal Justice and from the Division of Consumer Affairs were assigned to review and synopsize the consumer complaints. In addition, these investigators participated in further investigation of specific cases where it appeared that an enforcement action of some type might be warranted. From the above materials, the investigators selected for review and abstracted on tape over 900 consumer complaint files. Four attorneys from the Division of Criminal Justice and the Division of Law reviewed portions of the complaint transcripts as a source of information applicable to the areas of investigation within their responsibility. It is intended that at the conclusion of our continued investigation, all complaint transcripts will have been reviewed by an attorney.

The substantial task of reviewing the complaint files was undertaken to fulfill the following purposes:

1) To identify regulatory problems in the health insurance industry, that is, to learn those health insurance practices which result in apparent injustices to policyholders and either are permitted under existing statutes and regulations or can be remedied through regulatory changes as opposed to constant remedial attention;

2) To evaluate the marketing practices of Intercontinental and its agents;

3) To determine whether any remedial action is appropriate;

4) To evaluate the response of the Department of Insurance to complaints which it has received.

The Appendix Exhibit C is an analysis of the various consumer complaints which have been completely reviewed regarding Intercontinental or its agents according to the allegations expressed. This analysis includes complaints received from a total of 605 individuals voicing 656 distinct types of abuses. Categories of Complaint 2, 4, 9 and 10 involve what can be termed active agent misconduct* as opposed to the insurance company's conduct in the service of policies. Such misconduct complaints comprise 26.7% of the total expressed allegations.

Review of the consumer complaints indicates that many of the complaints do not involve violations of any statute or regulation of

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*Category 1 pertains to claims denied by Intercontinental on the basis of pre-existing conditions which were not disclosed on the policy application. Complaints in this category might include instances where agents intentionally did not properly complete the policyholder's health history on the application. However, the contents of the files allocated to this category do not reveal why the pre-existing condition was not disclosed on the application. An explanation of all categories appears in a legend to the analysis.

insurance law. Because of the absence of standard definitions uniformly understood by the average person for disease, injury and pre-existing conditions, insureds have had their claims rejected contrary to their expectations. On other occasions, insureds filed claims which were reimbursed only to find that the company would not renew the policy.* In these instances, the policyholders found themselves without insurance for the very purpose for which they sought the protection. This topic is substantial enough in its scope to merit treatment in a separate section of this report detailing areas for recommended legislative action. These issues are addressed in the section of this report entitled SUGGESTED LEGISLATIVE AND REGULATORY CHANGES.

Marketing Practices of Intercontinental and Its Agents

The analysis appearing in Appendix Exhibit C indicates that most complaints involving agent misconduct relate to alleged misrepresentation. Such instances include false statements regarding policy coverage, eligibility, what policy was being sold or facts external to the policy made to induce the sale. Another area receiving numerous complaints involving what can be termed agent misconduct is the failure of an agent to list past diseases or injuries revealed by the policyholder in the health history on the policy

*The Department of Insurance has advised us that the Commissioner will not accept new policy forms for filing which provide for renewal at the option of the company and has requested and obtained voluntary withdrawal of at least 10 Intercontinental policies containing that provision. Department of Insurance Interim Report, page 15.

application. This is a tactic known in the insurance trade as "clean sheeting". An agent "clean sheets" in order to be able to sell a policy to an applicant which the underwriting department of the insurance company would otherwise not approve for issuance because of the applicant's health history. The agent bears the risk that enough "clean sheets" will not have a claim experience, and therefore will not be discovered, to make such practice profitable.

The complaints against Intercontinental were analyzed to determine whether agents of its subsidiaries were complained about more frequently than independent agents selling Intercontinental policies. These two agencies employ 59 agents. Appendix Exhibit D demonstrates that approximately 70% of the complaints received were made against agents employed by these subsidiaries while these agents sold approximately 70% of the health policies marketed in New Jersey.

The conduct of individual Intercontinental agents, possible improprieties in group solicitations and the question of the corporate responsibility for such conduct have all received public comment. We said in our interim report that the efficacy of the consumer complaint review could not extend beyond the identification and substantiation of such problem areas. The complaint files contain allegations, not legal proof, of instances of misconduct. Any remedial action to be taken must involve further investigation to develop the proof legally necessary to institute a proceeding. The question then becomes whether the results of our review to date justify

embarking on such an effort or, having isolated the problem areas, should we concentrate solely on prophylactic measures to prevent similar occurrences in the future. The nature of the conduct which has been alleged is such that we believe that the public policy requires us to attempt to achieve redress for some of the instances of past misconduct.

While the complaint files do not constitute legal proof, their contents do as a practical matter justify a search for the evidence necessary to institute proceedings, civil or criminal, directed at violations of the law which can be established. At my direction, my staff has for some time been acquiring evidence regarding the abuses which have been identified. We cannot comment upon the specific areas of our past and continuing investigation for both practical and ethical reasons. We will make no further comment on these issues until a final determination can be made on the basis of the evidence gathered.

Processing of the Department of Insurance Consumer Complaints

In our interim report, we indicated that we would pursue an inquiry into the complaint processing by the Department of Insurance because of public criticism directed in that regard. This criticism reached a new level of intensity with the release of a document by the House Select Committee which was reported in the Newark Star Ledger on March 15, 1979 disparaging the regulatory activity of the Department of Insurance. We have completed this phase of our investigation.

Review of the consumer complaint files themselves provided insight into how complaints are handled by the Department of Insurance. We also obtained and reviewed internal memoranda of the Department regarding specific consumer complaints and general areas of consumer abuse to which the Department devoted its attention. In addition, the following individuals were interviewed wherein the processing of consumer complaint files was a subject of discussion: Commissioner Sheeran; Dr. Eleanor Lewis, Assistant Commissioner for Consumer Services; Elaine Goldin, Director of the Somerset County Department of Consumer Affairs; William White, former Chief Actuary Health and Life; April Auerbach, former Consumer Analyst; and personnel within the Department of Insurance who are involved in the consumer complaint process. These interviews are also discussed in the previous section, Allegations of Possible Improprieties. The Department of Insurance was completely cooperative in providing us access to files and in arranging for our interview of staff members.

The starting point for our analysis is the structure of the Department of Insurance with respect to the processing of health insurance complaints. Some major distinctions in the substantive operation of the Department of Insurance revolve around the type of insurance involved. The major distinction is between life and health and property and casualty insurance. Substantive regulation of the health insurance industry on a day to day basis resides in the Division of Actuarial Services, Life, Accident and Health. This Division is

eaded by the Chief Actuary for life and health. This position was ormerly held by William A. White who resigned in June 1978. The osition has been vacant since that time.

Within the Division of Actuarial Services is a unit called :he Complaint Section. This Unit is responsible for the initial processing of all consumer complaints in the area of health and life insurance. The Complaint Section has available a staff of 2.5 people to process a current volume of approximately 300 incoming complaints per month, with an approximate annual volume of 3,500.

There is a separate Division of Investigations and Complaints. This Division is responsible for the initiation of any administrative disciplinary proceeding against an agent regardless of the type of insurance marketed by the agent. However, the Division of Investigations and Complaints also is responsible for the initial processing of all consumer complaints in the area of property and casualty insurance. This Division has an investigative staff of ten people who process an average of 13,000 complaints a year almost exclusively in the property and casualty area.

After taking office in 1974, Commissioner Sheeran established the Division of Consumer Services within the Department of Insurance. Assistant Commissioner Eleanor Lewis has headed this Division since its inception. The purpose of the Division of Consumer Services is to give a consumer emphasis to the Department of Insurance. The Division devotes its attention to consumer matters relating to the

sale of all types of insurance. The Division develops educational material for the public on insurance of all kinds, attempts to identify common problem areas in the marketing of insurance for the development of regulations to deal with them and investigates patterns of consumer abuses for potential disciplinary action or voluntary cessation by the offending parties.

From our interviews of William White, Dr. Lewis and Commissioner Sheeran, we learned that traditionally the attention of the Department of Insurance involving health insurance was devoted primarily to the regulation of policy forms rather than the pursuit of disciplinary action against individual agents for market abuses. In his interview with us, Mr. White reiterated the views he expressed as Chief Actuary before the Assembly Banking and Insurance Committee on May 2, 1978. Mr. White views the area of abuses in the private health insurance market as a small segment in the vastness of the total industry which is regulated by the Department of Insurance. Mr. White feels that the pursuit of individual incidents of agent misconduct is not an economic use of the Department's limited resources. As Chief Actuary, he viewed the purpose of a Complaint Section in the Actuarial Division as a source of feedback to be used in reviewing new policy forms submitted for filing. Mr. White indicated in his interview that the content of the insurance statutes and regulations were implemented at the suggestion of the domestic industry "giants" who operate well within the confines of allowable activity. However, according to Mr. White, the parameters of the regulatory

statutes permit marginal companies to market policies economically undesirable to the policyholder. As to quality of policies, insurance companies are restricted up to a point by their own self-control and self-image.

Mr. White's analysis continues that the less desirable policies offer an opportunity for selling abuses since such policies cannot practically compete in a straightforward manner with better quality policies. In turn, this point is well recognized by the insurance sales force. The better quality agents seek employment with companies selling the better insurance shutting out the less talented and more unscrupulous agents to work for the lesser quality firms. Thus the potential exists that insurance companies offering the poorer product employ the agents who are the most likely to adopt abusive tactics. Mr. White believes that the pursuit of administrative actions against individual agents for individual incidents may be futile because it does not strike at what Mr. White perceives to be the root cause of low quality policy forms. Mr. White contends that the Department of Insurance should devote its sole attention to upgrading policy forms and thereby undercutting the generating force for market abuses.

Commissioner Sheeran believes that the Department of Insurance must devote some of its resources to direct action, in contrast to Mr. White's views, against abusive practices by companies and agents. However, the Commissioner has determined that the Department does not have the staff capability to pursue

individual administrative actions on a routine basis. Therefore, the Department's attention is focused on pattern practices or multiple complaints against an individual agent. Even in those instances where the Department has found what it considers an offensive practice, the matter is usually handled in an informal manner rather than through the institution of formal charges because of staff limitations.

As presently organized, all health and life insurance complaints are initially referred to the Complaint Section of the Division of Actuarial Services. This Unit responds to every consumer complaint which it receives. Where the complaint on its face expresses what would appear to be a legitimate grievance against a company or agent, the Department requests a response from the company and agent as the case may be. The Department has no decision-making authority as to disputed claims regarding benefits or coverage. Where there are disputed facts, the Department usually indicates to the complainant that it can be of no further assistance. Where the facts are not in dispute, the Department might suggest that the company act favorably toward the consumer. However, the Department can take no action against an insurer for refusing to follow its suggestion unless the insurer is acting at variance with the policy as accepted for filing. In instances where it is determined that the insurer or agent has acted within the law, the complainant is so advised.

It is the present practice of the Division of Actuarial Services not to pursue individual complaints against an agent

alleging misconduct where a factual question exists because of the response to the complaint provided by the agent. If such complaints were to be pursued, they would be referred to the Division of Investigations and Complaints for possible disciplinary action. Pursuant to departmental policy, the Complaint Section does maintain a record of complaints against individual agents and is instructed to apprise the Division of Investigations and Complaints of any pattern of complaints against an individual agent which might appear. This departmental policy is predicated on the fact that the agency does not possess sufficient resources to assess the credibility of each individual complaint either through investigation or formal hearing and must rely on the cumulative nature of complaints as support for their individual reliability.

Our conclusion is that the Department of Insurance has been unable to be as aggressive as it should be in pursuing individual instances of abusive and unfair sales practices. In our opinion this is due to a variety of reasons, including lack of manpower, lack of sufficient legislative authority, and some deficiencies in the organizational structure of the Department of Insurance as reflected in the above discussion.

VIII. SUGGESTED LEGISLATIVE AND REGULATORY CHANGES

The requirements of Title 17B, Life and Health Insurance Code, especially with respect to individual health insurance policies and the manner in which they are sold, are minimal. As previously discussed, Title 17B does not contain the legal "teeth" necessary for effective regulation of the health insurance industry. This lack of regulation has allowed the sale of shoddy policies and opens the door to unscrupulous agents who prey on the inexperience and fears of consumers, especially the elderly. Without requiring specific disclosures at the time of sale, it is easy for an unscrupulous agent to make a misrepresentation as to a policy's benefits in order to make a quick sale and thus his commission. This is especially true in the sale of health policies to persons eligible for the Medicare program since the federal program is itself confusing and the array of policies available are almost limitless in the variety of benefits offered and premium costs.

Some of the practices of the agents of Intercontinental are indicative of the larger problem. Moreover, problems exist because Title 17B does not require the use of standardized definitions. These key terms vary among companies and even among policies written by the same company. For example, Intercontinental has differing definitions of sickness and injury depending upon the type of policy sold. The

)olicy, captioned "Senior Care III (Form SC-73)" and marketed as a 'Medicare Wraparound Policy", is extremely restrictive in defining :hose terms. "Injury" is defined as bodily injury caused by an accident occurring while the policy is in force and resulting directly and independently of all other causes in a loss covered by the policy. Thus, it requires that the loss be directly and independently related to an accident occurring while the policy is in force. Furthermore, the term sickness is also limited since it means a sickness or disease contracted and commencing after the policy has been in force for not less than 30 days. Therefore, the company can deny benefits on the basis that the insured contracted an illness prior to the effective date of the contract even though no symptoms appeared until long after the policy was in force.* This is especially restrictive in light of the sale of this policy to elderly insureds who may have a history of ongoing health problems. Other policies of Intercontinental reviewed by this office contain less restrictive definitions and merely require that an illness be first manifested during the policy term.

*For example, one of the complaints analyzed indicates that an individual purchased an Intercontinental policy for hospitalization benefits in September 1975. The coverage for illness therefore become effective in October, 30 days after the purchase of the policy. In June of 1976 the insured was hospitalized and a kidney stone removed. The insured filed a claim which was refused. The medical history of the insured taken at the time of surgery indicated that in December of 1975 the insured had started complaining of "back pain". The company refused coverage offering only to rescind the policy and pay back the premium because it determined that the illness (i.e. kidney stones) had been "contracted and commenced" before the policy was in force even though the insured manifested no symptoms until December.

During the course of this investigation, this office reviewed six policies written by Intercontinental which are marketed generally to individuals eligible for Medicare. While the policies sold by Intercontinental conform to the existing law governing individual health insurance policies, N.J.S.A.17B:21-1 et seq., some are of limited value in supplementing the federal Medicare program. The policies are of two types: a daily cash indemnity for confinement in a hospital or skilled nursing facility, and policies which attempt to supplement the Medicare program by paying the deductible and co-payments. In order to complete this comparison two policies written by other companies were also included in the study. The daily hospital and nursing home indemnity policies sold by Intercontinental to supplement Medicare make no attempt to fill the gaps in the federal program. Medicare deductibles and co-payment features have been rising each year and the benefits under a daily indemnity policy make no attempt to keep even with these charges. Furthermore, the benefits of such policies are very narrow. The average hospital stay of an elderly person is only 11 days, and benefits are only paid to a policyholder if the individual is confined in a hospital or skilled nursing home. The Intercontinental policies which attempt to tie benefits into the gaps in Medicare are better policies for the elderly; however, they are expensive especially when compared to similar policies written by other companies. For example, New Jersey Blue Cross/Blue Shield issues a Medigap policy with an annual premium of approximately $115. This is considerably

ower than Interncontinental's Medicare supplemental policy GIM-3070) which had a premium of $218 as of January 1, 1977. lutual of Omaha writes a Medicare supplemental policy which costs ibout the same as Intercontinental's best policy, but provides benefits in excess of those provided by the Intercontinental policy especially in the area of physicians' fees. Attached as Exhibit E is a chart which sets forth the gaps in Medicare and the provisions of all policies reviewed. It must be noted at this point that Intercontinental is not the only company which writes medigap policies similar to those described above. A number of companies sell similar forms of marginal insurance in New Jersey because of the weakness of legislative provisions governing such policies. The law as it currently exists allows the sale of all but the most worthless policies.

All of this confirms the need for the suggested legislative changes discussed below which would give the Department of Insurance the authority to effectively regulate the individual health insurance industry.

MINIMUM STANDARDS

As previously noted, the policies sold by Intercontinental Life Insurance Company meet the current legislative standards for the approval and filing of individual health insurance policy forms. It is suggested that the statutory standards be strengthened in order to give the Department of Insurance the power to effectively regulate this industry. The Legislature is currently considering doing this by the passage of A-1474. This bill was originally drafted by the Department of Insurance with the aid of the Attorney General's Office several years ago. It would give the Commissioner the power to adopt regulations setting minimum standards for all individual health insurance policies including Medicare supplemental policies.

Other states, notably California, New York and Wisconsin, have adopted legislation or regulations setting minimum standards for policies. Exhibit F attached sets forth a synopsis of the minimum standards adopted by other states. The National Association of Insurance Commissioners has also proposed model legislation and regulations for the setting of minimum standards. Even the health industry has suggested the need for enacting such legislation.*

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*Statement of Thomas J. Gilooly, Associate General Counsel, Health Insurance Association of America to the Assembly Banking and Insurance Committee on May 2, 1978.

When A-1474 is adopted, the Department would have the authority to effectively regulate all companies selling individual health insurance policies and require the industry to conform to stricter standards with respect to such policies. The setting of minimum standards could require the use of standardized forms in easily readable language. Key definitions would also be standardized from policy to policy thereby allowing effective comparison of various policies. Full disclosure of the policy terms at the time an agent attempts to make a sale would also aid in eliminating many of the deceptive practices and misrepresentations currently being made. It would especially help senior citizens make a reasoned purchase of insurance to supplement the federal Medicare program.

Finally, such regulations should set minimum loss ratio standards. Such loss ratios could differ by reason of the type of policy provided. Other states have set such minimum loss ratios. Michigan requires at least a 65% loss ratio for policies issued to individuals 65 and older. California requires a minimum loss ratio of 55% for medicare supplement policies. Florida and Nevada appear to follow the "benchmark" set by the National Association of Insurance Commissioners of at least 50%. Again, even the health insurance industry has recognized the need to set satisfactory loss ratios.

The last loss ratio figures available from the Department of Insurance in 1977 show Intercontinental's average loss ratio for all of its health and accident insurance is 39%. In ranking the 217 companie

riting accident and health insurance by their average loss ratios, ntercontinental is 144. This means that there are 73 companies riting health and accident insurance with lower loss ratio averages nd there are 99 companies with average cost ratios of less than 0%, the NAIC benchmark.

The Department of Insurance has requested the assistance of :he Attorney General's Office in drafting the regulations to be)romulgated pursuant to A-1474. Attached as Exhibit G is an)utline of the possible areas to be included in such regulations.

In the Sunday Star Ledger of March 11, 1979, Mr. Herb Jaffe discusses the legislative background of S.1091, which would give an individual a 10-day period in which to read a policy and make a decision as to keeping or cancelling it with a full refund of premiums paid. While this would be meritorious legislation, it is of limited benefit in comparison to a minimum standards bill which is far broader in scope and which could include a 10-day free look provision as well as the other requirements discussed above.

MASS-MARKETED INSURANCE

Another area of potential abuse by companies selling health insurance to the general public and to Medicare eligible individuals is in the area of mass marketed policies. These are individual policies of health and life insurance offered by means of solicitation through a sponsoring organization but with a direct response by the

ember to the company. Part of this problem was uncovered in this ffice's investigation of Intercontinental's solicitation of groups. nother aspect of this problem are policies solicited through the ail or other mass-communications media (television, radio, newspapers, agazines). The Commissioner should have the specific authority to egulate the means used for solicitation including the advertising of uch policies. This is especially needed where a master policy is ssued to a group outside of New Jersey and thus exempt from regulation y New Jersey. This is a means used by some companies to escape egulation by the stricter states. In those instances, the Commissioner should minimally be able to require that the premiums bear a reasonable relationship to the benefits provided and to regulate the manner in which claims are settled in order to protect residents of this state. Legislation may be required to regulate some of this. The advertising regulations should also be reviewed for possible amendment to require further disclosure.

MONETARY PENALTY

Finally, it is suggested that "teeth" be put into Title 17B by giving the Commissioner the authority to fine a company for any violation of any provision of the Life and Health Insurance Code. Currently as enacted, Title 17B has no general monetary penalty provision. A monetary fine may be imposed only under limited circumstances. Thus, the Department is frequently faced with the choice

: putting a company completely out of business in New Jersey or
ıe issuing of a mere cease and desist order as to certain specified
nfair trade practices. The inability to fine a company has been
reviously pointed out to the Department of Insurance by this office
nd proposed legislation drafted.

EPARTMENTAL CHANGES

As to the Department of Insurance's current methods of handling
›olicyholder complaints, it is suggested that it allocate more staff
:o handle the complaints made by consumers concerning health insurance.
Currently, two people are handling an average of 300 to 350 complaints
received by the Department monthly. It is difficult, if not impossible,
for two people to adequately investigate and resolve this many
matters. The average state, according to the attachments to the
Pepper Committee Report, has an investigative staff of 15 people, nine
of whom are assigned to investigate abuses in the sale of accident and
health insurance. More staffing would enable the Department to take
action against companies and agents who are engaged in practices that
are in violation of existing statutory requirements. Furthermore, lines
of communication should be clarified so that the various people in the
Department handling consumer complaints against life and health
insurers can coordinate their investigations and a more concerted
effort can be made to take administrative action against companies
and agents.

APPENDIX

PRESS RELEASE

HOUSE SELECT COMMITTEE ON AGING

WASHINGTON, D. C. 3/15/79

For Information:
David Holton
House Select Committee on Aging
(202) 225-9375

A spokesman for the House Select Committee on Aging said today that a memo concerning Intercontinental life Insurance Company, the subject of a recent article in the Newark Star Ledger, was not intended for publication.

The spokesman said that the memo was drafted for the Committee Staff for the limited purpose of informing New Jersey Members of the past course of events as well as issues to be examined in the future.

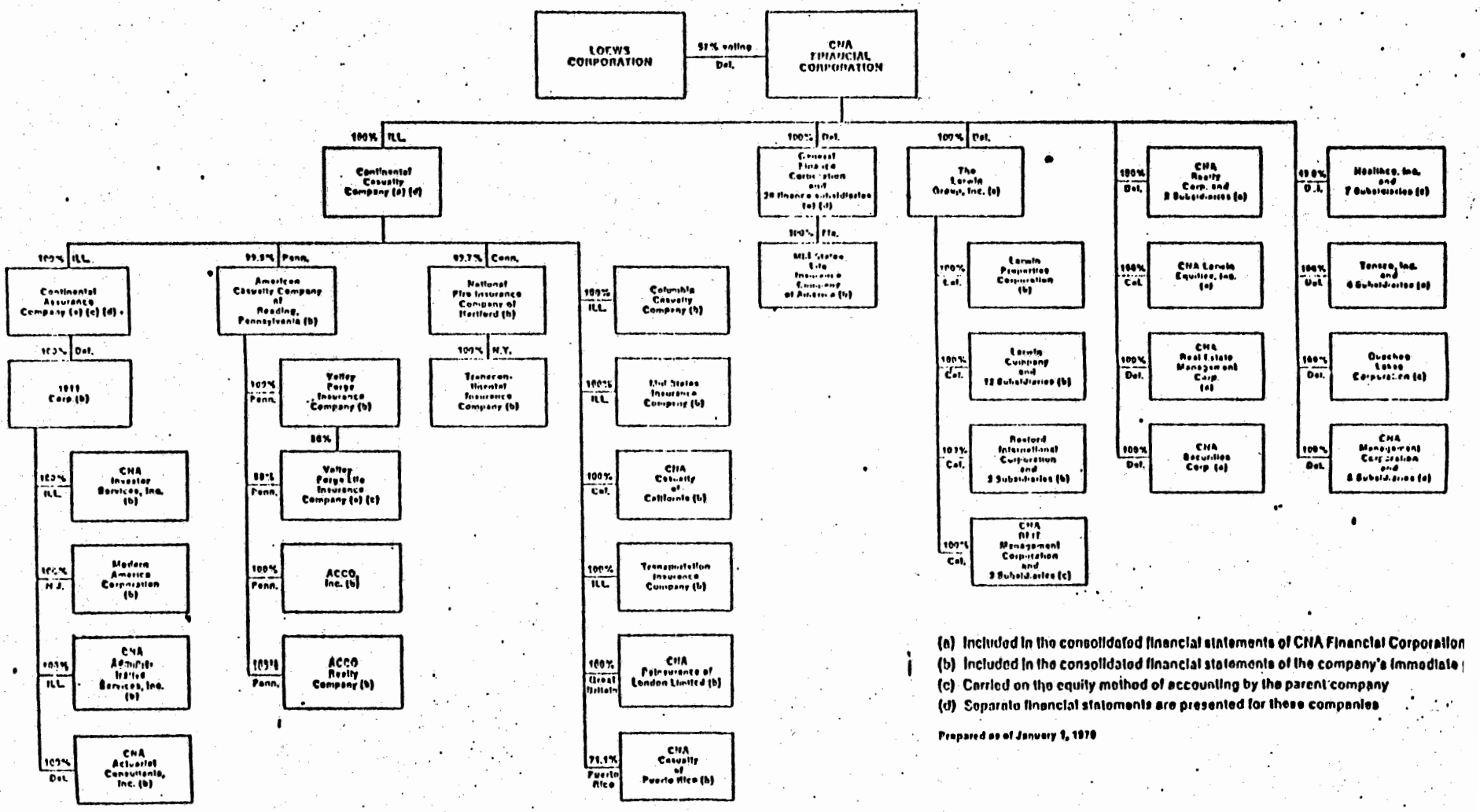
The memo contained allegations still under investigation. The memo, taken alone, conveyed the impression that Intercontinental has been singled out when, in fact, the company is one of several who are under scrutiny by the House Committee in various parts of the country.

The Committee will soon release a report which will detail the results of its ten month investigation into abuses of Health Insurance for the elderly.

-30-

PART 1. *Organizational Chart. Attach a chart or listing presenting the identities of and interrelationships among all affiliates within the holding company system. No non-insurer affiliate need be shown if its total assets are less than 1/2 of 1% of the total assets of the largest affiliated insurer.*

CNA FINANCIAL CORPORATION
CORPORATE CHART



(a) Included in the consolidated financial statements of CNA Financial Corporation
(b) Included in the consolidated financial statements of the company's immediate
(c) Carried on the equity method of accounting by the parent company
(d) Separate financial statements are presented for these companies

Prepared as of January 1, 1978

INTERCONTINENTAL LIFE INSURANCE COMPANY

ANALYSIS OF 605 COMPLAINTS

CATAGORIES OF COMPLAINTS	TOTAL
1. Undisclosed Pre-Existing Condition	95
2. Pre-Existing Condition Not Disclosed by Agent	28
3. Disputed Disallowance Due To Pre-Existing Condition	27
4. Misrepresentation of Policy	135
5. Requests for Information	67
6. Company Slow Making Refund or Paying Profits	95
7. Not Renewed Under a Non-Renewable Clause	60
8. Miscellaneous	102
9. Forgery	6
10. Unwanted Solicitation (Senior Citizens Groups)	6
11. Policy Cancelled Due to Lapse In Premium Payments, Policyholder Claims No Notification.	11
12. Paid After Dispute	24
TOTAL	656

(LEGEND FOR COMPLAINT CATEGORIES IS ATTACHED)

LEGEND FOR COMPLAINT CATEGORIES

1. Undisclosed pre-existing condition - This category lists the number of complaints voiced concerning a denial of benefits due to a pre-existing condition where the file is not conclusive as to whether the complainant had revealed the pre-existing condition to the selling agent.

2. Pre-existing condition not disclosed by agent - This category lists the number of instances where a complaint involving a pre-existing condition affirmatively states that the insured advised the agent of a pre-existing condition which the agent did not list on the application or that the agent completed the medical history on the application without questioning the applicant.

3. Disputed disallowance due to pre-existing condition - This category lists the number of instances where a dispute existed between the claimant and Intercontinental as to whether an insurable episode was in fact related to a pre-existing condition, disclosed or undisclosed.

4. Misrepresentation of policy - This category lists the number of times a complaint has alleged that the selling agent used misrepresentation in his sales presentation. The predominant misrepresentation alleged relate to the extent of policy benefits or eligibility of the insured for certain benefits.

. Requests for information - This category lists inquiries
o the Department of Insurance which do not complain against
ntercontinental.

. Company slow making refund or paying benefits - This
ategory is self-explanatory.

'. Not renewed under non-renewable clause - This category lists
:he number of complaints received where Intercontinental refused
:o renew a policy. The predominant number of complaints in this
:ategory involve situations where Intercontinental paid a claim on
the existing policy. A limited number reflect instances where the
particular policy in force was being withdrawn.

8. Miscellaneous - Many of the complaints in this category
involve interpretations of reimbursable costs under the insurance
coverage in force.

9. Forgery - Based on allegation in complaint.

0. Unwanted Solicitation (Senior Citizen Groups) - solicitations
to members of a group unauthorized by the group.

11. Policy Cancelled Due to Lapse in Premium Payments, Policyholder
Claims no Notification - This category is self-explanatory.

.2. Paid After Dispute - Pertains to claims originally rejected by
Intercontinental but eventually paid after intercession by the Department
of Insurance.

COMPLAINT COMPARISONS AS TO SOURCE OF COMPLAINTS

tal Number of Complainants.	605
tal Number of Specific Allegations.	682*
legations Attributable to Unknown Agents.	252
% of Total Allegations.	36.9%
.legations Attributable to Agents of itercontinental Subsidiaries.	300
% of Total Allegations.	44%
(The Allegations represent 70% of the allegations made against known agents)**	
llegations Attributable to Agents not ffiliated with Intercontinental Subsidiaries.	130
% of Total.	19.1%
(The Allegations represent 30% of the allegations made of known agents)	
gents Identified with Intercontinental Subsidiaries.	74
gents Not Identified with Intercontinental Subsidiaries.	60
otal Number of Agents Identified in Complaints.	134

* In certain instances, more than one agent may have been involved in a single consumer transaction. Thus, a specific allegation might involve more than one agent. For purposes of agent comparison, such instances were counted against each agent accounting for a greater number of allegations (682) than when the allegations are analyzed by type (656).

**In 1978 the wholly owned subsidiaries sold approximately 72.6% of all health policies and 33.6% of life policies of Intercontinental that were marketed in New Jersey.

BIT E

ct of Insurance Policies Which Supplement

edicare)

III (Indemnity) .95 to $761.25- age and risk tion as well as vel chosen. ng condition s.	$72 for 1st day $0 to $5 per day	$10 per day	$0 to $30 per day for 91st to 365th day	$0 to $5 per day 1st to 20th day $9 to $10 for 21st to 100th day	Hospital confined 20% of first $3,000 of expenses Not hospitalized -limited services with a maximum of $100	Private duty nurses while hospitalized - maximum of $16 for 7 days Accidental death and dismemberment benefits	Routine physical exams, long term nursing home, custodial care, prescriptions, dental care, glasses and hearing aids and other miscellaneous costs EXCESS CHARGES	Restrictive def injury (loss di independently to accident) a (contracted and 30 days after e date)
are Supp. 218 as of Jan.1, ceeding Medicare e and co-payments ng condition months	Deductible in full	Co-payment	Co-payment up to 150 days	Co-payment up to 100 days	Hospital confined 20% of 1st $3,000 of expenses Not hospitalized-limited services with a maximum of $100	Limited benefits for transportation, ambulances, blood and appliance rental	Routine physical exams, long term nursing home, custodial care, prescriptions, dental care, glasses and hearing aids and other miscellaneous costs EXCESS CHARGES	Restrictive def injury. Sickness first while policy i
are Supp. 199 as of Jan 1, ceeding as Medicare ing condition 6 months	Deductible in full	Co-payment	Co-payment up to 150th day 151st to 365th-$33.33 per day 365th and on-$16.66 per day Maximum- $10,000 for one spell of illness	Co-payment up to 100 days	Hospital confined 20% of 1st $3,000 of expenses Not hospitalized 1. limited services maximum of $100 2. $60 deductibles, then 20% of next $300	Limited benefits for transportation, ambulances, blood and appliance rental	Routine physical exams, long term nursing home, custodial care, prescriptions, dental care, glasses and hearing aids and other miscellaneous costs EXCESS CHARGES	(Same restrict GIM3079 above
or Care Weekly Cash $92.50 to $30 per indemnity depends isk classification level & waiting Pre-existing condi- -90 days if admt'd 1 years	$75 to $250 per week ($10.70 to $35.70 per day) Elimination period -0 to 14 days	$75 to $250 per week ($10.70 to $35.70 per day)	$75 to $250 per week ($10.70 to $35.70 per day) Maximum - 52 weeks	NOTHING	NOTHING	NOTHING	Nursing home, medical bills prescriptions, dental care, glasses, hearing aids, etc.	Restrictive d injury (loss independently to accident) (contracted 30 days afte date)
nded Care Cash) $46 to $140-depends nd benefit level ting condition 6 months	NOTHING	NOTHING	NOTHING	$3.33 to $20 per day for 21st to 730th day (Extended Care facility must be approved for payment by Medicare	NOTHING	Private duty nurses- maximum of $18 to $24 per day for 21 days Prescription drugs while confined-80%-maximum to total of $80 Other limited benefits	Custodial or long term nursing home care (other than skilled nursing facility) Hospitalization, medical bills, dental care, glasses hearing aids, etc.	Restrictive d injury (direct pendent) and only if first while policy
pital ent Benefits 5-31) -$.98 to $4.36 per nth in benefits- on age and benefit sting condition - 1 year	Benefits vary according to level purchased. ex/ $33.33 a day	Benefits vary according to level purchased ex/ $33.33 per day	Benefits vary according to level purchased ex/ $33.33 a day for as long as hospitalized	NOTHING	NOTHING	NOTHING	Nursing home, medical bills, prescriptions, dental care, glasses, hearing aids, etc. Maternity, etc.	Restrictive (injury (dire pendent) and (first manif
of Omaha - $277 sting condition - None unless speci- excluded by name or tion	Deductible in full	Co-payment	Up to 150th day -co-payment Thereafter will pay 80% of hospital expenses Maximum-hospital, skilled nursing facility, nurses-$10,000 per benefit period	Co-payment up to 100th day Thereafter $17 per day up to total of 1 year	Not deductible, but will pay 20% of co-payment of reasonable charges pursuant to Medicare Part B Maximum-$5,000 in benefits	Private duty nurses-maximum of $24 per day	Routine physical exams, long term custodial nursing home, prescriptions, dental care, glasses and hearing aids, etc.	None appare other than noted
lue Cross/ ield oup Individual-$113.2 $11.32	Deductible in full	Co-payment	Co-payment up to 150th day	NOTHING	Hospital confined-deductible and co-payment as long as hospitalized Not hospitalized-limited benefits with limited maximum	NOTHING	Medical bills, nursing home, prescriptions, dental care, glasses and hearing aids, etc.	None appar other than noted

EXHIBIT F

MINIMUM STANDARDS

REGULATIONS ADOPTED BY OTHER STATES

Wisconsin has set minimum standards for Medicare supplementary policies. By regulation, it has standardized the coverage under Medicare supplementary policies. It has set up four categories of such policies. Non-conforming policies cannot be sold as supplements to Medicare nor can a company or an agent relate the policy coverage to Medicare. These regulations only cover Medicare eligible expenses and, therefore, do not cover general nursing home care other than skilled nursing facility care, physician charges above the reasonable level set by Medicare, or other things which are not covered by Mediare such as routine physical exams or dental care. Some of the categories do not cover the entire deductibles under Medicare. Throughout all four categories pre-existing clauses are limited to a maximum of twelve months.

The first category, Medicare Supplement I, is the most comprehensive. It must cover all gaps relating to Medicare eligible expenses permitted under both Part A and B of the Medicare program. It must also include 75% of all prescription drug costs to the insured. The maximum benefits offered under a Medicare Supplement I category is: either $22,500 for both part A & B expenses, or in the alternative $15,000 for Part A coverage and $7,500 for Part B coverage.

Medicare Supplement II is similar to the category described above; however, the ceilings are lower and such policites need not include prescription drugs and certain other limited benefits.

Medicare Supplement III has still lower ceilings and removes requirements for Part B home health care, diagnostic tests and certain other benefits.

Medicare Supplement IV is split into two parts. Medicare Supplement IVa covers only hospitalization and all other Medicare Part A benefits. It has maximum payable benefits of $15,000. Medicare Supplement IVb covers Medicare Part B expenses only, and has a maximum payable benefit ceiling of $7,500. A Medicare Supplement IVb may provide catastrophic coverage with a deductible of up to $500.

All except Medicare Supplement IVb must include a minimum of 30 days of skilled nursing home care. These regulations also require certain disclosures to be made. An 18-page booklet is to be presented to all potential insureds. An outline of coverage including a clearly organized chart explaining Medicare supplemental policies and remaining gaps must also be provided.

However, Wisconsin's regulatory scheme does not apply to other forms of individual health coverage such as general health insurance, indemnity insurance and dread disease insurance.

The State of California has also adopted certain minimum standards. There are specific standards which relate to Medicare supplemental policies and regulate the basic coverage provided, the

ayment of deductibles and co-payments under Medicare, and limitations n the use of the pre-existing clause. California also regulates ther forms of individual health insurance including hospital indemnity nsurance. It sets general standards for Medicare eligible insureds nd requires a minimum daily benefit of $15. It also regulates the se of pre-existing clauses and waiting periods. Furthermore, minimum standards have been set with certain minimum benefit ceilings for dread disease policies. A dread disease policy is a policy that will only pay expenses for the treatment of a specified disease, usually cancer. California also regulates catastrophic Medicare supplement policies. Finally, it requires that policy disclosure forms include the name of the general agent or company representative other than the agent who sold the policy, the address of such a person, and a toll-free telephone number. There are also affirmative procedures to insure that disclosure forms are used. Lastly, California requires that Flesch Readability Test scores be submitted to the department with all submissions of new policy forms. This is to help the department in deciding whether the policy would be readable by the general public. The problem with the California regulation is that it does apply to mail order or group policies where a master policy is issued out-of-state.

Finally, the State of New York has probably the broadest form of minimum standards regulations. These standards govern the form, content, and sale of all health insurance policies. These rules govern the content of the various forms of individual insurance and the

anner in which these forms are set up and the language to be used
n such policies. Specific disclosure statements are required for
he various types of policies of individual health insurance sold in
he State of New York. These disclosure statements also include a
tatement of anticipated loss ratio for that particular policy period.

EXHIBIT G

SUGGESTED AREAS TO BE INCLUDED IN NEW JERSEY

INIMUM STANDARDS REGULATIONS FOR INDIVIDUAL HEALTH INSURANCE POLICIES

. FULL AND FAIR DISCLOSURE

A. All policies should include the following information in a concise and easily readable format on their face:

1. outline of coverage
2. benefits payable
3. premium
4. pre-existing condition and waiting periods
5. exclusions and other limitations; and
6. renewability clauses

B. Limited Policies must indicate in prominent terms on their face that they are:

1. accident only policy
2. indemnity only policy
3. a skilled nursing facility only policy, or
4. other type of limited benefit policy

C. Medicare Supplemental Policies or any individual policy proposed for sale to a Medicare eligible individual must meet the following:

1. Any policy supplementary to Medicare must include on the front page (or in a prominent position) the manner in which it fills in the gaps. This can be done by means

of a chart or in other graphic form showing Medicare coverage and how the policy would compliment it. Such graphics should be required at time of any sales presentation of an initial, replacement or additional policy. Replacement and additional policies should also show benefits under existing policies.

2. Clear indication that costs incurred will only be paid if eligible (other than exhaustion of benefits) for Medicare.

D. 10-Day "free look" provisions on all policies.

II. STANDARDIZATION AND SIMPLIFICATION OF LANGUAGE AND TERMS

A. Language

1. readability tests (plain english standards)
2. print size

B. Standardized definitions of policy terms - definitions should be no more restrictive than the definitions contained in the regulations for the following terms:

1. hospital
2. nursing home
   a. Skilled nursing facility
   b. Extended care facility
   c. Convalescent nursing home
3. Sickness
4. Accident, Accidental Insury, Injury, Accidental Means.
5. Pre-existing condition
6. Physician
7. Nurse

8. Disability

a. Total

b. Partial

c. Residual

9. Medicare

10. Renewability

11. Cancelability

12. Nervous disorder

C. Standardized description of policies including disclosure requirements

II. PROHIBITED POLICY PROVISIONS

A. Limitations or prohibitions against the use of certain policy provisions, such as:

1. Probationary or waiting periods

2. Pre-existing condition clauses (limit length of time - distinguish medicare supp. policies)

3. Certain limitations or reductions of benefits

B. Policies sold or offered for sale which are limited to losses due to a "dread" disease, i.e., cancer

IV. ECONOMIC VALUE

A. Loss ratios

1. Minimum loss ratios by policy type

2. Reporting requirements requiring company to file loss ratios annually or biannually by policy form

B. Limitation on expenses including maximum commissions as a percentage of the initial and/or renewal premiums by type of policy

7. ELIMINATION OF UNFAIR RENEWABILITY PRACTICES

All policies sold or issued for sale to a resident of New Jersey should be required to be renewed by the insurer except in certain specified instances.

VI. SALES PRACTICES

Regulations should prohibit:

A. Twisting

B. Stacking - some statement as to numer of policies in force should be included on any application (Use of graphics may help to lessen this by showing, in a clear straight forward manner, overlapping coverage).

C. Clean-Sheeting - the filling in of an application and failing to note the existence of a pre-existing condition that the applicant made known to the agent, broker and solicitor.

D. Misrepresentation

1. Must disclose at the beginning of any contact with a potential insured the agent's, broker's or solicitor's affiliation with an insurance company.

2. No representation, directly or indirectly, by a salesman or company, of any affiliation with a

government agency or government affiliated organization.

3. No representation, directly or indirectly, of any affiliation with any group, organization or association, unless in fact, there is such an affiliation. Proof of such affiliation must be supplied in writing.
4. No representation that existing policy is no longer in effect because of new minimum standards regulations or other regulatory action unless the regulation states so.