

PUBLIC HEARING

before

ASSEMBLY BANKING AND INSURANCE COMMITTEE

on

HEALTH INSURANCE

Held:

May 2, 1978

Senate Chamber

State House

Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman James W. Bornheimer (Chairman)

Assemblyman Michael F. Adubato

Assemblyman Patrick C. Pasculli

Assemblyman Carl A. Orechio

ALSO:

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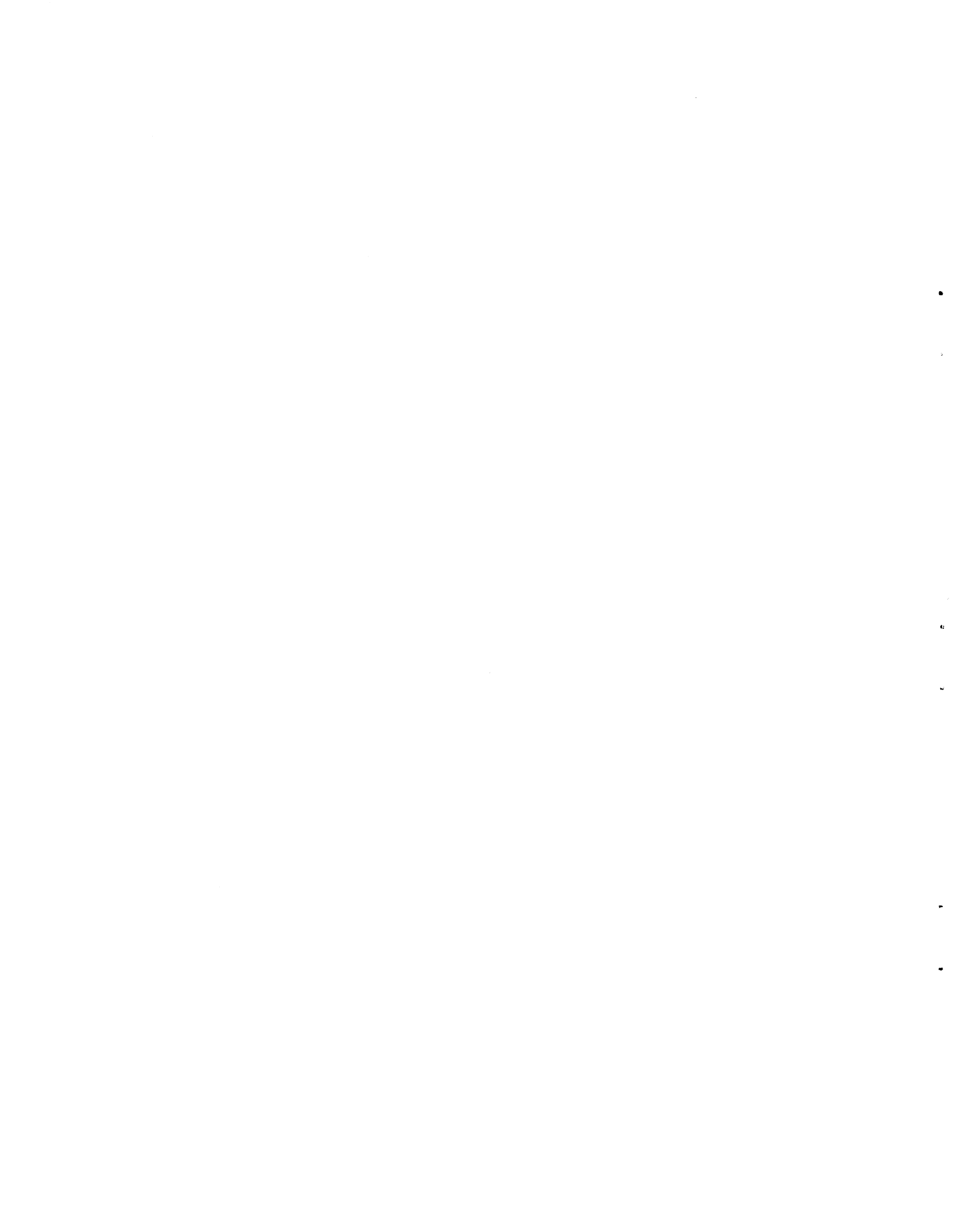
Legislative Services Agency

Aide, Assembly Banking and Insurance Committee

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ASSEMBLYMAN JAMES W. BORNHEIMER (Chairman): We will open the hearing now. The purpose of this hearing is to investigate the cost of health insurance, determine whether or not there are abuses, and find out as much information as we possibly can.

The first one to speak this morning is James Sheeran or his representative. Is he present?

MR. BLISS: Yes.

ASSEMBLYMAN BORNHEIMER: Walter Bliss will speak for the Commissioner.

W A L T E R B L I S S: Mr. Chairman and members of the Committee, my name is Walter Bliss. I am the Deputy Commissioner of the Department of Insurance.

Commissioner Sheeran has asked that I appear on his behalf this morning. He is in Biloxi, Mississippi, at an Executive Committee meeting of the National Association of Insurance Commissioners, where Commissioner Sheeran represents the northeastern region.

Commissioner Sheeran has prepared a written statement which he has asked that I read. Mr. Hooper, the Public Information Officer of the Department, is here with multiple copies of the statement.

Mr. Sheeran's statement follows: I thank you for the opportunity to appear before your committee. I hope my testimony will contribute to the development of a proper perspective for a better understanding of the health insurance marketplace in New Jersey.

I think we should all be grateful for the newspaper publicity about health insurance because it has focused public attention on a seldom-noticed, but important, aspect of regulating a giant industry.

A fully informed public is surely needed if we are to identify and root out the abuses in the health insurance field. Many of the victims can least afford such a raid on their pocketbooks and oftentimes they are the ones who most need the medical care that may prove to be non-existent or not what they had been led to believe that it would be.

In my testimony, I want to provide an overview of the problems associated with this one aspect of the health insurance market that has become the subject of newspaper publicity. I prefer to leave to my professional staff the more detailed and more technical explanations.

The first thing that I should do, however, is to shrink the problem to its proper size. Despite reports to the contrary, the individual health insurance policy, and that is what has brought us here today, is not a half a billion dollar a year industry in New Jersey.

The chief actuary for life and health insurance of the Department of Insurance, Mr. William White, will supply a more precise figure; but I can assure you that the premiums paid by New Jerseyans for the kind of insurance the newspaper series complained about is more nearly thirty million dollars than half a billion.

Another misconception that must be cleared away is that these individual health insurance policies are "neither regulated, carefully scrutinized by the State nor formally approved by the insurance commissioner."

As a matter of fact, these policies are regulated by the State. In 1977, the number of individual health policy forms submitted for the department's approval was almost 2,000.

It is absolutely untrue that insurers simply file their health policies with the Department of Insurance and use them without approval by the Department. New Jersey remains a prior approval state with respect to health insurance, just as it is for auto, homeowners and other lines of insurance.

A measure of the degree of the department's scrutiny can be seen in the fact that 65 percent of the initial submissions were rejected by the department for failing to meet our standards in 1977. Again, Mr. White will provide greater detail.

But I think it is important to realize that these policy forms cannot be used without approval, that they are not railroaded through, that they are given serious analyses by competent professional people, and that only those we believe to be consonant with New Jersey law are allowed to be marketed in New Jersey.

I agree that these policy forms are not approved "formally" by me in the sense that I review them personally and affix my signature to each and every one of them. But they do receive formal approval by the department according to administrative procedures that have been in use for many years within the Department of Insurance.

A major theme throughout the series of articles that should be emphasized is the role of the unethical, unscrupulous insurance agent in the sale of individual health insurance policies, that small percentage of so-called "bad apples."

In fact, much of the criticism was directed at the tactics of agents rather than the content of the policies themselves.

"I trusted the agent," was one lament reported in the newspaper.

"I succumbed to high pressure salesmanship," was another.

"That's not the way the agent sold it to me," was still another.

Again, the newspaper survey alleged that "failure to disclose material information on health insurance applications is a frequent occurrence with some agents, resulting in claims controversies between the policyholder and the company."

Further:

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

I am well aware of the capacity for mischief if the agent lacks scruples. It is the same in any business whether the product be health insurance or used cars. Much depends upon the integrity of the people one has to deal with.

One allegation in the newspaper series that left me puzzled and disturbed concerned disciplinary action against agents licensed to sell health insurance. The flat statement was made that not in anyone's living memory had the license of a health agent been revoked.

As a matter of fact, in 1977 there were five revocations; in 1976, nine revocations and one suspension; in 1975, seven revocations. And these revocations involved the time-consuming process of a public hearing.

What can be done to protect the public?

The Department of Insurance licenses agents who demonstrate their professional competence - after 24 hours of instruction in an approved school - by passing a written examination. If there is anything in an applicant's background that calls to question his honesty and integrity, there is an additional check

made before a license is issued.

After licensing, the agent is strictly on his own in the ethical posture he assumes. His company may be the best but he can be the worst. Certainly, short of assigning someone to follow an agent around, the Department of Insurance cannot monitor his ethical behavior, per se. All we can do is to act when problems are called to our attention and, as the newspaper series pointed out, we can, and do, aid aggrieved insureds, frequently recovering sums of money for them. And we can, and do, take action when an agent, no matter what kind of insurance he is selling, violates our laws and regulations, which the newspaper account failed to mention.

Perhaps we can lessen the influence of the fast-talking unethical agent through a better educated public. That is why the Department of Insurance has prepared a booklet on health insurance for senior citizens, who, fearful of illnesses that could cause catastrophic economic losses, appear to be favorite targets of the unscrupulous agent. A better-informed citizenry is an effective means of dulling the effectiveness of the unscrupulous agent.

The booklet is not a substitute for regulation, but I believe that the more the buying public knows about the complexities of insurance, the less willing it will be to accept an agent's representations uncritically.

One area of regulation that I have recently strengthened has been in the follow-up after a policy has been approved and marketed.

It takes about four years after marketing before a policy can be fully evaluated and a judgment made as to whether the policyholders are getting a fair share of benefits for the money they expend in premiums.

In the past, our follow-up has been limited, if done at all, because of a shortage of manpower. More than a year ago, however in January, 1977, enough evidence came to my attention to suggest that health insurance regulation should be tightened and I issued a directive to my staff to that effect. I believed that our new Division of Consumer Services had achieved the level of professional competence needed to evaluate, in cooperation with the Division of Actuarial Services, those accident and health insurance policies that had been approved by the Department of Insurance.

In May of 1977, the Division of Consumer Services initiated a survey of all accident and health policies approved in New Jersey since January 1, 1968, and still being sold. The purpose of the survey was to determine whether the benefits were worth the premium.

As a result of that survey, I have asked 71 insurance companies selling 146 individual accident and health policies to withdraw them. I have also suggested that they may submit revised policy forms in which they increase the benefits or decrease the premiums. The assistant commissioner in charge of consumer services, Dr. Eleanor Lewis, plans to discuss this investigation more fully.

A few weeks ago I also took another step to improve the market for individual accident and health policies by announcing that policies that permit the companies to refuse to renew at their option would no longer be approved. This non-renewal option is a holdover from the days when accident and health insurance was considered a casualty line of insurance. Primarily sold by casualty insurance companies, it tended to reflect the practices of the casualty insurance industry.

It seems to me that the non-renewal option is singularly inappropriate in health insurance because exercised after claims have been made against a policy, it can leave policyholders without insurance at a time when they need it most.

We are also in the process of having companies submit to us a list of all their accident and health policies with the objectionable non-renewal provision and any additional action that I take will await a compilation and analysis by my staff.

For the past 2 1/2 years, the Department has been making market conduct examinations of insurance companies. These examinations focus on the company's treatment of the policyholders, from the time of their initial solicitation to the time the last claim is paid. To date, we have in process, or completed, 18 market conduct examinations; six of these are life and health companies.

These market conduct examinations mark the first time in the Department's history that it has done examinations of companies focused solely on the treatment of policyholders. As a result of these examinations, we work with the companies to change their claims handling procedures and any other aspect of the operations that we feel are not being conducted as they should.

One final word: The newspaper series juxtaposed my claim of a personnel shortage with an assertion that the Department of Insurance earns \$40 million a year in premium taxes and license fees. The inescapable inference is that the Department of Insurance is not spending this \$40 million wisely. Aside from the fact that the amount of money is really closer to 70 million dollars than to 40 million dollars, the entire amount is paid to the General Treasury. The Department lives on an annual budget of approximately \$3 1/2 million.

Thank you, gentlemen. Dr. Lewis is in the audience, as is Mr. White, our chief life-health actuary; and I would be happy to answer any questions I can.

ASSEMBLYMAN BORNHEIMER: Does anybody on the Committee have any questions?

ASSEMBLYMAN ADUBATO: I would like to clarify something if I may. I would like to ask Walter - I realize you are reading the Commissioner's statement - is it correct to say that the investigation, the inquiry, if you will, concerned 71 companies?

MR. BLISS: Seventy-one companies were the subject of corrective action.

ASSEMBLYMAN ADUBATO: And 146 policies were asked to be withdrawn?

MR. BLISS: Yes.

ASSEMBLYMAN ADUBATO: On what basis? I know you went over premiums as related to claims experience. Did I understand you to say that they were asked to be withdrawn, setting the format of a four-year --- Does the time element come into play of a policy, that it has to be in effect four years before you can effectively state whether or not the claims to premiums ratio makes sense?

MR. BLISS: Yes. In other words, there are two steps in the process. The first step is the preliminary review and the Department by statute is permitted to disapprove any filing or any proposed policy form for which the premium is not reasonable in relation to the benefits provided. On that criterion alone, the Department knocks out about 65 percent of the proposed forms. Again, this perspective, or this initial screening process, addresses itself to probable loss ratios. There is an examination made to the best we are able actuarially to

predict the probable loss ratio. Those loss ratios must be up above minimums. The minimums used are those promulgated by the National Association of Insurance Commissioners. Subsequently, there is a retroactive check to check whether or not in fact those policies have lived up to the minimum loss ratios they were supposed to. And it is based on that retroactive check, which incidentally is a first in the Department's history, an additional 146 policies were knocked out.

ASSEMBLYMAN ADUBATO: I am a little confused. Are you saying 146 policies have actually been knocked out or the request was made ---

MR. BLISS: Request has been made.

ASSEMBLYMAN ADUBATO: So they haven't been knocked out.

MR. BLISS: Dr. Lewis has specific figures on which have been voluntarily withdrawn, which will be subject to hearings, and so forth.

ASSEMBLYMAN ADUBATO: I am aware of those figures. That is why I was questioning the statement that they were knocked out. They have not been knocked out. Some of them have been withdrawn.

MR. BLISS: Yes.

ASSEMBLYMAN ADUBATO: Some of them are being contested.

MR. BLISS: That is correct.

ASSEMBLYMAN ADUBATO: On some of them, we may hear later on progress reports from other people. But, just to set the record straight, 146 policies have not been knocked out. I think that is a fair statement.

MR. BLISS: That is a fair statement. One hundred and forty-six policies have been requested to be withdrawn from the market.

ASSEMBLYMAN ADUBATO: Voluntarily withdrawn.

MR. BLISS: Right, subject to a mandatory hearing process and subject to actual litigation, which is ahead of us.

ASSEMBLYMAN ADUBATO: I would like to ask your opinion on something else. We talked about the unscrupulous agent, the responsibilities and where they lay. Naturally, I agree with you that the agent is the direct link. But, in your opinion, don't you think that the companies that employ agents who are unscrupulous have a responsibility, not just the Department? Their agents set a pattern and it is not always necessary for the Insurance Department to take action, because the companies have a responsibility to let go of these agents without any action by the Insurance Department. Don't you think that is a fair statement?

MR. BLISS: I think that is a fair statement. However, I would characterize the traditional regulatory process in this area as involving individual, and usually isolated, allegations concerning representations by an agent, which when followed up by the Department with the company usually results in the company living by the agent's otherwise false representations. So the companies have been good in adjusting individual cases. To the extent that there is need for future action with future manpower, it is in the area of developing patterns of false representations against particular agents. Isolated cases are adjusted by the companies.

ASSEMBLYMAN ADUBATO: Mr. Bliss, maybe it is because I have been in the insurance business for almost 18 years and I am an agent, but my experience has been that the companies I have been associated with - not only worked with, but have been in contact with - most of them, if not all of them, that I am aware of - and I agree that I am not aware of all the companies and all the policies ---

but when they find complaints made by policyholders, most of them have taken action on their own and let go of agents.

Now, are you saying that this not your experience, that you have to fight them to ---

MR. BLISS: I am not saying that at all. I am saying that - that is your representation - we don't have specific data on how many agents against whom complaints have been made.

ASSEMBLYMAN ADUBATO: Exactly. The reason is that you wouldn't get it because they are probably not with the company anymore. The people that you are getting are those people who have not been exposed to the company and someone writes you directly maybe to the Department, or whatever. So there is no way that you would know that the company let someone go. I think the companies may be at fault by just letting an agent go and not getting him out of the industry altogether. That's the difference.

MR. BLISS: With an appropriate investigative staff and resources, I would assume it is possible for the regulator to develop patterns of fraudulent behavior and to pursue the individual agent, regardless of what company he works for. But again, the companies in the past have adjusted. The Department has followed up all of these allegations. Typically, the company adjusts the problem and makes the representations good.

ASSEMBLYMAN ADUBATO: Thank you.

ASSEMBLYMAN ORECHIO: Mr. Bliss, in your statement, you mentioned something about the unethical agent and the preparation of a booklet on health insurance that is available, I am sure. How is that distributed for senior citizens?

MR. BLISS: Dr. Lewis can give you some very specific details on that. The senior citizen booklet I believe is being printed right now. It has been in the process of preparation, together with the other consumer booklets that the Department has put out for some time now.

ASSEMBLYMAN BORNHEIMER: We will get to Mrs. Lewis soon.

ASSEMBLYMAN ORECHIO: Are you saying it isn't available yet?

MR. BLISS: It is not available at the very moment, no.

ASSEMBLYMAN ORECHIO: You also said it takes about four years after marketing before a policy can be fully evaluated. Why should it take that long?

MR. BLISS: Some policies are not ready to be evaluated even after four years. You need a credible volume of sales experience, and some policies will sell in very low volume. The loss ratios, therefore, are not credible in actuarial terms.

ASSEMBLYMAN ORECHIO: You also spoke about a shortage of manpower so that you are not able to follow up some of the problems that are called to your attention. What has the Department done about it?

MR. BLISS: I didn't mean to indicate that the Department had identified a task that it wasn't doing because of a shortage of manpower. I am saying that if there is a desire to have the regulator not only adjust complaints involving fraud, but also serve as a prosecutor, a policeman, an investigator in almost a criminal sense, because we are talking about criminal fraud here --- if the desire is to have the Department serve as a criminal investigator, then considerable additional manpower would be required to develop

these fraud cases. This is an area I do have some experience with in the criminal context. To develop a fraud case, to prove intentional misrepresentation, is extremely difficult and involves very large expenditures for attorney manpower.

ASSEMBLYMAN ORECHIO: Have you made requests for additional manpower in that area?

MR. BLISS: Yes, we have.

ASSEMBLYMAN ORECHIO: And what has happened?

MR. BLISS: Generally, we have been at a maintenance level of our budget; that is, our staff and personnel have been maintained at a fairly constant level over the years.

ASSEMBLYMAN ORECHIO: In another part of the statement, you say, "The Division is in the process of having companies submit to us a list of all their accident and health policies, with the objectionable non-renewal provision." You say you are going to have to await a compilation and analysis by the staff. Has there been a date set as to when that analysis is going to be completed?

MR. BLISS: The deadline for submission escapes me momentarily. May 1 is the deadline. So the information is just now in the Department.

ASSEMBLYMAN ORECHIO: When will we learn the results of that analysis?

MR. BLISS: I couldn't give you a specific date because then I would be prejudging the complexity of the task involved and the amount of information submitted. But you can be assured that it will be very prompt.

ASSEMBLYMAN ORECHIO: Thank you. That is all I have, Mr. Chairman.

ASSEMBLYMAN BORNHEIMER: Thank you, Walter.

MR. BLISS: Thank you, Mr. Chairman, and members of the Committee.

ASSEMBLYMAN BORNHEIMER: Our next witness will be Mr. William A. White, Chief Actuary, Life and Health, Department of Insurance.

Do you have a prepared statement?

W I L L I A M A. W H I T E: I have a prepared statement and an apology. When I left the Department of Insurance 15 minutes ago, my secretary was standing at the Xerox machine grinding out the last of the copies. I will have to ask your indulgence for the first page or two. Momentarily, one of my assistants should be here with the prepared statement.

My name is Bill White and I am Chief Actuary for the Department of Insurance and I have been with the Department of Insurance for almost nine years.

My statement today will attempt to accomplish three things: First, it will describe briefly in terms of numbers of people and dollars of premium the entire health insurance picture in New Jersey, so that an accurate feeling can be had for the dimensions of the problem which the Jaffe articles address. May I digress for a moment? I make numerous references to Herb Jaffe in my statement here. I am told by the more politically astute this isn't being done, but I have known Herb for the better part of nine years and respect him and have taken the liberty of referring to him in the statement.

My second objective will be to outline the process by which policy forms and rates for individual health insurance have historically been reviewed by the Department of Insurance.

My third objective is to comment on three statements in the articles where I indicated that individual health insurance as sold by commercial insurance companies is not my personal top-priority concern.

The first topic - Health Insurance in New Jersey. It is quite difficult to get an accurate picture of the distribution of health insurance in New Jersey. In part, this is because so many different parties are involved in providing health insurance. We have Blue Cross and Blue Shield, the commercial insurance companies, the federal government through Medicare, the State government through Medicaid, health maintenance organizations and unregulated employee benefit plans sponsored by employers, unions or municipalities. This leads to duplications of member counts such that the total number of people covered easily exceeds the population of the State. Just for example, the sixty thousand or so State employees covered by the State Health Benefits Plan represent about 155,000 Blue Cross-Blue Shield participants when dependents are taken into account. The plan also purchases major medical insurance from Prudential and would normally be included in Prudential's count of certificate-holders for which that company provides health insurance.

Similarly, the federal government covers about 800,000 New Jersey citizens under the Medicare program. The Blue Cross figure of 4.4 million participants includes 335,000 of these Medicare recipients to whom complementary coverage has been sold to fill the deductible and co-insurance gaps in the Medicare program.

Based on estimates provided by the Health Insurance Association of America, with adjustments made to eliminate duplications and to assign each person to the category which is primarily responsible for his health insurance coverage, then approximately seven and one-half million people in the State of New Jersey appear to be insured. And at this point there is a table in the presentation identifying Blue Cross-Blue Shield subscribers as 50 percent of the total; commercial-private insurance policyholders comprise 27 percent of the total; Medicare recipients is 11 percent of the total; Medicaid has 9 percent of the total; and uninsured individuals comprise 3 percent of the total.

Now, for the purposes of today's hearings, the key figure is the 27 percent of the State's population covered by commercial or private insurance. This is the category to which Herb Jaffe's half a billion dollars - I am quoting - paid by Jerseyans for health insurance policies that are neither regulated, carefully scrutinized by the State nor formally approved by the Commissioner, applies. This is the first paragraph of the first of the series of articles published on February 26th.

The statistics that lend validity to this contention of lax regulation is that almost 80 percent of the half billion dollars of premiums for commercial health insurance is comprised of group accident and health insurance where the statutes do not provide for any rate regulation. The reason for the absence of rate regulation is that most insurance is sold to and paid for by employers or union welfare funds where benefits are tailored to the specifications, often collectively bargained, of the group, and where competition among insurers is genuine, where premiums are very close to actual costs and where the degree of buyer sophistication obviates the need for Insurance Department rate protection.

Group health insurance is not sold by agents to individuals. So it is not subject to the criticisms and abuses identified in the Jaffe articles. The category that is subject to these criticisms consists of the remaining 100 million of the 500 million identified as paid by, or provided by, commercial health

insurers - the remaining 20 percent of the premium dollars. Here again, we run into problems of terminology because less than half of what insurance companies report as individual health insurance actually insures against the hospital's or doctor's expenses of sickness. Assistant Commissioner Lewis will discuss the May, 1977, survey of accidental health policies approved in New Jersey and currently being sold. Deputy Commissioner Bliss has already alluded to it and fielded questions on it.

We ran a distribution of the policies reported in that survey to get a feel for the kinds of health insurance included. There follows a table showing the number of policies and the 1970 amount of premiums for disability income, which comprised 35 percent of the policies and 55 percent of the premiums; for accident-only coverage, which comprised 31 percent of the policies and 13 percent of the premiums; for basic hospital medical-surgical coverages, which comprised 22 percent of the policies and 23 percent of the premiums; for major-medical insurance, 5 percent of policies and the same 5 percent of premiums; Medicare-complementary, 3 percent of policies and 3 percent of premiums; and the other category, 4 percent of policies and 1 percent of premiums, presumably, including the hospital supplemental income policies sold by mail-order, mass-merchandising plans.

Disability income insurance is the primary health insurance product of the life insurance industry, as I am sure you are aware. Just as life insurance protects a family from loss of income if the breadwinner dies prematurely, disability insurance protects the family if he is disabled by sickness or injury and unable to earn an income. For this reason, disability income is a logical part of the life insurance salesman's offering. And most disability income insurance is sold in conjunction with life insurance. Disability income insurance also has many of the characteristics of life insurance. Typically, it is non-cancelable and guaranteed renewable, meaning that the company cannot terminate the coverage as long as the insured continues paying the premiums; and the company cannot increase the premium rates.

Few, if any, of the problems discussed in the Jaffe articles can be attributed to this form of health insurance, which accounted for 55 percent of the premium volume in our 1977 survey. The kinds of health insurance to which the Star Ledger articles applied are basic hospital medical-surgical insurance, corresponding with Blue Cross and Blue Shield coverage; major medical insurance, providing coverage for catastrophic medical expenses of up to a quarter of a million dollars, after a deductible of something between \$500 and \$1000 has been satisfied; and Medicare-complementary insurance. Together, these three kinds of health insurance account for 30 percent of the policies and 31 percent of the premium volume in the survey. And it is particularly interesting to note that Medicare-complementary coverage, which was the principal target of the Jaffe articles, accounted for only 3 percent of the total individual health insurance studied.

Even if the accident-only and other categories are combined with the clearly medical expense sorts of policies, they account for about 45 percent of the individual health insurance premiums, or something less than \$50 million of the total "half a billion dollars" of commercial, private health insurance premiums.

Now we go to the regulation of individual health insurance in New Jersey, the second topic. There is little solace to be gained from having scaled down the magnitude of individual health insurance from 500 million to 50 million, if the policies represented by those premiums are, as the article quotes, "neither regulated, carefully scrutinized by the State, nor formally approved." However, it is totally inaccurate to infer that the individual health insurance policy forms and rates are not closely regulated. One entire chapter, Chapter 26, of the Life and Health Insurance Code is devoted to the individual health insurance regulation and it covers everything from the size and style of printing to the mandating of coverage for alcoholism and hospital and medical expense policies.

Section 1 of that chapter states: "No health insurance policy shall be delivered or issued for delivery unless the form thereof has been submitted to and filed by the Commissioner." During 1977, a total of 1992 individual health insurance policy forms were submitted for review by the technical personnel of the Department of Insurance's Division of Actuarial Services, the division I head. The average review required about one and a half hours and only 35 percent, or 707, of the forms were filed as submitted. Of the 65 percent of the forms disapproved - and Walter Bliss has alluded to this before - many were revised and resubmitted to eliminate objectionable features, to add required provisions, or to reduce premium rates. The net effect is that 991 individual health insurance policies were actually filed during 1977 or almost exactly half of those originally submitted. The check list used for review of individual health insurance policies comprises about 80 items, of which approximately 45 are taken directly from the statute, with the remainder stemming from regulations, circular letters, formal or informal guidelines, or the Department's established practices as to provisions which are considered unfair, misleading, inequitable, etc.

Rates for all new policy forms, as well as rate increases for forms previously approved, must also be approved. It is decidedly not true that New Jersey is a "file-and-use state" for individual health insurance, as reported in Jaffe's fourth article.

During 1977, we received 139 submissions for rate increases on individual health policies. Fifty-five percent of them or 77 of the 139 were disapproved. I think I can safely say that the overworked people in our approval section disagreed vehemently with the statement that, "health insurers are almost free to operate at will," from the eighth paragraph of the first of the series of articles.

Now, let me go to the personal observations - and this is far and away the most difficult part of my statement. I am quoted directly at three places in the series of articles on health insurance, first, saying, "Health insurance is like the illegitimate child"; second, that "Health insurance regulation in New Jersey has been less than a priority and that, until now, the chief concern in health premium rates has been Blue Cross and Blue Shield"; and, finally, repeating, in the fifth article that "With the exception of Blue Cross and Blue Shield, health insurance regulation in New Jersey has never really been much of a priority."

These three statements are essentially accurate, although the first was

reported out of context and the last two reflect a personal opinion, which is sharply at odds with the Department's personal policy-makers.

The illegitimate child first --and I am not sure that is the expression that I used talking with Herb. This topic arose at the beginning of a ten-minute discourse on the origins of health insurance. The point was that health insurance is the product of three very different insurance parents over the course of more than a century. And this mixed parentage accounts for much of the difficulty we have in regulating health insurance today.

The first parent was fire and casualty insurance --the companies today that are writing automobile or homeowner insurance as well as coverage for employer's liability, burglary and theft and workmen's compensation. A logical extension of protecting property against accidents was protecting human beings against accidents. And the earliest forms paid benefits only in the event of accidental death or dismemberment. The business later evolved so as to cover, first, medical expenses resulting from accidents and, finally, medical expenses resulting from sickness.

The business always retained the earmarks of the casualty business, however: policies renewable or cancellable at the option of the insurance company, freedom to change rates at any renewal date, and commissions that are a flat percentage of premiums. This background accounts for provisions, such as 17B:26-24, which begins, "There may be a provision as follows: cancellation - the insurer may cancel this policy at any time."

The second parent was the life insurance industry and the form of the resulting insurance was disability income. In the earlier section of the statement, I explained why disability income insurance was a logical outgrowth of life insurance, replacing the income of the breadwinner, and how disability income acquired many of the characteristics of life insurance, including guaranteed renewability and guaranteed premiums.

The third parent of health insurance was group hospital, medical, surgical benefits, as typified by Blue Cross and Blue Shield. This business got its big push during World War II when there was a freeze on wage increases and an opportunity to buy group insurance benefits in lieu of wage increases. This form of health insurance is what most people associate with the term health insurance, although on an individual basis, Blue Cross and Blue Shield are by far the most important suppliers with more than twice as much health insurance of this form in New Jersey as all commercial insurers combined.

So the illegitimate child status of individual health insurance was intended to describe the origins of the species and to explain the crazy "body of statutes" that surrounds it and which makes effective regulation very difficult. It was not intended to express scorn to the importance of regulating individual health insurance.

The question of relative priorities remains to be answered. This will require some background on actuaries, actuarial services, and on "yours truly."

The Division of Actuarial Services and its predecessor, the Actuarial Bureau, in the New Jersey Department of Insurance, was formed more than half a century ago for the essential purpose of regulating life insurance. A long line of distinguished actuaries, several of whom are now retired and living in the

Greater Trenton area, have served the Department; and most students of life insurance will agree that the New Jersey Department of Insurance was the dominant force in life insurance regulation, along with the New York Insurance Department, from approximately 1930 to 1970. The presence in New Jersey of the world's largest life insurance company probably helped to account for this dominance. When I personally joined the Insurance Department in 1969, after almost 20 years within the life insurance industry, it was in hopes of being a continuing, positive factor in the responsible regulation of life insurance. From an actuarial standpoint, life insurance is immeasurably more complex and less well understood by the general public than health insurance. The individual life insurance product, with all of the mathematical, legal, medical, investment, accounting and administrative wrinkles that surround it, makes the average health insurance regulation look easy.

The 25 or so people who work for me in the Division of Actuarial Services are primarily life insurance specialists. Their number, incidentally, is the same as in 1950 before the explosion that produced a tripling in the number of life insurance companies, myriad new products, and regulatory responsibilities. This year, New Jersey citizens will pay more than one billion dollars to 250 life insurance companies, on 5.4 million individual life insurance policies, providing more than \$47 billion of life insurance protection. I could go on with many more figures to point out the importance of life insurance and the effect of life insurance regulation, but I am sure you are already familiar with most of them.

It is from this background that I made the apparently callous remarks which Herb Jaffe quoted about insurance priorities. I fully appreciate the problems that thousands of New Jersey people are having with shoddy individual health insurance products that the law permits unscrupulous agents to sell. My people do a good job of policing health policy forms, I am convinced - the forms for rates and the complaints - a much better job than the Jaffe articles give them credit for. But I honestly wish I had twice as many people to do an even better job. I wish the laws of New Jersey were such that we could disapprove many of the policies we have had to approve and prohibit practices which we have had to tolerate. But, as a realist, I have to acknowledge that there is just so much that my people can accomplish and I resist the suggestion that the problems we helped Herb Jaffe to identify are so important as to warrant diverting our efforts from the full range of life and health insurance challenges with which we are faced.

I must emphasize again, these views on priorities are not shared by Commissioner Sheeran. The issue of relative priorities for life insurance and for individual health insurance is one of our many deep philosophical differences, and contributes significantly to my decision to leave the Department of Insurance at the end of this month. It is unfortunate that my personal attitudes towards regulatory priorities have been interpreted in the press as statements of department position and I want to clarify the misunderstanding.

Let me summarize. I feel that the Jaffe articles on health insurance were, in the vernacular, a bum rap. They overstated the scope of the problem and understated the steps that have been taken to control it. Because we acknowledge the existence of a problem - and, we all agree, a very real problem, but a

problem which we cannot immediately resolve - our regulation is attacked as "lax." One of the problems of government under glass, as defined in this administration and a concept which I heartily endorse, is that if you discuss a problem before you have an answer for it, you run the risk of being deemed responsible for the problem.

Despite the obvious difficulties, the Jaffe articles and this hearing will have been worthwhile if they move you to tighten the statutes affecting individual health insurance. I urge you to heed the suggestions of Commissioner Sheeran and Assistant Commissioner Lewis. Thank you.

ASSEMBLYMAN BORNHEIMER: Thank you, Mr. White.

Are there any questions by members of the Committee?

I have one question. Does your summary of disability insurance include the type that is sold with automobile policies also?

MR. WHITE: No, it does not.

ASSEMBLYMAN BORNHEIMER: The life in that type is not included in this?

MR. WHITE: This includes the figures --- Well, the original summary by group - individual, Blue Cross and the like - was obtained largely from the trade association. And the 500 million figure was obtained from the Commissioner's annual report. This reports accident and health insurance for 218 life insurance companies and for approximately 85 fire and casualty companies, broken into a half dozen categories, but regrettably in a very difficult form to analyze as to the kinds of insurance involved.

ASSEMBLYMAN BORNHEIMER: Thank you very much.

ASSEMBLYMAN ORECHIO: Mr. White, you said something about appreciating the problems we are having with shoddy individuals. You said something to the effect that the law permits unscrupulous agents to sell. Would you mind explaining exactly what you are talking about in that statement?

MR. WHITE: This touches on a question that Assemblyman Aduato asked earlier, the abilities of the Department to police poor sales practices. I come from much the same sort of insurance company background as Assemblyman Aduato, two large old mutual insurance companies. And, frankly, it was an eye-opener to me to be exposed to some of the smaller, newer, more profit-oriented insurance companies that are operating in the State.

Herb Jaffe made mention of one very significant problem in his articles, which is true of both health insurance and life insurance, and this is the problem of twisting or the unwarranted replacement of life insurance or health insurance. There are companies regrettably operating in the State, the bulk of whose business is obtained through twisting. The companies obviously and deliberately encourage their agents to replace existing life insurance with that company's life insurance. New Jersey has had a regulation on the books since 1971 concerning twisting and requiring a complete disclosure statement to be prepared by the agent who is replacing another company's life insurance. We find that the agents take to that like a duck to water. It becomes the track record - the department's authorization for what they are doing. The reputable agents - and mention was made in the Jaffe articles of Sid Decker, who is Chairman of the Ethics Committee of the New Jersey Association of Life Insurance --- the reputable agents constantly bring to our attention instances of poor sales practices. Frankly, most of them are in the life insurance area rather than in

the health insurance area. Almost invariably we find that we can't do anything about them because the agent has complied with the letter of the law and, as Deputy Commissioner Bliss indicated, it is an extremely tortuous process and one that I, as an actuary, am totally unprepared for, to bring an agent up and lift his license.

ASSEMBLYMAN ORECHIO: Have you made any recommendations to any of the Commissioners or to Commissioner Sheeran to correct this problem having to do with ---

MR. WHITE: The twisting problem?

ASSEMBLYMAN ORECHIO: Yes.

MR. WHITE: The National Association of Insurance Commissioners does have a new twisting regulation which I believe is more effective than the New Jersey regulation that has been in place since 1971. I would like to see it in place as an extreme measure - and I have discussed this within the National Association of Insurance Commissioners with actuaries from other states. It would seem desirable to establish by regulation a presumption of twisting and a requirement that premiums on twisted policies be refunded to twisted policyholders and the original policy reinstated if the policyholder brings the complaint about twisting.

One of the very frustrating things about the twisting complaints that we get in the Department of Insurance - and we probably get 20 or 30 a year - is that the complaint is almost invariably brought by the agent whose policy was twisted rather than the policyholder that was presumably victimized by the twisting. There is a tendency to regard this as an intraindustry squabble and a lot of us feel very uncomfortable when one agent says he will hold my jacket while I fight his battle with another agent for him. It is an extremely difficult problem. I wrote a paper which has been published by the Society of Actuaries about four or five years ago, trying to describe all of the problems and frustrations and incentives for twisting. It is one of the most frustrating problems I have had to deal with in my nine years with the department.

ASSEMBLYMAN ORECHIO: And, Mr. White, you say your people do a good job of policing health policy forms, rates and complaints.

MR. WHITE: Yes.

ASSEMBLYMAN ORECHIO: Are there any statistics available as to the kinds of complaints that we are getting, from whom, and what is being done about them - specific statistics?

MR. WHITE: There are - unfortunately I didn't bring them with me. I was speaking with the head of the Complaints Section within my division yesterday to try to get a relative feel for the number of health insurance complaints that we get concerning commercial insurance as opposed to Blue Cross and Blue Shield insurance. You would expect with the proliferation of Blue Cross and Blue Shield that they would outweigh the commercial insurers. I believe the figures she gave me was that in 1977 we received about a thousand complaints on Blue Cross and Blue Shield and about two thousand complaints on the much smaller volume of commercial health insurance.

ASSEMBLYMAN ORECHIO: Would you mind making those statistics available to the Committee?

MR. WHITE: Yes. I will make a note about it.

ASSEMBLYMAN ORECHIO: One last question. You stated, "I wish the laws of New Jersey were such that we could disapprove many of the policies we have had to approve and prohibit practices we have had to tolerate." Have you made any recommendations in those areas, as to how we can improve the conditions that you alluded to or alleviate them?

MR. WHITE: Well, Dr. Lewis will address most of the recent measures that have been taken. We have introduced more than once the National Association of Insurance Commissioners' minimum standards, legislation that would permit us to enact a minimum standards regulation. We worked with Legislative Services and Assemblywoman Martindell a couple of years ago to try to get legislation that would prohibit policies cancelable at the option of the company.

In the group areas and as an adjunct of our work in Blue Cross and Blue Shield, we have attempted to introduce the National Association of Insurance Commissioners' model group health conversion law in New Jersey. One of the embarrassments, I think, is that for many commercial group health insurers, if a member leaves the group, he cannot automatically convert his group health insurance to an individual policy as he can with any Blue Cross and Blue Shield policy or as any group health certificate holder in New York can, under the legislation in New York. I helped work with the NAIC on that model bill and we have attempted to get it introduced, without success.

If you want to go out on a limb and "blue sky" it, I, personally, would not object to a law to prohibit an agent from selling an individual health policy to any individual who is retired over age 65. As you well know, the sale of life insurance is totally different from the sale of health insurance to senior citizens. Life insurance to the agent is very adequately compensated through a sizable first-year commission because of the job he has done in persuading a policyholder to purchase a life insurance policy, which is one of the most unselfish acts that most people ever undertake, committing a large sum of money each year for the benefit of someone other than themselves. There is tremendous sales resistance and a tremendous amount of work that has to be done by a life insurance agent to accomplish this. And the pattern of commissions on life insurance policies reflects this work.

The situation with the senior citizen buying medi-gap insurance is totally different. Medi-gap insurance is available over the counter from Blue Cross and Blue Shield any day of the year at a premium which is significantly lower than that charged by most commercial insurers. It is not the kind of insurance that has to be sold. It is a form of insurance that senior citizens are clamoring to buy. Personally, it would not do any violence to my concepts of the freedoms that agents should have in the sale of insurance and a lot of that effect - and I know of no state even considering it - would make a very sizable dent in the most significant problem that Herb Jaffe has pinpointed, the unnecessary sale of Medicare complementary and similar insurances to people over age 65.

ASSEMBLYMAN ORECHIO: Thank you, Mr. White. I have no further questions.

ASSEMBLYMAN ADUBATO: First of all, I want to say that I think your leaving the State is our loss.

MR. WHITE: Thank you.

ASSEMBLYMAN ADUBATO: One of the problems that I have found in government is that we have not enough people with expertise. Sometimes people with good intentions and not enough information can lead us astray. I don't feel too comfortable today talking to you. I guess I am conditioned to the times we live in, that the enthusiasm in our society, with justice, to protect consumers sometimes can hurt the consumer. I think we have seen that at all levels of government today.

The health insurance products that we were talking about in your presentation, just to clarify the statement - when we talk about guaranteed renewable contracts and contracts renewable at the option of the company, we are talking about the real quality contracts, the kind that most of the old-line companies that handle this merchandise market. We are not talking about the articles, the initial thrust of Jaffe's investigation into Intercontinental and the products that they were handling. They are totally two different worlds. I think the public is under a misconception for the most part and with justification, because the follow-ups came on the heels, so to speak, of the initial expose and it lumped - I can't think of a better word - but it lumped everyone together. It was very unfortunate.

I feel uncomfortable because I make my living selling life insurance primarily. However, I feel it is time for people not only in government, but people in industry to get off the sidelines and to speak out, because I am very proud of being a member of the life insurance industry. I consider it to be, as I am sure you do, one of the bulwarks in our society, in maintaining our free enterprise system for one, and providing many, many benefits for a lot of people that the State doesn't have to because the life insurance man is selling them that need.

I don't defend anything as far as commissions because, you know, I think it is something like a hundred men have to be hired in the industry to maintain one for more than a year. I don't have the answers to all these problems. But I certainly will not allow anyone to discredit the industry or the people in the industry based on propaganda and based on lack of knowledge, with all their good intentions.

I find myself uncomfortable because I am also one of the biggest critics of life insurance companies for other reasons - not for these reasons - for other reasons that I won't get into right now. So that is my dilemma to you, sir. And I want to thank you for just being who you are and where you were at the time because I think you have done the State and its people a good service. I repeat, I am sorry to see you go.

MR. WHITE: Thank you, sir.

ASSEMBLYMAN BORNHEIMER: I, too, am sorry to see you go.
Thank you very much, Mr. White.

We will now take a five-minute break.

(Short Recess)

ASSEMBLYMAN BORNHEIMER: Our next person to testify will be Mr. Adam Levin, Director of the Division of Consumer Affairs.

A D A M L E V I N: Before I start, gentlemen, let me introduce to you Sister Ellen Patricia Meade, who is now working as a volunteer full time with the

Division of Consumer Affairs. Sister Ellen you may know as the retired Chief Administrator for St. Elizabeth's Hospital in Elizabeth and is our reigning wizard on health care up at the agency. She worked with me on this and she is a great source of strength to us. And we are grateful to the order for allowing us to steal her for a period of time.

I want to thank all of you for giving me the opportunity to present my agency's perspective on the crucial issue of health care and health insurance.

As an introductory note, I should explain why I, as the State Consumer Affairs Director, am here to speak on an insurance matter, something which does not strictly fall under the technical jurisdiction of my agency.

The Division of Consumer Affairs is an enforcement agency, but, equally important, it is also an advocacy agency. Our basic mandate is to root out and eliminate deception, fraud and misrepresentation in the marketplace. And where we have jurisdiction, we proceed directly against such anti-consumer practice.

We can improve the regulatory jurisdiction over a portion of the marketplace where there is an evident pattern of deceptive practices which prey at a particularly vulnerable class of citizens. The part of the marketplace to which I am referring, of course, is the private health insurance industry. As New Jersey's official consumer advocates, we at the Division of Consumer Affairs would like to see a refinement of the regulatory power over this field which is lodged in the Department of Insurance.

I am, in effect, here today to plead the case of the consumer by pleading the case for amplified powers and resources in a sister consumer agency, the Department of Insurance, which will help to eliminate anti-consumer practices in the health insurance industry. We have found at the Division of Consumer Affairs that unscrupulous operators of all kinds presume that senior citizens are an easy mark for a fast-talking con game or for scare tactics that exploit the special needs or limitations of the elderly.

The abuses in the health insurance industry center around senior citizens who are sold unneeded, duplicative policies which supposedly cover the real gaps in Medicare coverage. They are told that their policies include certain kinds of protection, only to learn later that a deductible is higher than they were led to believe or that coverage is excluded altogether because of some tenuous connection between their very real affliction and a supposedly pre-existing condition.

Elderly persons who have been covered all their lives with employer-group plans suddenly face the hard-sell and scare tactics when they retire.

What is to be done? We believe that strong and decisive action is needed in four main areas.

First, the Legislature through bills such as the one proposed by State Senator Merlino should give the Department of Insurance the authority to promulgate and enforce strict disclosure standards for health insurance policies. Such a law would make it clear the force of government stands behind the public right to know in all kinds of consumer transactions, including health insurance transactions. Such legislation would strengthen the department's position and the position of the consumer by the establishment of basic minimum standards.

Now, the next part, just to clarify what I am saying here, is by standardizing and simplifying the language in these policies, as opposed to very complicated legalese which we are all very familiar with, this will in effect have the following results: that companies would be telling consumers by the simplified language what the policy includes, what the deductibles are, what any pre-existing clause means, and what the cancellation and renewal options are.

Consumers are entitled to easy-to-read policies. Making an insurance policy understandable to the reasonably intelligent layman instead of incomprehensible to all but the most skilled interpreter of legalese is the most basic guarantee of proper disclosure. While the Department of Insurance has vigorously used its authority to reject policy forms that have been submitted to it prior to marketing, a minimum standard law would codify disclosure requirements, would take the burden off the department to perform this painstaking case-by-case analysis. It would put the health insurance industry on notice that they must meet certain standards in writing policies understandable to people.

Second, health insurance agents must be subjected to vigorous discipline and regulation. There should be no hesitation about revoking the license of agents who engage in clearly anti-consumer practices. With rising consumer awareness, the Department of Insurance has been burdened to the limit and its role should be strengthened in investigation and follow-up of the cases where agents misrepresent what is contained in a policy or engage in a practice of urging senior citizens to cash in one policy for another just to get the first-year commission payment. A health insurance agent is more than just a salesman of another product or service in the marketplace. When a consumer buys health insurance, the consumer is really purchasing protection, peace of mind, or at least the consumer is led to believe that is what is being purchased. The buyer-seller relationship in insurance transactions rests very heavily on the assumption of good faith. The good faith on the part of the seller approaches a fiduciary relationship with the buyer. In essence, the buyer is saying that he or she wants to be protected and is depending on the expertise of the agent to provide the coverage needed. This level of duty should be kept in mind in evaluating the conduct of these agents. What may pass for marginally acceptable conduct in other parts of the marketplace is totally unacceptable for insurance agents. The power to revoke licenses should be used justly, but with swiftness and certainty.

Third, by virtue of bills like the minimum standards bill, there must be review authority given to the Insurance Department concerning the cancellation of health policies by companies. The current practices amount to a Catch 22 for consumers, especially the senior citizen. Policies are construed so as to imply automatic renewal or so as to prohibit the consumer from canceling; but, at the same time, companies are allowed to cancel non-profitable policies.

Fourth, this State's senior citizens need a place where they can turn for advice and counselling concerning health insurance decisions. They need the advice of an expert, someone who doesn't have a financial interest at stake in the transaction on whether or not to buy particular insurance policies. They need someone who will be motivated by consumer interests in giving advice.

For these reasons, I believe the resources should be made available to

set up a centralized insurance counselling service in the Department of Insurance. Such a service would be available to senior citizens through a statewide, toll-free hot line, which would answer for senior citizens questions about the advisability of certain health insurance policies.

A consumer agency should stand up for sister agencies that are doing a commendable job in face of incredible odds. That is what I am doing here today. What I am calling for in effect is a refinement of the regulation of a part of the private sector. The currently fashionable anti-government notion treats all regulatory proposals alike as unwanted intrusions of government on free enterprise. The tendency today is to concentrate on the inherent evil of regulation, per se, and to forget about the evils the regulations are designed to eliminate. To automatically reject a regulatory scheme because of the fashionable, but simplistic, "all regulation is bad" notion would amount to a renunciation of responsibility to perform the basic duty of government, to protect those citizens who cannot protect themselves.

Let us not kid ourselves. To be involved in government in the latter part of the 20th century is to be involved in regulating many phases of the business and commercial life of a complex society. It is no answer simply to put forth simple choices between regulation and no regulation. Rather, it is our task to have the wisdom to create regulatory schemes which eliminate the social wrong while not being overly burdensome to the legitimate business interests of the regulated industry or to the taxpayer. Here the evidence of abuse is all too clear. Senior citizens are being victimized day after day in New Jersey. The fears, anxieties and special needs of the senior citizen provide little protection against deceptive, high-pressure, fast-talking, fear-inducing sales tactics available to the unscrupulous health insurance agent.

I come here today as a consumer advocate who recognizes the great contributions which have been made by Commissioner Sheeran. No one can doubt that he is one of the outstanding fighters for the interests of consumers in this nation and his leadership role has been recognized by his colleagues nationwide. His department has done a fine job, given the great task at hand. Mandating minimum disclosure requirements for health insurance policies plus some of these other recommendations would refine the department's regulatory authority and help it to do the job for the consumer even better.

I thank you for this opportunity. I am free to answer any questions. I want you to know that I have a little experience in the licensing and regulating area, in that 19 of the professions of this State which are licensed are within the Division of Consumer Affairs; and I know the formidable tasks faced by any licensing authority and the importance to balance all the interests in the licensing procedure, but also to take cognizance of the consumer's interests and try to fit it into a proper mold.

ASSEMBLYMAN BORNHEIMER: Any questions by members of the Committee?

ASSEMBLYMAN ADUBATO: Mr. Levin, not to just let your statement go out into the wind, your fourth recommendation dealing with the free-toll call for advice to senior citizens is very intriguing to me. I like it. Who would you consider an expert, however, to answer that phone? Do you have any qualifications or background or experience in mind as to who is going to be on the other end of that phone when a senior citizen calls?

MR. LEVIN: First of all, what I think we would have to do is

study the kinds of qualifications that are necessary for this kind of a person and try to perhaps device a committee --- I know that in other states, not in the insurance area, but in some of the other areas, especially, for instance, in the insulation area, they are now gathering together experts from the insulation field and putting them together to develop toll-free hot lines where people would be giving advice and not on a one-to-one basis in terms of a buying-selling relationship, but pooling advice. I am sure from both government and private industry, we might be able to come up with a committee of people who could develop guidelines or informational logs. I know, for instance, the Department of Energy is preparing an energy educational hot line to be established in Kean College in Union. This kind of format might be a possible format to follow.

ASSEMBLYMAN ADUBATO: I like the idea. However, I would like to make a recommendation that you have some ex-life insurance men, who are retired, who know what they are talking about, on the other end of that line. I think that is part of the problem that we have, not having enough people in government who really, really know, outside of book knowledge, what is going on.

Your whole presentation really focuses, I think, on what is the problem that we are facing; and, that is, the senior citizens getting ripped off more than anything else, which is a little different than what the newspapers, in my opinion, have been talking about lately and what part of this hearing is about. In talking about confusion to the layman, when he talks about health insurance, again we lump the sickness and accident, loss of time, disability contract, which, as has been pointed out by other people here, senior citizens don't really have too much of a need for; if they are being sold, they shouldn't be.

Some of the things that I found out in the marketplace, not only with regard to agents, but the mail order jobs, I think we ought to spell out a little clearer when we talk about what is really happening out there. I am a little disappointed so far that no one has pointed out, that I can recall, the big areas of the mail orders, the newspapers, and things like that, where there is no direct contact with an agent. No agents are involved. It is strictly through the mail. I think this is where a lot of people get hurt.

MR. LEVIN: I know in the Jaffe articles they talk about the famous postcard which appeared. Sister, was telling me --- In fact, it would be better if she told you herself.

ASSEMBLYMAN ADUBATO: Sure.

S I S T E R E L L E N P A T R I C I A M E A D E: I just retired on the 1st of January after 21 years as Chief Executive Officer in the hospital field. Since I retired and now that we have a choice, I asked myself, what can I do? I felt my biggest contribution would be to consumers and what they are not getting and what they should get and what they should not expect.

I have been astounded at the number of insurance companies who have sent to me, because now I am over 65, supplementary insurance. It doesn't take into consideration what Medicare does not provide. It doesn't take into consideration what you would have with supplementary Blue Cross and Blue Shield insurance and major medical. If I were not informed about the hospital field or health field and were looking at all of these - and that is their job to sell a good bill of goods - I would be frightened and wonder what kind of insurance we really need.

As I told Adam, I didn't realize I would be doing something particularly in this field; and since I have been in this office for the last week, I am sorry I didn't keep all of those advertisements. Maybe there are not many people over 65 in this room. Maybe I have seniority here.

ASSEMBLYMAN ADUBATO: They won't admit it, Sister.

SISTER MEADE: That, in itself, was enlightening. Then from my own experience, I have seen people come into the hospital with insurance coverage, thinking that they had adequate coverage, be really shocked to find out their policies did not cover what they felt they were paying for.

I know that Commissioner Sheeran's office has developed a shopper guide for senior citizens. That has to be very, very simple. I don't think that you recommend or tell people where to buy. I think everybody still wants freedom of choice. But I think on this hot line there have to be recommendations just as we recommended physicians. We would never give specifics. But I would never recommend a physician I wouldn't use for myself when I was asked to recommend physicians. I think the insurance carriers that are approved that are being recommended to senior citizens should not jeopardize them. They are not all wealthy people. Most of them are middle-income people. I just heard last week about a woman who is living on social security of \$179 a month. That is only \$2,000 a year. I'm Irish. The Irish are too proud to go for welfare. They are not going for welfare. They are not getting food stamps. You know this woman getting \$179 a month doesn't have adequate insurance even to come into the hospital.

I think when they are analyzing this - and I am not an insurance commissioner - I am not an actuary --- but I think when these studies are being conducted, they should look at the whole gamut because unfortunately the people over 65 that aren't covered by their former employees when they retire are faced with buying individual insurance. And that is where they are really taken.

I must have had correspondence from 30 or 40 different places. I was astounded and I thought to myself, this is why all these poor old people who go in and out of hospitals have so many problems.

ASSEMBLYMAN ADUBATO: Sister, I know the Committee and the Chairman will join in thanking you for joining us and helping us in Adam's office. You are right about the Irish, but the Italian are that way too, you know.

Adam, what Sister has brought to our attention, I think, in a very vivid way is the problem that I really wanted to also focus on. I want to thank your department and Assistant Commissioner Lewis's department. I have spoken to her on the phone about the mail order situation and what is happening there. I might say that I can speak not only for myself but many of my associates and tell you that we have never sold these products. And I confess to you that I am ignorant of what is happening in this area. I am not that familiar with it at all. But I know the problem is real and I don't think anyone can argue with you about the need for some kind of information and clear language.

In the sickness and accident field - I don't know whether it is through regulation or what - when a person buys a sickness and accident contract that provides for loss of time, it is spelled out very clearly --- maybe not in all contracts. I don't know about all contracts. But you also get a proposal with that in simple language normally that spells it out.

Through Jaffe's articles, we have heard about what Sister is talking about - such things as duplicate coverage. We have heard about coverage that isn't coverage. We have heard about people forging names. We have heard all kinds of things.

The one thing that concerns me is that in going after the culprit and the people that we want to focus - again, maybe it is personal ---

MR. LEVIN: We don't want to tar.

ASSEMBLYMAN ADUBATO: Out there in the general world when that article appeared and those 71 companies were mentioned - and most of them don't have anything to do with this product - it was a blanket kind of a thing. It was unfortunate that that happened. I was a little disappointed that that happened that way. I was also happy, however, to learn later that quite a few products were automatically removed - voluntarily taken off the market. Again, even the people in the industry don't really know what is going on throughout the industry. We don't know.

I want to assure you and Sister that there are a lot of good people in the insurance industry who, when they become aware of a situation like this, turn them in, believe it or not. I have turned in two people that I felt didn't belong in the business since I have been in it and requested that their licenses be lifted. Quite frankly, I know other people who have done that. It is not an easy thing to do. But if you believe in what you are doing, you do it.

I just want to thank you, Sister, for coming here today. We need your help. And maybe you will be on the other end of the hot line when my mother calls.

SISTER MEADE: There are 70, which surprised me. I was 24 years in this business. I really never was aware that people buying insurance coverage should make sure that the insurance carrier is licensed in the State of New Jersey. I found this out really in the past week, even though we had many complaints that originated because of people not understanding or thinking they were not getting what they had paid for. We had lots of problems, but I never thought of referring one of those people to the Commissioner of Insurance to see if they were getting what they were paying for. That is my point about educating the people. You might have a specialization in one field, but not in another.

This booklet for senior citizens has to be written so that it can be understood. Most of the senior citizens have an eighth-grade level of reading. Unfortunately, the eighth-grade kids don't have it today. But those people can read simplified language.

ASSEMBLYMAN ADUBATO: Right on, Sister; right on.

ASSEMBLYMAN ORECHIO: Director, do you get many complaints regarding some of these insurance practices?

MR. LEVIN: We have received a number of complaints over the years and those complaints have been forwarded to the Department of Insurance because of the lack of jurisdiction that we have. We do try to keep track of it and offer support services to the Department of Insurance, at least in terms of the areas of our expertise.

ASSEMBLYMAN ORECHIO: Do you have any statistics that have been compiled as to the number, the kind of complaints and from whom they come?

MR. LEVIN: I definitely can get those statistics for you from our

Office of Consumer Protection.

ASSEMBLYMAN ORECHIO: I think the Committee would appreciate that.

Let me ask you something. When you run across these unscrupulous operators, what happens? What action do you take aside from reporting it to the Insurance Division?

MR. LEVIN: Essentially, we can't. Perhaps under the Unconscionable Commercial Practice Section of the Consumer Fraud Act, there might be a way to do it. But, in general, we view our jurisdiction to be almost none in the insurance area and that's why we refer it to the Department of Insurance for action. Generally, the complaints are automatically forwarded.

ASSEMBLYMAN ORECHIO: You don't have the authority to take any other action?

MR. LEVIN: No. At least it has historically been that anything involving insurance is forwarded automatically to the Department of Insurance. Granted, under the Consumer Fraud Act, again, when you talk about unconscionable commercial practice, that would give us the hook to be involved in the case. I have discussed with Deputy Commissioner Bliss the possibility of interdepartmental approaches to these things. Of course, we would be delighted to lend whatever expertise and enforcement authority we could, being that we are a division of the Attorney General's Office.

ASSEMBLYMAN BORNHEIMER: Thank you, Mr. Levin; and thank you also, Sister.

MR. LEVIN: Mr. Chairman, just as a quick summation, I want you to know that we very much want to offer our support services to the Committee for any information; and any follow-up activity that you would deem necessary, we will certainly be delighted to do for you.

ASSEMBLYMAN BORNHEIMER: Thank you very much.

Our next witness will be Dr. Eleanor Lewis, Assistant Commissioner, Department of Insurance.

D R. E L E A N O R J. L E W I S: I am the Assistant Commissioner of Insurance specifically responsible for consumer services and for the Consumer Services Division of the Department. During the course of my duties, I have always inquired into the loss ratio of individual health and accident policies when I am doing anything in connection with such a policy. By individual health and accident policies, I mean policies which are sold to consumers directly by the agent, company, or mail order and are not purchased via an employer or any other group. Included in health and accident policies are policies covering disability, hospital indemnity, nursing home coverage, Medicare supplements, medical-surgical, and accidental death, dismemberment, and injuries.

As a result of my review of these loss ratios, I became concerned about the very low loss ratios I was seeing for some policies. Therefore, I decided that a more systematic review of the loss ratios should be done. No matter how carefully premiums and benefits are evaluated at the time a policy is approved, obviously the actual test is what happens after a policy is sold. While examinations based on loss ratios had been done in the past, it had been some time since the Department had last conducted one. After discussing the matter with

the Commissioner, he agreed that I should undertake such a review, using the resources of my Division and the Division of Life and Health Insurance.

N.J.S.A. 17B:26-1h(1) gives the Department the authority to continue to regulate rates after the policy has been approved. The Commissioner has the power to disapprove or withdraw approval of a filing when the benefits are unreasonable in relation to the premium charged. The measure of whether the benefits are unreasonable in relation to the premium charged is the loss ratio. The loss ratio tells you how much per premium dollar is being paid in claims. For instance, a loss ratio of 50 means that 50 cents of every premium dollar is paid in claims to the insured.

On May 11, 1977, Commissioner Sheeran wrote to the presidents of all life and health companies doing business in New Jersey requesting the loss ratio information we needed to examine the individual accident and health policies. These questionnaires were to be completed for all policies approved since January 1, 1968 and currently being sold. All replies were to be made by July 5, 1977. Copies of this letter and questionnaire are attached. (See pages 1X 7 2X.)

However, the Department was faced with the inevitable delays involved in gathering information from 265 companies. Some companies asked for a time extension and were granted it. Some companies at first had difficulty in completing the forms or submitted incorrect or incomplete data and had to be recontacted. All the requested data was finally submitted by late 1977. Questionnaires were returned for approximately 800 policies.

We then began the process of reviewing the loss ratios for the policies' experience period. In those instances where policies had been on the market four years or less and/or the block of business, the number of policies in force, was extremely small, we recognized that there was no actuarial significance to the data and put those policies aside for later evaluation when the policies' experience years increased. Approximately 350 policies are in this category.

The yearly loss ratio is determined by dividing the amount of incurred claims by the amount of earned premium. In the early years that a policy is in force, there is normally a low loss ratio. Also, the dollar amounts of incurred claims and earned premium are relatively small in comparison to the later years. In order to pro-rate the effect of that situation, we took a composite loss ratio for each policy form. In other words, all the incurred claims were added together and that sum was divided by the total amount of earned premium. In this way, we had a more accurate reflection of the overall block of business than a simple average of the loss ratios year by year would yield.

Our measure of the reasonableness of the premiums in relation to the benefits is actual loss ratio. The anticipated loss ratio is part of the basis on which approval of a given policy is made.

In actual practice, the loss ratio should not be more than 10 percent below the anticipated loss ratio. In other words, if the anticipated loss ratio as originally filed was 50 percent, the actual loss ratio should be no lower than 40 percent. If the anticipated loss ratio is 50 percent, the company is saying it expects to pay 50 cents of every premium dollar in benefits. If its actual loss ratio is 40 percent, the company is paying only 40 cents on the dollar. That 10 percent margin is generally considered a reasonable one from an actuarial standpoint. Approximately 300 policies were found to have a loss ratio within 10 percent of their anticipated loss ratio.

For the 146 policies from 71 companies that were not within 10 percent of the anticipated loss ratios originally filed, the Department sent a letter in late February stating that we found the benefits to be unreasonable in relation to the premium charged. Pursuant to N.J.S.A. 17B:26-1h(1), we asked each company to withdraw voluntarily the policy in question so it would no longer be sold in the State. The companies were advised that if the withdrawal was not made voluntarily, the Department would take administrative action to effect that result. The February letter also invited each company to submit another comparable policy form with either a lower premium or additional benefits to remedy the problem. Replies as of May 1 to the 146 letters requesting voluntary withdrawal are as follows:

36 policies will be voluntarily withdrawn.

68 policies have had additional data sent and further consideration was requested. These 68 policies are now being reviewed.

For 23 policies there has not yet been a response from the companies.

13 policies have been given additional response time.

For 6 policies, the Department is proceeding to a hearing for removal since the company refuses to remove the policy voluntarily.

As part of the Department's continuing regulation of health insurance, the Commissioner banned the approval of any more individual health insurance policies which are renewable solely at the option of the company. This order took effect on April 15, 1978. This action was taken to protect consumers from the inherently disadvantaged position these policies placed them in, since at any renewal date, the company can non-renew the policy. We find companies frequently non-renew a policy when the consumer has made several claims and obviously will have additional claims in the future.

ASSEMBLYMAN BORNHEIMER: Of the 68 companies --- They are being reviewed now?

DR. LEWIS: Yes.

ASSEMBLYMAN BORNHEIMER: What was the additional data you got, more claims experience, etc.?

DR. LEWIS: More claims experience, a detailed recitation of how the rates were set, of why the book of business has not matured yet, meaning that even though it is over 4 years, in this case the company feels that they need 6 years or 8 years or 10 years. Also some companies claim that when they file the anticipated loss ratio of 50, they are saying that over the life of the entire book of business at the end of 20 years, the loss ratio will be 50. But if you take a look at any point before that time, it may not be 50; it may be 60 or it may be 40. They feel that they should not be held to a standard that looks at them at a point in time other than at the end of time.

ASSEMBLYMAN BORNHEIMER: The 23 companies that haven't responded, have you notified them a second or third time?

DR. LEWIS: We haven't notified them yet because we haven't come to the point where we have nothing to do and we are just waiting for their responses. We will get to them a second time and I anticipate no difficulty.

ASSEMBLYMAN BORNHEIMER: Your department probably receives all the complaints, does it not?

DR. LEWIS: No, my division does not receive many individual complaints at all. They are received in Mr. White's division and in another area for property casualty. But I am constantly surveying and making overviews of the problems and the complaints that come in. I do see some complaints. I see 10 or 12 complaints a day.

ASSEMBLYMAN BORNHEIMER: In what areas are they mostly directed?

DR. LEWIS: The single largest area is auto insurance. After that, I would say the next largest area is probably individual health insurance and homeowner's insurance. Those two are probably tied.

ASSEMBLYMAN BORNHEIMER: Does anyone else have any questions?

ASSEMBLYMAN ORECHIO: Dr. Lewis, you say approximately 300 policies were found to have a loss ratio within 10 percent of their anticipated loss ratio. How many policies were examined?

DR. LEWIS: A total of 800.

ASSEMBLYMAN ORECHIO: When you say "anticipated loss ratio," you are taking into consideration reserves that have been set up?

DR. LEWIS: Anticipated loss ratio is the loss ratio they file with the department when they submit the policy initially for approval for sale in this State. They only submit it once and it is done at the beginning before they have sold one policy. And it has to be certified by an actuary as being accurate.

ASSEMBLYMAN ORECHIO: So that reserves are not a factor?

DR. LEWIS: Well, they are probably projecting reserves when they give us that 50 percent figure. It is all hypothetical because they have not yet sold one policy in New Jersey. They may have sold 300 thousand policies in every other state. But we ask them about their anticipated loss ratio in New Jersey.

ASSEMBLYMAN ORECHIO: When they are making requests for increases in rates, for example, aren't these factors a consideration?

DR. LEWIS: Yes, then it is.

ASSEMBLYMAN ORECHIO: And doesn't their loss ratio contain reserves based on their past experience?

DR. LEWIS: Yes.

ASSEMBLYMAN ORECHIO: That's all I have.

ASSEMBLYMAN ADUBATO: Dr. Lewis, first of all, I want to compliment you on the work you are doing. The fact that 36 contracts have been removed voluntarily by people in the industry indicates that there was a need for your inquiry.

DR. LEWIS: Thank you.

ASSEMBLYMAN ADUBATO: However, having said that, I will further say that I am interested in this not only as a legislator, which is my primary function today, but I also wear another hat, which I have mentioned, being in the insurance industry. I will try not to let them conflict.

First of all, let's clarify one thing. You are not dealing with life insurance; you are dealing with health insurance.

DR. LEWIS: Right - individual health and accident insurance.

ASSEMBLYMAN ADUBATO: Right. In the initial contact that was made, the ground rules, if I remember correctly, were to apply to the contracts since

January of '68 that were in force for at least four years. Is that correct?

DR. LEWIS: No. It was any policy that had been approved for sale in New Jersey since January 1, 1968, and was still being sold.

ASSEMBLYMAN ADUBATO: Regardless of the fact that perhaps it was in force for a month?

DR. LEWIS: Well, it was group data. It was all policies having been sold. You have a copy of the form.

ASSEMBLYMAN ADUBATO: Yes.

DR. LEWIS: It went by year. So let's say the policy was approved in 1970, but they didn't start to sell it until 1971, and in '71 they sold 100 policies and they collected \$1,000 and paid out nothing in claims. They would file that for '71. Then they go across to '72 and they had sold, let's say, 1,000 policies.

ASSEMBLYMAN ADUBATO: What I am asking and what I am really trying to get at is that we also go to '75 on this form.

DR. LEWIS: Yes.

ASSEMBLYMAN ADUBATO: Now this is 1978. If a contract was approved in '75 and two years plus have elapsed since its inception, do you think you could get an accurate actuarial reading of what the claims and loss ratio are going to be in that period of time?

DR. LEWIS: No, definitely not. You see, first of all, they received this in mid '77. So they could only complete it for data through 1976, because the data are summarized on an annual basis at the end of the year; and they received this letter May 15, 1977.

ASSEMBLYMAN ADUBATO: What I am saying then is that if the contract has only been sold by a company for two years or less, you would still get information.

DR. LEWIS: We have the information and ---

ASSEMBLYMAN ADUBATO: I think some of these companies in that number of 146 that were included in the inquiry, if I remember correctly, have not had their merchandise out on the marketplace for more than two or three years.

DR. LEWIS: No. There may have been a few at the borderline where they had four or where they had three and one-half. Let's say a policy is approved in January of a year and they start to sell it in March. Well, they have figures for that year, but it is not as large a body of figures as if they had sold it for 12 months instead of 9 months or 6 months. But, no, I would be shocked or it would be in error if any letter was sent to any company that had fewer than 3 or 3 1/2 years experience for sure. Basically, they were all excluded if they had fewer than 4 years - 4 or fewer.

ASSEMBLYMAN ADUBATO: I have information for you that may help you because I know of at least one company, a company I represent. Although I have never sold their product that was inquired about here, I want to thank you for bringing it to my attention because I didn't know it was in the portfolio. I am certainly going to sell it. It is a fantastic product. The contract about which the company has been asked to respond is a contract that has something like 20 people insured in New Jersey. It is a small number. We had a conversation on the phone about another company that had a similar product to the one I am talking about. I believe the one we spoke about was Guardian. It is not the

company I have any business with. But they were selling a similar product. First of all, do you recall the conversation? Was I talking to you?

DR. LEWIS: You were talking to me.

ASSEMBLYMAN ADUBATO: Good. The point I am making is that I see from the list I have that those two contracts are still included. If my memory serves me correctly, one was for Guardian and the other one was for Provident Life and Accident of Chattanooga.

Again, you are just a little late because if you had made me aware of this before, I might have been able to help some people. I mean that. I am not being facetious about it. I am personally affiliated with Provident Life and Accident. By the way - I have to tell you this - I have been with them since 1967 and I have never sold a sickness and accident contract for Provident Life and Accident. I am ashamed to admit it because, when their name appeared in the newspaper, I literally went nuts and started investigating what was happening. I found out how great their products were. So I have discontinued doing business with all the other companies I have been doing business with and I am going to sell all Provident Life and Accident. I really mean that. I want to thank you for that.

I see Provident Life and Accident is still in here. I see Guardian's contract is still listed in here, but they had more than one - Guardian. Provident has only that one. That contract dealt with loss of time in a business situation. It is almost like a buy-sell with life insurance, a similar kind of a thing.

When we talk about life insurance companies, we have mortality tables that are available so that we can get a more accurate figure. When we are dealing with health insurance, different companies have different experiences. Their underwriting is different, they accept different levels and classes of people, based on occupation, etc. And I think it is a little more difficult to understand loss ratio.

DR. LEWIS: That is exactly why we have 66 companies where we are re-evaluating the data that they sent in, because you can't make a statement across the board. They are pointing out their individual differences. We went over their submissions very carefully before we made the initial decisions. Mr. White was a party to all those decisions and there was an agreement to send out the letter. In most cases, we never sent it out for so few years as 4 unless there was some other reason.

ASSEMBLYMAN ADUBATO: Well, Provident Life and Accident got a letter and they have been on the market less than 4. I spoke to the vice-president of the company in California two weeks ago. I brought it to his attention because I was disturbed. I will be happy to share with you a letter I have from him.

DR. LEWIS: I am sure they have probably also responded to us. I will be glad to read your letter.

ASSEMBLYMAN ADUBATO: They did respond to you. I am sure they did. The thing is that I got calls from people who knew I represented Provident and they wanted to know why we were selling garbage.

DR. LEWIS: First of all, the department has never used the word "garbage" to describe any insurance policy. The reporters who did have free speech.

ASSEMBLYMAN ADUBATO: Quote, unquote - "garbage," in the paper.

DR. LEWIS: We cannot control them.

The other thing is that there has been great misunderstanding concerning this whole project among the press and the public. We got phone calls from people who assumed that any policy sold by the company was bad. These 71 companies probably sell over 5,000 different policies. We are only talking about 146. That is quite a leap. I don't know whether people don't read what is put out or not. It was very clear.

ASSEMBLYMAN ADUBATO: I compliment you and the department, but I would hope that in the future the Insurance Commissioner would control himself - maybe that's the word - because what happened was inflammatory.

DR. LEWIS: I don't think our press release was inflammatory. I think it was the way it was written up.

ASSEMBLYMAN ADUBATO: I didn't see the press release. I only saw what was in the newspaper. I believe you.

DR. LEWIS: I think all our press releases are reviewed by the Governor's Office before they go, and inflammatory information isn't going out. But we do get inflammatory articles, which we can't control.

ASSEMBLYMAN ADUBATO: The fact is that the easiest people to pick on are the biggest and I have a habit of doing that. I pick on the biggest companies and then I use them as examples for their lack of community involvement, etc., etc. Some of it is untrue, but some of it is also unfair. I think in this instance it was totally unfair to the insurance industry and to the people in the insurance industry. I take offense to it in the manner in which it was done. It was done with good intentions of helping people, of helping consumers, but the people who sell life insurance are also consumers. We have families and we have sensitivity too.

I don't want to carry that too much further - not you, personally - but I want the whole department to know and the Governor and the Commissioner that they should be a little more considerate when they issue press statements and releases involving 71 major companies, out of which - and I am not going to give you any figures --- but I would say just about every one that was mentioned in that article is a fine company and will do everything its contract says it will do. The people that you should be focusing on are the people who sell through newspapers and the people who sell through the mail, as well as some of the smaller and newer companies that are literally selling business. That was the initial thrust of this whole expose, but somewhere it got lost in the shuffle. That is where your attention should be focussed in my opinion, as well as continuing this. I am not saying to stop this. But if you want to get to the root of the problem look at the companies that sell business and look at the companies that have trusts set up - and you know what we are talking about - to avoid being licensed in the State of New Jersey. Some of them are good, but some of them are very bad. They also deal with health insurance.

I must say to you that too many people out there in the industry have a feeling that this inquiry was mainly motivated because of Mr. Jaffe's initial articles. That is my opinion.

DR. LEWIS: This project started on May 11th, 1977, and that was a long time before Mr. Jaffe wrote any article concerning health insurance in the department currently. He may have written one in 1975 or 1974. I can't say he

never did. But this project started on May 11th, 1977, almost one year ago and long before ---

ASSEMBLYMAN ADUBATO: Then why was it released in a press release when it was?

DR. LEWIS: Because that is when we came to the end. I can show you my calendar. We were working on it.

ASSEMBLYMAN ADUBATO: I wouldn't say you were at the end?

DR. LEWIS: We were starting to move on it. The day that Jaffe's first article came out, we were sending the first of the letters to the companies telling them that we wanted them to voluntarily withdraw. I had no knowledge that Mr. Jaffe's article was coming ---

ASSEMBLYMAN ADUBATO: I believe you. I am just telling you what the public whom I have spoken to feels. I believe what you are saying.

DR. LEWIS: That is an unfortunate coincidence.

ASSEMBLYMAN ADUBATO: But it is unfortunate the timing was what it was because I get the smear, if you will, of people saying, "Yes, we know what happened." I feel uncomfortable about that, quite frankly.

DR. LEWIS: The other problem is that Mr. Jaffe did an article on health insurance and he never spoke to me. He never spoke to the Commissioner.

ASSEMBLYMAN ADUBATO: And his figures were wrong in those articles.

DR. LEWIS: Right. I had no knowledge he was writing an article on health insurance or investigating it or that he had even been in the department talking to anybody. So when I opened up the paper the following Sunday and saw his articles, it was the first I knew. But our letters were already in the mail. Our letters were being typed the previous Wednesday. It take some time to get them typed and into the mail. And that was just a coincidence.

I also would like to tell you that this project was done with no intention of smearing any company, of smearing any policy, or of smearing anyone. It was done solely to look at loss ratios and it had to be done in this way because of the very narrow jurisdiction we have over loss ratios currently. The New York State Insurance Department did a similar project, probably in '74 or '75, shortly after they passed their minimum standards legislation. We don't have that legislation, so we couldn't do it their way. We had to use the one part of the law that specifically gives us the power and which I cited here today.

But if the letter went out from the Commissioner May 11th, 1977, you have to know it was under active discussion by April 1, 1977, because there is just a time lag in getting things moving. This was done 13 months before.

ASSEMBLYMAN ADUBATO: I, personally, don't doubt what you are saying at all. I don't want you to misunderstand what I am saying.

DR. LEWIS: I really think they shouldn't be brought under the same cover, even under the same rubric. They are two different entities.

ASSEMBLYMAN ADUBATO: But, unfortunately, the timing of the newspaper articles and the release by the department were realities.

DR. LEWIS: But we are not supposed to hide what we are doing. I don't think that would have been the better ---

ASSEMBLYMAN ADUBATO: I am not suggesting that at all. I am just saying that it was unfortunate.

ASSEMBLYMAN ORECHIO: I have one question. Did I understand you correctly to say that the Governor's Office approves or disapproves or edits your press releases?

DR. LEWIS: They sometimes review them, yes, for accuracy.

ASSEMBLYMAN ORECHIO: Thank you.

ASSEMBLYMAN BORNHEIMER: Thank you Dr. Lewis.

Forrest K. Van Horn.

F O R R E S T K. V A N H O R N: Mr. Chairman and members of the Assembly Banking and Insurance Committee, I appreciate the opportunity to bring to your attention a matter of concern to me.

My concern is with the manner of handling claims by one company in which I am insured, and their failure to respond to letters asking about progress toward settlement of my claim.

My policy was originally with the Valley Forge Insurance Company of Philadelphia, this coverage having been assumed by United Fire Insurance Company of 112 South Michigan Avenue, Chicago, Illinois, on January 1, 1974. The Center Insurance Agency, at the same address, are agents for both companies. My policy provides for a per diem payment after a seven-day waiting period when confined to a hospital.

Following a series of unsuccessful operations on my right eye, I entered Flower & Fifth Avenue Hospital in New York on July 25, 1977 and was discharged on August 9, 1977.

This was the only operation requiring a stay beyond the seven-day waiting period, so I wrote United Fire and asked for a claim form, which was subsequently received. Several questions on the claim form bothered me, so I wrote to Mr. Joseph E. Walle, president of the company, and asked why hospital records were required when coverage was only for a per diem payment. This letter was dated September 23, 1977 and a reply was received from a Mr. W. L. McElligott of the claim department, dated October 13, 1977.

Since he stated that this was a requirement stipulated in the policy, I signed the claim form giving them access to my hospital records and sent it to my doctor's secretary for them to provide the information for the Attending Physician's statement.

Never having had a copy of the policy, I asked for one in my letter. Mr. McElligott responded that I should write to their Policyholders' Service Department, a suggestion I considered a little absurd when he could have gotten a copy by just walking over to that department and enclosed it in his letter, which would seem to be a matter of good business relations.

It was not until November 28, 1977 that I could file a formal claim because of delay on the part of my doctor's office.

A month passed and on December 28, 1977, I received a form letter from United Fire informing me that they were asking Flower and Fifth for my records. The letter was addressed to "Van Horn K. Forrest" and the salutation referred to me as "Mr. Forrest."

I responded on December 31, 1977, giving them my correct name and provided my patient number, since they could not have gotten the information with the wrong name and without a patient number.

At this point it should be noted that I am also insured by AARP

Insurance Administrators, which is the Colonial Penn Insurance Company of Philadelphia, for per diem coverage and other protection.

I asked in my December 31st letter why they had to take so long to settle a claim, since AARP-Colonial Penn had settled my claim within two weeks on the basis of the same information provided them. I received no reply to this letter.

To facilitate matters, I had called the hospital to obtain a copy of my records, but it was not until January 31, 1978 that I was able to mail a copy of the record to the insurance company. I asked again when I might expect payment of my claim, but I got no reply to this letter.

Once more, on April 7, 1978, I wrote about the status of my claim, but did not receive a reply.

My last letter was written April 21 of 1978, but, as of yesterday, I have not received a reply to that.

An insured is expected to pay premiums within a stipulated time period and it is not unreasonable to expect that an insurance carrier should observe a similar rule providing a time period for claim settlement, barring unforeseen circumstances, about which the insured should be informed. Delay provides an insurance company opportunity to earn interest on claim money, which seems unreasonable. Perhaps this might be resolved by requiring payment of interest to the insured.

United Fire provided me with an amendment to the Valley Forge policy that states: ". . . this policy cannot be 'nonrenewed' during the lifetime of the insured." It also stated that premiums cannot be adjusted during the lifetime of the insured unless the change applies to all in the plan.

In view of this, their failure to answer letters and the fact that my individual loss ratio has probably been unprofitable, I have wondered if this is a form of harassment designed to discourage me so that I will cancel my policy. I have also wondered if this has happened to others who might simply cancel their coverage. Were it possible to pursue these questions to conclusion, the answers might prove interesting.

Incidentally, I have paid several quarterly premiums since filing my claim. Accepting premiums without intent to pay claims hardly constitutes good business practice. Were this so, an unhealthy atmosphere is created, which in this case could be resolved by a single letter explaining the reason for delay.

To fail to continue my coverage in United Fire would work a severe hardship for me. I have also experienced an operation for removal of a cancer, and there is no doubt in my mind that I would not be an acceptable risk for any other insurance company, even if only for the per diem coverage such as I now have and need because of rising hospital costs.

Meanwhile the whole matter is a source of embarrassment to me since I receive monthly reminders of my unpaid balance. In retirement, and living on Social Security and a small pension, the financial strain in responding to these reminders is awesome.

I am now confronted with the need for an operation on my left eye, for which, obviously, there is no guarantee of success. Should there be an adverse result, there are many problems with which I shall have to cope and I would not like to add to these worries by wondering whether or if a claim filed for this

matter will be paid. Thank you.

ASSEMBLYMAN BORNHEIMER: Thank you very much, Mr. Van Horn; and, as you know, your complaint has been forwarded to the Department and they are investigating it at the present moment.

MR. VAN HORN: Along with other things, I am just a little deaf too.

ASSEMBLYMAN BORNHEIMER: Your claim has been forwarded to the Department and they are investigating it now. They are contacting the company and trying to expedite your claim.

Thank you for coming down. We really appreciate it.

Jeff Lyon, Blue Cross-Blue Shield.

W. JEFFERSON LYON: Mr. Bornheimer and gentlemen, let me start by assuring Mr. Van Horn, the nice gentleman who was just here who has so many problems, that we all certainly sympathize with him. He mentioned the difficulty of getting any form of coverage because of the terrible conditions that he is afflicted with. I want to call to his attention that as soon as the Department of Insurance gets around to approving the contract which we have offered, we - Blue Cross and Blue Shield - will have an open enrollment continuing year-round. We will take anybody, regardless of their health condition, and I think that would help him a lot in his present situation.

The relative contributions to the public good of Blue Cross and our commercial health insurance competition is much in the news these days.

Over in the Senate, committee consideration is being given to a bill, S 446, which would extend State rate-setting authority to all users of hospital services. Today, the rates that are paid by Blue Cross and Medicaid alone are fixed by the State (the Department of Health). The bill's effect will be to raise the level of Blue Cross and Medicaid payments and reduce the payments on behalf of commercially insured and self-pay patients.

So, you see, our commercial competition would reap a windfall of multi-million dollar proportions and Blue Cross subscribers would be forced to assume an additional liability of \$30 to \$40 million a year.

I would like to point out that that bill, incidentally, is by Senator Merlino, but it is not the bill that was mentioned earlier this morning by Mr. Levin, which he said would bring about desirable regulation of the commercial insurance industry. I believe he was referring to S 419, in case you are looking for a pattern, by Senator Hagedorn, who is a member of the Institutions, Health and Welfare Committee. That bill also is on the Senate Committee's agenda, with the one I am talking about, 446.

In arguing for equal treatment in respect to rates of payment to hospitals, the commercials don't tell you that Blue Cross subscribers alone, through regulation, are now called upon to make substantial outlays to subsidize poor risk categories and to make comprehensive coverage broadly available at less than self-supporting rates.

This is what makes the Senate Committee's deliberations germane to your study today of commercial health insurance practices. The commercial carriers, as you have heard this morning, are relatively free of the regulation which the State applies to Blue Cross. So the bill - that's 446 - if it passes would not only give them a competitive advantage, but it sharply points up the

reason for your Committee's work today.

Some of the commercial carriers, if we believe the news articles which sparked today's meeting, are taking advantage of their freedom from regulation to inflict inferior coverages on individual buyers and charge exorbitant rates. The Insurance Department's yardstick of a 50 percent loss ratio as the dividing line between good and bad coverage, when contrasted with the historic Blue Cross loss ratio of less than 4 percent, seems to verify this.

The commercial health insurance carriers, beyond this measure of return on the policyholder's dollar, fail to meet Blue Cross standards in other ways. The commercial carriers are highly selective in their acceptance of applicants, as contrasted with the Blue Cross continuing "open enrollment" of persons with pre-existing conditions of poor health.

Even in their group coverages, the commercials don't measure up. They do not, for instance, universally allow persons leaving the group plan to keep their coverage at standard rate, as Blue Cross does. Their group coverage plans don't subsidize the poor risk categories, as is the case with Blue Cross. The rates they charge are not subject to prior approval with public hearings and intervention of the Public Advocate, as is true of Blue Cross.

Therefore, we commend the interest of your Assembly Committee on Banking and Insurance in the matter of commercial health insurance rates and benefits, and we hope that your deliberations will contribute to the better protection of the health care consumer.

Commercial health insurers should be required to give the interests of their insureds equal treatment to their own considerations of profitability. Thank you very much, gentlemen.

ASSEMBLYMAN BORNHEIMER: Thank you very much, Mr. Lyon.

Does anyone have any questions?

ASSEMBLYMAN AUDUBATO: I want to thank you for coming here today, Mr. Lyon. It was a good job of lobbying against the bill. I am going to look very closely at Senator Merlino's bill. I have already looked at it. I won't start a debate with you, but I fail to see any pertinent data in your statement to this hearing.

MR. LYON: I mentioned Senator Hagedorn's bill, which is also on their committee's agenda, 419. That is pertinent because it gives the Department regulatory powers they don't have today. That is part of the whole package of Senator Merlino's bill. The reason we think it is germane to today's operations is that it gives the competitors of Blue Cross a price break in the product that we are all buying, namely, a day's hospital care. But because of the fact that they are free from regulation, it puts us at a disadvantage because we do have regulatory subsidies and imposts laid on us by the Department of Insurance that they don't have. So really if you are talking about regulating the commercial carriers, as you are today - that is the subject of today's meeting really - you have to take that into consideration. That is my point of view, Mr. Audubato.

ASSEMBLYMAN ADUBATO: Thank you.

ASSEMBLYMAN BORNHEIMER: Thank you very much, Mr. Lyon.

The next gentleman to speak will be Thomas Gillooly, Health Insurance Institute of America.

T H O M A S J. G I L L O O L Y: Gentlemen, my name is Thomas J. Gillooly and I am Associate General Counsel of the Health Insurance Association of America. With me are James Olsen, an Actuary of the Prudential Life Insurance Company, and John Dineen, Assistant General Counsel of the Association, also Gerry Parker of the Guardian, which is one of the fine companies that is selling supplementary coverage for Medicare.

There are more than 300 insurance companies which are members of the Association, including the Prudential and the Mutual Benefits Life Insurance Company, both domestic New Jersey companies. Our members write approximately 85 percent of the private health insurance premiums of insurance companies in the United States.

There are four ways to evaluate the effectiveness of the private health insurance system in this country. These include its acceptability in the marketplace, the adequacy with which it protects its insureds, the relative cost of administering its services, and its general contribution to deflating the rising cost of health care.

My testimony here today will provide documentation in each of these four areas. In the process, I believe my statement will be responsive to the various charges which have been leveled at our business in the public press and elsewhere.

I am not going to read all these statistics to you, but the main thrust of them is that 164 million Americans or 87 percent of the population below age 65 are covered by some form of private health insurance. And the growth in the coverage of private health insurance has been dramatic indeed: in 1940, only 9 percent of the population; and now there is just 8 percent of the population which is not protected. A number of these people for religious or other reasons do not want insurance or have concluded that they do not need it.

There also has been a dramatic increase in the breadth or the adequacy of the coverage provided. You usually measure this in two ways: first, the level of benefits which have been purchased; and, second, the extent to which insureds are reimbursed for their expenses by their policy. The development of major-medical insurance in the early 1950's, when at that time some 108,000 people were enrolled, was a major step forward. And by the beginning of 1977, the total number covered under insurance company Major Medical policies, similar to plans written by Blue Cross, Blue Shield, and equally comprehensive coverage provided by H.M.O. type plans, reached 144 million people under age 65.

I am not here really to debate with my friend from Blue Cross, but if there wasn't pretty keen competition in this field nationwide, I don't think he would be complaining quite so much. When the rules are equal or relatively equal, as they are many places - and we do not think, with respect to hospital charges, that they are equal in New Jersey - private insurance companies do quite well. They compete in the marketplace and they more than hold their own with Blue Cross.

A recent Health Insurance Association of America study provides further documentation of the adequacies of private health insurance. This study indicates that 85 percent of health care expenses experienced by persons covered under group health insurance policies last year were reimbursed by their health insurance coverage.

The cost of administering private health insurance must be examined

in relation to the type of mechanism under which it is marketed. There are two major forms of marketing; namely, group insurance, which is ordinarily provided at the place of employment and where the employer ordinarily pays all or a major portion of the premium, and individual policies, which are sold either to supplement group coverage, or to individuals and their families who are either self-employed or do not have ready access to group enrollment. Currently, some 85 percent of the public which is insured is covered under group policies, and the remaining 15 percent under individual and family policies.

This is very important because the problem areas that you have heard about today - the problem areas that Bill White talked about, and he put this in perspective very well I think - and the problem areas that Dr. Lewis talked about - are within this 15 percent of the business that is being sold. Of course, as was evident from Dr. Lewis's study, there were 71 companies originally cited and about half of those citations, at least, are still in dispute; and these are generally just one or two policies of these companies. The unfortunate implication of the newspaper coverage, I think, was - and I agree with the question that you raised --- it left the unfortunate implication and question in many people's minds in the State that there is something wrong with their private health insurance coverage, when the policy that most individuals have is the policy that they have that covers them when they are at work, and this type of policy was not even being written about. And it didn't have anything to do with the citations that were issued by the Department. Whether those citations eventually proved to be justified or not, in many cases, hasn't been determined. So I think that what was lost as a result of both of these actions --- and I am not saying that there wasn't a basis for writing newspaper articles or for the Department to investigate. Both of these groups were doing what they are supposed to do. But what was lost in my opinion, and based on the calls that I had at my office, was that many people were disturbed and were misled by the very entities who were trying to expose what undoubtedly were some bad practices.

According to estimates of the Department of HEW, the administrative expenses for group medical expense insurance in 1975 was 12.7 percent of premiums. Included in the 12.7 percent is a substantial amount for payment of premium taxes to the several states, including New Jersey. The administrative expenses for individual and family policies were 46.1 percent, again including payment of State premium taxes. The expenses for administering individual policies are necessarily higher than they are for group policies because of the necessarily higher acquisitional costs resulting from the individually solicited consumers. There is also the expenses of individually underwriting the prospect and the added costs of individual claims administration. A further reason why administrative expenses are higher for individual policies than for groups is that the average premium per policy is lower. Inasmuch as administrative costs are generally at a fixed dollar level, and since the average premium is smaller, the ratio of administrative expenses to premiums is necessarily higher.

It is important to observe that the difference between benefits and premiums, namely, the costs of administering the benefits, does not represent the amount of funds retained by the companies. During the last seven years, the net amount of funds retained from operations for group health insurance was 0.44 percent. That is less than 4/10ths of 1 percent of incurred premiums.

For individual health insurance, the net amount retained during the last 7 years was 2.19 percent of incurred premiums. Overall, for the entire business, the net amount retained from operations during the last 7 years has been 0.7 percent of 1 percent of incurred premiums.

There was a great deal of publicity given in the Newark Star-Ledger in February and March with respect to the purported low loss ratios experienced by insurance companies on 135 of their policies. It is presumed that the cited policies represent coverages sold on an individual and family basis - and, as I mentioned earlier, 85 percent of this business is sold on a group basis. So that publicity has reference to some proportion, some undetermined proportion, of the 15 percent of the business which we write.

Let me say a few words about the meaningfulness of loss ratios. Loss ratios, when used by themselves, without consideration of all other relative factors, can be most misleading. The use of such a single factor without taking into consideration the ways in which an insurer establishes its premium will lead to misinterpretations.

Now I have set forth the way in which loss ratios are established here. Once again, I am not going to read this, but I would like to make this point. Our Actuarial Committee and our staff have worked with the insurance departments in other states on this question of loss ratios. Our Actuarial Committee has just completed a study and brought up to date their considerations. I have written the Commissioner and offered on behalf of the industry to sit down with him and with some of the best-versed actuaries that we have and work out a program. We can make the recommendations. It is up to the Insurance Department to decide what their standards should be, so that the companies can know in advance what the Department will be requiring of them. The Department, contrary to what my friend from Blue Cross says, does, in effect, have rate approval authority over these policies that are in question. The Department can disapprove them if the benefits aren't reasonable in relation to the premium charged. I used to be an insurance commissioner and I thought that was rate-approval authority. Evidently, Dr. Lewis thinks it is rate-approval authority and so does Bill White, their fine actuary.

So the authority is there. We are willing to work with the Department. It is an involved subject. I am not an actuary. There is a very fine actuary with me who can explain the details of it. But we think the level the Department has set, 50 percent, once again talking about individual insurance, not talking about group insurance, is reasonable. The reason 50 percent is reasonable for individual insurance is that insurance is something that has to be sold, especially when you are selling it to individuals. It is quite a different thing when you don't have the expenses and you don't have the agent's commission involved, which is a justifiable expense when you have to go to a person, do all the explaining that is necessary and convince him that he needs the coverage that he does need. This costs money and, of course, the loss ratios aren't as high there. When it comes to group insurance, our loss ratios will rival Blue Cross. This is why they like to continue the unfair discount which their insureds receive from the hospital, which our insureds do not receive.

In the design and administration of all of its products, including the individual policies under discussion, a constant concern of the health insurance

industry has been the containment of costs and the assurance of the quality of health care. This is the overall problem, the containment of costs. We are all concerned with inflation. It consumes our pay checks every week or every month. But the inflation that we normally experience with respect to most of our expenses is nothing compared to what it is in this area of hospital and medical charges. This far outpaces the rise in the cost of living anywhere else. This is why New Jersey needs this bill that Blue Cross is anguishing over - and New Jersey is going to have this bill and our nation is going to have this bill because, when you go to a hospital, you really aren't going to a competing agency. If I get sick up in Summit, New Jersey, I am going to go to Overlook Hospital because that is where my doctor puts me. I am not going to go shopping around for hospitals. Just as with utilities, there needs to be some public accountability. That is all we are saying. If Blue Cross has a more economical operation, then this Commission, which we hope is created in New Jersey, can take that into account and not give the private insureds as good a break as Blue Cross. But it shouldn't be simply on the basis that Blue Cross is a great, big, tough purchaser in bargaining with the hospitals, as they are now; and the insurance companies, because they don't have that many insureds from one company in each hospital, can't make that tough bargain. That shouldn't have anything to do with how a member of the public is charged.

We think some commission should be empowered by this Legislature - and I realize it isn't the problem of this particular Committee - but, after all, I didn't bring it up.

We think that the Insurance Department should be commended for its survey of loss ratios for individual policies. As I said before, we are willing to work with them. I agree that the publicity that attended it was very unfortunate. The Insurance Commissioner, as a matter of fact, has almost plenary authority, not only over Blue Cross, but over us already. I realize that the Department people come in and ask for more and more authority from you. We have a few suggestions here of bills that we think maybe would help. But there is hardly anything that the Department, if it puts its mind to it, can't ask of this industry that it won't get because of the existing authority that it already has.

I listened to insurance departments all over the country. I have known every insurance commissioner New Jersey has had for the past 30 years, and every insurance commissioner that any other state has had. When I hear Insurance Department people complaining about not having enough authority, I often think, if they would use the authority that they already have, they could get most of this job done.

We do think that this minimum standards recommendation that you have heard from several of the speakers is a reasonable one. We commend that to you. And we worked in the development of this minimum standards statute. It does meet a number of the problems and it is relevant to some of these problems of the aged that you have heard about.

Now, because there were assertions in the Star Ledger article concerning cancellation of coverage, we recommend legislation prohibiting cancellation or non-renewal of an individual's coverage due to reasons of deterioration of health. We are confident that this practice is not widespread, but such a statute would alleviate the instances of abuse. It would also be responsive to a recent action of the Commissioner, in which he notified companies that the Insurance Department

would no longer accept for filing those policies which can be individually non-renewed by companies.

Finally, a particular care must be taken in the sale of insurance to the elderly in order that there be full understanding of what the elderly purchase to meet their obvious health insurance needs. I think the single exception I would take to what Bill White said --not in his prepared statement, by the way, but in response to questions he gave what I thought was a very uncharacteristic answer. He suggested to you that private insurance should be totally abolished in this field. I don't believe that the testimony that you have heard here this morning substantiates that private insurers have no role in this field. I think that the testimony which you have heard and which I, as a spokesman for this industry, am willing to concede, is that there are unique problems in selling insurance to the elderly.

Now let me just mention a few of them.

Since almost all Medicare beneficiaries have had some form of medical treatment or advice in the past, there is a need, due to cost considerations, to have some form of pre-existing condition limitation. However, the normal pre-existing condition limitation period of two years appears to us to be too long for Medicare supplement coverage. Therefore, some shorter period of time would be more appropriate, such as one year or six months.

We are aware that there are some situations where the elderly have been sold more insurance than they actually need. This often takes place through the sale of multiple policies at different periods of time. We do not condone over-selling. We think that adequate use of disclosure will assist materially to cure this problem.

We have a booklet prepared which we have submitted to your Committee - that yellow booklet. It directs its attention to this specific question. Also, the form of disclosure which we have in mind would bring to the attention of an insured person that he would generally save money by buying only coverage which is necessary for his needs, rather than buying multiple limited policies. The Committee should also consider whether some legislative or regulatory sanction should be taken against agents who willfully sell more coverage than is needed.

I think there are a lot of ways to get at this problem. When I was a commissioner, I always hated to revoke an agent's license. This is a total solution. Just because a person has committed an offense and maybe even violated a law, I hesitated to revoke a license. I asked the Legislature to have limited authority to fine agents and use that, rather than just putting a man completely out of business.

The New York Insurance Department publishes a list of companies with relation to the complaints that they have received. That is another type of thing that you can do. There is some relevance to the number of complaints and the type of complaints that there are. I think there are a number of things that can be done in disciplining agents short of putting them completely out of business, not that that isn't required for under certain circumstances.

I would just say this final word. If the Committee, after further deliberation, finds that there are other problem areas, other than those mentioned today, which should be addressed, I would like to publicly state that we are willing to sit down with the Department in this area with respect to the aged,

and any other, and work out a proper regulation. I am almost certain that the Department already has the authority to adopt such a regulation. I think there are many fine companies that are writing this product and there are undoubtedly some that have no business writing it or who are writing it unfairly and improperly. Those companies should be curbed. I am not here to speak for them. But I am here to speak for a responsible industry that invites regulation and wants to cooperate with this Legislature and with this Committee and with the Insurance Department. Thank you very much.

(Written statement submitted by Mr. Gillooly can be found beginning on page 3X.)

ASSEMBLYMAN BORNHEIMER: Are there any questions?

ASSEMBLYMAN ADUBATO: It is not a question, but I think the Department ought to take up your offer of cooperation. For the record, I would recommend, Mr. Chairman, that we take up Mr. Gillooly's generous offer to be of assistance to the Department in helping us to regulate and get some of the bad apples out of our industry and also help the consumers in New Jersey.

I disagree with you about the over-65 market for one reason; and, that is, I just don't think that it is an area where the general public - for selfish reasons, I disagree with you -- where the general public would ever appreciate what is happening there and the complexities of the situation in dealing with the gaps between the Medicare payments, and so forth. I don't know whether I am making sense, but I think you know what I am talking about. There is a lot of heat that comes from that. Maybe I am a coward and I am just backing away from it, because I would never sell it. I would never market it and sell it to anyone because of that heat and the lack of understanding. You may have an excellent product - and it is not always necessarily an agent lying or deceiving.

When I first started selling insurance 17 years ago, we didn't supply proposals and illustrations accompanying the contract. You would tell the prospect what was in there, you would highlight it, show it to him and the whole bit. The following week he forgot it. He didn't know what was in there. He would say, "Gee, I didn't know that was part of the contract." Naturally now, we cover ourselves a little better by having illustrations. So it is not always the agent who misleads the public. I find many times the public is told what is there. I think it is our responsibility, however, to make it even clearer to the layman and to have layman's language accompanying contractual agreements in these products. The risk involved in dealing with certain policies was the major concern in those articles in the Star Ledger, with relation to the forgery by agents, and the fact that there was an over-abundance of coverage sold to people who couldn't afford the basic coverage and there were multiple contracts involved. I commend you for wanting to deal with that problem. I wish you would. While I still disagree with you, I wish you would offer your advice to the Department and maybe you can help straighten it out.

MR. GILLOOLY: May my colleague, Mr. Parker, whom I prevailed upon to come down here, say a brief word and perhaps give some perspective to this?

ASSEMBLYMAN BORNHEIMER: Go ahead, Mr. Parker.

G E R A L D P A R K E R: I speak because the Guardian has been writing a Medicare supplement policy since Medicare began in 1966. We have about 11,000

policies written, about \$2 million in premium volume. The claims are manageable, with some difficulty, and the complaints are almost minimal.

I would like to show you how we do it because I think that it is something that is not impossible and can do some good. I would just like to touch on some of the highlights. One of the problems, and I think one of the most serious problems, that come about with this is that people are selling Medicare supplement policies that have nothing to do with Medicare. They are calling hospital indemnity policies Medicare supplements and they are putting all kinds of stuff in that doesn't belong. It ought not be sold as a supplement unless it is one.

If you just follow the way we put this out, this folder describes our policy and it describes it in terms that our customers can understand. When he is in a hospital, it tells the buyer he pays the first hospital deductible of \$144; after that, it tells him what Medicare pays and then what we pay. We pay everything that Medicare doesn't pay, except the deductible; and after Medicare runs out completely, we pay \$60 a day plus 80 percent of the miscellaneous, for a year. Then it tells about doctor bills. Medicare pays 80 percent of the excess over \$60. We pay 20 percent of the excess over \$300, calendar year deductible. And I must say that our idea of what is reasonable is a little bit more liberal than Medicare's.

This is something that is needed because, in the case of the doctor, Medicare's 80 percent is more likely to be 50, 55 or 60 percent in today's market because they are using the 75th percentile of two years ago doctors' bills. But with ours, they are getting about 80 percent.

Private duty nursing - there is a tremendous wish among older people for private duty nursing coverage. Medicare doesn't provide it. Almost nobody provides it. But old people are often alone. They often have few, if any, relatives. They go to a hospital. They are scared, they are sick and they are afraid of dying. They are afraid of dying alone. They are desperate to have somebody with them. This is the benefit in our policy that accounts for about 45 to 50 percent of the benefit dollars. We pay for 80 percent of the charges for private duty nursing, around the clock, for 20 days, in a hospital. Then after they go from a hospital, we provide 80 percent for another 20 days, at two shifts a day, 16 hours a day.

Those are the major parts of this policy. But there are other things that are important, such as renewal. We won't write this policy if the applicant has too much other insurance, if he has any significant amount of other insurance except Medicare. We have the right to refuse to renew it only if he is over-insured. If a person buys other insurance to the point where he is overinsured, we can refuse to renew it. What we do is say: You either drop some of the other insurance or you drop our policy. And they always drop the other insurance if it happens.

This policy does not have any pre-existing disease exclusion. We write standard, without any restrictions, over 90 percent of the people that apply for it. We can live with that. We find that practically all people who are over 65 have pre-existing conditions. It is really almost impossible, I think, to offer coverage that has any significant pre-existent exclusions in this market and do a job that doesn't produce complaints and misunderstanding. Six months maybe is acceptable. But beyond that, I think it isn't acceptable. We find with this policy that it is not necessary because the people who think they are going to

have a long illness, suddenly die, and there is no claim. The people who think they are well can get sick and be terribly ill. You can't predict at this age what your health future is going to be.

One of the key things is that we don't pay that first hospital deductible. A lot of regulations come down and people who haven't thought it through ask that every Medicare-supplement policy should pay that first hospital deductible. That is like trading dollars. People at this age go to a hospital every two or three years. It would cost close to 100 percent of the cost to pay for it. If you don't do that, then you don't have to have the pre-existing condition exclusion.

ASSEMBLYMAN BORNHEIMER: Thank you very much.

Does anyone have any questions?

ASSEMBLYMAN ADUBATO: How much does it cost?

MR. PARKER: Right now, it is \$216 a year. That is just about making it.

ASSEMBLYMAN BORNHEIMER: I would like to thank you, Mr. Gillooly and your gentleman friend. We appreciate it very much.

The next person to speak will be Doris Levine, Project Director, DES, Women's Rights Information.

D O R I S L E V I N E: Mr. Chairman and members of the Committee, I want to thank you for letting me appear here today. I will be very brief, because, quite frankly, I did not know that I would be coming here until about 4:30 yesterday afternoon.

I am Project Director of a group called DES Search. It is a project of the Women's Rights Information Center. Very simply, I am here to ask that legislation be passed which would prohibit insurance companies from denying coverage or dropping coverage for any person exposed to Diethylstilbestrol. Now Diethylstilbestrol or DES is a synthetic hormone, an artificial estrogen, which has caused what are known as iatrogenic diseases - these are physician-caused illnesses.

Between 1940 and 1970, about three million women in the United States were given this medication by their physicians in an attempt to prevent miscarriage. In 1970, it was discovered that the female offspring of these women developed a very rare form of cancer or a benign condition known as adenosis. About two years ago, it was discovered that males are developing problems with the urogenital tract, problems which result in sterility.

It came to my attention in a letter from the Department of Insurance that many policies would contain provisions limiting liability for pre-existing conditions; and, theoretically, since this is a condition which was in utero, this would also be a pre-existing condition.

I know that New York State recently had legislation introduced which would provide the thing that I am requesting that you do. This is the reason I am here.

ASSEMBLYMAN BORNHEIMER: It so happens that I am aware of what you are talking about because my wife had taken some of that and we are checking the children now.

Do you have a copy of the legislation that was prepared in New York?

MS. LEVINE: Not with me, but I can easily get it.

ASSEMBLYMAN BORNHEIMER: We can get it.

MS. LEVINE: However, you have to remember that the New York legislation is a very large bill that covers the Department of Health and the Department of Insurance. I think you would only be interested in the very last two sections because, in New Jersey, these bills would have to be introduced separately.

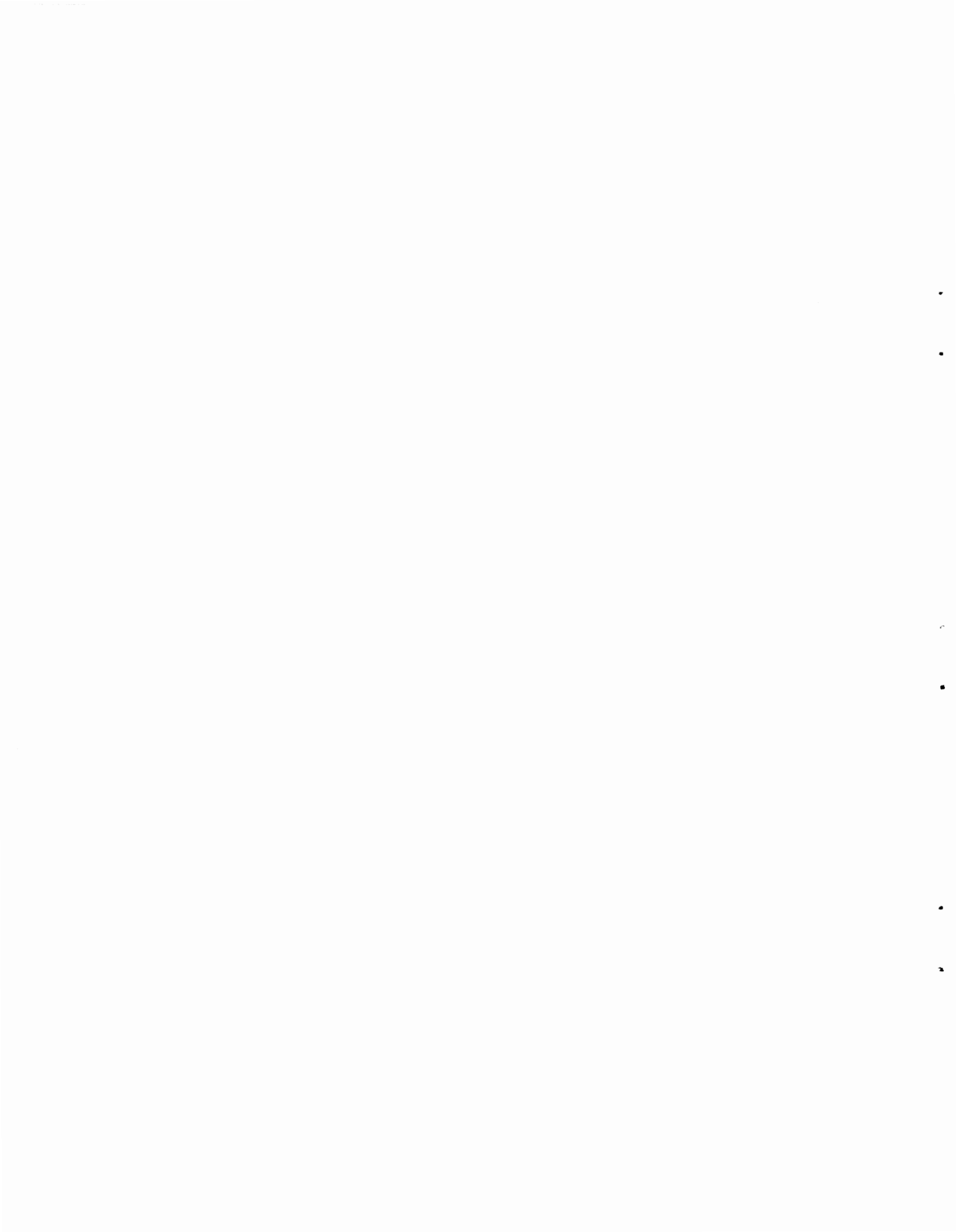
ASSEMBLYMAN BORNHEIMER: Fine. Thank you very much for testifying. We appreciate it very much.

MS. LEVINE: Thank you.

ASSEMBLYMAN BORNHEIMER: Does anyone else wish to testify? If not, the hearing is concluded.

(Hearing Concluded)

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SUBMITTED BY DR. ELEANOR J. LEWIS



State of New Jersey
DEPARTMENT OF INSURANCE
TRENTON 08625

May 11, 1977

JAMES J. SHEERAN
COMMISSIONER

(609) 292-5363

TO THE PRESIDENTS OF ALL LIFE AND HEALTH INSURANCE COMPANIES DOING BUSINESS
IN NEW JERSEY

CIRCULAR LETTER
LIFE AND HEALTH #77-3

**RE: LOSS RATIOS ON INDIVIDUAL HEALTH AND ACCIDENT POLICIES FILED BY THIS
DEPARTMENT**

For each individual health and accident insurance policy form that has been filed by this Department since January 1, 1968, and is currently being sold, will you please complete the attached questionnaire for each year sold. This form also should be completed for accidental death and dismemberment benefit policies, but not for accidental death and dismemberment riders attached to conventional life policies.

If you have any questions concerning this letter, please contact Eleanor J. Lewis, Assistant Commissioner, New Jersey Insurance Department, 201 East State Street, Trenton, New Jersey, 08625, phone number (609)292-5374. Please return the completed questionnaire by July 5, 1977.

Sincerely yours,

A handwritten signature in cursive script that reads "James J. Sheeran".

James J. Sheeran

np

Attachment

SUBMITTED BY DR. ELEANOR J. LEWIS
NEW JERSEY DEPARTMENT OF INSURANCE

Company Name _____

Name of Person Completing Form _____

Company Address _____

Title _____ Phone _____

Policy Type _____

Date Completed _____

Date Policy Filed By N.J. Department _____

Policy Form # _____

Dates on which rate increases were filed with N.J. Department: _____

NATIONWIDE DATA

NEW JERSEY DATA

# of	*	*	*
Policies	Earned	Incurred	Loss
in Force	Premium	Claims	Ratio

# of	*	*	*	Anticipated
Policies	Earned	Incurred	Loss	Loss Ratio Filed
in Force	Premium	Claims	Ratio	with Department

Year

1968

1969

1970

1971

1972

1973

1974

1975

1976

2X

*Please complete these figures on the same basis as completed for the Annual Statement, Accident & Health Policy

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There are four ways to evaluate the effectiveness of the private health insurance system in this Country. These include its acceptability in the market place, the adequacy with which it protects its insureds, the relative cost of administering its services, and its general contribution to deflating the rising cost of health care.

My testimony here today will provide documentation in each of these four areas. In the process, I believe my statement will be responsive to the various charges which have been leveled at our business in the public press and elsewhere.

The most recent estimates available, namely, as of January 1977, indicate that 164.0 million Americans or 87% of the population below age 65 was covered by some form of private health insurance. Most of the remaining population were covered by various governmental programs, including Medicare, Medicaid, and programs for the Veterans, Servicemen and their dependents, etc. We estimate that when those covered by private health insurance are combined with those covered under various governmental programs there remain only about

8 million persons in this country who are yet to be protected for their health care costs, many of whom do not need it or do not want it for religious or other reasons. The fact that this vast majority of the population are protected through the private health insurance mechanism is a clear indication of its acceptability in the market place. It should be noted further, that in 1940 only 9% of the population was protected; in 1950, 51% was protected, and the proportion reached 77% by 1960. During the 1970's the growth rate continued to climb to the level of almost 90%. There are few, if any other industries that have achieved such remarkable growth during such a relatively short period.

Along with the phenomenal growth in covering the population there has been an equally dramatic increase in the breadth or adequacy of the coverage provided. Adequacy of health insurance is ordinarily measured in two ways. First, the level of benefits which have been purchased, and second, the extent to which insureds are reimbursed for their expenses by their policy. As to the former, insurance companies introduced in 1951, a broad form of coverage known as "Major Medical" insurance and, at that time, some 108,000 people were enrolled. By the beginning of 1977, the total number covered under insurance company Major Medical policies, similar plans written by Blue Cross, Blue Shield, and equally comprehensive coverage provided by H. M. O. type plans, reached 144 million people under age 65. Thus, the bulk of the population currently has coverage which protects them for catastrophic expenditures due to major episodes of ill health.

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study indicates that 85% of the health care expenses experienced by persons covered under group health insurance policies last year, were reimbursed by their health insurance coverage.

The cost of administering private health insurance must be examined in relation to the type of mechanism under which it is marketed. There are two major forms of marketing. Namely, group insurance, which is ordinarily provided at the place of employment and where the employer ordinarily pays all or a major portion of the premium, and individual policies, which are sold either to supplement group coverage, or to individuals and their families who are either self employed or do not have ready access to group enrollment. Currently, some 85% of the public which is insured is covered under group policies, and the remaining 15% under individual and family policies.

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policies than for group is that the average premium per policy is lower. Inasmuch as administrative costs are generally at a fixed dollar level, and since the average premium is smaller the ratio of administrative expenses to premiums are necessarily higher.

It is important to observe that the difference between benefits and premiums, namely, the costs of administering the benefits, does not represent the amount of funds retained by the companies. During the last 7 years, the net amount of funds retained from operations for group health insurance was 0.44%. That is less than 4/10ths of 1% of incurred premiums. For individual health insurance, the net amount retained during the last 7 years was 2.19% of incurred premiums. Overall, for the entire business, the net amount retained from operations during the last 7 years has been 0.7% of 1% of incurred premiums.

There was a great deal of publicity given in the Newark Star-Ledger in February and March with respect to the purported low loss ratios experienced by insurance companies on 135 of their policies. It is presumed that the cited policies represent coverages sold on an individual and family basis rather than a group basis. As previously mentioned, approximately 85% of the private health insurance business written by insurance companies, is sold on a group basis, and only 15% on an individual and family basis. The publicity therefore, has reference to some proportion of the 15% of the business which we write.

Let me say a few words about the meaningfulness of loss ratios. Loss ratios, when used by themselves, without consideration of all other relative factors, can be most misleading. The use of such a single factor without taking

into consideration the ways in which an insurer establishes its premium will lead to misinterpretations. In establishing a proposed premium rate, the insurer must consider the expected claims, must consider trends, as well as past experience, expense requirements which must vary widely according to the form of benefit, the volume of business written, and the likelihood of fluctuation. Other relevant factors include the average size of premiums, the frequency of premium payment, the extent of guarantees provided, the average policy lifetime, and many other factors which can affect the relationship of benefits to premiums and hence, the reasonableness of that relationship.

There is, in addition, significant use of actuarially determined premiums leveled by age at issue. In determining such level premiums benefit costs expected over the entire lifetime of the policy must be considered. Medical costs inflate and claim costs increase greatly with age and such factors must be determined in setting the initial premium rate. Actuarial tables indicate for example, that the net annual claim costs for hospital benefits on male lives at age 60 exceed three times the corresponding costs at age 30. Any judgment as to the reasonableness of benefits under a policy with premiums in this form would require consideration of many factors other than the early or current loss ratio. In addition, insurance is essentially an averaging process, spreading individual risks among many. The relation of benefits to premiums for a given policy may well be affected by an insurer's risk and experiences on other types of similar policies.

Along with considering all relevant factors in evaluating a loss ratio, there is a need to exert extreme caution in interpreting loss ratios. A ratio

by itself does not provide an indication of the magnitude of the elements entering its numerator and denominator. Although ratios have a varied use in examination of trends, and, in some circumstances, as benchmarks, it is necessary to recognize their limitations. For example, ratios composed of results on more than one kind of policy or results on a single policy at different calendar periods during its use by an insurer can be misinterpreted.

In the design and administration of all of its products, including the individual policies under discussion, a constant concern of the health insurance industry has been the containment of costs and the assurance of the quality of health care in the United States. In order to achieve these goals, benefit plans have been designed to pay for care both in and out of the hospital. In addition, the industry is engaged in a whole variety of activities to promote these goals, such as experimenting with second opinions for elective surgery, pre-admission testing, reimbursement for home health care, improved claim review programs and work with the medical profession in peer review activities.

Our Association has also sought to improve the health care delivery system by active advocacy of appropriate Federal legislation in a number of areas, such as advocating amending P. L. 92-603 so that P. S. R. O.'s may be used by insurers in determining the appropriateness of medical treatment of our insureds.

Of particular significance to this Committee is the position of our Association on legislation which has been under consideration by this Legislature for the past several years, which would provide for review of hospital charges through a system of prospective budget review by a public authority.

We believe that the Insurance Department should be commended for its survey over the last year of loss ratios for individual policies. Whether the companies cited should withdraw these policies because of low loss ratios is a matter of fact and law, to be determined perhaps informally, or after a hearing on the merits, as provided by law. It may be that, with further examination of all relevant actuarial matters that the Insurance Department will conclude that these policies do provide benefits which are reasonable in relation to the premiums charged. Until this determination has been made, we do not believe it is appropriate for us to discuss the individual merits of these cases. We do believe, however, that in broad terms, the actuarial benchmark of 50% followed by the Department is appropriate.

We believe the administration of the statutes by the Insurance Department can be enhanced and simplified by the adoption of an administrative procedure so that all companies doing business in the state may know what is expected with respect to loss ratios. Insurance Departments in other states have established as a benchmark a certain percentage of premiums which companies are expected under prescribed circumstances to pay out in benefits. The Health Insurance Association of America, and its member companies, have worked with these departments in establishing guidelines and standards of acceptable loss ratios for individual coverage. Recently, our Actuarial Committee has re-studied this entire area and we are now in a position to provide the Department with the results of this study for its use in reviewing individual accident and health rates. The scale of anticipated loss ratios ranges from 60% for optionally renewable policies to 50% for guaranteed renewable policies to 45% for non-cancellable coverages, i. e., those on which no

premium increase may be sought. Final decision, of course, as to the acceptance of these recommended guidelines, is the prerogative of the Department, but we shall be glad to work cooperatively toward a fair and equitable result for both the insuring public and the companies.

We believe that there are effective remedies available for solving a number of problems set forth in the Newark Star-Ledger articles. We recommend the following legislative action which would be responsive to many of the problems set forth in the newspaper articles:

The Legislature should consider enacting a statute which would permit insurers to sell in New Jersey, only those individual policies which meet prescribed minimum standards. A number of states with the cooperation of the Association, have such statutes and regulations, including New York, Florida, California, Texas, Arkansas and Pennsylvania. The further purposes of such a minimum standards statute should be to provide reasonable standardization and simplification of terms and coverages of individual accident and health insurance policies, to eliminate misleading terms, and to provide for full disclosure in the sale of accident and health coverages. A minimum standards statute would provide the Insurance Commissioner with the power to establish regulations for the form and content of individual accident and health policies. This statute would also enable him to eliminate from the marketplace contracts which he considers to be misleading and not in the best interest of the public. The form of disclosure contemplated under such a statute would be an outline of coverage setting forth the broad, essential elements of the coverage. This outline of coverage provides an insured person with a handy reference to the essential

elements of his coverage, such as the terms of renewability, preexisting conditions, limitations, if any, and dollar limits of coverage.

Because there were assertions in the Newark Star-Ledger concerning cancellation of coverage, we recommend legislation prohibiting cancellation or non-renewal of an individual's coverage due to reasons of deterioration of health. We are confident that the practice of cancelling coverage due to deterioration of health is not a widespread practice, but such a statute would alleviate the few remaining instances of abuse. Such legislation would, we believe, also be responsive to a recent action of the Insurance Commissioner by which he notified companies that the Insurance Department would no longer accept for filing those policies which can be individually non-renewed by companies.

Finally, a particular care must be taken in the sale of insurance to the elderly in order that there be full understanding of what the elderly purchase to meet their obvious health insurance needs. Some insurers have marketed Medicare Supplement coverage for a number of years and have learned that there are unique problems in connection with the sale of this coverage. These insurers have attempted to correct these problems. Because the gaps in Medicare can add up to a considerable expense, there is a need for coverage through private insurance companies. The form of this coverage may be a wrap-around type policy which typically pays a high proportion of those expenditures which Medicare does not pay. For example, it may cover the initial hospital deductible of \$144. and the coinsurance

which begins on the 61st day of hospitalization. Another form of coverage is the hospital income policy which provides benefits on a daily basis when hospitalized. The virtue of this latter coverage is that it provides a reserve which can be banked against future illnesses. We do not have any recommendation about which form coverage should take because both forms of coverage have proved their worth in the past. However, there are several steps that should be taken in the sale of coverage to the elderly. The first is to assure that there is adequate disclosure to the purchaser of the benefits being sold and the limitations on coverage. Toward this end, the Health Insurance Institute, a branch of the Health Insurance Association of America, has developed a booklet designed to educate potential purchasers. Copies of this booklet are available to the Committee.

Since almost all Medicare beneficiaries have had some form of medical treatment or advice in the past, there is a need, due to cost considerations to have some form of preexisting condition limitation. However, the normal preexisting condition limitation period of two years appears to us to be too long for Medicare supplement coverage. Therefore, some shorter period of time would be more appropriate, such as one year or six months.

We are aware that there are some situations where the elderly have been sold more insurance than they actually need. This often takes place through the sale of multiple policies at different periods of time. We do not condone over-selling. We think that adequate use of disclosure will assist materially to cure this problem. You will note that the booklet which we have submitted to your Committee directs

its attention to this specific question. Also, the form of disclosure which we have in mind would bring to the attention of an insured person that he would generally save money by buying only coverage which is necessary for his needs, rather than buying multiple limited policies. The Committee should also consider whether some legislative or regulatory sanction should be taken against agents who willfully sell more coverage than is needed.

If the Committee, after further deliberation, finds that there are other problem areas which should be addressed, perhaps resolution of these problems could be left to the Insurance Department to resolve under a minimum standards regulation as discussed above. We would be glad to work with the Department to resolve these problems.

We appreciate the opportunity to appear today and will try to answer any questions you may have.

Thomas J. Gillooly
Associate General Counsel



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