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PRIVATE HEALTH INSURANCE SUPPLEMENTARY TO MEDICARE

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A WORKING PAPER

PREPARED FOR THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

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(Prepared by Gladys Ellenbogen, Ph. D.)

PREFACE

Congress must soon decide whether the United States will embark upon a national health insurance program for all age groups.

Of special concern to the Senate Special Committee on Aging is a fundamental question:

What can be done to assure that any such program provides more protection than the elderly now have under Medicare and Medicaid, rather than less?

An answer to that question cannot be formulated unless close attention is paid to (1) the present limitations of Medicare coverage, and (2) the effectiveness of private health insurance supplementary policies in closing Medicare gaps.

As is made clear in the working paper which follows, supplementary "Medi-Gap" insurance is no small matter. Approximately 11.2 million of the 21 million Americans of age 65 and up have at least one private health insurance policy. No official estimates of the cost for such policies is available, but the author of the paper—basing her findings upon her own calculations and methodology—has arrived at the conclusion that the elderly spend, at the very minimum, over half a billion dollars on premiums for private health insurance each year, in addition to the $1.6 billion they are paying for Medicare's part B premiums.

Dollars are important to older Americans. This committee has documented, on many occasions, the high rate of poverty and the special impact of inflation among the elderly.[1]

A decision to purchase Medi-Gap insurance is, therefore, sometimes a very difficult one for older persons to make. They want protection—particularly the assurance that they can meet the Medicare coinsurance and deductible payments that are likely to arise if illness strikes—and yet they are caught in an inflationary squeeze which is relentlessly driving up the cost of essential items.

Their difficulties provide ample reason for improving Medicare by closing several of its major gaps. Coverage of some out-of-hospital prescription drugs, for example, would reduce the overall health care expenditures of the elderly.

While this and other legislative actions are sought, however, more than 50 percent of all 65-plus Americans continue to pay Medi-Gap premiums.

What are they getting for their money? What consumer pitfalls do they face?

These questions are not definitively answered in this working paper; the author was not asked to do so.

Instead, she was asked to visit insurance commissioners in several States and to explore—since States have primary authority to regulate insurance sales—the problems they encounter in attempting to pro-

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[1] For a recent appraisal, see pp. 9–15 and 139–142, *Developments in Aging: 1973 and January-March 1974*, a report by the Senate Special Committee on Aging, May 1974.

tect consumers against misunderstanding or misrepresentation related to health insurance policies meant to supplement Medicare. The author visited insurance commissioners of five States. For reasons explained in her text, she believes—and with good reason—that her interviews provide important insights on important issues facing the elderly today.

Among those issues:

—In the States visited, Medi-Gap policies have stirred much concern among the regulators. Efforts have been made to deal with the worst of practices which sharply limit the amount of protection offered. In some cases, these limitations can readily be understood by an informed average person. In many other cases, these limitations can be understood only by the most sophisticated of consumers.

—Even though some States have acted to correct such difficulties, the extent and quality of such efforts in other States is far from uniform.

—One of the most compelling points for the Congress to consider is the great need for more intensive educational efforts upon the part of the Federal Government to inform older persons *about Medicare itself*.

It is not pleasant to think of older Americans as confused and even resentful against Medicare. But this working paper makes it clear—as do comments from the insurance commissioners interviewed—that serious gaps in public understanding do exist, and that they must be dealt with. Medicare, while certainly not perfect, has already done much to end the dread that elderly once felt so keenly when contemplating the effects of catastrophic or lingering illness upon their incomes and upon their overall well-being. It is too valuable a program to be affected adversely by lack of information and by outright confusion.

The Committee and Subcommittee on Health of the Elderly are fortunate that Dr. Gladys Ellenbogen agreed to prepare this document. Dr. Ellenbogen, a consultant economist, has written recently on such matters as: pension reform; the cost of living index as applied to automatic Social Security increases; and the measurement of medical prices. At Montclair State College, she served as professor and chairman of the department of economics. She worked with the Senate Committee on Aging on issues related to hearings on "The Economics of Aging" at a New Jersey hearing in 1969.

Her working paper is offered as an exploration of one more issue worthy of careful attention as the Nation prepares for debate and scrutiny related to national health insurance for all.

FRANK CHURCH,
Chairman, Special Committee on Aging.
EDMUND S. MUSKIE,
Chairman, Subcommittee on Health of the Elderly.

CONTENTS

	Page
Preface	iii
Part 1. The problem	1
I. Introduction	1
II. Background—Medicare	4
III. Why the elderly buy private health insurance to supplement Medicare	5
Part 2. Issues in private health insurance supplementary to Medicare	10
I. State departments of insurance	11
II. Standards	12
A. Readability	13
B. Minimum benefits	13
C. Preexisting conditions	14
III. Selling tactics	16
IV. Minimum loss ratios	17
V. Unit pricing	18
VI. Mail order advertising	19
Part 3. Informing the public	24
Conclusion	27
Appendix 1. Ronald V. Dellums, et al., plaintiffs v. United States Department of Health, Education, and Welfare; and Caspar W. Weinberger, defendants, Civil Action No. 181–72	29

PRIVATE HEALTH INSURANCE SUPPLEMENTARY TO MEDICARE

(By Gladys Ellenbogen, Ph. D.)

Part 1. The Problem

I. INTRODUCTION

Even though covered by Medicare, more than half of our citizens 65 and over are currently paying for private health insurance policies. These 11.2 million aged persons are purchasing private health insurance policies primarily to fill the gaps in Medicare protection.

There are two kinds of gaps in Medicare. First, there are the gaps in Medicare's covered services. Hospital and medical costs, for example, are covered by Medicare but they are not completely covered. The gaps in coverage exist because of the deductible and coinsurance requirements for both hospital and medical services.

Second, there are the gaps Medicare was not designed to cover and does not cover. Among these gaps are out-of-hospital prescription drugs, long-term nursing home care, and dental care.

The typical private health insurance policy purchased by the elderly fills the coinsurance and deductible gaps.[1]

The elderly spend, as a minimum estimate, over half a billion dollars on premiums for private health insurance policies each year.[2] This half billion dollars is, of course, in addition to the $1.6 billion they are paying for Medicare's Part B premiums.

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[1] See Table I. p. 8. Also, although hospital costs are the most adequately covered of all health costs under Medicare, health insurance organizations in 1972 paid out $766 million, or 62 percent of all their expenditures for persons 65 and over, in helping meet hospital costs. (Health Insurance Institute, *Source Book of Health Insurance Data*, 1973–1974, p. 42.)

[2] Our figure of half a billion dollars was computed for this study in the absence of official information. It is an estimate of the minimum number of dollars spent annually by the elderly for private policy premiums. Data are not available on the total number of dollars spent each year by the elderly for health insurance. We derived our estimate using the following procedure: the Blue Cross Association made available to us the monthly charge for each of its plans for Medicare complementary coverage, as of April 1974. There are 77 separate Blue Cross plans in the United States.

For some of these plans the monthly charge for the "low cost option" and the "high cost option" were listed. Since it is not possible to determine how many of the elderly in each of the plans had chosen one option or the other, we assumed all had chosen the low cost option.

The low cost option typically covers the Medicare hospital deductible, the coinsurance required for the 61st through the 90th day of hospitalization in a benefit period and the coinsurance for the lifetime reserve days. In some instances (15 of the plans) the rate for Blue Shield is included because, according to the Blue Cross Association, it is impossible to separate out the Blue Cross rates from the combined Blue Cross and Blue Shield monthly charge. In these instances the low cost option includes the Blue Shield coverage.

The low cost option rates were then annualized and applied to the number of persons covered by each plan as stated in the Blue Cross *Fact Book 1973*. Three of the separate plans, out of the 77, had to be eliminated either because the number of persons was unavailable for that plan or because the monthly charge was not stated. These are Baton Rouge, Louisiana, Detroit, Michigan and South Dakota.

Blue Cross coverage for persons 65 and over represents 50.1 percent of persons in that age category with private health policies. (*Social Security Bulletin*, February 1974, p. 25.) We added 49.9 percent of the premiums spent for Blue Cross as representing the amount spent for coverage through private carriers and independent plans. In this way we arrived at a total of $540 million as the amount spent by the elderly for private health insurance policies. The two basic assumptions are that persons choose low cost options and rates for non-Blue Cross coverage are the same as for Blue Cross coverage.

The major source of complaints from people of all ages, received by the department of insurance in many of our States, concern health insurance policies. Of 17,697 complaints, for example, disposed of by the California Department of Insurance, as reported in its annual report for 1971, 47 percent, or 8,305, concerned health insurance policies.

Some complaints, of course, are justified and some are not. A high proportion of the complaints come from the elderly. They write to their Senators and Representatives in Washington, as well as to their State insurance departments and State legislators, of their dissatisfaction with Medicare and with their private policies.

Although Medicare is primarily under the jurisdiction of the Federal Government, private policies—whether written by Blue Cross-Blue Shield, commercial carriers, or independent plans—fall within the jurisdiction of State departments of insurance.

This study focuses on the costs, coverages and complaints concerning private health insurance policies sold as supplements to Medicare. Inevitably it includes some of the problems encountered with the Medicare program and its administration. Policies to supplement Medicare are inextricably tied to the Medicare legislation and administration.

Much of what is said here is based on consultations with commissioners of insurance and their staffs in five States: California, Florida, Pennsylvania, Nevada, and Arizona. Other sources are materials prepared by some of the States not personally visited, and by Blue Cross-Blue Shield, and by the Health Insurance Institute, an organization composed of private companies writing health policies.

It is not a nationwide survey of State departments of insurance. On the other hand, it is hoped that its usefulness transcends the number of States chosen. There are several reasons for this hope. First, there was general agreement among the insurance departments in the States visited concerning the basic problems and the basic solutions to the problems that had been, or were being, encountered by the elderly with their supplementary policies. Even though they were located in different parts of the Nation, no State evidenced a unique problem.

Second, three of the five States studied in detail ranked as the first three in the rate of growth of their 65-and-over population in the period 1960 to 1970. In the rate of growth of this age group between the census years 1960 and 1970, Arizona ranked first, Florida second, Nevada third, California was ninth, and Pennsylvania 37th.[3]

Third, in terms of total population 65 and over, these five States accounted for 16 percent or one out of every six Americans in that age group. Florida, it might be noted separately, has the highest percentage of persons 65 and over of any State: this age category comprises 14.5 percent of Florida's population, contrasted with the United States average of 9.9 percent.

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[3] Herman Brotman, *Facts and Figures on Older Americans, State Trends 1950–1970*, Number 6. Administration on Aging, U.S. Department of Health, Education, and Welfare, 1973, Table 4.

Information about insurance problems comes to State insurance departments not only from their own residents and from insurance staffs, but also from their professional association, the National Association of Insurance Commissioners, which through periodic conferences as well as circulation of material keeps the States informed of situations throughout the United States.

It was Florida's Commissioner of Insurance, speaking in November 1973 to the Insurance Advertising Conference, who said with respect to senior citizens, "They are probably the most duped of all the public as far as the accident and health insurance field."

Florida's actions to protect its elderly population are discussed in Part 2 of this working paper. It may be noted here that Florida recalled more than 50,000 accident and health policies in 1972, covering persons under and over 65 years of age. After reviewing the policies, Florida's Department of Insurance issued guidelines which had to be met for policies to be sold in that State. Only 18,000 of the 50,000 policies were able to qualify for reissue under the new guidelines.

The guidelines cover items such as the relationship between the cost of policies to benefits provided, information to be offered to the public concerning the limitations as well as the details of benefit coverage, and acceptable selling and advertising techniques. In addition, Florida prepares and distributes, as do some other States, consumer pamphlets explaining some of the intricacies of health insurance policies.

As reported to us by consumer service bureaus of State insurance departments and by State and local offices on aging, many of the elderly are puzzled by the complexities of private health policies. They are very clear on the twin subjects of the rise in their health care expenditures and the fall in the portion of those expenditures paid for by Medicare. With personal health care expenditures for the aged rising—on a per capita basis they were $786 in 1970 and rose to $1,052 in 1973—and with Medicare's coverage falling to 35 percent, or $424 of the $1,052, private health policies and the protection they promise are of increasing significance.[4]

Private health insurance supplementary to Medicare is, therefore, important to the elderly and to their middle-aged children. Even though the latter may not be legally responsible for their parents' expenses, they often do pay the bills their parents cannot afford.

Furthermore, the role of private health insurance is also important at a time such as this when national health insurance is being considered. Some of the proposals reserve a role for private health insurance in a system covering all Americans similar to its supplementary role with Medicare.[5]

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[4] In the annual summary of medical care spending by different age groups published in the Social Security Bulletin, the authors state that 40.3 percent of the medical expenditures of the aged are met by Medicare. However, they note that included in the Medicare expenditures are the $1.2 billion in premiums paid by Medicare coverage of Part B (see Barbara Cooper and Paula Piro, "Age differences in Medical Care Spending, Fiscal Year 1973," *Social Security Bulletin,* May 1974, pp. 3–14.)

We have decreased the Medicare outlays by the $1.2 billion paid by the elderly for their own coverage. Calculated this way, Medicare paid only 35.0 percent of the personal health care expenditures of the aged in 1973.

[5] For example, when Senator Russell Long introduced S. 2513, the "Catastrophic Health Insurance and Medical Assistance Act of 1973," he stated:

"The plan like Medicare, would be financed by Social Security payroll taxes and administered by the time-tested Social Security Administration. Again, the catastrophic plan is not designed to replace basic private health insurance but rather to supplement that protection. The (catastrophic) proposal has two entirely separate deductibles which would parallel

(Continued)

II. BACKGROUND—MEDICARE

Medicare, technically known as "Health Insurance for the Aged and Disabled", is Title XVIII of the Social Security Act. Passed in 1965 as an amendment to the Social Security law, it became effective in 1966, and may be considered the first national health insurance law passed in the United States.

Its coverage is primarily for persons 65 and over and its benefit protection is primarily for hospital and physician charges. The Social Security Amendments of 1972, Public Law 92–603, extended Medicare protection to persons entitled, for at least 2 years, to cash disability benefits under the railroad retirement or Social Security programs.

The amendments also provided for coverage of persons under age 65 with chronic kidney disease who require hemodialysis or a renal transplant. Above all, Medicare is a program for persons 65 of age or over.

Medicare has two parts: Part A, Hospital Insurance Benefits for the Aged and Disabled; and Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled. Part A pays mainly for hospital costs and covers all persons 65 and over entitled to Social Security cash benefits with no premium cost for coverage. It also pays, in a limited way, for covered services in skilled nursing facilities and for some health services. These are its major coverages.

Part B helps meet the costs of services of physicians and certain other practitioners, is voluntary for persons 65 and over entitled to Social Security benefits, and has a monthly premium charge.

Medicare is a public-private program administered by the Social Security Administration. It is paid for in part from general revenues, which amounted to $1.6 billion or 17 percent of all its expenditures in fiscal 1973. Payroll taxes paid for 70 percent of expenditures; nearly 12 percent were met from premiums charged and slightly more than 1 percent were from Medicaid "buy ins". These "buy ins" are premiums paid for by the States for aged persons receiving public assistance or for aged persons who are medically indigent.[6]

One of its private aspects is that payments to providers of health care, whether hospitals or physicians or others, are made through fiscal intermediaries which are insurance companies and Blue Cross-Blue Shield organizations.

Premium payments, required only for Part B coverage, have three public aspects. First, premium payments are supplemented by Government payments from general revenues. Second, typically the premium is deducted by the Social Security Administration from the monthly Social Security check before the check is sent to a Social Security retirement beneficiary. Third, the amount of the premium is set by the Government.

There is not, under either Part A or Part B, first dollar coverage. There are deductibles under both Parts A and B. The concept of deductibles is borrowed from typical private health policies. Addition-

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(Continued)

the inpatient hospital deductible under Part A and the $50 deductible under Part B of Medicare." (*Congressional Record*, October 2, 1973, p. S18306.)

Senator Edward Kennedy in introducing S. 3286, the "Comprehensive National Health Insurance Act of 1974", stated that although he had "some reservations" about deductibles, coinsurance and the role of private insurance carriers. "We are building upon the Medicare record in the development of this program, which gives a role for the insurance carriers." (*Congressional Record*, April 2, 1974, S4958.)

[6] Barbara Cooper, Nancy Worthington and Paula Piro, "National Health Expenditures, 1929–73," *Social Security Bulletin*, February 1974, p. 6.

ally, there are coinsurance requirements as well as limits on hospital days of care. Further, there are limits on certain services, such as those provided by home health agencies. These features are similar to private policies.

Coupled with the built-in limitations of Medicare protection are the more frequent and costlier illnesses of the aged. These have resulted in out-of-pocket expenditures in 1973 for persons 65 and over of approximately three times the out-of-pocket expenditures for individuals under 65.[7] The Social Security Administration estimates that the direct payments of the aged were $311 in fiscal year 1973 for health care. To this we would add the premiums for Part B coverage which totaled $72.60 in fiscal 1973, for a total of close to $383.

Comparing last year's—1973—out-of-pocket medical cost outlay with the average Social Security benefit after the 1974 11 percent increase, we find the following relationship:

The average retired worker will receive $181 a month as his Social Security cash benefit. Assuming his medical costs do not rise above fiscal 1973, his out-of-pocket 1974 medical costs will be worth more than 2 months of retirement cash benefits.

An aged widow's monthly benefit, after the 11 percent rise, is estimated at $177. Her direct medical payments will also be more than 2 months of benefits. The same is true for the retired couple who will be receiving $310 with the 11 percent rise. The economic bind is clearly the reason for buying private policies, the continuing need for Medicaid, and the drawing on savings, and so forth, to meet health care costs.

III. WHY THE ELDERLY BUY PRIVATE HEALTH INSURANCE TO SUPPLEMENT MEDICARE

Medicare premium costs have steadily risen, from a monthly charge of $3 in 1966, the year of Medicare's inception, to $6.30 in January 1974, and $6.70 in July or from $36 annually to the current $80.40 annually per capita. At the same time, as noted earlier, Medicare is paying for a steadily decreasing share of the health costs of the elderly. In 1969, for example, it covered nearly 40 percent of the health costs of the aged and in 1973 only 35 percent. (In the computation, explained earlier, of these percentages we have deducted Medicare's expenditures by the amount of the premiums paid by enrollees since premiums are the expenditures of individuals and not the program.)

The typical private policy purchased covers the Medicare gaps, particularly the deductibles and the coinsurance gaps. A large number of the elderly are living on low incomes. Some have assets in the form of savings accounts or savings bonds or other securities. Aware of the high cost of medical care and fearful of the risk of great depletion in their liquid resources, they purchase private health insurance protection.

Among the reasons Medicare is paying for a smaller proportion of the health costs of the elderly are the following:

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[7] Cooper and Piro, *op. cit.*, p. 3.

(1) The dollar amount of the hospital deductible has risen steadily:

1966	$40
1969	44
1970	52
1971	60
1972	68
1973	72
1974	84*

(2) The hospital coinsurance has increased. Beginning with the 61st and going through the 90th day:

1966	$10
1969	11
1970	13
1971	15
1972	17
1973	18
1974	21

(3) The coinsurance for the 60 additional days of the "lifetime" reserve rose:

1968	$20
1969	22
1970	26
1971	30
1972	34
1973	36
1974	42

(4) The amount of the medical deductible under Part B, Supplementary Medical Insurance, rose from $50 in 1966 to $60 in 1973.

(5) Expenditures for physician fees have increased. The 20 percent copayment has remained fixed. The deductible, as mentioned just above, only rose to $60 in 1973. However, the rise in expenditures by the elderly for physician fees is due to the 20 percent applied to rising physician fees. The dollars the aged pay have risen.

(6) An increasing proportion of physicians refuse to accept assignment for their bills. When a physician accepts assignment the patient is not billed for any amount over what the physician is reimbursed by Medicare's intermediary. Without assignment, the patient is billed for the difference between the physician's charges and the Medicare reimbursement amount. The percentage of physician refusal to accept assignment has risen from 39 percent in 1969 to 47 percent in 1973.

(7) Adding to health costs for the elderly have been the retroactive denials by the Social Security Administration of claims, particularly for persons in skilled nursing facilities. What the Social Security Administration calls the "tightening" of controls on the use of skilled nursing facilities began in 1970.

(8) The continuing high rate of inflation has increased the price of items which remain uncovered by Medicare. There have been price rises as well as increased use of many of these uncovered

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*The Department of Health, Education, and Welfare has announced that this charge will rise to $92 in January 1975.

items such as out-of-hospital prescription drugs, eyeglasses, hearing aids, and nonsurgical dental services.

As Medicare has become less protective as a health financing system, the elderly have turned more to private health insurance policies for coverage of their health care costs.

There are two additional reasons for the purchase by the elderly of private health policies. Few of the elderly work at jobs which qualify them for an employer's group coverage. Another reason for their purchase of private policies (discussed in more detail later) has been the "hard-sell," "scare" tactics of some of the insurance companies, particularly those companies offering their policies by "mail order".

Table I, page 8, shows the enrollment under private health plans for persons 65 and over together with the types of care for which they have coverage and the insuring organization: whether commercial carrier, Blue Cross-Blue Shield, and so forth.

The 13.8 million figure, the gross enrollment for hospital care, includes duplication. That is, persons may have more than one policy to cover such costs. The table includes the estimates of the net number of persons with such coverage. For example, 13.8 million persons 65 and over have insurance against hospital costs. But it is estimated that close to 2.6 million persons have more than one policy covering hospital costs. Therefore, the net figure is 11.2 million persons. Put another way, 11.2 million persons 65 and over have one or more insurance policies covering hospital costs. These policies supplement Medicare's hospital coverage. The same distinction is made for the other health services covered by private plans, that is, the distinction between gross and net enrollment.

TABLE I.—ENROLLMENT UNDER PRIVATE HEALTH INSURANCE PLANS FOR PERSONS AGED 65 AND OVER AND ESTIMATES OF THE NET NUMBER OF DIFFERENT PERSONS COVERED, BY TYPE OF PLAN AND SPECIFIED TYPE OF CARE, AS OF DEC. 31, 1972

[In thousands]

Type of plan	Hospital care	Physicians' services				Dental care	Prescribed drugs (out-of-hospital)	Private-duty nursing	Visiting-nurse service	Nursing-home care	Vision care
		Surgical services	In-hospital visits	X-ray and laboratory examinations	Office and home visits						
Total gross enrollment	13,821	10,679	8,726	7,827	4,389	296	3,554	3,475	4,533	5,528	(1)
Blue Cross-Blue Shield	6,928	6,791	5,812	4,694	2,102	10	1,304	1,234	2,128	5,075	52
Blue Cross	6,670	324	232	(1)	59	(1)	(1)	(1)	(1)	(1)	(1)
Blue Shield	258	6,467	5,580	(1)	2,043	(1)	(1)	(1)	(1)	(1)	(1)
Insurance companies	6,343	3,268	2,290	2,507	1,713	142	1,920	1,870	1,870	210	(1)
Group policies	1,507	1,504	1,260	2,284	1,504	142	1,801	1,729	1,729	210	(1)
Individual policies	4,836	1,764	1,030	223	209		119	141	141		(1)
Independent plans	550	620	624	626	574	144	330	371	535	243	423
Community	168	237	237	237	239	52	132	169	228	82	226
Employer-employee-union	369	365	369	371	317	9	180	200	307	161	186
Private group clinic	13	18	18	18	18	2	18	2			11
Dental service corporation						81					
Net number of different persons covered, as estimated by—											
Office of Research and Statistics	11,270	9,813	8,155	7,750	4,346	296	3,519	3,441	4,488	5,473	(1)
Percent of civilian population [2]	53.2	46.3	38.5	36.6	20.5	1.4	16.6	16.3	21.2	25.8	(1)
HIAA	12,047	9,615	8,377	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Percent of civilian population [2]	56.9	45.4	39.6	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Gross enrollment as percent of net number of different persons covered, as estimated by—											
Office of Research and Statistics	122.6	108.8	107.0	101.0	101.0	100.0	101.1	101.0	101.0	101.0	(1)
HIAA	114.7	111.1	104.2	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)

[1] Data not available.
[2] Based on Bureau of the Census estimate of 21,177,000 as of Jan. 1, 1973.

Source: Social Security Bulletin, February 1974, p. 25.

Table II below shows the percentage distribution of gross enrollments and indicates, for persons with hospital care insurance, for example, that 50 percent have their policy through a Blue Cross-Blue Shield plan, 46 percent through private insurance companies. Of the 46 percent with insurance through a private insurance company, 35 percent are individual policies, 11 percent are group policies. The remaining 4 percent are through independent plans, not through the "Blues" or private carriers.

Two-thirds of the persons protected for surgical services and in-hospital physician visits buy their coverage from Blue Cross-Blue Shield organizations.

TABLE II.—PERCENTAGE DISTRIBUTION OF TOTAL GROSS ENROLLMENT UNDER PRIVATE HEALTH INSURANCE PLANS, BY AGE, TYPE OF PLAN, AND SPECIFIED TYPE OF CARE, AS OF DEC. 31, 1972

[In thousands]

Age group and type of plan	Hospital care	Physicians' service				Dental care	Prescribed drugs (out-of-hospital)	Private-duty nursing	Visiting-nurse service	Nursing-home care
		Surgical services	In-hospital visits	X-ray and laboratory examinations	Office and home visits					
Age 65 and over total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Blue Cross-Blue Shield	50.1	63.6	66.6	60.0	47.9	3.4	36.7	35.5	46.9	91.8
Insurance companies	45.9	30.6	26.2	32.0	39.0	48.0	54.0	53.8	41.3	3.8
Group policies	10.9	14.1	14.4	29.2	34.2	48.0	50.7	49.7	38.2	3.8
Individual policies	35.0	16.5	11.8	2.8	4.8	----	3.3	4.1	3.1	----
Independent plans	4.0	5.8	7.2	8.0	13.1	48.6	9.3	10.7	11.8	4.4

Source: Social Security Bulletin, ibid.

Part 2. Issues in Private Health Insurance Supplementary to Medicare

State departments of insurance are the regulatory bodies overseeing private health insurance companies and policies. Issues described and analyzed in this section are major concerns of State departments of insurance.

These issues cover a broad range, including minimum benefit standards, policy language, selling techniques, premiums, as well as certain particularly troublesome sections in policies such as preexisting condition clauses. In general, the issues affect most purchasers of health insurance, but as our discussion indicates, they have particular significance for the elderly.

As we noted earlier, private health insurance policies are purchased to cover two kinds of gaps in Medicare: gaps caused by the deductibles and coinsurance under Parts A and B, and gaps arising because Medicare leaves many services uncovered such as out-of-hospital prescription drugs, nonsurgical dental care, and routine medical examinations.

More private policies are purchased to fill the coinsurance and deductible gaps in covered services than to provide coverage for health care unprotected or sharply restricted by Medicare. As indicated in Table I, page 8, the elderly have nearly 14 million policies covering hospital care, close to 11 million policies for surgical services and nearly 9 million for in-hospital physician visits. These policies largely provide for the gaps in covered services.

With respect to private policies for protection for services Medicare ignores or restricts, there are only 296,000 policies for dental care, 3.5 million for out-of-hospital prescription drugs and 5.5 million policies for nursing home care.

The four Medicare gaps in covered services for which protection is sought through the purchase of private policies are: (1) The hospital deductible, (2) the hospital coinsurance, (3) the medical deductible, and (4) the medical coinsurance.

With regard to the hospital deductible, it is currently $84 *for each benefit period*. There may be several benefit periods in each year. A benefit period begins when a person enters a hospital and ends when a person has been out of a hospital (or skilled nursing facility) for 60 consecutive days. The next benefit period starts when the individual, having been out of the hospital or skilled nursing facility for 60 days, re-enters the hospital. Each hospital admission at the beginning of a new benefit period requires the payment of the hospital deductible.

POLICY TYPES

The words disability policy, accident and health policy, and health insurance policy are used interchangeably here following usual practice in the States. Disability policy, accident and health policy, and health insurance policy refer to policies which typically cover hospital, surgical and medical costs.

POLICY PAYMENT BASIS

Policies can provide either service benefits or can provide benefits on an indemnity basis. Service benefit means the insurance company will pay the cost of a particular service, regardless of the amount. For example, in a service benefit policy supplementing Part B's 20 percent coinsurance requirement, the insurance company will pay 20 percent of covered medical services regardless of the total dollars of cost.

Indemnity policies pay a flat, stated number of dollars for certain health services. For example, they may pay up to $25 a day for hospitalization after Medicare runs out. With rising costs a policy which pays a fixed number of dollars on a daily basis does not offer protection against inflation.

Many indemnity policies provide for benefits for only the hospital coinsurance requirement. This requirement starts with the 61st day of hospitalization. With the average length of hospital stay for persons 65 and over down to 11.4 days, as of March 1974, according to the American Hospital Association, the likelihood of someone collecting on a hospital policy which only pays *after* Medicare runs out is not great.

I. STATE DEPARTMENTS OF INSURANCE

The power of State departments of insurance derives from the insurance laws of the individual States and from the authority vested in insurance departments by these laws to issue rules and regulations.

Insurance departments have a formidable task. In California, for instance, in the period from 1969 through 1972, over 10,000 individual disability policy forms and related documents, such as riders, were submitted for review by the insurance department. In the fiscal year 1972 alone, the Pennsylvania Department of Insurance considered 5,989 accident and health policies, approved 2,913, approved with revision 760 and disapproved 2,316. In fiscal 1973, the Florida Department of Insurance recalled over 50,000 individual health insurance forms and policies for analysis. These figures refer to policies without regard to the age of the purchaser.

Depending on the wording of the statute, the power to review policy forms may be a very broad grant of power. In Florida, for example, the statutes provide that the department of insurance may disapprove any form for which benefits are unreasonable in relation to premium charged. A bill in the Florida State Legislature would increase the regulatory authority of the department of insurance by extending its health policy-form powers to include disapproval of forms for which premiums are "excessive, inadequate or unfairly discriminatory". The proposed legislation gives the department of insurance the right to set the standards for such determination, as well as to disapprove policies containing provisions which are "unfair or inequitable or contrary to the public policy of this State, or which encourage misrepresentation."

The major criterion used to determine "excessive" or "unfair" is the loss ratio of the insurance company. The loss ratio measures the relationship between claims paid out by the insurance company to premiums collected. (This is discussed in detail on page 17.)

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II. STANDARDS

State insurance departments use their power to approve policy forms to cover many aspects of regulation. The evidence indicates that, unless specifically prohibited by the insurance code of the State in which they are operating, many insurance departments have expanded their specified regulatory authority under their statutory power to approve policy forms.

One aspect of regulation is to withhold approval of a company's policy unless minimum benefits are specified in the policy.

The National Association of Insurance Commissioners (NAIC) has prepared a "model bill" for minimum standards in health policies. The subjects it covers are among the most important issues in health insurance regulation and are the greatest source of complaints brought to the attention of the State insurance departments.

The NAIC model would apply to all private health insurance policies, not just those supplementary to Medicare, but the standardization and clarification the model bill provides cover the most serious and frequent problems faced by the elderly with their supplementary policies.

The NAIC model bill is called the "Individual Accident and Sickness Insurance Minimum Standards Act" and has as its purpose the provision of:

> . . . reasonable standardization and simplification of terms and coverages of individual (accident and sickness) insurance policies . . . to facilitate public understanding and comparison, to eliminate provisions . . . which may be misleading or unreasonably confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of coverages.

The bill directs the insurance commissioner in each State, "in accordance with applicable laws of this State", to issue regulations covering, but not limited to, aspects of health policies enumerated just below. The insurance departments studied also cited many of these enumerated items as the major concerns and sources of misunderstanding for the elderly.

The list of items enumerated in the model bill are, in the order given in the model:

(1) Terms of renewability.
(2) Initial and subsequent conditions of eligibility.
(3) Nonduplication of coverage provisions.
(4) Coverage of dependents.
(5) Preexisting conditions.
(6) Termination of insurance.
(7) Probationary periods.
(8) Limitations.
(9) Exceptions.
(10) Reductions.
(11) Elimination periods.
(12) Requirements for replacement.

(13) Recurrent conditions.
(14) The definition of terms including, but not limited to, the following: hospital, accident, injury, sickness, physician, accidental means, total disability, nervous disorder, guaranteed renewable, and noncancellable.

Some of the States have already passed legislation covering many of these subjects; some States have legislative proposals under consideration similar to this model bill.

From our discussions with insurance departments we have selected for discussion from these 14 items those which particularly affect the 65 and over population. To these have been added several other items, some of which are implicit in the bill, because of their significance in health insurance regulation.

In the statement of the purpose of the model bill, there is included the provision for "reasonable standardization and simplification of terms and coverages".

A. READABILITY

In his concern for the individual's ability to understand his insurance policy, Herbert Denenberg, until recently the commissioner of the Pennsylvania Department of Insurance, issued readability guidelines to be used in the preparation of new policy forms. As published in the State of Pennsylvania's official *Pennsylvania Bulletin*, December 22, 1973, there is Denenberg's "Statement of Policy and Guidelines" concerning readability of policies. It is stated in the guidelines that:

> Insurance contracts need to be written so that consumers can understand them. The insurance department has found that contracts can be simplified and still be perfectly legal.
>
> When writing a contract, remember who will be reading it. Give a copy to a layman to see if he can understand it. Apply the Flesch (*The Art of Readable Writing*, Rudolf Flesch) readability test to help identify the problem areas. Finally, always look for unnecessary, ambiguous, or lengthy sentences and words. There should be a clear reason why something has been written the way it has.

The guidelines tell the policywriters to avoid "legalese." Illustrations are cited such as "hereinafter" instead of "in this policy." Other "legalese" to be avoided are "hereunder," "forthwith," and so on. In the guidelines test for measuring readability, the number of words and the number of syllables are to be counted for each sentence.

B. MINIMUM BENEFITS

Under the statutory authority to review forms, Commissioner Dick Rottman of the Nevada Insurance Department issued, effective April 1973, guidelines for minimum policy provisions in individual disability contracts as well as guidelines for minimum loss ratios for all individual health insurance contracts.[8]

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[8] Regulation LH 5, *Guidelines for Individual Disability Income Policy Forms and Rates and Minimum Loss Ratios for All Individual Health Insurance Contracts,* Insurance Division, State of Nevada, 1973.

In October 1972 California's Department of Insurance adopted "Rules and Regulations":

> Establishing certain standards of minimum benefits for individual and family disability (health) insurance policies within the meaning of . . . of the California insurance code.[9]

Interest in minimum benefits legislation is also beginning to appear at the Federal level. In the third section of the Long-Ribicoff bill, S. 2513, the "Catastrophic Health Insurance and Medical Assistance Act," a new program of voluntary certification would be established for private basic health insurance policies.

It is voluntary on the part of the insurers: the certification would be made by the Secretary of HEW, based on specified minimum criteria related to: (1) adequacy of coverage, (2) ratio of benefits paid to premium income, and (3) conditions of eligibility for coverage.

The advantage to the insurers is that they are allowed to advertise their policies as HEW certified. Advantages to the insured are similar to the advantages under the NAIC model bill: broadened benefit coverage, as well as elimination of exclusions and waiting periods.

C. PREEXISTING CONDITIONS

A preexisting condition is an illness that began or originated before the policy was written.

A major source of complaints reported to insurance departments by the elderly is the refusal of their insurance company to pay a claim on the grounds it involves a "preexisting condition."

A preexisting condition clause in a health insurance contract means a company has the right to refuse to pay claims for expenditures for *current* illnesses related to or developing from illnesses which began *prior* to the effective date of the insurance policy.

An example would include the following case: Mr. X suffers from arthritis in his knee and has been suffering from arthritis for some time. After the effective date of his insurance policy, an intense arthritic pain in his knee causes him to lose his balance. He falls and breaks his leg. With an ironclad preexisting condition clause, Mr. X's insurance policy would not pay for any hospital or medical costs incurred for his broken leg.

Because persons 65 and over may have multiple health problems, a preexisting condition clause, in the extreme form presented in the case of Mr. X, could provide no coverage at all to many aged persons. Therefore, the preexisting condition clause has become a very critical issue in health policies for the elderly.

Every State department of insurance studied in the course of this working paper considered problems related to preexisting conditions among the most numerous, the most serious and the most difficult for the elderly.

The departments see the solution, or at least partial solution, in the shortening of the period of the preexisting condition. The

[9] *Ruling No. 183, File No. RH–151,* Department of Insurance, State of California, 1972.

most favorable solution, at least to some of the elderly, would be elimination of preexisting condition clauses entirely. In such instances, regardless of what illness or injury occurred prior to the policy, the claim would be paid.

However, as was pointed out by one of the commissioners, elimination of the preexisting condition clause in its entirety raises the premium costs for all the elderly. Rates cannot be discriminatory. Premiums would be identical for all elderly purchasers of the same policy. The well elderly would be paying higher premiums than would be equitable because, to some extent, they would be paying for the ill elderly.

The most frequent solution for the preexisting problem used by the departments of insurance is to shorten the precondition period.

The model minimum benefits bill of the NAIC in its section on preexisting conditions recommends in those instances where the policy application form has no questions concerning health history or medical treatment history:

> . . . the policy must cover any loss occurring from any preexisting condition not specifically excluded from coverage by terms of the policy, and, except as so provided, the policy or contract shall not include a wording that would permit a defense based upon preexisting conditions.

Operating within its insurance code, which provides that "insurance economically unsound to the insured" shall be proscribed, the California State Department of Insurance has issued regulations forbidding disability insurance (hospital, medical, surgical) sold to persons 65 and over to supplement Medicare, from having a time limit exclusion for preexisting conditions of more than 12 months.

The decision of California's Chief Assistant Hearing Commissioner, F. Joseph O'Regan, in October 1972, stated a time limit of more than 12 months:

> . . . would be fraudulent, illusory and economically unsound to persons 65 years of age and over.

The recommendation of Mr. O'Regan was immediately adopted by the then Insurance Commissioner, Richards D. Barger.

In his *Shopper's Guide to Health Insurance*, Denenberg stated:

> We recommend that you try to avoid policies with an exclusion for preexisting conditions of longer than 1 year. Also check to see how far back in your medical history the company will go in searching for preexisting conditions. Some companies may go back as far as birth.

The New York State Insurance Department, in its pamphlet, *Insurance for Older Workers*, cautions:

> An important factor to bear in mind in evaluating a policy is the restriction it imposes on coverage of preexisting conditions which were known to you before applying for the insurance policy. Many insurers do not inquire into your current health status, but exclude benefits for 6 months for preexisting conditions. Some insurers ask questions about your health, and exercise the right to decline coverage.

In its *Consumer's Guide to Health Insurance*, published in February 1974, the Office of Comprehensive Health Planning of Massachusetts, warns:

> Many health insurance policies will not pay for any benefits for the first 2 years of the policy if the claim is for a condition the company believes existed before the coverage began. Different companies interpret "existed" in different ways.

In its section on mail-order insurance the Massachusetts health insurance guide states:

> Most mail-order policies require no medical examination. Instead, the company waits until you put in a claim to require a physical exam or to consult your medical records. Many claims are denied on the basis of preexisting conditions discovered by the company in this way.

In its *Rules of the Department of Insurance*, Florida states, with respect to advertising, "The use of the term 'preexisting condition' without an appropriate definition or description shall not be used."

It also requires that advertisements containing application forms, which will be returned by mail, contain:

> . . . a question or statement which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows: "Do you understand that this policy will not pay benefits during the first — year(s) after the issue date for a disease or physical condition which you now have or have had in the past?" ☐ YES

Thus, some of the States have set a maximum time period for preexisting clauses. Others require the clear presentation of the existence and meaning of such a clause.

III. SELLING TACTICS

The complaint and investigation departments of the various States have also called attention to unscrupulous dealings on the part of some insurance agents. The insurance departments, of course, have the power to issue and revoke licenses and each year some agent licenses are revoked.

On this subject two particularly unfortunate practices are overinsurance and unwise cancellation of a policy with the simultaneous purchase of a new policy from the same agent.

The sale of several policies to the same individual to cover the same risk results in a waste of the money spent for the premiums. Benefits are coordinated so that overpayments to policyholders are avoided. Preying on the fears of the elderly of being "wiped out" financially by a costly illness, the agent will sell what appears to be extra protection. Three policies, for example, which cover the hospital deductible, which today is $84 for a benefit period, will not provide a

windfall to the insured of $168 with one policy paying the hospital $84. Only one policy will pay the deductible. This is referred to as coordination of benefits.

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

The major disadvantage to the elderly person is the beginning of a new prior exclusion clause. Let us say a policy is sold effective January 15, 1973, with a 1 year exclusion clause. The policy will not provide benefits for any condition existing on or before January 15, 1973 until the policy has been in effect for 1 year. After the policy is in force for a year the exclusion clause expires. In the case posted all benefits would be paid for all conditions, regardless of the date they began, beginning with January 15, 1974, which is 1 year after the policy took effect.

Six months after the policy was sold, that is July 15, 1973, the agent suggests the policy should be canceled and a new one purchased. The new policy has an effective date of July 15, 1973 and a prior illness exclusion of 1 year so that it will not provide benefits until July 15, 1974 for illnesses related to conditions existing on or before July 15, 1973.

The elderly insured person now has an additional 6 month wait for coverage for prior illness. Had he retained the first policy, on January 15, 1974 prior illness-related benefits would be paid. With the new policy he must wait until July 15, 1974, for coverage of prior illness-related expenditures.

These are only two unfair practices. There are others, of course, particularly the refusal of an agent to show the policy in advance of purchase. However, the duplication of benefits and the replacement of one policy with the other were the most frequently cited by the investigation divisions of the State insurance departments as adversely affecting the elderly.

IV. MINIMUM LOSS RATIOS

Without exception the State insurance commissioners consulted emphasized the importance of loss ratios in the evaluation of health insurance companies and their policies.

Loss ratios relate benefits paid—technically called claims expense—to premiums collected. If, for example, for each dollar of premium income to the insurance company, 80 cents is paid out in benefits, the loss ratio is 80 percent.

The loss ratio is useful in at least two ways: first, it provides some insight into the size of the premium and its relation to the benefit expenses of the insuring organization; second, it provides insight into the claims-paying record of the insurance company. A very low loss ratio may indicate a company is disallowing many claims.

Actual loss ratio experience in 1971 and 1972 for health policies issued, regardless of the age of the insured is shown below:

	1971	1972
Blue Cross	94.7	91.8
Blue Shield	89.9	87.3
Insurance companies:		
All policies	86.8	83.6
Group	97.7	93.3
Individual	53.7	52.6

Note: Figures for insurance companies for 1971, our calculations from op. cit., p. 35.

Source: Social Security Bulletin, February 1974, pp. 32, 35, 36.

It is expected, of course, that private carriers have lower loss ratios than do the "Blues". The "Blues" are exempted from certain taxes the private insurance companies must pay; then there is the cost of agent commissions and other selling expenses for the private carriers, and so forth. A company just starting to write health policies will have a low payout because premiums are flowing in and claims are not yet flowing out in large amounts.

Some of the State insurance departments have sought to regulate the minimum loss ratios.

For example, in Nevada, guidelines have been issued by Commissioner of Insurance Dick Rottman concerning *Minimum Loss Ratios for Health Insurance Contracts; Reasonableness of Benefit in Relation to Premium.* In these guidelines, benefits are considered reasonable in relation to premiums if the ultimate loss ratios meet the standards set forth. The standards require a demonstrated anticipated loss ratio "of a minimum of 60 percent averaged over a period of time appropriate to the particular policy." A weighted average loss ratio may be used by the commissioner of insurance in the computation of the acceptable minimum loss. Extenuating circumstances are listed but the "final determination as to credibility" stays with the commissioner.

These Nevada guidelines "urge" companies to review their loss experience periodically so as to avoid the need for "exceptionally large rate increases" at some future time.

Florida requires companies writing accident and health policies to file exhibits as annual reports of their premiums earned and losses incurred. The Florida Department of Insurance considers a 55 percent to 65 percent loss ratio satisfactory for private carriers of health insurance.

In his *Shopper's Guide to Health Insurance*, Commissioner Denenberg has a table of the loss ratios for individual health insurance policies with the name of the company or the Blue Cross or Blue Shield organization whose experience is reflected in each loss ratio.

V. UNIT PRICING

The subject of the unit pricing of Medicare complementary policies was discussed in the various States in the course of this study. Unit pricing would provide a dollar amount of premium for each type of coverage. For example, the subscriber to the policy would be aware that it costs *X* amount for a policy to cover the Part A deductible and *Y* amount for a policy, or a clause, which covers the Part B deductible, and *Z* amount for coverage of the in-hospital coinsurance, and so forth. In this way, the policy buyer would be aware of the cost to him of

each type of coverage and would be in a position to evaluate whether he believes a particular type of coverage is worth its cost.

Admittedly, this is somewhat difficult for complex and comprehensive health insurance policies. But in the case of the policies to supplement Medicare, it could be done with relative ease. None of the State insurance departments said it could not be done. (In fact it has already been done for straight and term life insurance in Pennsylvania, with companies named and ranked in order of cost to the policy buyer.)

The issue that was raised in some of the insurance departments was the role of such a department in providing cost comparisons. Is it the proper role for a department of insurance to "shop around" for the consumer?

With respect to premium costs, the insurance departments noted their general inability to control their rise. This is largely due to the absence of cost review commissions or cost control legislation in the various States. Faced with insurance carriers and the "Blues" paying out larger benefits as health care costs rise in a period of inflation and having no wish to bankrupt the carriers and deny individuals the access to health insurance they desire, there is little the State insurance departments can do to avoid premium increases. The Medicare premiums and copayment requirements have also been steadily increasing.

VI. MAIL-ORDER ADVERTISING

In the late 1960's and early 1970's there began a tremendous surge of mass marketing of individual health insurance policies directed to the elderly. This took the form of the sale of health insurance policies by mail order rather than by insurance agents and was accomplished through magazine, newspaper, radio, and TV advertising.

The sales of these policies soared—health costs were rising, Medicare legislation was not providing a comprehensive insurance package, and elderly people were fearful of losing their life savings through long term illness.

But many of the mail-order insurance policies did not deliver what was expected from them. State insurance departments were alerted to the many deceptive advertisements by their own monitoring as well as by the complaints that poured into their consumer service bureaus. In many of the States the insurance departments issued guidelines for advertisements of health policies and in some instances provided for a mandatory review procedure for mail-order health insurance advertisements.

Policies advertised were primarily of two types:

(1) Hospital indemnity policies, which paid cash for some of the time spent in the hospital; and

(2) Policies which paid for some of the benefits uncovered or only partially covered by Medicare.

CASE STUDY—CALIFORNIA

The following material is based on an October 1972 interoffice memorandum of the California Department of Insurance concerning an advertisement which was considered in violation of the guidelines

issued by that State's Department of Insurance.[10] Cases such as the following arose in other States, not just in California. This one has been chosen for illustrative purposes.

The reasons for the California Department of Insurance's finding that the advertising material was not in compliance include the following points:

(1) The advertising material described some aspects of Medicare along with its own policy to supplement Medicare in such a way that it was difficult, throughout the ad, to distinguish between Medicare's coverages and the policy's coverages.

California required that all references to the policy had to be in terms of the XYZ Company's Medicare supplement plan and all references to Medicare had to be qualified by use of the word "Federal."

(2) At the top of the ad it was stated "enrollment period ends midnight of (day and date specified)."

Since the company would permit enrollment at some future date, they could not give the impression that if people did not enroll prior to the date mentioned, they would never have the opportunity to enroll again. California required the ad to state: "This enrollment period ends such and such a date."

(3) The ad stated, in the largest type it used in any part of the entire presentation, "Did you know that hospital Medicare doesn't cover all hospital expenses?"

Since the XYZ Company's policy did *not* cover all hospital expenses uncovered by Medicare, the California Department of Insurance did not allow the use of the question, "Did you know . . .". The policy discussed here did not cover, for instance, the initial hospital deductible.

(4) The XYZ Company's policy advertisement stated "Costs Not Covered by Hospital Medicare Have Gone Up." These words were in large type and were followed by an explanation which said the hospital deductible had risen and owners of the company's policy were fortunate to have coverage because, and this was italicized in the ad:

> Once again this plan automatically adjusts to cover increased hospital charges.

California disallowed this part of the ad since the policy did not cover the deductible. With or without the policy, the Medicare beneficiary had to pay a larger hospital deductible. The plan did not automatically adjust to cover the increased hospital deductible. It did not cover the hospital deductible in the first place.

(5) In a section presented in question and answer form, one question concerned the way in which the policyholder could "collect" his benefits.

California's regulations disallowed the use of the word "collect" as misleading. There are several reasons for this; the benefits may be assigned to the hospital and, too, the amount paid for by the policy was primarily the coinsurance payment required after a 60 day hospital stay in one benefit period. It was considered misleading to say "collect" as though the insured would get funds other than the money necessary to pay the coinsurance unpaid for by Medicare.

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[10] At the request of the California Department of Insurance, the name of the company involved is not used here. Since more than one company was not in compliance with respect to advertising material, it would be inequitable to single out this one in our study.

(6) The ad stated in its first paragraph:

> Did you know that hospital Medicare doesn't cover *all* hospital expenses?
>
> That's why XYZ offers this Hospital Medicare Supplement Plan.

The word this (Hospital Medicare Supplement Plan) had to be deleted, because *this* plan did not cover all hospital expenses either.

Many other changes were required by the California Department of Insurance in this ad before it granted approval.

In public hearings held in early 1972 on proposed regulations concerning advertising, for all types of health insurance policies, Commissioner Denenberg stated:

> The advertisement of National Home Life Assurance Company tried to make even an exclusion for preexisting conditions sound like a bonanza, a bonus, a good deal.
>
> After noting the exclusion, the National Home Life Assurance Company states: "The last provision is a real help if you already have a health problem. If you are sick before you take out this policy, you will even be covered for that condition after the policy has been in effect for only 2 years."

Some of the mail-order ads stated that premiums were low because agents were not used and commissions did not have to be paid by the company. However, Denenberg pointed to the misleading "gimmick" in such an ad, because "We will show that four of the leading mail order health insurance companies burn up 48 percent to 92 percent of the premium dollar in expenses. . . . That's hardly what we consider an efficient operation."

In Nevada, advertising guidelines were adopted in April 1972. They limited the preexisting condition clause to a maximum duration of no longer than 6 months in the case of mail-order policies requiring no extensive medical application form.

The Nevada Department of Insurance also came to grips with an advertising practice considered deceptive by all the departments consulted. This is the issue of *indemnity* policies. Such policies pay a stated number of dollars, usually for part of the hospitalization period, and are a flat amount per day. Service benefits, on the other hand, pay for expenses incurred and in a period of inflation are more closely related to health costs.

In his *Advertising Standards*, Commissioner Rottman of Nevada included the following:

> Specifically applicable to all hospital indemnity policies . . . only the daily indemnity will be permitted to be stated in the advertisement. The stating of weekly or monthly amounts are prohibited.

The kind of advertisement this *Standard* is directed against, for example, is one that was an insert in a large, widely circulated newspaper published in New York. The large, bold type said $200 cash each week, followed by a small print parenthetical ($28.57 per day). The inside pages of the ad, in the section on Medicare, said this com-

pany's policy will help take care of the expenses your other insurance may not cover when you are hospitalized.

Medicare pays all the expenses except the deductible, which is not mentioned in this ad, for hospitalization during the first 60 days of confinement. With the average length of stay in a hospital 12.4 days in 1971 for persons 65 and over, the chances of collecting on this policy were relatively small.[11]

Another policy stated that daily payments of $23.33 will be made for the first 2 months of hospitalization for persons aged 65 or over. But the cover of the ad stated:

> Now . . . for people of all ages. Get up to $1,000 a month ($33.33 per day).

As indicated earlier, some of the policies state that "No agent will call." Florida prohibits this statement in advertisements. Rather, it requires that the application be taken and the policy delivered through an agent licensed by Florida's Department of Insurance. This ruling of the State of Florida both avoids causing the misleading inference that a policy is less costly because agents are not used and, too, with its power to license agents, Florida's Department of Insurance exerts greater regulatory control than in instances where agents are not used.

In its rules on disability advertising, Florida prohibits any statement:

> . . . that the amount of the benefit is payable on a monthly or weekly basis when, in fact, the amount of the benefit payable is based upon a daily pro rata basis relating to the number of days of confinement. When the policy contains a limit on the number of days of coverage provided, such limit must appear in the advertisement.

As pointed out by Commissioner Millard Humphrey of the insurance department of Arizona, that State's advertising rules became effective as early as 1956. In addition to covering items mentioned above for other States, the Arizona rules include—and other States do also—prohibitions against the use of certain words and phrases which "exaggerate any benefit beyond the terms of the policy." Examples cited in Arizona's rules are "all," "full," "complete," "comprehensive," "unlimited," "up to," "as high as," "this policy will pay your hospital and surgical bills," or "this policy will replace your income."

The pattern of mail-order deception is well known by now to the departments of insurance throughout the Nation. Guidelines, rules, and regulations have been issued to deal with the problem. Vigorous enforcement of the rules and regulations appears to be the order in the insurance departments.

Much has been accomplished. More needs to be done and the insurance departments are aware of the continuing problems. For example, there needs to be continuous surveillance of new policies, riders and advertising material. The need to educate the public continues. Higher minimum benefit standards are a recognized necessity in many of the States. Insurance departments are not health cost review commissions. They are not

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[11] Cooper and Piro, "Age differences . . ." *op. cit.*, p. 10.

intended to be. Moreover, they recognize that in the absence of cost controls in the fields of health their power to hold down premium rises is limited. Unless minimum loss ratios are lower than the benchmarks set up by the various commissioners and their insurance departments, there is little that these departments can do to avoid granting premium rises when requested by insurance carriers. Without necessarily advocating cost controls or cost review commissions, the State departments of insurance are aware of their restricted powers in controlling policy costs.

Part 3. Informing the Public

Many persons do not understand Medicare's provisions or private policy provisions. Consultations with insurance commissions, their staffs and the directors of consumer service bureaus lead to the clear conclusion that health insurance, public or private, is not clearly understood.

In its brochures explaining the program, the Social Security Administration has tried to bring simplicity out of the complexity of the Medicare program. Apparently, because of its intricacies, the provisions and requirements of Medicare call for further clarification. This is a significant issue for a variety of reasons, most important is the shock of disappointment and the confusion resulting when anticipated Medicare claims are not paid and the elderly individual is required to make payments himself. Another important reason for wanting the elderly to be knowledgeable about their protection is to avoid duplication of Medicare benefits in private policies and enable them to choose wisely among the more useful of the supplementary policies.

Several methods have been suggested to increase the awareness of the elderly of Medicare provisions. One would be to include a clearly and simply worded explanation of a single aspect of Medicare along with the monthly retirement check sent by the Social Security Administation. Over a period of time many of the complex issues could be explained this way.

Other ways of educating the affected public include continuing efforts by State and county offices on aging, organizations of older people, State insurance departments and State and local consumer affairs bureaus. Certainly this has been done, but since the problem has not yet been solved and since each day many persons reach 65 years of age, increasing emphasis on educating the public on major points in Medicare is required. There must be a multiplicity of sources of information for the public as well as highly developed referral services.

Part of the difficulty of understanding public and private health insurance policies stems from not having to understand them during a working lifetime. In many instances, employees are covered by the group health insurance policy paid for partly or entirely by the employer. When illness occurs a claim is likely to be handled through the company's personnel department or, if it is a union administered plan, through the union. The need to understand the intricacies of the policy may never arise. It would be useful if policy language and basic health insurance concepts were explained by employers or unions to persons covered by the policies.

Labor, industry, government, and voluntary organizations can contribute to the public's understanding of health insurance,

whether private or public. Age 65 is not a magic age at which one is likely to become suddenly expert on the technicalities and legalities of insurance policies.

The Florida Department of Insurance has a noteworthy administrative structure. Rather than the typical setup of one or, at best, a few insurance department regional offices within the State, Florida has 21 local area offices. Questions and complaints can be brought to these area offices by affected persons. Even though the questions and concerns relate to all types of insurance, the staffs are trained in the handling of health policies supplementary to Medicare.

As the Florida Commissioner noted in his 1973 *Annual Report:*

> To respond more directly to the needs of insurance consumers, the 21 service offices were brought together into a bureau of field operations to become an important arm of the division of consumer services in helping people at the local level.
>
> As area supply centers they help in the distribution of department publications and educational booklets.
>
> Claims and complaints are now being handled by service office staffs whenever possible. During the 1972–73 fiscal year they responded to approximately 847,500 questions and complaints and helped recover over $7.5 million for insurance consumers.

In addition to replicating the Florida pattern, where feasible, there may well be study of the need for an increased number of Social Security offices; these offices are the primary source for Medicare information.

Some of the States have issued consumers' guides to health insurance. Although these guides are not limited to policies concerning Medicare enrollees, they include specific pages on policies supplementary to Medicare.

Based on the experience of the consumer service bureau chiefs and staffs in the State insurance departments studied here, the major economic dissatisfaction and disappointment with Medicare derives from the illusion, shared by many of the elderly, that it is a comprehensive insurance program. It is not such a program and it was not designed to be such a program.

The coinsurance requirement under Part B is the major source of misunderstanding by enrollees in the program. Part B covers primarily physician services. In addition to payment of the $60 annual deductible the patient is liable for coinsurance: 20 percent of the bill for covered services. Complicating the procedure is the provision in the Medicare legislation permitting physicians to choose to take or refuse to take assignment. The proportion of physicians accepting assignment fell from 61 percent in 1969 to 53 percent in 1973.[12] Where the physician refuses to take assignment, the typical procedure is for the doctor to bill the patient for whom he provided medical care. The bill is paid by the patient and then submitted to the fiscal intermediary for Part B, the Supplementary Medical Insurance section of Medicare.

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[12] Ibid., p. 11.

The length of time for the intermediary to reimburse the patient for the money he laid out is a source of many complaints. The response given by the intermediary to the patient, according to the insurance departments, is frequently "It is tied up in our computer" and "The doctor did not fill out the form properly." The only solutions here are to educate the physicians in form-filling out and to improve the computer handling of claims.

It has also been noted there are difficulties encountered when two intermediaries are handling Medicare benefits—one, typically Blue Cross, is the fiscal intermediary for Part A, the hospitalization section of Medicare, and another intermediary, Blue Shield or an insurance company, acts as the reimbursement agent under Part B. Admittedly there are enormous problems in the administration of such a program. In 1971 there were 247 million visits involving physician services. These include office and house visits, surgical care and so forth.[13]

Where physicians agree to accept assignment under Part B, they receive the "allowed charge" for the service rendered, as determined by the local intermediary, carrying out its functions under the Social Security Administration's guidelines and regulations.

In instances where the physician, under the choice provided by the Social Security law, opts to refuse assignment, the fiscal intermediary pays the "allowed charge" and any amount of the bill above the allowed charge, unless cancelled by the physician, is payable by the patient.

The allowed charge or dollars of permissible reimbursement have been considered a matter of confidentiality by the Social Security Administration since the inception of Medicare, even when the specific name of the physician was not requested but merely the allowable reimbursement for a specific medical or surgical procedure or an office or home visit.

In a highly significant decision, reproduced in Appendix 1, the U.S. District Court for the District of Columbia, on July 11, 1973, in the case of *Dellums* v. *U.S. Department of Health, Education, and Welfare*, required that reports prepared by the Social Security Administration setting forth prevailing private fees of doctors be made public.

The case concerned prevailing fee schedules in Pennsylvania, but as a result of the decision, reimbursement rates under Medicare's Part B must be made publicly available for the first time.

The decision was rendered under the Freedom of Information Act and the court ordered the Social Security Administration in its administration of the Medicare section of the Social Security Act to make the information public. Judge Jones in handing down the decision stated:

> The Freedom of Information Act is to be liberally construed so as to implement its chief purpose of increasing public access to government records.[14]

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[13] Charles B. Waldhauser, Health Insurance for the Aged: *Monthly Reimbursements Per Person By State, 1971,* Office of Research and Statistics, Social Security Administration, December 5, 1973, p. 4.

[14] *Ronald V. Dellums, et al., v. U.S. Department of Health, Education, and Welfare and Caspar Weinberger,* U.S. District Court for the District of Columbia, Civil Action No. 181–72, July 11, 1973; see appendix 1, p. 29.

The usefulness of information on reimbursement schedules to persons covered by Medicare is this: it makes clear to them, or relatively clear, why Medicare's Part B is paying for part of their medical bills and why they are paying for part and, more important, gives them a clue with respect to the amount of the bill for which they are reimbursed.

In the course of preparing this working paper, the prevailing fee schedule under Medicare Part B was obtained from the fiscal intermediary in one of the largest metropolitan areas in the Nation. In the form in which it is presented, it is of some value to the Medicare recipients who do not understand the disallowance by the carrier of some of the physician fees for which they are billed.

The more complete understanding there is of Medicare, the easier it is to choose intelligently among the private policies which are sold to supplement Medicare.

In this context it is useful to make reference to a report made at the request of the U.S. Senate Special Committee on Aging, by the General Accounting Office (GAO). The report, published in December 1973, *Study of the Application of Reasonable Charge Provisions For Paying Physicians' Fees Under Medicare*, was based on the experience of Part B intermediaries in four States. It is stated (p. 20):

> Beneficiaries and physicians seldom protest, or appeal to the carriers, the carriers' reasonable charge reductions. The four carriers' reconsideration and fair hearings activities were very low in relation to the number of claims denied and reduced.
>
> Of the reconsiderations, about 22 percent were favorable to the claimants at Prudential and from 39 to 53 percent were favorable to the claimants at the other three carriers.
>
> This suggests to us that, if beneficiaries request the carriers to take another look at their reduced or denied claims, their chances of obtaining some adjustment range from fair to very good. On the other hand, once a carrier has reconsidered a claim, a claimant's chances of obtaining adjustments through more formal protests seems remote.

To provide the protection Medicare and private health insurance policies are expected to provide to the elderly in meeting their enormous health care bills—over $1,000 per capita in 1973—more information on both the public and private insurance programs must be made available to the concerned public in a manner and form readily understandable to us all.

CONCLUSION

Medicare is a fine and useful program, but for the reasons cited, it is removing less and less of the crushing burden of health costs from the aged in our Nation.

Private insurance fills a need since Medicare was not designed to be a program to cover all health costs of the elderly. Unless Medicare is substantially expanded, private policies will continue to be important sources of protection

Our consultations with departments of insurance in some States indicate there exists a common set of problems concerning private health insurance for the aged.

Insurance departments consider the following to be among the major problems encountered by the elderly in their purchase of private health insurance: duplication of coverage, policies specifying flat dollar amount of payments without regard to rising health care costs, long waiting periods before the effective date on which the policy's protection begins, long preexisting condition periods and misleading advertising in the offering of policies.

The State insurance departments through their regulations and guidelines are increasingly setting standards for policies such as requiring minimum benefit coverages before the policy can be offered for sale in a State, as well as setting limits on prior condition clauses. Some States issue and distribute widely their consumer guides to the purchase of health insurance. They monitor the advertising and revoke licenses of agents whose code of conduct is unacceptable.

State insurance departments have limited power over premium charges because most States have no legislation or very limited legislation concerning health cost containment. The major technique used by the State insurance departments to evaluate a policy's premium charges and its equitable rate structure is the minimum loss ratio. They consider this a test of the fairness of charges and the practice of insurance companies in paying or denying claims. It would appear that other measures could be developed, such as unit pricing of specified coverages, in policies supplementary to Medicare. This might lower premium charges by increasing competition as unit pricing is made available to the public.

More information and in greater detail must be provided for the elderly and their families on the scope of Medicare and on private policies. A many pronged attack on the information gap is needed: government as well as private organizations such as senior citizen groups and other voluntary groups of interested persons. A concerted effort along these lines is critically important. Oversold to the American public in some respects, Medicare remains under-explained.

As long as Medicare continues to be a program of limited scope, private health insurance fulfills an important role. An equally important need is for the elderly to understand what protection they need additional to Medicare and how to buy such protection.

APPENDIX 1

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA

Civil Action No. 181–72

RONALD V. DELLUMS, ET AL., PLAINTIFFS,

v.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE AND CASPAR W. WEINBERGER*, DEFENDANTS.

MEMORANDUM AND ORDER

The plaintiffs have brought this complaint under the Freedom of Information Act, 5 U.S.C. § 552 (1970), seeking an order requiring the defendants to make available reports prepared by the Social Security Administration which set forth prevailing private fees of doctors in Pennsylvania.[1] Those reports were compiled by the Social Security Administration, an agency of the defendant Department of Health, Education, and Welfare [HEW], pursuant to its administration of the Medicare Law under 42 U.S.C. § 1395 u (1970).

The case is now before the Court on cross-motions for summary judgment. The Court finds that there are no genuine issues of material fact, and grants summary judgment for the plaintiffs.

The Freedom of Information Act is to be liberally construed so as to implement its chief purpose of increasing public access to governmental records. Records are to be turned over to the public unless they fall within specific statutory exemptions, which are to be strictly construed. The governmental agency bears the burden of proving that the requested information is within the ambit of the specific statutory exemption. *Soucie* v. *David*, 145 U.S. App. D.C. 144, 448 F.2d 1067 (1971); *Wellford* v. *Hardin*, 444 F.2d 21 (4th Cir. 1971). *See also Environmental Protection Agency* v. *Mink*, 410 U.S. 73 (1973).

In this case the defendants claim that the documents sought are exempt from disclosure under exemptions two (internal personnel rules and practices of an agency), three (material "specifically exempted by statute"), and five (intra-agency memoranda) of the Act, 5 U.S.C. §§ 552(b)(2), (3) and (5) (1970). The defendants have not met their burden of proving the applicability of any of the three exemptions to the documents in question and thus they must be made available to the plaintiffs.

The defendants place primary reliance for nondisclosure on exemption three of the Act, 5 U.S.C. § 552(b)(3), arguing that the docu-

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* Caspar W. Weinberger has succeeded Elliot L. Richardson as Secretary of the Department of Health, Education, and Welfare since this action was filed and accordingly has been substituted as a party defendant pursuant to Fed. R. Civ. P. 25 (d)(1).

[1] The original complaint also sought certain other documents denied plaintiffs. After the filing of the plaintiffs' motion for partial summary judgment to obtain access to those documents, the documents were made available to the plaintiffs under 42 U.S.C.A. § 1306 (d) and (e), enacted October 30, 1972. The plaintiffs then withdrew their motion for summary judgment as moot and filed a motion for summary judgment on the doctor's fee reports; see p. 26 for additional discussion.

ments are material specifically exempted from disclosure by statute, that is, 42 U.S.C. § 1306(a):

No disclosure . . . of any file, record, report or other paper, or any information, obtained at any time by the Secretary of [HEW] . . . in the course of discharging [his] respective duties under . . . [The Social Security Act] . . . shall be made except as the Secretary . . . may by regulations prescribe.

This statute, however, does not specifically exempt the documents sought from disclosure, but rather is a blanket exclusion on disclosure of all files, records and reports compiled under the Social Security Act. That blanket exemption is in direct contravention of the liberal disclosure requirement of the Freedom of Information Act, and cannot qualify as a specific exemption within the meaning of the Act. *Schecter* v. *Richardson*, Civil Action No. 710–72 (D.D.C. July 17, 1972); *Serchuk* v. *Richardson*, No. 72–1212—Civ—PF (S.D. Fla., Nov. 28, 1972). *But see California* v. *Richardson*, 351 F. Supp. 733 (N.D. Cal. 1972).

The defendants, however, make reference to a 1960 House Committee Print, referred to in the House report on the Freedom of Information Act, H.R. Rep. No. 1497, 89th Cong., 2d Sess. (1966), which listed 42 U.S.C § 1306 as being among some 100 statutes which restrict public access to specific government records. Even if the House report on the Freedom of Information Act were the authoritative report,[2] at least one other statute listed in that report as forbidding disclosure, 18 U.S.C. § 1905, has been held not to be specific within the terms of 5 U.S.C. § 552(b)(3).[3] *Grumann Aircraft Engineering Corp.* v. *Renegotiation Board*, 138 U.S. App. D.C. 147, 425 F.2d 578 (1970); *M. A. Schapiro & Co.* v. *SEC*, 339 F. Supp. 467 (D.D.C. 1972); *Consumer's Union, Inc.* v. *Veteran's Administration*, 301 F. Supp. 796 (S.D.N.Y. 1969), *appeal dismissed as moot*, 436 F.2d 1363 (2d Cir. 1971). Each statute forbidding disclosure must be examined to determine whether it specifically exempts the material sought or merely states a blanket exemption on all disclosures which is not specific within the terms of the Act. The Court has held section 1306 not to be specific.[4]

The defendants assert further that the prevailing fee reports are "tolerance rules" which are exempt from disclosure under the personnel rule and intra-agency memoranda exemptions of the Act, 5 U.S.C. §§ 552(b)(2) and (5) (1970). But the reports in question do not meet

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[2] The Court of Appeals for this Circuit has declared that the Senate report is the authoritative one in construing the exemptions to the Freedom of Information Act. Getman v. NLRB, 146 U.S. App. D.C. 209, 212 n. 8, 450 F.2d 670, 673 n. 8 (1971). *Accord* Hawkes v. Internal Revenue Service, 467 F.2d 787, 797 (6th Cir. 1972).

[3] In *California* v. *Richardson*, 351 F. Supp. 733 (N.D. Cal. 1972), the Court relied on Davis, *The Information Act: A Preliminary Analysis*, 34 U. Chi. L. Rev. 761, 786–87 (1967), for its conclusion that 42 U.S.C. § 1306 is a specific exemption within the terms of the Act. Professor Davis does mention the Committee Print relied upon by the defendants as indicating statutes which may fit within 5 U.S.C. § 552(b)(3). The particular example chosen by Professor Davis, however, is instructive in this case and demonstrates why section 1306 is not a specific exemption. Upon this example, 15 U.S.C. § 78 x (1970), "the revealing of trade secrets or processes in any application, report, or document filed with the [SEC]" is not authorized. That statute refers to specific matters, trade secrets or processes which are nondiscloseable, except under certain procedures. Section 1306, on the other hand, forbids disclosure of all reports under the Social Security Act, a prohibition nowhere near as specific as that of 15 U.S.C. § 78 x.

[4] The 1972 amendments to section 1306, 42 U.S.C.A. § 1306 (d) and (e), mandating the disclosure of certain reports which the plaintiffs originally sought in this case, note 1, *supra*, do not evidence an intent by Congress that all documents except those authorized to be disclosed by sections 1306 (d) and (e) were specifically exempted from the operation of the Freedom of Information Act. The Senate added those sections to the 1972 amendments and reported that they were not "in any way to be interpreted as otherwise limiting any disclosure of information otherwise required under the Freedom of Information Act." S. Rep. No. 92–1230, 92d Cong., 2d Sess. 306 (1972).

the definition of tolerance rules as outlined by Judge Hart in *Cuneo* v. *Laird*, 338 F. Supp. 504 (D.D.C. 1972), appeal docketed No. 72–1328, (D.C. Cir., Apr. 11, 1972) (Argued June 6, 1973).[5] According to *Cuneo*, tolerance rules relate to formulated agency policy setting forth guidelines for securing compliance with an agency's program objectives. Thus revelation of the audit information sought in *Cuneo* would have had a serious effect on the ability of the agency to maximize its effectiveness in monitoring compliance of government contractors with its rules.

In the instant case, the defendants have asserted nothing more than that the prevailing fee reports have "some of the characteristics and functions of 'tolerance rules.'" (March 23, 1972 Affidavit of Thomas M. Tierney, at 3). But the prevailing fee reports themselves are totally factual and consist of statistics. (May 22, 1973 Affidavit of Sylvia A. Law). The data contained are the raw facts which the defendants use for determining reasonable charges pursuant to their duties under the Social Security Act. They do not represent guidelines or instructions setting forth agency policy for the guidance of employees who determine which reported charges are to be allowed and in what amounts. Unlike the situation in *Cuneo*, disclosure of the reports will not enable anyone to evade the enforcement policy of the agency.

The defendants argue at length that revealing the prevailing charges will enable participating physicians to raise their charges and thus raise the cost of the Medicare program.[6] Assuming that this consideration is relevant and that participating physicians are unaware of the prevailing fee, the fears of the defendants would appear to be unfounded. As amended in 1972, 42 U.S.C.A. § 1395 u (b) (3), prohibits the use of a prevailing charge level higher than that in effect on June 30, 1973, except to the extent that the Secretary finds that the higher level is justified by economic changes. The Senate report on the amendment defines economic changes as those "justified by indexes reflecting changes in the operating expenses of physicians and in earnings levels." S. Rep. No. 92–1230, 92d Cong., 2d Sess. 191 (1972). Thus the danger of disclosure seen in *Cuneo* is not present in this case because the defendants themselves retain the power to prevent any possible abuses.

Therefore, it is, this 11th day of July, 1973, without hearing pursuant to Local Rule 9(f),

ORDERED

1. That the motion of the plaintiffs for summary judgment be and the same is hereby granted;

2. That the motion of the defendants to dismiss or in the alternative for summary judgment be and the same is hereby denied;

3. That the defendants produce their Reports on Prevailing Doctors' Fees in Pennsylvania for plaintiffs' inspection and copying within 20 days of the date of this Order or at such other time as the parties may agree upon.

WILLIAM B. JONES, *Judge*.

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[5] Although it is not necessary to the disposition of this case, the Sixth Circuit in Hawkes v. Internal Revenue Service. 467 F.2d 787, 796 n. 12 (6th Cir. 1972) noted the decision in *Cuneo* and specifically declined to accept its reading of the internal personnel exemption as covering more than documents dealing with conditions of employment.

[6] Under current regulations, doctors are prohibited from receiving reimbursement for a particular service which exceeds the 75th percentile of prevailing fees for such services. (March 23, 1972, Affidavit of Thomas M. Tierney, ¶ 3.)

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