

ACCESS TO CARE FOR THE ELDERLY

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS
FIRST SESSION

ABERDEEN, SD

AUGUST 7, 1989

Serial No. 101-7



Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1990

SPECIAL COMMITTEE ON AGING

DAVID PRYOR, Arkansas, *Chairman*

JOHN GLENN, Ohio

BILL BRADLEY, New Jersey

QUENTIN N. BURDICK, North Dakota

J. BENNETT JOHNSTON, Louisiana

JOHN B. BREAUX, Louisiana

RICHARD SHELBY, Alabama

HARRY REID, Nevada

BOB GRAHAM, Florida

HERBERT KOHL, Wisconsin

JOHN HEINZ, Pennsylvania

WILLIAM S. COHEN, Maine

LARRY PRESSLER, South Dakota

CHARLES E. GRASSLEY, Iowa

PETE WILSON, California

PETE V. DOMENICI, New Mexico

ALAN K. SIMPSON, Wyoming

JOHN WARNER, Virginia

NANCY LANDON KASSEBAUM, Kansas

PORTIA PORTER MITTELMAN, *Staff Director*

CHRISTOPHER C. JENNINGS, *Deputy Staff Director*

JEFFREY R. LEWIS, *Minority Staff Director*

CONTENTS

	Page
Opening statement of Senator Larry Pressler	1
CHRONOLOGICAL LIST OF WITNESSES	
Richard D. Mulder, M.D., Ivanhoe, MN	6
Stephan Schroeder, M.D., Miller, SD	16
Gerald Huss, hospital administrator, Faulk County Memorial Hospital, Faulkton, SD	19
Ray Hopponen, pharmacist, Burke, SD	21
Wayne Muth, vice president of Long-Term Care for Presentation Health System, Sioux Falls, SD	24
Gail Ferris, director, State Program in Adult Services and Aging, Pierre, SD ..	27
Lucille Stafford, Ipswich, SD	35
Frances "Peg" Lamont, former State legislator, Aberdeen, SD	39

APPENDIX

Item 1. Testimony submitted by Richard D. Mulder, M.D., Ivanhoe, MN, entitled "Medicare Reimbursement and Rural Health Care"	57
--	----

ACCESS TO HEALTH CARE FOR THE ELDERLY

MONDAY, AUGUST 7, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Aberdeen, SD.

The committee met, pursuant to notice, at 1:30 p.m., St. Luke's Midland Regional Medical Center, Aberdeen, South Dakota, Hon. Larry Pressler presiding.

Present: Senator Pressler.

OPENING STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Good afternoon. Welcome.

Thank you all for attending this official hearing of the Senate Special Committee on Aging. I see many familiar faces, many people who should be introduced who have contributed a great deal—not only to the elderly, but to health care in South Dakota.

We have many health care issues in our State and across the Nation. An example is the excessive cost of health insurance. This week, when I leave Aberdeen, I shall be driving to Buffalo, SD, stopping along the way for listening meetings in Mobridge, McLaughlin, Lemmon, Bison, Isabel, and Buffalo.

I always enjoy that annual trip because I love to see the countryside; it's a beautiful part of our State. However, in no part of the United States are there more problems with the delivery of health care services than in that area, plus Indian reservations.

In many ways, Aberdeen is blessed with a number of excellent health care professionals. I am well aware of the quality of the institutions here, because two of my sisters took their registered nurse training in this city.

But there are still great problems. We are going to talk today about some of those problems: the price of drugs and generally the problems of delivery of care to the elderly.

As a member of the Senate Special Committee on Aging, I fight very hard to try to find the right approach on these matters. Hearings such as this help me to do my job. The transcript helps others understand the rural problems. In Washington, DC, we have some of our biggest battles over urban and rural issues, for example Medicare reimbursement formulas and wage standards that are set without an understanding of the problems in small communities.

We have an outstanding group of witnesses today. We will hear from each of them and put their complete statements in the record. Once the eight witnesses have completed their testimony, we will have time for questions and answers.

I want to thank all of you who have taken the time to come because by coming you have shown interest and support for working on some of the severe problems that we have. I also want to thank Dale Stein and Byron Peterson of the St. Luke's Midland Regional Medical Center for their assistance in helping make the arrangements.

A transcript of the hearing will be made available to all members of the Senate Special Committee on Aging as well as my other colleagues in the U.S. Senate.

I know there are many technical problems with Medicare deductibles and coinsurance. I could go into those in more detail but I think I will let our witnesses do so. We will be hearing about the cost of prescription drugs, questions on long-term care in some of our nursing homes and public policy on access to health and social care.

At this point, I will place my own statement in the record.
[The prepared statement of Senator Pressler follows:]

OPENING STATEMENT BY SENATOR LARRY PRESSLER
SENATE SPECIAL COMMITTEE ON AGING
HEARING ON

ACCESS TO CARE FOR THE ELDERLY
ABERDEEN, SD
AUGUST 7, 1989

I welcome each of you to this official hearing of the U.S. Senate Aging Committee. A transcript of this hearing will be made available to all members of the Committee as well as my other colleagues in the U.S. Senate. Written statements and comments from all who are in attendance today are welcome and may be submitted for the record.

I want to begin by thanking Dale Stein and Byron Peterson of St. Lukes Midland Regional Medical Center for their assistance with the arrangements for today's hearing here at the hospital.

This hearing is an opportunity to examine the problems the elderly in obtaining adequate health care and accessing other resources. To live a good life, people need adequate food, clothing, shelter, medical care and financial resources. Society is constantly changing, and this affects how the basic needs of the elderly are met. For example, when bus service was discontinued between Aberdeen and Ipswich the elderly had to adjust and find other ways of meeting their needs. That could affect the older persons social relationships as well as access to services. If a town loses its doctor, or a hospital closes or the local meals-on-wheels program is discontinued, the loss of those services affects the elderly most of all. It is important that all of us become more sensitive to these situations.

The elderly are very concerned about the availability of affordable health care. That is why they strongly support the Medicare program. However, Medicare does not guarantee access to health-care services. If the closest clinic is located miles from an individual's home or the local hospital has closed and the older person cannot drive to another town, then Medicare doesn't help.

Another problem is paying for deductibles and coinsurance. Today a person on Medicare is asked to pay a \$560 deductible for hospital care and a \$1,370 deductible and coinsurance for physician and outpatient services. I know many elderly who have a supplemental or medigap policy to pay for those deductibles and coinsurance. However, a significant number of the elderly cannot afford those policies. What happens to them when they need care? What happens if the attending physician does not accept as payment in full what Medicare pays? I am pleased that our panel of experts includes two physicians, Dr. Richard Mulder and Dr. Stephan Schroeder, and a hospital administrator, Gerald Huss. Their testimony will help shed more light on those issues.

Prescription drug prices continue to escalate, and this has an obvious impact on the elderly. During a recent Senate Aging Committee hearing on the cost of prescription drugs, I heard that the problem is not the fault of the small town independent retail pharmacy. In fact, this issue is so complicated that future hearing are planned to unravel the problem. Many South Dakotans have told me that high prescription drug costs are a serious problem for them. I look forward to hearing more about this from Ray Hoppenan (HOP-EN-AN), a registered pharmacist.

Long-term care is often synonymous with nursing-home care. However, long-term care is not limited to nursing-home care. Long-term care includes a variety of living arrangements for older people as their needs change. Today the need for many alternatives is important. We are an aging nation. People are living longer. As we age, nursing-home care, as an alternative, is essential. However, there are other options, including at-home care with social support services, congregate housing, and personal-care homes. The need for alternative living arrangements will continue to grow along with our aging population.

Another need expressed by many seniors is affordable nursing-home insurance. Unfortunately, many private policies are very expensive and others have limited coverage. Congress will be examining this situation and exploring possible remedies. Issues are the extent of coverage and financing mechanisms. Two experts in long-term care and aging, Wayne Muth and Gail Farris, will help us better understand the nursing-home insurance picture.

Public policy on access to health and social care is a good only if it really helps people. Frequent communication between policymakers and the public, providers and consumers, is essential to making good policy. As a policymaker, I welcome the ideas and views of fellow South Dakotans. You help me understand the specific needs of those who live and work with the elderly. Peg Lamont and Lucille Stafford, who understand the needs of the elderly better than I, will share their views with us today. Peg and Lucille know the problems encountered by the elderly on a daily basis for example, the need for congregate meals and transportation, problems with Social Security and the special problems of the rural, poor elderly.

Our hearing will examine all of these questions from different perspectives. I look forward to hearing from our witnesses. At this time, I would like to introduce our first witness, Dr. Richard Mulder.

Senator PRESSLER. Our first witness is Dr. Richard Mulder, a certified family physician who is in solo practice in Ivanhoe, MN. He is known in this area as an expert in family practice. He was awarded the Bush Clinical Fellowship to do extensive study in geriatric medicine and rural health care. He has driven quite a distance to be here today, about 200 miles

We thank you very much, Dr. Mulder.

STATEMENT OF RICHARD D. MULDER, M.D., IVANHOE, MN

Dr. MULDER. I want to thank Senator Pressler for inviting me here, and certainly thank you folks for coming here. It looks like we're running out of chairs.

I've talked to a lot of senior groups in the past and I can see a lot of you have some real important questions and concerns for me. I hope we will have time to answer those later on.

I got my pharmacy degree at Brookings at South Dakota State. My friend Ray Hopponen is here. He was dean when my son started pharmacy there. Then I went to medical school at the University of South Dakota and interned at McKennan Hospital, in Sioux Falls. I'm from a small town in Iowa, and presently have been practicing in a small town in Minnesota right on the South Dakota border. So I'm an honorary South Dakotan, okay?

I've been interested in rural health care since I have been alone and the only physician in Ivanhoe for 24 years. We have been seeing the same problems I think most of you have been seeing. I want to talk a little bit about access to health care in our country today.

There are really three problems in the health care access area that exist.

First, we have a real problem in that many areas of this country simply do not have a doctor available and their hospitals have closed. Over 800 hospitals have closed in this country in the last 9 years. We had close to 7,000 hospitals in 1980 and we have only about 6,200 hospitals left and only 5,800 community hospitals.

The second problem is that we have about 39 million people who are uninsured or underinsured. They can't afford the insurance that they have to have in order to have comprehensive health care.

The third problem in access that we are having today is rationing of health care. I will talk a little more about that later. At the present time, only the very affluent in this country can afford 100 percent quality comprehensive health care, including dialysis and organ transplants. It's getting to be a very expensive proposition in the future.

This is the only country in the world where we have the availability of that health care and the freedom for patients to choose their hospital, to choose their physicians, and the freedom for physicians to choose their patients.

The only way other countries have been able to take care of the tremendous cost of their health care system is to ration health care. I have investigated every other country that I can get information about, and the bottom line is that they cut costs only by rationing health care. This is done by reducing the availability of physicians and hospitals, by decreasing the numbers and kinds of

procedures that are available, and in some cases by withholding medical treatment for certain diseases. This has been done for the most part against the wishes of physicians.

Most of these countries also have adopted the principle of distributed justice. What that means is that once there is rationing of care (in the State of Oregon they just passed a law to ration care, they will not do organ transplants in the State and Medicaid will not pay for organ transplants) then they adopt this principle of distributed justice that says if Medicaid can't pay for a liver transplant in a 2-year-old then nobody else can have a liver transplant.

So rationing now is even affecting the very affluent, the people that can afford all this care and organ transplants. Rationing will pretty soon make it impossible for everyone to get complete health care.

When we talk about what the proper definition of health care is, during World War II, we had a term that we called the "first golden hour." In the first 60 minutes, if we can get to a patient that has a severe injury or illness, we have a better result in saving that patient's life or reducing disability.

Right after the Second World War, our Congress decided that people should have better access to health care and they passed what's called the Hill-Burton Act. With that act, of the 7,000 hospitals we have left, we built more than 4,500 of the hospitals in this country. They were built from 1950 to 1973.

They also said at that time that no person should live more than 20 miles from a hospital or health care access. Now Congress is doing just the opposite of that by closing 800 hospitals. Of the 168 hospitals in Minnesota, 91 were built by this Hill-Burton Act.

Then in 1974, the National Health Planning and Resources Development Act established health systems agencies and certificate of need plans. But they also said at that time that no person should live more than 30 miles from acute care access or hospitals.

I have been on various committees including the National Rural Health Task Force Committee for the American Academy of Family Physicians. We are saying that we don't think any person in this country should live more than 30 minutes away from acute health care.

In Minnesota we have 18,000 people who now do not have that access. Just in the last 2 months, two more hospitals closed. A total of 10 hospitals have closed in our State recently. If the hospitals that we think are in trouble are going to close in the future, within the next 3 years we are going to have another 19,000 patients that do not have proper access to health care.

In South Dakota we have 56 hospitals. This year, 14 of those hospitals are going to have an 18.4 percent net loss from treating Medicare patients. We project for next year, if we don't do something about the \$3 billion cut that the Government wants to put on top of hospitals and physicians, those 14 hospitals will have about a 25 percent net loss from treating Medicare patients.

Statistically, we find that if a hospital loses money 3 or 4 years out of 4 years, that they are closed within 3 more years. We can project right now that within the next 4 or 5 years, 14 hospitals in South Dakota will close, unless there is something done, and that is what Senator Larry is here to do.

The same situation I think exists for all of rural America. Texas has been hit the worst. I think they have had over 46 hospitals close down. The biggest problem with our rural hospitals here in South Dakota and in all of rural America is that they are not being reimbursed adequately. Every senior citizen in this country has paid exactly the same rate for Social Security tax. That Social Security tax allows him to receive benefits for Part A Medicare, or treatment in hospitals.

Everybody pays the same rate, however, rural hospitals, and almost all the hospitals in this State are reimbursed 37 percent less than are the big city hospitals. They treat exactly the same disease, but because of what is called a DRG, or diagnostic related group, they are paid by the diagnosis only. So they get paid 37 percent less here in Aberdeen, or elsewhere in this State, than they do in New York or the larger hospitals in the country.

We all have to keep up with the technology that we have, and it is becoming almost impossible for small hospitals to do that because of their low reimbursement formulas.

Also, every senior citizen in this country pays exactly the same premium for their Part B Medicare, \$31.90 a month. Except that urban senior citizens, on a national average, are reimbursed twice as much than you folks are.

On the east coast (Miami, New York, and large cities like that), the seniors are reimbursed four times as much as you are, and yet they pay exactly the same premium for their Part B benefit. Part B, you know, pays for your physician's office calls and for your physician's care while you are in the hospital. This has resulted in you paying premiums that essentially subsidize the health care for those senior citizens on the east coast.

I think the reduction in reimbursement that we have had in the last 8 years has resulted in the problems of access that we are having now here in the Midwest and in South Dakota. I don't think that this is fair to our senior citizens. I think the Federal Government, by adopting these rules, is treating our senior citizens out here in rural America as second class citizens.

Many rules are being considered in Congress right now. The formulas for them are pretty good, but they aren't going to go into effect for about 5 years, and I am concerned that by then it's going to be too late to reopen hospitals that have already closed. To correct this situation, I would recommend that some type of reconciliation of these bills be adopted immediately, and be implemented immediately. They want to phase it in over 5 years and that's going to be too late. I think the reimbursement issues for both Part A and Part B Medicare have to be equal nationwide. It just is not fair to charge you the same taxes for Social Security, the same taxes for your Medicare Part B premiums, and then reimburse you one-half or one-fourth of what you should have.

The second problem that we have in access to health care is the fact that before World War II, we could charge patients different amounts. We were able to take care of the people who did not have insurance or the finances to be able to help take care of the health care cost, by charging the ones that had the money more.

Since we got our third-party payer system on line, we were told we have to charge everybody the same. Now in order for us to con-

tinue to treat these 39 million Americans without insurance, and not get paid for it, we have to charge everybody else more, or cost shift.

The system is going to cost a great deal, but somebody has to pay. And because we have cost shift, third-party payers are ending up paying more, especially businesses—up to 8 percent of their expenses now are for health care. They are yelling the loudest because they know they are subsidizing the care of these 39 million Americans.

The only answer that I can see for these 39 million Americans is to increase the amount of Federal funding to take care of them. It has to come from some place. It just can't come from cost shifting like it has been done in the past.

We talked earlier about rationing health care. There are three kinds of systems for rationing. One is the price type of rationing. This is where insurance is sometimes so expensive people can't afford it. Also they have to pay high deductibles and high co-insurance.

The second type of rationing we call implicit rationing. This is the DRG program I just mentioned, where the Federal Government pays hospitals different rates for taking care of an illness. They don't take care into consideration a lot of things—how severe a patient's illness is, how old they are and a lot of other humane things.

So they give us a number of dollars to treat a disease, and since rural America gets 37 percent less, we have to do a much more efficient job than they do in the big city. If we get a patient in one of our rural hospitals that has a very devastating and long-lasting disease, sometimes the expense of that patient in that hospital can be enough to close it up.

The third type of rationing that we are seeing now, and that has been passed in several States (such as Oregon), is explicit rationing. That's where State law says who we can treat and how we have to treat them (at what age hip surgery can be done, that we can't do bypass surgery over age 67; we can't do organ transplants, etc.). This is where they tell us what to do and how to do it. This type of explicit rationing affects everybody's access to health care.

There are a lot of other problems that exist here. When we talk about how much we spend, about 11.4 percent of our gross national product is spent for health care. We are spending 15 percent of our gross national product just to fund our national debt. If we didn't have the national debt we have, we would have twice as much money as we need to fund health care.

Finally, if we are going to continue to have comprehensive, high quality health care and if we are going to make this health care available to everyone in this country, then we are going to have to accept the fact that it is going to cost more money. We are the last country in the world to have the continued freedom for access to physicians and hospitals by all patients.

We, as physicians, can still choose our patients, we can still choose our hospitals and doctors as patients, and we have to be able to continue to practice high quality medicine. When patients come to me it is my responsibility and my duty to do everything right for that patient for his proper treatment and for his comfort.

I have to be my patient's advocate to do what I think is right, no matter what the politics are of third-party payers. The health and welfare of my patients has to be my first consideration. I can't let economics, and politics, or religion, or any other circumstance take preference.

This has been the philosophy of ethical physicians from time immemorial. I have taken an oath to uphold this philosophy and I believe most physicians in this country have done likewise. If the Federal Government continues their present economic philosophy, we not only will see more rationing of care, but we will also see further deterioration of access and quality of that care.

I want to thank you for being so attentive here. I hope everybody could hear me. If you have any questions later on, I'll do what I can to answer them.

Thank you.

[The prepared statement of Dr. Mulder follows:]

MY NAME IS RICHARD D. MULDER. I AM A BOARD CERTIFIED FAMILY PHYSICIAN AND HAVE BEEN IN THE PRIVATE PRACTICE OF FAMILY MEDICINE IN IVANHOE, MINNESOTA FOR THE PAST 20 YEARS. DURING THAT TIME I HAVE BEEN THE ONLY PHYSICIAN IN IVANHOE AND ALSO THE ONLY PHYSICIAN IN LAKE BENTON WHERE I HAVE A SATELLITE CLINIC. I HAVE A PHARMACY DEGREE FROM SOUTH DAKOTA STATE COLLEGE AT BROOKINGS, SOUTH DAKOTA AND A MEDICAL DEGREE FROM THE UNIVERSITY OF SOUTH DAKOTA AT VERMILLION, SOUTH DAKOTA AND HAVE INTERNEED AT MCKENNAN AT SIOUX FALLS, SOUTH DAKOTA. MY MD DEGREE WAS FROM THE UNIVERSITY OF IOWA.

I WANT TO THANK YOU FOR THE OPPORTUNITY OF GIVING YOU SOME OF MY THOUGHTS ABOUT ACCESS TO HEALTH CARE IN OUR COUNTRY. THERE ARE THREE PROBLEMS WITH RESPECT TO ACCESS TO HEALTH CARE THAT EXIST TODAY. FIRST, WE HAVE A RURAL PROBLEM NOW WITH MANY CITIES OF THIS COUNTRY NOT HAVING A PHYSICIAN OR HOSPITAL AVAILABLE TO THEM FOR ANY TYPE OF HEALTH CARE. SECOND, WE HAVE APPROXIMATELY 39 MILLION AMERICANS WHO ARE UNDERINSURED OR UNINSURED AND FINANCIALLY DO NOT HAVE ACCESS TO PROPER HEALTH CARE. THIRDLY, WE ARE HAVING VARIABLE LEVELS OF RATIONING WHICH ARE CAUSING A REDUCTION IN ACCESS TO HEALTH CARE TO MOST EVERY ONE ELSE IN THE COUNTRY.

AT THE PRESENT TIME, ONLY THE VERY AFFLUENT ARE NOW ABLE TO AFFORD 100% COMPREHENSIVE HEALTH CARE INCLUDING ORGAN TRANSPLANTS. BUT EVEN THIS AVAILABILITY IS BEING THREATENED BECAUSE OF RATIONING. THE AVAILABILITY OF COMPREHENSIVE QUALITY HEALTH CARE IS VERY EXPENSIVE. THE UNITED STATES IS THE ONLY COUNTRY IN THE WORLD THAT HAS HAD THAT AVAILABILITY, AND THE FREEDOM FOR PATIENTS TO CHOOSE THEIR PHYSICIANS AND HOSPITALS AND THE FREEDOM OF PHYSICIANS TO CHOOSE THEIR PATIENTS. IN EVERY OTHER COUNTRY IT HAS BEEN DETERMINED BY THEIR SOCIETY THAT THEY DID NOT WANT TO PAY THE PRICE FOR THAT FREEDOM OR THAT ACCESS. IT IS A FACT THAT THE ONLY WAY TO CONTROL MEDICAL COST IN EVERY OTHER COUNTRY HAS BEEN TO RATION HEALTH CARE. THIS IS DONE BY DECREASING AVAILABILITY OF PHYSICIANS AND HOSPITALS, BY DECREASING THE NUMBER AND KINDS OF PROCEDURES THAT ARE DONE, AND FOR SOME DISEASES, TO WITHHOLD ANY KIND OF MEDICAL TREATMENT. IN GENERAL THIS HAS BEEN DONE AGAINST THE WISHES AND HOPES OF PHYSICIANS. IN MANY WESTERN TYPE COUNTRIES, HOWEVER, THEIR GOVERNMENTS HAVE HAD DIFFERENT OPINIONS. THE PRINCIPLE OF THIS DISTRIBUTED JUSTICE SEEMS TO HAVE BEEN PARAMOUNT IN MOST COUNTRIES AND IT IS NOW THAT PRINCIPLE IS BEING CONSIDERED BY OUR GOVERNMENT. THIS MEANS IF THAT A PROCEDURE CANNOT BE OFFERED TO EVERYONE WHO NEEDS IT BECAUSE OF RATIONING, THEN IT HAS TO BE FORBIDDEN TO EVERYONE, INCLUDING THOSE THAT ARE PREPARED TO FINANCE IT THEMSELVES. THEREFORE, EVEN THE VERY AFFLUENT IN THIS COUNTRY ARE LOSING ACCESS TO COMPREHENSIVE CARE. WHAT IS PROPER DEFINITION TO ACCESS TO HEALTH CARE? DURING WORLD WAR II WE BECAME AWARE OF WHAT WE NOW CALL THE "FIRST GOLDEN HOUR". WHAT THIS MEANS IS THAT DURING THE FIRST HOUR AFTER A PERSON SUFFERS A CATASTROPHIC EVENT, INJURY, ILLNESS OR ACUTE MEDICAL EMERGENCY, THAT MANY THINGS CAN BE DONE TO SAVE THAT PATIENT'S LIFE AND TO PREVENT DISABILITY. AFTER THAT HOUR THERE IS A SIGNIFICANT DECLINE IN EFFECTIVE MEDICAL CARE.

THE CONGRESS OF THE UNITED STATES IN 1946 SET UP THE HILL BURTON ACT. THEY DECIDED THAT NO HOSPITAL SHOULD BE MORE THAN 40 MILES AWAY FROM ANOTHER HOSPITAL, THEY ALSO DECIDED THAT NO ONE IN THIS COUNTRY SHOULD BE MORE THAN 20 MILES AWAY FROM A MEDICAL FACILITY OR A HOSPITAL. THEY AUTHORIZED FUNDS TO BUILD HOSPITALS AND APPROXIMATELY ONE HALF OF ALL THE 7,000 HOSPITALS THAT WE HAVE IN THIS COUNTRY WERE BUILT DURING THAT PERIOD. OF THE 168 HOSPITALS THAT WE HAVE IN MINNESOTA, 91 WERE BUILT BETWEEN 1950 AND 1973 WITH HILL BURTON FUNDS.

IN 1974 THE NATIONAL HEALTH PLAN AND THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 ESTABLISHED THE HEALTH SERVICE AGENCY CONCEPT AND CERTIFICATE OF NEED PLAN. DURING THAT TIME, CONGRESS DECIDED THAT NO PERSON IN THIS COUNTRY SHOULD LIVE NO MORE THAN 30 MILES FROM A HOSPITAL OR ACUTE MEDICAL CARE FACILITY. ON VARIOUS RURAL HEALTH CARE COMMITTEES THAT I HAVE BEEN ON WE HAVE ALSO DISCUSSED THIS AND HAVE DECIDED THAT NO PERSON IN THIS COUNTRY SHOULD LIVE NO MORE THAN 30 MINUTES WAY FROM A HOSPITAL. IN MY STATE OF MINNESOTA THERE ARE 18,000 PEOPLE WHO BY THIS DEFINITION DO NOT HAVE ACCESS TO ANY HEALTH CARE. THIS IS A RESULT OF MANY HOSPITAL CLOSURES DURING THE LAST 8 YEARS. TWO MORE HOSPITALS RECENTLY CLOSED AND IF THERE IS NO CHANGE IN THE REIMBURSEMENT TO RURAL HOSPITAL IN THIS COUNTRY, MORE HOSPITALS WILL CLOSE AND 19,000 MORE PEOPLE WILL LACK ACCESS TO MEDICAL CARE. IN SOUTH DAKOTA, 14 OF THE 56 HOSPITALS ARE PREDICTED TO HAVE A NET LOSS OF 18.4% OR MORE FOR 1988 FOR TREATING MEDICAL PATIENTS. WHAT THIS MEANS IS THAT FOR EVERY DOLLAR OF EXPENSE THEY HAVE FOR TREATING MEDICARE PATIENTS, THEY ARE ONLY REIMBURSED ONLY 81.6 CENTS OR LESS. EVEN IF THERE WERE NO CUTS IN REIMBURSEMENTS FOR THESE HOSPITALS, IN 1990 14 OUT OF THE 56 HOSPITALS WILL HAVE AN AVERAGE OF 23.6% OPERATING LOSS. THERE HAS BEEN A TREND IN THIS COUNTRY THAT IF A HOSPITAL LOOSES MONEY, 3 OUT OF 4 YEARS THAT THEY EVENTUALLY WILL CLOSE IN ABOUT 3 MORE YEARS. IF THE TRENDS THAT NOW EXIST IN SOUTH DAKOTA CONTINUE, WE CAN EXPECT UP TO 14 HOSPITALS CLOSING IN THE NEXT FOUR OR FIVE YEARS, AGAIN RESULTING IN SIGNIFICANT REDUCTION IN ACCESS TO HEALTH CARE FOR THE PEOPLE THAT LIVE IN THOSE AREAS.

THE SAME SITUATION EXISTS FOR ALL OF RURAL AMERICA. THE BIGGEST PROBLEM THAT RURAL HOSPITALS IN SOUTH DAKOTA HAVE IS THAT THEY ARE NOT REIMBURSED ADEQUATELY BY THE FEDERAL GOVERNMENT. EVERY SENIOR CITIZEN IN SOUTH DAKOTA HAS PAID EXACTLY THE SAME SOCIAL SECURITY TAX AS DO ALL CITIZENS OF THIS COUNTRY. THAT ENTITLES THEM TO PART "A" MEDICARE FOR TREATMENT IN HOSPITALS FOR THEIR ILLNESSES. HOWEVER, ALMOST ALL THE HOSPITALS IN SOUTH DAKOTA AS WELL AS ALL OF RURAL AMERICA ARE REIMBURSED 37% LESS FOR TREATING THE EXACT SAME DISEASE AS DO HOSPITALS IN THE VERY LARGE CITIES. IS IT IMPOSSIBLE FOR OUR RURAL HOSPITALS TO CONTINUE TO KEEP UP TECHNOLOGICALLY WITH THE LARGE CITY HOSPITALS BECAUSE OF THE POOR REIMBURSEMENT. THERE IS ABSOLUTELY NO REASON WHY THE RURAL HOSPITALS SHOULD NOT GET REIMBURSED EXACTLY THE SAME AMOUNT FOR TREATING THE EXACT SAME DISEASES AS DO LARGE CITY HOSPITALS.

ALSO, EVERY SENIOR CITIZEN PAYS EXACTLY THE SAME AMOUNT OF PREMIUM FOR PART "B" MEDICARE WHICH ENTITLES THEM TO OUTPATIENT MEDICAL TREATMENT AND FOR REIMBURSEMENT TO THEIR PHYSICIAN FOR INPATIENT CARE. YET, ALL OF THE SENIOR CITIZENS IN SOUTH DAKOTA RECEIVE REIMBURSEMENT AT ABOUT 1/2 OF THE NATIONAL AVERAGE AND ABOUT 1/4 AS MUCH AS THOSE SENIOR CITIZENS THAT LIVE IN NEW YORK, FLORIDA, CALIFORNIA. THE NET EFFECT OF THIS IS THAT EVERY CITIZEN IN THIS STATE IS EFFECTLY SUBSIDIZING THE MEDICAL HEALTH CARE FOR ALL SENIOR CITIZENS IN THE VERY LARGE CITIES AND COASTAL STATES, AND THIS IS JUST NOT FAIR.

THIS REDUCTION IN REIMBURSEMENT FOR SENIOR CITIZENS AND THEIR HOSPITALS HAS RESULTED IN THE RURAL HEALTH CARE ACCESS PROBLEMS WE ARE NOW HAVING. THIS IS JUST NOT FAIR TO THE SENIOR CITIZENS OF THIS STATE OR FOR ALL OF RURAL AMERICA AND I BELIEVE THAT THE FEDERAL GOVERNMENT IS TREATING THESE SENIOR CITIZENS AS SECOND CLASS CITIZENS BECAUSE OF THIS POLICY THAT HAS EXISTED FOR 25 YEARS. WHILE MANY BILLS ARE BEING CONSIDERED IN CONGRESS TO EQUALIZE REIMBURSEMENT FORMULAS, MOST OF THEM WILL NOT CORRECT THE SITUATION FAST ENOUGH. I WOULD RECOMMEND IMMEDIATE REIMBURSEMENT CHANGES SO THAT HOSPITALS IN RURAL SOUTH DAKOTA ARE REIMBURSED AT THE SAME EXACT LEVEL AS OUR CITY HOSPITALS. ALSO, I WOULD RECOMMEND THAT THE "RESOURCE BASED RELATIVE VALUE STUDY" THAT HAS BEEN RECOMMENDED BY THE PHYSICIAN PAYMENT REVIEW COMMISSION BE ACCEPTED BY CONGRESS AND BE ENACTED IMMEDIATELY RATHER THAN BEING PHASED IN OVER FIVE YEARS OR MORE. AT LEAST DOING THESE TWO THINGS WILL PARTLY CORRECT THIS PROBLEM OF ACCESS.

THE SECOND LARGE PROBLEM THAT WE HAVE IN ACCESS TO HEALTH CARE IS THE UNINSURED. BEFORE WORLD WAR II IT WAS NOT UNUSUAL FOR HOSPITALS AND PHYSICIANS TO CHARGE THE VERY WEALTHY A VERY HIGH CHARGE FOR THEIR HEALTH CARE THAN THEY DID THOSE WHO COULD NOT AFFORD IT. THEREFORE, THERE WAS COST SHIFTING AT THAT TIME, AND IT MADE IT POSSIBLE TO HAVE HEALTH CARE EVEN FOR THOSE WITHOUT INSURANCE AND FOR THOSE WITHOUT THE FINANCIAL ABILITY TO PAY FOR THEIR HEALTH CARE.

NOW BECAUSE WE HAVE THIRD PARTY PAVERS, THE SITUATION IS CHANGING. PHYSICIANS, HOSPITALS AND HEALTH CARE PROVIDERS NOW CANNOT CHARGE DIFFERENT LEVELS TO DIFFERENT PATIENTS. THEREFORE, ALL PATIENTS HAVE TO BE CHARGED EXACTLY THE SAME RATE WITH THE EXCEPTION OF THE FROZEN CHARGES FOR MEDICARE PATIENTS. THEREFORE, EVERYONE NOW IS CHARGED A HIGHER PRICE. SO WHILE MOST PHYSICIANS CONTINUE TO SEE THESE 39 MILLION AMERICANS THAT CANNOT AFFORD INSURANCE, THE AMOUNT THAT WE CHARGE EVERYONE HAS TO BE HIGHER IN ORDER TO SHIFT THE COST OF TREATING THESE PATIENTS WHO DO NOT PAY FOR THEIR CARE.

THIRD PARTY PAVERS, THE FEDERAL GOVERNMENT AND ESPECIALLY BUSINESSES HAVE REALIZED THAT THIS HAS BEEN NECESSARY AND HAVE NOW REJECTED THAT METHOD OF PAYMENT. MANY THEORIES NOW EXIST ON HOW TO CARE FOR THESE PEOPLE, BUT NO ONE HAS FOUND THE MONEY TO DO IT. IT MAY BE THAT COST SHIFTING WHICH DISTRIBUTES THE COST TO EVERY SEGMENT OF AMERICA MAY STILL BE THE FAIREST WAY.

THE THIRD PROBLEM IN ACCESS TO HEALTH CARE IS RATIONING. WHETHER WE LIKE IT OR NOT, THERE HAS ALWAYS BEEN RATIONING IN HEALTH CARE. THE PRESENT SYSTEM TODAY THAT INCLUDES THIRD PARTY PAVERS USE THE PRICE TYPE OF RATIONING. INSURANCE FOR SOME PEOPLE IS SO EXPENSIVE THAT THEY SIMPLY CANNOT AFFORD THE PRICE AND THEREFORE ARE RATIONED OUT OF THE SYSTEM. THERE IS ALSO RATIONING OF PRICES BY USING DEDUCTIBLES AND CO-INSURANCE PAYMENTS BY PATIENTS. THERE IS ALSO RATIONING BY INSURANCE COMPANIES NOT ACCEPTING PATIENTS THAT HAVE A PRE-EXISTING DISEASE.

THERE IS ALSO IMPLICIT RATIONING. THE "DRG" PROGRAM FOR HOSPITALS LIMITS THE AMOUNT OF TIME THE PATIENT CAN SPEND IN THE HOSPITAL FOR A CERTAIN ILLNESS. BECAUSE OF THE SET FEE FOR THIS ILLNESS, THERE MAY BE PROCEDURES THAT COULD BE DONE AND ARE NECESSARY, BUT WHICH CANNOT BE DONE BECAUSE IF PERFORMED, IT RESULTS IN A LOSS OF PROFIT FOR THE HOSPITAL REIMBURSEMENT BASED ONLY ON THE DIAGNOSIS. DRG'S DO NOT TAKE INTO ACCOUNT THE SEVERITY OF ILLNESS AND THE COMFORT OF THE PATIENT AND OTHER HUMAN VARIABLES OF THE ILLNESS. THIS RATIONING BY THE FEDERAL GOVERNMENT IS WITHOUT CONSULTATION WITH THE PATIENT, PHYSICIAN OR THE HOSPITAL. NO RURAL PHYSICIAN OR HOSPITAL IN THIS COUNTRY CAN AFFORD THE SOMETIMES NECESSARY EXPENSIVE PROCEDURES AND EXPENSIVE TREATMENT THAT WOULD BE AVAILABLE IN LARGE CITY HOSPITALS, WHO ARE REIMBURSED 40% MORE. IN SOME CASES ONE PATIENT WITH A SEVERE ILLNESS THAT REQUIRES TREMENDOUS EXPENSES, COULD CAUSE ENOUGH PROBLEMS FOR A RURAL HOSPITAL TO CLOSE, DUE TO THE PRESENT FINANCIAL CLIMATE.

THEN THERE IS EXPLICIT RATIONING WHICH WE ARE SEEING MORE OF ALL THE TIME. THIS IS WHERE HOSPITAL AND PHYSICIANS ARE BEING TOLD WHAT TESTS CAN BE DONE, WHAT PROCEDURES CAN BE DONE AND WHAT MEDICINE CAN BE USED. OREGON HAS RECENTLY PASSED A LAW THAT LIMITS CERTAIN PROCEDURES. IT WILL LIMIT THE AGE AT WHICH CARDIAC TRANSPLANTS, BY-PASS SURGERY, HIP PROSTHESIS AND OTHER ORGAN TRANSPLANTS CAN BE PERFORMED.

EVERYONE IS UNDER THE ASSUMPTION THAT SINCE HEALTH CARE IN THIS COUNTRY CONSUMES 11.4% OF THE GROSS NATIONAL PRODUCT AND THAT IS MORE THAN ANY OTHER COUNTRY IN THE WORLD, AND THAT IS TOO MUCH. PROJECTIONS SHOW THAT BY THE YEAR 2000 THAT WE MAY BE SPENDING AS MUCH AS 14 or 15% OF THE GROSS NATIONAL PRODUCT ON HEALTH CARE. IT MAY BE THAT EVERYONE'S ASSUMPTION IS WRONG. MAYBE WE HAVE TO SPEND MORE THAN THAT FOR HEALTH CARE. IT WILL EVENTUALLY BE UP TO THE AMERICAN PEOPLE WHETHER THEY WANT TO HAVE ACCESS TO HIGH QUALITY HEALTH CARE AT A HIGHER PRICE, OR ACCEPT LACK OF QUALITY AND LACK OF ACCESS AT A LOWER PRICE.

THERE ARE MANY OTHER PROBLEMS THAT EXIST IN OUR COUNTRY. IT IS A FACT THAT WE ALSO SPEND 15% OF OUR GROSS NATIONAL PRODUCT JUST TO FUND OUR NATIONAL DEBT. IF WE DID NOT HAVE THIS NATIONAL DEBT, WE WOULD NOT BE SITTING HERE TODAY. IF WE WOULD BE USING THE MONEY THAT WE ARE SPENDING ON OUR NATIONAL DEBT FOR HEALTH CARE, WE WOULD HAVE TWICE AS MUCH MONEY AS WE NEED TO FUND HEALTH CARE. ALSO MAYBE WE DO NOT HAVE TO CONTINUE TO SPEND 28% OF OUR GROSS NATIONAL PRODUCT FOR NATIONAL DEFENSE. THERE ARE SOME PEOPLE THAT BELIEVE THAT THIS SPENDING IS COMPLETELY OUT OF HAND. I HAVE BEEN TOLD THAT THE MONIES THAT WE WILL NEED TO DEVELOP AN ADDITIONAL AIRCRAFT CARRIER TASK FORCE, INVOLVES MORE MONEY THAN MEDICARE WOULD NEED FOR THE NEXT FIVE YEARS. SOME PEOPLE SAY THAT SIX AIRCRAFT CARRIER TASKS FORCES THAT WE ALREADY HAVE ARE TWICE AS MANY WE NEED ANYWAY.

FINALLY, IF WE ARE GOING TO CONTINUE TO HAVE COMPREHENSIVE, HIGH QUALITY HEALTH CARE, AND IF WE ARE GOING TO MAKE THIS HEALTH CARE AVAILABLE TO ALL CITIZENS IN THIS COUNTRY, THEN WE ARE GOING TO HAVE TO ACCEPT THE FACT THAT IT IS GOING TO COST MORE MONEY. WE ARE THE LAST COUNTRY IN THE WORLD TO HAVE CONTINUED FREEDOM TO CHOOSE OUR HOSPITALS, CHOOSE OUR PATIENTS, AND BE ABLE TO PRACTICE HIGH QUALITY MEDICINE. WHEN A PATIENT COMES TO ME IT IS MY RESPONSIBILITY AND MY DUTY TO DO ABSOLUTELY EVERYTHING THAT IS NECESSARY FOR THE PROPER TREATMENT AND COMFORT OF THAT PATIENT. I HAVE TO BE MY PATIENT'S ADVOCATE AND DO WHAT I THINK IS RIGHT, NO MATTER WHAT THE POLICIES ARE OF THIRD PARTY PAVERS. THE HEALTH AND WELFARE OF MY PATIENTS HAS TO BE MY FIRST CONSIDERATION AND I CANNOT LET ECONOMICS, POLITICS AND RELIGION OR ANY OTHER CIRCUMSTANCE TAKE PREFERENCE. THIS HAS BEEN THE PHILOSOPHY OF ETHICAL PHYSICIANS FROM TIME AND MEMORIAL. I HAVE TAKEN AN OATH TO UPHOLD THIS PHILOSOPHY AND I BELIEVE MOST PHYSICIANS OF THIS COUNTRY HAVE DONE LIKEWISE. IF THE FEDERAL GOVERNMENT CONTINUES THEIR PRESENT ECONOMIC PHILOSOPHY, THEN NOT ONLY WILL WE SEE MORE RATIONING OF CARE, BUT WE WILL ALSO SEE THE FURTHER DETERIORATION OF ACCESS TO AND THE QUALITY OF THAT CARE.

I WANT TO THANK YOU FOR THE OPPORTUNITY TO BRING YOU THIS INFORMATION AND IF YOU HAVE ANY QUESTIONS, WILL DO MY BEST TO ANSWER THEM.

THIS IS MY TESTIMONY FOR THE SENATE SPECIAL COMMITTEE ON AGING FOR AUGUST 7, 1989.

RICHARD D. MULDER, MD
366 EAST GEORGE STREET, P.O. BOX A
IVANHOE, MN 56142

Senator PRESSLER. Thank you very much. What you have said about different levels of reimbursement around the country is a major problem for us from the Midwest. The Senate Rural Health Caucus is working to eliminate the rural/urban differential. We know some of the costs are higher, on paper, in some of the big eastern cities, but the costs here are also high. In fairness, we are trying to equalize some of those reimbursement levels.

Thank you, Dr. Mulder. You have an excellent statement about those concerns. I know of your national reputation in this field, and I thank you very much for being here.

Next I will call on Dr. Stephan Schroeder, a family physician from Miller, SD. Physicians who practice in small towns are a unique group of people, because they take great responsibility.

As I understand it, they are on duty virtually 24 hours a day. If you are a small town practitioner, your patients really depend on you. So often in the bigger cities there is a group working together, and someone is on duty, and the rest are totally off, and so forth. I admire the people who provide these services.

Dr. Schroeder comes to us from Miller, and we thank you very much for being here.

STATEMENT OF STEPHAN SCHROEDER, M.D., MILLER, SD

Dr. SCHROEDER. Thank you very much, Senator Pressler.

I would like to start off by addressing two things. First of all, there is a slight correction. I am not completely in solo practice. I do have partners who have taken the time to cover my practice and allowed me to come here and speak to you today.

The second task is to publicly thank Dr. Mulder for his efforts concerning the statistics that you just heard. My profession as well as you folks owe a debt of gratitude to him. He has taken a lot of time and effort to come up with these statistics. Hopefully they will be used to your advantage in the future.

The availability and quality of health care for the elderly is a subject that is very important to physicians such as myself. An estimated 50 percent of my practice is Medicare age, so you can see that the economic viability of my practice depends greatly upon Medicare payments.

The access to health care depends on available physicians. I understand well that nurses and other allied health care personnel are certainly vital to health care delivery in our State, but I am going to restrict my comments to physicians in small communities.

The recruitment and retention of physicians into rural settings is a complex situation involving a number of factors, such as spousal satisfaction, lifestyle, availability of technology and specialty backup, and not the least of which is reimbursement.

The challenge of rural practice can be rewarding both spiritually and financially. Only recently, the increasing frustration with the "business" of medicine may take its toll on those presently practicing and prospective practitioners in rural communities.

The spiraling costs of health care and the budgetary restrictions of the Medicare system are of concern to all of us, especially physicians. However, the continual effort to limit physician reimburse-

ment may eventually result in limited elderly access to health care.

The well-documented geographic disparity mentioned by Dr. Mulder will no doubt entice physicians to more urban practices. It seems inevitable that an overhaul of the present system is necessary and that present expenditure growth really cannot be tolerated.

In addition to payment inequality, rural physicians face other obstacles which I would like to discuss. One of these is what I term a bureaucratic nightmare of "medically unnecessary" letters. This is correspondence we receive from Medicare carriers that denies payment for certain services that may have been rendered to patients. For instance, if visits are scheduled too frequently, or patients request to be seen too often, payment can be denied for reasons that we, as physicians, have really never seen written down. It's quite a complex and confusing situation that I have yet to understand. But it certainly is a frustrating situation to receive correspondence like that.

Even more alarming to me is the difficulty encountered in obtaining Medicare payment for critical care services which are often rendered at inopportune times to extremely ill individuals. It often requires repeated correspondence to obtain payment for services that are probably a fraction of that which are billed.

As an example, my partner recently received a Medicare payment of \$63 for 2½ hours of acute care rendered at 2 a.m. to a heart attack victim. Certainly a persistent refusal to reimburse legitimate care is going to lead to fewer physicians who are willing to take on such responsibility. When compared to the charges of other professionals, physicians' fees really cannot be deemed excessive, in light of what has gone on there.

In addition to reimbursement problems, I would like to make a comment about the efforts of the peer review organizations. These are organizations that are contracting with the Government to oversee the quality and costs of Medicare care that is being delivered. The problem that it gives to physicians has become quite a dilemma.

Peer review organizations give physicians the responsibility of making the correct diagnosis at the correct time for patients that—at the present time it includes only hospital care—but basically, if a patient is deemed not ill enough for admission, or judged to be too sick at the time of discharge, the physician is reviewed by the peer review organization and left liable for possible sanction if wrongdoing is found.

The problem that we have run into is how does one appease anxious relatives who want their loved one, grandmother, aunt, whatever the case may be, admitted with what may be necessarily minimal symptoms?

On the other hand, how do we appease anxious hospital administrators, such as Mr. Huss, down at the end, who see huge DRG losses when someone with a severe illness is hospitalized for a great length of time?

I am not against PRO's, in fact I am vice president of the board of directors for the State PRO, so don't get me wrong. I am only

bringing them up as an example to show the difficulties that physicians encounter in dealing with the Medicare system.

As far as solutions to the problem, I think first and foremost, our elderly need to be informed and educated about the fact that health care is expensive and funds are limited. They need to understand that expenditure targets, DRG's, and "medically unnecessary" letters are all forms of health care rationing, however you cut it.

These items may well be needed to limit our growing expenditures, but recipients need to realize that they cannot expect limitless, high-technology care, and that Medicare won't pay for all of it. Patients must know that options such as home health care, swingbeds, and nursing home convalescence are alternative solutions to prolonged in-patient care. By the same token, organized medicine and Government bear the burden of delivering this message to our elderly.

Once patients and their families understand the financial situation of the Medicare system, I think we will all be better equipped to deal with the grim realities of economics and medicine. The idea that Medicare is the sole source of health care coverage for the elderly is probably erroneous, and needs correction.

Other solutions may lie in the implementation of a resource-based physician reimbursement system, one that does not have geographic disparity. Certainly safeguards need to be included in the system, so that excessive-balance billing by physicians is eliminated. By the same token we need to avoid inflexible expenditure targeting by the Government, especially in the areas of primary care.

Protection also needs to be afforded to needed rural hospitals by, again, emphasizing equitable reimbursement. These facilities would benefit perhaps by helping transform them into comprehensive health centers that are concerned with more than just in-patient care. I think you will hear more on that from Mr. Huss.

Specifically, rural clinics may be helped by legislation such as that of Public Law 95-210, which is known as the Rural Health Clinic Act. This is a system where health care recipients' care is reimbursed on a cost basis, rather than on a usual fee-for-service basis, and the experience thus far with clinics that employ physicians' assistants has been somewhat favorable, and the expansion of this idea may help rural health care.

Medicare's attempt to save physician payment has focused on such items as frozen fees, maximum allowable charges, and into forcing the acceptance of assignment. This, coupled with the inequitable payments, has reduced income to many physicians in rural areas. At the same time, needed practice items have not decreased or frozen their costs to any extent. Medical goods, malpractice insurance, diagnostic equipment, and pharmaceuticals have all increased prices dramatically.

A physician is prohibited from raising office fees to Medicare patients at the present time. However, at the same time, we are paying individuals such as X-ray machine repairmen fees of \$100 per hour, plus costs and mileage, etc., for items that we have no control over.

Rural health and elderly access to health care are presently popular topics for discussion. Unfortunately, it is going to take more

than talk to reverse the present trend and make family medicine in rural communities a popular choice. Presently, South Dakota could place 30 to 40 family physicians, and likely that many more in another 5 years. A supreme effort will be needed to accomplish that goal.

Continued governmental support for primary residencies and scholarships and loans for health care delivery in rural areas is essential.

I realize that health care reform is going to be a bitter medicine for individuals to swallow. I hope my comments will not be construed as those of a greedy, self-centered physician. I enjoy geriatric medicine, and never have nor will refuse to care for the elderly for any reason. Yet I fear the future because of our general trend. Hopefully our system and its patients can adjust to the change, and keep rural medicine dependent practices well-staffed and functioning in the future.

Thank you.

Senator PRESSLER. Thank you very much, Dr. Schroeder. Your testimony represents the grassroots practitioner in rural America.

Next I will call upon Gerald Huss, a Hospital Administrator at Faulk County Memorial Hospital in Faulkton, SD. The hospital is a small rural facility that provides health care for many older persons in that community, and people of all ages.

**STATEMENT OF GERALD HUSS, HOSPITAL ADMINISTRATOR,
FAULK COUNTY MEMORIAL HOSPITAL, FAULKTON, SD**

Mr. HUSS. Thank you, Senator Pressler, for this opportunity to testify before the hearing from a small hospital's perspective.

Ladies and gentlemen, when a rural hospital closes, the physician leaves. Nurses and other health professionals seek employment outside of the community, or are also forced to leave. Within a short time access to health care could be a big problem, and the people could be forced to drive many miles to seek routine health care, not to mention emergency care.

Limited access to health care affects everyone negatively. But who does it impact the most? The elderly and the poor, those who need it and use it the most, those who don't drive, those who can't afford an automobile, those who find it difficult to travel, those who must rely on others, and those, for some of the aforementioned reasons, simply put off seeking routine health care until they have a major health problem.

Hospitals not only provide the health care necessary for quality life in rural America, but also contribute a great deal to the economic survival of the community they are located in. The hospital is one of the largest employers, and one of the biggest industries in their community. Total annual expenditures of all hospitals in South Dakota is over \$370 million. They employ some 11,000 full- and part-time personnel, and are the second leading employer in the State.

Hospitals should be viewed not only for their contribution toward health care and quality life, but also from an economic development viewpoint.

The paramount problem is to not let hospitals close in a haphazard manner, but to identify and ensure the continuation of all strategically located rural hospitals, and have a planned transition for those other hospitals that may close. If any rural hospitals must close, there should be an orderly and well-planned transition to an alternative that would ensure that the professional, technical, and transportation components of health care will remain within that community which will guarantee access to primary health care.

In an effort to maintain access to rural health care, legislators must not only introduce and sponsor, but must champion legislation that would mandate that the Federal Government establish and provide for the following: eliminate the urban/rural payment differential; an optional cost-based reimbursement system for rural hospitals of 50 beds or less; a hardship fund for hospitals of 50 beds or less who are essential to their community and who have a high percentage of Medicare admissions, lose a physician or have a negative operating margin from Medicare patients; ensure adequate payment for outpatient medical services; expand the National Health Service Corps and increase Federal subsidies for physician extenders and nursing education; give additional special consideration and financial assistance to those who qualify as sole community provider hospitals; identify and ensure continuation of all strategically located rural hospitals; and define and ensure an orderly and well-planned transition for those other hospitals that may close.

It is an uphill battle for rural hospitals of 50 beds or less because the Medicare reimbursement system is simply not fair, and will result in many hospitals of this size closing. When a hospital closes, it strangles the economic life out of the community. It negatively impacts upon the quality of life, and ultimately inflicts fear and despair into the lives of those who remain.

All too many small and rural hospitals have already closed, and many more are in a critical stage and very near closing. Action must be taken to ensure that all strategically located rural hospitals continue to be open to provide quality health care and to ensure that the people who choose to live in rural America have access to a hospital, and are not forced to drive by a closed hospital to seek health care.

Senator PRESSLER. Thank you. That was one of the most precise presentations I have ever heard. I am working with my colleagues in South Dakota and other rural States on several of the items that you focused on, hardship funds for hospitals with 50 beds or less, the concept of an optional cost-based reimbursement system for rural hospitals of 50 beds or less. There are a number of things, such as your recommendation to expand the National Health Service Corps, to increase the Federal subsidy for physician and nursing education—that we will have to face up to. I think that your eight specific, concise recommendations are very, very useful, and I will certainly carry them back to the committee.

Next I am going to call on Ray Hopponen, the former Dean of the College of Pharmacy at South Dakota State University. He is a pharmacist. Recently, the Senate Aging Committee held a hearing on the price of prescription drugs.

I have read Ray's prepared statement and it is excellent. I am really pleased that he travelled all the way from Burke to be here today to share some of his views with us.

STATEMENT OF RAY HOPPONEN, PHARMACIST

Mr. HOPPONEN. Thank you, Senator Pressler.

Ladies and gentlemen, I would like to give you a little background of my own, first, so that you will understand where I am coming from.

I retired from the Deanship of the College of Pharmacy 3 years ago, and since that time I have been practicing as a relief pharmacist. This is a pharmacist who comes in and spends 1 day or a couple of days a week in the pharmacy so that the regular pharmacist has some time off, and fills in during vacations, also.

During these 3 years, I have worked in five different pharmacies, so I have had experience in seeing what goes on in more than one pharmacy. On the basis of that experience, I have become increasingly irritated with the way that prescription drug costs to the pharmacist have continued to escalate over the past several years.

This is a major concern to many South Dakota pharmacists, because we are the ones that have to face the consumer when the prescription price is increased, or when the price seems outlandishly high.

The Bureau of Labor Statistics show that the costs to the pharmacists during 1988 went up by 8 percent. In the preceding 3 years, they increased from 9 to 10 percent each year and prior to that, the increase was in the double digits. Now, this is more than twice the inflation rate of 4.5 percent. So there is something wrong there.

Prescription drug prices for early 1989 were up by 6.9 percent over the same period last year, and 17 major drug costs rose by an average of 8.9 percent. So again, we are exceeding the inflation rate in the way that the costs to the pharmacist of prescription drugs are going up.

The Lilly Digest is an analysis that is made of drug store operating statements each year by the Eli Lilly Co. Pharmacists send in their operating statements and about 1,500 to 2,000 pharmacists do this each year. The company analyzes them to see how their operations are going and how they compare with what happened the previous year. During 1988 pharmacy sales of these drug stores went up by 12.1 percent. However, the gross margins dropped by about one-half percent in 1988.

The cost of goods that pharmacists pay for increased by 13 percent. So you can see that there is a squeeze between his costs and his profits going on. His profits held steady at 3.3 percent, which is the same as it was in previous years, in spite of the fact that sales were up by 12.1 percent.

The decay in gross margins has been going on for 15 years. That indicates that the manufacturers' cost increases are not being passed on completely to the consumer, but the pharmacist is absorbing part of those increases. In October 1988, I started keeping track for myself of price increases in one of the stores that I worked in, because I was checking in drugs and placing them on

the shelf, and I was noting these price differences in the cost to us.

During this time, up until this past week, I recorded 121 price changes. Three of those were decreases of 4, 4, and 19 percent, respectively. The other 118 were increases that ranged from 4 percent to 48 percent, for an average of 11.95 percent. So the pharmacist was paying that much more for the prescription drugs that he uses to fill your prescriptions. Six of those drugs increased twice in 1 year.

One South Dakota pharmacist that I talked to dug out his computer records and showed me that his prescription prices increased by \$1 per year in the last 4 years. His prices went up from \$13 plus to \$17 plus. But his percentage of increase went down from 7.6 to 7.1, to 6.6 to 6.25 percent, showing that he was absorbing part of this cost that the manufacturer was charging him.

My own experience here is that when we get a cost increase, we tend to pass on to the patient the dollar increase only. We don't increase the percentage. Consequently, the amount that the pharmacist gets as a percentage of that prescription slowly shrinks.

A major concern of pharmacists—and I have spoken to a number of them about this, is one we believe is contributing to this increase in drug costs to the pharmacists—is what is termed differential pricing. This is a system that is followed by most of the pharmaceutical manufacturers in the United States. That is, they will charge different prices to different groups.

For example, a hospital will get a different price than a Main Street pharmacist. An HMO, or a doctor's clinic will get a different price than the pharmacy on Main Street gets. These prices are usually less than what the pharmacist pays. In fact, some mail order pharmacies can fill prescriptions for less than what it costs the Main Street pharmacist to buy that drug for use in his pharmacy.

Another thing that is creating some problems regarding mail order pharmacy is that patients will, because it is a long way away from the pharmacy that they deal with—in some cases it's 30 or 40 miles in our area since we serve a number of small towns in northwestern Nebraska—and in order to save money on their prescriptions they will use mail order pharmacies.

There is a problem there in that the service is not always the best, and patients sometimes forget to order soon enough and they run out. I have had on several occasions patients come to me with containers from mail order pharmacies asking that I provide them with some drug to carry them over until they can get their prescriptions from the mail order pharmacy.

These mail order pharmacies are a big problem in that the patient does not get as good service as he does from his local pharmacy. He doesn't get to talk to the pharmacist. The pharmacist does not get a chance to oversee the medications and check to make sure for example that he is getting his blood checked by the physician if he is taking coumadin, which is a blood thinner, or that he continues to take his medication regularly, or that he is not changing the dosage. This is impossible from the mail order pharmacy. That's a bit of a problem, I think, of health care in general.

I have noticed one other thing that is a bit of a problem, that is probably attributable to the patient's conception that prescription

prices are high. I personally feel that they are high, higher than they should be. There is a growing tendency among older patients on chronic care medications to try to cut down on the costs.

They do this in three ways. One is that they may extend the dosage schedule. Instead of taking one tablet a day, they will take one every other day, trying to stretch out their prescriptions, so that they can save a little money. Or, they will use one-half a tablet instead of a whole tablet when the directions call for one. Or, they may use it only when they feel that they need to. This is especially bad, because many medications that are used for chronic illnesses must be taken on a regular basis.

The evidence I have for this sort of thing happening is that the time period is extended between refills. Instead of getting a prescription every 30 days when the patient should be using one tablet a day, it might be 60 or 70 or 80 days before they get it refilled again, indicating that they are not taking their medication the way they should. Sometimes it is evidenced by the patient asking for only half the number of tablets that they should be getting.

In general, I think that the level of pharmacy services being provided in South Dakota is quite good. I am quite pleased with the drug distribution system that we have. We can get drugs from a wholesaler in 1 or 2 days, so that there is no place in the State that does not have access to all pharmaceuticals.

But these continually escalating acquisition costs that the pharmacist has to pay are creating a real price squeeze on the rural pharmacist, whose own margins are being squeezed and it is becoming more and more difficult for him to stay in practice.

The loss of any rural pharmacy will lead to a significant loss to a community. Not only has there been a loss of a source of prescription drugs, and over-the-counter medications, but there is the loss of an individual who is able to provide advice and information to the community at large and we do provide a lot of that advice to people who come in and ask about their prescription drugs, or ask about over-the-counter drugs or other medications.

Thank you.

Senator PRESSLER. Thank you very much, Ray. I think your two-page statement is an excellent summary of the issues of prescription drugs costs. In fact, one thing that I learned—and I'm never ashamed to say that I learn something new every day in these hearings, that's what they're for—is that some health insurance plans require employees to utilize mail order pharmacies for long-term medications. I did not know that about this arrangement and would like to learn more about it.

I think this is one reason why field hearings are good—they get us out of Washington. We learn about other issues that affect the delivery of services and the lives of people. I thank you very much.

Next I call on Wayne Muth. Wayne is vice president of long-term care for the Presentation Health System. Wayne provides guidance to Brady Memorial Nursing Home in Mitchell, Mother Joseph Manor in Aberdeen, and Prince of Peace Retirement Center in Sioux Falls.

STATEMENT OF WAYNE MUTH, VICE PRESIDENT OF LONG-TERM CARE FOR PRESENTATION HEALTH SYSTEMS

Mr. MUTH. Senator Pressler, I want to express my appreciation to you for bringing this type of hearing to our State. Many of us would not have this opportunity if we were not located right here.

The long-term care facilities that are operated by the Presentation Health System offer a wide range of service to the elderly. I want to concentrate my remarks on those services that deal with the in-patient nursing care. I took a quick count here, and this may not be accurate, but I would say we have about 160 or 170 people in the room. Do we have anyone here that is a resident of a nursing home?

I will refer to that a little bit later. The people that are residents of nursing homes are called many things, the "frail elderly," the "old old," the "ill elderly." Whatever title we may use to identify them, I think we need to understand that there are several characteristics of this group.

They are both old and in poor health. The average age of the individuals in our nursing homes is 86. Their care requirements have increased as they have been discharged earlier from hospitals, one of the results of DRG, which was mentioned by one of the earlier speakers.

They have a wide range of physical ailments. Many of them, a very high percentage, also suffer from Alzheimer's disease, or related dementia. They are definitely a minority group, representing a small percentage of the elderly population, less than 5 percent of those over the age of 65.

Most of us will never use the services of an in-patient nursing home, but I believe we have the responsibility to provide for those who will. I believe that the laws and public policy that exist are passed primarily for the weak, and the politically weak, especially. I think our society has always tried to protect the rights of minority groups. We have not always succeeded, but I think the advocacy has always been there.

I believe the frail and elderly nursing home patients represent the most oppressed minority group in our society today. They have no effective advocate. They are not represented at this very important hearing today, and if my count is correct, we should have at least eight nursing home residents with us today to represent that portion of the population over 65.

As an administrator in long-term care, I am involved in many things. I have been an administrator for 23 years. The environment has changed. It has intensified in many areas. I have found in my work an environment that has been weighted down with surveys, reports, documentation, deficiencies, plans of correction, and so forth and so on.

I have also found frail, oppressed, and rejected people. I have found loving relationships. I have found confused and frustrated families, mistrust between providers and regulators, and national policy that sometimes seems to want the provider and the regulators to be adversaries.

I have found staff who feel overworked, underpaid, and many times unappreciated by society. I believe in many ways, they too have become an oppressed minority group in our society.

We are honestly trying to develop public policy to make us all feel better about the aging process. We think that is one of the reasons that we have OBRA 1987—the Omnibus Budget Reconciliation Act of 1987—which is nursing home reform.

I am going to try to place some things on the table today that perhaps would not get there if I were not here. We need to make some basic directional changes very soon. I think we definitely have a crisis in in-patient long-term care today because our direction is off the mark, and also because our resources are not limitless. We have heard that already this afternoon, too.

We hear basically two things in our public policy direction today, quality must be improved—OBRA—and the Federal deficit precludes infusion of resources. I think we are in “fix-it” mode regarding nursing home reform. I don’t know if we will be able to, or whether we are going to be willing to pay for fixing it, and if we are not, it will not be fixed.

Sanctions are provided and can be applied, deficiencies can be issued, facilities can be decertified, but those actions will not fix the situation. I think we all like to fix whatever might be hurting us. That’s our nature—that’s our society’s human nature. I think one of the things that we are trying to do through public policy is to also help us fix our feeling about the aging process. Unfortunately, Senator Pressler and all the other people in Washington cannot fix many aspects of the aging process. We need, as a society, to start to cross over into accepting some of the realities of aging and of death, and I think public policy needs to help us do that.

A message that public policy does send us and one that is heard very well, especially by the people working in nursing homes, is that the poor elderly are not worth very much. That message is heard very loud and clear by the people working closest to the residents, those that provide the most hands-on care, the nursing assistants, housekeepers, dietary aides, etc.

Our public policy says to them that their work is not worth much, minimum wage, or slightly higher is what their worth is, and our public policy can’t even determine what that minimum wage should be. The public policy says “not worth much” but I think our public and you and I expect a great deal. We expect high quality, but in many ways we don’t want to pay for it.

Much has been said about access, and I would like to concentrate a little bit on that. Public policy has established layers of activities to help the poor and elderly. One of those layers is preadmission assessments that have been created to help people make the correct decision, and hopefully keep them out of the nursing home.

What it does in many ways is to make the obvious decision for that family, for that home unit, that much harder to make, and in the process increases the cost to society. In many ways the process disregards the family physician, and it substitutes Government bureaucracy.

Access to good health care is something that is important to all of us, but in many ways our public policy throws roadblocks in front of some very hurting people. Public policy says that we will

mandate quality and maintain budget neutrality. I think that's the message that I hear most often, and unfortunately many of us have started to believe that message. We can have quality, but we must be ready and willing to pay for it.

I think we must come to understand that our human resources are disappearing fast in a State like South Dakota. Do we really think that we can continue to convince enough people to work in our facility at a job that is very difficult, many times unappreciated, full of frustration, and then to do so at a wage below what others receive?

The reality is that we should not and cannot expect that. They won't continue to do this very important job, they won't continue to shoulder the burdens of our society. And we shouldn't expect them to.

Affordable nursing home care is something we all want, and one of the items that we wanted to talk about today. Usually, this might mean that what we have now is not affordable. I understand the concerns of people when it comes to the cost of nursing home care. I want to put another message out in front of us today, though, the fact that what we have for skilled, in-patient nursing care may be considered a bargain in our society, rather than too costly, too expensive, not affordable.

The highest Medicaid rate in South Dakota as of July 1 for a free-standing nursing facility was \$51.79 per day. That is the most any facility could expect from the Medicaid program for total care for some very dependent people, people who cannot do many of the things that you and I take for granted every day, that has to be done by somebody else. The staff of that nursing home is that somebody else.

Private rates range anywhere from \$30 to \$70 a day, depending on the amount of care, and the services that are delivered. Now what do you compare that with? It's rather difficult, but I know that there are many expenses that you and I have. Most of us have stayed in a motel, we know what that costs, we have eaten in restaurants, we know what those costs are. Some of us go to a laundromat once in a while to do our laundry, we know what those costs are, we may hire someone to do yard work, we may even have a housekeeper come in.

We probably have never hired an R.N. to come in, we haven't hired a dietitian or a therapist, or someone working in pastoral care, a social worker or a lot of other things that are provided for in those per-day costs in a nursing home. When we start adding all these costs up, I am convinced—and I am through being defensive or apologetic about the daily costs of a nursing home—I truly believe that our society needs to start to recognize that.

Nursing home care may not be affordable for each individual, and I certainly understand that. I do believe that it is the affordable solution for many of our society's problems, that we through our public policy debate and decisions, need to find those ways that we can best do that.

I would like to list some things that I think need to be considered as we develop that public policy. I think we need to utilize case mix reimbursement to assure adequate payment for services required by the "frail elderly." Remember that definition of a frail elderly

person, that's what I am talking about here. I am not talking about the vast majority of those of us that are at or near 65.

We need to fully recognize the cost impact of regulations and provide the resources to pay for them, or else relax the regulations. We need to acknowledge that in-patient nursing care is the appropriate cost-effective service program for the frail elderly. We need to recognize the importance of the family physician and other health care provider professionals, and encourage their participation in serving the frail elderly.

We need to assist families and other decisionmakers in utilizing the resources available. We need to recognize and reward the important work accomplished by the nursing home staff. We need to help society deal with the reality of the aging process, and we need to foster a better understanding and respect between providers of services and Government and consumer groups. We need more than simply adding more regulations to the nursing home industry, which is already the most heavily regulated part of our society.

It won't be easy. I think a lot of the people that need to help in that process are in this room, including our own Senator Pressler, and I am happy to be here.

Senator PRESSLER. Thank you very much, Wayne.

We next call on Gail Ferris. Before calling on her a couple of people asked me about notch. So let me say what we are going to do about it. We have been struggling. My mother from Humboldt, SD, is a notch baby. We have co-sponsored legislation to resolve the notch problem. It has not moved through the Finance Committee. There is a very strong feeling that the agreement of 1977 should remain as is to protect the fiscal integrity of the Social Security Trust Fund. Since that Trust Fund has a surplus, Senator Sanford and I have sponsored a bill to give the notch babies some adjustment. We think we are going to be able to pass that, although I will not promise anything. We are struggling with it.

There is great resistance to do anything that would open up the 1977 amendments that were agreed upon. But I want to say that I am well aware of notch, that I hear about it all the time, and I am co-sponsoring legislation to correct the notch problem. In fact, some people have criticized me for sponsoring the compromise bill.

Gail Ferris is the Director of the State Program on Adult and Aging Services. Gail directs programs throughout the State that assist seniors in living a quality life. She is one of our last three speakers. If they can each give us about 5 minutes of substance and then we will go into questions and answers.

STATEMENT OF GAIL FERRIS, DIRECTOR OF STATE PROGRAM ON ADULT SERVICES AND AGING, SOUTH DAKOTA

Ms. FERRIS. Thank you, Senator Pressler.

The Office of Adult Services and Aging is the same agency that is responsible for administering the Older American program and other programs that are intended to serve the elderly throughout the State. We appreciate this opportunity to provide testimony here since we have an obligation to be an effective and visible advocate for older South Dakotans.

I would like to give you just a little bit of background about the Office of Adult Services and Aging. We are a part of the Department of Social Services. We provide services to persons over the age of 60 through a couple of different networks.

One of those is a network of social workers. Many of you may know the social workers here in the Aberdeen area. Statewide we have about 60 social workers who provide services in case management, we have a network of homemakers that are also providing services. We have homemaker supervisors, and we have homemakers, we have people out there who are providing services in respite care, and adult foster care, and then over here—that's just very brief, but over on the other side we have a network of grantees who, through Older Americans Act moneys, provide nutritional programs for the elderly, transportation services, adult day care, we do a little bit of senior center renovation. So that gives you just a very brief picture of what we do within the Office of Adult Services and Aging.

Our group is here today to provide testimony about issues of long-term care. We are taking a wide-angle approach to the total needs of the elderly in terms of alternative services and access to those services. Now, in order to get a good picture of the total needs of the elderly, I would like for you to envision in your mind a continuum, think of long-term care as a continuum, beginning at one end is independence, and moving along to the other end, dependence, or institutionalization.

Out of necessity in South Dakota, the scarce resources that we have are targeted primarily to serve those at the most dependent extreme of the continuum, and that is the frail and vulnerable, the institutionalized elderly. Once individuals reach this point, this dependent-most point, they need a very intensive and very expensive level of care.

Over 50 percent of those residing in nursing homes in South Dakota must rely on Government funds to provide their care. This is not only burdensome for an already debt-ridden society, but it strips elderly people of more than their resources, it strips them of their dignity.

Early intervention is critical at this end of the continuum. Early intervention is critical in order to slow down their progression along this continuum of need. Early intervention can delay deterioration of one's mental or physical condition to the point of requiring institutional care.

Early intervention begins at the opposite end of the continuum with education and participation in preventive programs and supportive services. Let's take a look at an ideal continuum of care.

Some of these kinds of services we have in South Dakota, and others we do not. But if we start down here at this end of the continuum we look at things that are available for older people who are still very independent. There are educational programs for patients and family members to provide education on health and social problems, and among those is retirement planning.

We have started to do some retirement planning seminars and are working with AARP and through other community organizations. Also, at this end of the continuum are wellness programs, exercise programs, smoking cessation, all those kinds of things to

help keep people well. There are recreation and socialization things that happen at senior centers.

Independently, older people embark on travel. There are also humanities. We have a program in our office called Senior Olympics. I understand that there was the first Senior Olympics here in Aberdeen just a week or so ago, one of the hottest days of the year, I believe. We have a Statewide Senior Olympics that is the first week of September.

There are also continuing education programs, things like elder-hostels, senior volunteer programs. Aberdeen has a very active RSVP program to keep people involved in their communities.

Moving along this continuum, then, from total independence to where you have a certain amount of needs here, there are certain things available in the community. Things like housing, where older people can live together in a congregate living facility, for example, where a certain number of services may be available, maybe a meals program, or a transportation program, or a nurse who comes in from time to time, or a system of an emergency response, with call lights in their rooms, or whatever. Those kinds of things are available through housing.

There are adult foster homes, there are all kinds of shared living arrangements. Here again, I am talking about an ideal—these things may or may not yet exist in South Dakota.

Moving further along the continuum then, there are outreach and linkage kinds of services with health screening, blood pressure screening, cholesterol testing, those kinds of things take place in senior centers.

There is transportation. I would like to digress just for a moment and talk in a little more detail about transportation services for the elderly in South Dakota. One of the things that we use Older Americans' money for in this State is transportation for the elderly. Now, we have used all of the money that we have available for this particular purpose. We have no way that we can expand right now.

We have services in about 24 different projects statewide, and based in about 190 different communities throughout the State. That may mean that they get services every day of the week, or in some communities, they may get services once a month. We feel like we have coordinated very well with the Department of Transportation. They have a certain pot of money that they use for this thing as well.

We try to maximize resources by combining our funds. We use money from our office to match the money from the Department of Transportation. We have worked together in purchasing vehicles. We have coordinated together in purchasing vehicles. We have coordinated things from an administrative standpoint to where we do joint training sessions for drivers and managers, we do joint applications, joint assessments, and in some cases we have done joint audits of these particular programs, so we feel like we have coordinated as much as we can with these two particular resources to maximum services available to the elderly.

It seems though, there is only one way to get more transportation services for the elderly, to either expand services to more communities, or to make services available more frequently, and that

is, we need more money. We feel like we have reached the maximum with what we have available there in transportation.

Other community resources that are available are the congregate meals program. There are support groups, I mentioned adult day care, and in-home services. We move on along the continuum to in-home services where we have home-delivered meals, we have things like friendly visitor programs, telephone reassurance programs, and the homemaker program that I mentioned just briefly. There is personal care, emergency response systems, respite care, home health, and hospice care.

When we get further down here to the end we have institutional care. We have supervised personal care, intermediate care facilities, skilled nursing facilities, and hospitals.

Now in an ideal system of long-term care, care starts early. The system should help prepare older persons and their families for what lies ahead and link them to services that will help maintain independence.

As I mentioned earlier, the amount of financing for institutional care versus alternative care is highly disproportionate. In South Dakota, the ratio of dollars available is approximately 1 to 6—alternative versus institutional care. In South Dakota about 8 percent of those over the age of 60 reside in nursing homes. As one lives longer, of course, the chances of one day living in a nursing home climb to approximately 33 percent of those over age 85.

In order to balance the resources allocated to institutions versus alternatives and slow the growth of numbers entering nursing homes prematurely, South Dakota instituted a preadmission assessment process last July 1, 1988. The purpose of this assessment is to inform the elderly and their families of community services and the alternatives that are available, and of other options and help them to determine the appropriateness of institutional care.

In order to implement this whole big picture of long-term care, which involves skyrocketing health care costs, and as we know, a booming elderly population, more dollars must be earmarked for preventive and alternative services.

Thank You.

[The prepared statement of Ms. Ferris follows:]

WRITTEN TESTIMONY

by

Geil Ferris, Program Administrator
 Adult Services and Aging
 700 Governors Drive
 Pierre, South Dakota 57501-2291

The Office of Adult Services and Aging is the state agency in South Dakota responsible for the administration of Older Americans Act programs in our state. We appreciate the opportunity to provide testimony at this public hearing since we have an obligation to be an effective and visible advocate for older South Dakotans.

Our purpose today is to provide some testimony regarding issues in long term care, but taking a "wide angle" approach, looking more at total needs of the elderly in terms of alternatives and access to those services. In order to get a good picture of the total needs of older people, we need to look at the system of long term care as a continuum ranging from independence to total dependence.

Out of necessity, scarce resources are targeted primarily to serve those at the dependent - most extreme of the continuum - the frail and vulnerable, and the institutionalized elderly. Once individuals reach this point in the system, they need a very intense level of care - - and a very expensive level of care. Over 50% of those residing in nursing homes in South Dakota must rely on government funds to provide their care. This is not only burdensome for an already debt-ridden society, but it strips older people of more than their resources - - their dignity as well.

Early intervention is critical in order to slow down the progression along the continuum of need. Early intervention can delay deterioration of one's mental or physical condition to the point of requiring institutional care. Early intervention begins at the opposite end of the continuum, long before there is a crisis with education and participation in preventive programs and supportive services.

Let's look at an ideal continuum of care and the various levels of programs and services that appear along that continuum.

Independence.

- . Educational programs for patients, families and community members to provide information on health or social problems. Retirement planning courses.

- . Wellness programs - exercise programs, smoking cessation, weight reduction programs, nutrition education, health maintenance, stress management.

. Recreation/Socialization -- activities at senior centers, travel, arts and humanities programs, Senior Olympics, continuing education (elderhostels).

. Volunteer Programs -- recruit and involve older people to remain active, contributing members of the community.

The following will delineate a wide variety of resources and supportive services that, when available, provide continuous care as health conditions decline and needs increase:

Community Resources

Housing

- . Continuing Care Retirement Communities
- . Senior Housing
- . Congregate Care facilities
- . Adult Foster Homes
- . Shared Living Arrangements

Outreach and Linkage

- . Health Screening e.g. blood pressure, cholesterol testing.
- . Information and Referral - may be done through senior centers, Social Services.
- . Transportation

Congregate Meals -- fosters socialization, nutritious meals, happier, healthier lifestyles.

Support Groups -- education and support for victims of disease and/or their families and their caregivers.

Adult Day Care

- . Social models concentrate on socialization and supervision.
- . Medical models provide care for those with more severe physical impairment.

In-Home Services

- . Home-delivered meals
- . Friendly Visitor programs provide companionship to those who are homebound.
- . Telephone Reassurance - provides a checkup, monitoring service.
- . Homemaker Services
- . Personal Care
- . Emergency Response Systems
- . Respite Care
- . Home Health - nursing/medical care, therapy
- . Hospice

Institutional Care

- . Supervised Personal Care
- . Intermediate Care Facilities
- . Skilled Nursing Facilities
- . Hospitals

In an ideal system of long term care, care starts early. The system should help prepare older persons and their families for what lies ahead and link them to services that will help maintain independence.

As mentioned earlier the amount of financing for institutional care vs. alternative services is highly disproportionate. The ratio of dollars available is approximately _____.

In order to impact the LIC picture of the future -- skyrocketing health care costs and an aging population -- more dollars must be earmarked for preventative and alternative services.

In South Dakota, about 82% of those over the age of 60 reside in nursing homes. As one lives longer, of course the chances of one day living in a nursing home climb to approximately 33% of those over 85.

For those who wish to plan wisely their financial future and make provisions for the day they may have to live in a nursing home, there is the availability of long term care insurance.

A short time ago, Congress passed the Medicare Catastrophic Coverage Act of 1988. This Act improved the package of services under Medicare, but created a further awareness that nursing home expenses represent catastrophic costs to many elderly. During the past several years, states have often felt that private insurance companies could ease the expense of nursing home stays.

At the state level, much has been accomplished to promote and develop private resources to assist in payments for nursing home care. In April of 1986, Governor Janklow issued Executive Order 86-05 establishing a multi-disciplinary task force on long term care. This task force issued a report recommending the development of minimum standards for long term care insurance. This task force goal was realized in 1989 and now we have a complete chapter of the South Dakota code exclusively addressing long-term care insurance. Currently, the South Dakota Division of Insurance is working on a package of administrative rules to implement the new law.

With this progress, it is somewhat alarming to note efforts at the federal level to establish federal standards for long term care insurance policies. In most instances, where federal model standards are developed there is an expectation that states will conform to the federal requirements.

With the enactment of SDCL 58-17B, South Dakota recognizes the need to balance consumer and industry interests. We believe that states are in the best position to determine the nature and scope of this balance.

What is needed is an emphasis on education rather than intense regulation. A recent study by the Health Care Education Associates determined that there is a general lack of knowledge about long term care insurance. According to the study, 50% of hospital social workers either overestimated or underestimated the risk of needing long term care. About 23% overestimated or underestimated the annual cost of nursing home care. Nearly 20% incorrectly believed that long term care costs are fully paid by Medicare or Medicaid. Most have difficulty with questions dealing with the scope, cost and benefits of long term care insurance policies.

If hospital social workers are unable to correctly respond to questions about long term care, we can assume that many elderly are confused about the nature and intent of nursing home insurance.

Senator PRESSLER. Thank you very much, Gail. Both you and Wayne raised excellent points on nursing homes. I always tell people that even if you don't have a relative in a nursing home, we ought to have an interest in them, because we might end up in one some day, and it is something that we should think about.

Next we have Peg Lamont, who is very active in our State. Peg Lamont, a resident of Aberdeen, is one of my best friends and a former State legislator. She is well known for her work in the field of aging. In June of this year the National Association of State Units on Aging awarded Peg Lamont the Louise Gerrard Award for her work with rural elderly. In addition, Peg is a member of the Federal Council on Aging. The Council advises the President and Congress on the needs of the aged. I know she was a member of the White House Conference on Aging, probably no South Dakotan has done more work and continues to do more work with the elderly. She is also a person that I call when some of these bills come up.

Peg, we'd like to hear from you.

She went to the airport? She will be back, how about that?

Then we will call on Lucille Stafford. Lucille is from Ipswich, SD. She was my senior intern this summer. You haven't gone to the airport, have you, Lucille? Where are you? Right there. There you are, yes indeed.

Lucille comes here with a sense of community pride. Every year since I have been in the Congress and the Senate I have had a senior intern come to Washington. They come to Washington for about a week, and attend seminars on legislation that is pertinent to senior citizens. They return to the State and make speeches and give advice to our entire Congressional delegation and the Governor, and anybody else on some of the issues.

This is their program and it has been very successful. I know some of you here have applied for the program, but we can only take one a year into this group of legislative interns who do come.

Lucille did that this year. She has given some fine speeches. Lucille, I will call upon you at this time.

STATEMENT OF LUCILLE STAFFORD, IPSWICH, SD

Ms. STAFFORD. When I went to school I learned that they always saved the best for last, so I guess it is a good thing that Peg Lamont isn't here right now.

We all know that there is no fountain of youth. There is no way we can turn back the pages of time nor stop the aging process. That process begins the moment we're born, but medical science has made tremendous strides in its effort to slow down this natural phenomena and the life span of people has been extended and in turn multiplies the problems of our aging society.

Now according to statistics published just last week, the percentage of Americans 65 years and older has tripled since 1900. From 4.1 percent of population to 12.1 percent in 1986 and in 1986 there were over five times as many widows as widowers. There's a saying, "man's work is from sun to sun and woman's work is never done." Is that why women live longer?

There are four areas that I want to touch on and of course some of these have already been—I can relate to them and I must say that my first one is about our rural hospitals. If it hadn't been for our rural hospital that was opened in 1947, I wouldn't be standing here today.

My temperature shot up to 106 in the middle of the winter. If they had taken me to Aberdeen, I never would have made it. Our hospital in Ipswich closed over a year ago for the lack of a doctor. Government rules and regulations were basically some of the factors that contributed to its closure.

Not too many years ago this facility was enlarged and remodeled. It's a beautiful facility, but it's standing empty and hopes of it ever opening again are dashed. It opened up for a short time in March of this year when Dr. Photos came from Chicago, but it was not approved by Medicare for just a few simple, petty reasons.

And the horrendous costs of malpractice insurance and the lack of cultural activities in a rural area certainly doesn't attract doctors and their families. State and Federal governments do not permit a hospital to operate by itself like it used to years ago. The major concern for Ipswich right now is whether the clinic will be able to be saved in order that we still may have some form of physician services so that accident victims or the seriously ill can be stabilized for transport to the nearest hospital which is over 20 miles away.

And I can truly relate to that. My husband had to be taken by ambulance to the hospital last summer after our hospital closed and it was a draw between Aberdeen and Bowdle and that was over 40 miles away.

We do have two doctors in Edmunds County. Dr. McFee is at the Bowdle Hospital with clinic services in Roscoe, and Dr. Basil Photos is at the Ipswich Clinic but I understand that he may be leaving because of the fact that there is no hospital. They both give "in-house" service to the Ipswich Colonial Manor.

There is also a need in our area for more qualified E.M.T. personnel to administer first aid in emergencies. A nurse practitioner could help but that requires a nurse with a 4-year nursing degree and additional training, and due to so many controls this isn't very realistic. Additional training would take her out and away from her family as she would have to go to either Brookings or Vermillion.

Training closer to home could alter that situation. Someone mentioned to me that we should insist that children be put into car seats and that there should be a program mandatory like the "Just Say No" to drugs, otherwise many of our children will never live to be senior citizens like we are.

Now, the second issue that I want to touch on is the dollar sign. They have already mentioned that rural hospitals are not reimbursed percentage-wise as the urban hospitals. Guidelines set by Medicare are not always applicable for all areas. What may seem right for one is not adequate for another.

Ipswich has a population of about 1,150 and many are retirees and senior citizens. Since our area is almost 100 percent agricultural, those who retired and moved into town are now subsisting on a minimum Social Security benefit because farmers were not eligible

for Social Security until 1955, 20 years after Franklin Delano Roosevelt started the system to protect the elderly so that they could live out the sunset of their lives more comfortably and with free health care.

It was during those 20 years that farm income was at its peak. Then, in the 1950's and 1960's the elements here and low commodity prices really sliced into the earnings of that generation that was almost ready for retirement. When they started drawing benefits they got only the bare minimum.

Periodically a cost-of-living increase was added, but at the same time the increase in Medicare deductions swallowed their increases. I checked with Social Security just the other day, and I found that the maximum benefits are around \$800 per month and in some cases even higher with an average of possibly \$500. The minimum is less than \$300 when the Medicare deduction is taken out, as 10 percent of their check is taken for Medicare premiums—and the maximum recipients contribute only 3.987 percent or less of their checks into the trust fund.

So, what did the last 3 percent cost-of-living increase do for those at the bottom? Nothing. But those at the maximum level received anywhere from \$15 to \$30 more, but no more was taken out of their benefits for Medicare premiums, so the rich got richer and the poor got poorer.

Even the very wealthiest taxpayers in America, people earning more than \$200,000 per year, had their tax rates reduced 2 years ago. Now Congress has placed the full cost of Medicare "catastrophic" coverage on the backs of senior citizens 65 years and over. It is very unlikely that they will receive any benefits from the hospital part of that program because it only covers hospital stays of over 60 days, if I understand it correctly.

And only 3 percent of seniors even spend over 60 days in the hospital. Most seniors that have serious long-term illnesses like Alzheimer's don't spend a lot of time in the hospital either. They need skilled nursing to help provide care at home, and the new catastrophic care program provides only 80 hours of home care, only 80 hours, and then not until next year.

According to the Board of Trustees of the Social Security Trust Fund, Acting Social Security Manager Jo Miller of Aberdeen, reported last week that Social Security trust funds continued to increase in 1988 and will do so for many years in the future. They determined that the funds which pay retirement, survivors, and disability benefits will be adequately funded well over into the next century.

Now, during 1988 about 128 million workers made contributions to the Trust Fund. At the end of September 38.5 million persons were receiving monthly benefits under the program. Administrative expenses represented 1.2 percent of the benefits payments in fiscal year 1988. Income to the Trust Fund was \$258.1 billion while outgo was \$219.3 billion. Thus, the assets of the combined funds increased by \$38.8 billion during the fiscal year.

There is still no law to prevent the Administration from using the Social Security trust funds to free up money for other Government bills. That happened in 1985, but 75,000 national committee members demanded the funds be restored with interest and they

were. Now this committee is working to stop this practice. This fund should be a separate fund so it cannot be dipped into, in an effort to balance the Federal budget at the expense of older Americans.

Most farmers retired when they felt they had set aside enough savings to carry them through, but with the constant rise in living expenses they soon found themselves at the bottom of the barrel.

Transportation is the third issue. Now this is another dilemma for our senior citizens. Since there is no bus service through Ipswich any more, the people are more or less isolated. Many of them are no longer able to drive and many that could can no longer afford to own a car, what with the high cost of upkeep, let alone the cost of gasoline.

Ipswich does have a senior citizens bus which schedules shopping trips, to clinics or doctor appointments, but this does not meet the emergency needs that exist from time to time, so in some ways one can compare our senior citizens in our locality to the homesteaders whose horse died.

Our fourth issue is care of our elderly—I think we all agree that times have changed and those changes seem to echo “new and improved.” You see that all the time. Many changes are needed, but I oftentimes don’t agree as to the “improved.” I’m sure you’ve often heard the statement “how strange, one set of parents was able to take care of and raise a big family, but now not one family member can take care of the parent.”

It used to be in what is called the good old days, and many of us recall them with a lot of fond memories, that the business, farm, or whatever the occupation was of the breadwinner, upon retiring, it was handed down to a family member. When the parent or survivor was no longer able to live alone, they were cared for by the family in their home.

There were no nursing homes, but we must remember that people are living to a much older age now, and, in those days hired girls were available. You seldom saw an elderly person in a wheelchair. None of the homes were even built or designed to accommodate a wheelchair. Now, with the standard of living that is embraced today, modern day conveniences have freed women from a lot of the drudgery, but it takes two paychecks to make ends meet.

So who is left in that home to look after an aging individual? The TV might keep them occupied to a certain extent, but no refrigerator, automatic washer, or vacuum cleaner can offer comfort in the dismal hours of pain that many senior citizens endure, and it couldn’t help them in and out of bed either.

When visiting with one doctor, he felt that there should be more inspections of nursing homes, not planned ones, but those done unexpectedly. That way, he said, the elderly would be assured of decent and humane treatment. I have been a resident in a nursing home myself. I’ve seen it from the inside and the outside.

My mother-in-law was in one for 13 years, I certainly couldn’t complain about the treatment that I got. It was a marvelous thing and the people that worked there have to be almost superhuman. I have to admit that.

But this doctor also felt there is a need for the overhauling of Social Security for the minimum recipients in order that they may

live with dignity. He was aware of the fact, with all the elderly that he sees, that some people's pets live better than some of the elderly.

In getting back to the old days, they used to have a lot of simple, tried and true remedies and it seems that some doctors are starting to pick up on them and find that they worked. Now, no one has really ever come up with a cure for the common cold, but for chest congestion, they used to use onion poultices, frying the onions in goose grease, placing them between flannel and putting them on the chest. I can see the logic in that because the steam and vapor from that was inhaled.

Now the steamers, that you plug in, take care of that. And they also had a cure for the flu. I only hope our Congressmen don't have to use it on any of us to cure our ills. To cure the flu they fixed a very large batch of hot toddy and hung their hats on the bedpost or head of the bed. They took a drink of the toddy and then rested in bed for a few minutes and then had another drink of the toddy and continued resting and drinking. When they began seeing two hats, they felt they were cured.

Thank you.

Senator PRESSLER. Thank you very much for your humorous, excellent presentation.

On the catastrophic issue I have joined Senator McCain of Arizona in legislation that would delay the implementation of the surtax. For example, Federal employees are covered under both the catastrophic deduction and the Federal insurance that they already have.

Many people have a Medicare supplemental insurance policy. I think the catastrophic health legislation was strongly supported by the American Association of Retired Persons. When it came to the floor, I supported the voluntary option. I think it's very important that we have a voluntary option. Hearings will be held on the catastrophic program.

Peg Lamont, I gave you a very fine introduction and I turned and you had disappeared. I told them about your work as a member of the Federal Council on Aging, your work on the White House Conference on Aging and your continuing work with the rural elderly. You are our final speaker.

STATEMENT OF FRANCES "PEG" LAMONT, CHAIRPERSON, SOUTH DAKOTA ADVISORY COUNCIL ON AGING AND MEMBER OF THE FEDERAL COUNCIL ON AGING

Ms. LAMONT. Thank you, Senator Pressler, members of the Senate Special Committee on Aging, and ladies and gentlemen.

Thank you for allowing me the privilege of running off to the airport. It wasn't easy today on Highway 12. I said goodbye to my daughter who is flying to Montreal on the 3:20 plane, so she should be lifting off right now. She doesn't get home that often and I took the privilege of being a grandmother and parent as part of my role. It just didn't seem right to let her go without being out there.

It's really a hard act to follow Ms. Stafford. You shouldn't have ended on that note because I'm not nearly as funny or good as that. I'm here with a couple of hats. I am honored to have this op-

portunity to speak at the hearing, first in my role as Chairman of the South Dakota Advisory Council on Aging and second as a member of the Federal Council on Aging.

I will conclude with a just few personal remarks that are all my own, related to goals for the rural older Americans. I have to remind you and Senator Pressler and the advisory committee that, in fact, each State has a council on aging. These are the representatives, the voice of the people, in those States and their concerns.

It's supposed to be the grass roots input and in the same way the Federal Council which is set up under law is made up of 50 people nationwide who are supposed to be there to be the grass roots input, the voice of the people, to stand up for the people to represent them from all areas of the country, and I represent the rural area, and speak to them.

We wish that we could reach even more of the area and we wish that people would remember to call on us on either the State or Federal level as often as possible. One of the exciting things about being on the South Dakota Advisory Council on Aging, of which I was named chairman just recently by the Governor, is that I had been chairperson way back when it first started in the 1960's and had been on it in many different roles since that time.

This centennial year in South Dakota marks the 30th anniversary of the first time the word "aging" was talked about in South Dakota for the first White House Conference on Aging and the preparation which began in the spring of 1959. And then it took 9 years until Governor Nils Boe yielded to the action by the Brown County Council on Aging set up by executive order, made funding, Federal grants, senior centers, head starts.

We were also celebrating last year the 28th year of all the first senior centers of this State. But, let me emphasize the fact that there is still so much more to do and we're just an example of many other States, although we are proud that we have pioneered many different areas of services that have not turned up and are just beginning to emerge in some of the other States.

The present State advisory council, and you have heard Gail Ferris, who is the Director of Adult Services and Aging, and she is our leader. We are the group across the State that works under her. We review grants, work with educational programs, legal aid to the elderly, all the things that she talked about also and we take a leadership role in recommending and supporting progressive legislation in behalf of older citizens.

Successful legislation in the past has included the improved revisions of the tax relief for the elderly, which has improved greatly the last couple of years, the revision of the guardianship laws, and a landmark law protecting elderly and disabled from physical abuse and financial exploitation. This latter law has been used successfully just this spring.

And one of the goals is to add the word "neglect" to the physical abuse because there are cases of planned neglect, not accidental, that happens and there should be some way of tracking that and taking care of that and it is really necessary.

Of special importance is the effort made by the South Dakota Council to support the Governor's comprehensive plan to provide funding and legislation which will help maintain independent

living for the elderly who are all at home. We are proud of the Governor's Initiative on Aging which Governor Mickelson spearheaded during the 1988 and 1989 legislative sessions.

It is exemplary of the long-term goals of the Council and is focused on encouraging the highest level of independent living possible for older South Dakotans. The plan, as you probably know, includes a six-step approach beginning with preadmission screening mandated for those entering nursing homes to find some alternative, if it is possible. It may not be.

In 1988, the legislature enacted a temporary freeze on the construction of new nursing homes. The State applied for a Title 19 waiver, a Medicaid waiver, similar to that used by some other States so that money could be diverted to follow the person to provide not just funding for the person in the institution, but funding for them in an alternative setting such as if they were at home—something of that sort.

And we also, through the legislature, had a housing task force that the Governor set up to review other alternatives and as the group increases, as I have pointed out in the tax relief for the elderly, expanding the ceiling and making the amount greater for the more and more low-income elderly to continue living in present homes or apartments.

Finally, there was extra money funded in both those years in the Department of Health and the Department of Social Services to provide more people, more full-time employees, who would provide the health care necessary to follow up on those persons trying to live at home and perhaps with certain moderately handicapping disabilities but were still able to be on their own if they had some help. This is summarizing it very generally.

But it is a combination of intensive effort to provide support for those able to live independently and it is showing significant progress and is the most effective approach, we feel, to quality of life for older South Dakotans. Although still in its initial trial stages, alternatives in housing and increased support from the State for the low-income elderly is having great acceptance statewide.

And there's increased employment of elderly. More people are wanting to work even in the later years if there are jobs and jobs should be encouraged. We already have the program RSVP, Foster Grandparents, Senior Companions in Sioux Falls, and Green Thumb, which provides some volunteer and also some part-time work in some cases, some transportation and means in some cases.

Money spent on these programs multiplies the benefits manifold, and these moneys come not from the older Americans, but comes from other sources and should be looked at as an increase because it's one of the greatest benefits we can have for the elderly, with the use of volunteers and the part-time worker out in the field keeping them healthy and happy and serving other people at the same time.

South Dakota pioneered support programs for Adult Day Care way back in 1967. South Dakota had, I think the first Adult Day Care program in the Nation. And now it has Adult Foster Care, Respite Care, and a variety of in-home care and it is very important to see that those programs continue.

I would like to speak now going from some of the things that are happening in the State—change my hat—and speak as a member of the Federal Council on Aging. I'm one of 15 members. I was appointed first by President Reagan in 1982, reappointed and was appointed by the U.S. Senate in 1987 through 1990.

We meet quarterly, but we are charged under law to report directly to the President and to the Congress, so in doing testimony today I'm doing my civic duty in reporting to Senator Pressler's committee. We constitute a cross-section of rural and urban older Americans.

My personal goal is to focus on the special needs of the rural elderly because ever since I've been on the national Federal Council, I have found that most of the members are from urban areas. I am one of the few rural members. We now have a person from Iowa and someone from Kansas. I'm one of the few that comes from a State with a geographic distance such as we have in South Dakota and the nine Indian reservations.

It is very important that we get our recommendations across. We find that we have a very remote profile. People have never heard of the Federal Council on Aging. They get it mixed up with the National Council on Aging which is a very large group with hundreds and thousands of members and AARP which also has hundreds of thousands of members, but we are established under law as a small 15-member group to be the grass roots spokespersons for all of you and all those in our Nation, and it's a tough job.

The annual report is required by law and I just got this the day before yesterday, so I'm sure that it has already gone to Senator Pressler's desk because under law it is required to go to the President and to each Member of the Congress, especially to the two Special Committees on Aging in the Congress. It tells what we have been doing and how we are trying to work in behalf of the people nationwide and to bring some understanding of the needs nationwide that might be lost, that might be hidden.

So it's very important that people understand that they can speak to the Federal Council members and give us recommendations. One of the things I was delighted about was when I heard Mr. Muth talking about the frail elderly. It was a report by the Federal Council on Aging, a study, called "The Frail Elderly" that was done in 1970 before I was on the council, that started the use of that name as one that signifies the oldest and the most desperately delicate and fragile of all of our older people. That is a pretty good word gone over and over again nationwide and so now we use it as if it were an every day word.

Some of the other things that we have accomplished in the past—we had a study about 8 years ago which was the first time there had been an extensive criticism of the role of both the family members at home and the nursing home people that take care of people and the problems they have that has become a classic publication, as well as our report on hypothermia and some of the other things of that sort.

So these are some of the things the Federal Council does. In the last year we had a contract, a grant to the University of Illinois, Department of Gerontology, to do an extensive study on the possibility of a White House Conference on Aging for 1991 and to make

it workable, practical, economically feasible, and to see if it was worth doing, and then to report these findings and the plan to the President and to the new Secretary of Health and Human Services, Dr. Louis Sullivan.

This was done, including a massive hearing held in San Francisco last November in which every organization who worked with the elderly, from the Association of Hispanic Elderlies to the blind elderly all testified to what they would like if we did have a White House Conference. Was it worthwhile to spend the money on this report? The conclusion of these people was yes, it was needed.

There should be a type of review of where we have been and where we must go because with people living longer and a greater need to care for them we must find out what those needs are and so that recommendation went to the President. Whether the budget deficit will be able to recommend one, we do not know. It depends on the President to call such a council, and he may feel that it's not practical with all the pressures of today's world in other areas, but that was one of the major things we did last year.

I chaired what's called the Targeting Committee. Targeting is very complex, because we talked about the fact that the Older Americans Act requires by law each State to target funds for low-income and minority people based on a formula, and there is a difference between a formula for those interstate and those intrastate. There were some court cases in several areas in Florida but these formulas have had different interpretations so we've had to study that.

I chaired that committee and got input from people nationwide on that. Agencies working with the elderly, because there is what is called the "hold harmless" clause in the Older Americans Act that prohibits targeting on an interstate basis, while it requires it on an intrastate basis.

We are asking you members of the Special Committee on Aging to remember that the Federal Council on Aging has recommended last year and reinforced that recommendation this year that those words be reviewed and looked upon if at all possible for making that funding more precise so that we can target the funds where they are needed the most without getting tied up in legal problems.

In addition, the Older Americans Act needs clarification, we think, as members of the Federal Council, and we have recommended to the President and the Congress and the committees on aging that the word "adequate" which is used—what is adequate funding? How do you define the word adequate? This is a very difficult task for various States to define when talking about adequate funding to the low-income minority people.

And we ask that in the absence of abuse of discretion as determined by the Commissioner, subject to judicial review, the States' determination under section 306(a), section 2, shall be final.

The Council stills feels that this is an urgently needed amendment to the act.

In a lighter mood, the 1988 Federal Council spearheaded a study of guardianship standards and guidelines as the quality of life effort. We all know that there are times when an older person with Alzheimer's disease or some other various difficult condition has to have a guardian but the laws of the State are varied so much and

there have been times when it has taken away the rights of the individual completely.

The American Bar Association met with the Federal Council on Aging and we sent out recommendations to all 50 of the States in mailings of the model laws. We have been encouraging all the States to review and change their laws to make them more humane to protect the rights of the individual.

In other words, they should be flexible. If a person has a guardianship and suddenly recovers, the guardianship should be such that it can be reversed. There have been cases which some of you have seen on 20/20 and on the news that happened in the State of Michigan who were not qualified to be guardians were guardians and were, in fact, taking money from the elderly people who have no recourse.

Twenty-two States have responded to the Federal Council regarding the standards and guidelines. South Dakota is one of those States. In the past two legislative sessions South Dakota has passed several new laws that have updated and reformed existing laws which were already much better than many of these other States I have talked about. So we should be very pleased about that, but we do have to continue urging that the Federal Council stand firm in the belief of a most careful guardianship to keep people from being taken advantage of, and misused and having their rights taken away from them.

Finally, the Federal Council recommends that the Department of Housing and Urban Development maintain the Low Income Housing Tax Credit for nonprofit corporations to stimulate safe, affordable housing for older people. Employment of the older worker has always been a goal for the Federal Council and we wish to emphasize the need for more opportunities for jobs.

In conclusion, as an individual, I wish to emphasize some of these points. In 1977 when I went to the first White House Conference on the Handicapped as an observer, representing at that time Governor Kneipe, we were told that within a few years every State would have adequate vans for transportation that would have easy access for the handicapped. The States would have vans that "kneeled down," bent over on one side to let the person go in as well as the vans with wheelchair access.

It was a glorious forecast, but now nearly 9 years later some of that has come to pass. We do have some handicapped vans statewide, but it is far from the goal that we need to keep our rural people active and able to access various services.

The intergenerational programs and services are necessary because of the fact that older people are working more closely with youth now and it should be a cooperative effort. We have to create new health plans, new jobs for the able oldsters and new recreation and rehabilitation for the less active older person.

America needs a spokesperson for the older American in the Cabinet or on the President's staff to speak and interpret the requests and concerns of this growing population of older Americans. It's time for an ombudsman to serve as a pipeline to the President to convey the messages of the elderly to him and to the Cabinet and to serve as a catalyst and liaison for him. Our States already

are working for them, but on a national level we need such a person.

Perhaps the late Claude Pepper was that type of person. The aging need someone in a job role who can be the liaison from the people to the President.

Speaking finally for the rural elderly, there is always one primary hope we all share—and we have stated it over and over again—to remain as active and independent as possible. These older South Dakotans and prairie people are rugged, of pioneer stock, celebrating their 100th year of South Dakota statehood.

Yesterday I visited a 92-year-old friend. She said to me “But what use am I? I want to be useful and active and I’m not.” And then a few minutes later she gave me six or eight beautiful cucumbers and green beans from her garden, and I told her that she was an inspiration to me and to other people and that she shouldn’t worry about being useful, she was being useful. She didn’t believe me. She wanted to be more independent, she wanted to do more things.

That’s really the cry of almost all rural older Americans, whether they’re out at Eagle Creek, whether they’re out on the prairie where they can’t get transportation into town or get to a doctor. Because without transportation, we lack the key. It saves lives, it provides access to services, and in the long run saves the Nation from the grief and financial burden of long-term care.

Anything that we can do in providing independent living is the goal that all of our members have.

Thank you very much for listening and for giving me this opportunity, Senator Pressler.

[The prepared statement of Ms. Lamont follows:]

TESTIMONY FOR THE U.S.SENATE SPECIAL COMMITTEE ON AGING AT THE HEARING HELD AUGUST 7,1989 by U.S.SENATOR LARRY PRESSLER AT THE ST. LUKES HOSPITAL WELLNESS CENTER, ABERDEEN, SD.

From: Frances " Peg" Lamont, PO Box 1415, Aberdeen, S.D. 57402
Chairperson, South Dakota Advisory Council on Aging and Member, The Federal Council on Aging

The Hon. Larry Pressler, U.S.Senator, and members of the Senate Special Committee on Aging, :---

Senator Pressler, Members of the Committee;--I am former State Senator Frances " Peg" Lamont, Aberdeen, South Dakota, chairperson of the South Dakota Advisory Council on Aging by appointment of Governor George Mickelson, and member of the Federal Council on Aging 1982-1990, by appointment formerly of President Ronald Reagan, and since 1987 by the U.S.Senate.

I am honored to have the opportunity to speak at this hearing, first in my role with the South Dakota Advisory Council, and second, as a member of the Federal Council on Aging. I will conclude with a few personal remarks related to goals for the older American.

South Dakota's Advisory Council on Aging was established by executive order of then Governor Nils Boe in 1967 following action by the Brown County Council on Aging which I chaired at the time. After serving as S.D.delegate and planner for the first White House Conference on Aging 1959-1961 under a short term federal grant to the state, my determination to see that my state joined others in establishing a full fledged department on aging became the goal. Without a state office on aging, no federal funding, programs or services could be developed. This past year South Dakota celebrated not only its 100th birthday, but the 20th year for the first senior centers, multi service programs, transportation, and in-home care. As pilot chairperson, I was privileged to speak on the struggle from 1959 to 1989 which has brought about a comprehensive network of programs making South Dakota a leader in action for the elderly, especially rural elderly.

The present state advisory council reviews grants, works with educational programs, legal aid to the elderly, and takes a leadership role in recommending and supporting progressive legislation in behalf of older citizens. Successful legislation has included revisions of the tax relief for the elderly laws, revision of guardianship laws, and a landmark law protecting elderly and disabled from physical abuse and financial exploitation. This latter law has been used successfully.

Of special importance is the effort made by the Council to support the Governor's comprehensive plan to provide funding and legislation which will help maintain independent living for the elderly.

The South Dakota Governor's Council on Aging is

proud of the Governor's Initiative on Aging which Governor George Mickelson has spearheaded during 1988 and 1989 legislative sessions. It is exemplary of the long-time goals of the Council and is focused on encouraging the highest level of independent living possible for the older South Dakotan.

The plan includes a six step approach beginning with pre-admission screening mandated for those entering nursing homes. In 1988 the legislature enacted a temporary freeze on construction of new nursing homes. The state applied for a Title 19 waiver in order to divert funds for an accelerated effort to provide alternative programs and living arrangements. Housing options were redefined and a Governor's Housing task force studied alternatives. The legislature approved increases in the tax relief for the elderly law as recommended by the Governor, expanding the ceiling in 1988 and in 1989 voting a significant increase in funding to assist low income elderly to continue living in present homes or apartments. Additional funding and an increase in the number of full time employees in both health and social services departments enabled the state to upgrade and expand home health care programs to enable more elderly to continue living at home despite illness or moderately handicapping disabilities.

This combination of intensive effort to provide support for those able to live independently is showing significant progress and is the most effective approach to quality of life for older South Dakotans. Although still in its initial trial stages, alternatives in housing and increased support from the state for low income elderly is having great acceptance state-wide. Encouragement for employment of the elderly is also bringing about increases in job opportunities. Programs such as RSVP, Foster Grandparents, Senior Companion, and Green Thumb are popular and could double in size if funding were available. They provide both volunteer and work programs, transportation, and some provide meals. Money spent on these programs multiplies the benefits manifold.

South Dakota pioneered support programs of Adult Day Care, and provides Adult Foster Care, Respire Care and a variety of in-home care.

In speaking as a member of the Federal Council on Aging, I note that I am one of fifteen members charged under the Older Americans Act to serve as grass roots representatives for the nation's elderly, speaking out in their behalf, and reporting directly to the President and the Congress. At least nine of us must be older individuals. We constitute a cross section of rural and urban older Americans. My personal goal is to focus on the special needs of the rural elderly based on experience in South Dakota and the prairie states.

The Council is required by law to prepare an annual report to the President, members of the Congress and other interested governmental and private agencies. This report, has been distributed, and you may have already read it, but I have copies here which describe the public hearings and activities of the Council during 1988. The Federal Council works intensively to bring to your attention the special needs of the nation's older citizens. We hope you will take time to read this report with interest.

In 1988 each member of the Council served on the White House Conference on Aging committee. I chaired the committee on Targeting of services to the low income and minority elderly. Other committees included Quality of Life and Housing, Public Education and Employment, and Health and Insurance.

The Council met four times, and shared information and minutes with 82 organizations, ranging from the Advisory Council on Intergovernmental Affairs to the National Institute on Aging, to the Villers Advocacy Associates.

During 1988 action by the Council let a contract to the University of Illinois to develop an orderly, relevant, and economically feasible plan for a potential White House Conference on Aging 1991. Part of the study included a forum held in San Francisco in cooperation with the Gerontological Society of America Conference when 27 witnesses reported for national organizations concerned with Aging. Copies of the report prepared by the University of Illinois were presented to the President and the Secretary of Health and Human Services.

At the August 1988 meeting in Washington, D.C. the Council studied the problems relating to the intra state targeting of federal funds to the Older Americans Act. The goal is to target OAA funds to older low-income minority individuals in the greatest economic or social need, but the Council learned that in some states this issue has become entangled in legal action related to confusion and differing interpretations of the formula. There is special difficulty faced by those States with extremely large numbers of economically and socially needy minority older Americans caused by the "hold harmless" clauses in the Older Americans Act that prohibits targeting on an interstate basis, while requiring it on an intrastate basis.

The Council also learned that the word "adequate" in the OAA continues to need Congressional clarification. In its 1986 recommendations to the President and the Congress, the Federal Council suggested, "In the absence of abuse of discretion as determined by the Commissioner, subject to judicial review, the States' determination under Section 306(a) (2) shall be final". The Council still feels that this is an urgently needed amendment to the Act.

In 1988 the Federal Council spearheaded a study of Guardianship Standards and Guidelines as a Quality of Life goal. In a May forum in Washington members of the Federal Council continued to caution against the arbitrary removal of autonomy from potential guardianship wards while protecting them through this legal intervention of last resort. The Council worked closely with the American Bar Association, the Center for Social Gerontology, the National Conference of State Legislatures and other agencies in defining guidelines for guardianship. In recommendations, the Council endorsed the rapid implementation of guardianship programs and laws for the benefit and protection of older Americans as found in the recommendations of the American Bar Association, and voted to send copies of the Standards and Guidelines for guardianship to each of the 50 state departments of human services and aging. Twenty two states have responded to the Federal Council regarding the standards and guidelines. South Dakota is one of these states. In the past two legislative sessions new laws have passed to provide guardianship with emphasis on the rights and protection of the elderly. A guardianship law should be one which can be reversed as conditions change, recommendations indicated.

The Federal Council participated in the publication of AGING AMERICA, a book of trends and projections. Over 18,000 copies were distributed nationwide. In mid-year, an additional 5000 copies were authorized to supply the Natl Federation of State High School Associations with research on the 1988-89 Debate Topic which dealt with the graying of America.

In the realm of Long term Care Insurance, the Council in November of 1988 passed a resolution urging the insurance industry to face the need for an unified policy clearly stating its role in creating a viable place for private long term insurance. Unless an incentive such as a tax credit for premiums on a long term health care contract is offered, many Americans would not be motivated to plan for the future, it was felt.

At the June 1989 meeting, the Council looked with concern at the Catastrophic Health Care plan, and passed a resolution of concern for the impact of the financial responsibility of elderly under the present act .

In future goals, the Council considers the plan for a 1991 White House Conference on Aging a workable, practical format for the use of the new Secretary of HHS, Louis Sullivan, should the President choose to call such a conference.

The committee will continue to study intrastate funding formulas in the distribution of Federal Funds with hope that an improved formula will make targeting more effective.

The Council continues to speak out in behalf of increased funding of Title VI for Indian Reservations to meet critical needs. The change in the formula of distribution has benefitted some tribes but drastically cut others. This is a rural need of great concern to states such as South Dakota where we have nine reservations and areas of desperate poverty. As an example, where there were once eight nutrition sites on the Cheyenne River reservation, there are now two. Well balanced food is important, for diabetes is rampant. Many of the commodities furnished to the nutrition sites are heavily fatty or high in sugar content, exactly the wrong diet for diabetics, but what nutrition sites they have, attempt to provide correct balanced diets despite the roadblocks in funding and food supply.

Transportation for rural areas is funded on a population formula in many cases, yet studies show that rural transportation is more costly than urban and actually requires more money. Rural elderly cannot avail themselves of nutrition sites, blood pressure clinics, visits to the doctor, or social events unless they have transportation to get to the site where the service is offered. In the vast open spaces and sparsely populated Dakota prairies, transportation is the key to services to the elderly, both on and off the reservation.

The REA, Rural Electrical Association recently sparked a study of isolated elderly and the prevalence of clinical depression found among them. Lack of contact with other people, with services, even with church and social events, can trigger depression in older rural folk. Creative uses of funding to provide rural networks of transportation must be encouraged.

The Federal Council is also recommending that the Department of Housing and Urban Development maintain the Low Income Housing Tax Credit for non-profit corporations to stimulate safe,affordable housing for older people.

Employment of the older worker has always been a goal of the Federal Council, and along with services to maintain independent living, the council urges all Americans to recognize the potential of the elderly in the work force, and to provide opportunities for jobs.

In conclusion, as an individual, I wish to emphasize some of these points. In 1977 at the White House Conference on the Handicapped which I attended as the Governor's Official Observer for South Dakota, the promise of transportation with buses which "kneeled down" for access, and were provided nation-wide for the handicapped, all with inter-com, has been slow in fruition, although South Dakota now has many well equipped vans with hydraulic lifts and safe vehicles for older riders. The promise is still far from coming true as promised more than 12 years ago.

In South Dakota, it is 30 years this summer since the first step was taken to talk about the dignity, the needs, and rights of the elderly. I have been privileged to have served continuously on the planning councils for the state's White House Conferences on Aging since 1959, and to have attended all three past Conferences, and I personally hope that a 1991 Conference on Aging will be called. It is time to re-evaluate the goals, to change direction and focus on new aspirations based on the continuous change made possible by the increased longevity of Americans. It is a time to plan Intergenerational programs and services, to create new health plans, new jobs for the able older, and new recreation and rehabilitation for the less active older person.

We need a spokesperson for the Older American in the Cabinet or the President's staff to speak and interpret the requests and concerns of this growing population of Older Americans. It is time for an "Ombudsman" to serve as a pipe-line to the President conveying the messages of the elderly, and serving as a catalyst and liaison for them.

Speaking for the rural elderly, there is always one primary hope shared by all--to remain as active and independent as possible. These older South Dakotans and prairie people are rugged, pioneer stock, celebrating their 100th year of South Dakota as a state. "What use am I?" said a 92 year old woman to me yesterday. "I want to be useful and active". Then she gave me fresh cucumbers and green beans from her garden, planted, and gathered by her. But she wanted to be even more independent--and that is the cry of almost all rural Older Americans. It takes federal funding to provide the services, the transportation,

the programs, but it saves lives, and in the long run, saves the nation from the grief and financial burden of long term care. **

THANK YOU VERY MUCH

Frances S Peg Lamont
PO Box 1415
Aberdeen, SD 57401

Frances S. Peg Lamont

Chairperson, SD Governors Advisory Council on Aging and
Member the Federal Council on Aging 1982-1990
Former State Senator, Dist. 2, South Dakota

**
On June 14, 1989 I received the Louise B. Gerrard Award for
Contribution to Rural Older Americans from the National Association for
of State Units on Aging, (NASUA), the state governmental units which
manage funding for Aging nationwide. These personal thoughts above are
among my concerns expressed at that meeting on receipt of the award.

Senator PRESSLER. Thank you. I'm told that we're running out of time, but we will have a question and answer period. A staff person will be at the end of each table with a microphone. We have time for just a few questions. If you will keep the questions fairly short, we'll get the answers from the panel here.

Mr. WELLS. I'm R.G. Wells from Aberdeen. Dad was in a nursing home here in Aberdeen for approximately 8 years, so I'm addressing that point.

Let me just say that the problems in politics are connections. One connection is military spending versus medical spending. Somehow the administration that you are a part of, Senator Pressler, went off on a huge tangent with this military spending and now we find ourselves in a big debt and also with not enough resources to take care of things that are really important—housing, medical care, education, etc.

But, getting to the particular—I've met with Mr. Muth on several occasions when Dad was in his nursing home. I must say I came away with a negative feeling, that they were not providing as much assistance as they could. It was very good in terms of friendliness, of personal body care and the institution. However, Mr. Muth did not come in and inspect without prior notification. He did not see all the things that I saw when I went in unannounced.

Dad wasn't getting adequate care in terms of being fed. The food often was cold. I could not get an adequate response. Well, what can you say? I challenged Mr. Muth. I believe, like he does, that the most underpaid are the most important—the aides. And if he would agree with me that we should do something about this, I would match his funds, if I could, to assist the aides in getting some kind of special recognition and some kind of financial reward.

And I mean your funds, not the church's funds, but your personal funds. Put your money where your mouth is, that's what I say. Nurse aides should get training. An ombudsman should come in here, like Ms. Stafford said, and without prior notice check on these things. That is very important in these nursing homes. I believe your father is in one, Senator Pressler, is that correct?

Senator PRESSLER. Yes.

Mr. WELLS. Right. Dad was in almost 9 years.

Senator PRESSLER. Thank you, and let me respond in part by saying that I have been very impressed with the dedication of the people in our nursing homes. I know mistakes are sometimes made, but I have been impressed in South Dakota by the dedicated service people get. I think it's one of the best in the country.

Mr. Muth, do you want to make any comments on what has been said here?

Mr. MUTH. Very briefly, I think I have said it occasionally, that I am sorry Mr. Wells and I did not yet come to some resolution about our differing thoughts. I think the one thing he did say today that I would truly agree with him on, is providing resources for the people working in nursing homes. Our society has to do that. As a product of this society, I'm certainly willing to put my money where my mouth is. My money wouldn't make much difference, but society's would.

Senator PRESSLER. Mr. Schuman.

Mr. SCHUMAN. My name is Steve Schuman. I sell insurance and spend considerable time with senior citizens. My question will pertain to hospital and doctor charges in and around the Aberdeen area. For example an appendectomy would cost roughly \$650. In Portland, OR, the same procedure would cost double that amount. Is there a possibility, Senator, that we can put a cap on this type of thing? In other words, if it's going to be \$850 or \$650 here, how about \$850 in Portland or vice versa as the case may be?

What I am suggesting is a national cap on the amount that doctors and hospitals can charge. I realize that I may offend some doctor and hospital representatives here today by making that statement.

The second thing I'd like to bring to your attention concerns approved and unapproved charges by Medicare. As I have progressed in my insurance career I have discovered that there are an increasing number of items that are not being approved. Items that up to 3 years ago were being approved are not being approved today, and I wonder why. Why are we having that lower approval rate or non-approval rate of things that were being approved a while back?

I would recommend given the large number of Medicare supplemental policies available on today's insurance markets that all items should be approved by Medicare, at least within 5 cents or 10 cents. There are several company representatives in South Dakota and the United States that will pay the balance that Medicare does not if Medicare approves any portion of the bill.

In other words, if someone has an approved payment by Medicare of 5 cents on a \$385 bill—and I have a client that this has happened to—then the insurance company paid the entire bill. Why not have 100 percent approval rate across the board? Let the insurance companies assist our senior citizens in keeping those medical costs down.

Finally, I would like to address one comment to Dr. Mulder. His third point was rationing of health care. One procedure he mentioned was hip replacement overseas. At age 67, you can't get a hip replacement overseas anymore, so what happens. The overseas people come over here to get their hips replaced or whatever the transplant may be.

Within the United States, things are bordering on genocide, in other words, the killing of the elderly. Check California legislation. They are trying to get genocide in there. I deal with these elderly every day, Senator, and I don't want to see any old person be put away like an old dog. Thank you.

Senator PRESSLER. Thank you.

I'm going to call on Dr. Mulder for a response. Referring to the first part of your statement, that's the essence of what we're trying to get—some equity in the cost Government pays in some of these extremely high cost areas. Essentially, every one in this room is subsidizing the high cost areas, even Dr. Mulder.

Dr. MULDER. That's what we have been working on for the past 5 years, his first point, that we have a fee schedule.

Because you pay the same taxes you get reimbursed at the same level. If they want to pay the doctors in New York five times as much for doing the same thing then they should charge the seniors there five times as much payment. It's so simple to me. So the

Health Care Financing Administration then authorized, and Congress appointed, the Physician Payment Review Commission a few years ago and they authorized the AMA and the Harvard Medical School to study this.

They came up with a resource based relative value scale (RBRVS), which is a fee schedule. And just this spring, the Physician Payment Review Commission (PPRC), recommended to Congress that they accept this fee schedule which would effectively level the playing field and reimburse everybody in this country eventually the same amount because they would be paying the same premium.

They want to attach to that what we call "expenditure target." I don't want to get into that too much. Basically, the AMA is against it. Basically, the American Academy of Family Physicians is for it, with some restrictions.

So far all the cost cutting we've had in medical care in this country has been even, across the board.

But in rural America you are reimbursed generally 40 percent less for everything you do than you would be in urban America. It is harder and harder to do anything about it. Fifty percent of the people in this country live in 37 cities. It's hard to fight those big cities.

Fifty percent of the Members of the House of Representatives are from nine States. It's hard for the other 41 States to fight those 9 States. We have a majority (two-thirds of the Senators in the Senate), who are on our rural coalition. We are getting our biggest help from them. But in the House of Representatives we can't get even half of them to be on a rural coalition to do anything about it.

The reconciliation that is going on now not only is to reimburse hospitals the same, but to reimburse senior citizens for out-patient medical care the same. The bills that are sponsored want to start next April and then gradually phase it in over the next 5 years. I'm concerned that 5 years from now when 14 of your hospitals are closed in your State, it's going to be too late. So we want somebody to do something now.

The Social Security Act of 1965 started Medicare January 1, 1966. It based reimbursement on what was being charged by doctors out here in rural South Dakota in 1963. They haven't changed that reimbursement formula hardly at all. But since then we've been able to get better technology in Aberdeen or most rural hospitals in this State. We can no longer compete with the quality of medical care that they have in any big city and it is time now that Government funds cover everything equally.

Senator PRESSLER. Thank you very much for explaining the increased awareness of rural health care in the Senate. The main responsibility falls to us because in the House of Representatives, the large cities have sometimes 30 or 40 Representatives from one metropolitan area, mainly New York or Los Angeles. So we do have a great deal of extra responsibility in the Senate.

Mr. RAND. A lot of medical care for elderly in this State is provided by mid-level practitioners. Currently we're in a crisis. We have 17 positions right here in South Dakota that we cannot fill because we do not have any mid-level providers. Part of the reason for that is most training programs for mid-level providers are locat-

ed in urban areas. They find jobs in the urban areas and stay there. Something that I think Congress needs to look at is the development of training programs in rural States where rural people will be included into those particular programs if they would stay in the rural States.

We found this was true through our medical school in South Dakota. Fifty percent of those people who were trained here, and recruited from here remained in practice in South Dakota. I think we would find the same thing in training mid-level providers.

Presently, there are 50 new programs in this country that are paying mid-level providers to create new jobs. The attempt to fill those jobs is overwhelming.

The second point is something you and I have heard over the past 3½ years. It deals with the use of mid-level providers in nursing homes. We were able to get changes in the conditions of participation.

The new regulations for nursing homes were to go into effect 5 days ago, on the second of August. That has been delayed now until the first of January 1990. This depletes the number of providers in the nursing homes and caring for the elderly. We have multiple nursing homes in this State where the only medical practitioner is 70 miles away. A nurse acts as a physician assistant. At this point in time we cannot do this legally and provide care.

I have been operating a rural health clinic in Pollock and Herreid. Herreid has a nursing home. If patients come to the clinic, I can take care of them. If I go to the nursing home to see them—and some of these patients are very difficult to transport—I'm violating the conditions of the Federal law. In other words, the nursing home can lose their license for allowing me to do that. The proposed rules need to be put into effect.

Senator PRESSLER. Thank you very much.

I would like to thank the people who traveled to be here today. We have a lot of people who have driven for 4 hours. We've reached the time when we are supposed to be finished with the room. I thank you all very much.

[Whereupon, at 3:45 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Item 1

MEDICARE REIMBURSEMENT AND RURAL HEALTH CARE

by Richard D. Mulder, M.D.

ABOUT THE AUTHOR

Dr. Mulder is a board certified Family Physician who has been in solo practice in Ivanhoe, Minnesota, for 19 years. He was raised in the small community of Rock Valley, Iowa. He attended South Dakota State College in Brookings, South Dakota and received his Pharmacy degree in 1966. After attending the University of South Dakota at Vermillion, SD, he then received his M.D. degree at the University of Iowa in 1968. After a rotating zero internship at McKennan Hospital in Sioux Falls, South Dakota, he permanently located in Ivanhoe.

He has been active in all aspects of organized medicine, medical education, and medical research. He is a past president of the Minnesota Academy of Family Physicians.

In 1987 he was awarded the Bush Clinical Fellowship to do more extensive study in the areas of Geriatric Medicine and Rural Health Care. Therefore, it was after 10 years of formal medical training, 19 years of clinical experience, four years of special interest in rural health, and more than a year of concentrated study that he was able to formulate his evaluation on problems concerning medicare reimbursement and rural health care.

SUMMARY

Medicare patients in Minnesota are subsidizing the medical care of medicare patients in large urban coastal cities in an amount exceeding ONE BILLION DOLLARS a year.

Medicare patients in all rural areas of the United States are subsidizing the medical care of all urban senior citizens in an amount exceeding EIGHTEEN BILLION DOLLARS a year.

The reason for this tremendous loss of money from rural America is entirely due to a two-tiered system of medicare reimbursement, whereby senior citizens in urban America are being reimbursed more for their medical care than are rural senior citizens. And they all pay exactly the same Medicare Part B premium.

The fact that this two-tiered system has existed for 23 years has been responsible for BILLIONS AND BILLIONS of dollars of wealth being transferred from rural America to urban America. This fact may be a main contributing factor responsible for many of the rural economic problems, and the rural health care crisis that now exists.42,62

MEDICARE HISTORY

1965--The Social Security Act was adopted and the Medicare and Medicaid systems were formalized to begin in 1966. Under section 1833 of the Act, medicare payment for most medical services and procedures are provided for under Part B of the program. Payment was made by Medicare contractors known as carriers based on reasonable charges made by physicians in 1963.

With no "High-Tech" medicine being practiced in rural America in 1963, there was an inherent disparity in the amount of reimbursement. In fact, in Minnesota, two separate carriers were used. Travelers Insurance Co. was used for a high level of reimbursement in the Twin Cities and Rochester, and Blue Cross & Blue Shield was used for lower reimbursement in rural Minnesota. Payment was based on the lowest of these four factors:20

1. The actual charge.
2. The customary charge for similar services generally made by the physician furnishing the service.
3. The prevailing charge in the locality for similar services. This was set at the 90th percentile level.
4. Other factors that are necessary and appropriate.2

1969--The prevailing charge was lowered from the 90th percentile to the 83rd percentile of area charges.

1970--The prevailing charge was lowered to the 75th percentile where it is today.

1972--A Medicare Economic Index (MEI) was created by Congress to limit the rate of annual increases in prevailing charges.

1973--Wage and price controls were lifted for most of the economy, however, all controls were retained for physicians for an additional 15 months.

1976--MEI or The Medicare Economic Index was applied to prevailing limits. This Index was applied to the 1973 prevailing charges which were originally based on the 1971 charges.

1982--TEFRA, or the Tax Equity and Fiscal Responsibility Act, required hospitals to contract with PRO's or peer review organizations.19

1983--DRG's, or the Diagnosis Related Groups, were enacted as part of the Social Security amendments.

1984--DEFRA, or Deficit Reduction Act, created "participating" and "non-participating" classes of physicians and also FROZE reimbursement levels for customary and prevailing charges from June 1, 1984 to September 30, 1985 and was based on the 1983 level.

1985--EEA, or Emergency Extension Act, extended the Price Freeze from September 30, 1985 to March 15, 1986.

1986--COBRA, or Consolidated Omnibus Budget Reconciliation Act, replaced the freeze with the complex maximum allowable actual charge (MAAC) for non-participating physicians. Participating physicians were allowed a 3.2 % increase in charges over their 1986 levels.19

WHAT ARE THE RESULTS OF THE ABOVE LEGISLATION

Even though all Medicare recipients are paying the exact same premium of \$24.80 per month for part B Medicare, they were being reimbursed at widely different levels for the exact same service right from the start.¹² These payments should not be considered as physician payments. Most physicians did not take assignment at the beginning and billed their patients for their charges. Only 15% of rural physicians and 17% of urban physicians in Minnesota, take assignment on all their Medicare patients. However, all non-participating physicians occasionally take assignment on selected patients.⁵⁸ Also, from the beginning, the senior citizens in large metropolitan coastal cities were reimbursed at much higher levels than those senior citizens in rural America.¹² The net effect was that rural citizens had to pay more from the start.

These differences of reimbursement were only magnified by subsequent legislation and the use of the Medicare Economic Index. The gap, or difference in reimbursement in 1988, is much larger than it was in 1965.

All services and procedures are described by CPT codes. These are listed in the American Medical Association's, Physicians' Current Procedural Terminology, now in its fourth edition of 1987. (CPT-4) There are about 7000 different codes.

There is also a different reimbursement based on whether or not the service was provided by a medical specialist or a non-specialist, with a much higher level of reimbursement to patients treated by a specialist.

Another area of disparity was that different specialists were set at different levels of reimbursement.⁵¹ So a patient having, for example, a skin biopsy done by a plastic surgeon would be reimbursed at a much higher rate than the patient who had exactly the same procedure done by a general surgeon.

Medicare has set up 240 different payment locations⁷ in the United States.² And they reimburse the Medicare patients in those areas at widely different rates. This difference is based on variations that are almost impossible to measure and probably do not even exist today, as they may have existed in 1963. These include differences in living costs, malpractice premiums, quality of care, physician supply, and other equally difficult to define factors.² The Prospective Payment System, or PPS wage index, is the hospital wage index used to adjust payment rates. This index was developed by the Health Care Financing Administration (HCFA), and is based on average hourly wage costs. It doesn't make sense that a wage index could be used to reflect costs such as office rent, office equipment, or malpractice insurance. It is an indirect index at best.²¹

The Medicare system as created for itself a "monster" of a problem. With 7000 different codes and 240 payment areas and 44 different specialties and a completely different system for non-specialists they must be having a computer nightmare trying to keep track of the hundreds of thousands of different reimbursement possibilities. There has been no printing of this confidential information since 1984. Now if you want the information you have to order it on computer tape and it will cost you over \$1300.00. It also has to be a very expensive system to administer. To end up with a system that is so basically unfair to our rural senior citizens makes me wonder why no one has tried to correct the system for the last 23 years. Even though some changes have been made, it is still not even close to being equitable.

WHAT ARE SOME EXAMPLES OF THIS UNFAIRNESS

The U.S. Government Printing office in Washington D.C. produced a Medicare Directory of Prevailing Charges for 1984. This document used facts and figures provided by the U.S. Department of Health and Human Services and the Health Care Financing Administration.

For example, the approved Medicare charge for an open reduction of a fracture is \$412.60 for a patient in the state of Massachusetts (suburb district) versus \$2681.90 for a patient in New York (A district).

A urinalysis in Nebraska was reimbursed at the \$4.00 rate. In Alaska it was \$12.00.

Reimbursement rates differ in some cases as much as 700%. Please refer to exhibit number one for more examples. While these numbers were for 1984, the same disparities exist in 1988. They are just worse now and will continue to get worse unless something is done.

A WORD ABOUT SOME PERSONAL EXPERIENCES

When I began my medical practice 19 years ago, all I had was the microscope I used in my histology course in college, and a stethoscope and blood pressure cuff that the Eli Lilly drug company gave me in medical school. With a few more supplies I was able to do blood counts and a few urine tests. The hospital had an x-ray machine, an electrocardiogram machine and a spectrophotometer that could do a few blood chemistry tests. That is a far cry from what we have to have now. We were the first in our area to have a blood gas machine, a fetal monitor, and a second generation mammography machine. Now we have computerized medical records and billing systems. We have high-tech internal fetal monitors, automated blood chemistries, doppler ultrasound, state-of-the-art blood gas analyzer, high quality tomography, in-house holter monitor printouts, cardiac pacemaker programmers, and many other high-tech, state-of-the-art items of medical equipment. And even though we have contracted services for computerized axial tomography and real-time ultrasound, we still have to compete with the secondary and tertiary medical care centers and their NMR's and their Lithotrypsers and other high-tech equipment. When the Joint Commission of Hospital Accreditation (JCHA) visits our small hospital, they don't ask us what our reimbursement level is or whether or not we can afford high-tech equipment, they judge us right along with the largest and most expensive hospitals in the country. They are only concerned with quality care and the outcome from that care, not costs.

So when Medicare based their reimbursement on rural charges in 1963, they must have thought that I would still be using just my microscope and stethoscope as I did in 1969. Their reimbursement policies haven't taken into account the fact that most rural areas have also entered the high-tech medical era along with their urban counterparts.

Our patients have demanded that we continue high quality care. Rural physicians have always wanted to give high quality care. And most of us have done so, even at the expense of our time, our health, our families, and our income.

But we can only be pushed so far. We are up against that wall. Thirty-nine percent of my patients are over 65 and account for 59% of my patient contacts, and 52% of my income. Medicare only pays about 55% of all patient charges. If I would take assignment on my Medicare

patients, I would lose 25% of my income. And since my overhead is 77%, mandatory assignment would force me to move my practice elsewhere. That is not something any of us would want to do.⁶⁰

WHAT ARE SOME HEALTH CARE STATISTICS FACTS

Thirty-eight million Americans will receive \$307 billion in social security benefits in 1988. Of this total, \$88 billion will be for Medicare benefits. One hundred twenty-five million workers are paying into social security now. This means for every person collecting benefits now, there are only three people paying into the system. When it started in 1965, there were about 35 taxpayers paying in for the benefit of one person.

Part A is free for those that qualify and \$234/month for those that have not paid into social security and therefore do not qualify. For their hospitalization, they pay a deductible of \$540 in 1988 compared to \$520 in 1987. After 60 days they pay \$135 per day and after 90 days they pay \$270 per day.¹⁰

Part B Medicare costs \$24.80 per month compared to \$17.90 in 1987. For outpatient services there is a \$75 deductible and after that the patient pays 20% of the allowable physician charge.

The average USPPC (United States Per Capita Costs) for Part A is \$136.44, and for Part B is \$97.65. This is the cost of care for one patient for one month.

The ACR (or Adjusted Community Rate) that is used for contracts between Medicare and third party payers is 95% of the USPPC.⁴⁴ The ACR is that amount of money that Medicare will pay to a third party to pay for all the medical expenses for one Medicare patient for one month. In reading your counties ACR in exhibit number four, if your ACR is \$85.50, then Medicare will pay an HMO \$85.50 to take care of medical services and procedures expenses for one Medicare patient for one month.⁴⁴

The ACR in Minnesota ranges from \$42.75 in Meeker county to \$138.61 in Olmsted county. In the Twin Cities they are \$84.88 for Hennepin county and \$83.26 for Ramsey county. Most out-state counties average about \$50.00 and the average for the entire state is about \$79.00 which is far below the national average of \$97.65 for Part B Medicare. The ACR for Dade county Florida is \$192.16 which is about 450% more than Meeker county MN. This ACR, or Adjusted Community Rate, differential, very closely parallels the differential for reimbursement for our senior citizens.

Thirty-two states have averages far below the national average for almost all of their senior citizens and they also have a high percentage of rural elderly. In ten more states it affects a majority of its seniors. All states have some counties that are far below the national average.

Twenty-four percent of the population of the U.S. live in rural areas.

Twenty-nine percent of the population over 65 years of age live in rural areas.

Twelve point seven percent of the population in MN are over 65. Of the 4.35 million people in the state, 550 thousand are over 65. In the U.S. there are 30 million people over 65 out of a total of 246 million.

Physician availability for the U.S. is 163.3 per 100,000 people, while for rural counties under 10,000 there are 53.0 physicians per 100,000 people. This rural rate is about 1/3 the national rate.⁴

Medicare reimbursement for rural hospitals is 36.8% less than urban hospitals.

Fifty percent of the total Medicare reimbursement to Medicare patients is for services provided by only 10% of the physicians. The other 90% of physicians receive their reimbursement from patients who get the other 50%.²⁸

Twenty-five percent of all physicians are considered "older" physicians. However, in rural America, over seventy-five percent of physicians are "older" and closer to retirement.

Canada reimburses rural physicians 5% more than urban physicians because of the skills and experience required and because of the more difficult circumstances surrounding the practice of medicine in a rural area. In British Columbia there are licensed physicians who are not practicing medicine because the urban area is at their quota and the state won't let any more physicians practice there. But there is a shortage in rural B.C. Rather than practicing in a rural area these physicians would rather not work or they want to look for a different job in the city. The U.S. Medicare system reimburses urban physicians 40% more than rural physicians, when similar specialties and similar practices are compared.

According to Richard P. Kusserow, Inspector General for the Department of Health and Human Services, in a recent statement before the select committee on aging, the 1986 profit rates for Urban Hospitals was 10.82%, while rural hospitals average a loss of 0.69%.⁹ One out of 10 rural hospitals had a loss of 20% last year.²⁹ One hundred sixty five rural hospitals have already closed.

While there has been some PPS changes in reimbursement for rural hospitals, the way adjusted published rates has only changed the rural-urban differential from 39.6% to 36.8% for equivalent DRG's.

The cost of running rural hospitals has increased more than twice the market basket rate in the last two reported years.

Health care is the number one business in Minnesota as it is in many states. Total United States health care costs have increased from 6% of the gross national product (GNP) for 1974 to 12% in 1988 and may be \$500 billion this year.⁴⁷

Health care costs are expected to triple by the year 2000.

A 257 page report from a Ralph Nader organization concludes that poor people of Minnesota have the best chance of getting adequate health care of any state in the United States.²⁶

According to Kevin Fickenscher, Physician director of the Center for Rural Health Services in Grand Forks, ND, the elderly account for approximately 2/3 of the patients in rural hospitals as opposed to 1/3 in urban facilities.²⁴

Rural hospital occupancy rates have fallen from 60% to 28%, and in hospitals with fewer than 50 beds, the average occupancy rate is 18%.

Thirty-seven million Americans are not insured.⁵ Forty percent of rural workers are under-employed. Rural counties while having 24% of the population have 50 to 85% of the citizens who live in poverty.

There are 5 million people living and working on farms. This is the smallest number in 140 years. Farmers receive about \$27 billion in farm aid.

Rural Physicians see 20% more patients in their offices than do urban Physicians.

Persons 55 and older account for half of health care. By 2000, half of our population will be over 50 years of age. The over 65 age group spends over \$120 billion a year on health care and this is 15% of their income. The average out-of-pocket money expense in 1980 was \$1,060 a year and they visited the doctor eight times a year. The over-65 population will increase by 45%, the 75-84 group by 65%, and the over-85 age group by 52% by year 2000.⁷⁶ With these changes, physician visits will increase by 47% from 1980 to 2000.^g

Unless changes are made, the Medicare Trust Fund is projected to stay solvent only until the year 2005 to 2008.^{9,52}

About 1% of Americans 65 to 74 are always in a nursing home. Twenty-two percent of those 85 years and older are in nursing homes.

Over 400 hospitals in America have closed since 1980, and for 1989, it is expected that one hospital will close every 10 days.

Over FORTY BILLION DOLLARS has been re-directed from the Medicare budget and to national defense since 1983.

HOW DO THESE FACTS FINANCIALLY AFFECT SENIOR CITIZENS

When a physician in Dade County Florida charges \$140 for a skin biopsy, Medicare may allow him a payment of \$95, and the patient will rarely get billed the balance. When a patient in rural America has the same procedure done and the MAAC profile only lets the doctor charge \$60 and Medicare will allow a payment of \$40, that patient will get reimbursed only \$32. That physician is forced to "balance bill" the patient. The perception by the patient is that it cost them much more for procedures in rural America than it does in a larger city. While this is only an example, it is really the way it happens. Rural senior citizens end up paying more out of their pockets.⁵⁸ In addition, since the maximum allowable charge is so low, rural physicians have to bill their non-Medicare patients more to cover their overhead.⁵⁹ So all rural patients pay more. Factual examples of these reimbursement differences are listed in exhibit numbers one and two.

With the above facts proving a differential of 36.8% for hospitals and an overall average in ACR levels that vary 40% when comparing rural versus urban, and with HCFA's own numbers showing 40 to 50% disparity, most authors agree that a figure of 40% is close to being accurate when comparing rural and urban reimbursement. This does not take into account the fact that many urban patients don't have to pay a deductible because many of them contract with an HMO who often does not have to pay the deductible.¹³

With managed health care systems insuring up to 35% of the total population in some urban centers,¹⁶ it is not difficult to figure out why HMO's are staying away from rural America.¹⁶ Most HMO's are started up by entrepreneurs who only have one thing in mind--a profit. About 1% of our 32 million Medicare patients⁴⁴ have enrolled in some form of an HMO.¹⁷ It is easy to see why they are all located in areas that are reimbursed at a very high ACR level. Many HMO's have gone broke or have moved out of lower reimbursed ACR areas--they can't make any money there.

When consideration is given to the recently mandated catastrophic health insurance,⁶ qualifying levels of out-of-pocket expense have been argued at from \$1,100 to \$1,850 per year.⁵⁴ Knowing the levels of average out-of-pocket expense, and the numbers of Physicians taking assignment, it appears the rural senior citizens are paying \$480 per year more than their urban counterparts for their out-of-pocket medical expense. Twenty-nine percent of the 32 million Americans are living in rural areas. This is 9.28 million people. This amounts to 480 times 9.28 or \$4,064 billion dollars of extra out-of-pocket expense. Total annual expense for each urban patient is \$3940 and for each rural patient it is \$2364 or 40% less. The difference is \$1586, and \$1586 times 9.28 million patients is \$14,769 billion that Medicare is taking away from rural areas and is giving to the urban coastal cities. \$14,769 billion and \$4,064 billion is \$18,833,000,000.00 total that is being taken away from rural America and given to the large metropolitan areas.

With the number of senior citizens in Minnesota, this amounts to an extra \$250,000,000.00 per year of out-of-pocket money that they are paying for their health care. And another \$793 BILLION is being lost out of the state each year because of the disparity of reimbursement. Therefore, the total is well over A BILLION DOLLARS PER YEAR that the state of Minnesota loses to the large coastal states. Nationwide rural citizens are paying an extra \$18 billion more. Indirectly, this money ends up reimbursing those Medicare patients in urban America for their health care.

WHAT ABOUT MANDATORY MEDICARE ASSIGNMENT

Fourteen states have had attempts at establishing mandatory assignment. Ten have failed.⁵³ Four others have passed a law (Massachusetts, Connecticut, Rhode Island, and Vermont) and three have begun mandatory assignment.⁴³

It is easy to see by the data in exhibit number four why Massachusetts was able to pass the law. The medicare patients and hospitals in that state are already being reimbursed over 20% ABOVE the national average. In fact they are being reimbursed 200% MORE than all of rural America.

It is also easy to see why the good senators and representative from the states of New York, Massachusetts,⁵⁰ Florida, and California are all pushing for mandatory assignment and national health insurance⁵---they have already made sure that their senior citizens and their hospitals have been reimbursed more than anywhere in the country. So no matter what the PPRC (Prospective Payment Review Commission) or the AMA-Harvard Relative Value Index study recommends to us in their final report, and no matter if there is catastrophic health insurance or a national health insurance---their states have an enormous advantage by already benefiting from 23 years of high reimbursement. And if any of these programs are accepted, without any changes in reimbursement policy, their states will continue to get the highest reimbursement---at the expense of senior citizens of the rest of rural America.

For Minnesota and the other 32 rural states,⁴⁶ mandatory assignment will only tend to reduce the quality of medical care, and to reduce the access to medical care for most, if not all, of those senior citizens.⁵⁸

HOW DO THESE FACTS FINANCIALLY CREATE OTHER RURAL HEALTH CARE PROBLEMS

The recruitment of primary care physicians to rural areas is becoming more difficult every year.⁵⁹ Rural physicians see more patients, work longer hours, are on call more often, get paid less, have less free time, have fewer physicians with whom to consult with, and in general have to have more training and experience and be able to handle a wider variety of problems than their urban counterpart. Twelve percent of primary care physicians practice in the rural area and see 24% of all patients in this country, 29% of all medicare patients, over 66% of all Medicaid patients and over 85% of the unemployed or working poor.⁴⁹ Eight percent of rural Minnesota Physicians indicate they will leave their practice in the next year or two.⁴³ Thirteen percent say it is only somewhat likely that they will continue to practice.⁴³ So retention of physicians in rural areas is also a problem.¹⁵ It is more difficult to get "good" doctors in rural areas. ²⁷ It is my perception that rural areas are attracting more and more doctors that I would not call "good" doctors.¹⁵

Many hospitals in rural areas are having a more difficult time in hiring Registered Nurses. There is a definite nursing shortage. The lack of proper medicare reimbursement for hospitals as well as for physician's clinics make it almost impossible to reimburse a "good" nurse as much as they can get in the "big city". Therefore, it is not only difficult to get nurses, it is also more difficult to retain good nurses in medical offices as well as in hospitals.¹⁴

It takes a physician with intelligence, excellent training, and experience to be able to withstand the rigors of rural practice. Our training programs are not turning out these kind of primary physicians anymore. They are graduating from programs that make them more dependent on peripheral support and "quick" consultations.⁴ Because of higher Medicare reimbursement in large cities and large multi-specialty clinics, they will receive a much higher income if they stay away from rural areas.²² And since none or very few of their medical school professors are rural oriented physicians, these professors tend to "steer" these students away from rural areas.²³ Minnesota is very unique and fortunate because of the Rural Physician Associate Program (RPAP) started by Dr. Jack Verby. This unique program has been responsible for supplying many physicians to rural areas in the upper Midwest.

Because rural clinics see a higher percentage of patients who get reimbursed by medicare, they depend on this income to keep up with the high standards of medical care that their patients deserve. But with lower reimbursement for their patients and subsequently lower income for themselves, it is nearly impossible to purchase the high-tech equipment and medical and surgical supplies necessary to keep up with these standards. Consequently, I believe I am starting to see reduction in quality care in some rural areas.

According to Dr. Rodney U. Anderson at the annual meeting of the California Medical Association, the poor and uninsured were 27% less likely to visit a physician and 19% less likely to be hospitalized than were members of other groups, even though the poor were a sicker patient population. And in 1986, an estimated 1 million persons were actually physically turned away from health care for economic reasons, he said. If high quality medical care and ready access⁶¹ to medical care are our societies main goals, than these inequities⁵⁷ in reimbursements will have to be corrected as soon as possible.³³

We certainly have a need for the new catastrophic health insurance⁴⁵, ³¹ for many of our senior citizens, especially in rural areas.³¹ This need certainly would not have been so great⁴⁵ if these patients would have been reimbursed at a rate equal to the national average.³¹

Other problems such as the medical malpractice crisis, unemployment, and the lack of any health insurance in many rural areas, have been made worse because rural America has been shortchanged up to EIGHTEEN BILLION DOLLARS a year for last year, and a comparative amount for each of the last TWENTY THREE years. In most rural areas that have a hospital, that hospital and medical care system is usually the number one employer in the area. With medical care being the number one business in most towns and states, it's easy to see what a devastating effect this inequitable reimbursement can have.

If all of the above defined problems continue, then the Seniors of this country are going to hear about a new problem--The Nonprovider. There are already a few specialists that refuse to treat Seniors, and if inequitable reimbursement continues, there will be many more.

WHAT IS THE BASIC DEFECT OF THE SYSTEM

While you can argue that there may be some different views to the opinions expressed here, and while there may be some lack of agreement in the finite accuracy in the numbers stated above, the fact is, everyone will agree that there is definitely a large difference in reimbursement. The fact is, all Medicare patients pay exactly the same premium, but they get reimbursed at different rates and this just is not fair. If they pay the same premium, let them get reimbursed exactly the same. Otherwise charge that Medicare patient in urban America a higher Medicare Part B premium if they are being reimbursed more.³²

If a Medicare patient wants to go to a physician in Dade County Florida where the standard of living may be higher, or the physician may have more liability expense, then let that patient get balance-billed for the difference in reimbursement. Don't force all of our rural senior citizens to, in effect, subsidize the urban patients care by paying more out of their own pockets.

THAN WHAT IS THE SOLUTION TO THE PROBLEM

It is so very simple. Since they pay the same premium, reimburse them exactly the same rate for their Medicare service.³⁰ Get rid of the payment disparity for the 240 different areas. Get rid of the payment disparity for the different specialties. Have only one payment schedule for all medical services.^{30,31,32,33,34}

WHAT WILL THIS SOLUTION COST

Nothing. If all reimbursement was equivalent to the national average ACR, then there would even be a 5% reduction of federal Medicare costs. If this was done it could amount to a 22% increase in capital to the rural health care crisis areas. In fact, if we correct the loss for out-of-pocket money and the fourteen billion dollar reimbursement disparity, it could have a tremendous impact on all of the problems that we are having in rural America..

If a national Relative Value Index or a national fee schedule^{5, 27, 30, 56} was used that had only one price for each service and if this price list was at the ACR or Adjusted Community Rate, and if all Medicare patients who pay the exact same premium would get the exact same reimbursement, this would save the federal government 4.4 BILLION DOLLARS A YEAR.

WHAT IF NOTHING IS DONE

Then the senior citizens that are affected by this iniquity will continue to be treated as SECOND CLASS CITIZENS by the Federal Government and every State Government. And this will include all of the senior citizens in 32 states, most of them in 10 states and some of them in the remaining eight states. SOMETHING MUST BE DONE SOON.

Respectfully submitted,
Richard D. Mulder, M.D.
Ivanhoe, Minnesota

MEDICARE REIMBURSEMENT AND RURAL HEALTH CARE
by Richard D. Mulder, M.D.

All United States Citizens Pay exactly the same Social Security or F.I.C.A taxes. This entitles them to Medicare Part A, or Hospital Insurance benefits. All hospitals give the same quality of care and have to follow the same guidelines set up by the state, or by Medicare, or by welfare, or by the Joint Commission on Accreditation. They are all reimbursed a DRG, or Diagnostic Related Group, rate.

The rural hospitals in Minnesota and the rest of rural United States are being reimbursed at a rate of 37% below that of the urban hospitals, even though their patients have paid in the same exact tax.

Therefore rural senior citizens are being treated as SECOND CLASS CITIZENS by the United States Federal Government, and the state of Minnesota is losing two or three BILLION dollars a year because of this iniquity.

All United States Citizens Pay exactly the same monthly Part B premium of 31.90 so that they qualify for reimbursement for outpatient medical care and in-hospital medical services by a Physician.

The Senior Citizens in all of the state and especially those living in rural Minnesota, as well as all of rural America, are being reimbursed 40% less than are urban Seniors.

Therefore, rural Senior Citizens are being treated as SECOND CLASS CITIZENS by the United States Federal Government, and the state of Minnesota is losing over one BILLION dollars a year because of this iniquity.

The state of Minnesota has already lost two or three billion dollars a year the last twenty three years. And worse yet, all of rural America is suffering an annual loss of over FIFTY FOUR BILLION DOLLARS A YEAR.

If there is no change in this policy, there will be A REDUCTION IN ACCESS TO QUALITY HEALTH CARE FOR ALL OF THE CITIZENS living in rural America.

We must insist on EQUAL payments to all hospitals and EQUAL payments to all Senior Citizens since they pay the EXACT same tax.

Everyone must contact their senior citizen groups, their congressmen, and their state legislators and request them to take IMMEDIATE ACTION to correct this dangerous rural health care problem.

STATE AND FEDERAL ELECTED OFFICERS
FOR SOUTHWEST MINNESOTA

United State's President and Vice President

President George Bush
White House
Washington, D.C. 20500

Vice President Dan Quayle
White House
Washington, D.C. 20500

Minnesota's Representatives in Washington, D.C.

Senator Rudy Boschwitz
United States Senate
Washington, D.C. 20510
202-224-5641

Senator Dave Durenberger
154 Russell Senate Office Building
Washington, D.C. 20510
202-224-3244

Representative Vin Weber - 2nd Dist.
106 Cannon Office Building
Washington, D.C. 20515
202-225-2331

Marshall Address:
P.O. Box 1214
Marshall, MN 56258
507-532-9611

Governor of Minnesota:

Rudy Perpich
Room 130
State Capitol
St. Paul, MN 55155
612-296-3391

Lieutenant Governor:

Marlene Johnson
Room 121
State Capitol
St. Paul, MN 55155
612-296-2374

Minnesota State Senator: District 27

(Lincoln, Lyon, Pipestone, Rock County
and portions of Murray and Noble County)

Gary H. DeCramer
Box 38
Ghent, MN 56239
507-428-3578

Capitol Address:
303 State Capitol
St. Paul, MN 55155
612-296-6820

Minnesota State Representatives

District 27A - Lincoln and Lyon County

Jim Girard
RR 1, Box 111
Lynd, MN 56157
507-532-6829

Capitol Address:
213 State Office Bldg.
St. Paul, MN 55155
612-296-5374

District 27B - Pipestone and Rock County

Andy Steensma
RR 1, Box 46
Luverne, MN 56156
507-283-2581
612-296-4336 (Capitol Phone)

MEDIGAP INSURANCE: COST, CONFUSION, AND CRIMINALITY

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS
FIRST SESSION

—————
MADISON, WISCONSIN
—————

DECEMBER 11, 1989
—————

Serial No. 101-15



Printed for the use of the Special Committee on Aging

—————
U.S. GOVERNMENT PRINTING OFFICE

30-302

WASHINGTON : 1990

SPECIAL COMMITTEE ON AGING

DAVID PRYOR, Arkansas, *Chairman*

JOHN GLENN, Ohio

BILL BRADLEY, New Jersey

QUENTIN N. BURDICK, North Dakota

J. BENNETT JOHNSTON, Louisiana

JOHN B. BREAUX, Louisiana

RICHARD SHELBY, Alabama

HARRY REID, Nevada

BOB GRAHAM, Florida

HERBERT KOHL, Wisconsin

JOHN HEINZ, Pennsylvania

WILLIAM S. COHEN, Maine

LARRY PRESSLER, South Dakota

CHARLES E. GRASSLEY, Iowa

PETE WILSON, California

PETE V. DOMENICI, New Mexico

ALAN K. SIMPSON, Wyoming

JOHN WARNER, Virginia

NANCY LANDON KASSEBAUM, Kansas

PORTIA PORTER MITTELMAN, *Staff Director*

CHRISTOPHER C. JENNINGS, *Deputy Staff Director*

JEFFREY R. LEWIS, *Minority Staff Director*

CONTENTS

Opening statement by Senator Herb Kohl	1
--	---

CHRONOLOGICAL LIST OF WITNESSES

State Senator Russ Feingold.....	3
Wilma Blum, Monticello, WI.....	5
Harold Halfin, senior volunteer/benefit specialist, Dunn County Office on Aging	6
Troy A. Keeling, executive director, Western Wisconsin Area Agency on Aging, Eau Claire, WI	8
Timothy F. Cullen, vice president, Blue Cross & Blue Shield United of Wisconsin.....	15
Robert D. Haase, Wisconsin State Commissioner of Insurance.....	18
David L. Becker, Arneson/Becker Insurance Agency, Mount Horeb, WI.....	20
Geralyn Hawkins, Medigap hotline counselor, Wisconsin Board on Aging and Long Term Care	22
Betsy J. Abramson, director, elderly department, Center for Public Representation	33
Bette M. Johnson, president, Coalition of Wisconsin Aging Groups.....	36

APPENDIX

Item 1. Testimony from the National Council on the Aging, submitted by James T. Sykes	43
Item 2. Testimony from the Dunn County Office on Aging, submitted by Margaret Hagaman, Dunn County Benefit Specialist	48
Item 3. Testimony submitted by David L. Becker of Arneson/Becker Insurance Agency, Mount Horeb, WI	50
Item 4. Testimony with attachments, from the Wisconsin Office of the Commissioner of Insurance, submitted by Robert D. Haase, Commissioner	55

MEDIGAP INSURANCE: COST, CONFUSION, AND CRIMINALITY

MONDAY, DECEMBER 11, 1989

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Madison, WI.

The committee met, pursuant to notice, at 10 a.m., in room 421, State Capitol Building, Madison, WI, Senator Herb Kohl, presiding.
Present: Senator Kohl and State Senator Russ Feingold.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Ladies and gentlemen, I'd like to thank you on behalf of the U.S. Senate Special Committee on Aging for joining us today. The purpose of today's hearing is to examine the rising cost of Medigap insurance, the quality and amounts of the benefits which are being offered, and the fraudulent marketing practices by present-day agents of insurance policies at the expense of the consumers which are unnecessary and duplicative and result in untold costs, confusion, and border on criminality.

This year, approximately 22 million senior citizens will spend approximately \$17 billion on Medigap insurance. Many will have one, two, three or as many as four policies at any given time. In recent years, premiums for Medicare supplemental insurance policies or Medigap policies have increased faster than the overall cost of health care, which in itself has increased twice the rate of inflation. In 1987, the House Select Committee on Aging estimated that older Americans lost about \$3 billion because of fraudulent and deceptive Medigap practices alone.

The recent repeal of the Medicare catastrophic coverage care law creates an environment in which elderly citizens are even more vulnerable to price hikes, confusion, and fraudulent marketing tactics. Prior to the repeal, premium increases were expected to range from 10 upwards to 25 percent. Now that the policies are being changed to reflect the need for increased benefits, I am particularly concerned that senior citizens on fixed incomes are going to be asked to pay even higher prices for protection against illness and catastrophic health care costs.

The second question then is: What coverage are seniors getting for their money? A Federal law passed in 1980 requires that Medigap insurance companies return at least 60 percent of the premiums to the beneficiaries through benefit payments. The law was enacted with the intent of assuring, to some minimal extent, that

consumers could get a fair shake on their insurance coverage. We will look at how effective those loss-ratio requirements are.

In Wisconsin, this year's marketing of a basic Medigap policy with the option of purchasing additional benefits made it a lot easier for consumers to compare benefits, policies, and prices. And yet, I have to confess—it is mind-boggling to go through the policy comparison charts. Not only is it difficult to compare the cost of packages for a defined set of benefits, but quite frankly I'm not sure that even the most savvy of consumers can figure out exactly what some of those benefits are. Do consumers distinguish between Medigap policies and Medicare supplemental insurance policies?

And many of the plans offer a part B deductible benefit as a rider. Medicare asks beneficiaries to pay a one-time annual deductible of \$75 for annual doctor bills. Despite the fact that the maximum value of that benefit is \$75 per year, some Wisconsin elderly are paying \$80.37 a year for it. Do I think they would pay \$80.37 if they understood the most they could get for the expense is \$75? Of course not. And my conclusion is that they aren't being told the value of the benefit up front.

And there are so-called phantom benefits. Benefits that are so totally dependent on a series of events: Hospitalization, Medicare payment for extended home health care, and then Medigap coverage—that you really have to ask yourself what the real value of that benefit is. But if, as an elderly person, you fear going into a nursing home and if you think that this home health benefit is going to protect you, well then why wouldn't you spend as much as \$395 a year for the benefit?

Unfortunately millions of senior citizens are being snowed by some of these policies. And somehow, we have to do a better job of helping them plow their ways through these policy options.

And that comes to the third issue we will examine in today's hearing: The role of the agent in the ethical marketing of Medigap insurance and the roles of the State and Federal Governments in eliminating fraudulent insurance practices. We have had, since 1980, criminal penalties for fraudulent activities connected with the sale of Medigap policies. But are they being enforced?

We will hear from witnesses today about the victimization of American citizens. It is enough that they live in fear of catastrophic illnesses and the need for long-term care. They need not be terrorized in their own homes by unsavory agents seeking to line their own pockets with replacement commissions.

We will hear some stories from benefit specialists, who spend their days assisting Wisconsin senior citizens in sorting out unclear and noncomparable policy descriptions.

And we will hear from the insurance industry and advocates who will help the committee to formulate appropriate responses to the problems with the Medigap insurance system.

It is my hope that by the end of this morning's proceedings we will have a clearer sense of what we can do to assure Medicare recipients access to the health benefits they need, without subjecting them to exorbitant costs, confusion, and criminality.

Thank you. The Chair will now ask the first panel of witnesses to make their individual presentations. Would you please come forward?

We are fortunate to have with us today Mrs. Wilma Blum from Monticello, WI, Mr. Harold Halfin, a senior volunteer and benefit specialist from the Dunn County Office on Aging, Mr. Troy Keeling, director of the Western Wisconsin Area Agency on Aging, Eau Claire, and we are particularly pleased that Mr. Keeling is able to join us today, and, finally, we have with us State Senator Russ Feingold, a longtime spokesperson for the elderly. Russ will testify on the first panel as I understand he has some pressing business and will be required to leave us after his testimony.

Senator Feingold, would you make your presentation, please?

STATEMENT OF STATE SENATOR RUSS FEINGOLD

Senator FEINGOLD. Thank you, Senator Kohl, for holding this important hearing on Medicare supplemental insurance. We are all very pleased to have a Wisconsin Senator, and especially you, on the Senate Special Committee on Aging.

For the past 7 years I have chaired the Senate Aging Committee in Wisconsin. That position has given me an unusual opportunity to begin to understand some of the problems facing Wisconsin's older population. The problems are considerable, and as the elderly population grows, and it is our fastest growing population, those problems will intensify.

Though the social and emotional pressures are many, the economic pressures are especially serious. Contrary to a popularly held and too often repeated belief, the elderly are poorer than other adults in our country. In 1986, the median income of families with heads of household age 65 or older was less than two-thirds that of families with heads of household under 65. And for elderly not living in families, the median income was actually less than half of comparable nonelderly. For the very elderly, the disparity in income is even greater. For family heads over 85, median income is less than half of those under 65, and for elderly living alone, median income is less than 40 percent of individuals under 65 living alone.

While income for the elderly is relatively low, their living expenses are disproportionately high. Wisconsin's high property tax falls particularly hard on the elderly. In an area of special concern to our committee, long-term care costs have also gone up dramatically. The cost of a nursing home care can run higher than \$30,000 per year in some homes, and averages more than \$20,000. And there are long waiting lists for the Community Options Program, Wisconsin's pioneering home and community-based long-term care program. The focus of today's hearing, Medicare supplemental insurance, is yet another stress on Wisconsin's elderly, requiring attention at the Federal level. Abuses have surfaced in what was supposed to be a model of public-private partnership in providing health insurance for older Americans.

We have heard evidence of unscrupulous insurance agents selling some elderly unneeded replacement policies for supplemental insurance. With the temptingly high bounties paid by insurance companies in the first year of a new policy, some agents have been unable to resist opportunities to sell unsuspecting consumers supplemental policies they probably don't need.

The problem is compounded by the inability of a policyholder to cancel a supplemental policy in mid-term, or to receive a refund for the unused policy. This means that older consumers may be saddled with several policies at one time, having to pay for all of them, but receiving no additional coverage.

I assume most insurance agents act ethically in providing the elderly with supplemental policies. In fact the problem of multiple replacement policies caused by high first year commissions was brought to my attention by an insurance agent who is a constituent of mine from a rural area. He proposes that we prohibit those high first year commissions and instead allow only the lower replacement commission, thus eliminating an incentive to push more and more policies on an unsuspecting consumer.

We should also do a better job of educating agents on Medicare supplemental insurance, though, as they may often be as confused about changing Medicare coverage as are consumers. This is even more likely now, with the controversy over the Catastrophic Health Act.

Beyond the problem of face-to-face sales tactics of some insurance agents, consumers are too often duped into buying unneeded policies by the slick television advertising that features popular, and trustworthy celebrities promoting supplemental policies. By merely calling a toll-free number, older consumers can buy the same policy their favorite TV star claims to have. Those ads can be extremely persuasive, and as a result, some elderly end up with a dozen or more Medicare supplement policies. These telemarketing firms are beyond the reach of our State regulators, making it nearly impossible for Wisconsin's government to protect its consumers in this area.

Another concern is the wide range of prices currently charged by different insurance companies for essentially the same policy. In one example, the rate for one policy described in the "Individual Medicare Supplement Insurance Policies" packet published by the Office of the Commissioner of Insurance [OCI], one insurance company charges over 60 percent more than another company for a Medicare supplemental insurance policy with identical benefits—a difference of nearly \$300. Adding to the rate disparity problem are the policy riders that, in some instances, cost more than the benefit they cover. The OCI packet noted earlier lists one insurance company that offers a rider to cover the \$75 part B deductible. That rider cost \$99 to purchase!

Let me say, however, that Wisconsinites are fortunate in a couple of respects. First, we have the Medigap Hotline, administered by the Board on Aging and Long-Term Care. They do an excellent job of providing older consumers with help and information about Medicare supplemental insurance policies, as well as other issues. And they are an excellent source of information for the legislature both in directly helping our constituents and as we develop policy on aging issues.

Second, we have several effective consumer advocacy groups, and I would especially bring to your attention the Coalition of Wisconsin Aging Groups and the Center for Public Representation. Both the coalition and the center have representatives here today, and I

know their suggestions and recommendations carry weight with this committee.

Finally, Senator Kohl, as you seek solutions to the problems of Medicare supplemental insurance, I urge you to apply the lessons we are learning from this public health care insurance system to the area of long-term care. Reforming Federal long-term care policies and programs is the greatest need of older Americans and should be the highest priority of Congress and the Senate. Your hearing here today is a clear sign to the people of Wisconsin that the concerns of older people in this State are at the top of your legislative agenda.

Thank you.

Senator KOHL. Thank you, Senator Feingold.

Mrs. Blum.

STATEMENT OF WILMA BLUM, MONTICELLO, WI

Mrs. BLUM. Good morning, Senator Kohl. My name is Mrs. Wilma Blum. I am 77 years old and my husband is 82 years old. We have been residents of Monticello, WI, for over 50 years. I appreciate the opportunity of sharing my experiences with the Senate Special Committee on Aging, and I hope the testimony I'll give today will help other senior citizens avoid the experiences that I and my husband have had.

My husband and I had separate supplementary policies with the same insurance company—Guaranteed Trust. His initial premium was approximately \$300 and it went up by \$100 in each of 4 years. The benefits did not increase in relation to the rate increases. My policy, with the same company, cost me \$197.87 per year.

In 1985 an insurance agent came to our home uninvited. My husband and I told her that we were unhappy about our Medicare supplemental policies. The costs kept going up and we didn't think the benefits were very good. She sold us new policies with United American at a cost of \$789 per year for the two of us.

We kept United American for almost 2 years. In 1986 we were paying over \$1,200 for our two policies. The agent gave us the impression that the Central States policy would pay 100 percent of whatever outstanding medical bills we might have. Both my husband and I had surgery and we found that the 100 percent coverage was not there.

Then in 1987 we bought a National States policy for my husband—\$857 per year. My husband got ill, and National States gave poor service in paying. We still had the United American policy, and the premiums had reached \$1,051 per year. Sometime in 1987 the agent came back and said she had a better supplemental policy that involved less paperwork. She sold us a policy with Central States Insurance, with a yearly premium of \$930.18 for myself and \$1,127.36 for my husband. We have had Central States for nearly 2 years. We were told that Central States would pay 100 percent of medical bills after Medicare but it has not.

We now must make a decision to purchase another policy or to continue with Central States. I realize that these numbers may be confusing. They certainly have been to us. But we cannot be without supplementary insurance at our age. It was only when the

Green County Benefit Specialist, Ruth Flannery came to see us that we were given any helpful information about the kind of health insurance choices we are trying to make.

I hope what has happened to us can be prevented from happening to other senior citizens. We get so little information and often the insurance agents promise to explain these policies to us but never do. Thank you again for holding these hearings. I will do my best to answer any questions you might have.

Senator KOHL. Thank you for a fine statement, Mrs. Blum.
Mr. Halfin.

STATEMENT OF HAROLD HALFIN, VOLUNTEER, DUNN COUNTY OFFICE ON AGING

Mr. HALFIN. I'm Harold Halfin from the Dunn County Office on Aging. I'm a volunteer and I work for a number of people as a Medicare helper and, in addition, I have had training from the Office of the Commission of Insurance regarding Medigap policies. I also enroll people, who qualify, for the Partner Care Program.

I serve in the northern part of Dunn County as a volunteer, and I would like to speak this morning from the point of view of consumer protection for the elderly.

I would like to speak from the point of view of consumer protection for, in the majority of cases, the female elderly. This is not to say that the male elderly does not have a problem. In rural west central Wisconsin the majority of people calling for help are the vulnerable female elderly whose husband in many cases took care of the books and paid the bills and when he died she did not have any inkling of what to do or how to do it. These female elderly may or may not be low-income elderly. Some are just above medical assistance income while some have sufficient funds. Some are on PartnerCare. Some have a visual problem while some have difficulty reading and understanding the written word. Some are very lonely and some have no family in the immediate area.

With the above background I would like to discuss three different cases where the elderly have been subjected to unethical insurance agents. These agents are determined to sell their policies even though the additional policy or a policy change is not necessary. They—the agents—butter up these female elderly and they—the elderly—buy another policy or a replacement policy. Sometimes, in taking the application the agent fills out the application not listing the preexisting conditions and when it is time to collect the insurance company will not pay because they say it is a fraudulent application.

Case No. 1: A widow, 92 years old, whose income is just above the medical assistance level but eligible for PartnerCare thought she was buying insurance coverage for a nursing home. She currently has a comprehensive Medigap policy with an HMO. An insurance agent called on her and found she was concerned about nursing home coverage and proceeded to tell her he had the policy she needed. She paid him \$861 for another policy which was nothing more than a Medigap policy with coverage considerably less than her HMO. The agent would have collected 60 percent or \$516.60 for this day's work.

Here is a case where the agent was so nice and told the lady that she needed help and he was there to help her using what I call the nice guy syndrome and instilling fear in her about the need for nursing home coverage. After 3 weeks she wondered if she had done the right thing and called the Office on Aging. We wrote the company about the policy; we also wrote the complaint department of the Commissioner of Insurance about this unethical practice. This agent did not follow correct procedure because all agents are to provide an OCI brochure on Medigap policies prior to any sale. This he did after the sale. Also the signature of the agent was illegible and no address was given. As yet she does not have her money back.

Case No. 2: A 76-year-old widow who shows serious signs of dementia has no family support and loves to have visitors. She also is unable to say no to insurance agents. Her banker asked the county benefit specialist to investigate when this woman was overdrawing her accounts due to a number of large checks written to insurance companies. During a 2-year period this woman had bought 15 different insurance policies. Two other additional Medicare supplements had recently lapsed. The policies included seven Medicare supplements, one daily indemnity, five life insurance, and two cancer policies.

Upon investigating it was obvious that this woman had no understanding of insurance. She didn't even know the difference between life insurance and a Medicare supplement.

Several agents switched her regularly every year to either a new company or a new policy for her Medicare supplement. Other agents sold her one of each kind of policy.

With the assistance of the benefit specialist and the Office of the Insurance Commissioner some money was recovered, however, most of the policies lapsed or were canceled.

Three years later this vulnerable woman still has little protection from unethical agents. Her banker, neighbors, and social worker try to check on her regularly. However she is unwilling to ask for help, has no family, and the court system is unwilling to intervene saying she is still competent to make her own decision.

Case No. 3: This involves a couple who purchased a supplemental policy and the insurance agent completed the application incorrectly on preexisting conditions. There are questions on the application that ask about the possibility of preexisting conditions. These questions were, according to the couple, answered honestly detailing the preexisting conditions of the wife. The agent answered "yes" to the question whether she had been advised by a physician * * *, and the agent proceeded to check "no" on medical history of the wife even though she told the agent of her medical history. The wife became ill and later filed a claim which was refused on the basis of a preexisting condition not shown on the application. This couple had to pay or is paying out of their pockets for this tragic mistake which should not have happened.

What is needed is a rule or legislation that requires agents to be more responsible for their actions. Possibly a form requiring the agent to indicate whether the policy he/she is trying to sell is a new policy, an additional policy, or a replacement policy. The agent should indicate why the different policy is better and detail exactly

what is covered on a separate sheet of paper. The agent should sign the form and come back at a later time to get the person's signature and payment. This form would become part of the policy and it would also be sent to the Office of the Commissioner of Insurance. Such a rule has been proposed by the Commissioner of Insurance.

One last note, the people I contact are only a small portion of those needing assistance with Medigap insurance issues.

Thank you, Senator, for the opportunity for being here today.

Senator KOHL. Thank you, Mr. Halfin. That's a fine statement.

Mr. Keeling, thank you for being here today.

**STATEMENT OF TROY A. KEELING, EXECUTIVE DIRECTOR,
WESTERN WISCONSIN AREA AGENCY ON AGING, EAU CLAIRE, WI**

Mr. KEELING. Thank you, sir, Senator Kohl. I was pleased when I learned you were going to be on this committee. When you first went into the Senate we thought maybe it would have been better for you if you had gone into banking, but my agency has enjoyed working with you and with your field staff here in Wisconsin.

For the record, my name is Troy Keeling. I am director of the Western Wisconsin Area Agency on Aging. This agency serves 19 counties and 2 tribes in rural Wisconsin. Thank you for this invitation to speak to the concerns of this region's elderly population. Medigap supplemental insurance is problematic for aging persons here, as well as for those throughout this Nation. I will speak directly to, and from, the consumer-beneficiary perspective.

The term "Medigap" identifies the real problem. The need for gap filling insurance creates and nourishes an entire family of anxieties for older people. The supplemental insurance policies, their benefits or lack of benefits, fright-filled multipurchasing, along with other complex concerns, represent confusion and doubt in all elements of the supplemental insurance constellation. The elderly are confused over, and by, the complexity of Medicare, confused by the quasi-governmental sounding language of private Medigap supplemental insurance policies, confused by the bewildering plethora of advertised promises of insured salvation and confused by government and private insurance company exercises in frail attempts at clearing up the confusion. Administrators and providers of medical services are entrapped in red tape confusion in attempts to decode for the elderly the complicated payment system. Even the advocates for the elderly and aging programs are confused by the unclear messages sent out by the Federal Government even as it attempts to wander through a self-created maze of the complicated solutions.

The elderly, after 24 years of Medicare, don't understand why the government, along with private insurance, can't or won't provide comprehensive, all-inclusive health insurance. They wonder at the very idea of a gap between Medicare, for which they pay an ever-increasing price, and the actual cost of their medical care. Older persons hear of other nations close by and far away providing either national health insurance or national universal health care and continue their wondering. A gap between their health care needs and the Nation's inability to provide health care with-

out their being reduced to penury doesn't square with the image they have carried from the cradle of a beneficent democratic Nation.

The rising cost of Medicare supplemental insurance is, of course, directly related to the ever-higher cost of medical services and the reforms in Medicare throughout the present decade which reduced paid-for services while continuing obtuse policy language, further confusing the consumer. The growing sense of a lack of security and the need to feel secure at least in being prepared for future health needs, has caused older people to neglect the most basic of their needs in order to not go the dreaded welfare route. The public mind, which now leans more to a "greedy geezer" portrait of the elderly, doesn't focus well on improved benefits through Medicare. The growing sense of insecurity gains credence by the growth of the elderly's increase in daily living expenses and growing debt in many elderly families.

The growing insecurity caused by a widened gap in cost and coverage has made the elderly prey to insurance activities and their own imprudence caused by fear. The very ethics older people have been raised by breaks down with increased fear of not being able to take care of their own needs. For various reasons, some frail elderly find that the way out of their dilemma is to break the hard gained nest egg and stock up on insurance coverage.

In the 1980's, the State of Wisconsin's Aging Network has found a partial solution to eliminating the confusion, fear, and insecurity caused by the complexities of paying for health care. Supported by the Coalition of Wisconsin Aging Groups and other advocacy groups, the Bureau on Aging, of the State Department of Health and Social Services, created a benefit counseling service. At first funded only with Title III-B funds under the Federal Older Americans Act, the State's area agencies used their funds to give legal back-up to a county service to older persons. Over the past years, since 1983, the State legislature and administration has added significant funds to the program, allowing for a benefit specialist in all 72 counties, at least on a part-time basis.

The well-trained corps of benefit specialists, known as tape cutters, work in the counties through the county aging units. Older consumers are guided through the maze of paperwork assisted by one-on-one contact and through group training in understanding the complexities of the Medicare system. One of the most important services offered by this well-run, if underfunded program, is in the area of medigap supplemental insurance. Senator Kohl, it would be hard to imagine the State of Wisconsin going back to a haphazard system of information provision now that the elderly are provided with a service which helps explain a system and at the same time assists the consumer through their insurance problem. The benefit specialist is kept informed of changes in the State insurance laws and in Federal Medicare. This important service is given legal and benefit counseling back-up by the State's area agencies on aging.

I would suggest that the State of Wisconsin's model for offering benefit counseling could be built into the Medicare system. As the Federal laws change and grow even more difficult to track and understand, one serious problem grows for the elderly. That is having

the ability to know and understand what is available in insurance and service. Not knowing causes a vulnerable portion of our society to live lives in fear and anxiety. The Social Security Administration now does its main business with an aging population by telephone. The Veterans' Administration is reducing counseling services while eliminating their transportation resources at a time when the number of aging veterans increases. A better informed consumer will eventually decrease the communication problems for the Medicare system. If the Federal Medicare system doesn't care about the fear and insecurity caused by a complex program, then Congress has a very clear mandate for real reform.

Speaking on the floor of the Senate on November 21, 1989, during the debate on the Medicare Catastrophic Act of 1989, Senator Weiss, speaking of the recent estimates which indicate that there are over 37 million people with no health care insurance coverage in the United States, made the following statement:

The United States is the only major industrialized nation, with the exception of South Africa, that doesn't have a national health plan for its citizens. Although establishing a national health plan is not the issue at hand today, I would like to reaffirm my strong support for such a plan. I believe that all Americans—young and old—are entitled to quality medical care.

This advocate for the elderly maintains that given the fact that the State and Federal Government is apparently not yet ready to provide for a national health service, now is the time to advance the cause of a national universal health insurance program. At the very least, Congress could assist State government with the institution of Medicare certification for basic coverage policy on the order of QMB. Private insurance then would offer coverage as if under a national seal of approval. The conditions which caused the problem for the consumer of Medigap insurance are the complicated language in policies, the complicated coverage items and the seriously complicated consumer evaluations. These conditions breed aggressive agents who are tempted to mislead, oversell, and misrepresent.

Again, Senator Kohl, I thank you for the opportunity to appear here today to continue with you the effort to take some of the confusion and insecurity out of the Medigap insurance picture. A secure feeling of having adequate insurance will go a long way in enhancing the lives of older people.

Senator KOHL. Thank you, Mr. Keeling, for a very fine statement.

Mrs. Blum, I'd like to ask you just a few questions. Mrs. Blum, how did you find out about the county's services and while you were struggling with these various policies did you ever try to get outside help?

Mrs. BLUM. No, we did not. This lady who was selling us insurance acted like she was doing us a good deed, but she was not because every time the policy was changed we'd have to have a new policy; we'd have to have a 90-day waiting period. So, that was hard.

We had to pay the extra 3 months there. And then, each time the policy went higher so she was making pretty good money, I think.

Senator KOHL. So you weren't in a position to deal with outside help; you were dealing with the insurance agents and you thought they were providing you with all the information you needed?

Mrs. BLUM. I thought she was doing us a good job. I had talked to a social service lady one other time.

This one time when my husband went to National State's policy the insurance agent came there when I was not there and he talked to my husband and he tried to tell him how good the policy that he was selling was going to be for a nursing home. Of course, that kind of sold my husband.

And then, of course, we had the other policy in force and we thought we'd better keep it and, here, before the 90 days were up he got sick and had to go to the hospital. So, we didn't get—they didn't want to pay much for the claim.

Well, I can see where they didn't, but finally—they kept on sending bills back and forth to our doctor, and finally I went there one day and I said, "What is wrong here?" An office girl said, "We have had so many papers that they sent us to fill out," and she says, "We have done the same thing many times and we don't know what to answer them anymore."

So, the insurance man called up my husband and he says, "What's wrong?" And he says, "I'll tell you what's wrong. Our doctor here is having a fit because we have sent these bills in time and time again and answered your questions but we have to answer the same thing every time."

So, then we did get a lump-sum settlement but we did keep the other insurance in force because we knew we weren't satisfied with National States.

Senator KOHL. And you paid the huge premiums to four different companies?

Mrs. BLUM. Two different companies.

Senator KOHL. Were you aware of the fact when you wrote these policies with them that 60 percent of the first year's premium went to commission for them? Did they make you aware of that?

Mrs. BLUM. No.

Senator KOHL. You were not aware of that?

Mrs. BLUM. No, but we started to get wise to it.

Senator KOHL. Do you believe today that in your case that this particular agent was probably switching your policies in order to make money for herself?

Mrs. BLUM. I thought she was. She called me the other day and I was very short with her. And I said—we've got two things; I've got another thing with her. And it's with my life insurance policy, and she has done a very nasty trick with me, but I can't present that today.

Senator KOHL. Do you feel, Mrs. Blum, that you and everybody else has a right to be protected against insurance representatives like this one?

Mrs. BLUM. Yes, we do. We trusted her, but I don't anymore.

Senator KOHL. So, the relationship between yourself and many, many other people who seek to purchase the right policies and the insurance agent, while oftentimes depicted as a friendly, trusting, cooperative relationship, really isn't that kind of a relationship. Is that an accurate statement?

Mrs. BLUM. That's right.

Senator KOHL. And there's nobody between you and them to inform you and protect you?

Mrs. BLUM. Well, there probably would have been, but I guess—

Senator KOHL. No, that you knew of?

Mrs. BLUM. That's right. You know, social services has been in our town for a long time and I talk to her occasionally but, I don't know, I just didn't realize how far you could go with it.

And when your policy comes due you're naturally not going to let anything lapse. We wanted to get it straightened out.

Senator KOHL. Absolutely, that's very good.

Mrs. BLUM. That's what our problem was. That's why we stuck with her.

Senator KOHL. Mr. Halfin, do you regard Mrs. Blum's situation as typical?

Mr. HALFIN. Typical.

Senator KOHL. Typical?

Mr. HALFIN. That's right, in rural Wisconsin.

Senator KOHL. In rural areas?

Mr. HALFIN. Um-hum.

Senator KOHL. Are you saying to us today that you, as an experienced person who understands this field and understands what Mrs. Blum has just said and has had many years of involvement with regard to her situation, at least in terms of rural areas, it's not atypical at all?

Mr. HALFIN. I can give you numerous cases where people who are elderly—female and in some cases husband and wife—do have two policies but only need one plus a cancer policy.

Mrs. BLUM. We had that too.

Senator KOHL. You had that, too?

Mrs. BLUM. We had a cancer policy; but not from her.

Senator KOHL. OK. Mr. Halfin, in the case of that 92-year-old woman you talked about, could you tell us the name of the insurance company involved?

Mr. HALFIN. Guaranteed Life and Trust of Glenview, IL.

Senator KOHL. Guaranteed Life and Trust, OK. I'd like to know that if the woman is willing to share information with you or me and my staff. Perhaps we can be of some assistance. I would like to pursue that with your permission and your help.

Mr. HALFIN. Yes, I'd appreciate that.

Senator KOHL. Mr. Halfin, do you think more of the responsibilities should be placed on the seller to avoid selling duplicative policies and replacement policies. Or, if the agents didn't have such strong incentives to sell replacement policies and duplicative policies, do you think that would help?

Mr. HALFIN. Yes, definitely.

Senator KOHL. Do you regard that as one of the worst abuses to the system?

Mr. HALFIN. Yes, during the first year. In other words, first they make the sale and then they come back a year later and tell them, "I have a better policy now. I think you should buy this." And they sell again, sell again, sell again, and sell again.

Senator KOHL. Well, how can we see that this pattern is not repeated in the future? I'm assuming that for most older Americans, as well as most citizens trying to understand these policies, it is really very difficult, if not impossible, and most of us need help.

Mr. HALFIN. Yes.

Senator KOHL. I would say that about myself if I were buying one of these policies. How do you suggest that we do something that will eliminate this problem? What would you suggest?

Mr. HALFIN. I would have a separate sheet detailing exactly what is in the policy if it's a new policy—1, 2, 3, 4, 5, 6, 7, 8—or if a replacement policy it must be compared with the policy it is to replace. The agent must sign it; also, a friend must sign it, and then, the person buying the policy would sign it.

And if, in some cases the person doesn't have a friend to sign the agent signs that he/she is responsible for duplication, and errors of omission. We need to have those agents pay for some of the mistakes they're making for these people.

Senator KOHL. Are we pursuing these agents that are making these mistakes? Is there any real pursuit at any place in our State that—

Mr. HALFIN. Let me say that at least by writing the Commissioner of Insurance we do get a response. I think we have a very good advocate in the Commissioner of Insurance Office—I'll name her—Donna Bryant—and she does help a great deal.

Senator KOHL. After the fact?

Mr. HALFIN. Yes.

Senator KOHL. Would it be helpful if every senior citizen were required to get the help of a professional?

Mr. HALFIN. That would be very good, yes. It would be helpful also to wait for a week or a lapse of time, before payment is made so that the person has the opportunity to get help if necessary.

Senator KOHL. No signing on the spot?

Mr. HALFIN. No signing on the spot or making any payment on the spot.

Senator KOHL. Do you think that's a good suggestion, Mrs. Blum?

Mrs. BLUM. Yes, it is.

Senator KOHL. Is there a big push when you're sitting with the insurance agent to get it signed?

Mrs. BLUM. Yes, and if you don't they don't leave you alone; they call you back and get you really confused.

Senator KOHL. Let me ask this question. What would be wrong with a system whereby when you have an insurance policy you want to sign in 7 days you send it to a place of government professionals that have a chance to look it over and send it back or call you, or whatever else, so that, when you sign it you'll know that somebody who is very competent has looked it over first and told you it's a service to buy. Would that be helpful?

Mrs. BLUM. Yes.

Senator KOHL. Mr. Halfin.

Mr. HALFIN. Yes. However, if it's a replacement policy how much better is it than the replaced policy has to be detailed also.

I had a lady tell me recently that she had an agent in her house for 6 hours determined to sell her a policy.

Mrs. BLUM. Mine was there for 2 hours.

Senator KOHL. Mr. Keeling, how do seniors needing your services find out about them and how many people do you serve in your area? How many resources do you have to do outreach?

Mr. KEELING. We're fortunate to have fairly good resources to do outreach in this State. Agent services are done through what we call county-based planning where 72 counties have units and the Bureau on Aging serves these 72 counties.

So, we do have professionals in all of the counties. They are, of course, generally overworked and understaffed but every one of those counties attempts to get out newsletters through the senior center and through the meal sites and various outreach programs. They attempt to get into the homes with the message of how to buy insurance, how to have access to good information.

The problem I think that I sense is that we tend to always start with the little people in the United States, and the little people sometimes are the victims of a bigger system.

And I think that one of the things that we've discovered in our area is to try to get the big people and the big people are the insurance companies, themselves.

Also, it's people in government who are not being clear, not passing the right kind of laws, not taking the right kind of surveillance, and I think it's also our own agencies.

I envision this happening. A young person out of work finds a job, takes a job as an insurance agent or someone fresh out of college, someone who has a master's degree, someone who has long years and skill at the lathe or something. It's usually somebody who has an unfortunate circumstance.

And I envision this kind of person going out there in their one suit and one tie attached, and everything, wanting to bring home money to the family. They're probably in debt, probably mortgaged the car, and they have incentives to find themselves in a position to do unethical things.

But it seems to me that if the insurance industry were regulated in such a sense they would be able to create a system that would not tend to prey but would tend to be very helpful.

I, for one, am a little discouraged with the primary insurance industry. I have not seen an awful lot of stomach or heart on the part of insurance companies, Senator, to do much other than to try to sell insurance for a profit motive.

So, I've seen very little imagination between government and private insurance in trying to assist these people and trying to get the little people, trying to get the information out to the little people and do a pretty good job of it.

I am pleased with all of the persons who are here with us and all of the staffs and all of the aging units in our counties. They do yeoman's work. They are working in the areas and they're working with the victims. Most of them are victims themselves because the system doesn't back them up, doesn't give them muscle, and doesn't look to what the real problems are.

You and I both know that the real problem is limited care long-term support itself. So, Mrs. Blum and her husband have worked hard for their nest egg; they don't want to cause you or me or anybody else a problem, and they find themselves in the very pursuit

of that care, falling into traps that hurt them and make their life almost unbearable.

Senator KOHL. Well, this has been remarkable and I want to thank you all for making the effort to come here today, and I want you to know that what you've said is going to cause some action to be taken. Thank you very much.

Mr. KEELING. Thank you very much. It was nice to be here.

Senator KOHL. I'd like to call our second panel at this time. We have with us David Becker of the Arneson/Becker Insurance Agency in Mount Horeb; GERALYN HAWKINS, the benefits hotline specialist for the Wisconsin Board of Aging; ROBERT HAASE, Wisconsin State Commissioner of Insurance; and TIM CULLEN, Vice-President of Blue Cross and Blue Shield Insurance Co.

And it's good to have you all with us this morning, folks.

Tim, would you like to start off?

**STATEMENT OF TIMOTHY F. CULLEN, VICE PRESIDENT, BLUE
CROSS AND BLUE SHIELD UNITED OF WISCONSIN**

Mr. CULLEN. I certainly would, Senator.

I appreciated hearing Senator Feingold's comments this morning. I had the privilege of helping establish the first Senate Committee on Aging as I was the first Chairman of that Committee. I also had the privilege as Senate Majority Leader to appoint Senator Feingold to succeed me. He's done an outstanding job in that capacity.

Thank you for the opportunity for Blue Cross and Blue Shield to participate in this hearing. We believe that government monitoring and government regulation of Medigap policies is not only appropriate but badly needed today. To get right to the issue, I would like to focus first on the Medigap insurance sales arena following the repeal of catastrophic coverage under Medicare.

How does repeal impact on private insurance sales activities toward senior citizens? The act of repeal becomes a sales tool. Agents can tell seniors that "now more than ever" you need a policy to fill the gaps in Medicare.

What actions can government take to protect consumers? Number one, more rigorous enforcement of the existing laws. Current law requires loss ratios of 60 percent on individual policies and 75 percent in group policies. Loss ratio is a term stated in the negative. Consumers benefit from higher loss ratios. The higher the loss ratio, the higher the percent of the premium dollar that is paid out in claims and the lower the percent of the premium dollar that is kept by the insurance company. A higher loss ratio generally means a better value to consumers.

The attached list shows the loss ratio of companies selling individual Medigap policies in Wisconsin in 1988. As you can see, 14 of the top 20 sellers had loss ratios below the required 60 percent. Although the numbers are complex, let me put this issue into dollars. A large majority of the business on this list is, in fact, Medicare supplement business. If regulation and enforcement were toughened to bring the average up to 60 percent minimum, elderly consumers would save more than \$10 million per year.

The second thing the Government can do is more rigorously prevent agent abuse. I call your attention to an incident in Fond du

Lac of an agent representing himself as a Blue Cross and Blue Shield agent to gain access to a senior citizen in order to talk her into switching her coverage to a company that pays higher first-year commissions. The company the agent was encouraging her to switch to had a 54 percent loss ratio in 1988, and much higher first-year commissions than Blue Cross and Blue Shield.

Blue Cross and Blue Shield pays low commissions on Medigap policies—a flat \$36 per year—much less than 10 percent—so that agents licensed with several companies can see a financial incentive to switch peoples' coverage to companies that pay higher commissions.

The Government could raise the required loss ratios. This not only gives the policyholder more of their premium dollar in benefits, but it also restricts the insurance company's ability to pay high commissions, which only encourages the possibility of agent abuse.

How can rate increases on Medigap policies be controlled? Given the deregulated health care field in Wisconsin, the best single tool is probably putting more managed care provisions into Medicare itself. Currently Medicare only has managed care on the hospital side. Managed care on Medicare will lead to more managed care on Medigap policies.

Senior citizens would probably be better served by having Medigap policies marketed through reputable senior citizen organizations, such as the Coalition of Wisconsin Aging Groups.

I look forward to your questions and comments. Thank you.

OTHER INDIVIDUAL ACCIDENT & HEALTH

RANK	INSURER	% OF MARKET	PREMIUMS WRITTEN	LOSS RATIO
1	BLUE CROSS & BLUE SHIELD UNITED OF WI	12.2	\$ 43,317,867	66
2	WISCONSIN PHYSICIANS SERVICE INS CORP	8.8	31,358,157	71
3	BANKERS LIFE & CASUALTY CO	6.0	21,522,267	55
4	AMERICAN FAMILY MUTUAL INS CO	5.7	20,309,163	57
5	PHYSICIANS MUTUAL INS CO	5.2	18,424,097	65
6	TIME INSURANCE CO	4.6	16,492,209	43
7	AMERICAN FAMILY LIFE ASSUR CO OF COLUMBUS	4.6	16,450,947	51
8	COMBINED INSURANCE CO OF AMERICA	4.2	15,168,145	39
9	MUTUAL OF OMAHA INS CO	3.8	13,430,596	59
10	UNITED AMERICAN INS CO	3.4	12,018,028	54
11	STATE FARM MUTUAL AUTOMOBILE INS CO	3.1	11,019,536	71
12	MIDAMERICA MUTUAL LIFE INS CO	2.2	7,828,529	72
13	AID ASSOCIATION FOR LUTHERANS	2.1	7,591,375	62
14	NORTHWESTERN MUTUAL LIFE INS CO, THE	2.0	7,343,491	47
15	CONTINENTAL CASUALTY CO	1.6	5,675,314	42
16	CENTRAL STATES HEALTH & LIFE CO OF OMAHA	1.5	5,313,364	39
17	GOLDEN RULE INS CO	1.4	5,203,794	46
18	DELTA DENTAL PLAN OF WI INC	1.4	5,162,895	90
19	PIONEER LIFE INS CO OF ILLINOIS	1.3	4,895,455	10
20	PENNSYLVANIA LIFE INS CO	1.1	4,190,309	49
TOTALS FOR 20 RANKED INSURERS		77.15	\$ 272,915,558	59
TOTALS FOR 352 INSURERS WRITING THIS LINE		100.00	\$ 353,744,235	57

SOURCE: Wisconsin Insurance Report, Robert D. Haase, Commissioner of Insurance, Business of 1988, p. 118.

Senator KOHL. Thank you, Tim.
Mr. Haase.

STATEMENT OF ROBERT D. HAASE, WISCONSIN STATE
COMMISSIONER OF INSURANCE

Mr. HAASE. Senator Kohl, I think probably you could read my speech. I'd rather talk about some of the things that have been coming up this morning, and then, if you have any questions I'll be glad to answer them.

Quite a lot has occurred in the last 2 years in the area of Medicare supplement insurance. I've just come back from the National Association of Insurance Commissioners meeting, and while we were waiting to find out whether or not President Bush is going to sign or veto this bill we adopted some rules which do some of the following things.

One of the things that came up this morning is this problem of switching, churning, or twisting. What we adopted was a premium level approach, which will become the law in the State of Wisconsin. Under the rule the first year commissions could never be greater than 200 percent of the renewal commissions; commissions provided in subsequent years must be equal to the commissions provided in the second year and for a number of years; and on replacement policy sales the commission can be no greater than the replaced insurer's renewal commission unless the benefits are substantially greater than the benefits under the replacement policy. The only commission you can receive is what the renewal commission would have been on the policy you are switching.

This will be the law all over the country shortly because, as you, I'm sure, are aware, under the Medicare bill when the National Association of Insurance Commissioners adopts rules, they become the law as soon as the States adopt them. If the States don't adopt them they become law anyway. So, that is one of the things that will be done to help solve this problem.

Second, there are a number of other things that have been done. There is a 30-day look-see regulation that the person is guaranteed after they buy the policy. They have 30 days in which they can say they want to cancel it.

In addition to that, it's always been against the law to make any misleading or false statements or to use high pressure tactics.

So, as soon as the bill is signed into law they will be unable to use cold-lead advertising, which is where an agent simply tells a prospect that you are coming to see them. The agent must disclose in a conspicuous manner the purpose of the meeting and who they are representing.

Whenever an agent goes to sell a prospect a policy they have to give them one of our booklets from the Department before they can make the sale. Of course, the person is not going to have much of a chance to read it, I suppose, but that's the best we can do with it.

It does explain a lot of the problems that exist and, also, tells you how to contact our Office if you're having problems with what's going on.

A sale which would provide an individual with more than one Medicare supplement policy is prohibited unless the two policies together would cover only 100 percent of a person's needs.

Also, from now on every insurance company will be required to report to the Insurance Commissioner's office on an annual basis any policy holders who have more than one Medicare supplemental insurance policy in force with that company.

It has been possible up to now to replace one policy with another and then start another 6-month waiting period, or whatever it has been. Now that will not be possible. If you're going to replace a policy with a policy if they've already got their 6 months in you have to accept it as is.

So, I think these things will to a large extent from the legal end of it, at least, discourage agents from twisting and churning and selling more policies than are necessary.

As far as the rate regulation is concerned the law in Wisconsin is that you have to have at least a 60-percent loss ratio, as Tim pointed out, for individual policies, and a 75-percent loss ratio for group policies. The average in Wisconsin last year for the full State for the year 1988 was 67-percent which means that they were above the 60-percent loss ratio.

And maybe that isn't high enough. I'm not here to say whether it is or isn't. That's something for someone to decide. But we have had that and it has kept rates down in Wisconsin. Not every State has done it this way.

As a matter of fact, the assumption is that the rate increase in Wisconsin next year will be about 11 percent, whereas, in many of the States it's going to be well over 100 percent.

And so, while I'm not bragging about it, I'm just simply pointing out some of the facts.

Also all the new Medicare supplement policies will have to include the rates they will be charging. We will have to have a filing to include the impact of the repeal of the Medicare Catastrophic Act.

And if it was stated in 1988 that they were reducing their premiums because something was worth 10 percent and now they want to increase their rates in 1989 because that is gone we're not going to let them say, "Now it's going to be 20 percent." If they want to increase it they will have to use the same figures that they used in the past.

We try to monitor these things as much as possible. Obviously, there is a problem with education, and we have Donna Bryant and others in our department who meet regularly with the county benefits specialist who was talking to you this morning, holding training seminars all over the State of Wisconsin on a regular basis.

They'll be going out again now with the new changes to bring them up to date as to what is in the bill, what is in the law, what kinds of things are problems, and so forth. And we'll be doing that again because it has changed. We also have a Medigap hotline number that they can call free if they have any questions.

But I do think it is possible to get a better educational method for the information to the older people. That would be probably as great a benefit as any because in all forms of insurance none of us do enough shopping around; none of us really understands, includ-

ing myself, what's in the policy we're buying and we should. We take somebody's word for it—the guy or gal, we play golf or bridge with.

And if there's a way to educate people as to what is there, what is better, that they should contact the professionals who are in the counties or call our office with any of these questions, we should find that.

So, with that let me close and let me thank you for inviting me. I'll be glad to answer any questions.

Senator KOHL. Thank you. Commissioner.

Mr. Becker.

STATEMENT OF DAVID L. BECKER, ARNESON/BECKER INSURANCE AGENCY, MOUNT HOREB, WI

Mr. BECKER. First of all, I appreciate the opportunity to be here.

I'm a marketer of insurance. I have chosen this profession for the last 21 years, and I have found myself exposed to the use and abuse of marketing practices in the Medicare supplement area.

My purpose today is to discuss the marketing practices of Medicare supplement policies by the independent agent. I will describe an abuse of the delivery system and present a possible solution to the problem.

Independent agents have an opportunity to gain a great deal financially at the expense of both the public and the companies they represent. They can secure contracts which pay as much as 75 percent of the first year premium as their commission. Renewal commissions range from 5 to 12 percent.

I will describe a scenario today using an annual premium of \$1,200 per year, first year commission of 60 percent, and renewal commission of 10 percent.

The events I will describe are presently a daily occurrence in Wisconsin.

The agent makes a call on a prospect and writes a Medicare supplement policy. He collects \$1,200, and keeps 60 percent, or \$720 of the premium as his commission. Sometime later during the first policy year, he/she calls on the insured to renew the policy. But, instead of renewing the insurance, the agent replaces it with a policy from another company. Perfectly legal. The agent replaced the policy for the sole purpose of collecting another first year commission. The difference between first and renewal commissions is incentive enough to encourage the agent to replace. Since the Medicare part A deductible increases each January 1, and all companies amend their policies and premiums at the same time, the agent has a reason to see the insured every year to renew the policy. Once in the door, a replacement is easy. The person who benefits most from this transaction is the agent. Both the insured and the company are victims of this activity. Here's why the insured suffers:

(1) Many policies have a preexisting condition clause. The agent, however, covers this clause by dating the new policy 60, 90, or 180 days prior to the time the existing policy expires. The insured has double coverage during that period, and has paid double premiums during that period. This tactic can be, and is repeated year after

year by the same agent. The agent can earn up to four first year commissions within 2 years, and the insured can pay four annual premiums for Medicare supplement insurance during the same period.

(2) The insured may have had a change in health and may not qualify for the new coverage. The agent can, and sometimes does, answer the questions incorrectly so the policy can be issued quickly, and he can get his money. If the company learns of the action later, and it usually does when a claim is presented, the claim can be denied, and the policy can be canceled.

The company suffers:

(1) When issuing a new policy, the company pays a first year commission to the agent, and perhaps an override commission of 10 to maybe 30 percent to a general agent. When the home office expenses are added to the cost of issue, my best guess would be that it could cost the company up to 125 percent of the first year premium just to issue the policy. If the agent writes with company A in year one, company B in year two, and goes back to company A for the third year, company A has absorbed issue costs twice within 3 years for the same person. It is more profitable for the company to collect the renewal premium and pay 10 percent renewal commission than to reissue the policy.

(2) Agents will usually encourage only the healthy people to switch policies, and avoid those who may be uninsurable. The good risks leave the company, and those who might generate the claims remain. This is known as selection against the company, or adverse selection, and is costly to the company.

(3) Current replacement regulations require completion of a simple form, in duplicate. One copy for the insured, one for the replacing company. The company being replaced does not know about the replacement until its policy lapses, which may be several months following the replacement action.

To discourage, and hopefully eliminate this type of activity, four things must happen:

(1) The financial incentive to replace Medicare supplement policies must be removed.

(2) Companies must take another look at their in-force business, and determine if the same people are written, lost, then re-written at a latter date.

(3) Companies must look more closely at their agents, rewarding them for good persistency (keeping business in force), and penalizing them for frequent replacements that are not in the best interest of the policyholder.

(4) Replacement regulations need fine tuning to become more effective in curbing violations.

I propose the following action to be taken:

(1) Companies will pay the full new business commission to an agent who:

(a) Writes the first Medicare supplement or nursing home policy for a person, or

(b) Writes a Medicare supplement or nursing home policy for a person who has had no coverage of this type in force for 6 months prior to the new policy date. This may

be someone who had a policy, but it lapsed, and he has been without coverage for 6 consecutive months.

- (2) Companies will pay the renewal commission if:
- (a) The policy replaces an existing Medicare supplement or nursing home policy, or
 - (b) There has been a policy of the same type in force during the 6 months immediately prior to the new policy date.
- (3) Require a replacement form to be completed in triplicate, with one copy each to the insured, the replacing company, and the company who is losing the customer.

If these actions are implemented, the following goals should be accomplished:

(1) The financial incentive for the agent to replace these policies will be removed. A replacement will pay a service fee of 5, 10, or 12 percent, and not 60 percent or more. An agent would not be as aggressive and quick to replace insurance at those numbers. A replacement that is justified will now benefit the insured more than the agent.

(2) The companies should find their operations more profitable, with more policies renewing. And the cost to issue a policy is reduced by, perhaps 50 to 60 percent if it is a replacement policy. The savings might be passed on to the customer in the form of lower premiums.

(3) Companies can track the activities of their agents, who must now notify them if a replacement is pending. Companies can cancel contracts of agents who victimize them by replacement of policies written by the same agents.

(4) Our senior citizens can have a little peace from the constant barrage from health insurance agents. The exploitation of them can cease, and since policies in our State are standardized, they can purchase one policy and stay with it, modifying it as needed, and replacing it only if it is in their best interest.

With that, I thank you for your time and I thank you for this hearing, and I'll be happy to answer any questions.

Senator KOHL. Thank you, Mr. Becker.

Geralyn.

STATEMENT OF GERALYN HAWKINS, MEDIGAP HOTLINE COUNSELOR, WISCONSIN BOARD ON AGING AND LONGTERM CARE

Ms. HAWKINS. The Medigap Hotline is a toll-free telephone number for Wisconsin residents to call for objective, unbiased information and individual counseling about health insurance to supplement Medicare. As a counselor for the Medigap Hotline, I have talked with nearly 25,000 individuals in the past 10 years about Medicare, Medicare supplement insurance, and other forms of health insurance which are marketed to older persons. I am pleased to have this opportunity to share with you some of the problems I observe and concerns that older Wisconsin residents express to me about Medicare supplement insurance.

LIMITATIONS OF MEDICARE SUPPLEMENT INSURANCE

One limitation of most Medicare supplement policies is that their universe of covered expenses is usually identical to Medicare's. Supplements pay benefits for expenses where Medicare has deductibles or co-payments, but seldom do they expand coverage to areas that Medicare does not cover: preventive health exams, prescription drugs, vision, hearing, and dental care, many nursing home and mental health expenses, and medical expenses which Medicare does not consider to be reasonable or necessary. Thus, even with a Medicare supplement policy which the agent assures "will pay everything Medicare does not pay," persons may face significant out-of-pocket medical expenses. Consternation with the shortcomings of this system is especially acute among persons I speak with who report a series of medical expenses where once the claims are all processed, the policyholder pays more out-of-pocket on noncovered expenses than what his or her own supplement paid.

SALES SOLICITATIONS

The methods that some of our less scrupulous insurance agents employ to meet potential customers range from intimidation to carefully calculated approaches which count on the consumer drawing a mistaken conclusion. For example, someone who is told "I have important information I would like to deliver to you about changes in your Medicare benefits" may agree to a meeting, assuming that this individual is acting for Medicare. If questioned, the agent will deny claiming to represent Medicare and blame it on an elderly person's misunderstanding, not remembering precisely, or not hearing correctly, what was said.

Another tactic is to send brief notes to people warning of drastic Medicare benefit reductions or escalating health care costs. The consumer is then encouraged to send for information on an insurance plan that will safeguard them. These letters carry such names as Senior Security Benefit Service or National Association of Retired Persons. The names and addresses collected this way are sold to insurance agents or companies as sales leads. The people expecting to receive further information in the mail instead get insurance agents at their doors. The June 1989 issue of Consumer Reports magazine details problems with lead cards and lack of regulatory oversight and enforcement in many States.

CONFUSING AND MISLEADING POLICY PROVISIONS

A problem consumers encounter in attempting to compare and understand Medicare supplements is confusing and misleading policy provisions.

Here are two examples from Medicare supplements offered in Wisconsin:

In their description of Medicare part B supplementary benefits, Pioneer Life (IMP-9061-A) and United American (MAXC+R188) state that their policies pay all additional covered expenses not paid by Medicare. Many conclude that the policies offer identical benefits. Yet in the definitions section of each policy, a couple of pages removed from the benefit description, a different picture emerges. Pioneer Life defines "covered expense" to mean amounts

not exceeding 180 percent of the Medicare approved figure; while to United American covered expense means up to 140 percent of the Medicare approved figure. A second version of the Pioneer supplement (IMP-9055-A) defines covered expense to be up to 140 percent of the Medicare approved amount. The definitions used are not even consistent within the same company.

In another case where consumers were attempting to compare the part B supplementary benefits of two policies, one policy paid 40 percent of the actual charge—in this case actual charge really means actual charge—and the other paid up to 140 percent of the Medicare approved amount. The conclusion many had reached is that since 140 percent is so much greater than 40 percent, the plan offering to pay 140 percent must have more benefits. However, because policies are paying percentages of different amounts—actual and Medicare approved charges—direct comparison of the percentages is not meaningful. In fact, once benefits are calculated, the policy paying 40 percent of the actual charge pays more than the one offering up to 140 percent of the Medicare approved amount.

In response to these types of problems, the Wisconsin Insurance Commissioner's office revised its standards for Medicare supplement insurance nearly 1 year ago. Confusing policy provisions such as those I described no longer appear in supplements issued after January 1, 1989. Administrative rule INS 3.39 requires policies to use a standard benefit structure which includes an obligatory set of basic benefits and certain uniform additional benefit riders which insurers may elect to offer. These changes simplify benefit comparisons, and enhance the consumer's understanding of policy differences.

This change has been very helpful to consumers and I compliment the Wisconsin Insurance Commissioner's office for implementing it. I would also suggest to this committee that incorporating the idea of uniform benefit standards into the Federal standards for Medicare supplements would enhance the ability of all consumers to make meaningful comparisons of policy benefits, even those consumers who want to compare benefits of a supplement sold in their own State with a supplement offered to them through the mail from another State.

COST

People frequently contact the Medigap Hotline because of concern about costs for Medicare supplement insurance. They are concerned about whether they can afford to continue the coverage but also fear whether they can afford to risk not having a supplement. The single Medicare supplement policy with the largest number of subscribers in Wisconsin, Blue Cross and Blue Shield's Medex-Plus, has seen its rates increase 77 percent from 1986 to what it has announced for 1990. Many consumers assume that the State Insurance Commissioner regulates health insurance rates, much as the State Public Service Commission regulates utility rates. But Medicare supplement rates are only regulated retrospectively. If a policy's loss ratio is less than 60 percent, then the Insurance Commissioner can demand that the company takes steps to raise that ratio. However, in examining some of the disparity in rates for policies

with very similar benefits (see rate comparison attached), I think we need to consider whether there may not be a role for the Insurance Commission's office earlier on in the process. The most striking example of inadequacies in the present rate review system is in the wide range of premiums charged for an additional benefit rider which increases the number of covered home health care visits from 40 to 365 per year. The annual rates for a 65-year-old range from \$1 to \$395; for a 75-year-old rates range from \$1 to \$575 per year. This excessive disparity in rates for the same benefit should at least lead the insurance commissioner to investigate whether insurers are interpreting benefits correctly and using sound actuarial principles in pricing the benefit.

This past year when the Medicare Catastrophic Coverage Act increased Medicare benefits and thereby reduced the responsibilities of supplements for certain hospital and skilled nursing facility expenses, many consumers expected lower premiums for their Medicare supplements. But only a small number of policies did lower their rates. Nearly half of the Wisconsin policies increased their premiums. Insurers attributed the lack of premium decreases to the fact that the benefits Medicare absorbed represented only a small part of the total premium. With repeal of the Medicare Catastrophic Coverage Act, insurers will presumably be adding the once-removed hospital and skilled nursing facility benefits back into their policies. Since removing these benefits from supplements did not result in any significant reductions of premiums then, logically, reinstating the benefit should not result in large premium increases.

AGENT COMMISSIONS

Insurance agents earn commissions for selling Medicare supplements. Commissions are a percentage of the annual premium. In Wisconsin, first year sales commissions range from about 15 percent to 75 percent. The commission that the agent earns as the policy is renewed in subsequent years is usually much less than what is earned during the first year. This difference appears to lead some agents back to policyholders after a couple years to replace their coverage. Repeated inappropriate and unnecessary replacements of coverage means income that companies could have applied to paying health care costs or lowering premiums instead goes for the higher first year commissions. Restructuring of commission levels should be explored to remove this built-in incentive for unnecessary replacements.

Dangers for consumers include exposure to new waiting periods before pre-existing health conditions are covered, possibly higher costs due to purchasing at higher ages; and possibly reduced benefit levels. After purchasing the replacement policy, the surprise waiting for some is the discovery that their initial insurer ignores their cancellation request and refuses to refund the balance of their premium. The only time Wisconsin laws require refund of a Medicare supplement premium is during the 30-day free look provision following receipt of the plan. In fact, for a Wisconsin Medicare supplement policyholder who dies in March after having paid an

annual premium January 1, all they can depend on is the goodwill of the insurer to refund the balance of the premium.

CLAIMS

For those who have survived or avoided problems with benefit limitations, confusing policy provisions, and costs of Medicare supplements, another trial may be filing and collecting a Medicare supplement claim. Some companies appear to put obstacles into the claims filing process which serve no purpose other than discouraging the policyholder from pursuing a claim. For example, there are policies which pay 20 percent of Medicare-approved amounts on Part B, but require an itemized bill to be submitted in addition to the Medicare explanation of benefits form. The claim is not paid if the itemized bill is not included, even though the explanation of benefits from Medicare clearly shows what amount has been approved.

DISABLED MEDICARE BENEFICIARIES

Often overlooked in the Medicare supplement area is the disabled Medicare beneficiary—a recipient who is entitled to Medicare before 65 due to receiving Social Security disability benefits. The gaps in Medicare are the same for those under 65 as for those 65 or older. But the great majority of Medicare supplement plans are offered only to persons 65 or older. For many disabled Medicare recipients the best route to additional health insurance coverage is simply to remain with the health insurance they carried prior to becoming Medicare-eligible. However, many are disappointed to find that once they are eligible for Medicare and have Medicare as their primary insurer (which greatly reduces the insurer's liability for many expenses, such as hospitalization), their health insurance premium does not change. In fact their health care expenses increase because now they must also pay the Medicare Part B premium. Discontinuing Part B is not an option in many cases because policies include clauses stating that if the insured is eligible for Medicare, policy benefits will be paid as if the person has Part A and B of Medicare, whether they are actually enrolled or not.

What I have presented here is a summary of some of the concerns that consumers voice to me about Medicare supplement insurance. I appreciate the committee's timely interest in this area—the passage and subsequent repeal of the Medicare Catastrophic Coverage Act compound the omnipresent confusion about Medicare and puzzlement with Medicare supplement insurance.

Thank you.

**COST COMPARISON CHART FOR SELECTED
INDIVIDUAL MEDICARE SUPPLEMENT POLICIES
APPROVED FOR SALE IN WISCONSIN***

prepared by: Center for Public Representation and
Medigap Hotline of the Wisconsin Board on Aging and Long-Term Care

Premiums listed are for policies for a female living in Milwaukee with basic coverage of seven required benefits PLUS additional benefits of Medicare Parts A and B deductibles and 365 home health visit options. All of these policies pay the 20% of Part B expenses.

	<u>65 years old</u>	<u>75 years old</u>
American Family Mutual Insurance Company	\$ 391.70	\$ 510.00
Wisconsin Physicians Service Insurance Corp.	\$ 586.80	\$ 586.80
State Farm Mutual Automobile Insurance Company	\$ 464.60	\$ 658.00
Bankers Life and Casualty Company	\$ 504.32	\$ 816.62
United American Insurance Company	\$ 825.00	\$ 880.00
Blue Cross & Blue Shield United of Wisconsin	\$ 961.62	\$1,017.51

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989.

**COST COMPARISON CHART FOR SELECTED
INDIVIDUAL MEDICARE SUPPLEMENT POLICIES
APPROVED FOR SALE IN WISCONSIN***

prepared by: Center for Public Representation and
Medigap Hotline of the Wisconsin Board on Aging and Long-Term Care

Premiums listed are for policies for a female living in Madison with basic coverage of seven required benefits PLUS additional benefits of Medicare Parts A and B deductibles and 365 home health visit options. All of these policies pay the 20% of Part B expenses.

	<u>65 years old</u>	<u>75 years old</u>
American Family Mutual Insurance Company	\$ 391.70	\$ 510.00
Wisconsin Physicians Service Insurance Corp.	\$ 586.80	\$ 586.80
State Farm Mutual Automobile Insurance Company	\$ 464.60	\$ 658.00
Bankers Life and Casualty Company	\$ 504.32	\$ 816.62
United American Insurance Company	\$ 825.00	\$ 880.00
Blue Cross & Blue Shield United of Wisconsin	\$ 804.00	\$ 957.06

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989.

Senator KOHL. Thank you, Ms. Hawkins. Mr. Cullen, as you look at the various costs on the basic policy that we have on this chart, do you have any comments to make? I mean, this is a basic policy, which I understand is very common and prevalent, but all these different varieties of costs—what do you say to a consumer, Mr. Cullen?

Mr. CULLEN. First of all, I would say to them, "Your chart is inaccurate as it relates to my company on two counts: the age 65 rate and the age 75 rate."

The second thing is that my company sets rates by sex and by region of the State, so by choosing to show a chart of females living in Milwaukee, that's the highest category rate Blue Cross and Blue Shield charges. If you were going to show the rate for people in Mount Horeb or Eau Claire they would be much less. Whereas, the other large companies have a uniform rate across the State.

So, for the record, I will make those two points about the chart.

The other point is senior citizens ought to buy based on value. I think it is important to know where a company's rates are over a period of several years. That's the kind of thing the senior citizen and an agent, one-on-one at a kitchen table, are never going to resolve in the interests of the senior citizen.

I think where there's a marketplace there are three agents in the kitchen at the same time. In that situation the senior citizen might have a chance to do okay, but that never occurs to my knowledge. In most situations it's one agent and one senior citizen and, therefore, there really isn't a marketplace.

So, my response is government ought to say, "There's one policy. These are the benefits. Any company that wants to sell it, they can sell it."

Then, the senior citizen knows no matter who they buy it from they're getting the same level of benefits and they let the company figure out what price they're going to charge.

Senator KOHL. So, if you were in a position to mandate a resolution of what we're discussing here this morning you would say, "Let's have a governmentally endorsed, approved policy, the benefits of which are the same no matter which company markets it." The senior citizen understands clearly that that's the policy and they can price it out as they wish between all the different companies.

Does anybody disagree with Mr. Cullen on that?

Mr. HASSE. That's what we're now doing. There will be one basic policy and there are other coverages a person might want which will be sold by rider with a price tag on them.

This will be done all over the United States. This is what the NAIC has adopted and the Federal Government wanted us to adopt. And that is a basic policy and anything else you want to add to it will be done by a rider and you pay for it.

Senator KOHL. Mr. Becker, do you have a comment on that?

Mr. BECKER. I'm concerned with riders because they're confusing. I'm grateful that Wisconsin does have a uniform policy and I would like to see a national policy basically because Medicare is something that is federally mandated, it's there, and so, the policy should be the same.

I believe that companies can learn how to operate efficiently and decide how they're going to price them; they can decide how they want to market it and the cost of marketing and so forth. I agree with the Federal policy.

Senator KOHL. Ms. Hawkins.

Ms. HAWKINS. If you're envisioning the Federal Government coming out with just one package of benefits—no riders, simply one package—I think before we could get to that point the Federal Government has to deal with the Medicare Part B issue of the difference between Medicare approved amounts and what people are actually being charged. If you mandate a Medicare supplement plan that is Government endorsed and will pay 20 percent of what Medicare approves, and yet, we still have a zillion providers out there who charge more than what Medicare approves, then you'll have many consumers wanting to buy something that pays more than just the 20 percent to cover themselves for the gap in Medicare's approved charges and the actual charges.

I am familiar with the system we are using here in Wisconsin and if it is going to be adopted nationwide I would welcome that. We have had limited time to work with it here in Wisconsin—just this past year—but my perception is that it is going pretty well.

We limit the number of possible riders the companies can offer. They can not just dream up everything and anything and say, "We sell this as a rider. Does your Medicare supplement?"

We have identified for insurers approximately half a dozen riders that can be offered with a policy and have told companies, "If you are going to offer rider No. 1, rider No. 1 is the same benefit whether you are buying it from Blue Cross, United American, or whoever. This system allows people to make direct benefit comparisons, which allows the price comparisons to be meaningful.

Senator KOHL. Tim Cullen, would you support rate approval by States?

Mr. CULLEN. Yes.

Mr. HAASE. Are you talking about prior approval?

Senator KOHL. Yes.

Mr. HAASE. It doesn't work.

Senator KOHL. You would not support it?

Mr. HAASE. I don't support it. I got rid of it and I'm pleased we did. We have, I think, quite a bit of rate control here when you start regulating the the commissions with the level of commission thing, when you say you have to have at least a 60-percent loss ratio, you've gotten over all these silly arguments—"What's the trend factor?" et cetera.

If you don't think 60 percent is high enough then it can be raised to 70 percent. I don't have a problem with that.

And another thing is, in an election year how much rate increases do you think you're going to get when needed?

Senator KOHL. What about these companies who consistently fall below the loss rate?

Mr. HAASE. If they fall below the loss rate consistently we require them to refund the money or increase the benefits without premium increases. With anybody who consistently falls below they have to show us how their rate is going to get to the 60 per-

cent. We would be working with them to either reduce premiums or else increase their benefits.

Senator KOHL. I'm not sure I'm a hundred percent correct but we have several—Wisconsin Health at 30 percent loss rate, American Family Life at 27 1/2?

Mr. HAASE. OK, I'll tell you what that is. American Family Life was 46 percent last year; they have a very little bit of premium. They had less than \$1 million in premiums last year, so they will be getting it into shape this year.

Senator KOHL. HMO Midwest—24 percent?

Mr. HAASE. Again, you're talking about HMO's. I have many problems with the way HMO's function; they're difficult to deal with. Again, they only have \$15 thousand in premiums. It's not credible to say to them, "You've got to have a 60 percent loss ratio of premium."

Senator KOHL. So, you say that the cooperation between the insurance companies operating in this State, in your experience, has been good and sufficient in all cases so that you've never had to revoke a license?

Mr. HAASE. I can't answer that. I don't know. I was Commissioner so many years ago the first time I don't know. I'm sure somewhere along the line we have revoked licenses, yes.

Senator KOHL. Mr. Becker thought we should be doing more about revocation.

Mr. HAASE. We revoke a lot of agents' licenses very frequently.

Senator KOHL. You do?

Mr. HAASE. Yes.

Senator KOHL. Mr. Becker, do you have a comment on that?

Mr. BECKER. Well, frankly, I've seen revocations for violations far less in my estimation than the ones that are printed in your bulletin. Contrary to what one of the gentlemen said, Mr. Keeling, I believe you can't always sell insurance; I really believe that marketplace demands a professional, and some people who do graduate with a bachelor's and master's degree are going into the insurance business, believe it or not.

I can't say I'm in the company of the true professional public-serving people. However, to make the case that to revoke a license means to eliminate someone's livelihood is hogwash; I think it's totally hogwash and when people are out gaining the trust of unsuspecting senior citizens who want so desperately to have some help. Agents have gone to far more "how to get people's trust" seminars than they have product seminars.

Perhaps on the horizon is a continuing education requirement for agents. I believe agents ought to pass standards; I believe they ought to have these standards updated.

For this gentleman in this case it was his second violation within 2 years. It was the second fine, the second suspension, and he'll be on the streets January 15, and you can bet your boots the same thing is going to happen unless the incentive is taken out of it, and I don't see that happening shortly. And I see our Office receiving phone calls from many of our clients saying, "What is this person doing in our home?"

Senator KOHL. Mr. Haase, I would like to ask you a question. What would you say to Mr. Halfin, who's an experienced man over

many, many years in the field, and who said to us today that the incidence of abused consumers is huge and they're not in a position to make the kinds of judgments based on no experience that benefit them. As the Insurance Commissioner what would you say to Mr. Halfin?

Mr. HAASE. My answer is one, is "too many." And going back a few years, that's why we went in Wisconsin to a three-tiered system of Medicare supplement policies. Nobody could understand them. People were selling cancer policies and Medicare supplement policies. So, we put together three definite specific policies; you had to sell one or the other.

But now I think it works better to have a simplified procedure. If in fact agents are violating this and it comes to our attention we will take action. Our problem I think is that older people don't really like to get involved—and I realize this is part of the problem—they don't like to get involved in this big mess that's going to take place. They're afraid, they're insecure, and they're not ready to call up and say, "This guy just cheated me." If they do that we will take action.

Senator KOHL. Mr. Halfin, if you had to respond to Bob today, what would you say?

Mr. HALFIN. I agree with him—once we get the person to contact the insurance commissioner's office—but it's that education he talked about. They won't pick up the phone and call. I've given the number to a person to call, and I go back and say, "Did you call?" and the person will say, "No."

There's something, they just don't want to do that for some reason.

I'll pick up the phone and call for them or write a letter for them and have them sign it. And, Ms. Hawkins, I commend you for what you do, because if I can't get them to call I would call Ms. Hawkins to help with it.

And I can't complain about the insurance commissioner's office, however, we do need to educate the seniors out there on how to buy or what to do with Medigap insurance. It's a mammoth problem and rural Wisconsin is really hurt because you have this farm lady right here with a half a mile of nothing on either side of her and she's vulnerable for that agent because she's lonely and she wants to talk to somebody.

I don't know whether I've responded to him or not.

Senator KOHL. Thank you. Any other comments anybody would like to make?

Mr. HAASE. Just that I would welcome any suggestions you might have as you study this as to what we can do here. I think we're all in the same boat, not one government and another.

Senator KOHL. Somebody suggested that there be a 7-day waiting period before someone could finalize that policy and during that 7-day period that the policy should be sent somewhere for someone to authorize.

Mr. HAASE. If you can find the "somewhere" I have no problem with that. We do right now have a law that says you have 30 days after you get the policy to reject it. We'll look at it; it's not a bad idea.

Senator KOHL. Tim, do you have a comment to make regarding that suggestion?

Mr. CULLEN. I think it's great. Fundamentally, I think when you try to put band-aids on this problem you have to eliminate the need to have agents in the farmhouse with the senior citizen one-on-one. We can change that if the policies are sold through organizations such as the Coalition, providing uniform policies or, of course, closing the gaps of Medicare.

Also, I think Ms. Hawkins alluded to a separate but very related issue which is the issue of physicians accepting Medicare assignments. We're talking about how much a policy covers, 100 percent of this or 40 percent of that.

That is all driven on whether or not a physician accepts Medicare assignments. Some physicians do, some don't. It's a huge issue. It's an issue for both the State and Federal policymakers.

If all physicians accepted Medicare assignment a lot of this goes away.

Senator KOHL. Well, it's been a great panel. I want to thank you all for coming. You've been very helpful, very informative. Thank you.

We'll call our last panel. We have Betsy Abramson, the director of the Elderly Department Center for Public Representation in Madison, and Bette Johnson, president of the Coalition of Wisconsin Aging Groups. Folks, we look forward to your testimony and a few questions. Betsy, go ahead.

**STATEMENT OF BETSY J. ABRAMSON, DIRECTOR, ELDERLY
DEPARTMENT, CENTER FOR PUBLIC REPRESENTATION**

Ms. ABRAMSON. Thank you.

The Center for Public Representation appreciates the opportunity to present testimony to your committee today. The Center is a nonprofit, public interest law firm, representing the rights of traditionally unrepresented and underrepresented individuals and groups, including the elderly, health care consumers, families, and women. We have extensive experience in Medicare supplement issues, through the operation of our lay advocate legal assistance program for the elderly, known as the benefit specialist program in Wisconsin, as well as our national training contract on these and other issues with A.A.R.P.

I have been asked today to suggest areas for Federal action in Medicare supplement legislative and regulatory reform, and I am pleased to do so. I find it encouraging, first and foremost, that your committee is recognizing that the Federal Government's long-standing deference to the States on matters of insurance can no longer be tolerated, at least in the area of Medicare supplement insurance. Medicare supplements are, of course, tied to Medicare—the Federal Government insurance program and, given Congress' constant changes to the Medicare Program—nowhere more painfully evidenced than the on-again, off-again catastrophic program—the Federal Government must take the lead in regulation of the Medicare supplement insurance market.

I would like now, to identify 10 problem areas that we have noted in Wisconsin over the years and proposed solutions for your consideration.

(1) Inappropriate replacements—The changes resulting from Congressional action on the catastrophic program have only exacerbated the long-standing problem of unscrupulous agents making inappropriate replacements, which results in beneficiaries being subject to higher premiums, new underwriting conditions, and new waiting periods for pre-existing conditions.

Proposed solution.—The Federal Government must put limits on the first-year commission to agents, which we believe is the main motivator of these sales. Additionally, there must be strong regulations on suitability, including the replacing company sending a notice to the current insurer, and stiff penalties for violations.

(2) Out-of-State marketing abuses.—State governments have little or no control over the type of celebrity endorsement and invitation to toll-free phone line types of television pitches, which result, in our experience, from consumers often purchasing on their own excessive numbers of policies.

Proposed solution.—The FTC should be given regulatory authority over this area and should develop regulations which restrict the use of toll-free phone lines and require such companies to comply with the replacement rules of the State in which they are marketing.

(3) Mid-policy term right to cancellation and refund.—Many companies require 3, 6, or even 12 months' premium at one time, and then refuse to refund any prepaid premium when a policyholder cancels during the policy's term.

Proposed solution.—Federal law should require companies to refund consumer premiums upon 30 days' notice of cancellation by the insured.

(4) Gross rate disparities.—As the charts you have already seen demonstrate, companies selling the same policy have rates varying by over 200 percent. The percentage of premium increases each year also clearly demonstrates the need for improved rate regulation. This issue, too, has been heightened by catastrophic: Last year at this time, companies told us that "catastrophic wasn't adding that many benefits" so their policies still would increase, although not quite as much as they otherwise would have. This year, the New York Times, October 25, 1989 reports, and Wisconsin experience confirms, that insurers assert that, with the repeal of catastrophic and the burden of these benefits being returned to the Medigap insurers, premiums will increase by, in some cases, as much as 76 percent. Without meaningful rate regulation, some insurance companies appear to be making a huge profit on the backs of some understandably confused Medicare beneficiaries. In Wisconsin, we have no rate regulation, other than use of a loss ratio—companies are to pay out \$0.60 of every \$1 collected. We do not believe the Wisconsin Insurance Commissioner is adequately enforcing this.

Proposed solution.—The Federal Government should require State insurance commissioners to vigorously enforce loss ratios, applying it to each benefit (where benefits are provided by riders),

publicizing annually the loss ratios for each of these companies, and requiring annual notice to each policyholder.

(5) Nonstandardized benefits make cost comparisons impossible.—Wisconsin has made important strides in this area in the last year by requiring a standard basic policy, with additional benefits to be provided by rider. This has greatly reduced the “comparing apples and oranges” problem.

Proposed solution.—The Federal Government should make such standardization mandatory in all States.

(6) The continued sale of dread disease and indemnity plans results in consumers’ spending limited dollars for health care inefficiently.—The purchase of “cancer insurance” and hospital indemnity policies is, in almost all cases, duplicative of Medicare and therefore, a waste of premium dollars.

Proposed solution.—The Federal Government should follow the lead of several States in banning their sale.

(7) Poorly trained agents’ sales pitches misinform the public.—A Medigap agent **MUST** possess an extensive knowledge of both Medicare and Medicaid law in order to competently and accurately present a Medigap policy’s value to a consumer.

Proposed solution.—The Federal Government should require specialized initial, as well as continuing education training for agents in this area. State insurance commissioners should be required to develop and conduct these training programs so as to both avoid putting this responsibility on companies, and to ensure accurate, consistent information.

(8) Lack of consumer education continues to be a major problem resulting in poor insurance choices by consumers.—Wisconsin is also in the forefront in this area by having developed consumer brochures (with required agent distribution), comparison charts available to the public, and a toll-free Medigap Hotline staffed by knowledgeable, objective counselors.

Proposed solution.—Such initiatives should be required by the Federal Government in every State. The “Medigap Hotline” should be funded by a small tax on agents.

(9) State enforcement and complaint-handling is inadequate.—Unfortunately, Wisconsin is a good example of a State in need of improved enforcement and complaint-handling. Our insurance commissioner, and those of other States, must have the authority to make individuals whole, by returning premium dollars and requiring payment on inappropriately denied claims. Consumers must be given a clear private right of action under the insurance code, and consumer protection laws must not exempt insurance. Toll-free complaint lines must be staffed by consumer-friendly, real people, and enforcement efforts must show the public that more than wrist-slapping is going on.

Proposed solution.—The Federal Government should require toll-free complaint lines in every State, should make clear that all consumer protection laws apply with full force to insurance matters, should establish a private right of action for consumers, and should enact systematic, clear standards for penalties for violations. Regular publication of insurance department enforcement efforts should be made to the public, and copies should be sent to the State-funded Medigap Hotline.

(10) Mandated benefits are in some cases only phantom benefits.—In coverage areas where Medicare does not have the traditional “cost gaps,” Medigap coverage must, by definition, provide more generous coverage (i.e., less restrictions/conditions for coverage) or the benefit will be meaningless. An example of where we believe such is currently the case in Wisconsin is home health care.

Proposed solution.—The Federal Government must carefully look at mandated benefits and provides State, with the directive, and tools, to ensure that such benefits are actually paid out. Some ideas include, selected claims review by the State, enforcement of the loss ratios on the benefit, review of policy criteria, and strengthened regulation.

I would be happy to answer any questions the committee might have regarding my testimony, and again, I wish to thank the committee for its invitation to participate today.

Senator KOHL. Thank you, Ms. Abramson.

Ms. Johnson.

STATEMENT OF BETTE M. JOHNSON, PRESIDENT, COALITION OF WISCONSIN AGING GROUPS

Ms. JOHNSON. Thank you for this opportunity to testify at this very important hearing.

My name is Bette Johnson and I'm president of the Coalition of Wisconsin Aging Groups.

The Coalition of Wisconsin Aging Groups is an organization of 587 groups representing thousands of older adults. I feel the Coalition is the voice of Wisconsin's elderly. When we get together, what we hear most about is health, that is, maintaining a state of health that will avoid an involvement with the Medigap supplemental insurance mess. And a mess to them it is—confusing Medigap supplemental coverage and, if they do understand it, the majority are not able to afford the astronomical rate. Is this then a compassionate way to treat Wisconsin's and the Nation's elderly; these people who have given so much of their talent, time, and energy to help build a great country? Many Members of Congress refer to these folks as those people in their golden years. The Coalition of Wisconsin Aging Groups agrees with them and will be, as we always are, watchful of the State of Wisconsin's role in the Medigap supplemental insurance.

It is so easy to prey on the fears of the elderly regarding inadequate health care coverage; an indiscriminate salesperson has an easy, quick sell. We must have State and Federal laws regulating protection for these older people. To my knowledge, there is nothing at present to address this problem. With the integrity the State of Wisconsin has shown in the past regarding regulations and laws protecting the elderly, I am confident the State will address the problem. However, all States do not have the same attitude our State has; therefore, we must have Federal laws for the same protection. We repeatedly hear about older people who have been at the mercy of salespersons who have used fraudulent means to sign up people for Medigap supplemental insurance through scare tactics.

This generation of Americans believes in the celebrities they grew up knowing so well. They put their faith and trust in these celebrities. Now, some of us feel this is foolish, but many older people believe celebrities like Art Linkletter, James Roosevelt, and others would never sell them a lemon. Again, foolish though it is of these older people, where is the credibility of these celebrities who sell a less-than-honest product, including Medigap supplement insurance, that is clearly geared toward an elderly market.

We in the Coalition of Wisconsin Aging Groups are proud of our efforts as advocates for Wisconsin's elderly. We recognize the elderly people's concern, not only for their children and grandchildren, but all children and grandchildren. Why then do we continue to approach the major health problem in our State and country with band-aid solutions? What we need desperately is a health care plan that will care not only for the elderly, but the children, grandchildren, and the millions of uninsured people in this country.

The recent enactment and then swift repeal of the catastrophic program stands as clear proof that the piece-meal approach to health care for the American citizenry will not work. Catastrophic failed because it offered a few benefits to only one segment of the population and asked that one segment to bear the entire burden of it. Medicare's popularity these almost 25 years, however, has been rooted in its social insurance structure and its universal eligibility. We all (young and old) pay in so that the elderly and disabled—our parents now and ourselves in the future—will have this protection. The American public wants such a program of national health care for all citizens now, young and old now, one that we all pay into and all are eligible to use as we need it. Parceling out this government responsibility to insurance companies will leave us with another form of the Medigap mess. Let us learn from our experiences these last 20 plus years: The Government must firmly take the lead.

What is the principal role of Government? Government is the servant of the people, to do for the people what they cannot do for themselves. A wise old friend once told me that "when all is said, nothing is done." Senator Kohl, I would ask you and your colleagues on the U.S. Senate Special Committee on Aging to accept the challenge of becoming the leadership toward providing a universal health care plan for all citizens in our country.

COMPARISON OF SELECTED INDIVIDUAL MEDICARE SUPPLEMENT POLICIES APPROVED FOR SALE IN WISCONSIN*

Premiums listed are for policies for a female living in Milwaukee with basic coverage of seven mandated benefits plus additional benefits of Medicare Parts A and B deductibles and 365 home health visit options.

POLICY	Age 65	Age 75	1st Year Commission to Agent
American Family Mutual Insurance Company	\$391.70	\$510.00	18.75
Wisconsin Physician Service Insurance	\$586.80	\$586.80	15
State Farm Mutual Automobile Insurance	\$464.60	\$658.00	18
Bankers Life and Casualty Company	\$504.32	\$816.00	35/25
United American Insurance Company	\$825.00	\$880.00	60
Blue Cross & Blue Shield United of Wisconsin	\$961.62	\$1017.51	\$3/mo.
Pioneer Life Insurance Company of Illinois	\$928.00	\$1247.00	67.5
Colonial Penn Life Insurance Company	\$1150.00	\$1510.00	75/65

*Source of Information: Office of the Wisconsin Commissioner of Insurance Medicare Supplement Policy Chart, July 1, 1989, and Wisconsin Insurance Report, Robert D. Haase, Commissioner of Insurance, Business of 1988, p. 118.

TABLE II
DOES THE STATE REQUIRE THAT MEDIGAP PREMIUM INCREASES
BE FORMALLY APPROVED BEFORE GOING INTO EFFECT?

STATE	INDIVIDUAL POLICIES		GROUP POLICIES	
	YES	NO	YES	NO
Alabama		X		X**
Alaska				X**
Arizona	X			X*
Arkansas	X		X	
California		X		X**
Colorado	X		X	
Connecticut	X		X	
Delaware	X		X	
Florida	X			X
Georgia	X			X
Hawaii				
Idaho		X		X
Illinois	X		X	
Indiana	X			X
Iowa	X		X	
Kansas		X		X**
Kentucky	X			X**
Louisiana		X		X
Maine				
Maryland		X		X**
Massachusetts	X			X
Michigan	X			X**
Minnesota	X			X**
Mississippi	X		X	X**
Missouri	X		X	
Montana		X		X
Nebraska				
Nevada				
New Hampshire	X		X	
New Jersey	X			
New Mexico	X			X*
New York	X			X*
North Carolina	X			X**
North Dakota				
Ohio	X			X**
Oklahoma		X		X
Oregon	X			X**
Pennsylvania	X			X**
Rhode Island	X		X	
South Carolina	X			X**
South Dakota	X		X	
Tennessee	X		X	
Texas		X		X**
Utah	X		X	
Vermont	X		X	
Virginia	X			
Washington	X			X**
West Virginia	X			X
Wisconsin		X	X	
Wyoming		X		X**
Dist. of Columbia		X		X
TOTAL	<u>32</u>	<u>12</u>	<u>16</u>	<u>28</u>

* A limited number of group policies are reviewed.

** Group Medigap policies do not even have to file (inform) the State of changes in premiums. (15 States)

Senator KOHL. That was a very fine statement, Ms. Johnson. I appreciate it very much.

Betsy, on the issue of loss ratios would you agree with the argument put forth by the Commissioner? In your opinion are they being enforced, and in the event the States are negligent in that enforcement, what Federal leverage would you suggest? Would it be levied against the State or against the firm itself?

Ms. ABRAMSON. I was intrigued by Commissioner Haase's answers to your questions. For every company that you put out he had a separate excuse. One "hadn't had enough years of experience" and a couple "hadn't enough premium collected" and another one was an HMO and, "We all know about HMO's."

What I go by is looking at the numbers, that is, the premiums. As I said, it seems incredulous to me that each company could possibly be in compliance with the loss ratios when the premiums differ so much. I also question whether this loss ratio check, retroactive check, is actually being made on both the base and the loss ratio. It can't possibly be.

A company who sells a separate rider for the \$75 part B deductible for a cost of \$79 couldn't be paying out all they should on that benefit, so I don't believe it's being enforced in Wisconsin.

As to how it should be done, I do tend to agree that I'm not sure rate regulation is the way we should go. First of all, Geryllyn pointed out the example of rate regulation in public utilities, and we certainly know in this State that for consumers to try to go to those rate hearings and crunch out numbers as speedily as the industry's 15 number-cruncher experts do would be impossible.

I think the Federal Government needs to get serious about rate regulation. For instance, I noticed in Commissioner Hasse's testimony that he stated one of the reasons rates haven't been going up in Wisconsin is that we have been imposing our loss ratios for years and other States are just beginning this.

So, I guess the answer to your question is, "No." I don't trust that States are enforcing the loss ratios on their own if they just happened to notice that compliance with loss ratios has been required for 7 years. So, I do think that the Federal Government needs to get behind that and push at that more.

As to the whole other bigger issue of rate regulation, I'm not prepared for consumers having to go toe-to-toe with the industry in justifying rates because I think that's a losing proposition for consumers. I do think that simply requiring companies to file their rates before they use them is notice by the companies to the Commissioner. And if I was in the Commissioner's office it would certainly make me wonder how there could be this huge rate disparity in identical policies, and I would start to do some checking up on this.

Senator KOHL. Is your concept of the Insurance Commissioner's Office in this State or in any State an office that should coequally represent both business and the consumer or just the consumer or just the business?

Ms. ABRAMSON. Coequal.

Senator KOHL. Coequal. And that should be the proper role of representation, coequally business needs and consumer needs?

Ms. ABRAMSON. I'm not so naive as to think that consumers aren't benefiting from companies staying solvent, so I'm not suggesting that companies all be required, for example, to charge premiums of no more than \$150 if they're all going to go bankrupt and consumers are left with no insurance.

So, I think there is a tie-in in looking out for the interests of business. This will be helping consumers as well, but I think their primary goal should be looking at it from the consumer end.

Senator KOHL. OK. Bette Johnson, I'd like to assure you that there are both Federal and State policies for fraudulent marketing of Medigap policies. A Federal law has been on the books since 1980, but according to the GAO it has not been enforced.

One question—how can we do a better job of enforcing the laws that are already on the books? Do you have any comments to make on that?

Ms. JOHNSON. Yes, I do, Senator Kohl. The one thing that I particularly think we are so fortunate in the State of Wisconsin to have is our Elderly Benefits Specialist Program. I think these people are very helpful. They're educated, they're informed, and they are such an aid for elderly people and they will know those hard, sticky, confusing questions that older people have. They are well informed and they can inform the people.

And I think that we in the Coalition of Wisconsin Aging Groups have been very supportive of this program. In fact, we advocated and we worked very hard in the assembly and in the State Senate and with the Governor to further fund the program, and I would say that this would be something that has to be continued.

The misinformation and the lack of good information, as we have heard this morning—even with the Elderly Benefits Specialist Program we have folks that hesitate to make this call. People don't like to be looked at as kind of a little bit stupid, and they hesitate to make the call.

And we need to do more education, too. We need to make the older people aware that Elderly Benefits Specialist Program is out there to help them. And it isn't difficult to say, "I don't know"; I say it all the time.

And I think that we are very very fortunate to have that in place, and I think as an advocacy group, as we are in the coalition, we will continue to work with informing older people of the benefits of the Elderly Benefits Specialist Program, and I would hope that they will be able to continue to work as well in the future as they have in the past.

Senator KOHL. Very good. Well—

Ms. ABRAMSON. If I could just add one thing—I think it's two things.

First of all, as Mrs. Johnson points out, many people are reticent to come forward and make complaints. I think that's the "Gee, how could I have been duped?" syndrome.

And, also, people who have been through the complaint process with the Commissioner before figure, "Is it worth it? If I'm not going to be able to get my premium back or will not be made whole, how will it help?" and the answer being, "Maybe you'll help the next person who gets duped by this agent."

Second, I think OCI should be required, on a quarterly basis, for example, to relay information to the Medigap Hotline so the public is made more aware of it. Right now if an individual wants to, he or she can write to OCI and find out the numbers of complaints that have been filed against a company, but unless they go over and look through all the files they can't track those files and find out how many ultimately resulted in any enforcement.

Senator KOHL. Thank you. Well, you comprised a really great panel. I very much enjoyed having you here. It was well worth it for us, and thank you for coming.

Mr. JOHNSON. I have in here a packet of material describing the Coalition of Wisconsin Aging Groups. I am always selling the Coalition of Wisconsin Aging Groups, and I'd like you to know more about it. We all would thank you again.

Senator KOHL. Well, we have had an excellent hearing, folks. There's a lot of information on the table and a lot of work that needs to be done. And I want to assure you that my office will do everything that it can to follow up on the information we have heard today and to see that we effect improvements on what clearly is a very serious problem in our State and in our country.

[Proceedings were concluded at 12:20 p.m.]

APPENDIX

Item 1

Testimony of James T. Sykes,
for the National Council on the Aging,
before Senator Herbert Kohl, Member,
Senate Special Committee on Aging
December 11, 1989

Senator Kohl, I am James Sykes, Chair of the National Council on the Aging's Public Policy Committee, and the founder of a successful community based long-term care system in Wisconsin. I teach in the Medical School at the University of Wisconsin-Madison. I mention these three roles because in each I have witnessed the need for a national policy on long-term care which ensures that all persons of every age facing chronic illness have access to comprehensive, affordable, quality care.

You have come to Madison to take testimony on the Medigap insurance situation. While there are many steps that can be taken to correct problems within the Medigap industry, we believe that the problem for which Medigap insurance is an "answer" is so systemic that only a comprehensive, national policy on health care--including especially long-term care--will work for the citizens of America.

The time is now for a truly comprehensive national policy on health care for all citizens. Stop-gap measures, tinkering with Medicare or Medicaid to add limited services for those who need care--in their homes or in institutions--with minimal funds, simply will not do. The mandate of this Commission demands a dramatically new approach to health care in America, for those who suffer the consequences of double jeopardy, serious illness and the fear of impoverishment due to the cost of care.

These consequences affect the families of those in need as surely as they do the individual. Indeed, the entire community pays the price of a system that works for some, but not others, covers certain illnesses, but not others, and provides options for some, but institutionalization and impoverishment to others.

The NCOA concurs with the direction of the findings of the Joint Economic Committee's Subcommittee on Education and Health that "National health insurance, modeled after the Canadian approach, would ensure all Americans access to high quality, affordable health care," that "standards of care based on outcomes research must be developed and applied by the health care community to limit unnecessary tests and procedures," and that research priorities must be changed. Health promotion and disease prevention and problems afflicting the elderly, such as arthritis, dementia and incontinence, must receive greater attention."

We find the words of Wisconsin's Bureau on Aging Director, Donna McDowell, precisely on target. She wrote that our long term care efforts carry the "scent of failure."

"Failure of a caregiver to be durable over the long haul.

"Failure of a long term care system to provide acceptable, affordable care.

"Failure of a government to finance the care of its chronically disabled citizens.

"Failure of a mental health system to respond to chronic mental illness.

"Failure of an economy to sustain adequate employment and retirement income.

"Failure of a marriage, of a parent.

"Failure of a social worker to "fix" a bad scene.

The failures, Mr. Chairman, are ours. Benign neglect, on the one hand, and over-reliance on a patchwork system of private out-of-pocket spending and Medicaid, on the other, must be replaced by a comprehensive national health care system.

We have the capacity to correct these failures.

Repeatedly, polls have shown that we want a sensible, affordable, quality health care system; and, those same polls show, we're willing to pay for it through our taxes rather than facing directly the high costs of long-term care. We need political leaders--with the vision and commitment of Claude Pepper--to put us on a course toward a national health system, based on a flexible social insurance model. Only such a system can provide the framework for efficiency and universality.

We need to expedite the national dialogue on such a system now or the catastrophic "Medicare crisis" and the scandal of millions of citizens lacking health care protection will become mere symptoms of a more profound economic and political crisis in the decade ahead.

I've read the testimony which the Pepper Commission has received. While the NCOA supports many of the recommendations contained in the testimony--and could provide hundreds of examples of what neglect and reliance on a means-tested patchwork non-system costs our elders, their families, and others in need of health care--I would like to draw your attention to three problems calling out for solution.

"The need to build the service infrastructure in neighborhoods and communities to provide options and support to vulnerable individuals and their families.

"The need to enable elders to continue to live where they prefer, in special places--elderly housing, group homes, continuing care retirement communities, and naturally-occurring retirement communities.

"The need to recruit and train professionals, managers, chronic care workers and volunteers to provide the care and support essential to a health care system that works for all.

Only within the framework of a comprehensive, universal national health care system can these--and countless other problems--be properly addressed.

Such a system will make long-term care an integral part of a comprehensive national health care entitlement--a goal the NCOA has advocated over many years. We recognize that an individual's physical and mental health demand appropriate attention, and that chronic care as well as acute care must be provided to all in need--not just those in nursing homes or hospitals.

In fact, we believe that for most persons care should be delivered to where one lives not the other way around with the ill transferred to facilitate providers or to simplify administrative process. We know that attention must be given to both the one directly in need of intervention and support and the providers of care. The NCOA affirms that the individual must be at the center of every care plan, controlling and sharing responsibility for his or her care.

Such a national policy must be grounded on principles such as the following, developed and approved by the Board of the NCOA with counsel from our membership units comprised of professionals and agencies working in the community with and in behalf of the elders of our society. These principles provide the foundation for an effective long-term care system.

A Yardstick for Action on Long-Term Care

1. **Shared Responsibility** Access to appropriate and affordable long-term care is a right of all Americans. While assuring such access to quality and comprehensive long-term care services is a responsibility shared by the whole society, clear roles must be accepted by government.

The federal government has a fundamental role in guaranteeing access, setting basic quality standards and, in large measure, financing that care. State governments, under federal guidelines, have responsibility to share in costs and for operational aspects of the system, including selection of providers, assurance of needed transportation services, and monitoring quality and compliance. Responsibility to assess eligibility and needs under consistent state-wide standards and to monitor the provision of services must reside with local public or private entities.

This system must encourage those who require care or who are at risk to engage in programs of self-care and in activities which can enhance recovery and wellness. Such a system must also ensure support for informal caregivers and account for their participation in care decisions.

2. **Eligibility** The design of eligibility and assessment standards and care plans should be free of limiting age and income factors. Such plans and standards must be keyed to functional impairments, including medical and psychological elements, and not to specific diseases in determining who is to be served.

3. **Financing** The financing of a comprehensive long-term care system should reflect social insurance principles, with the burden shared through federal payroll and income taxes, state and local resources, and modest copayments by users of services. Such financing could incorporate private long-term care insurance and copayments based on sliding fee-scale principles. The current system of public financing requiring the exhausting of life savings to qualify for services must be ended.

4. **Supportive Environments** All persons requiring long-term care have an inherent right to care in the least restrictive health and social service setting. That environment is preferably and practically the home and the neighborhood. Where necessary, the setting may be institutional but with a home-like atmosphere, supportive of both care recipients and caregivers.

5. **Housing** A comprehensive long-term care policy must include support to provide an accommodating housing environment at affordable prices for persons experiencing diminishing capabilities and changing needs. Such a policy would undergird the desire to remain in one's own home or in independent senior housing facilities by providing the financing and development of appropriate home and community-based service arrangements.

6. **Providers of Care** The salaried providers of care must be appropriately trained and adequately compensated in salary and benefits. Informal caregivers should also be provided with training, counseling, respite, recognition, and, where appropriate, financial incentives.

7. **Personal Autonomy** Persons who require care in their own home or in community settings, or those who are residents of institutions, have a right to determine care decisions either directly or through caregivers and guardians, including the right to refuse or terminate services. The exercise of that right requires choice from among an appropriate range of health and social services.

8. **Rehabilitation** A comprehensive long-term care program should include rehabilitation services to restore and maintain optimal physical and mental functioning.

9. **Multi-generational Needs** Impairments affect persons of all ages. The personal and public burdens of care are largely cross-generational. Long-term care public policy must be designed to incorporate these multi-generational factors.

10. **Cultural Diversity** An effective long-term care system must respect cultural and group differences among beneficiaries as well as among providers of care.

11. **Research** A comprehensive long-term care system includes adequate outlays of public and private research resources into the causes and treatment of chronic impairment. The findings of past and existing research must be more efficiently incorporated into current community and institutional practice with special care to assist informal caregivers to utilize new information. Such research must include efforts to define and advance quality standards for long-term care.

Addressing the first problem, building community services to care for those able--with help--to remain in their homes and their home communities, let me mention Wisconsin's Community Options Program--a program that works.

I suggest that the Senate Special Committee on Aging investigate the success of Wisconsin's Community Options Program. Such a study will offer evidence that providing appropriate services to individuals in their homes, and support to their care providers, is not only effective and humane, but also less costly than institutional care for the overwhelming majority of persons served. One major problem, the need for community-based service providers and care managers, is being solved in many Wisconsin communities as a revenue stream is assured through the Community Options Program. Funding follows the individual and is adequate to provide essential services.

We've found in Wisconsin that a sum equal to about 60% of the skilled-nursing facility rate is sufficient to cover a wide array of personal needs. We don't manipulate so-called core services, but, following assessment, we develop a plan that includes what one needs, not what a federal or state program permits. Our legislators and Governor, having reviewed the success of this program, are increasing appropriations for the program--evidence of strong community support.

A second Wisconsin program deserves comment. In Sun Prairie, a small community in a rural setting not far from the capitol in Madison, a true community serving elders has evolved which provides a wonderful example of what should develop across the nation. At the heart of the campus is a senior center which offers opportunities for elders to be involved in life enhancing programs, nutritious meals, health education, humanities and arts programs, and much more planned by the seniors and attractive to people who are vigorous, competent and well.

To those who have grown frail, the center provides services including adult day care, transportation, counseling, home delivered meals, therapies, exercise programs, support groups and various levels of housing to meet their diverse and changing needs for shelter with services.

Financed largely by the participants with support from local businesses, the United Way, and a mix of modest federal, state, local and county funds, the Colonial Club--as it's called--has become a "community" in which those with need for support and intervention, and their care providers, are part of the community, sharing as they are able and receiving as they have needs. A home health care agency--so badly needed by this quadrant of Dane County--has gone out of business because the federal government reneged on its commitment to reimburse such agencies in a timely and adequate manner.

The examples I've cited--Wisconsin's Community Options Program and the Sun Prairie Senior Center--underline NCOA's evidence that community-based service systems can deliver humane, effective, appropriate, comprehensive services when a solid funding foundation is provided. The NCOA has thousands of members currently delivering essential components of community long-term care on a shoestring--relying on charitable giving, volunteers, and ridiculously stingy government funds.

We can and must do a whole lot more to build supportive environments around where one lives--in the community.

With support--that flows to individuals in need rather than to categorical programs--the service infrastructure will develop at the community level, caring professionals will be attracted to provide services, and the goal of meeting the needs of people where they live, and without demeaning means tests and complicated administrative rules, will be achieved.

A second major concern the NCOA would like the Special Committee on Aging to consider pertains to the integration of shelter with services. The idea of "aging in place" is so important to so many people at-risk that a national health care policy must facilitate services that make the difference between one being forced to move and one being able to continue to live, independently with help, in familiar settings.

What is required includes training housing managers to create supportive environments for those residents increasingly in need of assistance. We need a system that will provide services to people no matter where they live. We don't need more evidence to prove that limiting services to people already in institutions--or imminently at risk of institutionalization, or recently released from institutions--makes no sense.

We need the strong support of both health care providers and housing industries to ensure that we have affordable, appropriate housing designed to enable individuals at-risk to age in place. We need to find ways to integrate services with housing to assist vulnerable residents to stay where they prefer--in their homes and apartments and not forced to relocate to nursing homes or to inappropriate shelter.

The supply of appropriate, affordable housing has shrunk over the past decade due to mis-guided efforts to limit the nation's debt at the expense of maintaining and enlarging the supply of decent housing. We know what needs to be done. We need a federal housing commitment to strengthen an effective shelter with services strategy such as the congregated housing services program. Housing is an essential part of a health care system.

Senator Kohl, the NCOA's third issue involves the impending crisis of recruiting, training, placing and supporting care providers--including both highly-trained health and social service professionals and chronic care workers who provide so much of the care vulnerable citizens require. In addition, we need to ensure that family care providers, neighbors, volunteers--those who now and in the future will continue to provide the bulk of care at home and in the community--receive support and respite.

An effective national health care system must guarantee that the human resource needs of increasing numbers of chronically ill individuals and their families will be met. We need a national service corps, raising service to those in greatest need to high priority and respect. We need to incorporate strategies to attract individuals to the caring professions, compensate them appropriately, recognize their value to a caring nation, and undergird them with research, training and support. This matter--of who will care for those in great need--demands thoughtful planning and substantial resources.

The NCOA has reviewed national survey data and confirms the findings with the comments of our members throughout this nation--that the nation's families and those unfortunate individuals suffering from chronic or acute illness--need comprehensive health care, financed through social insurance.

Removing the cap on earnings, taxing the more than \$900 billion of unearned personal income, and imposing additional taxes on alcohol and tobacco will place a solid, fair, financial base under a national health care system.

Americans find the current system confusing, under-funded, biased toward acute illness and institutionalization, and terribly expensive. The Congress should avoid tinkering with an already discombobulated non-system and offer the people of this nation a sensible, responsive, fairly financed, quality health care system. NCOA members, with forty years of experience in providing care and services in the nation's communities, will assist the Commission in designing such a system and building a constituency for its enactment.

The National Council on the Aging believes a national health care system that incorporates a responsive long-term care system is urgently needed. We must provide comprehensive services to enable persons with physical and mental impairments to remain, when possible, in their homes and, when necessary, to receive appropriate institutional care. We believe that eligibility for services must be based on impairments and not on arbitrary demarcations of age or income. Financing should be assured by social insurance.

We urge the Senate Special Committee on Aging to "dream no little dreams" when it concerns the urgent and growing need for an adequate response to our overwhelming need for comprehensive, quality, person-centered, health care. The health care system we envision includes disease prevention and health promotion, supports informal caregivers, and incorporates significant research and training commitments. Financing this program requires universal social insurance; fiddling with private long term care insurance schemes would waste precious time and limited resources.

Item 2

Dunn County Office on Aging



808 Main Street
 Monomonie, Wisconsin 54751
 Phone: (715) 835-6308 232-4006

December 1, 1988

Honorable Senator Herbert Kohl
 708 Hart
 Senate Office Building
 Washington, D.C. 20510

Dear Honorable Senator Kohl,

The following are a number of cases where the elderly have been subjected to either fear or the very nice guy syndrome by unethical health insurance agents who are determined to sell their policies even though the additional policy or a policy change is not necessary. In one case the same agent in a year called on this person to convince her that the previous policy is not as good as the policy he now has for sale. Please note the agent receives up to 70% of the first year's premium and one can see why the agent wants to sell a replacement policy.

In another case, a lady I like to think of as a pillar of the community, was sold five policies. She needed one policy to meet her needs. Or, the lady who had an agent in her home for six hours (wouldn't leave) trying to sell her a replacement policy.

Names are not listed because of confidentiality. Because of the ages of the people in the cases listed and their frailty prevents them from being at the senate hearing today.

The cases are:

- Case #1: A widow of 82 years old, just above the medical assistance income level, thought she was buying coverage for nursing homes. After paying for the policy she was given the booklet explaining coverage. The policy was a Medicare Supplement.
- Case #2: An 83 year old widow on PartnerCare has had a 20% Medicare Supplement for many years costing \$584.00 per year. An agent from 200 miles away convinces her to buy a policy for \$900.00 that covers usual and customary charges which is not necessary in her situation.
- Case #3: A woman told the agent of preexisting condition. However the agent did not accurately complete the form. Later when a claim was filed there was no coverage because of these preexisting conditions. The company canceled the policy.
- Case #4: A 79 year old widow was advised to drop insurance because of serious heart problems. Three different agents are involved switching her to four different individual policies during a four year period. All during this time she continues to keep a Medicare Supplement through AARP, two cancer policies with different companies and an accident policy. She spends over \$1,700.00 per year for health insurance policies (not including Medicare) but has a medical assistance medically needy spend down of \$735.00 a year.

- Case 85: A couple is dropped from their group health insurance when she turns 65. She is not insurable under any Medigap individual policy without a waiting period because she is in the hospital and seriously ill.
- Case 86: An 83 year old single woman who has shown signs of serious confusion for several years has five Medicare Supplements and a nursing home policy. The last agent to sell a policy helps to cancel all previous policies. This woman has Social Security Income of only \$318.00 per month. A relative is power of attorney now that she is in a nursing home after a fall.
- Case 87: A woman is told by an agent that he can sell her a policy that is a "twin" to her present Medicare Supplement but at half the price! She buys the policy but finds out later after talking with the County Benefit Specialist that it isn't even a Medicare Supplement. The policy was a surgical/medical policy.
- Case 88: A 78 year old widow with no family support had shown serious signs of dementia. Her bank notified the County Benefit Specialist because all her checks were being written to insurance companies. In the previous eight years she had been sold nine Medicare Supplements (four of the policies were still in force), one daily indemnity, five life insurance policies (three in force but she didn't want life insurance) and two cancer policies. Several agents switched policies regularly or sold her one of each kind of policy. This woman was unable to say no to agents. Three years later she still has no protection from unethical agents since she is not willing to ask for help. She has no family willing to intervene and the court system is saying she is still competent enough to make her own decisions.
- Case 89: Agent sells a couple a Medicare Supplement costing over \$2,800.00 for both. They already have two other Medicare Supplements and a cancer policy. They do not understand Medicare or supplemental insurance.
- Case 90: Three widows in their 80's have been on the high option group plan with the federal government at \$187.00 per month. The low option for \$36.00 per month has never been explained to them and they have been afraid to change.

These are just a few examples of cases showing the confusion and problems older people are having with Medicare Supplements. There are many others who never come to the attention of the County Benefit Specialist or volunteers assisting as Medicare Helpers. What is happening to them?

The Wisconsin proposed rule change would be a move in the right direction but more must be done to protect older people and help them understand the complicated health care system.

Sincerely,

Margaret Hagaman

Margaret Hagaman
Dunn County Benefit Specialist

ME/sb

David L. Becker

Item 3

Testimony to:

SPECIAL COMMITTEE ON AGING

Field Hearing Madison, Wisconsin December 11, 1989

The role of insurance agents in the sale of Medicare supplement policies cannot be addressed without considering the overall marketing practices of the companies and the confusion of the public over the issue of health care for senior citizens. The Federal Medicare program and its ever-changing position in delivering benefits requires private insurance companies to adjust the benefits and premiums annually. As the premiums and benefits offered by companies are altered, agents who represent these companies have opportunities to review policies with senior citizens every year. Since these activities are closely interrelated, I will attempt to describe the situation as seen from the sales arena, try to describe the scenario as it exists now, and propose a possible solution to eliminate injustices to our senior citizens.

For the purpose of this testimony, I will assume that all companies issue policies that are adequate, fairly priced, and claims are paid with fairness and dispatch. My testimony will deal with the statement that it is the delivery system which is suspect, and which should change.

The career insurance agent who is captive, or represents one company, solicits business by writing the first policy for a citizen at age 65, or compares coverages and rates with existing policies already in force on those policyholders who are over 65. Although there are some people over 65 who do not have a Medicare supplement policy, a large percentage of them do, and an agent can gain an interview rather easily by offering a free "review of your Medicare supplement policy" or, offer to "come out and explain your Medicare to you". Although there are laws dealing with ethical practices, the "any way to get in the door" approach seems to prevail in the marketplace. The practice of the single company agent is limited to represent or misrepresent the policy of his company as being better than another in-force or proposed policy. The one-company agent is not the usual culprit in the exploitation of senior citizens in the marketing of Medicare supplement insurance.

The independent agent, on the other hand, has great opportunity to abuse the system, and to exploit both the senior citizen and the company. The independent agent is an agent who is licensed to represent several companies who market the same or similar products. Many companies that do business in our state are those who market their products through independent agents. Since each company knows the independent agent is free to place the business with the company of his choice, each company will try to become the preferred company of that agent by offering higher first year commissions than the companies whose agency force is "captive". Currently, the commissions on policies marketed by independent agents may range from as low as 15% to as high as 75% of the first year premium. The independent agent will obtain contracts with the companies paying the higher commissions, thus making his business more profitable for each sale he makes.

The scenario that has caused concern by advocacy groups, commissioners' offices, outreach workers, and others, is this:

1. The agent makes a legitimate approach to the prospect to review the Medicare supplement insurance. If the prospect has a Medicare supplement policy in force, the agent is making the call with the sole intent to replace the policy. If the policy was originally written by the same agent and the insured pays the renewal premium, the agent will receive a renewal commission of 10-12% each time the premium is paid. However, if it is replaced with a policy of another company, the agent receives the new business commission, up to 75% of the annual premium.

2. Most, but not all policies contain a pre-existing condition clause, which excludes coverage for any condition or treatment which occurred during a specific time period prior to the effective date of the policy. This period of time may be 60, 90, or even 180 days. If the new policy in a replacement situation has such a clause, the agent is jeopardizing coverage for the insured, since any condition not covered by the new policy would be covered by the existing one. However, if a strong enough case is made by the agent, the policy is still replaced, the agent is paid for his action, and the insured is exposed to severe loss for the period of time covered by the pre-existing clause.

If the agent is aware of the time factor, he will call on the insured 60, 90, or even the full 180 days prior to the renewal date of the existing policy. The new policy will be dated as of the date of the call, and for the time period stated above, the insured will have coverage from two policies, for which premiums have been paid, and first year commissions have been paid to the agent. After the time period has expired, the new policy will cover those pre-existing conditions, and the old policy is allowed to lapse. The result of this action is this: The agent has been paid 2 new business commission checks within 6-9 months, the insured has paid 2 annual premiums within the same time period, and has had double coverage for an extended period.

3. The agent has just begun with this insured, however. With each change in the Medicare law, or increase in the deductible, the agent can call on the insured again and again, each time telling the insured that there's a very good reason for replacing the policy he has. The waiting periods are carefully watched, and the insured could pay 3 and even 4 annual premiums for Medicare supplement insurance over a 2 year period. When there is a husband and wife situation, this can be accomplished twice in one household. With an average premium of \$1200, and a commission of 60%, the agent could conceivably pocket \$4,680 within 1 year and 9 months, if the 90 day pre-existing clause is in evidence. If one policy were sold and renewed for one additional year, the commission to the agent would be \$1,680, assuming a 10% renewal commission.

It must be noted that the above practice may be the exception, and not the rule. However, the practice is real, and since I have begun talking with outreach workers and other advocates for the elderly, I have learned that the situation we witnessed in our town was one of many in our county and area.

This practice of replacement also exploits the companies. While I don't have hard figures, I am aware that the sales organizations for most companies who work through independent agents market their products through General Agencies, who receive an override, or a commission in addition to that paid by the agent. Thus, we can safely add 20% to perhaps 25-30% commission payment on the first year premium. In essence, then, the cost to the company for issuing a new policy could be in excess of 100% of the first year premium in commission payments alone. And there are other underwriting costs, which are not considered here. I have written to 9 companies asking them to tell me the cost of issuing a Medicare supplement policy, and as of this date, do not have a response. My assumption is that it will cost the company approximately 125% of the first year's premium to issue a new policy. This means that in order for the company to realize a profit on a policy, it must be renewed at least once, with no claims against it.

The scenario and it's effect on the companies is this:

1. The agent writes policy #1 from Company A. Company A absorbs all issue costs. Agent is paid first year commission.

2. One year (or less) later, the agent calls on the insured to "renew" the policy, and replaces the policy from Company A with policy from Company B. Company A's policy lapses, resulting in a loss to Company A. Company B absorbs issue costs. Agent is paid another first year commission.
3. One year (or less) later, the agent calls on the insured to "renew" the policy again. Perhaps due to changes in Medicare coverages, agent can convince insured that Company A's policy, which was not good enough "last year" now is better than Company B's policy. Another replacement. Another lapse. Company B loses, Company A assumes a second issue cost on the same insured, agent receives the third first year commission on this person. This practice could continue for years. I'm familiar with two such replacements on a 96 year-old lady!
4. The companies would experience an "adverse selection" situation, in that the agent who replaces insurance will approach only those insureds who are healthy and can qualify for a new policy, and will avoid those who are poor risks. Those who have had claims, or those who have had a deterioration of health would be unable to secure a policy from another company because of their condition or claims history. They would be likely to generate additional claims in the future. Those who qualify would leave the company, with the higher risk policyholders remaining. Good leaves / bad stays.

One would think that the companies would "get wise" to this activity. I'm sure some of them are. However, because of our experience with an agent formerly with our agency and our conversations with one company and one general agency, we found deaf ears because the agent was demonstrating "sales activity". I have also asked the companies I contacted if they kept records on retention, and if they could tell which agents seem to have poor persistency. I asked them if they felt it was more profitable to renew a policy than to reissue it every other year. As I understand it, in our state, when a Medicare policy or other health insurance policy is replaced, the insured signs a replacement form in duplicate. One copy is left with the insured, and one copy is sent to the replacing company. The company whose policy is in jeopardy is not contacted. Later, when the policy lapses, the agent may or may not receive notification from the company. Usually, however, by the time this occurs, the replacement policy has been in force for several months, due to the overlap, and the pre-existing condition clause. When the replacing agent and the agent whose policy was replaced are the same agent, it's assured that nothing is done to conserve the original policy. The entire system of delivery seems to lend itself to continuous replacement to the advantage of the agent and the disadvantage of the insured(s) and the company.

In light of the above information, I am making a proposal that by regulation, legislation, or by company policy the following action be taken: (some states currently have regulations in force that are similar to this)

1. Pay the full new business commission to an agent who:
 - A. Writes the first Medicare supplement or nursing home policy on a senior citizen, or:
 - B. Writes a Medicare supplement policy or nursing home policy for a person who has had no coverage of this type in force for 6 months. (someone who has had a policy, but it had lapsed, and the person has been without insurance for 6 months)
2. Pay the company's current renewal commission rate on first year and subsequent year premiums if:
 - A. The policy written replaces an existing Medicare supplement or nursing home policy, or:
 - B. There has been a policy of this type in force during the six months immediately prior to the effective date of the new policy.

3. Require a 3-part replacement form to be completed and signed by the insured and the agent, with one copy to the insured, one copy to the replacing company, and one copy to the company whose policy is being replaced. (Life insurance regulations currently require this practice, and require the address of the agent to be included)

It is my belief that implementation of the above recommendations can accomplish the following:

1. Eliminate the profit incentive for the agent who makes it standard practice to continually prey on the same people who have once trusted him/her, and to deceive and exploit them.

The agent who is serious about marketing products in the senior market can still make a good living by prospecting in the market of those seniors who are reaching Medicare age. The "chronic replacers" will find their source of income such that they would not continue the practice.

2. Restore confidence in the insurance industry, by replacing the pure profit motive with a service-oriented attitude. A "policy review" will now be a policy "re-view", and not an excuse to replace.

The agent who replaces a policy still is paid for his/her efforts, and the replacement transaction would likely be one of more direct benefit to the insured than to the agent. Perhaps a company has a lower premium, or a better benefit, and the agent can receive a fee for being of "good service" to the client.

3. Enable the company to monitor the activities of its agents more closely. An agent replacing a policy will be disclosing to each company what his/her intentions are. If the agent replaces the business he/she wrote originally, the company whose policy is replaced can respond and, if this activity reaches an unacceptable level, the company may cancel the contract with the agent. If the agent has no company contract, he's not in business with that company from that point on. We have seen behavior to circumvent it, but with the profit gone, hopefully, so is the bad agent.

4. Increase the profitability of the companies.

1. Ideally, only one incentive-based high issue cost would be incurred by any company on each person who purchases a Medicare supplement or nursing home policy. If a company issues a policy, and subsequently loses it, and reissues it again for whatever reason, the liability to the agent would only equal the same commission as though it had been renewed. The home office would incur its clerical and other costs of issuing a new policy, but if it pays 12% instead of 65% of the premium as commission, the company can retain 50% or more of the annual premium to offset those costs.

2. The policies written with a specific company would stay with that company. With retention levels increasing, and with both the healthy and the unhealthy persons remaining with the company to "balance the book" as it were, the loss experience would improve, and profits for the company would rise. Adverse selection would not be a problem for the company.

3. The companies would be in a better position to monitor the practices of the agents who represent them, since the agent who replaces a policy discloses his/her actions to both the new and the former company. Since Medicare supplement policies in our state have been standardized, each can be modified to match those sold by other companies. Companies can capture their market share by being competitive with rates and service. They wouldn't be "shooting themselves in the foot" by contracting agents who abuse the independent status by annually replacing their book of business at the expense of the company.

It is my hope this information has some value to your committee. The senior citizen population in our country is growing rapidly, and with that growth come problems and opportunities.

To this point, at least in the industry I represent, the problems have been laid at the feet of the senior citizen, and the opportunities have been handed to the independent insurance agents, who convert them to profit with the resulting:

1. Financial loss to the companies
2. Further erosion of confidence in our industry which already suffers from the stigma of greed on the part of the agents and companies.
3. Exploitation of our senior citizen population, who are confused about the ever-changing Medicare situation, and who write checks to agents under unnecessary pressure.

There is a better way. I believe there is no alternative to insurance that can provide what it delivers. A partnership between the governmental bodies and private industry, better supervision of agents, and sound product delivery practices can accomplish the goal of helping our senior citizens enjoy their golden years more worry free. There should be the opportunity, not the problem.

Item 4



Tammy G. Thompson
Governor

State of Wisconsin

OFFICE OF THE COMMISSIONER OF INSURANCE

Robert D. Haase
Commissioner

123 West Washington Avenue
P.O. Box 7873
Madison, Wisconsin 53707
(608) 256-3585

Testimony by
ROBERT D. HAASE
Commissioner of Insurance
Office of the Commissioner of Insurance (OCI)
Madison WI 53707

December 11, 1989

Senator Kohl, ladies and gentlemen. Thank you for inviting me to comment on Medicare supplement policies from the regulator's perspective. You asked me to limit my remarks to four areas:

1. Describe the current process of regulation.
2. Give the history of rates and benefits for the past five years.
3. Indicate what impact repeal of the Catastrophic Health Care Act has had on the content and cost of Medicare supplement policies.
4. Discuss the role of hospital indemnity policies and whether they should be prohibited.

In order to do that, let me first give you a thumbnail sketch of the evolution of Medicare supplement policies.

Prior to Medicare, health insurance for the elderly was virtually non-existent. After the creation of Medicare, insurers realized that a market existed where they could define the limits of their potential risk. Insurers began marketing policies to fill the gaps in Medicare in the early 1970s. Many abuses occurred. Persons purchased policies that offered little or no protection against the costs not covered by Medicare.

Both the National Association of Insurance Commissioners (NAIC) and the Congress began studying the problem. As a result, the NAIC adopted its first model act to regulate Medicare supplement policies in 1980. Congress adopted the Baucus amendment the same year. This law required minimum standards for policies designed to supplement Medicare and directed the states to develop minimum standards for the policies.

Wisconsin was a leader in attempting to resolve the problem and to develop standards for Medicare supplement policies. Former commissioners Wilde and Mitchell worked with congressional committees and chaired the NAIC task force that developed the model regulation for minimum policy requirements.

Wisconsin first promulgated rules to regulate Medicare supplement policies in 1977, before either the NAIC or the Congress took action. This regulation, Wisconsin Administrative Code s. Ins 3.39, was revised in 1980 to bring it into accord with the Baucus amendment. We have revised the rule several times since then to bring it into accord with federal law and to alleviate abuses that occurred. Assuming that President Bush will not veto the bill, just last week we issued an emergency rule to bring the regulation into compliance with federal law following repeal of the Catastrophic Health Care Act.

Ins 3.39 specifies the benefits a policy must provide to be called a Medicare supplement policy, details provisions that insurers must include on the face of the policy, spells out type size and color, requires minimum loss ratios, and requires that the "Health Insurance Advice for Senior Citizens" booklet be given at the time of solicitation. In addition, Wisconsin has stringent rules governing the marketing and advertising of Medicare supplement policies.

In addition to the state laws and regulations that govern all health insurance policies, persons who purchase Medicare supplement policies are guaranteed the right to return the policy within 30 days of receipt and receive a full premium refund. Also, insurers may not exclude pre-existing conditions for more than 6 months.

When our department first promulgated Ins 3.39, insurers were permitted to offer four categories of Medicare supplement policies. A Medicare supplement policy 1 offered the most comprehensive benefits, and a Medicare supplement policy 4 offered the least. In 1980, the Medicare supplement 4 policies were no longer allowed.

When the Catastrophic Health Care Act passed, we saw it as an opportunity to revise our regulations and, hopefully, make comparison shopping easier for the consumer. We required all insurers offering a Medicare supplement policy to develop a basic benefits package that complied with federal requirements. The company could then offer only specific riders offering benefits not covered by Medicare.

Insurers can only offer riders for: the Part A deductible, Part B deductible, usual and customary charges for outpatient prescription drugs, additional home health benefits, foreign travel, and Part B usual and customary charges over and above what Medicare allows.

Following the repeal of the Catastrophic Act, we retained the basic policy with the six specific permissible riders. However, we now require insurers to cover the hospital copayments beyond the 61st day under the base policy and allow them to include a \$100 deductible to the outpatient prescription drug rider.

The late action by Congress has thrown the Medicare supplement insurance market into a quandry. Companies have not had time to react, particularly those that market in several states. We expect, however, to have 5-10 policies submitted and approved by the end of the month.

In most cases, policies that are in effect today will continue to provide coverage as long as the premium is paid. However, even there, we don't know what the premium will be as insurers have not had the opportunity to develop the rates. The Health Care Financing Administration is part of the problem as it is unclear what the Part A hospital and skilled nursing copayments will be for 1990.

What impact will repeal of the Catastrophic Act have on rates? We can't be certain until companies actually begin filing those rates with us. However, according to the results of a survey released by the House Select Committee on Aging, Wisconsin rates are only anticipated to increase 11% as opposed to 133% in Arizona, 120% in Missouri and 75% in several states. I think that Wisconsin's lower rate of increase is attributable to a number of things.

First, we have imposed minimum loss ratios for several years. Some other states are only now taking this approach. Second, we have a very competitive health insurance market. This tends to keep increases at a minimum. Third, although the overall costs of health care are increasing, the rate in Wisconsin has not increased at the same rate as some of the states that report astronomical rate increases for the Medicare population.

When talking about rates, it is important to remember, Senator, that health insurance premiums reflect what is happening in the marketplace. Health care costs continue to increase at double the rate of inflation. People live longer and, consequently, require more care. Technology has improved but is costly. People demand more health care. Because Medicare supplement policies actually supplement Medicare, their rates also reflect decisions that the Health Care Financing Administration makes about what is allowable under Medicare.

I have provided you some historical rate data (Exhibit 1). Although Wisconsin does not pre-approve rates, companies are required to file their rates with us. Because of the minimum loss ratio requirement, we closely review the rate filings to assure that the companies are complying.

Senator Kohl, you asked me to comment on hospital indemnity policies and whether they should be allowed. Personally, I believe that consumers should have the right to purchase a hospital indemnity policy if they so choose as long as they receive adequate disclosure about the limited benefits of the policy. We have attempted to do that through regulation and consumer information. Any hospital indemnity policy marketed in the state must contain a disclosure on the face of the policy indicating that it is a limited benefit policy (Exhibit 2). In addition, the "Health Insurance Advice for Senior Citizens" booklet (Exhibit 3) that must be given to all seniors at the time of solicitation contains an explanation of limited policies such as hospital indemnity policies.

Thank you for the opportunity to appear before you.



Tommy G. Thompson
Governor

State of Wisconsin \ OFFICE OF THE COMMISSIONER OF INSURANCE

Robert D. Haase
Commissioner
123 West Washington Avenue
P.O. Box 727
Madison, Wisconsin 53707
(608) 256-2585

EXHIBIT 1

Attached are 1988 Wisconsin Medicare Supplement Experience Data, 1987 Wisconsin Medicare Supplement Experience Data, and 1988 Medicare Supplement Market Shares.

The experience data for 1987 and 1988 includes data for business written only in those respective years. Loss ratios are determined by dividing the incurred claims by the earned premium.

Incurred claims are the claims paid during the respective year plus the current year's unpaid claims and reserves less unpaid claims incurred for prior years. Reserves are an actuarially determined amount.

Open block means that new policies were issued during the respective year, either 1987 or 1988. Closed block means policies are still in force and are still being renewed by existing policyholders but where no new policies were issued during the respective year.

Loss ratios are developed over a number of years for a particular block of business. A low loss ratio may indicate that the company has only recently started marketing the block of business or has a small volume of business in Wisconsin. The loss ratio increases as the block of business ages.

SDA:bm
235b
Attachment

1988 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

COMPANY	1988 EARNED PREMIUMS		1988 INCURRED CLAIMS		RESERVE INCREASE		LOSS RATIOS		TOTAL	
	OPEN BLOCKS	CLOSED BLOCKS	OPEN	CLOSED	OPEN	CLOSED	OPEN	CLOSED		
1 AAL	1,773,323		1,143,554		238,192		77.92%	ERR	77.92%	
2 AM FAH LIFE ASSU	778,387	549,221	108,922	256,203	0	0	15.99%	46.64%	27.50%	
3 AMERICAN FAMILY	890,872		415,941		0		46.46%	ERR	46.46%	
4 AMERICAN INCOME							ERR	ERR	ERR	
5 AMER. MOTORISTS							ERR	ERR	ERR	
6 AMER. REPUBLIC	745,767	77,492	309,167	17,704	0	(5,680)	41.46%	15.52%	39.01%	
7 BARRIERS LAC	14,829,996	1,252,047	8,340,147	751,577	115,075	19,086	61.11%	57.65%	60.82%	
8 BC/BS OF WIS.	27,730,000	15,242,000	18,325,000	9,020,000	0	0	66.08%	59.18%	63.63%	
9 BENEFIT TRUST	277,840		155,592		6,150		58.21%	ERR	58.21%	
10 CENTRAL STATES	4,154,142		1,712,711		119,861		44.11%	ERR	44.11%	
11 COLONIAL PENN	1,779,580		960,980		0		54.00%	ERR	54.00%	
12 COMBINED IHS	15,117		4,950		2,852		51.48%	ERR	51.48%	
13 COMPICARE		443,416		336,904		0	ERR	75.98%	75.98%	
14 CHA	2,495,220	23,323	1,383,614	16,601	85,050	(5,158)	58.86%	49.06%	58.77%	
15 CONT GENERAL	136,345		97,093		2,391		72.96%	ERR	72.96%	
16 DEAN HEALTH PLAN	5,547,749		4,508,027		0		81.26%	ERR	81.26%	
17 FAMILY HEALTH PL	11,992,426		6,421,930		0		53.55%	ERR	53.55%	
18 FEDERAL HOME	544,025	252,190	325,994	133,436	8,182	4,733	61.43%	54.79%	59.32%	
19 FEDERAL LIFE	455,529		222,299		0		48.80%	ERR	48.80%	
20 GLOBE LAA		37,384		24,473		(2,129)	ERR	59.77%	59.77%	
21 GGT LA CROSSE	666,625		480,383		0		72.06%	ERR	72.06%	
22 GP HEALTH EAUCLAIRE		364,560		335,174			ERR	91.94%	91.94%	
23 GNC SOUTH CENTRA	104,186		55,793		0		53.55%	ERR	53.55%	
24 GUARANTEE TRUST	1,369,750	181,961	669,127	162,414	82,752	(11,488)	54.89%	82.94%	58.18%	
25 HMO MIDWEST	15,587		3,742		0		24.01%	ERR	24.01%	
26 HMO OF WISCONSIN	682,102		504,941				74.02%	ERR	74.02%	
27 LUMBERMEN'S							ERR	ERR	ERR	
28 LUTH. BROTH.	125,351	130,991	50,400	65,160	16,127	13,699	53.07%	60.20%	56.72%	
29 MASS INDEMNITY							ERR	ERR	ERR	
30 ME ASS HMO	758,219		669,269				88.27%	ERR	88.27%	
31 MEDICO LIFE	30,595	52,417	28,518	26,792	0	0	93.21%	51.11%	66.63%	
32 MIDAMERICA LIFE	588,723		388,822		11,120		67.95%	ERR	67.95%	
33 MIDELFORT CLINIC	1,819,304		1,198,983		0		65.90%	ERR	65.90%	
34 MUTUAL OF OMAHA	3,931,933	1,853,104	2,430,350	1,452,557	0	0	61.81%	78.38%	67.12%	
35 MUT. PROT. LIFE	219,799		67,513	243,547	29,488	0	110.80%	45.56%	95.00%	
36 NATL CASUALTY	2,311		13,016	3,063	17,035	37	209	134.14%	132.48%	132.73%
37 NATIONAL HOME		109,334		70,623		(2,681)	ERR	62.14%	62.14%	
38 NATIONAL STATES	2,398,445		581,259	912,292	490,760	21,093	38.92%	85.74%	48.05%	
39 NATL TRAV LIFE	12,054		7,725	12,970	3,965		107.60%	51.33%	85.62%	
40 NEW YORK LIFE		198,409		93,818		(8,992)	ERR	42.75%	42.75%	
41 NORTH AMERICAN		55,582		43,015			ERR	77.70%	77.70%	
42 NORTH CENTRAL	345,868		249,024				72.00%	ERR	72.00%	
43 PENN LIFE							ERR	ERR	ERR	
44 PEKIN LIFE	121,973	1,479	50,670	(1,539)	14,141	(632)	53.14%	-146.79%	50.74%	
45 PIONEER LIFE	2,742,654		1,420,849				51.81%	ERR	51.81%	
46 PHYS. MUT. LIFE	10,307,859	3,734,455	7,440,426	2,957,035	533,046	164,364	77.35%	83.58%	79.01%	
47 PHYSICIANS PLUS	713,509		424,076				59.44%	ERR	59.44%	
48 PRINCIPAL MUT	6,299,034		4,557,240				72.35%	ERR	72.35%	
49 RURAL		1,384,001		1,043,550		0	ERR	75.40%	75.40%	
50 SECURITY HLT PLA	11,408,296		9,396,078		0		82.36%	ERR	82.36%	
51 STATE FARM MUT	2,461,626		1,508,383		0		61.28%	ERR	61.28%	
52 TIME		470,952		160,310		20,320	ERR	38.46%	38.46%	
53 UNION LABOR LIFE	274,637		191,712		6,964		72.34%	ERR	72.34%	
54 UNITED AMERICAN	10,385,216	756	6,208,338	52	588,282	(20)	65.45%	4.23%	65.44%	
55 WIS HEALTH ORG	69,095		26,901		0		37.63%	ERR	37.63%	
56 WPS	5,848,383	20,787,483	3,798,350	16,656,732	0	0	64.95%	60.13%	76.80%	
TOTAL	137,849,442	47,971,962	87,965,248	34,171,757	1,850,113	194,520	65.15%	71.64%	66.83%	

1987 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

COMPANY	EARNED PREMIUM	INCURRED LOSSES	LOSS RATIO TOTAL
1 UNITED AMERICAN	0	0	ERR
2 GLOBE L&A	0	0	ERR
3 WIS HEALTH ORG	30,203	34,075	112.82%
4 DEAN HEALTH PLAN	3,683,629	3,869,235	105.01%
5 MIDELFORT CLINIC	959,098	928,279	96.58%
6 PHYSICIANS PLUS	462,249	406,779	88.00%
7 GP HEALTH EAUCLA	81,340	70,332	86.46%
8 HMO OF WISCONSIN	472,850	400,859	84.78%
9 MED ASS HMO	636,529	530,539	83.35%
10 PHYS. MUT. LIFE	11,752,906	9,190,125	78.19%
11 UNION LABOR LIFE	298,150	235,017	78.81%
12 MUT. PROT. LIFE	335,568	260,968	77.77%
13 AAL	1,623,773	1,240,849	76.42%
14 PRINCIPAL MUT	5,648,592	4,202,200	74.39%
15 WPS	24,518,203	18,051,417	73.63%
16 SECURITY HLT PLA	10,432,305	7,632,249	73.16%
17 NORTH CENTRAL	197,688	142,235	71.95%
18 FAMILY HEALTH PL	6,556,737	4,375,559	68.83%
19 CNA	2,290,377	1,581,029	68.16%
20 NATIONAL HOME	132,060	84,232	63.82%
21 MUTUAL OF OMAHA	5,605,125	3,571,944	63.73%
22 RURAL	1,426,392	899,185	63.04%
23 PENN LIFE	7,901	4,909	62.13%
24 AMERICAN INCOME	8,681	5,379	61.96%
25 BANKERS L&C	15,199,445	9,337,759	61.43%
26 BENEFIT TRUST	371,305	227,011	61.14%
27 BC/BS OF WIS.	49,789,000	29,539,000	59.33%
28 NATL CASUALTY	18,112	10,683	58.98%
29 STATE FARM MUT	1,344,040	773,402	57.54%
30 GRT LA CROSSE	310,935	178,257	57.33%
31 FEDERAL LIFE	255,098	143,966	56.44%
32 COMPCARE	462,959	253,322	54.72%
33 MEDICO LIFE	128,709	69,737	54.18%
34 PIONEER LIFE	576,745	308,443	53.48%
35 LUTH. BROTH.	190,708	101,827	53.39%
36 FEDERAL HOME	981,045	518,977	52.70%
37 MIDAMERICA LIFE	509,974	263,114	51.59%
38 NEW YORK LIFE	240,585	123,377	51.28%
39 AMERICAN FAMILY	608,542	303,968	49.95%
40 PEKIN LIFE	101,299	47,244	46.64%
41 GUARANTEE TRUST	1,664,995	714,729	42.93%
42 GHC SOUTH CENTRA	99,576	42,495	42.67%
43 CENTRAL STATES	1,555,806	641,136	41.21%
44 AMER. REPUBLIC	528,370	206,075	39.15%
45 NATIONAL STATES	2,845,865	1,085,060	38.13%
46 CONT GENERAL	83,624	24,013	28.72%
47 TIME	445,881	127,753	28.65%
48 AM FAM LIFE ASSU	367,968	96,833	26.32%
49 AMER. MOTORISTS	750	162	21.60%
50 NATL TRAV LIFE	19,510	1,174	6.02%
51 MASS INDEMNITY	2,414	137	5.68%
52 LUMBERMEN'S	4,485	(23,407)	-521.90%
TOTAL	155,564,539	102,764,282	66.06%

MEDICARE SUPPLEMENT MARKET SHARES

COMPANY	1988 EARNED PREMIUM	1988 POSITION	1988 MARKET SHARE	1987 EARNED PREMIUM	1987 POSITION	1987 MARKET SHARE
BC/BS OF WIS.	\$42,972,000	1	23.13%	\$49,789,000	1	30.08%
WPS	26,635,866	2	14.33%	24,516,203	2	14.81%
BANKERS L&C	16,181,953	3	8.71%	15,199,445	3	9.18%
PHYS. MUT. LIFE	14,042,314	4	7.56%	11,752,906	4	7.10%
FAMILY HEALTH PL	11,992,426	5	6.45%	6,356,737	7	3.84%
SECURITY HLT PLA	11,408,296	6	6.14%	10,432,305	5	6.30%
UNITED AMERICAN	10,385,972	7	5.59%	9,876,841	6	5.97%
PRINCIPAL MUT	8,299,034	8	3.39%	5,648,592	8	3.41%
MUTUAL OF OMAHA	5,785,039	9	3.11%	5,605,123	9	3.39%
DEAN HEALTH PLAN	5,547,749	10	2.99%	3,683,629	10	2.23%
CENTRAL STATES	4,154,142	11	2.24%	1,555,806	15	0.94%
NATIONAL STATES	2,979,704	12	1.60%	2,845,865	11	1.72%
PIONEER LIFE	2,742,654	13	1.48%	576,745	22	0.35%
CNA	2,518,543	14	1.36%	2,290,377	12	1.38%
STATE FARM MUT	2,461,626	15	1.32%	1,344,040	17	0.81%
MIDELFORT CLINIC	1,819,304	16	0.98%	959,098	19	0.58%
COLONIAL PENN	1,779,580	17	0.96%			
AAL	1,773,323	18	0.95%	1,623,773	14	0.98%
GUARANTEE TRUST	1,551,711	19	0.84%	1,664,995	13	1.01%
RURAL	1,384,001	20	0.74%	1,426,392	16	0.86%
AM FAM LIFE ASSU	1,327,718	21	0.71%	367,968	30	0.22%
AMERICAN FAMILY	890,872	22	0.48%	608,542	21	0.37%
AMER. REPUBLIC	823,259	23	0.44%	526,370	23	0.32%
FEDERAL HOME	796,215	24	0.43%	981,045	18	0.59%
MED ASS HMO	758,219	25	0.41%	636,529	20	0.38%
PHYSICIANS PLUS	713,509	26	0.38%	462,249	27	0.28%
HMO OF WISCONSIN	682,182	27	0.37%	472,850	25	0.29%
GRT LA CROSSE	666,625	28	0.36%	310,935	32	0.19%
MIDAMERICA LIFE	588,723	29	0.32%	509,974	24	0.31%
TIME	470,952	30	0.25%	445,881	28	0.27%
FEDERAL LIFE	455,529	31	0.25%	255,098	34	0.15%
COMP CARE	443,416	32	0.24%	462,959	26	0.28%
GP HEALTH EAUCLA	364,560	33	0.20%	81,348	42	0.05%
NORTH CENTRAL	345,868	34	0.19%	197,688	36	0.12%
MUT. PROT. LIFE	287,312	35	0.15%	335,568	31	0.20%
BENEFIT TRUST	277,840	36	0.15%	371,305	29	0.22%
UNION LABOR LIFE	274,637	37	0.15%	298,150	33	0.18%
LUTH. BROTH.	256,342	38	0.14%	190,708	37	0.12%
NEW YORK LIFE	198,409	39	0.11%	240,585	35	0.15%
CONT GENERAL	136,345	40	0.07%	83,624	41	0.05%
PEKIN LIFE	123,452	41	0.07%	101,299	40	0.06%
NATIONAL HOME	109,334	42	0.06%	132,068	38	0.08%
GHC SOUTH CENTRA	104,186	43	0.06%			
MEDICO LIFE	83,012	44	0.04%	128,709	39	0.08%
WIS HEALTH ORG	69,095	45	0.04%	30,203	44	0.02%
NORTH AMERICAN	55,362	46	0.03%			
GLOBE L&A	37,384	47	0.02%	75,074	43	0.05%
NATL TRAV LIFE	19,779	48	0.01%	19,510	45	0.01%
HMO MIDWEST	15,587	49	0.01%			
NATL CASUALTY	15,327	50	0.01%	18,112	46	0.01%
COMBINED INS	15,117	51	0.01%			
AMERICAN INCOME	0	52	0.00%	8,681	47	0.01%
PENN LIFE	0	53	0.00%	7,901	48	0.00%
LUMBERMEN'S	0	54	0.00%	4,485	49	0.00%
MASS INDEMNITY	0	55	0.00%	2,414	50	0.00%
AMER. MOTORISTS	0	56	0.00%	750	51	0.00%
						NO INFORMATION
TOTAL	\$185,821,404		100.00%	\$165,516,454		100.00%

1987 WISCONSIN MEDICARE SUPPLEMENT EXPERIENCE DATA

COMPANY	EARNED PREMIUM	INCURRED LOSSES	LOSS RATIO TOTAL
1 BC/BIS OF WIS.	49,799,000	29,539,000	59.35%
2 WFS	24,516,203	18,051,417	73.63%
3 BANKERS L&C	15,199,445	9,337,759	61.48%
4 PHYS. MUT. LIFE	11,752,906	9,190,125	78.19%
5 SECURITY HLT PLA	10,432,305	7,632,249	73.16%
6 FAMILY HEALTH PL	6,356,737	4,375,559	68.83%
7 PRINCIPAL MUT	5,648,592	4,202,200	74.39%
8 MUTUAL OF OMAHA	5,605,123	3,571,944	63.73%
9 DEAH HEALTH PLAN	3,683,629	3,888,235	105.01%
10 NATIONAL STATES	2,845,865	1,085,080	38.13%
11 GHA	2,290,377	1,561,029	68.16%
12 GUARANTEE TRUST	1,664,995	714,729	42.93%
13 AAL	1,623,773	1,240,849	76.42%
14 CENTRAL STATES	1,555,806	641,186	41.21%
15 RUKAL	1,426,392	899,185	63.04%
16 STATE FARM MUT	1,344,040	773,402	57.54%
17 FEDERAL HOME	981,045	516,977	52.70%
18 MIDELFORT CLINIC	959,098	926,278	96.58%
19 MED ASS HMO	636,529	530,569	83.35%
20 AMERICAN FAMILY	608,542	303,968	49.95%
21 PIONEER LIFE	576,745	308,443	53.48%
22 AMER. REPUBLIC	526,370	206,075	39.15%
23 MIDAMERICA LIFE	509,974	263,114	51.59%
24 HMO OF WISCONSIN	472,850	400,859	84.78%
25 COMPCARE	462,959	253,322	54.72%
26 PHYSICIANS PLUS	462,249	406,779	88.00%
27 TIME	445,881	127,753	28.65%
28 BENEFIT TRUST	371,305	227,011	61.14%
29 AM FAM LIFE ASSU	367,968	96,833	26.32%
30 MUT. PROT. LIFE	335,568	260,968	77.77%
31 GRT LA CROSSE	310,935	178,257	57.35%
32 UNION LABOR LIFE	298,150	233,013	78.15%
33 FEDERAL LIFE	255,098	143,966	56.44%
34 NEW YORK LIFE	240,585	123,377	51.28%
35 NORTH CENTRAL	197,688	142,235	71.95%
36 LUTH. BROTH.	190,708	101,827	53.39%
37 NATIONAL HOME	132,068	84,292	63.82%
38 MEDICO LIFE	128,709	69,757	54.18%
39 PEKIN LIFE	101,299	47,244	46.64%
40 GHC SOUTH CENTRA	99,576	42,493	42.67%
41 CONT GENERAL	83,624	24,013	28.72%
42 GP HEALTH EAUCLA	81,348	70,332	86.46%
43 WIS HEALTH ORG	30,203	34,075	112.82%
44 NATL TRAV LIFE	19,510	1,174	6.02%
45 NATL CASUALTY	18,112	10,683	58.98%
46 AMERICAN INCOME	8,631	5,379	61.96%
47 PENN LIFE	7,901	4,909	62.13%
48 LUMBERMEN'S	4,485	(23,407)	-521.90%
49 MASS INDEMNITY	2,414	157	6.50%
50 AMER. MOTORISTS	750	162	21.60%
51 UNITED AMERICAN	0	0	ERR
52 GLOBE L&A	0	0	ERR
TOTAL	155,564,539	102,764,282	66.06%



Colonial Penn Life Insurance Company

Colonial Penn Plaza/19th & Market St./Philadelphia, PA 19181

A STOCK COMPANY also referred to in this policy as COLONIAL PENN

HOSPITAL CONFINEMENT INDEMNITY POLICY

This policy provides a daily benefit for covered hospital confinements. The daily benefit amount is shown in the SCHEDULE OF BENEFITS. Please read your entire policy carefully.

WHO IS COVERED

COLONIAL PENN certifies that the person who is named on the POLICY SCHEDULE and for whom the premium has been paid is covered. The terms "you" and "your" refer to the person named.

YOUR INSURANCE POLICY

This policy is a contract between Colonial Penn and you. Payment of the premium puts this policy in force on the Effective Date shown on the POLICY SCHEDULE for the period for which premium is paid. Colonial Penn will pay benefits for covered confinements and care which result from sickness or injury, as provided in this policy.

GUARANTEED RENEWABLE/RATE CHANGE

You may renew this policy by paying the premium when due or during the 31-day grace period that follows. Colonial Penn cannot refuse to renew your policy.

Your premium is based on your age on the Effective Date of this policy. Colonial Penn can change the premium rates for this policy, but only if the same change is made for all persons of your class and state who are covered under policy form series 4-82-363. Any change in your premium will take effect only on an anniversary of your Effective Date. Colonial Penn will notify you of any change in your premium.

NOTICE OF YOUR RIGHT TO EXAMINE THIS POLICY FOR 30 DAYS

If you decide that you do not want this policy, you may return it to Colonial Penn, or to the agent through whom it was purchased, within 30 days after you receive it. Colonial Penn will then refund any premium paid. If returned, this policy will never have been in effect.

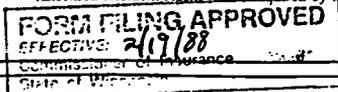
IMPORTANT NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR YOUR INSURANCE

Please read the copy of the application attached to your policy. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Colonial Penn Life Insurance Company, Colonial Penn Plaza, 19th & Market Sts., Philadelphia, PA 19181 within 10 days if any information shown on the application is not correct and complete or if any medical history has not been included. The application is part of the insurance contract. The insurance contract was issued on the basis that the answers to all questions and any other material information shown on the application are correct and complete.

101-2999-001

Countersignature

(Licensed Resident Agent where required by law)



442-363(44)

2/4/88



Colonial Penn Life Insurance Company
Colonial Penn Plaza 19th & Market Sts./Philadelphia, Pennsylvania 19181

EXHIBIT 2

This policy is not designed to fill the gaps in Medicare. It will pay you only a fixed dollar amount per day when you are confined to a hospital. For more information, see "Health Insurance Advice for Senior Citizens", given to you when you applied for this policy.

SAMPLE OF DISCLOSURE THAT MUST BE ATTACHED TO FACE OF
HOSPITAL INDEMNITY POLICY WHEN MARKETED TO MEDICARE
ELIGIBLE.

COVERAGE REQUIREMENTS

Hospital Confinement Colonial Penn will pay the Daily Benefit shown in the SCHEDULE OF BENEFITS if you are confined in a *hospital* as an inpatient. To be covered, the *hospital* confinement must:

1. begin while your coverage is in force; and
2. be required for the treatment of your *sickness or injury*; and
3. be *medically necessary* and recommended by your *physician*.

The maximum number of days payable is determined by adding together all covered days of confinement during a *period of confinement*. The maximum number of days payable during a *period of confinement* is shown in the SCHEDULE OF BENEFITS.

The Daily Benefit will not be paid for the day of discharge unless the *hospital* makes an inpatient room and board charge for that day.

Limitation: Government Hospital Confinement

Colonial Penn will pay the Daily Benefit shown in the SCHEDULE OF BENEFITS for up to a maximum of 120 days during a *period of confinement* if you are confined in any of the following:

1. a military or veterans hospital; or
2. any hospital contracted for, or operated by, any national government or agency for the treatment of members or ex-members of the armed forces.

The Daily Benefit will not be paid for the day of discharge from any of the above unless the *hospital* makes an inpatient room and board charge for that day.

WHAT IS NOT COVERED

War Loss caused by or resulting from war or any act of war whether declared or undeclared is not covered.

Care Outside U.S.A. Confinement occurring outside the United States or its possessions is not covered.

Mental Illness Confinement for the treatment of mental, psychoneurotic or personality disorders, without demonstrable organic disease, is not covered.

Other Coverage with Colonial Penn You may have coverage with Colonial Penn under more than one policy providing hospital confinement indemnity benefits. However, the aggregate of the initial daily benefit amounts payable under all policies may not exceed \$150 per day, if you are under age 65 on this policy's Effective Date, or \$100 per day if you are age 65 or over on the Effective Date. If the aggregate exceeds \$150 per day (\$100 per day if you are age 65 or over) part or all of the coverage of this policy will be void. The premium paid for any coverage which is voided shall be returned to you.

BENEFITS AFTER THIS POLICY TERMINATES

If you are confined in a *hospital* on the date this policy terminates, benefits will be paid as though this policy had not terminated, but only while you remain continuously confined.

POLICY DEFINITIONS

Hospital	<i>"Hospital"</i> means an institution which meets all of the following requirements: (a) holds a State license as a <i>hospital</i> (if a license is required) and operates pursuant to law; (b) is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the <i>hospital</i> on a pre-arranged basis and under the supervision of a staff of duly licensed <i>physicians</i> , medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis; and (c) provides 24-hour nursing service by or under the supervision of registered graduate professional nurses (RN's). Note: An institution which is: 1) primarily a clinic, nursing home, rest or convalescent home; or 2) other than incidentally, a place for the treatment of alcoholics or drug addicts will <i>not</i> be considered a <i>"hospital"</i> . Confinement in a <i>hospital</i> unit or area which functions primarily as a skilled nursing facility or other type of nursing home, rest or convalescent home will <i>not</i> be considered <i>"hospital"</i> confinement.
Injury	<i>"Injury"</i> means bodily injury caused by an accident.
Medically Necessary	A <i>hospital</i> confinement is <i>"medically necessary"</i> when you have a medical condition which requires a degree and frequency of medical services and treatment which can be provided only in a <i>hospital</i> on an inpatient basis.
Period of Confinement	<i>"Period of Confinement"</i> means continuous or intermittent confinement as an inpatient in a <i>hospital</i> . A <i>"period of confinement"</i> : 1) begins on the day you are admitted as an inpatient in a <i>hospital</i> ; and 2) ends on the day when 60 consecutive days have passed during which time you have not been confined in a <i>hospital</i> . Confinements not separated by 60 consecutive days are considered one <i>"period of confinement"</i> .
Physician	<i>"Physician"</i> means a licensed practitioner of the healing arts acting within the scope of his/her license. The <i>"physician"</i> cannot be: 1) someone who ordinarily resides in your home; or 2) you or your spouse; or 3) your or your spouse's child, brother, sister or parent.
Sickness	<i>"Sickness"</i> means an illness or disease.

WHEN YOU HAVE A CLAIM

Notice of Claim	You must notify Colonial Penn in writing when you have a claim. Your written notice must be provided within 20 days after the loss begins or occurs, or as soon as is reasonably possible. Notice given by you or by someone else on your behalf with enough information to identify you shall be considered as sufficient notice to Colonial Penn when mailed to its Health Claims Department, Colonial Penn Plaza, 19th & Market Sts., Philadelphia, Pennsylvania 19181, or when given to an agent of Colonial Penn.
Claim Forms	When Colonial Penn receives written notice of your claim, it will send claim forms to you to file your proof of loss. If claim forms are not sent to you within 15 days after you have notified Colonial Penn of your claim, you may provide proof of loss within the time limits stated in the "Proofs of Loss" paragraph by sending Colonial Penn written proof of the occurrence, character and extent of your loss.

Proofs of Loss	You must provide Colonial Penn with written proof of your loss within 90 days after the date of your loss. If it is not reasonably possible to furnish the necessary proof within the 90 days, a claim will not be reduced or denied solely because of failure to do so. The necessary proof must, however, be furnished as soon as reasonably possible, and not later than one year from the end of the 90-day period. The one year limit will be extended indefinitely while you are not legally capable of furnishing sufficient proof.
Time of Payment of Claim	After you have filed sufficient proof of loss, all benefits will be paid as they become due.
Payment of Claim	All benefits will be paid to you. You may, however, direct Colonial Penn in writing to pay your benefits directly to the person or institution providing the care. Any benefit unpaid at your death will be paid to your estate. If any benefit is payable to your estate or while you are not competent to give a valid release, Colonial Penn may pay a benefit up to One Thousand Dollars (\$1,000) to any relative Colonial Penn decides to be justly entitled to it. Any payment made to your relative in good faith will fully release Colonial Penn of its responsibility only to the extent of the payment.
Physical Examination	When you submit a claim, Colonial Penn has the right to have you examined, at its own expense, when and as often as it may reasonably require while your claim is being considered or during any period for which benefits are being paid by Colonial Penn.
Legal Actions	You cannot bring any action at law or in equity for any benefits under this policy until 60 days after you have filed written proof of your loss. No such action can be brought after 3 years from the date you were required to file proof of your loss.
Misstatement of Age	If your age is misstated, the amount of any overpayment of premium will be refunded to you, or the amount of any underpayment of premium is due to Colonial Penn.

GENERAL MATTERS

Time Limit On Certain Defenses	Misstatements in the application: Up to 2 years after the Effective Date, misstatements in your application can be used to void the policy or deny any claim; and, after 2 years from the Effective Date, only fraudulent misstatements in your application can be used to void the policy or deny any claim for loss incurred after such 2-year period.
Premium Payment	Premium must be paid when due. Premium is payable to Colonial Penn.
Grace Period	If any premium after the first premium is not paid when due, it may be paid during the following 31 days. During the grace period, this policy will stay in force. At the end of the grace period, this policy will terminate. If your policy terminates, benefits otherwise payable under the terms of this policy will be provided for the duration of any covered confinement which began while your policy was in force.

Entire Contract Changes

This policy with the attached application and papers, if any, is the entire contract between you and Colonial Penn. No change in this policy will be effective until approved by a Colonial Penn officer. This approval must be noted on or attached to this policy. No agent or other person may change this policy or waive any of its provisions.

Reinstatement

You may reinstate this policy if the policy terminates for non-payment of premium. Payment of the premium to Colonial Penn (or to an agent authorized to accept premium) will reinstate this policy. However, you may be required to complete an application for reinstatement.

If Colonial Penn or its agent requires you to complete an application, you will be given a conditional receipt for the premium. If your application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 30th day after the date of the conditional receipt unless Colonial Penn has previously notified you in writing of its disapproval.

Your reinstated policy will cover only confinement and care that result from an injury sustained or sickness that starts after the date of reinstatement. In all other respects the rights of you and Colonial Penn will remain the same, subject to any provisions noted on or attached to your reinstated policy.

Signed for Colonial Penn Life Insurance Company by its president and secretary in Philadelphia, Pennsylvania.

Secretary

President

POLICY INDEX

	Page		Page
Who is Covered	1	Policy Definitions	3
Your Insurance Policy	1	When You Have A Claim	3 & 4
Guaranteed Renewable/Rate Change	1	General Matters	4 & 5
Coverage Requirements	2	Policy Schedule	6
What is Not Covered	2		

**HOSPITAL CONFINEMENT
INDEMNITY POLICY**

POLICY SCHEDULE

Issued to:
.....
.....
.....

Date of Birth: 99999999
Policy Number: 9999999999
Effective Date: 99999999

Initial Premium:

SCHEDULE OF BENEFITS

This SCHEDULE OF BENEFITS is a brief outline of your coverage. Please read your entire policy carefully for a full description of your coverage.

HOSPITAL CONFINEMENT
(during any one period of confinement)

Days 1 through 365

Days 366 and after

DAILY BENEFIT

..... per day

No Benefit

INDIVIDUAL HOSPITAL CONFINEMENT INDEMNITY APPLICATION

HOME OFFICE USE ONLY

COLONIAL PENN LIFE INSURANCE COMPANY
PHILADELPHIA, PENNSYLVANIA 19181

Special Instructions

Policy applied for: [Daily Benefit \$ XX.XX]

Name: John Doe DOB: [2-18-22] Age: [45] Sex: M F
Address: [123 Main Street] [City] [State] [0000] Phone #: [123-4567]

Are you covered under another policy not being replaced by the policy you are now applying for, that provides Daily Hospital Confinement benefits (other than Medicare or Medicare Supplement Insurance)? YES NO

If yes, Company Name: _____
Policy Number: _____
Daily Benefit: _____

IF THE ANSWER TO EITHER QUESTION 9 OR 10 IS YES, THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

Have you been confined as an in-patient in a hospital, nursing home, facility for mental or nervous disorders, or other medical facility within the last 6 months? YES NO

Has confinement or surgery been recommended or discussed by your physician within the last 6 months? YES NO

Is the policy applied for intended to replace any Hospital Confinement Indemnity policy which you plan to terminate? YES NO

If yes, company name: _____
Address: _____
Policy Number: _____

Name and address of personal physician:

John Smith
895 Spruce St.
Antown, USA 00000

Premium: A \$ [SA \$ XX.XX] Q \$ _____ Other \$ _____ Policy Fee: XX.XX

Paid with application: [333-333] If spouse application submitted concurrently, his/her name: _____

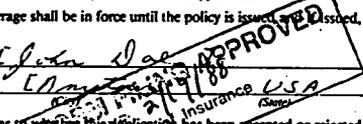
I apply to Colonial Penn Life Insurance Company for a policy to be issued in reliance on my written answers to the above questions. The answers are true to the best of my knowledge and belief. I understand that a copy of this application will be attached to and become a part of my policy and that a false statement or answer, which materially affects the acceptance of the risk or hazard assumed by Colonial Penn, can be used to void the policy as of its effective date or to deny a claim. I have received an outline of coverage for the policy applied for and if eligible for Medicare, a Medicare Supplement Buyer's Guide.

I authorize any insurance company, hospital, medical or medically related facility, physician or other medical practitioner or any other organization, institution or person that has any records or knowledge of me or my health to give to Colonial Penn Life Insurance Company and its underwriters any such information.

I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 30 months from the date signed. I further understand that, upon request, I or an authorized representative have a right to receive a copy of this authorization.

I understand and agree that no coverage shall be in force until the policy is issued. If issued, that coverage will be effective on the date shown in the Policy Schedule.

Applicant's signature: X [John Doe] Date: [8/4/87]
Application signed at: [Antown, USA] [00000]



You will be notified within 60 days as to whether this application has been accepted or rejected or the reason for any delay.

I certify: (1) I have accurately recorded the information supplied by the applicant; (2) I have given to the applicant an outline of coverage for the policy applied for and if eligible for Medicare, a Medicare Supplement Buyer's Guide.

Agent's signature: X [James Doe] Agent number: [895-437]
Agent's name and address: [345 Main St] [Antown USA 00000]

A check or money order for the first premium and policy fee, made payable to CPLIC, must accompany application.
4-82-364



Colonial Penn Life Insurance Company
 Colonial Penn Plaza / 19th & Market Sts. / Philadelphia, PA 19181

**NOTICE TO APPLICANT REGARDING REPLACEMENT
 OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Colonial Penn Life Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, certain facts should be pointed out to you which should be considered before you make this change.

1. Health conditions which you may presently have may not be covered under the new policy. This could result in a claim for benefits being denied which may have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.
4. The new policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
5. The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew the policy.
6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on:

 (Date)

 (Applicant's Signature)

3-82-930(48)

REPLACEMENT NOTICE

S-8463 788

Colonial Penn Life Insurance Company
 Colonial Penn Plaza / 19th & Market Sts. / Philadelphia, Pennsylvania 19181

**HOSPITAL CONFINEMENT
 INDEMNITY COVERAGE
 OUTLINE OF COVERAGE**

1. **Read Your Policy Carefully:** This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

2. **Hospital Confinement Indemnity Coverage** is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. A covered injury or sickness must begin while your coverage is in force and be medically necessary and recommended by your physician. Coverage is provided only for the benefits outlined below, subject to any limitations as set forth in the policy.

3. **Benefits:**

Hospital Confinement Daily Benefit

\$~~XX~~^{XX} per day beginning on the first day of hospital confinement during any one period of hospital confinement.

Maximum Benefit: 365 days per period of confinement. A new period of confinement begins after 60 consecutive days without hospitalization.

4. **Exclusions/Limitations:**

a) **War:** Confinements for the treatment of an injury or sickness due to any act of war (whether declared or undeclared) are not covered.

b) **Confinement outside U.S.A.:** Confinements and care received outside the United States or its possessions are not covered.

c) **Mental Illness:** Confinements for the treatment of mental, psychoneurotic or personality disorders without demonstrable organic disease are not covered.

d) **VA or Governmental Hospitals -** Benefits for confinements in a V.A. or Government Hospital are paid for up to a maximum of 120 days per period of confinement.

e) **Other Coverage with Colonial Penn -** You may have coverage with Colonial Penn under more than one policy providing hospital confinement indemnity benefits. However, the aggregate of the initial daily benefit amounts payable under all policies may not exceed \$150 per day. If the aggregate exceeds \$150 per day part or all of the coverage of this policy will be void. The premium paid for any coverage which is voided will be returned to you.

5. **Guaranteed Renewability:** You may renew this policy by paying the premium when due or during the 31-day grace period that follows. Colonial Penn cannot refuse to renew your policy.

6. **Premium:** Your premium is based on your age on the Effective Date of this policy. Colonial Penn can change the premium rates for this policy, but only if the same change is made for all persons of your class and state who are covered under policy form series 4-82-363. Any change in your premium will take effect only on an anniversary of your Effective Date.

7. **Initial Premium Rates:**

Age:

_____	50 - 54
_____	55 - 59
X _____	60 - 64

Premium Mode:

Other	\$ _____
Quarterly	\$ XX ^{XX} - XX ^{XX}
Semi-Annual	\$ _____
Annual	\$ _____

If you and your spouse apply at the same time and you are both approved, your premiums will be reduced by 5%.

8. **Policy Fee:** A policy fee of \$20.00 is payable at the time of application.

Exhibit 3



**HEALTH INSURANCE ADVICE
FOR
SENIOR CITIZENS**

For more information on health insurance call:

**MEDIGAP HOTLINE
1-800-242-1060**

This is a statewide toll-free number set up by the Wisconsin Board on Aging and Long Term Care and funded by the Insurance Commissioner's Office to answer questions about health insurance and other health care benefits for the elderly. It has no connection with any insurance company.

*Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873
January 1989*

For information on filing an insurance complaint call:
"Insurance Complaint Hotline"
1-800-362-3020

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, Wisconsin 53707-7873

TABLE OF CONTENTS

	PAGE
Introduction	1
Medicare and Medicare "Gaps"	2
Types of Coverage	6
Medicare Supplements	7
Medicare Replacements	8
Comparison Charts	10
Buying Tips	15
Limited Policies	19
Filing a Claim	20

INTRODUCTION

This booklet briefly describes the Medicare program. It also describes the health insurance available to those on Medicare. A list of the individual Medicare supplement policies currently being sold in Wisconsin may be obtained by sending a large, stamped, self-addressed envelope to:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873

If you have questions or concerns about your insurance company or agent, write to the insurance company or agent involved. Keep a copy of the letter you write. If you do not receive satisfactory answers please contact:

Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-0103

For information on filing a complaint with the Insurance Commissioner's Office call:

"Insurance Complaint Hotline"
1-800-362-3020

MEDICARE AND MEDICARE "GAPS"

Medicare is the health insurance program administered by the federal Health Care Financing Administration for people over 65 and for some people under 65 who are disabled. It pays many health care costs for eligible persons. The chart on the following page gives a *brief outline* of those costs which Medicare does and does not pay.

Medicare is divided into two types of coverage. Hospitalization Insurance (Part A) pays hospital bills and certain skilled nursing facility expenses. Medical Insurance (Part B) pays doctors' bills and certain other charges.

Beginning in January 1989, there will be several changes in the Medicare program. The changes in 1989 will affect *only* the Part A coverage for hospital and skilled nursing facility care. In 1990 there will be changes in Part B—including placing a cap on out-of-pocket expenses for certain Part B benefits and beginning some coverage for outpatient prescription drugs. In 1991, more extensive coverage of outpatient prescription drugs will be added. The changes which will take effect in 1989 are described in the chart on page 4. Changes which will take place in 1990 and the following years will be described in detail in later editions of this booklet.

A booklet entitled *Your Medicare Handbook* is available free from any Social Security office. It gives a detailed explanation of Medicare.

Compare the items Medicare will not pay with the insurance policy you are considering. The deductible figures are for 1989 only.

ATTENTION: Medicare pays for covered services which are medically necessary. The amount paid by Medicare is based on the "Medicare-approved" charge for the service. This amount is often less than the amount you are charged by a doctor or other provider. It is sometimes referred to as the "reasonable" or "allowable" charge.

Sometimes a provider or health care plan accepts "assignment." This means that the doctor or health care plan will be paid directly by Medicare and will accept the "Medicare-approved" amount as full payment. A list of doctors in Wisconsin who accept assignment is available from Wisconsin Physicians Service, 1717 W. Broadway, Madison, Wisconsin 53713 or may be reviewed at your local Social Security office. The State Medical Society and the Coalition of Wisconsin Aging Groups operate "Partnercare" — a program through which doctors agree to accept assignment for low-income patients. For more information on this program, contact the State Medical Society, 330 E. Lakeside St., Madison, WI 53715 or your County Commission on Aging.

SKILLED NURSING CARE: Medicare pays limited benefits in a skilled nursing facility approved by Medicare if you need skilled nursing care as directed by Medicare. **MEDICARE DOES NOT PAY FOR PERSONAL CARE SUCH AS EATING, BATHING, DRESSING, OR GETTING IN OR OUT OF BED. MOST NURSING HOME CARE IS NOT COVERED BY MEDICARE!** For more information, send a stamped, self-addressed envelope to the Insurance Commissioner's Office and ask for the "Buyers Guide to Long Term Care."

PART A — HOSPITAL INSURANCE BENEFITS

HOSPITAL INPATIENT (Semi-private Room and Board, General Nursing, and Miscellaneous Hospital Services)
FOR EACH CALENDAR YEAR

Initial Deductible: YOU PAY THE FIRST \$560.
Medicare pays the balance for up to 365 days each calendar year.

SKILLED NURSING FACILITY (Skilled nursing care in a Medicare-certified facility if you qualify)

First 8 days: Medicare pays all but \$25.50 a day.
9th to 150th day: Medicare pays the entire cost.
After 150th day: YOU PAY ALL COSTS.

INPATIENT PSYCHIATRIC CARE

Medicare pays the same as other hospitalization, up to a lifetime maximum of 190 days. YOU PAY ALL COSTS AFTER 190 DAYS.

HOME HEALTH CARE
Home Health Care

Medicare pays for a limited number of visits which are considered medically necessary by Medicare. Medical necessity is narrowly defined and you will need to meet other criteria before qualifying for benefits.

PART B — MEDICAL INSURANCE BENEFITS

Physicians' Services
Inpatient and
Outpatient

EACH CALENDAR YEAR YOU PAY A \$75 DEDUCTIBLE AND 20% OF ALL MEDICARE-APPROVED CHARGES.

Outpatient Medicare
Services and Supplies

Medicare pays 80% of the approved charges.

Outpatient Physical
and Speech Therapy
Ambulance

NOTE: UNLESS YOUR DOCTOR OR OTHER HEALTH CARE PROVIDER ACCEPTS MEDICARE ASSIGNMENT, YOU ARE RESPONSIBLE FOR ANY CHARGES WHICH ARE HIGHER THAN THOSE APPROVED BY MEDICARE. YOU ARE ALSO RESPONSIBLE FOR ANY SERVICES WHICH MEDICARE CONSIDERS UNNECESSARY.

Outpatient Psychiatric
Care

Medicare pays the same as for other physicians' services but benefits are limited. YOU PAY ALL COSTS IN EXCESS OF THE LIMIT (\$1,375 in 1989), PLUS THE \$75 DEDUCTIBLE, 20% OF APPROVED CHARGES, AND THE CHARGES WHICH ARE HIGHER THAN THOSE APPROVED BY MEDICARE.

Home Health Care

Medicare only pays for up to 38 consecutive days of home health visits which are considered medically necessary by Medicare.

Blood

YOU PAY FOR THE FIRST 3 PINTS AND 20% AFTER THAT. Medicare pays 80% after the first 3 pints of blood.

Custodial Care in a
Nursing Home, Dental Care,
Eye Care, Hearing Aids, Routine
Check-ups

YOU PAY FOR ALL THESE ITEMS.

TYPES OF COVERAGE

There are several ways to buy health insurance policies after you turn 65. Some people continue the coverage they had before turning 65 with a change in benefits. Others buy group or individual insurance policies. Others are eligible for Medical Assistance, a program which provides health care for low-income people, and do not need to buy private insurance. There is no one answer which is right for everyone and finding the right coverage at an affordable price may be difficult.

GROUP INSURANCE

There are two types of group insurance available. The first is bought through an employer. The second is bought through a voluntary association.

Employer group: Many people have group health insurance while they are employed. If you have group coverage, find out before you retire if it can be continued or converted to suitable Medicare supplement coverage when you reach 65.

Both state and federal law require many employers to offer continued health insurance benefits to people whose group coverage ends because of divorce, death of a spouse or termination of employment for reasons other than discharge for misconduct. Check with your employer for more information.

If your spouse is included in your group plan, find out what happens if he or she reaches 65 before you do. If you request it, the insurer must give you a written explanation of the benefits you will have after you become eligible for Medicare.

If you continue to work after age 65, be sure to ask your employer about federal regulations relating to Medicare and group health insurance policies. Your local Social Security office also has information on "Medicare as Secondary Payor."

REMEMBER: Employer group coverage is often available regardless of your health and usually does not include any waiting periods for pre-existing conditions.

Voluntary Associations: A number of organizations, such as associations of retired persons, offer "group" health insurance to members over age 65. The value of these plans differs. Some appear to give low rates but actually cost more than comparable individual policies. These plans are not as strictly regulated by the state as other policies and you should be sure that you understand the benefits. The checklist on the inside back cover may be used to compare these policies.

INDIVIDUAL INSURANCE

If you do not have adequate group insurance and are not eligible for Medical Assistance, you may want to buy an individual policy. There are two types of individual policies available — Medicare Supplements and Medicare Replacements. These are described below.

MEDICARE SUPPLEMENTS

Medicare Supplements are available both from traditional insurers and from health maintenance organizations (HMOs). HMOs are prepaid health plans. You pay the HMO a set amount each month for all covered services. You must use the doctors and hospitals which are connected to the plan. You will have less paperwork to worry about if you join an HMO.

With a traditional insurance plan, you are billed for each service you receive and you are permitted to go to any doctor. You will have to submit your claim to the insurer for payment.

Prior to January 1, 1989, all individual Medicare supplement policies sold in Wisconsin fit into one of three categories. The categories were: Medicare Supplement 1, Medicare Supplement 2, and Medicare Supplement 3.

Beginning on January 1, 1989, there will be only one type of Medicare supplement — a basic Medicare supplement policy. Insurers will be permitted to add a limited number of specified additional benefits to the basic policy. The minimum required benefits and the optional additional benefits are described on the charts on pages 10, 11 and 12, 13.

IMPORTANT NOTICE

The changes in Medicare supplement policies do not mean that you should give up a policy you bought before January 1, 1989. These policies will be modified by the insurer to eliminate any duplication with Medicare. Your insurance company will notify you each year about these modifications.

MEDICARE REPLACEMENTS

A Medicare replacement policy is a special arrangement between the federal Health Care Financing Administration (HCFA) and certain HMOs. Under these arrangements the federal government pays the HMO a set amount for each Medicare enrollee. The HMO agrees to provide all Medicare benefits. The HMO will also provide some additional benefits at additional cost. These are sometimes referred to as "Medicare direct risk contracts." Enrollees continue to pay their Part B premium to HCFA.

Anyone who enrolls in an HMO which has a risk contract with HCFA is "locked in." This means that, except for emergency or urgent care situations away from home, enrollees must receive all services, including Medicare services, from HMO providers. If you go to a doctor or hospital who does not belong to your HMO without a referral from your physician, you will be responsible for the entire cost of the services you receive including Medicare costs.

EMERGENCY AND URGENTLY NEEDED SERVICES

Emergency services are defined by the federal government as covered inpatient or outpatient medical and other services provided by an appropriate source within or outside the HMO's service area, which may not be delayed until HMO providers or services can be used without risk or permanent damage to the patient's health.

Such services must be needed immediately to prevent the death of the enrollee or serious impairment of his or her health.

Urgently needed services are "covered services which enrollees require to prevent a serious deterioration of an enrollee's health that results from an unforeseen illness or injury if the enrollee is temporarily absent from the organization's geographic area and receipt of the health care service cannot be delayed until the enrollee's return to the organization's geographic area."

Anyone who enrolls in a Medicare replacement policy may disenroll at any time. Disenrollment will become effective four to six weeks after the HMO is notified that you want to disenroll. At the time your disenrollment is effective, any unused premium will be returned to you. After your disenrollment is effective, you will again be eligible for regular Medicare and, if you want coverage for Medicare "gaps" you will need to buy a separate supplement policy.

REMEMBER: If you buy either a Medicare supplement or a Medicare replacement policy from a health maintenance organization, you will not have to file claims. Except for out of area claims, the HMO will take care of all your paperwork. You also do not have to worry about the difference between Medicare's approved charge and the actual charge.

MEDICARE SUPPLEMENT POLICIES

MEDICARE PART A BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	BASIC MEDICARE SUPPLEMENT POLICY PAYS	OPTIONAL ADDITIONAL BENEFITS***
HOSPITALIZATION. Semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room, anesthetics and rehabilitation services.	First \$560	Nothing	Nothing	1. \$560 deductible
	After first \$560	100% of costs	Nothing	Nothing
POSTHOSPITAL SKILLED NURSING CARE.* In a facility approved by Medicare if you meet Medicare's criteria.	First 8 days	All but \$25.50 a day.	\$25.50 a day	Nothing
	9th to 150th day	100% of costs	Nothing	Nothing
	150th to 365th day	Nothing	100% of costs	Nothing
INPATIENT PSYCHIATRIC CARE. In a participating psychiatric hospital.	190 days per lifetime	Same as other hospital	175 days per lifetime in addition to Medicare	Nothing
	After 190 days	Nothing		Nothing
BLOOD. While hospitalized.		All but first three pints	First 3 pints	Nothing
HOME HEALTH CARE.**		All visits considered medically necessary by Medicare	40 visits in addition to those paid by Medicare	2. 365 visits including those paid by Medicare

***See Page 14 for more information on optional additional benefits.

MEDICARE SUPPLEMENT POLICIES				
MEDICARE PART B BENEFITS	PER CALENDAR YEAR	MEDICARE PAYS	BASIC MEDICARE SUPPLEMENT POLICY PAYS	OPTIONAL ADDITIONAL BENEFITS***
MEDICAL EXPENSES. Eligible expenses for physicians' services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and outpatient psychiatric care.	First \$75 After first \$75	Nothing 80% of Medicare's approved charge Note: There is a limit on outpatient psychiatric care	Nothing 20% of Medicare's approved charge	3. \$75 deductible 4. The difference between Medicare's approved charge and the usual and custo- mary charge as determined by the insurer
OUTPATIENT PRESCRIPTION DRUGS. Which you buy yourself.****		80% of approved charges for immuno- suppressive drugs in 1st year after a transplant	Nothing	5. 75% of outpatient prescription drugs
MINIMUM CALENDAR YEAR POLICY LIMITS. For benefits to supplement Medicare Part B.		No limit	\$10,000	

***See Page 14 for more information on optional additional benefits.

* Medicare supplement policies also include 30 days of skilled nursing care in a skilled nursing facility. The facility does not need to be certified by Medicare and the stay does not have to meet Medicare's definition of skilled care.

** HOME HEALTH CARE. Medicare provides for all medically necessary home health visits. However, medical necessity is defined quite narrowly, and you must meet certain other criteria. All Medicare supplement policies will pay up to 40 home care visits per year in addition to those provided by Medicare, if you qualify. Your physician must certify that you would need to be in the hospital or a skilled nursing home if the home care was not available to you. Home nursing and medically necessary home health aide services are covered on a part-time or intermittent basis, along with physical, respiratory, occupational, or speech therapy.

Insurers are required, at the request of the insured, to provide coverage for 365 home health care visits in a policy year. Insurers may charge an additional premium for the additional coverage.

*** OPTIONAL ADDITIONAL BENEFITS. These optional benefits may either be included in the basic policy or sold as separate riders to a basic policy. If sold as separate riders, they will have the following titles:

1. Part A deductible rider;
2. Additional home health care rider;
3. Part B deductible rider;
4. Part B usual and customary charges rider;
5. Outpatient prescription drug usual and customary charges rider.

Insurers may also offer benefits for preventive health services and for services you receive while travelling in a foreign country.

**** PRESCRIPTION DRUGS. Drugs which are furnished by a hospital or skilled nursing facility, which cannot be self-administered, are covered if the hospital or skilled nursing home stay is covered by Medicare. Medicare benefits for outpatient prescription drugs are limited to immunosuppressive drugs in the first year after a transplant.

BUYING TIPS

NO INSURANCE POLICY WILL COVER EVERYTHING WHICH MEDICARE DOES NOT.

Medicare excludes certain types of medical expenses. *So do many Medicare supplement and Medicare replacement policies.*

Some items frequently excluded from these policies are: *custodial care in nursing homes, private duty nursing, routine check-ups, eye glasses, hearing aids, dental work, cosmetic surgery, and prescription drugs.* Some policies may include benefits for prescription drugs.

There are two other exclusions which are frequently misunderstood:

1. Medicare pays only for charges which are considered reasonable and services which are considered necessary. Medicare's determination of a reasonable, or "approved" charge may be much less than the actual charge for a covered service. Many Medicare supplement policies follow Medicare guidelines.

Medicare replacement and Medicare supplement policies offered by health maintenance organizations usually cover the entire charge for covered services and are not limited to coverage of Medicare-approved charges. Some non-HMO Medicare supplements may cover the entire charge.

2. Medicare pays for skilled nursing care in a skilled nursing facility approved by Medicare if your doctor certifies that it is necessary and you meet certain other criteria. There are no benefits for custodial care. In general Medicare supplements and Medicare replacements cover only skilled — not custodial or intermediate — care. Skilled nursing care is quite narrowly defined.

MANY POLICIES HAVE WAITING PERIODS, LIMITATIONS AND EXCLUSIONS.

Many health insurance policies have waiting periods before coverage begins. This waiting period may apply to those illnesses or physical disorders which are new or those which existed prior to the purchase of the policy, or both.

If the policy excludes pre-existing conditions for a limited time, that must be stated clearly in the policy. The waiting period for pre-existing conditions may not be longer than six months in a Medicare supplement, and only conditions treated during the six months before you take out the policy may be excluded. The waiting periods may be applied only to conditions which have not been disclosed on the application or which have been excluded by specific description.

REMEMBER: Some companies have "open enrollment" periods. This means that you will be accepted regardless of your health. However, there may be waiting periods before coverage begins. Health maintenance organizations which offer Medicare replacement policies are required by federal law to have a 30-day open enrollment period each year when any person on Medicare may enroll. There are no waiting periods for pre-existing conditions under Medicare replacement policies.

POLICY DELIVERY AND REFUNDS ON POLICIES SHOULD BE MADE PROMPTLY BY INSURANCE COMPANIES.

If you do not receive your policy within a month, or there is a delay in receiving a refund, call or write the insurance company.

IF YOU BUY FROM AN AGENT, FIND A GOOD LOCAL INSURANCE AGENT WHO CAN HELP YOU BUY THE RIGHT POLICY AND WILL ALSO ASSIST YOU WITH MAKING CLAIMS.

KEEP A COPY OF THE POLICY IN A SAFE PLACE.

It is a good idea to choose someone ahead of time who can take over your affairs in case of a serious illness. This person should know where your records are kept.

BUY ONLY ONE POLICY

Buying the most complete Medicare supplement or Medicare replacement policy you can afford is much better than buying several incomplete policies. Duplicate coverage is costly and unnecessary. This is true for both group and individual policies.

MEDICAL ASSISTANCE

Anyone eligible for Medical Assistance (Medicaid) does not need to buy private health insurance. This program pays almost all of the health care

costs for anyone who is eligible. For more information, contact your county social services department.

AN AGENT OR COMPANY MUST GIVE YOU AN OUTLINE OF COVERAGE WHEN SELLING YOU A NEW POLICY OR CONVERTING ONE YOU ALREADY OWN.

The Outline of Coverage is very important. It contains a chart summarizing the benefits provided by Medicare Parts A and B, and the Medicare supplement or replacement benefits provided by the policy. *The chart also shows which expenses are not covered by either.*

DO NOT BE MISLED BY AGENTS WHO INDICATE THAT YOUR MEDICAL HISTORY ON AN APPLICATION IS NOT IMPORTANT. OMITTING SPECIFIC MEDICAL INFORMATION ON YOUR APPLICATION CAN BE VERY COSTLY.

If your application for individual health insurance includes medical information, be sure that you answer *all* medical questions completely and accurately. If an agent helps you fill out the application, *do not* sign it until you read it. If you omit medical information and the insurance company finds out about it later, the company may deny your claim and/or terminate the policy.

If the application is part of the insurance contract, you will get a copy with the policy. Make sure that it has not been changed and that all the medical information is accurate.

POLICIES WHICH ARE GUARANTEED RENEWABLE OFFER ADDED PROTECTION.

Be sure to ask the agent or company about the renewability of the policy. If the policy is guaranteed renewable for life, it means that you can keep the policy as long as you pay the premium. It does not mean that the insurer won't raise the premium.

MAKE CHECKS PAYABLE ONLY TO THE INSURANCE COMPANY. DO NOT PAY CASH OR MAKE A CHECK OUT TO THE AGENT.

Be sure you have the agent's name, address and Wisconsin agent's license number and the name and address of the company from which you are buying the policy.

ASK YOUR DOCTOR ABOUT ASSIGNMENT.

If your doctor accepts assignment, you will not be charged more than the Medicare-approved charge for the services you receive. Most HMOs which offer Medicare supplement policies accept assignment for all services provided at the HMO. HMOs offering Medicare replacement policies accept assignment for all covered services.

ALMOST ALL INDIVIDUAL HEALTH INSURANCE POLICIES SOLD IN WISCONSIN HAVE A 10-DAY FREE LOOK.

Medicare supplement policies have a 30-day free look. If you are at all dissatisfied with a policy, you may return it to the company within this time and get a full refund. You should use the time to make sure the policy offers the benefits you expected. Check for any limitations, exclusions or waiting periods.

If you buy a Medicare replacement policy you will not have a "free look" period. However, if you enroll in a Medicare replacement policy you may disenroll at any time. Disenrollment will become effective four to six weeks after the HMO is notified that you want to disenroll. At the time your disenrollment is effective, any unused premium will be returned to you and you will be returned to regular Medicare.

LIMITED POLICIES

THESE POLICIES SHOULD NOT BE BOUGHT AS SUBSTITUTES FOR A COMPREHENSIVE MEDICARE SUPPLEMENT OR MEDICARE REPLACEMENT POLICY.

Nursing Home Coverage. There are now several nursing home insurance policies on the market in Wisconsin. These policies may not cover all types of nursing home care.

A Buyer's Guide to Long Term Care Insurance and a list of Nursing Home Policies approved for sale in Wisconsin are available from the Insurance Commissioner's office. Please send a large stamped, self-addressed envelope with each request.

Hospital Confinement Indemnity Insurance. These policies pay a fixed amount per day for a specific number of days. These policies are not related to Medicare and may not be necessary if you have a good Medicare supplement or Medicare replacement policy. Check on how many days you need to be hospitalized before coverage begins and the daily benefit you will receive after you become hospitalized.

Specified Disease Coverage. Policies which provide benefits for a single disease or group of specified diseases are not Medicare supplements. *These policies should not be bought as alternatives to Medicare supplement or Medicare replacement insurance.*

An INFORMATION SHEET ON CANCER INSURANCE prepared by the National Association of Insurance Commissioners is available by sending a stamped, self-addressed envelope to the Commissioner's office.

ATTENTION

There are several other policies marketed to the elderly. These include accident, travel accident, and intensive care policies. These are very limited in scope and do not provide the benefits important for people on Medicare and should not be used as a substitute for a Medicare supplement or Medicare replacement policy.

FILING A CLAIM

It is important to file claims properly. The following list will help:

Keep an accurate record of all your health care expenses with your health insurance policies.

Whenever you receive treatment, present your Medicare card and any other insurance card you have.

File all claims promptly. With each claim payment from Medicare, you will receive an "Explanation of Benefits." If the insurance company requests this, make a copy of it and write down the date you send the copy to the insurance company. Keep copies of any information you have concerning services received, the dates of services, and the persons who provided the services.

Many large clinics provide a special billing for your insurance company. If your physician does not, make sure that you get an *itemized* bill. This bill should include the date, type of service and amount charged for each service performed.

For more information on filing claims, you may want to contact the benefit specialist at your County Commission on Aging.

If you enroll in a health maintenance organization with a Medicare replacement policy, you will not have to file claims for covered services. All claims for covered services will be handled by the HMO.

POLICY CHECKLIST - 1989

Name of Company:

Name of Agent:

Cost of Policy:

Part A (Hospital)

	Basic Policy	Optional Benefits
Hospitalization		
Initial Deductible		
Skilled Nursing Facility		
1st to 8th Day		
Beyond 9th Day		
Home Health Care		
Inpatient Psychiatric Care		
Blood		

Part B (Medical)

Medical Expenses		
Initial Deductible		
Medicare Approved expenses (after deductible)		
Beyond Medicare Approved Expenses		
Home Health Care		
Outpatient Psychiatric Care		
Blood		
Outpatient Prescription Drugs		
Part B Limit		

Other Benefits: