BLUE CROSS AND OTHER PRIVATE HEALTH INSURANCE FOR THE ELDERLY

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE ELDERLY

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

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NOTE.—Three hearings on Blue Cross and other health insurance were held as follows:
Part 1.—Washington, D.C., April 27, 1964.
Part 2.—Washington, D.C., April 28, 1964.
Part 3.—Washington, D.C., April 29, 1964.
Part 4A.—Appendix.
Part 4B.—Appendix.

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BLUE CROSS AND OTHER PRIVATE HEALTH INSURANCE FOR THE ELDERLY

TUESDAY, APRIL 28, 1964

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE ELDERLY
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met at 10:15 a.m., in room 4232, New Senate Office Building, Senator Pat McNamara (chairman of the subcommittee) presiding.

Present: Senators McNamara, Neuberger, Dirksen, Carlson, and Fong.

Also present: Senator Douglas.

Staff members present: Jay B. Constantine, and Frank C. Frantz, professional staff members; Patricia Slinkard, chief clerk; Toby Berkman, research assistant; and John Guy Miller, minority staff director.

Senator McNAMARA. The hearing will be in order.

The first witness this morning is State Senator George R. Metcalf, the chairman of the Committee on Public Health of the New York State Senate.

Will you come forward, Senator?

We are glad to have you here this morning.

Senator METCALF. It is nice to be here this morning.

Senator McNAMARA. You may proceed in your own manner.

STATEMENT OF GEORGE R. METCALF, NEW YORK, CHAIRMAN, COMMITTEE ON PUBLIC HEALTH OF THE NEW YORK STATE SENATE, AND CHAIRMAN, JOINT LEGISLATIVE COMMITTEE ON HEALTH INSURANCE PLANS OF THE NEW YORK STATE LEGISLATURE

Senator METCALF. On behalf of the New York State Joint Legislative Committee on Health Insurance Plans, I am greatly honored at your invitation to present my views to you on this occasion.

Sixty percent of our senior citizens had some form of health insurance protection at the close of 1962, according to the Health Insurance Institute. This figure seems reassuring to the private carriers, but, in addition to the fact that 40 percent are unprotected, these figures tell us nothing of how much of the coverage in force for the favored 60 percent is totally inadequate in relation to today's astronomically high costs of medical care. How many policies, for instance, pay $10 a day for hospitalization when last year's average

charge was $39.33? Then there is the question of noncancelable, guaranteed renewable coverage for the elderly.

Because of legislation our committee sponsored a few years ago, insurance companies in New York State may not now cancel individual health insurance policies after they have been in effect for 90 days and may not refuse to renew them after they have been in effect 2 years, solely because of the physical or mental condition of the policyholder. The legislation also provides that workers covered by a group policy are entitled immediately to convert to an individual policy from the same company when they leave their job to retire, or for any other reason. This legislation, unfortunately, was a compromise, in the face of opposition from the commercial insurers, between what we hoped to achieve and what it was realistically possible to have enacted into law.

Until recently, the 65-plus group covered by Blue Cross had relatively little to worry about because of Blue Cross dedication to service benefits, liberal conversion privileges, and community rating. But now Blue Cross plans are having difficulties in continuing to function as the enlightened social mechanisms they were when they first came into existence, because of the overweening desire of commercial carriers to experience rate their policies.

Skyrocketing costs of hospital care are imposing serious drains upon Blue Cross resources. In recent weeks, the Blue Cross plan serving 7,400,000 subscribers in the New York City area applied not only for a substantial premium increase but announced its intention to abandon community rating.

Blue Cross needs more money, unquestionably, but I urged the New York State Insurance Department to deny, for the time being, its request to abandon community rating in favor of experience rating.

Elderly people are worried and desperate about their need for health insurance protection. Many marginal health insurance subscribers in the upper age levels are just not going to be able to pay the new, increased Blue Cross premiums predicated on experience rating. There is, therefore, a clear and inescapable obligation under the circumstances to protect, through some form of governmental subsidy, these men and women against the onslaught of sudden need for medical care.

It may be politically necessary to start with the social security structure, but reliance exclusively on a payroll tax would impose an unfair burden upon lower income groups. If the social security structure is employed, however, some way must be found of spreading its cost more equitably. Those with higher incomes, it seems to me, should be required to pay a higher share of the cost of the program.

I hope we can profit by our experience with the Kerr-Mills program. Much hospital and nursing home care could be avoided if diagnostic and preventive programs were encouraged.

Benefits should be provided primarily for medical-surgical treatment, only secondarily for hospital and nursing home care. Such an approach would stimulate ambulatory rather than bedside therapy, which is more desirable medically, economically, and socially. We should also beware of providing benefits with which to encourage profit-minded investors in proprietary nursing homes.

Finally, in my view, it would be wiser to have existing Blue Cross-Blue Shield and commercial carriers undertake the responsibility of

a Federal program, with Federal support, than for the Government to enter the field as the insurance agent. The carriers have the essential experience, the manpower, and the skills. For the Government to compete with them would be unnecessarily wasteful and likely to arouse opposition unrelated to the merits of the program.

I shall be delighted to expand upon these points in response to any specific questions you care to put to me.

Senator McNAMARA. Thank you, Senator.

I notice you stress the unfair burden that this hospitalization program under social security would place upon the people who are least able to pay. I think you said the lower paid workers. You do recognize that it would amount to about 25 cents a week under the present King-Anderson bill. Do you think this is an unfair burden considering the fact that it would fill a great need for people in their retirement years?

Senator METCALF. Well, Senator, in reply to your question, I would have to say that as you phrase it, of course, it would not be a heavy burden, but I can only assume that a program such as King-Anderson would enlarge itself into a much more substantial program with larger benefits and at that time I think it would undoubtedly be a very heavy and severe burden on the people in the low-income groups.

In this connection I would like to say to you that when I was in England several years ago, I asked people who were in charge of the social program in England how much of that was supported by payroll tax and the answer was 12 percent.

It seems to me that while the social security program has a great deal of appeal as we know from a great many people in this country, I think unless it is coupled with some other tax mechanism in order to share the burden with people who are making more than $5,200 a year, that it would be unfair to those in the low-income groups.

Senator McNAMARA. Of course, the same argument was used at the inception of the social security plan, and after well over 25 years, this did not develop into this great——

Senator METCALF. Yes; I appreciate that, but ordinarily in the social security pension plan you receive back what you put into it presumed on the amount of your contribution, where in this particular instance, this is a completely social program in which everybody should bear the burden.

Senator McNAMARA. Senator Carlson, do you have any comment or questions?

Senator CARLSON. Senator, having served in the Kansas State legislature and been Governor of a State, I was interested in this committee of yours—the New York State Joint Legislative Committee on Health Insurance Plans.

How many years has this committee been in existence?

Senator METCALF. We started in 1955. It has been in existence almost 10 years.

Senator CARLSON. I would say, having had some experience in State government, that this should be a very important committee because it is a problem that concerns citizens of individual States. Of course, we have also a national problem on this.

I was interested in your statement that you thought probably it would be wiser to have existing Blue Cross-Blue Shield and commer-

cial carriers undertake the responsibility of a Federal program with Federal support.

That intrigued me a little.

Do you have, after many years of study, some suggestions on Federal support on this type of program?

Senator METCALF. Well, I think as far as the Federal support is concerned it would be—that is a very good question.

Senator CARLSON. It is a question that confronts me and confronts the Members of the Congress, I can assure you. I am interested in your suggestion on your program.

Senator METCALF. I was thinking of private carriers using Federal tax moneys to pay benefits under a Federal health insurance program. If you get away from the insurance concept then you accept the means test upon which Kerr-Mills is based, and I think that a Federal health insurance program which you are discussing cannot be based on a means test.

Senator CARLSON. I want to say, Senator, I happen to be a member of the Senate Finance Committee and helped write the Kerr-Mills bill and I sincerely hope it can be implemented so it will be a program that will be of real benefit to the aged in need of medical care.

Senator METCALF. If I may say something in that connection, regardless of what you do on King-Anderson, there will be ample need for Kerr-Mills for many, many years, because even with a health insurance program, a person will exhaust the benefits of the program and, therefore, must have some way, some mechanism of taking care of his medical care needs. For this reason I cannot see, in the foreseeable future, how Kerr-Mills can be eliminated.

Senator CARLSON. Well, I sincerely hope that it is not eliminated. I hope it is improved and extended. I was opposed to the King-Anderson bill on the theory that a burden was placed on a group of people—young people particularly—who are establishing homes, raising families, educating children, for the care of those who are in need of medical attention past 65, and I think those of us who are over 65 ought to carry the burden; I think it ought to be nationwide in scope instead of just placing it on persons paying social security taxes. I have consistently taken that position and I am hoping we can work out something that will take care of those who need medical care after the age of 65. I hope you will study it further. I think we need some help on it. I appreciate it. That is all, Mr. Chairman.

Senator MCNAMARA. Thank you, Senator.

I would like to ask you, in your opinion, why is Blue Cross in New York trying to drop the community rating principle in favor of the experience rating program?

Senator METCALF. Why they are?

Senator MCNAMARA. Yes.

Senator METCALF. Well, I think basically the reason why they are forced into that position is because of the attitude and the practices of the commercial carriers who have stimulated this kind of insurance writing for a number of years. As a matter of fact, one of the main reasons they have gone into experience rating is to protect a great many of the contracts they now have where members insist upon experience rating as the price of remaining in the Blue Cross fold.

So, I think this is primarily a step in the direction of protecting themselves against competition.

Now, of course, those people who are in the direct pay groups, and who cannot realize the advantages of experience rating, are going to have a higher rate to pay. As a matter of fact, it was brought out during the testimony in New York City that those rates could increase by as much as 100 percent within a period of 3 years.

Now, if anything like that should happen, which I doubt—but it could happen—those people on reduced incomes would almost certainly risk the possibility of having their insurance taken from them.

Senator McNamara. In your enlarged statement—and we appreciate that you abbreviated it and summarized it—you seem to suggest that we should avoid establishing incentives to the expansion of proprietary nursing home facilities.

What is your reason for that?

Senator Metcalf. Well, I fear that unless you are very careful about the kind of benefit structure you construct under the King-Anderson program, you will have succeeded in enlarging the number of proprietary nursing homes in this country.

I know that a few years ago when it seemed the Federal health insurance plan was going to be enacted, there was a noticeable increase in New York State in the number of requests to build nursing homes, and I feel that this would be unfortunate if something like this were to happen.

We find, for instance—and this would be interesting to Senator Carlson—that in New York State, 90 cents of every dollar that is spent on the Kerr-Mills program goes into hospital or nursing home care. I think this is investing our dollars in the wrong way. We should keep people out of hospitals and nursing homes by emphasizing ambulatory and medical-surgical care. If private operators see a chance of earning a profit as a result of the legislation you pass, nursing homes will spring up regardless of their need.

Senator McNamara. On the basis of your experience, do you think that the health needs of the aged can be met by existing commercial insurance, Blue Cross, plus the Kerr-Mills bill?

Senator Metcalf. No; I certainly do not.

Senator McNamara. You feel that additional legislation is needed at the Federal level; is that correct?

Senator Metcalf. Oh, yes.

Senator McNamara. I think your committee, in the New York Legislature, has performed a great service in putting on the public record a great deal of information that was not otherwise available to people who were trying to bring some light into this program—I mean students and other groups.

It seems to me that the work of your committee has performed a great public service by bringing about the registration of insurance companies. Are there about 800 companies operating in New York?

Senator Metcalf. I think that is about right; yes, sir.

Senator McNamara. And this does bring some information?

Senator Metcalf. I am sure the insurance men here could tell you about that.

Senator McNamara. I think this has been a great service and I do not think you get enough credit for it.

We appreciate your help, and you can be sure we will study your testimony in great detail.

Senator METCALF. Thank you very much.

STATEMENT BY SENATOR GEORGE R. METCALF, CHAIRMAN, NEW YORK STATE JOINT LEGISLATIVE COMMITTEE ON HEALTH INSURANCE PLANS

On behalf of the New York State Joint Legislative Committee on Health Insurance Plans, I am deeply honored at your invitation to present my views to you on this occasion.

In some ways, we face an embarrassment of riches, in this country, with regard to information about the extent to which the American people are covered by health insurance. A publication issued annually by the Health Insurance Institute, at 488 Madison Avenue, New York City, for example, provides abundant data as to the generally favorable extent, distribution and nature of the coverage in force and its growth in recent years.

However, the latest, 1963, issue of this publication devotes only 1 of its 88 pages to the extent to which this coverage is in force for persons aged 65 and over. According to this source:

"At the end of 1952, the earliest year for which data are available, only 26 percent of the aged population were covered by some form of health insurance. This compares to 60 percent of the senior citizens with some form of health insurance protection at the close of 1962."

The HII pamphlet also contends that "the rate of growth of persons over 65 with some form of health insurance has increased much faster than those under 65.

"During the past 5 years alone, the proportion of those 65 and over with health insurance increased from 39 to 50 percent. The proportion of the population protected under 65 grew from 74 to 78 percent over the same 5-year span."

On the fact of it, these figures seem reassuring. However, when we come to examine what is meant by the phrase, "some form of health insurance," the figures provide little cause for self-congratulation.

We do not know, for example, from the HII figures, how many oldsters in their totals are covered by a type of policy, for example, which pays $10 per day toward the cost of a hospital room for a maximum of 10 days—and nothing else. The Health Insurance Institute claims such policies are on their way out, which is probably true. But they had no information as to how many such policies were still in effect. We must therefore wonder what happens to an elderly person with such a policy who falls ill and requires hospitalization for, say, 30 days in an institution where the daily rate is about $35, which is not at all unusual. Such an individual may very well find his illness costing him a whopping $950 to be paid out of his own pocket for hospital room and board alone. Yet, an indeterminate number of such oldsters are included in the rosy statistical presentation of the Health Insurance Institute.

Ever since its establishment in 1955, our committee has been fighting an uphill battle in our State to do something about improving the availability and quality of health insurance coverage for the aged. Although we have made progress, it was achieved only in the face of stubborn opposition and after more compromises than were socially defensible. But we came to recognize that we had to make compromises if we expected to pass any legislation at all.

We had originally hoped to provide, through legislation, that as soon as an individual was covered by health insurance, he would be entitled to such coverage on a noncancelable, guaranteed renewable basis for as long as he lived. We wanted him to have his conversion privilege guaranteed in the event he left his job for any reason, or to retire. And we wanted to provide that the benefit structure of the coverage after retirement would be at least as broad as before, at a cost of no more than 20 percent additional in premiums to allow for administrative expenses. Such requirements, if enacted into law, would compel the insurance companies, we thought, to fund their programs so that the additional costs of carrying the elderly policyholders would be covered by slightly increased premiums charged the active members of the groups.

Unfortunately, the insurance companies vigorously resisted this kind of legislation, contending it would require premiums so high as to make their policies unsalable. The best we were able to do, after wearying months of meetings and negotiations, was to enlist their reluctant support for a series of bills that fell short of these objectives.

The bills which were eventually enacted into law now require insurance companies doing business in New York State not to cancel individual health insurance policies after they have been in effect for 90 days and not to refuse

to renew them after they have been in effect for 2 years solely because of the physical or mental condition of the policyholder. They also provide that workers covered for 3 months or more by a group policy on their jobs are entitled immediately to convert to an individual policy from the same company when they leave their job to retire, or for any other reason. The individual policy must provide at least $10 per day for hospital room and board, up to 21 days; at least $100 of hospital expense benefits; and at least $200 of surgical expenses benefits. In case of the worker's death, the law also extends this conversion privilege to the worker's wife and child.

Our committee is proud of the part we were able to play in bringing about this kind of reform but we are all too conscious, at the same time, of how inadequate a step it really is. For example, many policies now covering today's elderly people were taken out before July 1, 1959, the effective date of our legislation. For constitutional reasons having to do with the inviolability of contracts that legislation necessarily covers only policies taken out since then. Other inadequacies of the legislation were part of the price we had to pay, in the face of stubborn resistance on the part of commercial insurors in our State, to allowing any legislation to circumscribe the freedom with which they operated.

Until recently, we felt that our major concern would have to be those aged citizens either with no health insurance at all or those with inadequate policies issued by the commercial health insurance companies. We felt that people covered by Blue Cross policies, at least, had relatively little to worry about because of the traditionally enlightened social outlook of Blue Cross plans generally—their dedication to service benefits, liberal conversion privileges and, above all, community rating. But recent events have forced us to revise our attitudes toward Blue Cross.

We have been aware for some time, of course, that Blue Cross plans are having difficulties in continuing to function as the enlightened social mechanisms they were when they first came into existence back in the thirties, when service benefits, easy conversion, and community rating were all closely identified with their program. We knew that skyrocketing costs of hospital care were imposing more and more serious drains upon the resources of Blue Cross plans which were committed to providing the care but unable to raise their premium rates except with the permission of duly constituted authority—in New York State, the superintendent of our insurance department. But the seriousness of the situation was brought home to us with particular impact in recent weeks with the announcement that Associated Hospital Service, Inc., the Blue Cross plan serving 7,400,000 subscribers in the New York City area, was applying not only for a substantial premium increase but that it also intended virtually to abandon community rating in favor of a form of experience rating.

There seemed to be no question but that Blue Cross in New York City needs more money if it is to continue to function. In 1963, the plan paid out $17 million more in benefits than it took in. It is now paying out $1.25 for every $1 it receives in premiums. So the plan requested a 35-percent average increase, for next year and another 11 percent next year.

As I said at the insurance department's hearing:

"We feel that the present move by AHS to abandon the community rating principle in favor of experience rating—albeit with a 5 percent deduction on group contracts for the aid of individuals likely to be adversely affected—is a step so serious in its potential and implications as to call for the most careful study before it is approved. * * * We therefore urge that the request by AHS to abandon community rating in favor of experience rating be denied at this time."

Ever since the plan announced that it would have to raise its rates—and particularly when it announced that the new experience type of rating would probably mean that persons in the upper age brackets would have to bear the brunt of the rate increases—our office has been deluged with pleading letters from elderly people.

These letters obviously come from people in a wide variety of circumstances. Some are written in the trembling handwriting typical of advanced age; others are carefully typed but no less moving. Some are eloquent; others are rambling and confused. But all have one important characteristic in common. They reflect a pitiful helplessness and a sense of desertion; all represent a cry for help. To read them and to realize how difficult it is to promise any sort of tangible help brings on feelings of frustration. Let me quote from just a few of these letters—and these quotations are selected at random:

"My wife and I are living on social security as our only income and, believe me, it is hard for us to pay the premiums. We are both under doctors' care.

We have to meet payments also, besides medications. This is not covered by Blue Cross. We cannot afford to drop it; still, we cannot afford to pay for it. We do need help."

"We are both past 70 and it makes it hard to meet our needs, when Blue Cross raises rates. We hear Mutual of Omaha is going to raise again, too. The old folks are being pushed out, it seems."

"We have never had to use the plan, but now that we are in the upper age bracket, they want to increase us out."

On the one hand, then, we have all these elderly people—worried and desperate about their need for health insurance. Their number is increasing every year, as the triumphs of medical science give more of us a longer and longer lifespan. On the other hand, there is Blue Cross beset by rising hospital costs and driven—as in the case of Associated Hospital Service of Greater New York—to embarking upon a course which puts them into almost the same kind of operation as that of commercial insurance companies—charging groups and individuals whatever the actuaries tell them must be charged if the enterprise is to function successfully—regardless of whether the subscribers or policyholders can afford to pay the premiums.

Obviously, many marginal health insurance subscribers in the upper age levels are just not going to be able to pay the new, increased Blue Cross premiums predicated on experience rating. This has for some time been the situation of elderly people trying to purchase policies from the commercial health insurance companies, the premiums for which are all too often prohibitively expensive. Inevitably, if we are not to turn our backs on these unfortunate people, we have a clear and inescapable obligation—to provide through some form of governmental subsidy or other action—for these men and women to continue to be protected against the onslaught of sudden need for medical care. In so acting, we shall simply be following a course which has long been recognized as a governmental responsibility by virtually every other civilized country in the world.

I would therefore hope that if we do ultimately employ the social security structure as the means by which we subsidize or pay completely for the cost of health insurance protection for our senior citizens, we must find some way of spreading its cost more equitably over all the economic groupings of those who pay for it.

With regard to the benefit structure of any federally subsidized health insurance program, I would hope that we could profit by our experience with the Kerr-Mills program. Our committee has had occasion to hold several hearings to determine the effectiveness of that program. One of the most striking deficiencies we uncovered was that 98 cents of every dollar being expended in our State—and a comparable proportion elsewhere, too, I believe—is being spent on hospital and nursing-home care. Such care is necessary, of course, but much of it could be avoided if diagnostic and preventive programs could be brought into being. I would therefore hope that any federally subsidized program would give considerable emphasis to diagnosis and prevention in its benefit structure.

More specifically, it will be wise for us to see to it that we provide benefits primarily for medical and surgical treatment and drugs and only secondarily for hospital and nursing-home care. Otherwise we shall be repeating the mistake we are making with Kerr-Mills, which in effect says to the elderly person: "You must be in a hospital or nursing-home bed before you are entitled to benefits."

Only through such an approach shall we encourage our older folks to remain out of bed and ambulatory as long as possible—an objective which is desirable medically, as well as economically and socially. We must avoid setting up inducements to these folks to surrender to the all-too-tempting alternative of taking to their beds before it is absolutely necessary.

A further important consideration is that we must avoid, through socially motivated legislation, establishing an incentive to profit-minded investors in such facilities as proprietary nursing homes—which is all too real a risk if we make large sums of money available exclusively for the providers of this kind of care.

I am told, for example, that when it seemed likely, at one point in the recent past, that medicare would be enacted into law with its present emphasis, there was an alarming increase in the number of operators rushing to invest in the construction of proprietary nursing homes. I would urge that we do everything we can to avoid this kind of pitfall.

The only other suggestion I have with regard to the specific topics you recommended to my attention has to do with what carrier would be given the responsibility for health insurance coverage of the aged. Here I happen to feel strongly that it would be much wiser to have existing Blue Cross and Blue Shield plans

and the commercial carriers undertake this responsibility, with Federal support, than for the Federal Government to enter the field itself. The carriers have the experience, the manpower and the skills which are essential to the conduct of any such program. To attempt to duplicate them and compete with them would be, to my mind, inefficient and wasteful, as well as likely to arouse unnecessary opposition from those quarters which resent the invasion of Government into any areas now functioning under private or voluntary auspices.

Once more, let me express my sincere appreciation for the privilege of coming here today. I shall be delighted to expand upon any of the points made, in response to any specific questions which you would care to put to me.

Senator McNamara. The second witness this morning is Mutual of Omaha, Mr. A. M. Hansen, vice president.

Mr. Hansen, will you introduce your colleagues for the record?

STATMENT OF A. M. HANSEN, VICE PRESIDENT, MUTUAL OF OMAHA; ACCOMPANIED BY JAMES E. BARRETT, VICE PRESIDENT, AND DONALD SCHONBERG, VICE PRESIDENT

Mr. Hansen. Senator, I am Mr. A. M. Hansen, vice president of Mutual of Omaha, and on my right I have Mr. Schonberg, who is also a vice president, and on my left Mr. James Barrett, also a vice president of Mutual of Omaha.

Senator McNamara. Thank you.

Mr. Hansen. Mr. Chairman, members of the subcommittee, we are real pleased to be able to present our views and be of whatever assistance in your discussions that we may be. We feel that our statement, which has been filed with you and will be made a part of the record, fairly and thoroughly presents our situation. We do hesitate to take up too much time of the subcommittee with repetition and we are going to summarize in the following manner.

Mutual of Omaha has just announced a new enrollment-type health insurance plan which is available regardless of past or present health history and which cannot be canceled because of changes in health or because of the amount or number of times that benefits are paid.

This plan can pay up to $20 a day in hospital-room benefits, and can be tailored to provide a most comprehensive series of ancillary benefits ranging from X-ray to major medical, radiotherapy, and nursing home coverage. This is in addition to the many other forms of health insurance coverage that we offer to people age 65 and over.

As to retention, our records show that in a survey of a substantial block of our senior business, our lapse ratio is barely above the death rate of the age group studied and the persistency is higher than on our regular business.

Most all of our policies for folks aged 65 and over are not subject to individual cancellation.

The premiums on this business we feel to be reasonable and just and we have been able to maintain the same premiums on our senior security policies since they were introduced in 1959. Premiums will, I believe, always be held in line by the competitive nature of private insurance.

As to the number, we know that we have 1,280,000 policies in force on persons over age 65. We further know of dependent coverages that raise this total to about 1,341,000. Duplication is possible, but the percentage of duplication or the exact numbers we cannot determine.

In conclusion, we do feel that Mutual of Omaha is doing a good job in this area and we feel very much that the problem is a diminishing one.

The people in this age bracket today grew up in an era before pensions and lifetime guaranteed policies, before paid-up coverages at age 65, and many of them do not even have OASDI benefits. We feel that in a few years the extension of the modern trends plus the development in group insurance areas will nearly eliminate the problems.

Thank you.

Senator McNamara. Thank you, sir. You use the figure 1,280,000 policies. We seem to be unable to obtain any figure of the number of persons covered by your company in this field of hospital insurance. Based on the available information our subcommittee staff has been able to gather, it seems that you have about 500,000 different-aged people covered by basic hospital expense policies. Do you have any reason to dispute this estimate on the part of the subcommittee staff?

Mr. Hansen. Senator, I would like to refer that question to Mr. Schonberg.

Senator McNamara. All right, we will be glad to have his viewpoint.

Mr. Schonberg. Mr. Chairman, I think we get into a matter of semantics here. The instructions, as they came out, determined by your committee, asked a question of policyholders over age 65. We have included here in the policies in force those policies which are over age 65.

To the extent that some of these perhaps might be classified as reimbursement of expense by loss of time, the question, of course, comes in, this money is available to pay hospital.

Senator McNamara. All right, sir. I note in the Wall Street Journal of April 6, your company has seriously considered the possibility of premium increases on your senior security policies.

Was that statement accurate? What do you think of it?

Mr. Hansen. I would say that statement is inaccurate. We are not considering a rate increase.

Senator McNamara. Senator Carlson, do you have any questions or comment?

Mr. Carlson. Mr. Chairman, I just want to make one comment, coming from the neighboring State of Kansas I am proud to have Mr. Hansen represent this great insurance corporation in Omaha. We are all proud of it and wish it were in Kansas. I do appreciate the fine work they are doing not only in the Midwest but all over this Nation.

I think the Nation is indebted to Mutual of Omaha and other insurance corporations for trying to work out a program that will be helpful with insurance plans for those over 65. I appreciate very much your appearance here this morning.

Mr. Hansen. Thank you, sir.

Senator McNamara. Thank you. Senator Neuberger?

Senator Neuberger. What is a mutual company that is different from some other kind of company?

Mr. Hansen. A mutual company is a company that is owned by its policy owners as distinguished from a stock company where people invest money in the company and therefore become part owners thereof.

Senator NEUBERGER. And therefore they share in the profit?

Mr. HANSEN. In a stock company, that is true, the profits, if any, go to the stockholders. In a mutual company, any excesses belong to the policy owners.

Senator NEUBERGER. Well, how much of your profits have been returned to policyholders during the last few years?

Mr. HANSEN. We have returned to policyholders in the form of benefits a number of additional benefits. For example, as I pointed out in the statement, we have gone into——

Senator NEUBERGER. Now, wait a minute. When people sign up with a mutual company—I would expect if I signed up for a mutual, I do not expect just more benefits. If I wanted more benefits, would I not buy more benefits? What I would want is cash.

Mr. HANSEN. Well, is that necessarily true?

Senator NEUBERGER. Well, which way do you put it to them? Why do they not buy the benefits and then you pay them cash? Would that not be a better way to do it?

Mr. HANSEN. I do not believe so. I think we—people benefit under their insurance program, such things as grace periods and additional——

Senator NEUBERGER. Well, this is not a mutual company then, is it?

Mr. HANSEN. Yes, it is.

Senator NEUBERGER. We do not mutually hold an interest in the profits of this company. That disillusions me about mutual companies. I would want to know, have you paid any cash at all to policyholders at any time if they demanded cash or asked any accounting for cash, could they have any cash?

Mr. HANSEN. There has been no cash returned to policy owners under the mutual operation. They have been given extended benefits in the form of grace periods, travel accident riders, additional coverages, to enhance their insurance program and make it more valuable to them.

Senator NEUBERGER. But that is for them to determine whether it is more valuable to them. Yesterday we heard testimony from insurance companies here who said that they could not determine what was adequate for the person. That is something he must determine for himself. So, this way you are determining for the policyholder what he should have and it seems to me that is a personal decision, but then—well, this is an interesting development to me.

I am sorry I was not here to hear the first part of your testimony, but we asked this of all the companies. Do you have policies which can be canceled after they have been in force for some time?

Mr. HANSEN. Our policies are lifetime guaranteed renewable——

Senator NEUBERGER. I am sorry, I do not hear you.

Mr. HANSEN. Our policies are lifetime guaranteed renewable and the individual policies cannot be canceled.

Senator MCNAMARA. You do not have any that can be canceled then?

Mr. HANSEN. The policies we are selling today may not be canceled. Now, we have some of the old type cancelable contracts that were sold many years ago that are still on the books, but those policies by company policy are not cancelable by any deterioration of health.

Senator NEUBERGER. Can you give us the number or proportion of those policies canceled or not renewed; let us take 1 year, last year?

Mr. HANSEN. Last year we did not cancel a policy because of deterioration of health.

Senator NEUBERGER. You did not cancel any?

Mr. HANSEN. We did not.

Senator NEUBERGER. What are the principal reasons whenever you do find it necessary to cancel?

Mr. HANSEN. Now let us distinguish cancel from lapse.

Senator NEUBERGER. Yes; if a person does not pay his premium, of course, I know the policy lapses.

Mr. HANSEN. The only reason that a policy might be canceled in and of itself, would be fraud in the securing of the policy.

On the other hand, if a person lapses we have no reason, no way of knowing why he did not pay his premium. It is recorded as a lapse.

Senator NEUBERGER. Of course, this is the fault of insurance for protecting old people, especially people who are on incomes with $3,000 or less. There may come a time when they just cannot pay a premium annually, you are in business, and you are not in business for your health, let us say, and you have a right to let the policy lapse. That is the virtue of another kind of protection for old people that I am interested in. But the thing is, what sort of reasons, let us put a different terminology, would you not renew a policy?

Mr. HANSEN. We would renew it——

Senator NEUBERGER. If somebody had a long illness and kept drawing benefits, and drawing benefits, as long as they kept up the premiums you would not cancel the policy.

Mr. HANSEN. That is correct.

Senator NEUBERGER. You would never cancel it?

Mr. HANSEN. We would never cancel it.

Senator NEUBERGER. Could you tell us the number of hospital expense policies that are issued to your subscribers which pay a daily hospital benefit from $10 or less?

Mr. HANSEN. Senator, I would like to defer that question to Mr. Schonberg.

Senator NEUBERGER. First of all, what do most of your policies pay for cost of daily hospital care?

Mr. SCHONBERG. I would like to ask you if you want to limit this to the over age 65 or under, or both.

Senator NEUBERGER. I am much more concerned with the over 65; yes.

Mr. SCHONBERG. We have two manners of policies which we endeavor to operate in the over age 65. One of them being a nonselective program and one being a selective program. In the nonselective program at this particular time our past policy has been for $10 a day.

Our new nonselective program will vary from $5 a day up through $20 a day. Our selective program, where we, as a company, sell to an individual at his voluntary choice, we will sell a policy depending upon his needs and fit it in with his program of other coverages.

We will sell from $3 up through $25 and, in some cases, in the metropolitan areas they even go higher.

Senator NEUBERGER. Well now, that is what you offer, but what do people have? What we are trying to find out—I am trying to find out and I think other members of the committee are—is how well can private insurance take care of these older people? What do most of your

policyholders have? What do they buy? Do they buy $10-a-day coverage, $20-a-day coverage, or $5-a-day coverage?

Mr. HANSEN. Our average policy—while I do not have the records with me at this particular time but, we do have such information—I would say that our average policy, which varies from $3 up through the $25, that our average policy that is purchased by the individual at his own choice would probably be somewhere in the neighborhood of $12.50 to $12.75; some place like that a day. This is for room and board only.

Senator NEUBERGER. How much does that cost him a year?

Mr. HANSEN. Senator, I would have to check some very different records on this from the standpoint of the choice, because here we also get into the situation where we give this individual an opportunity to choose a policy which pays for 30 days, 60 days, 90 days, so far as even a year or 500 days, and these all vary the rates.

Senator NEUBERGER. Well, pick one out the air, how much would it cost? I do not know how much it costs to get a policy that pays $10 a day for 30 days—take that one, that ought to be cheap.

Mr. HANSEN. I would like to comment on that, Senator. Let us take our senior security policy on which we have had 11 enrollments. This is the policy that provides $10 a day in room benefits for 60 days. It has a miscellaneous benefit of the first $100 miscellaneous expenses deducted but 80 percent of the balance of the in-hospital miscellaneous expense up to $1,000 is covered.

It has a surgical benefit. It has a nursing home benefit, and the cost of that policy is $8.50 a month.

Senator NEUBERGER. So, it is a deductible policy of $100.

Mr. HANSEN. Just the miscellaneous expense, the daily room benefit is not deductible, just the in-hospital miscellaneous expense.

Senator NEUBERGER. Is that like an operating room or recovery room, or——

Mr. HANSEN. That is correct.

Senator NEUBERGER (continuing). Or surgery?

Mr. HANSEN. Surgery is not deductible. There is no deduction against the surgical schedule.

Senator NEUBERGER. Well, then, how many people hold that policy?

Mr. HANSEN. Mr. Schonberg will answer that.

Mr. SCHONBERG. As of the end of 1963, in that particular policy, we had 206,000.

Senator NEUBERGER. Is that available to people under 65, too?

Mr. SCHONBERG. That policy is not available to people under 65. It is sold only on an open enrollment basis to people 65 and over.

Senator NEUBERGER. Thank you.

Senator McNAMARA. Thank you. Senator Dirksen?

Senator DIRKSEN. Well, Mr. Hansen, I am sorry I was not able to hear your statement, but getting back to this question of mutuality. After all, in a mutual company, it constitutes, in effect, a contract that everybody enters into with each other when they become policyholders—shareholders in a co-op. In a similar way there is mutuality created when one joins a savings and loan association. Reference has been made to the practice in mutual health insurance of not paying in cash money received in excess of costs. Such "profits" are paid to the

policyholders, instead, in the form of benefits and services that a company can render. Is that not correct?

Mr. HANSEN. Yes, sir.

Senator DIRKSEN. And that is the very idea of mutuality in an insurance company as distinguished from a stock company?

Mr. HANSEN. That is correct.

Senator DIRKSEN. Well, your statement speaks pretty well of it, and I have seen it and I do not believe there are any questions I have at this time.

Mr. HANSEN. Thank you, Senator.

Senator MCNAMARA. Thank you, Senator. Senator Fong, do you have any questions or comments?

Senator FONG. Yes, Mr. Hansen, your company has been in the State of Hawaii for many years and I believe it is conceded to be one of the outstanding companies among this health group. Do I understand that as a mutual company you do not make any profit? That is, you charge the policyholder what it costs you to really give him the benefit. Is that correct?

Mr. HANSEN. That is correct.

Senator FONG. So, from that standpoint, if the cost is low your premium will be low, and if the cost is high, your premium will amount accordingly?

Mr. HANSEN. That is correct, there is no money paid out of our organization to stockholders who may buy stock for the purpose of seeking a profit.

Senator FONG. But does the premium you charge reflect what it really costs you?

Mr. HANSEN. It does.

Senator FONG. Now, how many policies have you written in the 65-year-and-above age group?

Mr. HANSEN. We have—let me give that question to Mr. Schonberg here.

Mr. SCHONBERG. Senator, in the policies issued in the 65-years-of-age-and-over age group, during the year of 1961, we sold 194,000. In the year of 1962, 304,000. In the year of 1963, 198,000.

Senator FONG. How many policies have you now existing?

Mr. SCHONBERG. In the 65 years of age or older, on the number of policies——

Senator MCNAMARA. I think you previously gave us the figure of 1,280,000, or thereabouts; is that not right?

Mr. SCHONBERG. Yes, sir.

Senator FONG. So you write approximately about 13 to 14 percent of those policies that are written for the age group 65 years and above, assuming that approximately 9 million policies are written for 65 years and above?

Mr. SCHONBERG. Yes, sir.

Senator FONG. How long have you had your guaranteed renewal policy for 65 years and above?

Mr. HANSEN. We started writing that, Senator, in 1959.

Senator FONG. So, you have approximately 5 years of experience?

Mr. HANSEN. Yes, sir.

Senator FONG. As an officer of the company, would you say that policy is here to stay?

Mr. HANSEN. It certainly is here to stay.

Senator FONG. And that a person having a policy like that can renew it from time to time even though he may be having a continuous sickness?

Mr. HANSEN. Yes, sir.

Senator FONG. You state that a senior citizen has a combination of five basic coverages. You give him about 50 policy forms. Is that correct?

Mr. HANSEN. Yes, sir.

Senator FONG. And the average costs run from $4.30 per month to $17.35 per month?

Mr. HANSEN. That is correct.

Senator FONG. In other words, $51.60 to $208.20, a year. So, therefore, you have all kinds of policies which have been worked out by your actuaries.

Mr. HANSEN. The new policy which we have just announced has some 600 different varieties of possibilities.

Senator FONG. So, therefore, you should be able to give us a rate or your actuary could work out a rate as to what the benefit package of the King-Anderson bill, which was voted on by the Senate in 1962, and which lost by two votes, your company could really give us some figures as to what that package would cost; could you not?

Mr. HANSEN. I am sure they could.

Senator FONG. Would you be willing to give those figures to this committee?

Mr. HANSEN. Yes, sir.

Senator FONG. I have no further questions, Mr. Chairman.

Senator MCNAMARA. Thank you very much, Mr. Hansen. We appreciate your testimony. I think the final request of the Senator from Hawaii to furnish the figure would be very helpful to us.

Mr. HANSEN. Thank you very much. It is indeed a pleasure to be here.

Senator MCNAMARA. Thank you, sir.

(See p. 113 for King-Anderson cost figure.)

PREPARED STATEMENT BY ALBERT M. HANSEN, VICE PRESIDENT, MUTUAL OF OMAHA

Mr. Chairman and members of the subcommittee, my name is Albert M. Hansen, vice president of the Mutual of Omaha Insurance Co. It is a pleasure to appear before you and assist you in your consideration of health insurance of those 65 years and over.

Mutual of Omaha, Mr. Chairman, is the largest writer of individual health insurance for people of all ages and is one of the pioneers of coverage for our senior citizens. My company is licensed and does business in all 50 States, all Provinces of Canada, Puerto Rico, the Republic of Panama, the Canal Zone, and portions of the West Indies, with travel insurance facilities in over 50 foreign countries.

Our policies are available to the public through a labor force of more than 9,000 independent, licensed, local agents. These agents—residents and members of the communities in which they live—have been carefully selected and thoroughly trained in the knowledge of our products so that they can properly counsel and advise people of all ages on health insurance programs. In addition, a labor force of 4.500 is employed to serve the needs of our policyowners.

The activities of our organization are directed by a board of directors composed of outstanding national leaders, including such men as Lt. Gen. James H. (Jimmy) Doolittle, (ret.) Los Angeles, Calif.; Dr. Charles W. Mayo, Rochester, Minn.; Thomas F. O'Neil, New York, N.Y.; and Clair M. Roddewig, Chicago, Ill.

Service to policyowners is available through more than 500 local offices. Each working day over 5,300 benefit checks are sent to policyowners and an average of over $3,800,000 in benefits is paid each week. More than $1.8 billion in accumulated benefits have been paid.

In order to ascertain the degree of performance of our organization, an independent survey of our policyowners was conducted and in response to the question, "Are you satisfied with Mutual of Omaha's overall service?", 97 percent of the policyowners replying said "Yes." Control of the mailing of these questionnaires and the receipt and tabulation of the replies are attested to by the nationally known firm of Arthur Andersen & Co.

Mutual of Omaha has always provided an exceptionally high return to policyowners. According to the latest independent statistics, Mutual pays out 23.3 percent more in benefits and operates at 13.5 percent lower costs than the combined average of the next 24 companies in the individual health insurance field. Mutual of Omaha lives up to its slogan—maximum benefits at minimum costs.

As the pioneer in the health insurance business, we have been privileged to introduce to our policyowners many liberalizations of their contracts—at no additional cost—such as: Addition of a 31-day grace period; extension of oversea travel benefits; guarantees of reinsurability for servicemen recalled to active duty during the Berlin and Cuban crises; and, most important of all, the addition to most individual policies of special travel accident benefits, the aggregate face amount of which now totals over $2½ billion.

Responding to our civic responsibilities to encourage outstanding contributions in the fields of health and safety, Mutual of Omaha's board chairman, V. J. Skutt, established the Mutual of Omaha Criss Award consisting of a $10,000 grant and a gold medal. This award has been given to such outstanding men as Dr. Edward Kendall and Dr. Phillip Hench for their work with cortisone; Dr. Howard Rusk for his work in the field of rehabilitation; Dr. Jonas Salk for development of the Salk vaccine; W. Earl Hall for his work in traffic safety; the late Dr. Thomas Dooley for his people-to-people program; and J. Edgar Hoover for his contributions to the personal security and safety of the American people.

Mutual of Omaha also gives a public service award. The most recent recipient was Lt. Frank Ellis, valiant young disabled Navy officer who successfully rehabilitated himself and was reinstated as a pilot by the U.S. Navy. For its work in the field of rehabilitation, the company received the President of the United States Distinguished Service Award.

Many times in the past, Mutual of Omaha has recognized its responsibility to help the overburdened Federal Government. We have had the opportunity to be of service by:

(1). Pioneering voluntary group insurance coverage for Federal employees:

(2) Extending low-cost MATS flight insurance to the members of the military (passengers on transport flights) and their dependents as they travel the world pursuant to Government orders;

(3) Perfecting a system of insurance to protect the flight pay of pilots in the Air Force; and

(4) By acting as fiscal agent for the true medicare program (hospitalization for military dependents) in 20 States. Mutual has performed this service at a cost-only basis. We are proud that in the years of its administration our per unit cost of this program to the Government has been about one-half of the cost of other administrators in the other States. A copy of the latest report on this true medicare program as submitted to the Congress by the office for dependents' medical care is attached to our statement. (The information relative to cost is on p. 37 of the report.)

From the beginning, Mutual of Omaha's individual policies could be continued without regard to age. In 1944 a hospital program was made available to those between the ages of 65 and 75 years. Continuing the program in 1949, a new series of policies which were issued without regard to age was prepared.

This path of progress continued, and again in 1955 new programs of insurance encompassing the improved coverage were marketed by Mutual of Omaha.

In 1958 the concept of more liberal renewal guarantees and improved coverages was continued again by the introduction of new product lines.

In 1959 Mutual of Omaha pioneered the first national enrollment of those age 65 or over in an insurance program. The approach was that of mass enrollment regardless of medical history and without requirements for a physical examination or a physical questionnaire. This concept also introduced a unique policy renewal agreement. This policy cannot be canceled because of changes in health or because of the number of times or the amount of benefits paid. This mass approach utilized electronic procedures to streamline costs. This protection was merchandised through local resident agency forces. The policy provided benefits of $10 per day for 60 days in hospital, miscellaneous expense benefits, a surgical schedule, and—for the first time—coverage for accredited nursing home

care for each illness. Benefits could total as much as $1,825 for each separate illness or accident. The monthly cost for this coverage is $8.50, or 28 cents a day.

In addition, in November of 1959 the company made available on a nonselective (issued regardless of health) enrollment basis a policy which provided cash benefits of $50 per week for 50 weeks in hospital. This policy also carried the special renewal agreement as outlined previously. The cost of this contract is $4.25 per month, or 14 cents a day.

In the period of 1950 through 1963, the company through its many thousands of field representatives conducted 11 nationwide enrollments. In these enrollments, over 602,600 applications were received and processed. In conducting these enrollments, we are pleasantly surprised by two factors not common to that segment of our policyowners under age 65. The first was that approximately 50 percent of the applicants tendered an annual premium with their applications; this number was in excess of the average for applicants under 65. Second, our senior security policyowners have shown their satisfaction with this form of private voluntary health insurance and their ability to pay for their protection with an unusually high renewal persistency.

Figures assembled by a recently conducted survey of our records show a lapse ratio on this business of only 1 percent per month, including terminations caused by death. The 1958 CSO mortality tables, the accepted standard tables in the life insurance industry, show a death rate of about 1 percent per month at the average age of our enrollment policyowner in the block of business surveyed.

While the company was developing this mass enrollment technique it also continued to make improvements in individual policies made available to those age 65 and over on a selective underwritten basis. Broad benefits—up to $25 a day in the hospital—were made available.

In 1960 the company introduced a policy which provides, on a paid-up basis at age 65, hospital room benefits, miscellaneous benefits and a surgical schedule. This policy is available to people through age 55. Depending upon the age of the purchaser and the scope of coverage selected, the annual premium varies from $15.80 at age 20, to $153.20 at age 55. The contract provides for full premium refund in the event of death before age 65.

In 1961 a lifetime guaranteed renewable $10,000 major medical policy, available to people of all ages, was introduced. The premium, depending on the age of the purchaser and the plan he selects, varies from $6.92 to $15.17 per month.

Also in 1961, a lifetime guaranteed renewable major hospital expense policy paying 80 percent of the expenses up to $5,000 exceeding a deductible amount selected by the policyowner was introduced. There are no age limits. Depending on the plan selected and age, premiums vary from $3.92 to $10.84 per month.

Also in 1961, a lifetime guaranteed renewable policy providing benefits for doctor's calls for treatment and surgical operations, was introduced and available to all ages. Medical benefits are payable regardless of the place of attendance.

During 1963 alone, senior citizens were issued coverage on over 50 policy forms, most of which are specially tailored for persons age 65 and over.

Since 1963, the company has offered a lifetime guaranteed renewable policy which provides up to $30 a day for 90 days in hospital, miscellaneous expense benefits, and a surgical schedule to those people between the ages of 60 and 74. Depending upon the type of plan selected, the monthly premium varies from $4.30 a month to $17.35 a month.

It is my pleasure, Mr. Chairman, to advise you that my company has requested State insurance department approval of a new comprehensive senior security policy to be made available on an enrollment basis without regard to health. This new contract is unquestionably the most outstanding over-age-65 contract available today. For the first time, all senior citizens can choose any combination of five basic coverages. Maximum benefits are available up to $11,637.75 for each separate sickness or accident.

Coverage A: Daily room benefits up to $20 a day for hospital confinement, and $10 a day room benefits for convalescent or nursing home confinement.

Coverage B: Basic hospital miscellaneous expense benefit.

Coverage C: Basic radiotherapy, surgical, and anesthetic expense benefit.

Coverage D: Catastrophe hospital and convalescent home expense benefit.

Coverage E: Catastrophe out-of-hospital and hospital outpatient expense benefit.

The premium, dependent upon the plan or plans selected, varies from a minimum of $5 a month to a maximum of $38.30 a month.

We intend to make this exciting new policy available again through our field labor forces, which we have found after many years of experience are absolutely essential to the placement of proper health insurance for each individual. It should be pointed out that this broad new coverage will be available to policyowners who may convert or supplement their present policies if they so desire.

In conclusion, Mr. Chairman, I would like to offer some observations on the future of health insurance for our senior citizens. As an underwriter who has had the opportunity throughout 20 years with this great organization—having worked in close cooperation with the insurance industry—I feel that great substantial strides will continue to be made by voluntary insurance in meeting the needs of the American public of all ages, and particularly those over age 65.

I have witnessed the birth and growth of senior citizen insurance.

I predict that voluntary insurance operating within the American competitive system will continue to produce outstanding coverages to suit each citizen's own needs and wants. We can and do consider such diversities as religious beliefs and partial coverages available through employers which can be supplemented by individual contracts.

I foresee continued development in the field of paid-up hospital insurance.

I have noticed with satisfaction the great strides made in the group insurance field in providing continuance of hospital coverage to retired employees, oftentimes with the employer paying all or part of the premium costs.

We hope that this statement is of assistance to you and that it provides information useful in considering the availability, adequacy, retention, cost, and extent of health insurance for persons age 65 and over.

Thank you.

Senator McNamara. The next witness is Mr. J. F. Follmann, Jr., director of information and research, and Mr. David Robbins, Assistant director of statistical research of the Health Insurance Association of America.

Will you tell us for the record what the term "Insurance Association of America" indicates? Would this be a federation of all the associations in the field or a number of companies in the field?

STATEMENT OF J. F. FOLLMANN, JR., DIRECTOR OF INFORMATION AND RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA; ACCOMPANIED BY DAVID ROBBINS, ASSISTANT DIRECTOR OF STATISTICAL RESEARCH, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Follmann. It is a customary business association composed of over 300 insurance companies which write health insurance.

Senator McNarama. But you write no health insurance?

Mr. Follmann. That is right.

Senator McNamara. Thank you very much. You may proceed in your own way.

Mr. Follmann. With me, Senator, is Mr. David Robbins, assistant director of statistical research, who is responsible for our statistical surveys and analyses. There are nine principal methods being employed by insurance companies to make health insurance available to both the present aged population as well as those that will become senior citizens in the future.

These methods include both group approaches, mass enrollment techniques, and individual coverages of various types. In addition, there are, of course, coverages available through Blue Cross and Blue Shield plans. It is clear that private health insurance is generally available, regardless of physical condition, for both the present and future aged.

Almost half of the aged insured with insurance companies are covered under group policies. For such persons, it is not infrequent that the employer pays some or all of the premium charge.

Vigorous competition among insurance companies and Blue Cross plans, all under the supervision of State insurance departments, assures the public of a reasonable relationship between benefits and premiums in the instance of both group and individual policies.

In all cases, the cost of insurance can only reflect the cost of and expenditures for hospital and medical care. As the cost of care rises, largely in response to the remarkable growth of medical technology, as well as the general inflation in the general economy, the cost of providing health insurance must necessarily rise.

This is true with respect to any type of program for financing or providing medical care, whether through a voluntary private program, a public welfare program, or through a compulsory governmental program.

We estimate that 60 percent of the aged were insured at the end of 1962. This proportion is more than twice the 26 percent covered at the end of 1952. The slightly over 10 million aged persons with private health insurance at the end of 1962 is three times the number with such insurance 10 years previously. There is every reason to believe that this remarkable rate of growth shall continue.

With 60 percent of the aged population covered by private health insurance at the end of 1962, with an additional 14 percent recipients of old age assistance and hence entitled to medical care without costs, and with others eligible for benefits under the medical assistance for the aged program, as veterans of the Armed Forces, as members of health care professions, or because of affiliations with unions, lodges, or religious groups, it is apparent that for over three-fourths of the aged, provision has been made for payment of some or all of their hospital costs.

The function of the system of private health insurance is to make available to the public a wide spectrum of coverages distributed in a variety of ways, so that the circumstances of different individuals can be met in the most efficacious manner possible. It is our conviction that in the main, and recognizing that experimentation continues, this has been accomplished and that the growing public acceptance of the coverages made available testify to the public confidence in what has been done.

Coverages available with insurance companies range, under individual policies, from $5 a day for 21 days to $30 a day for 400 days. Miscellaneous hospital expense benefits are available in amounts from $30 to $1,000. Surgical expense maximums run from $100 to $600. Major medical expense coverages are offered with maximum amounts which range from $1,000 to $10,000 and higher.

The adequacy of these coverages can be equated in relation to the customary utilization of health care services by older people. Experience, for example, indicates that 82 percent of the aged who are hospitalized have a length of stay of 30 days or less in a year. Only 6 percent stay as long as 2 months.

At a time when the average daily room and board charge was $17 a day, in mid-1961, we know that 29 percent of the aged with insurance company coverage had policies with room and board benefits

paying $15 a day or more, 18 percent had such benefits ranging from $11 to $14 a day, and 53 percent had such benefits in an amount of $10 a day or less. We could not distribute such data by geographical area although we do know that the daily room and board charge varies significantly geographically. In addition, at about that time, a fifth of the aged were covered by major medical or comprehensive policies, and this proportion increased to a fourth by the end of 1962. Such policies provide coverage for all the usual and customary hospital and medical expenses, including prescribed drugs, nursing care, surgery, physicians' visits, and at times skilled nursing home care which in the opinion of the physician is warranted.

Our studies indicate that the aged, once insured, have excellent possibilities for retention of the coverage. As of mid-1961, we found that 90 percent of the aged insured with insurance companies were covered under group policies, had individual guaranteed renewable policies, or other individual policies not subject to individual renewal as a result of health deterioration of the individual. Although the remaining 10 percent were covered under policies subject to such renewal, there is ample evidence available, including studies furnished to your subcommittee, which indicate the limited extent to which insurance companies exercise their right to nonrenew policies.

Extensive development of State 65 programs in California, Connecticut, Massachusetts, New York, and Texas, under which many thousands of aged persons have acquired health insurance since mid-1961, makes it likely that the current proportion of the aged with health insurance coverage, including the right to retain this coverage, has increased considerably.

Mr. Chairman, I had the pleasure of appearing before your Subcommittee on the Problems of the Aged and Aging about 5 years ago. At that time I reported that the most recent nationwide estimate as to the extent of health insurance coverage of the aged was 39 percent as of March 1957. Just 5 years later, as we now find, 60 percent of the aged had acquired this protection. We have every reason to believe that this significant growth will continue.

Senator McNamara. Thank you very much, sir. As I take it from your statement, your organization is strongly opposed to the King-Anderson bill?

Mr. Follmann. We have so testified before the House Ways and Means Committee.

Senator McNamara. You do not consider your group lobbyists, do you, in the broad sense of the term? Or do you?

Mr. Follmann. I believe we are registered.

Senator McNamara. Oh, you are registered as a lobbyist?

Mr. Follman. I believe so.

Senator McNamara. Thank you. Senator Dirksen?

Senator Dirksen. Mr. Follmann, I think there was some testimony yesterday to the effect that you indicated that 3 million of the actively employed aged were carrying health insurance and that you used that in part as a basis for the estimate that about 60 percent of the aged now have health insurance. There was evidently an intimation that the figure was not correct. Have you some comment to make on that?

Mr. Follmann. I believe this was based on an incorrect assumption with respect to our methodology. The methodology which we employ, Senator, is set forth in the studies which we have filed with your sub-

committee. They are not based on the assumption which was made yesterday as we understood it.

Now, if you would like us to go into the details of our methodology, Mr. Robbins would be very pleased to do so.

Senator DIRKSEN. Well, I would like to see some clarification for the record.

Mr. FOLLMAN. Would you like that now?

Senator DIRKSEN. Yes. It does not have to be long.

Mr. FOLLMAN. Mr. Robbins.

Mr. ROBBINS. Senator, the assumption made yesterday is entirely invalid. The methodology which we use is based on a survey conducted by means of questionnaire among member companies of our association. The most recent survey we did was based on results from 123 insurance companies that reported to us as to the extent to which they insured aged persons for basic hospital expense coverage and comprehensive major medical expense coverage.

In the definition we use we combine those that have basic hospital expense coverage with those that have comprehensive policies and this is how we arrive at our count for people with some form of health insurance coverage with insurance companies.

Now, in our survey these 123 companies reported, as I recall it, about 4.8 million people with this health insurance coverage and we had to make an estimate for those companies that did not report to us.

We used what we felt was the most adequate method available for that estimate. Actually, it turned out that we had underestimated for the nonreporting companies in that survey, but in any case, we did not use the assumptions that were made yesterday by, I believe, it was Mr. Cruikshank.

Senator DIRKSEN. I think it was hinted also that in one case you were relying on census figures going back to 1950 and 1951.

Mr. ROBBINS. Well, that is just not true. We have with us here a study conducted several years ago by Dr. Ida Merriam who appeared before you yesterday, and the data we use is taken from this study by Dr. Merriam. It is from a table which appears on page 14 of that study, and the data clearly indicate that in 1960, which is the year we attributed the data to, 27 percent of the males were at full-time jobs and 7 percent of the females, and not 1950, as was indicated.

Now, what may have happened in connection with that testimony is that the individual looked at the footnote to our testimony and we have checked that footnote and find it was an incomplete footnote, but the figures were correct.

Senator DIRKSEN. You gather data from 312 companies. How current do you keep those data?

Mr. ROBBINS. Well, we have 312 membership companies in our association. We do not conduct—we have not in the past conducted annual surveys on the aged if that is what you are referring to.

The most recent study we have is as of 1962. The most recently completed study.

Senator DIRKSEN. You say that slightly over 10 million aged persons with private health insurance at the end of 1962 is three times the number with such insurance 10 years previously?

Have you projected a figure for the next 5 years or the next 10 years on the basis of the data that you have been gathering from the companies that you represent?

Mr. ROBBINS. In our testimony before the Ways and Means Committee of the House last November we estimated that kind of a figure, Senator. And if I can just quote from that, we said that with a 60-percent coverage level reached in 1962 it is apparent that the extent of coverage can be expected to reach or exceed our high level predictions of 68 to 75 percent of the aged insured by 1969.

That is the end of the current decade.

This assumes a continuance of the tremendous rate of growth we have had in the last few years.

Senator DIRKSEN. Thank you.

Senator MCNAMARA. Thank you, Senator. The staff technician would like to ask a couple of technical questions for the purpose of clarifying the record.

Mr. CONSTANTINE. Mr. Follmann, in your full statement to the committee you say that you would have had to revise your figures downward on the basis of the revision by one member company were it not for the fact that you had underestimated the data for a nonmember company.

Now, the member company you refer to was presumably Continental Casualty, which had reported 1,450,000 policyholders or somewhere in that area but which actually had only 900,000 different persons insured.

Mr. FOLLMANN. That is correct.

Mr. CONSTANTINE. The question is this: You say that your member companies reported 4.8 million elderly and that you estimated the policies of nonmember companies on an aggregate basis. That is, the nonmembers accounted for 30 percent, of the total accident and health insurance premiums for all ages and you assumed, therefore, that they had 30 percent of the aged with commercial insurance.

Now, you had 4.8 million for your member companies and you estimated the nonmember companies at 30 percent.

Mr. FOLLMANN. That is not a correct assumption.

Mr. CONSTANTINE. On an aggregate basis? You can clarify that. But according to all that you have published you did not make individual estimates for nonmember companies, so how would your revision be affected by one nonmember company? What did you originally estimate for that company, that nonmember company, and what was your correction?

Mr. FOLLMANN. Mr. Robbins will go into that detail.

Mr. ROBBINS. As we indicated a few minutes ago, our member companies reported 4.8 million aged persons. We assumed that the nonreporting companies covered 1.3 million aged persons making a total of 6.1 million with some form of health insurance with insurance companies.

What we did was on a conservative basis assume that about two-thirds of the 30 percent premium written by nonreporting companies was applicable—that is that about two-thirds of it was for companies which provided coverage to aged persons.

We were inclined to feel that companies that report to us do a far larger job on the aged than the nonreporting companies. That being the case, on a conservative basis, we only used two-thirds of the 30 percent of the remaining premium and for that reason we underestimated this coverage among the nonreporting companies.

For example, this one company, and I believe it is the Bankers Life & Casualty as they reported yesterday, have 1.1 million aged persons insured of which about 700,000 are for basic hospital expense coverage as well as what we call hospital disability policies which in your definition you excluded from coverage but in our definition this is a policy which pays hospital benefits and we choose to include it.

Now, therefore, the Bankers Life & Casualty we would include in our survey at about three-quarters of a million people. Based on the fact that we assumed that all nonreporting companies had written only 1.3 million people, you can see how we underestimated.

In effect, although as you quite correctly point out, we did not separately estimate for each nonreporting company, in effect we had given credit to the Bankers Life & Casualty of about 400,000 people, which is well below, and we were as surprised as evidently you were at the size of the business that that company does on the aged.

Mr. CONSTANTINE. One more question, do you not normally take out, subtract the policies which pay $5 a day or less? In your survey of member companies, you do not include policies that pay $5 or less a day, is that correct?

Mr. ROBBINS. I think you are referring to our regular survey on persons of all ages. This one did not specify, it asked them to include—well, you have the questionnaires. It did not specify that.

Mr. CONSTANTINE. The only reason we were confused was that your full statement and the report you cited gave a different interpretation of the methodology you used, it just said 30 percent.

Mr. ROBBINS. Is it clear now?

Mr. CONSTANTINE. I think so.

Mr. ROBBINS. Had we wanted to inflate these figures, we would have used the 30-percent figure entirely and we would have come up with over 7 million aged.

Mr. CONSTANTINE. Thank you.

Senator MCNAMARA. Thank you. Senator Neuberger do you have any questions or comments?

Senator NEUBERGER. A great deal of emphasis is put on the fact that 60 percent of the noninstitutionalized aged population are covered by some form of private health insurance. Obviously the intent is to show that there is no need for further expansion of Government aid to these elderly people because so many are already protected; but you talk about the numbers that are protected as a result of your survey but you never make public, that I know of, any data on a quality of coverage.

This is quite important if you have a lot of these people getting $5 a day coverage or $10 a day coverage when they need from $17 to $20 a day coverage. So, in this 60 percent of all the people over 65 in this country who are covered, are they adequately covered for hospital care in your opinion?

Mr. FOLLMANN. Senator, I do not know of any definitive answer to a question like that. There are too many related factors which come into play. We look at this, we tried to gain an impression. It is extremely difficult.

For example, we are interested in the growth of major medical expense coverages among the aged. This is a quite recent development, one which was completely unforeseen a few years back, and the growth, for example, just between 1961 and 1962 was from 730,000 to over 1 million among just our own reporting companies.

This is a growth which we consider of significance. Also, we know some 13 percent of the aged have duplicate coverage—that is, they have more than one form of coverage.

So that we find no way of arriving at a definitive answer, particularly when you recognize that what is adequate coverage is an individual matter which depends entirely on the circumstances of the individual concerned.

Senator NEUBERGER. You must know, issuing this many policies, that you expect a certain amount of what do you call it, lapsing or cancellation due to failure to pay the premium. You might have issued so many million policies during 1962, how many of them could you expect to hold up for a period of 5 or 10 years?

Mr. FOLLMANN. Well, in the first place we do not issue any policies. We are an association of insurance companies, you recognize that.

Senator NEUBERGER. All right, how about one of the companies in your association, how many would default?

Mr. FOLLMANN. There is no distinct answer to a question like that——

Senator NEUBERGER. Oh, come, come, come, you must know how many out of a million policies issued, there must be some kind of a percentage of those that will not continue that policy for more than 2 or 3 years.

Mr. FOLLMANN. Senator, we do not have such a figure. Now, I would like to point this out, that this is a matter which happens at any age. Some people do not renew. It is a problem in our own business which we refer to as persistency, because it can be a costly matter to a company when policyholders do not renew.

Now, with respect to the aged, as was pointed out yesterday, there is quite a factor, because of the late age bracket, of death, and I believe there are findings among the over 65 plans that some one-third of those who do not renew, do not renew because the covered person has passed away.

Senator NEUBERGER. If you can estimate that 60 percent of the noninstitutionalized persons in America over age 65 are covered by health insurance, then you surely must have some way of estimating what percent of those will drop their insurance before they have had it 5 years or before they have had it 10 years.

That would take them to age 70 or 75.

Mr. FOLLMANN. It would not be of value to us as an association. Individual insurance companies would have an interest in this, but if we attempted to collect data from all the companies it would be meaningless data because a person may drop coverage with one company and take out coverage with another company. And this we would have no way of knowing because each company as it reported to us would have no way of knowing what happened to the dropped policyholder. So that anything we would gather would be meaningless.

Senator NEUBERGER. Does that not work the other way. You get these statistics from the other companies saying that 60 percent are covered. Well, maybe this company has a fellow who is also covered in another company, so then you have duplicates, so it might not be 60 percent.

Mr. FOLLMANN. We estimate that is the case in 13 percent of the cases. And so does the National Health Survey.

Senator NEUBERGER. Do you add 13 to 60 or do you subtract it from 60?

Mr. FOLLMANN. We get the aggregate figure and subtract the 13 percent.

Senator NEUBERGER. Thank you.

Senator McNAMARA. Senator Fong?

Senator FONG. Yes, sir. Mr. Follmann, how many companies write health insurance policies?

Mr. FOLLMANN. For all ages?

Senator FONG. Yes.

Mr. FOLLMANN. Oh, upward of 800.

Senator FONG. And you represent about a little over——

Mr. FOLLMANN. Over 300.

Senator FONG. You said your 312 companies write about 80 percent of all health insurance written by insurance companies. Is that correct?

Mr. FOLLMANN. That is correct.

Senator FONG. How many of your 312 companies are mutual companies?

Mr. FOLLMANN. I have never counted.

Senator FONG. Would you say a large proportion or a small proportion?

Mr. FOLLMANN. I would have no idea, maybe half. There could be a difference between a company count and a volume-of-business count. I have no idea, Senator.

Senator FONG. By company, by numbers, would you say about half, your guess?

Mr. FOLLMANN. That would be a blind guess; yes.

Senator FONG. Now, what proportion of health plans are written by insurance companies as differentiated by plans written by Blue Shield and Blue Cross? Do you consider Blue Shield and Blue Cross an insurance company?

Mr. FOLLMANN. Well, they are incorporated under different types of statutes, of course.

Senator FONG. When you say insurance company, you do not regard Blue Shield and Blue Cross as being in that category of insurance companies?

Mr. FOLLMANN. That is correct, nor do they consider themselves as insurance companies.

Senator FONG. What proportion of the health plans are written by insurance companies?

Mr. FOLLMANN. I would suppose in the neighborhood of half.

Senator FONG. And would the other half be written by Blue Cross and Blue Shield?

Mr. FOLLMANN. Yes; of course, there are what are referred to as independent plans.

Senator FONG. Yes.

Mr. FOLLMANN. These are the plans which are not Blue Cross and Blue Shield and are not insurance companies. These may be a union health and welfare plan, they may be employer provided plans, they may be prepaid group practice plans, they may be certain different types of community plans, they may be health cooperatives. There is quite a wide assortment within that general classification.

Senator FONG. Then would you say that more than half of the health policies are written by mutual companies or companies or groups or organizations that do not make a profit on this type of insurance?

Mr. FOLLMANN. Well, most of the so-called independent plans, I believe, are nonprofit. The Blue Cross-Blue Shield plans are nonprofit. And then, and here I am making a blind assumption, if half of those covered by insurance companies are covered by mutual companies you would then have over three-quarters of those people covered by a mutual insurance company, a Blue Cross-Blue Shield plan, or an independent plan.

Senator FONG. And then the premium——

Mr. FOLLMANN. I am making rough guesses here, you know.

Senator FONG. Yes; these are rough guesses. Then the premium would naturally be commensurate with what it costs to have the plan go into effect without any percentage for profit?

Mr. FOLLMANN. That is correct.

Senator FONG. You stated that 90 percent of the aged had guaranteed renewable plans. Of the approximately 800 companies that write aged insurance would you say 90 percent of them offer a guaranteed renewable policy?

Mr. FOLLMANN. I did not say that 800 companies write coverages for the aged. When you asked that question I said this is for all ages.

Senator FONG. How many of them write for the aged, 65 and over?

Mr. FOLLMANN. About 200 companies at a rough guess. They write coverages for those over age 65.

Senator FONG. Of the 200 companies, how many of them offer a guaranteed renewable policy?

Mr. FOLLMANN. Seventy-two is the last count I recall, that is guaranteed renewable for life.

Senator FONG. Is that increasing or decreasing?

Mr. FOLLMANN. That is increasing quite considerably. A few years ago, for example, just a few years ago, it was 31. So it has more than doubled.

Senator FONG. As an executive of the Health Insurance Association, would you say that this is going to increase in the future or do you foresee that it will decrease in number?

Mr. FOLLMANN. Oh, it will not decrease certainly, and there is every reason to expect that it will increase.

Senator FONG. Would you say from your position as an executive of the Health Insurance Association, that this type of policy is here to stay?

Mr. FOLLMANN. Oh, yes, definitely.

Senator NEUBERGER. Here to stay at the same rate?

Senator FONG. No. It is here to stay as a policy with the various rates that will be asked like any other policy, is that correct?

Mr. FOLLMANN. That is right.

Senator NEUBERGER. The costs are——

Senator FONG. It will be actuarially sound. You do not have to depend on your actuaries to set the premium, every policy you offer is on an actuarial basis.

Senator NEUBERGER. Will the Senator clear this up? If you took out a policy providing this hospital care at $8 a month, it is not guaranteed that it will continue at $8 a month.

Senator FONG. No, it will not, depending on the cost of the services.

Mr. FOLLMAN. The principal determinant, Senator, is the cost of medical care.

Senator NEUBERGER. But just hospital care if it is just a hospital policy, how long do you anticipate that it might go without an increase in rates? I suppose you cannot tell?

Mr. FOLLMANN. We have no way of knowing that. Company by company, that could depend on how the rate was originally constructed and what assumptions were made—in other words, how much they would anticipate increases in the future. If you did not anticipate any, then the rate increase would come fairly rapidly. If you made a good anticipation then there could be a delayed reaction.

Senator FONG. Do we know, Mr. Follmann, judging from the number of policies that are written by the various groups like insurance companies and Blue Shield and all the others that, following the same trend, most of the insurance would be written by groups which will not make a profit on this type of insurance?

Mr. FOLLMANN. That is correct.

Senator FONG. You stated that there are approximately 10 million policies that have been written up to the year 1962, out of 17 million aged. Is that correct?

Mr. FOLLMANN. I am sorry, I did not hear the question.

Senator FONG. You stated that there are approximately 10 million health insurance policies that have been written.

Mr. FOLLMANN. Yes.

Senator FONG. Up to the end of 1962. And it is estimated that there are approximately 17 million aged.

Mr. FOLLMANN. Yes.

Senator FONG. You stated also that with that 60 percent and an additional 14 percent which you allocate to those who are under old-age assistance and others taken care of by being members of the Armed Forces and being members of the unions, and so on for 75 percent of the aged provision has been made for some policy of health insurance.

Mr. FOLLMANN. That is right.

Senator FONG. As a research body, have you looked into the number of people that might be taken care of under the Kerr-Mills law if Kerr-Mills were enacted by all of the States of the Union?

Mr. FOLLMANN. We have not. We have tried, but we do not have enough data to go on, Senator.

Senator FONG. Could you venture a guess as to how many Kerr-Mills can take care of?

Mr. FOLLMANN. Well, you see, it is dependent on the standards set up in each State. The eligibility standards.

Senator FONG. Taking the minimum standard.

Mr. FOLLMANN. Another factor, of course, as with almost any kind of program, certainly a program of this type, there is often a delayed reaction until the public becomes fully aware of a program, and this can be true of an insurance company program. We have people in our own office who probably do not know they are covered, so that with a program like Kerr-Mills, I think there can be anticipated a timelag until the public becomes fully aware of the benefits which have been established by Congress.

Senator FONG. You have given us a figure of 14 percent for the aged, plus those under various plans, and you have added that to 60 percent. Could you venture a percentage guess if Kerr-Mills programs were enacted in all of the 50 States, on the percentage would that increase in the number of people who will be taken care of someway or the other?

Mr. FOLLMANN. I do not believe you can make an estimate, Senator, because the number of aged on old-age assistance has been declining. Just a relatively few years ago it was 23 percent, for example, As the economic condition of the aged has been improving, and it has been, and there is every indication it will continue to, the number receiving old-age assistance benefits has been declining rather rapidly for quite a while.

Therefore, you might have some counterbalance—as you had more coming in under the MAA program, you may have less under OAA, so I do not know how you could possibly arrive at such an estimate.

Senator FONG. You stated that 82 percent of the aged have a length of stay in the hospital of 30 days or less. And you have stated that in 1961 that the cost of the average stay in the hospital was $17 per day; $17 times 30 gives us a figure of $510. For benefits that will give you $510 how much premium would you have to pay, I do not know enough about the insurance business to give you a type of policy, but could you venture a guess for $510 benefit to the individual to take care of his hospital bills for a period of 30 days, how much premium will he have to pay on an actuarial basis?

Mr. FOLLMANN. I cannot tell you that, Senator, because, again, not being an insurance company we are not engaged in ratemaking processes.

Senator FONG. Would you say that to get $510 that you need to pay a premium of, let us say, one-fourth of that?

Mr. FOLLMANN. I cannot answer your question, Senator. We do not make rates for coverages.

Senator FONG. I understand, but you are familiar with insurance policies, and you are familiar with actuarial figures, I presume. Would you guess as to whether to give you a benefit of $500 whether you would have to expend in premium an actuarial basis more than $100, more than $200?

Mr. FOLLMANN. Our only benchmark could be the coverages which are available.

Mr. ROBBINS. It just occurred to me that you could look at policies that are on the market today. For example, the Mutual of Omaha's policy, for 60 days at $10 a day I believe they're selling that for around $8 or 8.50 a month, which would run close to $100 a year, and would also include a surgical expense benefit and miscellaneous hospital expense benefit and some nursing home benefits.

Senator FONG. Yes, but $10 a day for 60 days?

Mr. ROBBINS. That is correct. I believe the gentleman this morning, Mr. Hansen, testified to that effect. I think that runs around $8.50 a month.

Mr. FOLLMANN. But that has benefits other than the benefit you were speaking of.

Mr. ROBBINS. In addition to the hospital expenses it includes surgical and nursing home care.

Senator FONG. But here we have a little different problem where you have the average individual or the majority of them, 82 percent of them staying in the hospital 30 days or less.

Mr. ROBBINS. Sir, if I may, I would like to point out that the figure we were using was a length of stay of those who are hospitalized. That is of those that are hospitalized, 82 percent go out of the hospital in under 30 days, but the average length of stay is not 30 days, it is 18 days according to this same actuarial study.

In other words, the 82 percent refers to those who were discharged in under 30 days, but the average aged person who goes to the hospital according to our studies stays about 18 days.

Senator FONG. So, if you multiplied 18 days by $17 it gives you $306 benefit? Would you have to pay $100, say, one-third, or would it be that high?

Mr. FOLLMANN. We cannot answer that, Senator. I am sorry.

Senator FONG. Could you get us an answer?

Mr. FOLLMANN. I beg your pardon?

Senator FONG. Could you get us an answer?

Mr. FOLLMANN. Certainly, we could try, we could ask some of the companies and their actuaries to make some estimates.

Senator MCNAMARA. If you will do that for the committee.

I think we are fortunate in having one of the members of the Finance Committee with us today, Senator Douglas. The Senator is very much interested in the subject we are considering here today and, of course, any legislation that might develop in this field will be handled by the Finance Committee.

I want the record to show Senator Douglas is here. Do you have any questions or comments?

Senator DOUGLAS. No questions, I am trying to inform myself, Mr. Chairman.

Senator DIRKSEN. Mr. Chairman.

Senator MCNAMARA. Senator Dirksen?

Senator DIRKSEN. Mr. Follmann, does your association develop figures with respect to the increasing hospital costs? By that I mean that some years back I suppose a standard wage for a nurse would have been $10 a day. Then it went to $15, and then it went to $20. I think presently it is $22 for an 8-hour day.

Hospital employees through collective bargaining, have brought up their wage levels. There have been increasing food costs and maintenance costs. So one of the things we often forget when we talk about premiums is that hospital expenditures are going up year after year so that when a company writes health insurance it does have to have in mind exactly what the cost is going to be.

I think that in the Navy hospital here, contrary to what people think, that that is just free for Members of Congress [laughter], they charged me $34 a day when I was there. I did better by going to a private hospital in Washington the last time I had to go to a hospital.

But the fact of the matter is that hospital costs go up and up and obviously it is going to have to be reflected in the premium that is finally paid.

Now, does your association keep current figures on increasing costs for hospitalization?

Mr. FOLLMANN. Well, on the cost of hospital care we follow and place reliance on the data, and it is quite comprehensive, which is

gathered yearly by the American Hospital Association. Then, of course, we watch our own insurance cost data.

There are other factors than those which you have mentioned, too. General acute illness hospital care becomes more and more technical all the time. This not only requires the purchase of equipment which can rapidly become obsolete, but it also requires an increasing number of technical employees within a hospital, and the American Hospital Association has some quite vivid figures on that point which show the way the number of employees in relation to a patient has increased over the past decade or so.

This is an important factor, and it is one of the factors which makes the subject unpredictable. If somebody comes up with the development of something, say, comparable to the cobalt bomb, immediately every patient stricken with that type of illness wants that kind of care, because it is conceded to be the best and, therefore, each hospital immediately has to consider responding to this demand.

And this can cause a sudden jump up in the cost of care. Now, we have a distinct interest, obviously, in this whole subject so that we are interested in the development within the hospitals of what are called utilization committees, the purpose of which is to take a hard look at utilization in order to avoid unnecessary care in the hospital.

I was just reading in the New York Times the other day that someone in New York City had made the statement that 41 percent of the long-term cases, those over 30 days, in the New York City hospitals is not medically indicated. This can be a housing problem, particularly when you get to older people. They have recovered from their illness, but you simply cannot throw them into the streets.

But this is not a medical care problem, so that it is a very complex subject with which we try to come to grips, but there are many things, such as the factors you have indicated, which essentially are beyond anyone's control.

Senator DIRKSEN. Thank you.

Senator McNAMARA. On page 4 of your statement you deal with some of the things we have been talking about here, and you state:

> The cost of health insurance is and must remain a reflection of the cost of expenditures for hospital and medical care.

Doesn't insurance company overhead account for almost half of the premiums paid on individual policies and would this not be an important factor in the cost of providing insurance?

Mr. FOLLMANN. No, Senator. In the data which we have with respect to coverages for people over 65, for example, in the statewide programs, the expense of operation runs from 5 or 7 percent to 10 to 15 percent. This is made up of essentially three components, two of which are about equal; one being operating costs, and the other being what we call acquisition costs—the cost of putting the business into effect. The third factor is taxation.

Senator McNAMARA. So you think that it is closer to; shall we say, 10 percent. This is slightly exaggerating the figures you gave us—the overhead involved in insurance premiums?

Mr. FOLLMANN. That is right; the cost of operation and taxes.

Senator McNAMARA. Well, this sounds astonishingly low to me, but it is your evaluation of the situation. We appreciate it very much.

Thank you, sir; and thank you, gentlemen, very much for your helpful testimony.

PREPARED STATEMENT OF J. F. FOLLMANN, JR., HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. Chairman, my name is J. F. Follmann, Jr. I am director of information and research of the Health Insurance Association of America whose 312 member companies write over 80 percent of all health insurance underwritten by insurance companies in the United States. With me is David Robbins, assistant directer of statistical research, who is responsible for our statistical surveys and analyses. We appear today in response to the invitation contained in Chairman McNamara's letter of April 6, 1964. We were asked to testify upon five topics:

1. The availability of health insurance for the aged;
2. The cost of such insurance;
3. The number of older people covered by health insurance;
4. The adequacy of such coverage; and
5. The ability of older persons to retain health insurance, once secured.

First, as to the availability of health insurance for the aged.

Today the aged have available insurance company coverage through:

(*a*) Individual company mass enrollment programs, first introduced about 7 years ago, affording coverage irrespective of condition of health.

(*b*) Voluntary associations of insurance companies offering coverage regardless of condition of health on a statewide mass enrollment basis. These are the programs which began in Connecticut in 1961; in Massachusetts and New York in 1962; in Texas in 1963; and this year in California, North Carolina, and Virginia. A similar program has recently been announced, but not yet in operation, in Ohio. Other State programs are under consideration.

(*c*) Group insurance plans for those who remain as active employees beyond age 65.

(*d*) Continuance of group insurance coverage to retirees under private industry, Federal, State, and local government employee benefit plans.

(*e*) Conversion of group coverages at retirement.

(*f*) Coverage under group contracts issued to associations of retired persons such as the American Association of Retired Persons and retired civil servants, including retired Federal employees.

(*g*) Continuance of individual coverages, many of which are guaranteed renewable for life. At least 175 insurance companies make available such coverages, and of these at least 126 will renew the coverage for life; at least 72 being guaranteed renewable for life.[1]

(*h*) Purchase of individual or family policies after age 65. At least 170 companies now offer such policies.[1]

First. Individual policies which become paid up at age 65: In addition, of course, there are the coverages available through Blue Cross-Blue Shield plans and other types of private insurance mechanisms.

It is evident from the foregoing that private health insurance is generally available for the present or future aged who desire such protection. The several approaches taken demonstrate the flexibility of private insurance and the variety of choices available.

Second. As to the cost of health insurance for the aged, the Health Insurance Association of America has neither conducted studies of, nor collected data pertaining to, the premiums charged by insurance companies for their coverages of any type or for any age group. Such information is generally available through trade publications, sales literature, and advertising material.

Although our association cannot provide data on the cost of health insurance, I wish to invite the subcommittee's attention to certain factors concerning health insurance premiums:

(*a*) Almost half of the aged covered by insurance companies are covered under group insurance policies either as active employees or as retirees.[2] For such aged persons, it is not infrequent that the employer pays some or all of the premium charge.

(*b*) The cost of health insurance is and must remain a reflection of the costs of and expenditures for hospital and medical care. As the cost of care rises,

[1] An estimate of the extent of private health insurance coverage of the aged as of Dec. 31, 1962, Health Insurance Association of America, July 1963, and earlier studies.
[2] Ibid.

largely in response to the remarkable growth of medical technology, as well as general inflation in the economy, the cost of providing health insurance must necessarily rise. As public demand, and consequently expenditures, for modern medical care continues to increase—a consequence of many interrelated factors including a rising standard of living, changes in our socioeconomic existence, increased levels of education, and more astute health consciousness—this must be reflected in the cost of any insurance program. This is true with respect to any type of program for financing or providing medical care, be it a voluntary private program, a public welfare program, or a compulsory governmental program.

(*c*) Vigorous competition, among insurance companies and with Blue Cross-Blue Shield plans, under the supervision of State insurance departments, assures the public of a reasonable relationship between the premiums and benefits.

(*d*) The premium charges for the multicompany statewide programs for the aged are subject to the review and approval of the insurance commissioner in those States where such plans are operative, as well as to the influences of competition.

Third, as to the number of older people covered by health insurance.

We estimate that 60 percent of the noninstitutionalized aged population were covered by some form of private health insurance at the end of 1962. This proportion is more than twice the 26 percent covered at the end of 1952. The slightly over 10 million aged persons with private health insurance at the end of 1962 is 3 times the number with such insurance 10 years previously. There is reason to expect that this growth in private health insurance will continue.

Two developments have caused us to reevaluate our estimate with respect to the insured aged population. First, one of our member companies which reports to us in our various surveys concerning the aged population recently indicated that they had revised their statistics with respect to the number of aged persons which they have insured. This revision would, in turn, have caused us to revise our estimate were it not for another matter which has been brought to our attention more recently. We have found that one of the companies which does not report to us in our various surveys insures far more aged persons than we estimated under our conservative methodology. As a result, there has been an understatement for nonreporting companies. In developing our estimate for companies which do not report to us in our surveys, we have always been most careful to avoid the possibility of overstatement.

The net effect of these adjustments is to reaffirm the validity of the 60 percent estimate furnished the House Committee on Ways and Means in November.

With 60 percent of the aged population covered by private health insurance at the end of 1962, with an additional 14 percent recipients of old-age assistance and hence entitled to medical care without cost, and with others eligible for benefits under the medical assistance for the aged program, as veterans of the Armed Forces, as members of health care professions, or because of affiliations with unions, lodges, or religious groups, it is apparent that for over three-fourths of the aged, provision has been made for payment of some or all of their hospital and medical costs.

Fourth, as to the adequacy of health insurance coverage for the aged.

Adequacy can be measured only in terms of need in relation to all available resources or means, including current income; assets and other holdings; benefits deriving from such entitlements as veterans status or membership in religious, social, philanthropic, or labor organizations; assistance from relatives; and insurance. Since the relationship of these elements differs in individual cases, it is extremely difficult to evaluate the adequacy of available health insurance coverages. Furthermore, health care costs vary extensively among communities and geographic areas. In some instances (we estimate about 13 percent), an older individual has more than one form of health insurance or more than one policy.

The function of the system of private health insurance is to make available to the public a wide spectrum of coverages distributed in a variety of ways, so that the needs of different individuals can be met in the most efficacious manner possible. It is our conviction that in the main, and recognizing that experimentation continues, this has been accomplished, and that the growing public acceptance of the coverages made available testify to the public confidence in what has been done.

Health insurance properly should enable individuals and families to purchase coverages which will provide benefits sufficient to prevent a substantial

change in their living standards because they experience nonroutine health care expenses. Both private and public health care programs recognize that coverage of 100 percent of all health care expenses is not generally feasible, either socially or economically. The insurance objective is to provide for the major portion of the health care costs above the routine or budgetable items. Widely owned hospital and surgical coverages meet a large portion of this objective. With the use of deductibles and coinsurance to eliminate routine items and to provide a degree of control of overutilization, catastrophic hospital and major medical benefits are available which provide substantial protection against the unusually expensive illness.

Today, realistic benefits in relation to the actual utilization which occurs in the vast majority of hospitalization episodes experienced by the aged are available under individual and group policies and significantly are provided under mass enrollment programs. The July 1, 1963, edition of the "Report on Guaranteed Lifetime Health Insurance," published by the Health Insurance Institute, documents this statement.

The coverages made available by insurance companies on an individual policy basis offer a wide range of benefits. Hospitals per diem benefits are available from $5 a day for 21 days to $30 a day for 400 days. Coverages for miscellaneous hospital expenses are available in amounts from $30 to $1,000. Surgical expense maximum amounts run from $100 to $600. Amounts for skilled nursing home care range from $5 to $20 or more a day, and cover from 31 to 200 days of care. Major medical expense coverages, usually with no per diem, per item, or duration limit, and covering practically all forms of care in and out of hospital, are available with maximum amounts which range from $1,000 to $10,000 or higher. Group insurance benefits patterns are varied, subject to the demands of the purchaser.

The adequacy of these coverages, in general terms, can be equated in relation to the customary utilization of health care services by older people and the usual cost of such services. According to insured lives experience, 82 percent of the aged who are hospitalized in a general hospital have a length of stay of 30 days or less in a year. Only 6 percent stay as long as 2 months. The average length of stay in hospitals for all persons age 65 and over is 18 days.[3]

Based on a sampling obtained from insurance companies as of July 1961, among aged persons covered by insurance companies, 29 percent had room and board hospital benefits of $15 a day or more; 18 percent had such benefits ranging from $11 to $14 a day; 53 percent had such benefits in the amount of $10 a day or less.[4] We were not able, from the information available to us, to relate these amounts to the geographic areas where the respective benefits were in effect.

It should be noted that in 1961, according to data of the American Hospital Association, the average daily room and board charge in non-Federal, short-term, general hospitals was $17 a day.[5] Also, insurance coverages always provide, in addition to a room and board benefit, benefits for ancillary hospital services such as operating room, X-ray and diagnosis, and other charges; for surgery; and in some instances for physician's visits and skilled nursing home care.

In mid-1961, about a fifth of the older people insured by insurance companies were covered by major medical or comprehensive policies. By the end of 1962, this proportion had increased to a fourth.[6] Major medical policies are especially designed to help offset the more serious medical expenses, whether occasioned in or out of the hospital, resulting from severe or prolonged illness or injury. Included in the coverage is protection up to 75 or 80 percent of expenditures for hospital care, surgery, physician services, nursing care, drugs, and frequently skilled nursing home care; with an aggregate benefit as high as $10,000. Since the conduct of these surveys, there have been extensions of the State 65 plans mentioned earlier and other major medical plans offered to the aged by individual companies. It is reasonable to assume, therefore, that the extent to which senior citizens have major medical benefits has undoubtedly increased since the end of 1962.

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[3] Annual Statistics 1960—Cases Discharged From British Columbia Hospitals, prepared by British Columbia Hospital Insurance Services.

[4] The Extent of Insurance Company Coverage for the Medical Expenses of Senior Citizens as of July 1961, Health Insurance Association of America, 1962.

[5] Hospitals, August 1962, American Hospital Association.

[6] Ibid.

Another manner of evaluating these coverages would be to determine the degree to which they cover the actual expenditures of the insured aged for items of health care against which they are insured. Unfortunately, industry-wide statistics for both the numerator and the denominator of this relationship are not available. At times a comparison is made, based on estimates resulting from household interview surveys, which purports to relate the benefits received by the aged from health insurance to their health care expenditures. Such a comparison for the purposes of evaluating the effectiveness of health insurance is not valid because: (1) the numerator consists of the estimated voluntary health insurance benefits received by the insured aged and the denominator includes the estimated health care expenditures of all the aged, both insured and uninsured; and (2) the denominator includes estimated expenditures by the aged for nonprescribed drugs and medicines such as tonics and vitamins, and similar health care items which are not properly a function of insurance.

The most recent published set of data on this subject has been gathered through the U.S. National Health Survey. These indicate that in the period July 1958 to 1960, of those older persons discharged from short-stay hospitals and who were insured, 82 percent had more than half the hospital bill covered by insurance, and 59 percent had three-quarters or more of the bill covered.[7]

Therefore, while evaluation of available coverages for the aged is difficult at best, it is readily apparent that a wide choice of benefit patterns is available to the members of the public and that they, in the last analysis, must choose in relation to their respective needs.

Fifth, as to the ability of older persons to retain health insurance once secured.

The most recent study conducted by our association concerning renewal provisions contained in policies covering aged persons was in mid-1961.[8] At that time, slightly over half of the aged persons covered by health insurance were protected by Blue Cross plans.

As to the half of the aged insured with insurance companies in mid-1961, about 90 percent were covered under group policies, had individual guaranteed renewable policies, or had other individual policies not subject to individual nonrenewal as a result of health deterioration of the individual. Although the remaining 10 percent were covered under policies subject to such nonrenewal, there is ample evidence available, including studies furnished to your subcommittee, which indicates the limited extent to which insurance companies exercise their right to nonrenew policies.

Since the mid-1961 study, there have been extensive developments of the State 65 marketing technique under which many thousands of aged persons have acquired health insurance. Again, such coverages are not subject to individual nonrenewal. It is very likely, therefore, that the current proportion of the aged with health insurance coverage including the right to retain this coverage, has increased considerably.

In conclusion, Mr. Chairman, I should like to add that the Health Insurance Association of America recognizes the social responsibility and the economic necessity of providing adequate health insurance to all of the people of the United States who can be reached through established insurance institutions operating in a free and competitive environment.

A great variety of health insurance plans and policies are available to the present and future aged. New approaches and coverages have been developed and undoubtedly will be expanded in the future. Better methods of administration and distribution are being developed. The number of aged persons covered is an accomplishment unforeseen a decade ago. Finally, real progress can be seen in the trend upward in the purchase of broader benefits which can be and are being obtained and kept in force by the aged. Mr. Chairman, I had the pleasure of appearing before your Subcommittee on Problems of the Aged and Aging almost 5 years ago (June 18, 1959). At that time, I reported that the most recent estimate of the number of aged with some form of health insurance was 39 percent as of March 1957. Five years later this proportion had increased to 60 percent. We have every reason to believe this growth will continue.

[7] "Proportion of the Hospital Bill Paid by Health Insurance," U.S. National Health Survey, July 1958-June 1960, series B, No. 30.

[8] Ibid.

Senator McNAMARA. Our next witness this morning is Mr. James R. Williams, vice president and general manager of the Health Insurance Institute.

How do you do, sir.

Mr. WILLIAMS. Good morning, Senator.

Senator McNAMARA. Will you be seated and proceed in your own manner?

STATEMENT OF JAMES R. WILLIAMS, VICE PRESIDENT AND GENERAL MANAGER, HEALTH INSURANCE INSTITUTE

Mr. WILLIAMS. Thank you. Senator, my statement that I presented to this subcommittee is fairly short, so if I may briefly review that for you.

My name is James R. Williams, I am vice president and general manager of the Health Insurance Institute, a central source of information about health insurance provided by insurance companies. Our function is to transmit information to the public to aid people in understanding more fully the uses of their health insurance policies offered by insurance companies.

We review and utilize information originated by many sources, both private and public. We are financially supported by the more than 300 member companies of the Health Insurance Association of America, but we have a separate staff and budget from that of the association.

As an information agency for the health insurance business, the institute endeavors to create a greater public awareness of health insurance. We try, also, to stimulate broader public knowledge of health care services and their relationship to the cost of health insurance.

In the field of inquiry outlined by your subcommittee, the institute reports on the types of insurance policies available including the kinds of plans, the levels of benefits, and the range of premium charges.

No special emphasis has been placed on any particular form of health insurance but rather on the variety of insurance arrangements which are available for people planning a retirement program, or those already retired.

The public which the institute provides information for includes educators, students, business and professional associations, labor groups, civic organizations, women's organizations, government information specialists, and the press.

Materials published by the institute are based on facts and figures gathered by research personnel in organizations both within and outside the insurance business. One of our principal publications is the "Source Book of Health Insurance Data." This annual publication highlights statistics on the number of people who have some form of health insurance, the types of private insuring organizations, and the amount of health insurance premiums received and benefits paid by insurers in the United States.

The source book also includes data on both the cost of medical care in the United States and the frequency of illness and injury among the American people. This information is compiled from surveys

and published reports of insurance associations, health insuring plans, Government agencies, and hospital and medical groups.

Our services to various public or groups include the preparation and distribution of a series of regularly issued publications offering a broad view of the health insurance field. From time to time, the institute has prepared and distributed pamphlets on specific aspects of health insurance.

Because the institute is essentially an information and data transmitting organization, as we indicated in our responses to the specific questions submitted by you, Mr. Chairman, the institute feels it can best contribute information to the subcommittee on the availability of health insurance offered by insurance companies to persons 65 years old and over.

As we indicated in our letter, some of the subjects which the subcommittee is interested in are not within the scope of activity of the institute. However, we publish an annual report which may have some bearing on the retention of health insurance by employed people at the time of retirement. This study was referred to in our response to question No. 3 of those submitted to us by the subcommittee.

The most recent report, covering 1963, was based upon a survey of 47 insurance companies which accounted for some 75 percent of total group health insurance premiums written by insurance companies in the United States in 1962. This analysis was taken from a sample of new cases underwritten by reporting companies in 1963. It indicates the types of insurance arrangements those employees of companies reported on will have at retirement, and this can be a broad scope from those in the early twenties up to those in the fifties or beyond.

I would like to quote from this publication:

> Out of a total of 317,301 employees eligible for hospital and medical care benefits, 70.6 percent had the option to continue their health insurance into retirement by converting their group coverage to an individual policy.
>
> Some 80,051 workers, 25.2 percent of those surveyed, had the right to remain with the insured group after retirement. Barring duplication of policies, the sample study found that 82.6 percent of the employees under hospital and medical care protection had the right to retain their health insurance upon retirement—either by conversion to an individual policy or by continuation under a group policy.

A copy of this publication has been made available to the subcommittee. With respect to the availability and cost of insurance, the institute would like to present to this subcommittee the information it has collected. This information is contained in a booklet, "Report on Guaranteed Lifetime Health Insurance; for Persons Over 65; for Persons Under 65."

Every effort was made to assure that each of the three editions of this booklet published by the institute provided as complete a listing of insurance companies and associations as possible although it is not all inclusive.

The first edition provided information as of mid-1961. At that time 66 different companies and associations were listed as providing some 126 guaranteed-for-life policies and plans.

The second edition, published as of January 1, 1962, showed 81 companies and associations offering 157 guaranteed-for-life policies and plans. The third edition, published as of July 1, 1963, listed

95 companies and associations offering 191 such insurance arrangements.

The latest edition broke down into eight categories the health insurance programs available from insurance companies to those in or near retirement. Each category showed the premium range of the various policies and plans for a person at a selected age which was done for purposes of example. The range of benefit provisions in the policies were listed by company or association, and the address of each organization was given.

The booklet shows a wide-ranging variety of policies and plans which can be tailored to the varying needs of families. A copy of the latest edition has been made available to the subcommittee.

The booklet lists plans available on a group, mass enrollment, or individual basis. Because this subcommittee has heard, or will hear, from representatives of these mass enrollment and group plans, we will concentrate on the programs available on an individual basis.

Even more than the other plans, the individual policies show a wide range of benefit provisions and of premiums. Among the many plans, for example, the institute booklet lists guaranteed renewable hospital-surgical expense plans available to a 65-year-old man.

For instance, one company offers a plan which would pay $10 a day toward hospital daily room-and-board charges for up to 30 days; all of the first $100 of miscellaneous hospital expenses, and 80 percent of the next $250 of such expenses; a $200 maximum surgical schedule; $3 a day for in-hospital doctor visits for up to 30 days, and various other expenses. The premium for this 65-year-old man would be $86.60 a year.

Another company, for example, has a plan paying $30 a day for hospital room and board for up to 180 days; $750 in miscellaneous hospital expenses; and a $600 maximum surgical schedule. The premium for this individual at the same age would be $207.80. A third company has a plan, to show the variety of plans available, paying $50 a day for room-and-board charges in a hospital for up to 365 days; $1,000 for miscellaneous hospital expenses, and a $1,000 maximum surgical schedule.

The premium is $547.15 a year. While this latter example is obviously for an individual who would want the finest accommodations available and also who would have to pay a substantial premium, but it does illustrate the breadth of coverage being made available at widely varying premiums.

The programs listed in these booklets indicate the broad range of policies offered by insurance companies to people in or near retirement. And since the publication of the third edition additional companies have announced new plans and others have announced broader benefit programs, particularly of the major medical variety.

I recognize that the information we are able to provide your subcommittee is necessarily limited in relation to your broad scope of study. We hope the information the institute has provided will prove useful in your inquiry of private health insurance for the aged.

Senator McNamara. Thank you very much. I am sure the information you provide is helpful in a general way.

You do stress the fact that your statistics are compiled from information put out by various insurance companies plus some queries that

you have directed to these companies. Therefore, you indicate that you take no responsibility for the figures, but that these are insurance company figures?

Mr. WILLIAMS. They are not gathered by the institute, Senator.

Senator McNAMARA. They are used by you and you take the figures without going behind them?

Mr. WILLIAMS. That is right, we accept the figures as they are given to us, and also in our reporting we give the references.

Senator McNAMARA. Your press releases and publications that you have been putting out on the subject are really a reflection of the statements made by the organizations that are members of your institute?

Mr. WILLIAMS. I am not quite sure I understand your question, Senator.

Senator McNAMARA. Let me see if I can make it plainer.

I started out by saying you assume no responsibility for these figures; you are using figures that have been furnished to you?

Mr. WILLIAMS. That is right.

Senator McNAMARA. Out of this kind of data, then, you put out the publications that you refer to and the press releases that emanate from your organization; this is correct?

Mr. WILLIAMS. That is correct.

Senator McNAMARA. But you do not go beyond that?

Mr. WILLIAMS. No, sir.

Senator McNAMARA. Thank you very much.

Do you have a comment or question?

Mrs. Neuberger?

Senator NEUBERGER. When you change from this group coverage to an individual policy, does the cost change?

Mr. WILLIAMS. It would change; yes, Senator. To what extent I do not know, because it varies from company to company, depending upon the group plan that is in effect that the person would be going from into retirement. But there would be a change in premium; yes, ma'am, from the group policy.

Partly that is true also because in most of these group plans, all or part of the costs are paid by the employer.

Senator NEUBERGER. But I am referring to this quote from your booklet on page 3. It seems to make a virtue of the fact that if you have been carrying insurance, yes, you keep right on carrying it; but, of course, if you convert to an individual policy, I think it would be more costly.

The institute, of which you are vice president, has advertised paid up in full at age 65.

Now, what does that mean?

Mr. WILLIAMS. Are you referring to the booklet that I referred to in my statement?

Senator NEUBERGER. No, press releases and other advertisements that came to us carried an ad called "Paid Up in Full at Age 65 Policy." Now, when did you pay it up in full?

Mr. WILLIAMS. I do not recall that we had any ad like that, but we do report on the various types of plans and paid up at 65 is one of the many types of insurance arrangements that we refer to.

Senator NEUBERGER. How do you pay up at age 65? I mean, do you pay up a lump sum of $10,000 or what?

Mr. WILLIAMS. Oh, I see what you mean. That type of policy is if it is taken out by an individual at 25, he pays the regular premium and then at the age of 65, he does not have to pay any more and it accepts itself in force.

Senator NEUBERGER. But when he took it out at age 25, he probably though that $10 a day hospital would be adequate coverage, so at age 65 he finds that it is not adequate coverage; is that not true?

Mr. WILLIAMS. That could happen; yes.

Senator NEUBERGER. This is the fault of insurance versus health care under a social security plan because it does not allow for this big increase in hospital costs that we are talking about, so paid up in full at age 65 is misleading advertising, it seems to me, because it does not tell what you are buying for that cost?

Mr. WILLIAMS. It is the name of a policy and I think when the policy is sold to an individual, it is pretty well clear to him or should be clear in his mind what he is buying.

Senator NEUBERGER. When you say "It is the name of a policy, that is just a name for the policy," reminds me of a story.

We have a dentist in Portland, Oreg., who advertised painless dentistry. This is 50 years ago.

Senator MCNAMARA. Before your time.

Senator NEUBERGER. And the FTC and other such organizations said there is no such thing as painless dentistry, and this man's name was Parker and he had been advertising under the name of Painless Parker, so he went to the bureau of registration in the State of Oregon and had his name changed; his name legally was Painless Parker and he continued to advertise under that. [Laughter.]

So, that is a little bit like this reminds me, "Paid Up at Age 65" is just the name of a policy.

Mr. WILLIAMS. But I do not think the companies have registered it with the bureau. [Laughter.]

Senator NEUBERGER. You do say in your booklet that many companies offer such coverage but how many different people are actually covered by—how many people reach age 65 and find their insurance is all paid and they do not have to pay anything more?

Mr. WILLIAMS. Senator, I do not know. That question was asked us earlier in the letter from the chairman. We just cannot get the information, because it is not kept that way in insurance company records. They do not keep these statistics——

Senator NEUBERGER. Then they do not buy it by this name, they do not buy it by the name, "Paid Up in Full at Age 65."

Mr. WILLIAMS. That is why I say it is more of a merchandising name rather than a formal name.

Senator NEUBERGER. Well, how many of these policies are in force right now, do you know that?

Mr. WILLIAMS. No, I do not, Senator.

Senator NEUBERGER. Or how many were sold in this last year?

Mr. WILLIAMS. I do not know.

Senator NEUBERGER. Well, one company that does advertise this is the Prudential. Are they still selling that policy, I wonder?

Mr. WILLIAMS. I do not know, and I think that they could better answer that than I could, because it is their policy.

Senator NEUBERGER. The information that we got is that they had stopped selling it and I wonder if anybody knew why they had stopped selling it?

Mr. WILLIAMS. I think that was their decision and I think they would be the ones who could perhaps supply that information to you.

Senator NEUBERGER. What is the purpose of your organization?

Mr. WILLIAMS. We are an information organization established by the insurance companies [laughter] but we do not have all the answers, Senator.

Senator NEUBERGER. Thank you.

Senator MCNAMARA. Thank you very much. Senator Fong, do you have any questions at this time?

Senator FONG. Mr. Williams, you stated that in 1961 there were 66 different companies and associations who are listed as providing guaranteed-for-life policies; that in 1962, you listed 15 more companies; and in 1963 this was increased by another 14 companies.

Now, this field of health insurance is quite a new field; is it not?

Mr. WILLIAMS. Yes; comparatively speaking, yes; it is.

Senator FONG. And this field for the aged as far as health insurance is concerned is very, very recent?

Mr. WILLIAMS. That is right, sir.

Senator FONG. With your knowledge of the business, naturally in your type of work, you are called upon to make projections into the future?

Mr. WILLIAMS. No; we are not. We do not try and project into the future. What we try and do, and we are a fairly new organization, Senator—what we try and do is develop what information we can obtain from various sources and make it available to many groups. But we do not go into the forecasting of——

Senator FONG. Is it not correct that an insurance company is always looking for different types of policies to present to the public?

Mr. WILLIAMS. Well, yes. Well, in one sense that is correct the way you state it. Another way might be that they are always trying to measure public needs and public attitudes and if they feel that another type of policy would be made available to the public and they would purchase it they certainly would construct a policy that could be sold.

In other words, they are trying to respond to public need and public desire.

Senator FONG. And this is a great public need?

Mr. WILLIAMS. That is right.

Senator FONG. And being a great public need like life insurance, naturally all of these companies will be interested?

Mr. WILLIAMS. Yes, sir.

Senator FONG. And there is going to be tremendous competition in this field; would you say that?

Mr. WILLIAMS. Yes; there is a lot of competition in this field, Senator. In our source book which I referred to, as of December 31, 1962, we list 170 companies who are writing 65-and-over policies.

That is a growth from 1958 of from 108, and there have been additions since that time.

Senator FONG. We can expect the insurance industry, whether it is Mutual, Blue Cross, or Blue Shield, or these stockholder companies, to do everything possible to see that almost every individual who can afford a policy buys one? That is the way you are urging the American citizen to buy insurance on his life?

Mr. WILLIAMS. Yes; I could not agree with you more.

I used to sell this insurance before I got into my present job, and this is the kind of insurance which strangely enough—people do not buy it, you have to sell it and you have great competition for other desires of the public.

Senator FONG. Then you can expect great progress to be made in this field——

Mr. WILLIAMS. Based on past performance, I would say yes.

Senator FONG. And that a great effort will be made for those over 65?

Mr. WILLIAMS. Yes, sir.

Senator FONG. I have no further questions.

Senator MCNAMARA. Thank you very much, Mr. Williams.

Mr. WILLIAMS. Thank you, Senator.

Senator MCNAMARA. The next witness is Mr. Morton D. Miller, president of the New York 65 Health Insurance Association.

STATEMENT OF MORTON D. MILLER, PRESIDENT, NEW YORK 65 HEALTH INSURANCE ASSOCIATION

Mr. MILLER. Mr. Chairman, my name is Morton D. Miller. I am president of the New York 65 Health Insurance Association and vice president and associate actuary of the Equitable Life Assurance Society of the United States.

I am here at the invitation of the chairman of the Subcommittee on Health of the Elderly to discuss the activities of the New York 65 Health Insurance Association, a group of 49 leading insurance companies which offers elderly residents of New York State health and hospital insurance in accordance with the provisions of law as enacted by the New York State Legislature.

You have a detailed statement from us and with your permission, I will proceed with the summary statement.

Senator MCNAMARA. If you will, because we recognize that the noon hour is here. We have some people here who are being very patient and we appreciate the cooperation. You go right ahead.

Mr. MILLER. Perhaps the most significant fact about the New York 65 Health Insurance Association is that it is doing its job. During the course of the past 18 months, it has succeeded in bringing low-cost health and hospital and major medical insurance to more than 120,000 elderly residents of New York State, many of whom might have had a large part of their savings wiped out by the cost of a serious or prolonged illness if they had not had this protection.

Since it began operation on October 15, 1962, New York 65 has paid over $15.6 million in benefits to some 32,000 policyholders and issued over 74,500 claim checks. About one out of every four policyholders has received some benefits from New York 65. Individual claim payments have ranged from a few dollars to more than $6,500.

The legislation which made New York 65 possible, passed unanimously by both houses of the New York State Legislature at the 1962 session, this legislation stated in part:

> It is the concern of the legislature that many residents of this State of advanced years do not have readily available to them health insurance adequate to their needs. It is the legislature's intent to encourage and facilitate the writing of such insurance by private insurers on a nonprofit group basis in order to make available to such persons broader coverage at lower rates than is possible on a regular commercial basis.

The basic health and hospital and the major medical plans offered by New York 65 have been made "readily available" as the legislature has directed. All qualified residents of the State—those 65 and over, and their spouses regardless of age—have been invited to enroll through extensive newspaper, consumer and trade magazines, television and radio advertising, and a supporting educational campaign. No physical examination is required. Any interested person may apply directly or by mail. Anyone, such as a son or daughter, is permitted to file an application for a parent or any other qualified person.

The legislature further authorized every agent and broker licensed to sell health insurance in New York State to sell our New York 65 protection. To assist these agents and brokers, New York 65 held meetings with them throughout the State, in advance of the public offering of New York 65 benefits, to familiarize them with its provisions. More than 25,000 agents and brokers have participated actively in enrolling the elderly in New York 65. These agents and brokers have given of their time and talents for only a nominal financial return because they believe in what New York 65 is trying to accomplish.

Other groups in the State have likewise cooperated in making information about the New York 65 program available to the public. These include agents and brokers' associations, the State medical society, nursing groups, hospital administrators, chambers of commerce, banks, and a variety of others.

The provisions of the New York 65 coverage offer a comprehensive and balanced package to meet hospital, medical, surgical, convalescent nursing home, and other costs connected not only with hospital confinements but also with illnesses at home. The rates have been set as low as possible in light of the broad coverages afforded. As earlier stated, no physical examination is required. Once insured, a person has the guaranteed right to continue his coverage. More complete details of the coverages are given in exhibits A–F (pp. 114–172).

Open enrollment periods were held in 1962 and 1963 and one is currently being conducted this month of April. In addition, special continuing enrollment opportunities are available to those who reach 65 or who retire after 65.

In considering the 120,000 elderly individuals currently covered under New York 65, it must be borne in mind that New York 65 is only one of the mechanisms for health insurance protection available to the elderly in New York State. Many older individuals who retired in recent years have been able to continue their health insurance without interruption. In addition, there are a wide variety of other health insurance plans which are available on an individual or group basis.

Nevertheless, we feel New York 65 has filled a hitherto unmet need as evidenced by the response received to the offering of our plan. The average age of those covered by New York 65 is nearly 74. In this connection, it is interesting to note that a recent check showed that 50 of those covered were 100 years old or over, and 1,966 of those covered were between the ages of 90 and 99.

New York 65 was designed for the group which does not need the kind of help that is already available under the Kerr-Mills program. This group, we believe, is made up of self-reliant people and their families who have paid their own way all their lives and wish to continue to do so. Just as they need liability insurance to protect against the financial impact of automobile accidents, they also need health and major medical insurance to guard against the crippling financial impact of the cost of serious illnesses. To them and their families it is a matter of personal pride, dignity, integrity, and independence, to finance the costs of such protection out of their own pockets.

New York 65, we believe, is still a developing program. We have been in operation for only 18 months. We are continuing with the help of our 49 member companies and with that of other elements of the insurance industry—nonmember companies and agents and brokers throughout the State, and other public-spirited groups—to bring information about the advantages of New York 65 protection to more of our senior citizens who stand to benefit from the plan. We are still learning and are continuing our efforts to find the most effective and economical methods of reaching and dealing with the elderly who need what New York 65 has to offer.

To sum up, New York 65 health insurance is a much-needed protection against the costs, which are often catastrophic, of serious illness or accidents that can destroy a lifetime's hard-earned savings in a matter of months. It is currently doing this for more than 120,000 people. In addition, it is helping to provide peace of mind and a feeling of greater security, which in themselves are powerful mental stimuli in keeping elderly persons strong and healthy.

New York 65 has carried out the mandate of the State legislature. It has made low-cost, broad-coverage health insurance, designed to meet the needs of the elderly, readily available to them.

Senator McNamara. Thank you very much.

This New York 65 plan is restricted only to the State of New York, or is it New York City?

What area do you cover?

Mr. Miller. We cover the whole of the State of New York, but there are similar plans, Senator, in other States. The first of these plans whom you will hear from later was established in Connecticut in 1961 and another plan was established in Massachusettts in 1962; in 1963 a plan was established in Texas; one has just been established in California; and another is underway in North Carolina and Virginia; and lastly, one is actively currently being planned for Ohio.

Senator McNamara. Your New York 65 plan covers doctor's expense as well as hospital expense?

Do you have a separate program available for people who wanted only hospital insurance?

Mr. Miller. We have tried, in setting up our New York 65 benefits, to have broad-benefit packages, and so both our basic coverage and

our major medical coverage include benefits for both hospital charges and for other charges.

Senator McNamara. You do not have separate plans for hospital only?

Mr. Miller. No, sir.

Senator McNamara. You refer to it as low cost and apparently you are quite proud of the fact that this is a low-cost plan. However, you indicate by the figures that you have submitted that it would cost a couple about $450 a year for this coverage. Do you still think that people in this retired group who have comparatively low income through social security and maybe other minor sources—do you find generally they can afford this plan?

Mr. Miller. There are two parts to our package, Senator, and deliberately so.

The basic part of our program costs $10 a month per person, and the major medical part costs $9 per person a month, and it is the two parts together which you have reference to. We were conscious of the fact that persons who are in advanced years have somewhat more limited income. It had been our purpose to design these packages separately so that those who felt that they could not afford the full amount of this protection would have a reasonably good basic health insurance policy available to them at the cost of $10 a month. And we felt that was well within range for quite a few of these older folks.

Senator McNamara. You still only reach 120,000 people. Is your rate of enrollees increasing or is it rather constant?

Mr. Miller. Well, to answer the first part of your question first.

On the 120,000, we are exceptionally well endowed in New York State with insurance companies and prepayment plans who offer plans to our citizens, and New York 65 is only 1 of the means by which they can secure coverage. There are well over 200 companies actively writing health insurance in the State through insurance agents. Among them are the largest, such as the company by which I am employed. In addition, we have seven Blue Cross and seven Blue Shield plans and a number of individual plans that operate besides those. So the number we cover must be viewed in relation to the proportion of the persons with coverage in the State and as an addition to those who have coverage through one of these other means, we believe that probably New York is ahead of the national average of 60 percent that has been referred to as a proportion of persons with coverage.

The second part of your question was to ask whether our enrollment was increasing or not, and I think it is. We have had these 3 enrollment periods, as I mentioned, and we presently insure 120,000, which is significantly more than what we began with at the end of the first enrollment period.

We also have plans for developing our marketing possibilities more fully. The State legislature this year extended our authority at our request to permit us to provide benefits for a retired person who might live in New Jersey, for example, and who had worked for a New York employer, or a person who was over 65 and working in New York and living out of the State.

We hope to use that as another means of developing our coverage further.

Senator McNAMARA. You indicated this plan had been in effect only about 18 months?

Mr. MILLER. That is right, sir.

Senator McNAMARA. Do you have any questions or comments, Senator Fong?

Senator FONG. Yes.

You have five plans here; is that right?

Mr. MILLER. That is right, sir.

Senator FONG. Under your basic plan, which costs $10 a month, or $120 a year, you will pay $18 a day up to 31 days; is that correct?

Mr. MILLER. For hospital room and board; that is right, sir.

Senator FONG. There is no deductible?

Mr. MILLER. There is no deductible.

Senator FONG. So, you are paying $558 if a man stays in the hospital for 31 days?

Mr. MILLER. That is right.

Senator FONG. You pay miscellaneous hospital charges of $150?

Mr. MILLER. That is right.

Senator FONG. Doctor's fees in hospital up to $145; $6 per day first week, $5 per day second week——

Mr. MILLER. That is just an elaboration of the $145. The $145 is the maximum that may be required for someone in 31 days and it is arrived at at $6 per day for the first week, $5 per day for the second week, and $4 per day thereafter.

Senator FONG. This refers to $145 doctor's fees?

Mr. MILLER. Yes.

Senator FONG. That is only for the payment of doctor's fees?

Mr. MILLER. For nonsurgical situations.

Senator FONG. Then for the convalescent nursing home, up to $7.50 a day, following at least 5 days' hospital confinement?

Then you have coverage here, surgery in or out of the hospital, and radiation therapy for malignancy, according to the schedule, up to $250.

Suppose a person needs all of the benefits that you give here; how much are you making available to him?

Mr. MILLER. Well, if you simply add up all of the maximum benefits you get something that is, I believe, in excess of $1,000.

Senator FONG. You gave that package for $120 a year; is that correct?

Mr. MILLER. That is correct, sir.

Senator FONG. With this package here, how much of the medical cost of the average person—say you had 120,000 people, it has been in operation for 18 months—what percentage of the medical costs would this take care of? Have you been able to figure that out?

Mr. MILLER. We designed our plans with the intention of, we hoped, being able to cover about 75 percent of the hospital costs within the limits of the benefits provided, and for the surgical charges we have incorporated into our benefits, and deliberately so, the Blue Shield schedules that were being used by the Blue Shield plans and honored by the doctors in the State for persons under $6,000 of income.

So, we hoped that in relation to the surgical and the other medical fees that our benefits would cover the major part of the load for those.

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I should add in the major medical plan where we add in other benefits like the cost of drugs and medicines and diagnostic X-ray examinations, and so forth, they are in the plan specifically at about an 80-percent level after the deductible is paid. So we were attempting to provide for persons whose incomes were under $6,000; something around three-quarters of their costs.

Senator FONG. Thank you.

You were trying to take care of those people who were making $6,000 a year or less?

Mr. MILLER. Primarily.

Senator FONG. Yes.

What would you say would be the minimum income of a person who could afford it?

Mr. MILLER. In answer to that question, I would say that we hoped—we were conscious, also, when we designed our plans, of the fact that our New York Kerr-Mills program is a very broad one and that the defined eligibility in terms of a family income at the time it was established of $2,600 a year. It has since been improved to extend that to $2,750 just this past year.

In addition, our New York program has a phasing-out aspect of the Kerr-Mills which I think is a very fine thing. A person whose income is just a little bit over the $2,600 or $2,750 does not fall out of Kerr-Mills, he simply has to take care of expenses to the extent that his income is in excess of the Kerr-Mills limit, so that, for example, if his income was $3,000, he would have to pay the first $250 before being eligible, and that arrangement is maintained as income increases.

We had hoped that our benefits, particularly the basic plan, would be attractive to folks who were below those Kerr-Mills limits as well as some that are above. We are also aware of the fact that many times a son or a daughter will seek to provide coverage for a parent or another relative and pay the premiums for them. It is one reason that we have made our coverage so easily available that any person can apply for coverage for someone else, and we have found, based on our records of other addresses, that at least a third of our coverage is provided by presumably a son or daughter on behalf of an older person.

So, I would say that we did not have in mind any minimum income and undoubtedly we insure quite a number of persons who do not have any income of their own.

Senator FONG. I see.

You said that you worked out this plan with Kerr-Mills in mind?

Mr. MILLER. We had in mind the Kerr-Mills limit.

Senator FONG. And that is up to $2,600.

Mr. MILLER. It is up to $2,750 now.

Senator FONG. So, this was primarily for those between $2,750 and $6,000?

Mr. MILLER. We still hoped there would be a substantial number under that who would choose to be insured. We do not have any information to substantiate that there are. But undoubtedly there are many.

Senator FONG. You have another package; catastrophic, which you give for $9 a month, $108 a year, and your maximum benefit for any confinement is $3,600?

Mr. MILLER. That is right.

Senator FONG. In selling these policies to 120,000 people, could you tell us what percentage took the basic and what percentage took the catastrophic?

Mr. MILLER. Yes, sir, based on the persons we now insure, 38 percent have the basic alone, and 38 percent have the catastrophic, many of them as an addition to other insurance that they have; and 24 percent have both plans with us.

Senator FONG. Thank you.

Senator McNAMARA. Thank you very much, sir.

The discussion you just had with Senator Fong indicates that there seems to be sort of general agreement that 75 percent of the cost of hospitalization is considered adequate?

Do you feel that is a true statement?

Mr. MILLER. Well, that is what we aimed to do in establishing our plans; we were trying to provide benefits at approximately a three-quarters level, covering a broad spectrum of benefits; we did find that a sample of our claims showed that we were actually paying out $31.43 per diem of hospital costs against indicated hospital charges of about $40.

In other words, we were paying about 78 percent.

Senator McNAMARA. Thank you very much, sir.

STATEMENT BY MORTON D. MILLER, PRESIDENT OF THE NEW YORK 65 HEALTH INSURANCE ASSOCIATION

My name is Morton D. Miller.

I am president of the New York 65 Health Insurance Association, and vice president and associate actuary of the Equitable Life Assurance Society of the United States.

I am here at the invitation of the chairman of the Subcommittee on Health of the Elderly to discuss the activities of the New York 65 Health Insurance Association, a group of 49 leading insurance companies which offers elderly residents of New York State health and hospital insurance in accordance with the provisions of law as enacted by the New York State Legislature.

Perhaps the most significant fact about the New York 65 Health Insurance Association is that it is doing its job. During the course of the past 18 months, it has succeeded in bringing low-cost health and hospital and major medical insurance to more than 120,000 elderly New York State residents, many of whom might have had a large part of their savings wiped out by the costs of a serious or prolonged illness if they had not had this protection.

Since it began operations on October 15, 1962, the New York 65 Health Insurance Association has paid over $15.6 million in benefits to some 32,000 policyholders and issued more than 74,500 claim checks. About one out of every four policyholders has received some benefits. Individual claims have ranged from a few dollars to more than $6,500.

ENABLING LEGISLATION

The legislation which made New York 65 possible (exhibit A), passed unanimously by both houses of the New York State Legislature, at its 1962 session, stated: "It is the concern of the legislature that many residents of this State of advanced years do not have readily available to them health insurance adequate to their needs. It is the legislature's intent to encourage and facilitate the writing of such insurance by private insurers on a nonprofit group basis in order to make available to such persons broader coverage at lower rates than is possible on a regular commercial basis."

The legislation specified that the association of insurance companies shall file with the superintendent of insurance "(1) its plan for offering, selling, issuing and administering health insurance which plan shall be subject to his approval as conforming to the purpose and requirements of this section, and (2) any

policy, contract, certificate or other evidence of insurance, application or other forms pertaining to such insurance together with the premium rates to be charged therefore. No such policy, contract, certificate or other evidence of insurance, application or other form shall be sold, issued, or used; and no endorsement shall be attached to, or printed or stamped thereon, unless the form thereof and the premium rates to be charged therefor shall have been approved by the superintendent."

The legislation also provided "that the excess, if any, of premiums received by it (the association) from insureds over the cost of providing such insurance benefits shall be used solely for the benefit of the insureds." Furthermore, in order to reduce the cost of the insurance, New York 65 premiums were exempt from the New York State premium tax.

FORMATION OF NEW YORK 65

As soon as the legislation had been signed by the Governor in March 1962, a group of New York domiciled insurance companies started to make plans for implementing the legislation. A steering committee was formed and held frequent meetings. By August 9, articles of association were signed by seven companies. All other life and casualty companies licensed to sell health insurance in New York State were invited to participate. A total of 49 joined (exhibit B). The member companies made available necessary initial financing and the actuarial assistance, legal counsel, sales and promotion guidance, claims and procedural programing and executive direction essential for the development of the program. These were volunteered as a public service contribution by the participating companies.

As directed by the legislature, basic health and hospital insurance and major medical insurance were offered by New York 65.

The plans were designed to offer a balanced package of benefits toward the costs of hospital confinement and medical services both in hospitals and convalescent nursing homes and slewhere, even at home.

BASIC PLAN

The regular basic plan provides at a monthly premium of $10 per person.

Benefits for up to 31 days for:

Hospital room and board up to $18 a day;

Miscellaneous hospital charges up to $150;

Doctor's fees in hospital (nonsurgical) up to $145, $6 per day first week; $5 per day, second week; $4 per day thereafter;

Convalescent nursing home charges for 31 days up to $7.50 a day following at least 5 days of hospital confinement; and

Plus surgery, in or out of a hospital, and radiation therapy for malignancy according to a schedule, up to $250.

The same plan was also made available on an optional basis with hospital room-and-board benefits limited to $12 per day and all other benefits the same at a reduced cost of $8 per month per person. Less than 2 percent of those who enrolled in New York 65 availed themselves of this optional plan.

MAJOR MEDICAL PLAN

The New York 65 major medical which costs $9 per month per person has two parts:

The first part pays benefits for hospital and convalescent nursing home care with a maximum of $3,600 for any one confinement.

The second part provides benefits for other medical expenses up to a maximum lifetime benefit of $10,000.

The first part of major medical provides benefits for:

Hospital room and board up to $18 a day after the first 31 days of confinement;

Other hospital services and supplies at 80 percent of the amount by which expenses exceed $150; and

Convalescent nursing home benefits up to $7.50 per day for maximum of 60 days following at least 5 days of hospital confinement.

These benefits were planned so that after the insured had been out of a hospital or convalescent nursing home for 90 days he is entitled to a new maximum benefit of $3,600 for any future confinement.

The second part of New York 65 major medical provides benefits at 80 percent of the amount by which expenses exceed $75 in a calendar year up to a maximum lifetime benefit of $10,000 as listed below:

Doctor's medical and surgical services for home, office, or inhospital care—with the maximum expense equal to the excess of: the established Blue Shield fees in the insured's community for families with maximum yearly income of $6,000 over the benefits payable under other plans for these services;

Private-duty nursing services by registered professional nurses, registered visiting nurses, or licensed practical nurses, not in excess of charges of $1,000 in any calendar year;

Drugs and medicines which require a doctor's prescription;

Diagnostic X-ray and laboratory examination and outpatient diagnostic services;

Physiotherapy; artificial limbs and eyes; trusses and crutches;

Anesthetics;

Oxygen and rental of equipment for its administration;

Rental of radium and radioactive isotopes;

Blood and blood plasma;

Rental of a wheelchair, hospital-type bed, iron lung, or other equipment for the treatment of respiratory paralysis; and

Local ambulance service to or from a hospital or convalescent nursing home.

The New York 65 major medical is designed to supplement New York 65 basic or similar coverage. If the insured does not have New York 65 basic coverage he should be prepared to meet the equivalent of New York 65 basic benefits out of his own pocket.

Further details are included in the promotional folder for the current April 1–30 open enrollment period (exhibit C) and the certificate booklet for the combined basic and major medical plan (exhibit D).

EXCLUSIONS AND LIMITATIONS

Preexisting conditions for which treatment or diagnosis had been received during the 90 days before New York 65 coverage became effective, are not covered during the first 6 months. Confinement in a hospital or convalescent nursing home on or during the 31 days prior to the effective date of New York 65 coverage means that protection would not begin until 31 days after the end of the confinement.

Other principal exclusions are: injuries and diseases covered by workmen's compensation; care for mental and nervous conditions outside a hospital; dental care; eye examinations and glasses; hearing aids; diseases or injuries arising out of any war; expenses for services and supplies furnished without charge by any government; expenses which there would have been no legal obligation to pay if no insurance was available. Payments for New York 65 benefits are nonduplicating with benefits paid under any other health insurance plans which the enrollee might have.

To allow those who enroll to study the plan and make sure that it meets their needs a special 10-day "free look" provision is included. This means that the enrollee has 10 days after he receives his certificate booklet to examine and study it and, if he is not satisfied, he can return it and get his money refunded in full.

STEPS TAKEN TO MAKE NEW YORK 65 READILY AVAILABLE

Any New York State resident 65 years old or over and his spouse, regardless of age, is eligible to enroll during open enrollment periods. No physical examination or medical history is required. Any interested person may obtain New York 65 protection through his agent or broker or directly by mail. Anyone, such as a son or daughter, is permitted to file an application and pay the premium for a parent or any other qualified person. As a matter of interest, pre-

miums on approximately one-third of the policies are being paid by persons other than the insureds.

The legislature had authorized every agent and broker licensed to sell health insurance in the State to offer New York 65 to the public. To assist agents and brokers, New York 65 held meetings with them throughout the State, in advance of the public offering of New York 65, to familiarize them with its provisions. More than 25,000 agents and brokers have participated and are continuing to participate actively in enrolling the elderly in New York 65. These agents and brokers have given, and are continuing to give, of their time and talents for only a nominal financial return because they believe in what New York 65 is trying to accomplish.

To make New York 65 protection readily available a statewide advertising campaign was undertaken through newspapers, consumer and trade magazines, television, and radio. This was supported by an educational program which sent information about the plan to news media, doctors, nurses, hospital administrators, chambers of commerce, and other organized groups. Direct mailings were undertaken to lists of prospects and other interested persons.

OPEN ENROLLMENTS

In order to afford all eligible persons the opportunity of getting New York 65 coverage and to protect the plan and the persons insured under it from adverse antiselection, and at the same time to enable us to concentrate our sales and promotion efforts, open enrollments are held periodically.

The first open enrollment period was set for October 15 to November 15, 1962, and 107,404 applications were received. Of these, 39,739, or 37 percent, selected the basic plan alone; 41,888, or 39 percent, selected the major medical plan alone, and 25,777, or 24 percent chose the combination of both plans.

A second open enrollment period was held from June 1 to 15, 1963. During this period, 33,552 applications were received and 702 persons who already had some coverage with New York 65 took this opportunity to add additional coverage. The results of the second enrollment showed that 40 percent chose the basic plan; 36 percent the major medical; and 24 percent a combination of both plans.

At the present time, during the month of April, New York 65 is conducting its third open enrollment. To capitalize on previous advertising and promotional efforts and because New York 65 has become better known throughout the State, this enrollment campaign is being conducted without public advertising. We are working with the wholehearted support of the State's agents and brokers who, in previous enrollments, have been responsible for the majority of the applications. Our ability to enroll substantial numbers on this basis has the added advantage of keeping enrollment costs to a minimum. As of April 23, 1964, over 12,000 applications have already been received.

SPECIAL ENROLLMENT OPPORTUNITIES

New York 65 provides special enrollment opportunities for those who become eligible for New York 65 protection between open enrollment periods. These include persons who reach their 65th birthdays, those who retire after 65, those over 65 who move into New York State, those who marry an over 65 enrollee and those over 65 who become widowed. Such individuals may join New York 65 within 31 days of their eligibility date (Exhibit E "Special Enrollment Opportunities in New York 65").

CONTINUATION OF COVERAGE

Every person insured for New York 65 coverage has a guaranteed right to continue his insurance by timely payment of premiums. He can keep his New York 65 protection even if he moves out of the State, provided he continues to live in the United States or Canada.

The total number of persons who actually became insured under New York 65 from its inception to March 1, 1964, was 134,679. Of this number, 110,135 were still insured as of March 1, 1964.

The average age of enrollees during the first enrollment period was 73.5 and during the second enrollment the average age was 73.3. In considering withdrawals from New York 65 it should be borne in mind that in this advanced age group death alone is an important cause of terminations. We estimate that deaths are responsible for about one-half of the terminations. In connection with the ages of the insureds it is interesting to note that the oldest enrollee, who has since passed away, was 106. A recent check showed that 50 of those enrolled were 100 years old or over and 1,966 were between the ages of 90 and 99.

New York 65 reserves the right to modify or discontinue the New York 65 program. The coverage of an individual cannot be modified or canceled, nor can his premiums be increased unless similar action is taken for all persons enrolled for the same plan.

ADEQUACY OF COVERAGE

New York 65 desired to provide a reasonable level of benefits in respect to each type of services, and planned to reimburse about 75 percent of the expenses incurred by elderly persons of some means. In designing New York 65 protection we undertook to provide broad coverage in the scope of the medical services covered and in the amount of benefits provided for each type of service. Thus we offered benefits for hospital charges, convalescent nursing home charges, physicians charges in hospital and office, and a wide range of other services and expenses.

A measure of how New York 65 has worked out is given by a study made of 2,440 claims involving hospital charges where the insureds had both basic and major medical protection. The benefits for the expenses of hospital confinement are a daily allowance of $18 for room and board supplemented by a benefit for other hospital charges. This study showed that the average daily charge for hospital room and board and other hospital services was $40.44 and that New York 65 paid an average of $31.43. Thus New York 65 paid 78 percent of the total of the daily hospital costs.

New York 65's surgical and inhospital medical allowances were based upon the prevailing Blue Shield schedules used in different areas of the State for families with incomes of less than $6,000 annually. It was anticipated that in the great majority of cases such allowances would cover the major part of the charges of the services since most of the elderly insured under the plan are in this income group.

The allowance toward the cost of other medical services, including such items as drugs and medicines, private duty nursing, X-ray and laboratory fees, blood and blood plasma, oxygen, etc., is approximately 80 percent of such charges that are inexcess of the deductible. All of these allowances under New York 65 are, of course, subject to the overall maximum specified in the plan.

PROGRAM STILL DEVELOPING

New York 65 is still a developing program. We have been in operation for only 18 months. We are continuing with the help of our member companies and with that of other elements of the insurance industry—nonmember companies and agents and brokers throughout the State and other public spirited groups—to bring information about the advantages of New York 65 protection to more of our senior citizens who stand to benefit from the plan. We are still learning and continuing our efforts to find the most effective and economical methods of reaching and dealing with the elderly who need what New York 65 has to offer.

We are seeking to expand our program to extend our coverage. A bill passed in the current 1964 session of the New York State Legislature and signed by the Governor, empowers New York 65 to insure groups of over 65 employees even though they may not be New York State residents provided their place of employment is within the State. It also makes New York 65 protection available to those over 65 who have already retired and may reside outside the State provided that at retirement they were employed in New York State.

It was also found that in the cases of some insureds who had only Blue Cross but no Blue Shield surgical and inhospital medical protection, New York 65 major medical left gaps in their coverage since it assumes that the insured has

some kind of basic hospital and surgical protection and deducts the equivalent of New York 65 basic from major medical benefits. A special new plan to bridge this gap is now being planned which will provide for more complete coverage.

LEVEL OF PREMIUMS

With a legislative mandate to produce costs under the level of commercial insurance, and as low as possible considering the broad benefits offered, New York 65 has charged premiums which contain very narrow margins for expenses and contingencies.

The question has been asked whether any premium changes are anticipated, or will be required during the next 2 years.

It is difficult at this time to answer this question. Our original projections on which our current premium rates are based were made for 2 years. So far we have been running somewhat ahead of our estimates as far as payments of benefits are concerned.

We are presently conducting our third open enrollment during the month of April and at this time we do not know what the final results will be in terms of numbers of new enrollees and in terms of additional premium income.

Our original projections indicated that if medical and hospital costs continue to increase at the same rates as they had for the previous 2 years, it seemed likely that some upward adjustments in the premium rates would have to be made at the end of the second year or reasonably soon thereafter. So far, medical and hospital rates have continued to increase at rates similar to those of the 2 previous years.

With the unknown of additional premium income due to new enrollments, which exclude benefit payments for preexisting conditions for 6 months, it is difficult for us to come to definite conclusions concerning future premium rates at this time.

All other indicators, however, point to the need for modest increase within the next 2 years unless our current claims demands change from their present pattern.

CONCLUSION

In considering the 120,000 elderly individuals currently covered under New York 65, it should be borne in mind that New York 65 is only one of the mechanisms for health insurance protection available to elderly New York State residents. Many older individuals who retired in recent years have been able to continue their health insurance without interruption. In addition, there are a wide variety of other health insurance plans that are available on an individiual or group basis. In fact, at the time New York 65 became available many thousands of New York State senior citizens already had health insurance protection. New York 65 filled the gap for those elderly persons not then insured, many of whom were at very advanced ages.

New York 65 was designed for elderly persons and their families who wish to and are able to pay their own way. Just as they need liability insurance to protect against the financial impact of automobile accidents, they need health and major medical insurance to guard their nest eggs against the crippling financial impact of the cost of serious illness. To them and their families, it is a matter of personal pride, dignity, integrity and independence, to finance the costs of such protection out of their own pockets.

To sum up, New York 65 health insurance provides much-needed protection against the costs, often catastrophic, of serious illness or accidents that can destroy a lifetime's hard-earned savings in a matter of months. It is currently doing this for 120,000 people. In addition, it is helping to provide peace of mind and a feeling of greater security, which in themselves are powerful mental stimuli in keeping elderly citizens strong and healthy.

New York 65 has carried out the mandate of the New York State Legislature. It has made low-cost, broad coverage health insurance, designed to meet the needs of the elderly, readily available to them.

JUNE 29, 1964.

Hon. HIRAM L. FONG,
U.S. Senator from Hawaii,
Senate Office Building, Washington, D.C.

DEAR SENATOR FONG: During the recent McNamara subcommittee hearings, I promised that our actuaries would work out the estimated costs for the King-Anderson bill as that bill was presented to the Senate.

Basing our calculations for S. 880 on our experience, we also considered the following factors:

(*a*) The eligible exposures in 1966 provided by the Division of the Actuary, HEW.

(*b*) The projected average per diem hospital charge in 1966 of $44.75.

(*c*) The hospital frequencies and average stays experienced under Mutual of Omaha's senior security policies (4HSO series) during 1962 under its first five enrollments (enrollments from April 1959 through February 1961).

(*d*) The assumed distribution by option of 70 percent under the 45-day plan, 10 percent under the 90-day plan, and 20 percent under the 180-day plan. Our calculations show that both the 45- and 180-day plans are worth 4 percent more than the 90-day plan.

(*e*) Estimated costs by the Health Insurance Association of America for the outpatient hospital diagnostic, home visit, and nursing home benefits were used, since we have no comparable experience in these areas.

	Per exposure per year
1. Outpatient hospital diagnostic	$4
2. Home visits	6
3. Nursing home	7

Based on the above, the following 1966 statistics are produced:

Age	1966 eligibles [1]	Annual hospital frequency	Average benefit	Annual cost per eligible	Total annual cost [1]
65–69	6.0	0.311	$581.83	$180.95	$1,085.70
70–74	4.4	.308	608.24	187.34	824.30
75–79	3.0	.330	636.43	210.02	630.06
80–	2.1	.361	682.97	246.55	517.76
Total	15.5			197.28	3,057.82

[1] In millions.

Therefore, based on Mutual of Omaha's senior security costs for the hospital benefits and the HIAA estimates for the other benefits, the cost in 1966 per eligible is $214, which is broken down as follows:

Benefit	*Annual cost per eligible*
Inpatient hospital	$197
Outpatient	4
Home visits	6
Nursing home	7
Total	214

For the 15.5 million OASDI eligibles in 1966, this would produce a total claim cost for 1966 of $3,317 million. Costs of administering such a program are not included in this estimate.

It should be noted that, while 1962 costs were requested, we did not have eligible data for that year. Therefore, we based our calculations on 1966 eligibles and per diem cost levels combined with frequencies and average length of stay experienced in 1962. We will be happy to make other calculations if furnished with 1962 eligibles.

Sincerely yours,

A. M. HANSEN, *Vice President.*

EXHIBIT A

Copy of New York 65 Enabling Legislation

NEW INSURANCE LAWS SERVICE

NEW YORK

Laws 1962

Chapter 236

(A. Int. 4871)

Effective March 27, 1962

AN ACT TO AMEND THE INSURANCE LAW AND THE TAX LAW, IN RELATION TO AUTHORIZING JOINT ACTION BY INSURANCE COMPANIES IN UNDERWRITING GROUP HEALTH INSURANCE FOR PERSONS SIXTY-FIVE YEARS OF AGE AND OVER

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The insurance law is hereby amended by adding thereto a new section, to be section two hundred twenty-one-a, to read as follows:

§ 221-a. Joint underwriting of group health insurance for persons aged sixty-five and over. 1. It is the concern of the legislature that many residents of this state of advanced years do not have readily available to them health insurance adequate to their needs. It is the legislature's intent to encourage and facilitate the writing of such insurance by private insurers on a non-profit group basis in order to make available to such persons broader coverage at lower rates than is possible on a regular commercial basis. It is, therefore, the purpose of the legislature to authorize and regulate, in the public interest, cooperative action among such insurers in the preparation and issuance of policies of health insurance, the making of rates to be charged therefor and other matters within the scope of this section.

☞ EXPLANATION—*Italics* is new, [bracketed matter] is law repealed.

2. Wherever used in this section, the following terms shall have the respective meanings hereinafter set forth or indicated, unless the context otherwise requires:

"Association" means a voluntary unincorporated non-profit association formed for the sole purpose of enabling cooperative action to provide health insurance in accordance with this section.

"Health insurance" means hospital, surgical and medical expense insurance, provided by a group health insurance policy or contract issued in accordance with this section.

"Insurer" means any insurance company authorized to do the business of accident and health insurance in this state.

"Insured" means a person covered under a group policy or contract issued pursuant to this section.

3. Notwithstanding any other provision of this chapter or of any other law which may be inconsistent herewith, any insurer may join with one or more other insurers, on a uniform basis with respect to premium rates, policy provisions, commissions and other matters within the scope of this section, to offer, sell and issue to a policyholder group health insurance covering residents of this state who are sixty-five years of age or older and the spouses of such residents. Such insurance may be offered, issued and administered jointly by two or more such insurers through an association formed by such insurers solely for the purpose of offering, selling, issuing and administering such insurance in accordance with this section. Membership in such association shall be open to any insurer.

4. Such association shall offer health insurance coverage to all residents of this state who are sixty-five years of age or over and their spouses, subject to reasonable underwriting restrictions to be set forth in the plan of the association. Such coverage may consist of one or more of the following types: (i) basic hospital and surgical coverage, (ii) basic medical coverage, (iii) major medical coverage, and any combination of those types; provided, however, that if coverage of the first or second type is offered, it shall not be required as a condition of obtaining same that coverage of the third type also be obtained.

5. Such association shall file with the superintendent (1) its plan for offering, selling, issuing and administering health insurance which plan shall be subject to his approval as conforming to the purpose and requirements of this section and (2) any policy, contract, certificate or other evidence of insurance, application or other forms pertaining to such insurance together with the premium rates to be charged therefor. No such policy, contract, certificate or other evidence of insurance, application or other form shall be sold, issued or used and no endorsement shall be attached to or printed or stamped thereon unless the form thereof and the premium rates to be charged therefor shall have been approved by the superintendent. The superintendent shall, within a reasonable time after the filing of any such premium rates, policies, contracts, endorsements, applications or other forms, notify the association filing the same of his approval or disapproval thereof. The superintendent may disapprove such premium rates if he finds them to be unfairly discriminatory or unreasonable in relation to the benefits provided and he may disapprove such policies, contracts, certificates, applications, endorsements or other forms if in his judgment they contain provisions which he finds to be unjust, unfair, inequitable, misleading, deceptive, prejudicial to the insured or otherwise contrary to law or to the public policy of this state. The superintendent may, after notice and hearing, withdraw an approval previously given, if (1) the use thereof is contrary to the legal requirements applicable thereto at the time of such withdrawal, (2) the premiums are unfairly discriminatory or unreasonable in relation to the benefits provided or (3) in his judgment they contain provisions which are, or the continued use thereof would be, unjust, unfair, inequitable, misleading, deceptive, prejudicial to the insured or otherwise contrary to law or to the public policy of this state. Any such withdrawal of approval shall be effective at the expiration of such period, not less than ninety days after the giving of notice of withdrawal, as the superintendent shall in such notice prescribe. In exercising the powers conferred upon him by this subsection the superintendent shall not be bound by any other requirement of this chapter with respect to standard provisions to be included in accident and health policies or forms. The action of the superintendent in disapproving

any such forms or rates or withdrawing approval as provided in this subsection shall be subject to judicial review. The name of such association or any advertising and other promotional and solicitation material used in connection with health insurance offered, sold or delivered pursuant to this section shall not be such as to mislead or deceive the public.

6. Such association may solicit the sale of such health insurance through any insurance agent licensed pursuant to section one hundred thirteen of this chapter and any insurance broker licensed pursuant to section one hundred nineteen of this chapter. It shall not pay to such agent or broker or any other person any commission, compensation or other fee or allowance not in accordance with a schedule thereof which shall have been filed by it with and approved by the superintendent. Except as aforesaid, it shall not pay any commission, compensation, fee or allowance to any person but it may pay a salary or compensation to persons regularly employed by it.

7. Such association shall file annually with the superintendent, on such date and in such form as he may prescribe, a statement with respect to its operations.

8. Notwithstanding any other provision of this chapter, an association may offer, sell, issue or administer such a group policy or contract of health insurance on a non-participating basis, provided, however, that the excess, if any, of premiums received by it from insureds over the cost of providing such insurance benefits shall be used solely for the benefit of the insureds.

9. Premiums for policies issued pursuant to this section shall not be included in "premiums" for purposes of section five hundred fifty-two[1] of this chapter and section one hundred eighty-seven[2] of

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[1]Section 552 of the Insurance Law imposes premium taxes on foreign and alien casualty and fire insurers, and alien life insurers.

[2]Section 187 of the Tax Law imposes premium taxes on domestic insurers, on foreign life and casualty insurers, and on alien fire insurers.

the tax law, nor shall section sixty-one[3] *of this chapter be construed as subjecting the premiums for such policies to taxation.*

Sec. 2. Subsection five of section five hundred fifty-two of such law, as renumbered by chapter three hundred seventy-four of the laws of nineteen hundred sixty-one, is hereby amended to read as follows:

5. Subject to the provisions of section five hundred fifty, in ascertaining the amount of direct premiums upon which a tax is payable under this section, there shall be first determined the amount of total gross premiums, less return premiums thereon, charged during such preceding calendar year for business effected at any time on all policies, certificates, renewals and policies subsequently canceled, which were executed, issued or delivered during such preceding and all prior calendar years on property or risks located or resident in this state, including premiums for reinsurance assumed, to the extent that the same covers property or risks located or resident in this state.

The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section two hundred twenty-one-a of this chapter.

The term "return premiums thereon," as used in this section, shall include return premiums paid or credited during the taxable year where the original gross premiums or adjustments thereof shall have been concurrently or previously reported under this section or under chapter twenty-eight of the consolidated laws, as amended.

Sec. 3. Subdivision five of section one hundred eighty-seven of the tax law, as last amended by chapter four hundred ninety-eight of the laws of nineteen hundred forty, is hereby amended to read as follows:

5. In ascertaining the amount of direct premiums upon which a tax is payable under this section there shall be first determined the

[3]Section 61 of the Insurance Law imposes retaliatory taxes.

amount of total gross premiums or deposit premiums or assessments, less returns thereon, on all policies, certificates, renewals, policies subsequently cancelled, insurance and reinsurance executed, issued or delivered on property or risks located or resident in this state, including premiums for reinsurance assumed, and also including premiums written, procured or received in this state on business which cannot specifically be allocated or apportioned and reported as taxable premiums on business of any other state or states. The reporting of premiums for the purpose of the tax imposed by this section shall be on a written basis or on a paid-for basis, consistent with the basis required by the annual statement filed with the state superintendent of insurance pursuant to section twenty-six of the insurance law.

The term "gross direct premiums," as used in this section, shall not include premiums for policies issued pursuant to section two hundred twenty-one-a of this chapter.

After determining the amount of total gross premiums, less returns thereon, as hereinbefore provided, there shall be deducted the following items:

(a) Such premiums, less return premiums thereon, which have been received by way of reinsurances from corporations or other insurers authorized to transact business in this state;

(b) Dividends on such direct business, including unused or unabsorbed portions of premium deposits paid or credited to policyholders, but not including deferred dividends paid in cash to policyholders on maturing policies, nor cash surrender values.

Sec. 4. This act shall take effect immediately.

Approved March 27, 1962.

EXHIBIT B

List of the 49 Member Companies and Home Office Location of the New York 65 Health Insurance Association

Aetna Life Affiliated Cos., Hartford, Conn.
Allstate Insurance Co., Skokie, Ill.
American Casualty Group, Reading, Pa.
American Mutual Liability Insurance Co., Wakefield, Mass.
American Progressive Health Insurance Co. of New York, Mount Vernon N.Y.
Bankers Life Co., Des Moines, Iowa.
Beneficial Fire & Casualty Insurance Co., Los Angeles, Calif.
Citizens Life Insurance Co., New York, N.Y.
Consolidated Mutual Insurance Co., Brooklyn, N.Y.
Commercial Travelers Mutual Accident Association, Utica, N.Y.
Empire State Mutual Life Insurance Co., Jamestown, N.Y.
Equitable Life Assurance Society of the United States, New York, N.Y.
Farmers and Traders Life Insurance Co., Syracuse, N.Y.
Federal Life and Casualty Co., Battle Creek, Mich.
Fidelity and Casualty Co. of New York, New York, N.Y.
Great American Insurance Co., New York, N.Y.
Guardian Life Insurance Co., of America, New York, N.Y.
Hanover Insurance Co., New York, N.Y.
Hartford Group:
Hartford Life Insurance Co., Boston, Mass.
Hartford Accident and Indemnity Co., Hartford, Conn.
Home Life Insurance Co., New York, N.Y.
International Life Insurance Co. of Buffalo, Buffalo, N.Y.
John Hancock Mutual Life Insurance Co., Boston, Mass.
Liberty Mutual Insurance Co., Boston, Mass.
Lincoln National Life Insurance Co. of New York, New York, N.Y.
Lumbermens Mutual Casualty Co., Chicago, Ill.
Massachusetts Mutual Life Insurance Co., Springfield, Mass.
Metropolitan Life Insurance Co., New York, N.Y.
Mutual of New York, New York, N.Y.
National Casualty Co., Detroit, Mich.
Nationwide Mutual Insurance Co., Columbus, Ohio
New England Mutual Life Insurance Co., Boston, Mass.
New York Life Insurance Co., New York, N.Y.
Northeastern Life Insurance Co. of New York., New York, N.Y.
Old Republic Life Insurance Co., Chicago, Ill.
Paul Revere Life Insurance Co., Worcester, Mass.
Penn Mutual Life Insurance Co., Philadelphia, Pa.
Phoenix of London Group, New York, N.Y.
Provident Life and Casualty Insurance Co., Chattanooga, Tenn.
Provident Mutual Life Insurance Co of Philadelphia, Philadelphia, Pa.
St. Paul Insurance Cos., St. Paul, Minn.
Security Mutual Life Insurance Co. of New York, Binghamton, N.Y.
Springfield-Monarch Insurance Co., Springfield, Mass.
Standard Security Life Insurance So. of New York, New York, N.Y.
State Mutual Life Assurance Co. of America, Worcester, Mass.
The Travelers Insurance Co., Hartford, Conn.
Union Labor Life Insurance Co., New York, N.Y.
Union Mutual Life Insurance Co., Portland, Maine.
Unity Mutual Life Insurance Co. of New York, Syracuse, N.Y.

EXHIBIT C

Promotional Folder and Application Form for Apr. 1–30, 1964, Open Enrollment

NO MEDICAL EXAM REQUIRED!

LOW-COST

BASIC and

MAJOR MEDICAL

HEALTH INSURANCE BENEFITS

FOR

New York State
Residents 65 and Over

OPEN ENROLLMENT

APRIL 1 — APRIL 30, 1964

33–420 O—64—pt. 2——5

This New, Low-Cost Insurance Plan Could Save You Thousands of Dollars In Doctor, Surgical and Hospital Bills

Here's your chance to take advantage of the unique health insurance provided by New York 65 — the new, low-cost program for people over 65, offered as a public service by a non-profit Association of 49 leading insurance companies serving New York State.

New York 65 provides Basic hospital-surgical-medical benefits, and under a separate Major Medical plan offers broad benefits beyond basic coverage to give vital protection against the expenses of prolonged illness or serious accident. Either of these plans may be obtained separately, or in combination.

As you'll see below, New York 65 has brought individuals over 65 (or their sons and daughters) substantial protection against doctor and surgical bills and hospital and convalescent nursing home charges. In total, through the end of 1963, the Plan has issued almost 50,000 claim payment checks for more than $10 million to some 24,000 beneficiaries.

This folder outlines the principal benefits of New York 65. Please read it carefully. *Then see your Agent or Broker for full details and help in enrolling. There is no additional charge for his services.*

Every Day Brings Letters Like These From Grateful Participants in New York 65

Here are excerpts from letters received by New York 65 from people who have participated in the Plan's benefits. They are entirely unsolicited, and give most eloquent testimony to the critical need now fulfilled by New York 65.

"A million thanks for the financial aid you have rendered through these trying months and we shall ever be grateful to the wonderful New York 65 Plan." S.M.

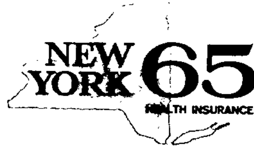
"This insurance has been the most fabulous insurance policy I have ever heard of. Since my mother had no income & I was responsible for payment, this insurance has kept me out of the poor house. I do not know how I would have ever made all the hospital & doctor bill payments by myself, since I have a family of my own." O.J.D.

"Thank you very kindly for your prompt and thoughtful consideration of this claim. I have nothing but the greatest praise for your service and will without reservation recommend New York 65."

P.N., M.D.

"The benefits we received under New York 65 were a great help to us during my mother's illness. We would not have been able to do without New York 65." J.E.

"While this coverage has been indeed, a great help at a difficult time, it served a far greater need,— the sense of security and peace of mind that it gave mother when we told her about it as she lay in her hospital bed, concerned about things which she shouldn't have been even thinking about." B.A.F.



These special features highlight New York 65 benefits

- No medical examination.
- The husband or wife (regardless of age) of an enrollee may enroll in New York 65 at the same time.
- Sons and daughters may enroll their eligible parents without requiring them to sign the application. In fact, anybody may enroll any eligible person.
- New York 65 Major Medical is especially important for sons and daughters. Catastrophic major medical expenses could fall upon them disastrously even though their parents may already have basic hospital or medical coverage.
- The Major Medical plan pays benefits for hospital or convalescent nursing home charges up to $3600 for each confinement . . . and in addition pays lifetime benefits up to $10,000 for doctor bills and many other medical expenses.
- You can keep New York 65 if you move out of the State and continue to live in the U.S. or Canada.
- You have 10 days after receiving your Certificate Booklet to decide whether you are satisfied with New York 65. If not, you may return the booklet and your money will be refunded in full.
- The Association may modify or discontinue the New York 65 Program, but your coverage cannot be modified or cancelled, nor your premiums increased, unless similar action is taken for all persons enrolled for the same plan.

HOW NEW YORK 65 WORKS — HOW THE MAJOR MEDICAL PLAN EXPANDS BASIC PROTECTION TO HELP PAY REALLY BIG MEDICAL BILLS

New York 65 Major Medical provides health insurance against the big medical and hospital bills incurred by a serious accident or illness—bills above and beyond those normally covered by basic hospital-surgical-medical plans. It's offered as a vital addition to any basic plan.*

This is how the Major Medical works, assuming you have New York 65 Regular Basic:

After the Basic has paid room and board benefits for the first 31 days, New York 65 Major Medical picks up and extends this benefit. After benefits for miscellaneous hospital charges up to $150 have been paid by the Basic, the Major Medical begins to pay 80% of additional such charges of this type.

And after the Basic has paid benefits for 31 days of convalescent nursing home care, New York 65 Major Medical steps in to extend this benefit through another 60 days.

The Major Medical plan pays benefits for these hospital and convalescent nursing home charges up to $3,600 for each confinement.

New York 65 Major Medical also provides Other Medical Expense Benefits for doctor bills, nursing services, drugs, X-Rays, etc. The plan starts paying for these charges after you pay a yearly $75 cash deductible and after the program's Basic benefits, or their equivalent, have been used up. New York 65 Major Medical then pays 80% of such benefits, up to $10,000 over your lifetime.

****You are eligible for the Major Medical plan alone, whether or not you have Basic coverage. However, if you do not have basic hospital-surgical-medical coverage, or if your coverage is not at least equal to New York 65 Regular Basic benefits, you should be prepared to meet the equivalent of such benefits out of your own pocket.***

ENROLL TODAY — ENROLLMENT PERIOD APRIL 1 — APRIL 30 ONLY!

NEW YORK 65 REGULAR BASIC

($10 a Month)

Pays Benefits Up to 31 Days For

- Hospital room/board up to $18 a day
- Miscellaneous hospital charges up to $150
- Doctors fees in hospital (non-surgical) up to $145

  $6 per day, first week — $5 per day, second week — $4 per day, thereafter
- Convalescent nursing home charges up to $7.50 a day following at least 5 days hospital confinement

PLUS: Surgery, in or out of a hospital, and Radiation Therapy for Malignancy according to a schedule, up to $250.

Same plan available on Optional basis at a cost of $8 per month with room and board benefits limited to $12 per day.

The important benefits and limitations of New York 65 are presented in this folder. Complete details are given in the Certificate Booklet you will receive shortly after you enroll.

NEW YORK 65 MAJOR MEDICAL BENEFITS

($9 a Month)

Pays Hospital and Convalescent Nursing Home Benefits

(Maximum Benefit $3600 FOR ANY ONE CONFINEMENT)

- Hospital room and board benefits up to $18 a day **after** the first 31 days of confinement
- Benefits for other hospital services and supplies at **80% of the amount** by which expenses exceed $150
- Convalescent nursing home benefits up to $7.50 per day for a maximum of 60 days following at least 5 days hospital confinement

(NOTE: After you've been out of a hospital or convalescent nursing home for 90 days, you're entitled to a new maximum benefit of $3600 for any future confinement.)

Pays Other Medical Expense Benefits

(Maximum Benefit $10,000 DURING YOUR LIFETIME)

Pays benefits for the following medical expenses at **80% of the amount** by which expenses exceed $75 in a calendar year:

- **Doctor's medical and surgical services for home, office or in-hospital care — with maximum expense equal to the excess of:**

  the established Blue Shield fees in your community for families with maximum yearly income of $6,000,

  over

  the benefits payable under other plans for these services.

  If you have no basic coverage for surgery or doctor fees in hospital, you should be prepared to meet the equivalent of New York 65 Basic benefits out of your own pocket.
- Private duty nursing services by registered professional nurses, registered visiting nurses, or licensed practical nurses, not in excess of charges of $1,000 in any calendar year
- Drugs and medicines which require a doctor's prescription
- Diagnostic x-ray and laboratory examination and out-patient diagnostic services
- Physiotherapy . . . artificial limbs and eyes . . . trusses and crutches
- Anesthetics
- Oxygen and rental of equipment for its administration
- Rental of radium and radioactive isotopes
- Blood and blood plasma
- Rental of a wheel-chair, hospital-type bed, iron lung, or other equipment for the treatment of respiratory paralysis
- Local ambulance service to or from a hospital or convalescent nursing home

Benefits under New York 65 are subject to reduction if you have other hospital, surgical or medical insurance

APPLICATION FOR ENROLLMENT IN NEW YORK 65 *(please print all information)*

OFFICE USE ONLY

Name of Enrollee—Person to be insured (Husband and Wife must enroll separately):

LAST FIRST INITIAL

County in N. Y. State in which enrollee resides

DATE OF BIRTH: MO. DAY YR.

SEX: M ☐ F ☐

Send mail to (name of person if different from Enrollee): MR ☐ MRS ☐ MISS ☐

Address to which mail should be sent:

If enrollee is eligible because spouse is enrolled (or now enrolling) please give name of spouse:

Agent or Broker submitting this application:

NAME

STREET AND NO.

CITY ZONE STATE

Check **ONE** *plan below*

PLAN	MONTHLY PREMIUM
[3] ☐ Major Medical	$ 9.00
[1] ☐ Regular Basic	10.00
[2] ☐ Optional Basic	8.00
[4] ☐ Major Medical and Regular Basic	19.00
[5] ☐ Major Medical and Optional Basic	17.00

Has enrollee been confined in a hospital or convalescent nursing home in the last 31 days? ☐ Yes ☐ No

Does enrollee now have Blue Cross or any plan or policy providing hospital benefits of $10 or more per day? ☐ Yes ☐ No

NOTE: See your Agent or Broker for help in enrolling. He will gladly answer your questions, and there is no additional charge for his services.

I certify all information given here to be correct. It is agreed no agent or broker may make or modify any contract of insurance or bind the Association in any way. *I understand that benefits under N. Y. 65 are subject to reduction if Enrollee has other health insurance, and that N. Y. 65 coverage is effective as provided in the Certificate Booklet.*

SIGNATURE OF PERSON REQUESTING ENROLLMENT DATE SIGNED

Attached is check or Money Order for $______ to cover______ monthly payments for the plan checked. Make check payable to: NEW YORK 65, 101 West 51st St., New York 19, N. Y.

603F N.Y. D

Who is Eligible for New York 65

You are eligible — during any open enrollment period — to join New York 65 if you are 65 or over and reside in New York State. Your spouse (regardless of age) may also enroll if *you* are enrolled. Protection begins upon receipt by New York 65 of your first premium payment.

If you became 65 after the close of an open enrollment, or retire and are already over 65, you may enroll within 31 days of reaching 65 or your retirement.

If you were confined in a hospital or convalescent nursing home on or during the 31 days prior to the date your coverage in New York 65 would otherwise become effective, your protection will begin 31 days after you are no longer so confined.

How to Enroll in New York 65

It's easy to enroll in New York 65 — no complicated forms — no long list of questions. Your Agent or Broker will gladly give you specific answers concerning New York 65 — will offer you any assistance you want in enrolling. There is no additional charge for his services. So see him today — or, if you prefer, fill in, tear off and mail the convenient application form printed inside.

Expenses not Covered Under New York 65

Expenses during the first 6 months of your insurance—or during any period of hospital confinement commencing in the first 6 months—for any condition for which you received treatment or diagnosis during the 90 days *before* your New York 65 insurance became effective.

Other principal exclusions are: injuries and diseases covered by Workmen's Compensation; care for mental and nervous conditions outside a hospital; dental care; eye examinations and glasses; hearing aids; diseases or injuries arising out of any war; expenses for services and supplies furnished without charge by any government; expenses which you would have no legal obligation to pay if you did not have insurance.

Benefits under New York 65 are subject to reduction if you have benefits under other hospital, surgical or medical plans.

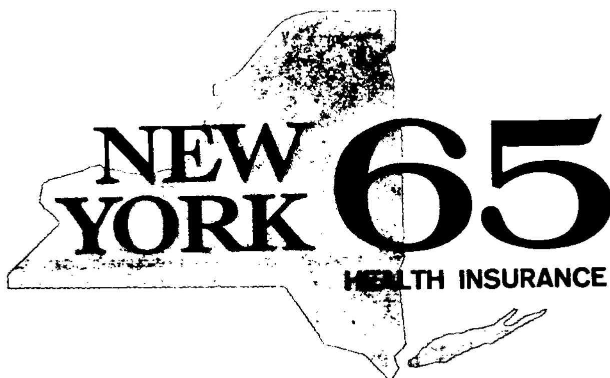
OFFERED AS A PUBLIC SERVICE BY A NON-PROFIT ASSOCIATION OF 49 LEADING INSURANCE COMPANIES

Aetna Life Affiliated Companies
Allstate Insurance Company
American Casualty Group
American Mutual Liability Insurance Company
American Progressive Health Insurance Co. of New York
Bankers Life Company
Beneficial Fire and Casualty Insurance Company
Citizens Life Insurance Company
Consolidated Mutual Insurance Company
Empire State Mutual Life Insurance Company
Equitable Life Assurance Society of the United States
Farmers and Traders Life Insurance Company
Federal Life and Casualty Company
Great American Insurance Company
Hanover Insurance Group
Hartford Accident and Indemnity Company
Hartford Life Insurance Company
Home Life Insurance Company
International Life Insurance Company of Buffalo
John Hancock Mutual Life Insurance Company
Liberty Mutual Insurance Company
Lincoln National Life Insurance Company of New York
Lumbermens Mutual Casualty Company
Massachusetts Mutual Life Insurance Company
Metropolitan Life Insurance Company
Mutual of New York
National Casualty Company
Nationwide Mutual Insurance Company
New England Mutual Life Insurance Company
New York Life Insurance Company
Northeastern Life Insurance Company of New York
Old Republic Life Insurance Company
Paul Revere Life Insurance Company
Penn Mutual Life Insurance Company
Phoenix of London Group
Provident Life and Casualty Insurance Company
Provident Mutual Life Insurance Company of Philadelphia
St. Paul Insurance Companies
Security Mutual Life Insurance Company of New York
Springfield-Monarch Insurance Companies
Standard Security Life Insurance Company of New York
State Mutual Life Assurance Company of America
The Commercial Travelers Mutual Accident Association
The Fidelity and Casualty Company of New York
The Guardian Life Insurance Company of America
Travelers Insurance Company
Union Labor Life Insurance Company
Union Mutual Life Insurance Company
Unity Mutual Life Insurance Company of New York

NEW YORK 65 HEALTH INSURANCE ASSOCIATION
101 WEST 51st STREET, NEW YORK 19, NEW YORK

EXHIBIT D

New York 65 Certificate Booklet—Basic and Major Medical Expense Benefits



CERTIFICATE BOOKLET

BASIC AND MAJOR MEDICAL EXPENSE BENEFITS

This booklet does not represent and is no evidence of enrollment under New York 65 unless the official Association label is affixed hereto.

Group Health Insurance Policy

Issued pursuant to Section 221-a
of the New York Insurance Law

PROVIDES

BASIC BENEFITS — HOSPITAL, IN-HOSPITAL MEDICAL, CONVALESCENT NURSING HOME, AND SURGICAL EXPENSE BENEFITS

AND

MAJOR MEDICAL EXPENSE BENEFITS
designed to supplement New York 65 Basic Benefits or similar benefits which you may have obtained elsewhere.

NON-DUPLICATION OF BENEFITS

Benefits under New York 65 Plans are subject to reduction if you have benefits under any other hospital, surgical, or medical plan.

If, for any reason, after examining this Certificate Booklet, you are not satisfied with this insurance, then within ten (10) days after receipt of this booklet, you may return it to:

New York 65
101 West 51st Street
New York 19, N. Y.

Your insurance will then be void from the beginning and any premium paid will be returned.

Read this entire Certificate Booklet carefully. It contains the benefit provisions which are a part of the New York 65 Group Health Insurance Policy held by the New York 65 Health Insurance Association. This Certificate Booklet is subject to the terms, provisions and conditions of such policy. Keep this Certificate Booklet in a safe place.

Highlights
Of Your New York 65 Plan

A more detailed description appears on subsequent pages of this booklet.

Basic Hospital, In-Hospital Medical, Convalescent Nursing Home, and Surgical Expense Benefits	
Regular Basic Benefits (See Note Below)	(a) Hospital room and board benefits up to $18 a day for a maximum of 31 days. (b) Other hospital service benefits for services during the first 31 days of confinement, up to $150. (c) Benefits for doctors' visits for non-surgical care in the hospital. (d) Convalescent nursing home benefits up to $7.50 a day for a maximum of 31 days. (e) Surgical expense benefits.

NOTE: The Optional Basic Plan provides a maximum benefit for hospital room and board of $12 a day.

Major Medical Expense Benefits	
Part I Extended Hospital and Convalescent Nursing Home Expense Benefits	(a) Hospital room and board benefits up to $18 a day after the first 31 days of confinement. (b) Other hospital service benefits to the extent of 80% of the amount by which the expenses exceed $150. (c) Convalescent nursing home benefits up to $7.50 a day for a maximum of 60 days. Maximum — $3,600 for any one confinement.
Part II Other Medical Expense Benefits	Benefits for certain other medical expenses to the extent of 80% of the amount by which expenses exceed $75 in a calendar year. Maximum — $10,000 during your lifetime.

WHO IS ELIGIBLE?

You are eligible for this insurance if your principal place of residence is in the State of New York and

1. you have attained your 65th birthday, or

2. you are the wife or husband of a person who has attained his or her 65th birthday and who is enrolled in any New York 65 Plan.

No person who has not attained his or her 65th birthday will become covered under any New York 65 Plan unless and until his or her spouse is covered.

EFFECTIVE DATE OF INSURANCE

If you enroll during an enrollment period specified by the Association, your insurance will become effective on the date of receipt by the Association of your completed enrollment form together with your first required monthly premium except as provided in the next two paragraphs.

If you are confined in a hospital or convalescent nursing home on the date your insurance would otherwise become effective, or were so confined on any day within the 31-day period immediately preceding that date, YOUR INSURANCE WILL BECOME EFFECTIVE ON THE FIRST DAY FOLLOWING A CONTINUOUS PERIOD OF 31 DAYS DURING WHICH YOU WERE NOT SO CONFINED EXCEPT AS PROVIDED IN THE NEXT PARAGRAPH.

If your insurance would otherwise become effective on the 29th, 30th or 31st of any month, it will become effective on the 1st day of the next month. In no event will the effective date be earlier than October 15, 1962.

MONTHLY PREMIUM

Type of Coverage	Monthly Premium
Regular Basic — Hospital, In-Hospital Medical, Convalescent Nursing Home, and Surgical Expense Benefits (Hospital Daily Benefit up to $18) plus Major Medical Expense Benefits	$19.00
Optional Basic — Hospital, In-Hospital Medical, Convalescent Nursing Home, and Surgical Expense Benefits (Hospital Daily Benefit up to $12) plus Major Medical Expense Benefits	17.00

The Association will send you premium cards for premiums becoming due after your insurance becomes effective.

Each monthly premium is due on the date specified on the card for that month and payment thereof on or before the due date will continue the insurance in force until the next succeeding monthly due date. However, a grace period of ten days will be granted for the payment of each monthly premium falling due after the first monthly premium, during which grace period your insurance shall continue in force.

If you pay premiums in advance, send the premium card for each premium you pay.

Make checks or money orders payable to New York 65 and mail them together with your premium cards for the premiums you are paying to:

New York 65

Box 6500, General Post Office

New York 1, N. Y.

The Association reserves the right to change the premium rates upon appropriate notice.

BASIC HOSPITAL, IN-HOSPITAL MEDICAL, CONVALESCENT NURSING HOME, AND SURGICAL EXPENSE BENEFITS

IN-HOSPITAL BENEFITS

A. Hospital Expense Benefits

If, while insured, you become confined as an inpatient in a hospital on account of an injury or sickness, the Plan will pay an amount equal to the daily room and board charge made to you by the hospital for each of the first 31 days of any one period of hospital confinement, up to $18 per day under the Regular Basic Plan; or $12 per day under the Optional Basic Plan.

If, while insured, you receive in a hospital

(a) treatment on any day of confinement for which room and board benefits are payable, or

(b) emergency treatment on account of an injury suffered in an accident and within 24 hours after the time of the accident, or

(c) treatment in connection with and within 24 hours after a surgical procedure,

the Plan will pay the actual amounts charged to you by the hospital for necessary hospital services and supplies furnished in connection with such treatment during any one period of hospital confinement, up to $150.

B. In-Hospital Medical Expense Benefits — For Doctors' Visits for Non-Surgical Care in the Hospital

If, while insured, you become confined in a hospital for reasons other than surgery, and receive, on any day of such confinement for which room and board benefits are payable, necessary services of a doctor which are neither surgical services nor related to surgical services, the Plan will pay the actual amounts charged to you for such services, up to

$6 for each of the first seven days,
$5 for each of the next seven days, and
$4 for each of the next seventeen days,

of any one period of hospital confinement.

For the purpose of determining in-hospital benefits payable, successive periods of hospital confinement, regardless of cause, which commence while you are insured will be considered as one period of hospital confinement unless between such periods of confinement there were at least 90 consecutive days during which you were not confined in a hospital or a convalescent nursing home.

CONVALESCENT NURSING HOME EXPENSE BENEFITS

If, while insured,

(a) you become confined as an inpatient in a hospital for at least five days and your doctor certifies that such confinement is necessary for the treatment of an injury or sickness, and

(b) within seven days after termination of such confinement, you are moved on orders of your doctor to a convalescent nursing home to recuperate from that injury or sickness, and

(c) you continue to receive treatment from your doctor for that injury or sickness during your confinement in the convalescent nursing home,

the Plan will pay an amount equal to the daily charge made to you by the convalescent nursing home, up to $7.50 for each of the first 31 days of any one period of convalescent nursing home confinement.

For the purpose of determining convalescent nursing home expense benefits, successive periods of nursing home confinement, regardless of cause, which commence while you are insured will be considered as one period of confinement unless between such periods of confinement there were more than seven consecutive days during which you were not confined in either a hospital or convalescent nursing home.

Not more than 31 days' benefits shall be payable for all periods of convalescent nursing home confinement following (or between) all periods of hospital confinement which are considered one period of hospital confinement.

SURGICAL AND RADIATION THERAPY EXPENSE BENEFITS

If, while insured, you undergo a surgical procedure on account of an injury or sickness or undergo radiation therapy for malignancy, the Plan will pay an amount equal to the actual expense to you of the doctors' fees for such procedure up to the Maximum Amount

BASIC BENEFITS — Continued

shown under the Schedule of Procedures. Hospital confinement is not required for payment of benefits for such procedures.

When two or more operative procedures are performed at the same time, payment hereunder shall be limited to that operative procedure for which the highest maximum amount is set forth in the Schedule of Procedures. However, when the procedures are performed in different operative fields, as determined by New York 65, the Plan provides the greater amount plus one-half of each lesser amount subject to a maximum of two times the greater, or $250.00, whichever is the lesser.

When an operative procedure is performed in two or more steps or stages, payment for the entire procedure shall be limited to the amount set forth in the Schedule of Procedures for such operative procedure.

The maximum payment for all procedures performed during all periods of hospital confinement which are considered one period of hospital confinement is $500.

The maximum payment for all procedures performed in any one calendar year while you are not confined in a hospital is $250.

NON-DUPLICATION OF BENEFITS: If you are covered under any other plan, the benefits otherwise payable under your New York 65 Basic Plan will be reduced so that the benefits payable under such Basic Plan together with the benefits payable under such other plan or plans for each item of expense will not exceed the actual amount charged.

EXCLUSIONS AND LIMITATIONS: The benefits under the Basic Plans are subject to the limits set forth above and also to the sections of this booklet titled "Definitions" and "Exclusions".

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SCHEDULE OF SURGICAL AND RADIATION THERAPY PROCEDURES

Surgical Procedure	Maximum Amount
BLOOD VESSELS	
Arteriotomy, with removal of embolus	
Abdomen	$200.00
Neck	150.00
Extremity	150.00
Ligation and division of long saphenous Vein at saphenofemoral junction with or without retrograde injection, or distal interruptions	
Unilateral	75.00
Bilateral	110.00
BREAST	
Complete (simple) mastectomy	
Unilateral	100.00
Bilateral	150.00
Radical mastectomy (including breast, pectoral muscles and axillary lymph nodes)	
Unilateral	200.00
Bilateral	250.00
DIGESTIVE SYSTEM AND ABDOMEN	
Appendectomy (independent procedure)	125.00
Cholecystectomy	150.00
Colectomy, resection of large intestine, all or part, one or more stages, including colostomy and closure, if necessary	250.00
Local Excision of stomach ulcer or benign neoplasm	150.00
Total Gastrectomy	250.00
Fistulotomy or Fistulectomy (independent procedure)	75.00
Hemorrhoidectomy, by excision, internal or internal and external	75.00
Herniotomy, inguinal or femoral	
Unilateral	125.00
Bilateral	175.00
Ischiorectal Abscess, incision and drainage (independent procedure)	50.00
Proctectomy, complete, combined abdomino-perineal procedure, one or more stages	250.00
EYE	
Extraction of lens, intracapsular or extracapsular, with iridectomy (combined cataract extraction)	175.00
Sclerectomy for glaucoma, with scissors, punch or trephination	140.00
GENITO-URINARY SYSTEM	
Anterior Vaginal Wall Repair, repair of cystocele (independent procedure)	80.00

SURGICAL SCHEDULE — Continued

Surgical Procedure	Maximum Amount
Panhysterectomy, total hysterectomy (corpus and cervix) (with or without dilation and curettage, and surgery on tubes, ovaries, ligaments, etc.)	$200.00
Radical Hysterectomy for Cancer (Wertheim), including lymph glands and adenexa	250.00
Prostatectomy	200.00
Salpingo-oophorectomy, complete or partial, unilateral or bilateral	125.00
Ureterolithotomy, abdominal	150.00
Cystoscopy (independent procedure)	
Diagnostic — With or without biopsy	
Without ureteral catheterization	
Initial	25.00
Subsequent	10.00
With ureteral catheterization	
Initial	35.00
Subsequent	15.00
Operative	
With fulguration of bladder tumor	
Initial	50.00
Subsequent	25.00
With stone removal	
Initial	50.00
Subsequent	20.00
Transurethral electro resection of vesical neck, female	125.00

LUNGS AND PLEURA

Lobectomy, total or subtotal	250.00
Thoracotomy, exploratory, by rib resection	125.00

MUSCULOSKELETAL

	Closed Reduction	Open Reduction
Fracture, simple		
Radius		
Shaft	$ 65.00	$ 97.50
Distal end, Colle's (including ulnar styloid)	65.00	125.00
Elbow (distal end of humerus, proximal end of radius, proximal end of ulna)		
Multiple bones	125.00	175.00
Humerus, surgical neck or shaft	100.00	150.00
Ankle, bimalleolar	100.00	135.00
Tibia, shaft	100.00	150.00
Knee (distal end of femur, proximal end of tibia)	100.00	150.00
Femur, shaft	175.00	250.00
Acetabulum (with or without other fractures of pelvis)	120.00	180.00

NERVOUS SYSTEM

Excision of brain cyst, neoplasm, or abscess	$225.00
Trephination (or burr holes) exploratory	
Unilateral (independent procedure)	75.00
Bilateral (independent procedure)	100.00

Surgical Procedure	Maximum Amount
Drainage of subdural, epidural or subarachnoid space for abscess or hematoma	
Cranial	$175.00
Spinal	100.00

THYROID GLAND

Thyroidectomy	
Total or complete	175.00
Subtotal or partial	
Unilateral	125.00
Bilateral	175.00
Local excision of small cyst or adenoma of thyroid	125.00

The maximum amount for any surgical procedure not specified in the above schedule will be determined by the Association on the basis of the severity of the type of procedure, in an amount consistent with the maximum amounts for procedures listed.

RADIATION THERAPY FOR PROVEN MALIGNANCY ONLY

X-RAY THERAPY

Head and Neck:	Maximum Amount per Treatment	Maximum Amount
Larynx — Intrinsic, Extrinsic		
Definitive treatment	$ 7.50	$200.00
Postoperative treatment	7.50	150.00
Thyroid	7.50	150.00
Chest:		
Lung (palliative)	7.50	125.00
Genito-Urinary Tract:		
Prostate palliative or postoperative	7.50	150.00
Gynecological Tract:		
Uterus corpus	7.50	150.00
Uterine cervix, x-ray alone	7.50	175.00
Breast:		
Postoperative	7.50	150.00
Primary (inoperable) radio-therapy only	7.50	175.00
Bone:		
Primary	7.50	150.00
Miscellaneous:		
Lymphosarcoma, Fibrosarcoma, Neurosarcoma and other soft tissue sarcomas	7.50	150.00
Spinal Cord Lesions	7.50	75.00

RADIUM THERAPY

Oral cavity	75,00	150.00
Esophagus	75.00	150.00
Rectum	75.00	150.00
Bladder	75.00	150.00
Uterus corpus	75.00	150.00
Uterine cervix	87.50	175.00
Vagina	75.00	150.00

RADIOACTIVE ISOTOPE THERAPY

Radioactive iodine	75.00	150.00
Radioactive gold	75.00	150.00
Radioactive phosphorus	50.00	100.00

MAJOR MEDICAL EXPENSE BENEFITS

PART I. EXTENDED HOSPITAL AND CONVALESCENT NURSING HOME EXPENSE BENEFITS

A. Hospital Expense Benefits

If, while insured, you become confined as an in-patient in a hospital on account of an injury or sickness, the Plan will pay benefits for hospital room and board and other hospital services and supplies furnished while you are insured under this Plan, on the following basis:

(a) Hospital Charges for Room and Board: For each day of confinement subsequent to the 31st day of any one period of hospital confinement — the amount charged by the hospital up to the smaller of:

(i) $18, and

(ii) the amount by which the actual amount charged exceeds the benefits payable under any other plans.

(b) Hospital Charges for Services and Supplies, Other Than Room and Board: 80% of the amount by which such charges incurred during any one period of hospital confinement exceed the greater of:

(i) $150, and

(ii) the benefits otherwise payable for such charges under New York 65 Basic and under any other plans.

For the purpose of determining hospital expense benefits payable, successive periods of hospital confinement, regardless of cause, which commence while you are insured will be considered as one period of hospital confinement unless between such periods of confinement there were at least 90 consecutive days during which you were not confined in either a hospital or a convalescent nursing home.

B. Convalescent Nursing Home Expense Benefits

If, while insured,

(a) you become confined as an in-patient in a hospital for at least five days and your doctor certifies that such confinement is necessary for the treatment of an injury or sickness, and

(b) within seven days after termination of such confinement, you are moved on orders of your doctor to a convalescent nursing home to recuperate from that injury or sickness, and

(c) you continue to receive treatment from your doctor for that injury or sickness during your confinement in the convalescent nursing home,

the Plan will pay an amount equal to the daily charge made to you by the convalescent nursing home for each day of confinement while you are insured under this Plan, up to $7.50 per day, to a maximum of 60 days for any one period of confinement. However, no benefits are payable for any day of such confinement for which benefits are otherwise payable under New York 65 Basic or under any other plans.

For the purpose of determining convalescent nursing home expense benefits, successive periods of nursing home confinement, regardless of cause, which commence while you are insured will be considered as one period of confinement unless between such periods of confinement there were more than seven consecutive days during which you were not confined in either a hospital or convalescent nursing home. Not more than 60 days' benefits shall be payable for all periods of convalescent nursing home confinement following (or between) all periods of hospital confinement which are considered one period of hospital confinement.

Maximum Benefit For Part I — Up to $3,600 of Extended Hospital and Convalescent Nursing Home Expense Benefits will be payable for all such expenses incurred during (a) all periods of hospital confinement which are considered one period of hospital confinement, and (b) all periods of convalescent nursing home confinement following (or between) such periods of hospital confinement.

PART II. OTHER MEDICAL EXPENSE BENEFITS

If, while insured, you incur allowable expenses for any of the following Covered Medical Services or Supplies, the Plan will pay 80% of the amount by which the aggregate of such expenses incurred in a calendar year exceeds a deductible amount of $75. Any expenses incurred during the last three months of a calendar year that are used to satisfy the $75 for that calendar year will also be used to satisfy the $75 for the next calendar year.

Allowable Expense for Covered Medical Services and Supplies

A. Medical or Surgical Services of Doctors in office, home or hospital:

The amount of allowable expense for such services is the excess, if any, of (i) the doctor's actual fee but not more than the established fee in the area in New York State in which you reside under the local community medical expense indemnity plan (Blue Shield) for families with maximum yearly income of $6,000, over (ii) the amount of all benefits otherwise paid or payable for such expenses under New York 65 Basic and under all other plans.

If your family yearly income is more than $6,000, the benefits under this Plan will be computed on the same basis as if your family yearly income were $6,000, and in such case any excess of the doctor's actual fee over the local plan schedule fee for families with a yearly income of $6,000 will not be included in the calculation of benefits under this Plan. If a fee for a particular service has not been established by the local community medical expense indemnity plan, the maximum expense included in item (i) above will be the customary charge for or reasonable value of such service for families with maximum yearly income of $6,000.

B. Other Services and Supplies

Expenses for the following services and supplies, in the amount, if any, by which such expenses exceed the amount of all benefits otherwise paid or payable for such expenses under New York 65 Basic and under all other plans:

• Private duty nursing services by registered professional nurses or licensed practical nurses, or home nursing services through visiting nurse or public health nursing organizations; not in excess of $1,000 for such services received in any calendar year.

- Drugs and medicines legally obtainable only upon written prescription of a doctor.

- Diagnostic x-ray and laboratory examination and out-patient diagnostic services.

- Physiotherapy.

- Anesthetics.

- Oxygen and rental of equipment for its administration.

- Rental of radium and radioactive isotopes.

- Blood and blood plasma, including the administration thereof, to the extent it is not donated or otherwise replaced.

- Rental of a wheel-chair, hospital-type bed, iron lung or other mechanical equipment for the treatment of respiratory paralysis.

- Artificial limbs and artificial eyes, but not repairs or replacements thereof.

- Trusses and crutches (initial cost but not replacement).

- Local ambulance service to or from a hospital or convalescent nursing home.

No benefits are provided under this Part of the Major Medical Plan for charges made by a hospital or convalescent nursing home for in-patient care. Benefits for such charges are provided in accordance with Part I.

Maximum Benefit For Part II — Up to $10,000 will be payable for expenses incurred for these Covered Medical Services and Supplies during your lifetime.

NON-DUPLICATION OF BENEFITS — The benefits payable under the New York 65 Major Medical Plan are subject to reduction if you have benefits under any other hospital, surgical, or medical plan.

EXCLUSIONS AND LIMITATIONS — The benefits under the New York 65 Major Medical Plan are subject to the limits set forth above, and also to the sections of this booklet titled "Definitions" and "Exclusions".

EXCLUSIONS APPLICABLE TO BASIC AND MAJOR MEDICAL EXPENSE BENEFITS

The following expenses are not covered under any New York 65 Plan; hence benefits are not payable for them and they do not count toward the Major Medical Expense Benefits deductible amount.

(1) Expenses for services and supplies received before the effective date of your insurance under the Plan.

(2) Expenses for services and supplies furnished during the first six months of your insurance under the Plan, or during any continuous period of hospital or nursing home confinement which commenced during the first six months of your insurance, in connection with an injury or a sickness or any condition related thereto for which you received any medical or surgical care or treatment or underwent diagnostic studies during the 90 days immediately preceding the effective date of your insurance.

(3) Expenses for or in connection with dental services of any kind, except that expenses for such services required for correction of damage to natural teeth caused by accidental injury sustained while you are insured under the Plan will not be excluded if they otherwise qualify for benefits.

(4) Expenses for or in connection with cosmetic surgery or treatment, except that expenses for such services required for correction of damage caused by accidental injury sustained while you are insured under the Plan will not be excluded if they otherwise qualify for benefits.

(5) Expenses for or in connection with treatment of any mental or nervous condition received while you are not confined as an in-patient in a hospital or convalescent nursing home.

(6) Expenses for or in connection with treatment of an injury or sickness for which a benefit is payable upon application in accordance with the provisions of any workmen's compensation or similar law whether or not such benefit covers the entire expenses you incur.

(7) Expenses for services and supplies furnished without charge directly or indirectly by any government or instrumentality thereof.

(8) Expenses with respect to which you would have no legal obligation to pay if you did not have insurance.

(9) Expenses for care, treatment, services, or supplies not recommended and approved by a doctor, or not customarily furnished for the necessary treatment of the injury or sickness involved.

(10) That portion of any expense charged for care, treatment, services, or supplies which is in excess of the customary charge for or reasonable value of such care, treatment, services, or supplies.

(11) Expenses for services and supplies not specifically listed in the description of benefits in this booklet, for example: hearing aids, eyeglasses, and eye examinations; and expenses for comfort services such as telephone, radio, television, barber or beauty service.

(12) Expenses for the professional services of a doctor for:

(a) Treatment of weak, strained, or flat foot, of any instability or imbalance of the foot, or of any metatarsalgia or bunion (but not excluding charges for an open cutting operation).

(b) Treatment (including cutting or removal) of corns, calluses, or toenails (but not excluding charges for partial or complete removal of nail roots) except when prescribed by a doctor of medicine (M.D.) who is treating the individual for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease, such as arteriosclerosis.

(13) Expenses for services and supplies furnished by any person immediately related to you or to your spouse, by blood, adoption, or marriage as father, mother, child, brother, sister or spouse, or by any person regularly residing in your home.

(14) Expenses for services furnished by a doctor while you are confined in a convalescent nursing home if the doctor has a financial interest in the convalescent nursing home or is responsible for its supervision.

(15) Expenses charged by a hospital or by a convalescent nursing home for any private duty special nursing services or for the professional services of a resident, intern,

EXCLUSIONS — Continued

or other employee of such hospital or nursing home.

(16) Expenses for or in connection with treatment of any injury or sickness sustained as a result of war, or any act of war (whether war is declared or not), or as a result of any act of international armed conflict, or conflict involving armed forces of any international authority.

If benefits have been paid under New York 65 on account of any expenses and thereafter it is established that benefits were not payable hereunder with respect to all or part of such expenses, the Association shall be entitled to a refund of the amount of such benefits paid.

DEFINITIONS

Wherever the following terms appear in this booklet they have the limited meanings indicated below.

"Doctor" means a duly licensed doctor of medicine (M.D.) or a duly licensed doctor of osteopathy (D.O.). The term includes surgeons and other specialists if they meet this definition. A duly licensed dentist is also considered a "doctor" for purposes of the dental work and oral surgery covered by the Plan, and a duly licensed podiatrist (chiropodist) is considered a "doctor" for purposes of the foot conditions covered by the Plan. Types of practitioners not specifically mentioned in the preceding sentences are not considered "doctors" for purposes of this Plan.

"Hospital" means only an institution which meets fully every one of the following tests:

(1) It is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis.

(2) It maintains facilities for diagnosis of injury and sickness and for treatment by or under the supervision of a staff of doctors.

(3) It continuously provides 24-hour a day nursing service by registered professional nurses.

(4) It maintains organized facilities for major surgery, except in the case of a hospital primarily concerned with the treatment of chronic diseases.

(5) It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a nursing home, a hotel, or a similar institution.

"Convalescent Nursing Home" means only an institution which meets fully every one of the following tests:

(1) It is regularly engaged in providing skilled nursing care for sick and injured persons under 24-hour a day supervision of a doctor or registered professional nurse.

(2) It has the services of a doctor available at all times.

(3) It has such other nursing personnel as may be necessary to provide continuous care of patients.

(4) It complies with all licensing and other legal requirements.

(5) It maintains a daily medical record for each patient.

(6) It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or a similar institution.

"Room and Board Charge" means the entire charge for room, board, and general duty nursing, and any other charge by whatever name such charge is called, made by the hospital at a daily or weekly rate, or regularly made as a condition of occupancy of the class of accommodations occupied, but not including any charge for professional services of doctors.

If the hospital makes a flat daily charge, without stating how much is for room and board and how much for other services and supplies, 60% of the flat daily charge will be considered to be for room and board. If it uses a schedule of daily charges which become lower the longer you stay and become constant after a period of days, 90% of the lowest daily charge contained in such schedule will be considered the room and board charge. In no event, however, will the amount that is considered to be the daily room and board charge be less than the smaller of $10.00 and the full amount of the daily charge.

"Surgical Procedure" means any procedure specifically listed in the Schedule of Procedures and any other procedure involving cutting, suturing, electrocauterization, coagulation, endoscopic procedures, or manipulative reduction of a fracture or dislocation.

"Calendar Year" means a period beginning with any January 1st and ending with the next following December 31st, *EXCEPT* that the first "Calendar Year" will begin on the effective date of your insurance and end on December 31st of the same year.

DEFINITIONS — Continued

"Other Plan" — Wherever reference is made to benefits under any other plan or other plans, "other plan" means any other plan providing benefits or services for hospital, surgical, or medical care or treatment, other than any plan covering automobile liability, personal liability, or travel accident liability only.

If a plan provides coverage in the form of services rather than cash payments, the amount of benefits under that plan shall be taken as the amount which the services furnished would have cost in the absence of such coverage.

The date on which any services or supplies are received or furnished will be considered the date on which any expense for such services or supplies is incurred.

TERMINATION AND MODIFICATION OF INSURANCE

If you fail to pay your required monthly premium before the expiration of the grace period for payment of that premium, your insurance will automatically terminate at the end of the grace period.

The Association reserves the right to discontinue these Plans in the event circumstances arise which, in the Association's sole discretion, make the continuance of these Plans impracticable. If these Plans are discontinued, your insurance will automatically terminate as of your premium due date during the calendar month in which such discontinuance occurs.

The Association reserves the right to modify or change these Plans at any time.

The Association will not discontinue, modify, or change your coverage under your Plan unless such discontinuance, change, or modification applies to all persons insured under your Plan.

Your eligibility under New York 65 Plans and your insurance will automatically terminate when you have resided outside the United States of America and Canada for a continuous period of six months.

Termination or modification of your insurance will not adversely affect any claim for benefits on account of services and supplies furnished prior to the effective date of termination or modification.

TEMPORARY EXTENSION OF COVERAGE

Under a Basic Plan — If, when your insurance terminates, you are confined in a hospital or a convalescent nursing home because of an

injury or sickness, benefits will be payable for expenses incurred while you remain continuously so confined for such injury or sickness on the same basis as benefits payable for expenses incurred while you were insured.

Under the Major Medical Plan — If at the date of termination of your Major Medical Expense Insurance

(i) you are receiving medical care for an injury or sickness and benefits are payable for expenses incurred on account of such injury or sickness prior to termination of insurance, or

(ii) you are confined in a hospital or convalescent nursing home because of an injury or sickness,

benefits will be payable for expenses incurred on account of such injury or sickness during the 90 consecutive days following the expiration of the period for which you have made your premium payments (or following the termination of your insurance by the Association, if earlier), on the same basis as benefits payable for expenses incurred while you were insured.

PROOF AND PAYMENT OF CLAIMS

Claim Forms. — At the time of enrollment, you were sent a Claim Form to be used to submit proof of claim for benefits. Send the completed form to:

New York 65
Box 6565, General Post Office
New York 1, N. Y.

Upon receipt of each Claim Form, the Association will mail another form to you for subsequent use.

If you do not have a Claim Form, you should notify the Association at the above address as soon as it is reasonably possible after the occurrence or commencement of any loss for which benefits are payable and a Claim Form will be sent to you. If such a form is not furnished you within fifteen days after you give notice, you may comply with the requirements as to proof of claim by submitting, within the time fixed for filing proofs of claim, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Claim. — Written proof of any claim must be furnished to the Association within ninety days after the date of the loss for which claim is made. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably

PROOF & PAYMENT OF CLAIMS — Continued

possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

Payment of Claim. — All benefits payable under this Plan will be paid as they accrue immediately upon receipt of due written proof of claim.

All benefits (except benefits which you have assigned) will be paid to you provided you are able to sign a valid release for such benefits. If in the opinion of the Association you are either physically or mentally incompetent to give a valid release for any benefit which becomes payable to you, or if any benefit becomes payable to your estate, the Association reserves the right, at its own option, either to pay such benefits directly to the hospital or other person or persons on whose charges payment of such benefit is based, or to pay such benefit to any of your relatives by blood or adoption or connection by marriage deemed by the Association to be equitably entitled thereto. Any payment made by the Association in good faith pursuant to this provision shall fully discharge the obligations of the Association to the extent of such payment.

Physical Examination. — The Association at its own expense shall have the right and opportunity to have a doctor examine any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during pendency of a claim.

Assignment. — You may assign

(a) Benefits for hospital expenses to the hospital.

(b) Benefits for nursing home expenses to the nursing home.

(c) Benefits for fees charged by an operating surgeon to the surgeon.

(d) Benefits for in-hospital medical expenses to the doctor.

No assignment of any other benefits will be accepted by the Association. No assignment will be binding upon the Association unless made in writing and until filed with the Association. The Association assumes no responsibility for the validity of any assignment.

Legal Actions. — No action at law or in equity shall be brought to recover on this Plan prior to the expiration of sixty days after written proof of claim has been furnished in accordance with the requirements of this Plan. No such action shall be brought after the expiration of three years after the time written proof of claim is required to be furnished.

Index For Basic and Major Medical Benefits

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HOW TO FILE YOUR CLAIM FOR BENEFITS UNDER NEW YORK 65 BASIC AND MAJOR MEDICAL

This information applies to persons who are enrolled in one of the New York 65 BASIC Plans and also in New York 65 MAJOR MEDICAL.

FORM 850.46 (OCT. 62)

33–420 O—64—pt. 2——7

HERE ARE SOME HELPFUL ANSWERS TO GENERAL QUESTIONS ABOUT FILING YOUR CLAIM FOR NEW YORK 65 BENEFITS

Sometimes people find that insurance claim forms are complicated and difficult to fill out. We have tried to avoid this in developing these forms for New York 65, and hope that the following answers to general questions will simplify things even further for you.

WHO MAY MAKE A CLAIM?

You, the Insured, must personally make claim for your New York 65 benefits. If you are unable to do so, the claim form may be completed by a near relative (not a minor), with an explanation of the reason you did not sign it personally.

WHEN SHOULD A CLAIM BE FILED?

You may send in Part One of the claim form as soon as your hospital confinement ends or as soon as you receive the first bills for covered expenses incurred in connection with your illness or injury. You need not wait until you have received all bills, because New York 65 will send you another blank claim form each time a completed form is received from you. You may submit additional forms as you receive additional bills.

Suggestion: Keep bills for prescribed medications and other small covered expenses that are incurred during the early part of each calendar year so that you can file a claim after your total covered expenses exceed the deductible amounts described in your Certificate Booklet.

WHERE MAY I GET CLAIM FORMS?

A claim form is included in this initial enrollment material. As explained above, a new blank form will be sent to you each time that you send in a completed form. If at any time you do not have or cannot find a claim form, you may obtain one by writing to New York 65.

SHOULD I ASSIGN MY BENEFITS?

The only difference between assigning and not assigning a benefit is in the name of the payee on the benefit check. In either case, the check will be mailed to *you*. If you have assigned the benefit by signing your name by the appropriate arrow on the claim form,

> **IMPORTANT** Be sure to read your CERTIFICATE BOOKLET carefully. It contains a detailed description of the maximum benefits and the specific kinds of charges that are covered by New York 65 plans, and it is the ONLY official and authoritative description of those benefits and charges.

the check will be *payable* to the hospital, nursing home or doctor, as the case may be. Many people find it convenient to have the check made payable to the institution or doctor to whom money is owed so that it may easily be forwarded by mail.

WHERE SHOULD I MAIL THE CLAIM FORM?

Send your completed claim forms to the following address:

NEW YORK 65
BOX 6565, GENERAL POST OFFICE
NEW YORK 1, N. Y.

You should also use that address when you write to New York 65 in regard to any claims question.

WHERE SHOULD I CALL THE NEW YORK 65 OFFICE?

If you would like to discuss claims questions by telephone with the New York 65 office, you may call the following number in New York City:

LT 1-6500 AREA CODE 212

If you wish to call personally at the New York 65 office in New York City, the street address is:

101 W. 51st STREET
NEW YORK 19, N. Y.
THE NEW YORK 65 OFFICE IS ON THE 15th FLOOR

101 W. 51st Street is located between the Avenue of the Americas (Sixth Avenue) and Seventh Avenue.

NEW YORK 65 CLAIM FORM (MME)
FOR HOSPITAL AND NURSING HOME BENEFITS

PART ONE

SEND CLAIM FORMS AND CORRESPONDENCE TO:
NEW YORK 65
BOX 6565, GENERAL POST OFFICE
NEW YORK 1, N. Y.

READ YOUR CLAIM INSTRUCTION FOLDER BEFORE COMPLETING THIS FORM

NAME OF INSURED: INSURED I M
CERTIFICATE NUMBER: 9999999

PLAN OF INSURANCE: MAJOR MEDICAL AND REGULAR BASIC
EFFECTIVE DATE OF INSURANCE: 10/15/62

A — INSURED'S STATEMENT

NATURE OF ILLNESS OR INJURY (if injury, when, where and how did accident happen?)
FALL IN BATHROOM OF HOME, JANUARY 3, 1963, FRACTURED WRIST

DATE OF FIRST TREATMENT FOR THIS ILLNESS OR INJURY: JANUARY 3, 1963
HAS A CLAIM FOR WORKMEN'S COMPENSATION BEEN PRESENTED OR CONTEMPLATED? ☐ YES ☒ NO

DO YOU HAVE OTHER HEALTH INSURANCE OR SICKNESS BENEFITS? ☒ YES ☐ NO
IF YES, COMPLETE SECTION ① OR ② BELOW

① HEALTH INSURANCE CONNECTED WITH PRESENT OR FORMER EMPLOYMENT

NAME OF EMPLOYER: JOHN DOE MANUFACTURING CO.
LOCATION: 123 MAIN ST., HOMETOWN, N.Y.

GROUP BLUE CROSS ☐ YES ☒ NO
GROUP BLUE SHIELD ☐ YES ☒ NO

GROUP INSURANCE OR WELFARE PLAN ☒ YES ☐ NO
IF YES, GIVE NAME OF COMPANY OR OTHER ORGANIZATION: JOHN DOE Company EMPLOYEE BENEFIT ASSOCIATION

TYPE, NAME OR DESCRIPTION OF POLICY OR PLAN: HOSPITAL ROOM AND BOARD BENEFITS UP TO $8.00 A DAY

POLICY NUMBER, CERTIFICATE NUMBER, ETC: MEMBERSHIP NO. 31

② INDIVIDUAL HEALTH INSURANCE POLICY

BLUE CROSS ☐ YES ☐ NO
BLUE SHIELD ☐ YES ☐ NO

INSURANCE COMPANY OR OTHER ORGANIZATION ☐ YES ☐ NO IF YES, GIVE NAME

TYPE, NAME OR DESCRIPTION OF POLICY OR PLAN

POLICY NUMBER, CERTIFICATE NUMBER, ETC.

IF YOU HAVE RECEIVED ANY BENEFITS FROM OTHER INSURANCE OR PLAN IN CONNECTION WITH THIS ILLNESS OR INJURY, PLEASE ATTACH COPY OF STATEMENT SHOWING AMOUNTS RECEIVED: STATEMENT ATTACHED

I hereby authorize any hospital, convalescent nursing home, employer, organization or other insurance company to release the information requested on this form or to release information as to the benefit, either payable or available as a result of this claim

INSURED SIGNS HERE → Irving M. Insured
DATE

MAILING ADDRESS OF INSURED: 450 ELM STREET, HOMETOWN, N.Y.

This is SECTION A of the Form —YOUR Important Statement

Whenever you file a claim for benefits with New York 65, the *first* section you come upon is Section A — your *own* statement of what happened and what your other insurance coverage might provide in the way of benefits.

As you'll see in a typical example given above, the purposes of Section A of the Claim Form are:

1. To learn from you, in your own words, the nature of the illness or injury for which you are claiming benefits.

If an illness: State the *Kind* of illness (name of disease). If you had an operation, state the nature of it.

If an injury: State the *Kind* of injury, the *Date*, the *Cause* (fall, automobile accident, etc.) and the *Place* (home, street, highway, etc.)

2. To learn whether a claim for Workmen's Compensation has been or will be made. Generally speaking, Workmen's Compensation will not be involved unless you were injured while performing the duties of your job. If your illness or injury is not related to any employment, you should answer this question "No".

3. To find out whether you have other health insurance.

Do You Have Health Benefits From Sources OTHER Than New York 65?

Here are several examples of other insurance or plans that might be the source of benefits to you in connection with an illness or injury for which you are filing a claim with New York 65:

An individual health insurance policy issued by an insurance company.

An individual Blue Cross or Blue Shield membership, or both.

A group health insurance plan under which you may still be insured in connection with present or former employment. This might be a group plan where an insurance company has issued policies in the name of the employer, or

A group Blue Cross or group Blue Shield Plan.

A welfare fund or plan related to present or former employment.

If you have received, or expect to receive, benefits from any of the sources mentioned above in connection with the same illness or injury for which you are making claim to New York 65, New York 65 cannot duplicate those benefits. You should give as much information as possible in answering the questions on the claim form about the source of such other benefits.

If you have already received benefits from another source, you probably received along with the check a statement from the insurance company or other plan. Or you may have received a copy of a hospital or other bill which has been paid in your behalf by the insurance company or other plan. If so, please attach the statement or bill to the New York 65 claim form. This will be returned to you later, if you so request.

If you receive treatment, medications or other health services *without charge* from some other plan, you should not claim benefits from New York 65 for those same items.

IF YOU INCURRED EXPENSES WHILE IN A HOSPITAL

- Separate Parts One and Two at the perforation.
- Fill out "A. Insured's Statement" and sign your name next to arrow 1 to authorize release of information to New York 65.
- If you wish New York 65 to make the check payable to the hospital, sign your name next to arrow 2.

Leave the form with the hospital to fill out, and ask them to mail it to New York 65 after completing "B. Hospital Statement".

IF YOU INCURRED EXPENSES IN A CONVALESCENT NURSING HOME

Separate Parts One and Two at the perforation.

Fill out "A. Insured's Statement" and sign your name next to arrow 1 to authorize the nursing home to release information to New York 65.

If you wish New York 65 to make the check payable to the nursing home, sign your name next to arrow 3.

Leave the claim form with the nursing home, asking them to fill in "C. Convalescent Nursing Home Statement" and mail this to New York 65.

The amount of expenses allowable under New York 65 Major Medical for medical or surgical services of doctors is the excess, if any, of (i) the doctor's actual fee but not more than the established fee in the area in New York State in which you reside under the local community medical expense indemnity plan (Blue Shield) for families with maximum yearly income of $6,000, over (ii) the amount of all benefits otherwise paid or payable for such expenses under New York 65 Basic and under all other plans. For an example of how this provision would operate in your case, write to New York 65, giving your Certificate number, and describing any health insurance benefits that you might receive from plans other than your New York 65 plans.

IF YOU HAD AN OPERATION PERFORMED IN A HOSPITAL

(Presumably you have already separated Parts One and Two and have completed "A. Insured's Statement" on Part One in connection with the steps indicated above for making claim for hospital benefits.)

Sign your name next to arrow 4 on Part Two to authorize your surgeon to release information to New York 65.

If you wish New York 65 to make the check payable to your surgeon, sign your name next to arrow 5.

Give Part Two of the claim form to the surgeon, asking him to complete "D. Surgeon's Statement" and to mail the form to New York 65.

IF YOU HAD AN OPERATION PERFORMED IN A PLACE OTHER THAN A HOSPITAL

Do NOT separate Parts One and Two. Complete "A. Insured's Statement" and sign your name next to arrow 1.

Sign your name next to arrow 4 on Part Two to authorize your surgeon to release information to New York 65.

If you wish New York 65 to make the check payable to your surgeon, sign your name next to arrow 5.

Give Parts One and Two to the surgeon who performed the operation and ask him to complete "D. Surgeon's Statement", mailing the form to New York 65.

IF YOU HAD DOCTORS' FEES FOR REASONS OTHER THAN AN OPERATION

Complete "A. Insured's Statement" and sign your name next to arrow 1.
Sign your name next to arrow 4 on Part Two to authorize your doctor to release information to New York 65.
If you wish New York 65 to make the check payable to your physician, sign your name next to arrow 6.
Give Part Two of the form to your doctor and ask him to complete "E. Physician's Statement", and mail the form to New York 65.

IF YOU HAD OUT PATIENT LABORATORY OR X-RAY EXPENSE INCIDENT TO DIAGNOSIS

Complete "A. Insured's Statement" and sign your name next to arrow 1 (unless you have already done so in connection with some other section of the claim form).

If you do *not* have a bill to cover the X-ray or laboratory expense, ask the doctor, laboratory or hospital which provided the service to complete "F. Laboratory Statement," and mail the form to New York 65.

If you *have* a bill covering the X-ray and laboratory expense, it is not necessary to complete "F. Laboratory Statement". Instead, you may submit the bill to New York 65 as instructed below.

IF YOU HAD NURSING CARE EXPENSE

(Private duty nursing services by registered professional nurses or licensed practical nurses, or home nursing services through visiting nurse or public health nursing services). Since nursing service must have been recommended by your doctor, you have presumably sent in "A. Insured's Statement" in connection with other expenses for this illness.

If you do *not* have bills to cover your nursing expense, each nurse who cared for you should complete and sign the appropriate portion of "G. Nurses' Statement". You should then mail the form to New York 65.

If you *have* a bill or bills to cover your nursing service, it is not necessary to complete "G. Nurses' Statement". Instead, you may submit the bills to New York 65 as instructed below.

IF YOU HAD EXPENSE FOR MEDICATIONS PRESCRIBED BY YOUR DOCTOR OR FOR PRESCRIBED APPLIANCES OR EQUIPMENT

(See your Certificate Booklet for the kinds of "Other Services and Supplies" for which it may be possible to claim New York 65 Major Medical Expense benefits.) You have presumably sent in "A. Insured's Statement" in connection with other expense for this illness.

Ask the doctor who prescribed the medicines, special appliances or special equipment to complete and sign "H. Prescribed Medications or Special Item Statement".

Attach the bill or bills to the claim form and mail it to New York 65.

IF YOU HAVE BILLS RELATED TO ANY OF THE FOREGOING KINDS OF EXPENSE

You should fill out "I. Listing of Attached Bills" if bills of any kind are attached to the claim form, even though the bills may be referred to in one of the other sections. Listing the bills here helps the New York 65 office to give you fast and accurate claim service.

Sign your name next to arrow 7, fill in your mailing address, and mail the form, with bills attached, to New York 65.

IT'S EASY TO FILE YOUR CLAIM FOR NEW YORK 65 BENEFITS

Making a claim for New York 65 benefits is simple. As you'll see inside this folder, after you have given the essential information needed in Section A — the Insured's Statement — you need only sign your name opposite the arrows in the other Sections. This authorizes release of information to New York 65, or assigns benefit payments to the hospital, convalescent nursing home, physician or surgeon, as the case may be.

You'll note that the New York 65 Claim Form comes in two Parts. Part One covers hospital and nursing home benefits, and Part Two covers surgical, medical and miscellaneous expenses.

If your claim requires that *both* Parts be filled in, you merely separate these at the perforation — leaving Part One with the hospital or convalescent nursing home to complete and mail to New York 65. Part Two may then be handed to your doctor, laboratory or nurse for similar attention and action.

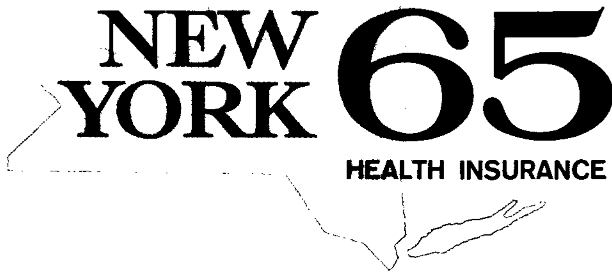
Generally, the two Parts of the form will be filled in separately and mailed to New York 65 at different times. Therefore, upon mailing its benefit check, New York 65 will also mail you *another* blank Claim Form — so you won't have to wait for all bills to come in, or wait to fill in *all* Sections of the form before filing for benefits under any particular *other* Section.

For example, suppose you have been in a hospital and your doctor has recommended that you complete your recovery in a convalescent nursing home. As soon as you are ready to leave the hospital, you should complete "A. Insured's Statement" on Part One of the form and ask the hospital to complete "B. Hospital Statement," and mail this to New York 65.

When New York 65 mails a check for the hospital benefit to you, it will at the same time mail you another blank claim form.

When you are ready to leave the convalescent nursing home, you will thus have another Part One which you and the nursing home may use to file claim for the expenses incurred in the nursing home.

Similarly, Part Two may be handed to your doctor or surgeon for completion and for mailing to New York 65. Again, another blank form will be sent to you by New York 65, and you will have it available for any other claim need that might arise, such as diagnostic x-ray and laboratory examination.



**The New York 65
Health Insurance Association
Is a Non-Profit Organization of
Leading Insurance Companies
Serving New York State Residents**

NEW YORK 65 HEALTH INSURANCE ASSOCIATION
[illegible] WEST [illegible] NEW YORK [illegible] NEW YORK

EXHIBIT E

Promotional Folder for Special Enrollment Opportunities in New York 65

SPECIAL ENROLLMENT OPPORTUNITIES IN

BASIC and

MAJOR MEDICAL

HEALTH INSURANCE BENEFITS

FOR

New York State Residents Over 65

LOW-COST...NO MEDICAL EXAM REQUIRED

HOW NEW YORK 65 WORKS...HOW THE MAJOR MEDICAL PLAN GIVES YOU PROTECTION TO HELP YOU PAY REALLY BIG MEDICAL BILLS

New York 65 Major Medical is designed to provide health insurance against the *big* medical and hospital bills incurred by a serious accident or illness — bills *above and beyond* those normally covered by basic hospital-surgical-medical plans, such as New York 65 Basic, Blue Cross-Blue Shield, and others. It's offered as a vital addition to *any* of these basic plans.

For example, assuming you have New York 65 Regular Basic (*or the equivalent benefits under another basic plan**) this is how New York 65 Major Medical works:

After the Basic has paid room and board benefits for the first 31 days of hospitalization, New York 65 Major Medical picks up and extends this benefit.

After benefits for "other hospital services and supplies" have been paid by the Basic, the Major Medical picks up and *continues* to pay 80% of such charges.

And after the Basic has paid benefits for 31 days of convalescent nursing home care, New York 65 Major Medical steps in to extend *this* benefit through another 60 days.

As pointed out in the schedule below, the Major Medical plan pays a maximum benefit for all these charges up to $3,600 *for each confinement.*

New York 65 Major Medical also provides benefits covering Other Medical Expenses (doctor bills, nursing services, drugs, X-Rays, etc.). The plan starts paying for *these* charges after you pay a yearly $75 cash deductible and after the program's Basic hospital-surgical-medical benefits, or their equivalent, have been used up. New York 65 Major Medical then pays 80% of the benefits shown below, up to a maximum of $10,000 over your lifetime.

Just think how vitally important New York 65 Major Medical protection could be to *you!* And it costs only $9 a month!

**You are eligible for the Major Medical plan alone, whether or not you have basic coverage. However, if you have no basic coverage, you should be prepared to meet the equivalent of New York 65 Regular Basic benefits out of your own pocket.*

EXPENSES NOT COVERED UNDER NEW YORK 65

Expenses during the first 6 months of your insurance — or during any period of hospital confinement commencing in the first 6 months — for any condition for which you received treatment or diagnosis during the 90 days *before* your New York 65 insurance became effective.

Other principal exclusions are: injuries and diseases covered by Workmen's Compensation; care for mental and nervous conditions outside a hospital; dental care; eye examinations and glasses; hearing aids; diseases or injuries arising out of any war; expenses for services and supplies furnished without charge by any government; expenses which you would have no obligation to pay if you did not have insurance.

Benefits under New York 65 are subject to reduction if you have benefits under other hospital, surgical or medical plans.

HERE'S HOW NEW YORK 65 MIGHT BENEFIT YOU!

NEW YORK 65 REGULAR BASIC

($10 a Month)

Pays Benefits Up to 31 Days For

- Hospital room/board up to $18 a day
- Miscellaneous hospital charges up to $150
- Doctors fees in hospital (non-surgical) up to $145.

  $6 per day, first week—$5 per day, second week—$4 per day, thereafter
- Convalescent nursing home charges up to $7.50 a day following at least 5 days hospital confinement.

PLUS: Surgery, in or out of a hospital, and Radiation Therapy for Malignancy according to a schedule, up to $250.

Same plan available on Optional basis at a cost of $8 per month with room and board benefits limited to $12 per day.

The important benefits and limitations of New York 65 are presented in this folder. Complete details are given in the Certificate Booklet you will receive shortly after you enroll.

NEW YORK 65 MAJOR MEDICAL BENEFITS

($9 a Month)

HOSPITAL AND CONVALESCENT NURSING HOME BENEFITS

(Maximum Benefit $3600 FOR ANY ONE CONFINEMENT)

- Hospital room and board benefits up to $18 a day after the first 31 days of confinement.
- Benefits for other hospital services and supplies at 80% of the amount by which expenses exceed $150.
- Convalescent nursing home benefits up to $7.50 per day for a maximum of 60 days following at least 5 days hospital confinement.

(NOTE: After you've been out of a hospital or convalescent nursing home for 90 days, you're entitled to a new maximum benefit of $3600 for any future confinement.)

OTHER MEDICAL EXPENSE BENEFITS

(Maximum Benefit $10,000 DURING YOUR LIFETIME)

Benefits for the following medical expenses at 80% of the amount by which expenses exceed $75 in a calendar year:

- **Doctor's medical and surgical services for home, office or in-hospital care — with maximum expense equal to the excess of the established Blue Shield fees in your community for families with maximum yearly income of $6,000 over the benefits payable under other plans for these services.** ***If you have no basic coverage for surgery or doctor fees in hospital, you should be prepared to meet the equivalent of New York 65 Basic benefits out of your own pocket.***
- Private duty nursing services by registered professional nurses, registered visiting nurses, or licensed practical nurses, not in excess of charges of $1,000 in any calendar year.
- Drugs and medicines which require a doctor's prescription.
- Diagnostic x-ray and laboratory examination and out-patient diagnostic services
- Physiotherapy . . . artificial limbs and eyes . . . trusses and crutches
- Anesthetics
- Oxygen and rental of equipment for its administration
- Rental of radium and radioactive isotopes
- Blood and blood plasma
- Rental of a wheel-chair, hospital-type bed, iron lung, or other equipment for the treatment of respiratory paralysis
- Local ambulance service to or from a hospital or convalescent nursing home

BENEFITS UNDER NEW YORK 65 ARE SUBJECT TO REDUCTION IF YOU HAVE OTHER HOSPITAL, SURGICAL OR MEDICAL INSURANCE

YOU MAY ENROLL WHEN YOU MEET ANY OF THESE SPECIAL "INTERIM" ENROLLMENT OPPORTUNITIES

When you come under any of the special "interim" enrollment classifications listed below, you can sign up immediately for New York 65. You do not have to wait for an open enrollment period to obtain this vital coverage. Even though the program is not at that time open to the public generally, you can enroll at once *if you apply within 31 days of your eligibility date.*

Here are the "interim" eligibility dates:

1. Your date of retirement if you are over 65.
2. Your 65th birthday.
3. Date you move into New York from outside the State, if then over 65.
4. Date that your spouse became eligible under any one of the preceding 3 classifications, provided he or she enrolls.
5. Date of death of your spouse, if you are over 65.
6. Date of your marriage to an enrolled person who is over 65.

Your insurance begins upon receipt by the Association of your completed application and first premium payment. *If you were confined in a hospital or convalescent nursing home on or during the 31 days prior to the date your coverage in New York 65 would otherwise become effective, your protection will begin 31 days after you are no longer so confined.*

SEE YOUR AGENT OR BROKER TODAY OR WRITE NEW YORK 65 FOR FULL DETAILS ABOUT THE PLAN'S BENEFITS AND LIMITATIONS... AND FOR HELP IN ENROLLING

HIGHLIGHT FEATURES OF NEW YORK 65 BENEFITS

- No medical examination.
- The husband or wife (regardless of age) of an enrollee may enroll in New York 65 at the same time.
- Sons and daughters may enroll their eligible parents in New York 65 and the parents are not required to sign the enrollment form. In fact, *anybody* may enroll *any* eligible person.
- New York 65 Major Medical is especially important for sons and daughters. Even though the parents may already have Blue Cross or other basic coverage, or sufficient funds to pay basic expenses, catastrophic major medical expenses could fall upon the son or daughter disastrously.
- The Major Medical plan pays benefits for charges in a hospital or convalescent nursing home up to $3600 for each *confinement* . . . and in addition pays lifetime benefits *up to $10,000* for doctor bills and many other medical expenses. (See details inside.)
- You can keep your New York 65 insurance in force if you move out of the State and continue to live in the U. S. or Canada.
- You have 10 days after receiving your Certificate Booklet to decide if you are satisfied with New York 65. If not, just return the booklet and your money will be refunded in full.
- The Association has the right to modify or discontinue the New York 65 Program, but your individual coverage cannot be modified or cancelled, nor your premiums increased, unless similar action is taken for all persons enrolled for the same plan.

This New, Non-Profit Program Helps Answer a Vital Need of N. Y. State Residents Over 65

Here's how you might take advantage of the unique health insurance protection offered by New York 65—the new low-cost program recently introduced for New York State residents over 65.

Well over 100,000 older people in the State have already enrolled. And you, too, will welcome New York 65.

It offers *Basic* hospital-surgical-medical benefits, and under a separate plan called New York 65 *Major Medical,* provides broad benefits *beyond* basic coverage to give vital protection against the potentially disastrous expenses of *prolonged* illness or serious accident. Either of these plans may be obtained separately, or in combination.

Until recently, *Major Medical* coverage had not been readily available to those 65 or over at a cost they could afford, or without their having to take a medical examination. Yet it's the one form of health insurance they usually need *most!*

In recognizing this critical need, leading insurance companies serving New York State joined forces in a *non-profit* Association to bring you New York 65—a program that could save you literally thousands of dollars in doctor and surgical bills and hospital and convalescent nursing home charges.

Read about New York 65 carefully. Then, for full details, call your Agent or Broker. Or write New York 65.

EXHIBIT F

Responses to Questions as Requested by the Senate Subcommittee on the Health of the Elderly on March 10 and 17, 1964

NEW YORK 65 HEALTH INSURANCE ASSOCIATION,
New York, N.Y., April 15, 1964.

Hon. PAT McNAMARA,
Chairman, Subcommittee on Health of the Elderly, Special Committee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR McNAMARA: The attached information is submitted in response to your letter of March 10 and that of Mr. Constantine dated March 17.

Sincerely yours,

MORTON D. MILLER, *President.*

Question 1. All literature describing benefits and rates including scripts and "tear-sheets" used in promotion.

Answer 1. The following material is enclosed: [1]

Initial open enrollment, October 15 to November 15, 1962:
- Exhibit No. 1. New York 65 filmstrip and record.
- Exhibit No. 2. Proofs of four newspaper ads.
- Exhibit No. 3. Sales aids kit (agents-brokers).
- Exhibit No. 4. Talk for community groups.
- Exhibit No. 5. Kit for hospital administrators.
- Exhibit No. 6. Insureds enrollment packet.

Second open enrollment, June 1–15, 1963:
- Exhibit No. 7. Proof of newspaper ad.
- Exhibit No. 8. Sales aids kit (agents-brokers).
- Exhibit No. 9. Two TV scripts.
- Exhibit No. 10. Inquiry letter.

Special enrollment opportunities:
- Exhibit No. 11. Agent-broker kit, February 1963.
- Exhibit No. 12. Agent-broker kit, October 1963.

This material constitutes the major portion of the promotional material prepared by New York 65 and directed to the general public or the agents and brokers of New York State.

Question 2. (*a*) Total number of different persons enrolled in program from inception to March 1, 1964; (*b*) total aged persons insured as of March 1, 1964; (*c*) total number of persons accepted for coverage during initial enrollment period and total number of persons insured immediately prior to commencement of second open enrollment period. (Please provide subtotals indicating persons covered for basic only, major medical only, and basic and major medical.)

Answer 2. (*a*) The total number of persons who submitted applications for coverage from inception to March 1, 1964 were:

Initial open enrollment (Oct. 15 to Nov. 15, 1962)		107,404
Interim enrollments (see folder entitled "Special Enrollment Opportunities in New York 65" for eligibility requirements)		1,734
Second open enrollment (June 1–15, 1963)		[2] 33,552
Basic added	281	
Major medical added	421	
Total	702	
Total applications		142,690

The distribution by plan is as follows:

	Initial open enrollment	Interim enrollments	Second open enrollment
Basic	39,739	523	13,421
Major medical	41,888	844	12,079
Combination	25,777	367	8,052
Total	107,404	1,734	33,552

[1] Retained in committee files.
[2] In addition, 702 persons who already had some coverage with New York 65 took this opportunity to add additional coverage, as follows:

Of the 142,690 applications received by New York 65 from the inception of the program until March 1, 1964, 3,031 applications (2,237 in the initial open enrollment and 794 in the second open enrollment) could not be processed because the individual was not eligible due to age or nonresidence, or was confined to a hospital or nursing home, or no premium payments were received or the application was incomplete in other respects.

Deducting the 3,031 leaves 139,659 applicants to whom certificate booklets were issued of whom 4,980 (3,723 in initial open enrollment and 1,257 in the second open enrollment) took advantage of the free-look provision under which an individual has 10 days after receiving his certificate booklet to decide whether he is satisfied with New York 65. When he is not, the certificate booklet may be returned and the premium paid is refunded in full. In such cases, the insurance is considered as never having been issued.

Therefore, the total number of different persons who became insured under New York 65 was:

Basic	50, 658
Major medical	51, 749
Combination	32, 272
All plans	134, 679

(b) Total aged persons insured as of March 1, 1964:

Basic	41, 741
Major medical	41, 882
Combination	26, 512
All plans	110, 135

(c) Total number of persons who became insured during the initial enrollment period and total number of persons insured immediately prior to commencement of second open enrollment period.

	Initial open enrollment	Prior to 2d open enrollmen
Basic	37, 534	33, 21
Major medical	39, 564	34, 76
Combination	24, 346	21, 05
All plans	101, 444	89, 03

Our terminations during the 4 months, December 1963 through March 1964, have been less than 1 percent per month and our best estimate indicates that more than one-half are due to death. This is only to be expected, based on our average age of about 74 years.

Question 3. How many of those persons accepted for insurance during your initial open enrollment period were still insured under the program as of March 1, 1964?

Answer 3. Of the 101,444 persons insured during the initial open enrollment period, 81,822 were still insured as of March 1, 1964. We have no breakdown of this last figure by plan.

Question 4. What was the average age of New York 65 policyholders as of the end of your initial open enrollment period? What was the average age of your policyholders as of March 1, 1964?

Answer 4. The average age of policyholders at the end of the initial open enrollment was 73.5 years.

Plan	Male	Female	Total
Basic	74. 6	74. 0	74.
Major medical	71. 8	71. 3	71.
Combination	75. 9	75. 7	75.
All plans	73. 7	73. 4	73.

The average age of persons who enrolled during our second "open" enrollment period was 73.3 years.

Plan	Male	Female	Total
Basic	74.2	73.7	74.0
Major medical	71.8	71.2	71.4
Combination	75.7	75.2	75.4
All plans	73.6	73.2	73.3

We believe that the average age of those insured as of March 1, 1964, is substantially the same.

Question 5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various segments of the New York 65 program (provide separate data for the regular basic and major medical portions).

Answer 5.

	Basic	Major medical	Total
Premiums earned	$8,880,894	$8,119,186	$17,000,080
Total claims incurred	8,204,283	6,461,166	14,665,449
Number of beneficiaries			23,069
Number of claim payments			47,989

These figures relate to the period from October 15, 1962, through December 31, 1963.

Question 6. Based upon all available information, advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years.

Answer 6. It is difficult at this time to answer this question. New York 65 has been operating for slightly more than 17 months. Our original projections on which our current premium rates are based were made for 2 years. So far we have been running somewhat ahead of our estimates as far as payments of benefits are concerned.

We are presently conducting our third "open" enrollment during the month of April. Since this enrollment is being undertaken without widespread public advertising, we do not at this time know what the final results will be in terms of numbers of new enrollees and in terms of additional premium income.

Our original projections indicated that if medical and hospital costs continue to increase at the same rates as they had for the previous 2 years, it seemed likely that some upward adjustment in the premium rates would have to be made at the end of the second year or reasonably soon thereafter. So far, medical and hospital rates have continued to increase at rates similar to those of the 2 previous years.

With the unknown of additional premium income due to new enrollments, which exclude benefit payments for preexisting conditions for 6 months, it is difficult for us to come to definite conclusions concerning future premium rates at this time.

All other indicators, however, point to the need for a modest increase within the next 2 years unless our current claims demands change from their present pattern.

We do not now anticipate any change in benefits.

Question 7. Note: To extent possible, provide all data for persons age 65 and over, excluding spouses who are under age 65.

Answer 7. We do not maintain such records. However, our best estimates would indicate about 3 percent of our insureds are spouses under the age of 65.

Question 8. Supplemental request of March 17: Results of your mail survey of several thousand recent terminations designed to determine the principal reasons for such termination and their relative frequency.

Answer 8. A questionnaire (copy attached) was mailed in November 1963 to 1,748 individuals and replies were received from 703, or about 41 percent.

The replies to the questionnaire were as follows:

Unsatisfactory experience with a claim	22
Bought other health insurance protection	114
Benefits too limited	40
Moved out of New York State	1
Did not receive offer to reinstate the insurance	14
Combination of 2 of the above reasons:	
Benefits too limited and bought other health insurance protection	52
Unsatisfactory experience with a claim and benefits too limited	19
Unsatisfactory experience with a claim and bought other health insurance protection	5
Other	
Deceased	139
Cost	46
Confined to home for the aged	42
Duplicate coverage	7
Requested reinstatement	45
Questioned premium status	145
Miscellaneous	12

The 139 replies stating that the insured had died are significant in that we had eliminated the deaths which had been reported to us before mailing out the questionnaires.

Senator McNamara. The next witness; and I might say there are only two more and we hope they are going to be short.

The Associated Connecticut Health Insurance Cos.; Mr. L. J. Kendall, Jr., general manager.

We are very happy to have you here.

Mr. Seery. Senator, I am Mr. Seery, the chairman of the executive committee of Connecticut 65. Mr. Kendall is our general manager and he was not able to be here.

Senator McNamara. All right, sir; you may proceed, then.

We have your statement. It came in a little bit late, but we have it and we appreciate it very much. Proceed in your own manner.

STATEMENT OF WILLIAM N. SEERY, CHAIRMAN, EXECUTIVE COMMITTEE, ASSOCIATED CONNECTICUT HEALTH INSURANCE COS.

Mr. Seery. Thank you, sir. We apologize for being late with the statement but I have been out of town and it seemed to have been mislaid somewhere along the line.

Mr. Chairman, my name is William N. Seery. I appear as chairman of the executive committee of the Associated Connecticut Health Insurance Cos., in response to the invitation extended to the associated companies in your letter of April 6, 1964.

There are 32 insurance companies in this association which for 2½ years have successfully offered to residents of Connecticut, age 65 and over, a major medical insurance program now widely known as Connecticut 65.

In response to a request from Chairman McNamara under date of March 10, 1964, I furnished to him on April 15 extensive information with respect to Connecticut 65. This included statements that I was privileged to make to the insurance committee of the Connecticut General Assembly on March 7, 1961 as to the purpose of the proposed

legislation under consideration, and at a public hearing in Connecticut on October 23, 1963, giving an accounting of Connecticut operations to that time. I do not believe it is necessary for me to repeat here all of the detail which is contained in those two statements.

In 1961, I stated to the insurance committee of our legislature our conviction that most senior citizens can and want to take care of their own needs, given an appropriate vehicle, and that we proposed to offer them an additional insurance opportunity especially designed to protect against major financial losses due to the cost of medical care. I said that we proposed to do this without any requirement that the individual submit medical evidence of good health. In Connecticut 65 we have carried into effect these proposals and are proud of the accomplishments of this program.

What are the initial results of this private experiment in the field of voluntary health insurance coverage for the elderly? Well, in the first 29 months of its existence, Connecticut 65 gave major medical protection to 35,166 individuals whose average age was slightly over 74. Approximately 25 percent of these enrollees have received benefits in excess of $6 million with an estimated additional $1 million awaiting final claim filing. This represents an average of $817 per claimant.

This average of over $817 each for approximately 25 percent of the enrollees in the space of 29 months is clear evidence of the need of senior citizens for Connecticut 65 coverage and of its value to them.

At the end of our initial enrollment period in 1961 we insured 21,849 people. On March 1, 1964, we insured 25,479 people. These included 15,619 of those who became insured in October 1961. This persistence is notwithstanding the lapse rate contributed to by the high death rate among this age group, which is a major problem facing any health insurance plan to cover the aged. We estimate that at least 35 percent of the dropouts in Connecticut 65 have been the result of deaths.

We have estimated that Connecticut 65 covers about 10 percent of the residents of the State 65 years of age and over. The number of aged in Connecticut has increased and our enrollment has increased correspondingly.

We think that over 80 percent of our 260,000 senior residents now have some form of basic health insurance coverage. Most of them have hospital coverage. For example, Connecticut Blue Cross covers 160,000 people 65 and over. Many employers continue health insurance for retired employees, including the major medical coverage they provide for active employees, and this trend has been accelerating. In addition, some 50,000 to 60,000 have coverage through individual insurance company contracts. Basic health insurance is widespread among Connecticut senior citizens. Thus, it is not surprising that only slightly over 3,600 enrollees carry their basic benefits with Connecticut 65.

It is significant, however, that four out of five Connecticut 65 enrollees have chosen the high option $10,000 major medical coverage. Furthermore, the premium payments that Connecticut 65 enrollees make for major medical insurance are in addition to payments they make for basic health insurance.

I have referred to the fact that Connecticut 65 was a pioneering effort and that it was experimental in nature. Connecticut 65 is continuing to employ various marketing methods, always seeking those most productive per dollar of outlay. By this means, we expect continually to improve the position of Connecticut 65 and to assure the public of a continuing opportunity to obtain good major medical coverage at lowest possible cost.

As you are no doubt aware from the material furnished you by others as well as by Connecticut 65, the cost of health insurance care has been increasing and is expected to continue to increase due to costs attendant upon the improvement in medical knowledge and medical techniques, as well as to the upward trend in labor and other costs. Increases in the charges for health insurance must, of course, follow increases in cost of the benefits provided. Connecticut 65 increased its rates effective January 1, 1964, and you will no doubt be interested in the results. The net loss in Connecticut 65 enrollment was less than 1 percent at the time the increase was made effective. Furthermore, since January 1964 when the rate increase went into effect, new enrollees have once again exceeded terminations so that even this modest loss will be completely recovered very shortly.

In conclusion, may I say that we are proud of our program thus far and expect that they will be still better in the future. Furthermore, it is to be noted that the example set by Connecticut 65 has led other States to inaugurate similar programs, programs that are but one more illustration of the dynamic way the insurance companies of this country are meeting the needs of its citizens.

Senator McNamara. Thank you, Mr. Seery.

You have recently had an increase in your rates, and this has to be approved by the State insurance commissioner?

Mr. Seery. Yes, sir.

Senator McNamara. You indicated at the time that this was not a sufficient increase, that you expected to have to have further increases?

Mr. Seery. That is correct. And in my statement I cited Wilbur Cohen, Assistant Secretary of Health, Education, and Welfare, who a few years ago stated that hospital care costs would increase 5 to 10 percent a year for the foreseeable future. And it is just bearing out what Mr. Cohen had said.

Senator McNamara. Is it true that your company received the aid of many insurance executives who donated their services to your program?

Mr. Seery. In launching any program such as this, Senator, it requires a little extracurricular work. We felt this was a very worthy cause and it might have meant we worked a few Saturdays and Sundays that we otherwise would not have, but we were more than willing to do it.

Senator McNamara. I am sure it is a good cause.

Does this reduce the cost of your plan somewhat? If you had to hire these executives, I suppose it would add a great deal to your overhead.

Mr. Seery. I presume it would. Depending on the length of time they spent there.

This is significant. In our original testimony we estimated the expense would be between 10 and 12½ percent, including a State

premium tax of 1¼ percent, which we pay and New York does not pay. For the first 9 months of 1963, I have these figures available, they were in my testimony before the Connecticut Insurance Commission. We were to target with 12.4 percentage points which represented State premium tax.

Senator McNAMARA. Do you feel you will continue to get the help of these insurance executives?

Mr. SEERY. As a matter of fact, it is not needed today to that extent. The executive committee meets possibly three or four times a year; we have a paid staff running the organization now, and our contribution is rather limited currently.

Senator McNAMARA. Do you pay the people for attendance at the executive committee meetings?

Mr. SEERY. No, as a director of an insurance company of which you are an employee you do not get fees for attending a director's meeting, so we do not here either.

Senator McNAMARA. This goes in as part of their regular job?

Mr. SEERY. That is correct.

Senator McNAMARA. Do you have any comments?

Senator FONG. Are the 32 insurance companies domiciled in the State?

Mr. SEERY. No; as far away as California, the Beneficial Standard, Continental, Allstate, from New York we have the Equitable, the Hancock, Massachusetts Mutual.

It being a pioneering venture, only 32 entered this one——

Senator FONG. Did you invite any insurance company——

Mr. SEERY. We invited any insurance company that had $100,000 or more of premiums in the State in order to keep the expenses down.

Senator FONG. They were all requested to participate?

Mr. SEERY. No; they were given the privilege of participating. We Connecticut companies would have gladly taken it all had they not elected to come in.

Senator FONG. Do you know how many States have such policies?

Mr. SEERY. It is pretty hard to keep count. I heard Mr. Miller speak here. I saw recently where the State of Michigan is contemplating such a program as this. Whether the legislation has been enacted or not, I do not know.

Actually, in effect today we have Massachusetts, Connecticut, New York, Texas, and California, with, as Mr. Miller said, Virginia and North Carolina enrolling currently. Legislation has passed in Ohio, and it is coming at us pretty fast right now.

Senator FONG. Have you given to this committee some of your brochures?

Mr. SEERY. Yes; those were sent to the committee here I believe about 2 weeks ago.

Senator McNAMARA. We have them.

Senator FONG. Thank you very much.

Senator McNAMARA. Thank you very much again, sir.

Our next and final witness is Mr. Herbert Woods, general manager of Massachusetts 65 Health Insurance Association of Boston, Mass.

Will you see that the reporter gets the name of your associate?

STATEMENT OF HERBERT S. WOODS, GENERAL MANAGER, MASSACHUSETTS 65 HEALTH INSURANCE ASSOCIATION; ACCOMPANIED BY RAYMOND L. BURATI

Mr. Woods. My associate is Mr. Raymond L. Burati, a member of Massachusetts 65.

Senator McNamara. You may proceed.

Mr. Woods. My name is Herbert S. Woods. I am general manager of the Massachusetts 65 Health Insurance Association headquartered in Boston, Mass. I am here in response to the invitation of the chairman of the Senate Subcommittee on Health of the Elderly, Senator McNamara, to discuss the activities of Mass 65. My comments will be directed to the areas of inquiry stated in your chairman's letter of April 6, 1964.

Massachusetts was the second State, following Connecticut, to provide this kind of health insurance protection for its elderly citizens. While the enabling legislation and the basic need for such insurance varied from that of our neighboring States, Connecticut and New York, the coverage Mass 65 provides is similar to both Connecticut 65 and New York 65.

Mass 65 was authorized on April 30, 1962, in chapter 392 of the Acts of the Commonwealth of Massachusetts. The purpose of this act was:

> An Act authorizing joint action by insurance companies in underwriting a single group policy of health insurance insuring persons 65 years of age and over and their spouses.

Mass 65 is a voluntary association of 46 leading insurance companies It was founded in recognition of the need for low-cost major medical protection which was not generally available to many of the State's citizens age 65 and over. In recognizing this need, Mass 65 was aware that many persons age 65 and over already had basic health insurance coverages; that a variety of basic insurance plans were already available; and, that Massachusetts was one of the first States to make MAA help available to those residents who most needed the assistance it offered.

To provide major medical coverage Mass 65 offered plan 1, major medical only. This type of coverage offers benefits to cover a wide range of medical expenses that may not be covered by other available plans. It is intended to help meet the sizable bills that accumulate when prolonged or serious illness strikes. It is intended primarily to supplement existing basic insurance protection many aged persons already have.

For those persons who had no basic health insurance coverage, or who could not, for any reason, get it, Mass 65 also offered basic hospital-surgical coverage in combination with major medical. This coverage was known as plan 2. It was intended to provide complete coverage to those who could not take advantage of the major medical protection offered by plan 1. Complete details of both Mass 65 plans has been presented to Senator McNamara prior to today's hearing.

You may, however, be interested in the following features which we believe are unique and which were deemed necessary by the spon-

soring companies to make Mass 65 available to as many persons as possible.

No medical examination is required. Signature of the insured is not required. Parents and relatives can be enrolled by other family members. Anyone can enroll any eligible person. The spouse of any applicant can also become insured if 50 years of age or over and if not employed 30 hours or more per week. Coverage continues if member moves anywhere in the United States or Canada. Applicant gets 10-day inspection and can have premium refunded by returning initial premium receipt. Members may cancel at any time, but coverage cannot be canceled for any individual by Mass 65 so long as he remains eligible and pays premiums.

We submit today that Mass 65 is doing the job it set out to accomplish and cite the following facts from the first year of our stewardship to the senior residents of Massachusetts who have joined this voluntary health insurance plan:

More than 12,000 individual claims have been paid and incurred during the first 15 months since the plan became effective. These claims total more than $6 million.

More than one out of every four persons insured have received one, or more, of these benefit payments.

Nearly 50,000 persons enrolled in Mass 65 when it was initially offered in October 1962. Nearly 40,000 are currently insured.

Nearly 40,000 persons age 65 and over are enrolled in Mass 65 today, although attrition due to death is estimated at 12 percent annually and no major public promotion has been undertaken since the original enrollment in late 1962.

Massachusetts 65 is not content to rest on the progress indicated to date. The executive, technical, legal, sales and promotion, and the medical relations committees are at work continually to make Mass 65 available to more of the State's deserving elders and to improve the coverage provided by the current plans at the least possible cost to present and prospective members.

This review of Massachusetts 65's progress would not be possible, nor complete, without tribute to the unselfish cooperation of the thousands of Massachusetts insurance agents and brokers; the medical profession and the hospitals; the dedicated headquarters staff; and of the member companies who sponsor the plan. All have indeed evidenced a sincere desire, backed with action, to provide the health insurance protection Massachusetts 65 has made available to our elder citizen.

Senator McNamara. Thank you very much, sir.

I think the way you described your plan is an indication that this would be an excellent supplement to the basic benefits which King-Anderson seeks to supply.

I do not expect you to agree with that.

Mr. Woods. No comment. [Laughter.]

Senator McNamara. It would seem to me that it would be one of the plans that would work in very well with the King-Anderson plan, and I do not ask you even to comment on it. [Laughter.]

Is it not probable from your experience up to now that you will also have to seek an increase in rate costs as the previous gentleman who testified stated they will?

Mr. WOODS. Senator, we sum that up briefly in our replies to the questions. If I may repeat.

The initial premium rates assume that during the first 2 years incurred claims would be equal to 85 percent of the premium. At the end of the first policy year the actual experience was, in fact, at this level. After a thorough review of the experience statistics, the executive committee authorized the continuance of the initial premium rates for the policy year through December 31, 1964, at which time there will be a further review of accumulated claim experience.

Senator McNAMARA. Do you have these periods where you have an open season when people can apply, and then closed the rest of the year, or is yours available the year around?

Mr. WOODS. Sir, we are in the middle now of an open enrollment period. We also have a quarterly enrollment basis; we also add people when they become 65, when they move into the State, and other means.

Senator McNAMARA. Will you tell me the logic behind this open enrollment period? Why do you not have this thing continuously? Why cannot people apply any time?

Mr. WOODS. Well, there is a selection against it if you had it open at any time, and, therefore, we have these periods in which we ask for a time limit.

Senator McNAMARA. Does it cut down on the overhead, the bookkeeping, and so forth, so you spread your overhead over a larger period?

Mr. WOODS. That is correct.

Senator McNAMARA. That would be one justification?

Mr. WOODS. Yes, sir.

Senator McNAMARA. Thank you very much for your cooperation with the committee. We appreciate your being here.

We will resume at 10:15 tomorrow morning.

Thank you all very much.

(Whereupon, at 12:55 p.m., the hearing was adjourned, to reconvene at 10:15 a.m., April 29, 1964.)