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

EIGHTY-EIGHTH CONGRESS

SECOND SESSION

PART 4A

APPENDIX

WASHINGTON, D.C.

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NOTE.—Three hearings on Blue Cross and other private 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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APPENDIX A

RESPONSES TO SUBCOMMITTEE QUESTIONNAIRES RECEIVED FROM INDIVIDUAL INSURANCE COMPANIES:

1. BANKERS LIFE & CASUALTY CO.
2. CONTINENTAL CASUALTY CO.
3. FIREMAN'S FUND INSURANCE CO.
4. MUTUAL OF OMAHA.

1. BANKERS LIFE & CASUALTY CO.

BANKERS LIFE & CASUALTY CO.,
Chicago, Ill., April 22, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR MCNAMARA: Enclosed herewith is table 1–A which we request that you kindly add as an addendum to our submission dated April 15, 1964, of material responsive to questions submitted to us by your committee. You will note that the added table segregates the numbers of insured persons having hospital-surgical plans, medical-surgical plans, and hospital indemnity plans. The totals add up to the same number of policyholders as appeared on our original submission.

It was our impression that you originally requested figures as to total policyholders of health insurance over age 65 excluding only disability income. This was the basis upon which we supplied the material as originally submitted. With the addition of table 1–A you will have the benefit of the breakdown as above indicated. It should be noted, however, that with the exception of those insured under the GR–706 and P–12, certain scheduled benefits for X-rays, laboratory, etc., were payable whether such expenses were incurred in or out of a hospital on other listed medical-surgical policies. All of the medical-surgical plans contain a surgical schedule, the benefits of which could be assigned to the hospital.

Yours very truly,

EDWARD J. KELLY, *First Vice President.*

[1] References appear in the several appendixes to certain enclosures and attachments which have been omitted due to limitations of space. These data are on file with the subcommittee and are available for study in the subcommittee offices upon written request.

TABLE 1–A

NUMBER OF PERSONS AGE 65 AND OVER APPEARING ON TABLE I HAVING HOSPITAL-SURGICAL PLANS

Plan	In force as of—		
	Dec. 31, 1961	Dec. 31, 1962	Dec. 31, 1963
GR-702	1,285	1,176	869
GR-708	----------	121	242
GR-709	----------	16,589	43,255
P-5	151,036	148,824	133,354
P-6	72,295	65,993	58,544
P-15	1,596	1,470	1,298
P-27	71,375	119,081	143,444
P-33	1,018	869	831
P-45	190	162	119
P-56	1,284	1,676	1,664
P-62	950	2,985	2,674
P-65	101,634	72,770	65,835
P-72	3,289	2,560	2,260
P-76	7,137	9,736	10,685
P-77	5,649	6,883	6,664
P-85	233,400	210,367	186,323
OBS	9,167	9,333	8,609
NC-701	92	119	186
Subtotal	661,397	670,714	666,856

NUMBER OF PERSONS ELIMINATED FROM TABLE I HAVING MEDICAL-SURGICAL PLANS

GR-706	----------	12,824	33,079
P-9	25,841	23,345	20,785
P-12	139,442	130,996	113,140
P-19	1,503	1,361	1,213
P-69	2,419	24,040	21,874
P-89	181,490	163,991	147,027
Subtotal	350,695	356,557	337,118

NUMBER OF PERSONS ELIMINATED FROM TABLE I HAVING HOSPITAL INDEMNITY PLANS

GR-710	----------	7,379	17,702
P-39	15,602	15,719	14,391
P-55	73,167	71,613	64,277
Subtotal	88,769	94,711	96,370
Total per table I	1,100,861	1,121,982	1,100,344

BANKERS LIFE & CASUALTY CO.,
Chicago, Ill., April 15, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SENATOR MCNAMARA: This company is happy to respond with the best available data to the questions submitted to us by the subcommittee. Our personnel has been most appreciative of the assistance of the subcommittee staff members in clarifying problem areas and providing guidance to assure maximum responsiveness.

The material, related information, sources, and exhibits with respect to persons aged 65 and over for the last 3 calendar years will be treated in the order of your questionnaire.

I. TOTAL POLICYHOLDERS (CLASSIFIED BY GROUP AND INDIVIDUAL)

Figures below refer to individual and family group policies written by this company—not true group insurance. Under true group insurance, not a significant part of this company's business, we insure only about 3,000 persons 65 years of age or over.

Total policyholders covered under individual, hospital-medical, and surgical policies (estimated):

As of Dec. 31, 1961	1,100,861
As of Dec. 31, 1962	1,121,982
As of Dec. 31, 1963	1,100,344

Data providing answers to this question was not readily available from standard company records. We have attempted to use the most accurate techniques applicable to the pertinent information to formulate the above estimates.

Our policy P-27 is written exclusively on an individual basis for people age 65 and over so for this policy we have an exact count. Under policies GR-735, GR-739, P-7, P-7A, P-29, 959, 978, and P-86, we assumed no insureds would have reached 65 because the maximum issue ages combined with the maximum duration as of December 31, 1963, would have resulted in few, if any, insureds being 65 or more.

The total number of FH-42 and FH-75 policies was only 3,522, too small a number to have substantially affected the results, prompting us to assume no over 65 insured among these policyholders.

For policies 706, 709, and 710, we were able to analyze by computer the issues of the first 6 months of 1963 and from the data obtained by such analysis estimate the total number of persons insured under these plans at ages 65 and over.

Our estimate for all remaining policies was based on a computer analysis of the age of the applicant for 15 selected plans plus studies of various samples of in-force business made in the past.

A. Available data concerning other health insurance coverage held by policyholders

This company has no data regarding other health insurance coverage of our policyholders.

II. BENEFITS AND PREMIUMS

A. Policy forms, benefits, changes

B. Monthly premium charge, changes

The enclosed binder, "The Modern Answer," contains detailed information on benefits, premiums, and changes on each policy, plus sample policies, for each plan available to persons over 65 during 1961, 1962, 1963. Rate cards indicate rates applicable to those years. Also included are rates which are applicable on policies written since January 1, 1964. Policies issued prior to that date continue at previous rates.

C. Number of policyholders for each policy described

Attached hereto as table I is our estimate of policyholders for each policy form. Included are those covered by policy forms in exhibit noted above (II-B). Other policies appearing in table I were available to persons over 65 prior to the years requested in this survey.

III. EXPERIENCE

A. Premiums earned by policy form

B. Claims incurred by policy form

Present company recordkeeping does not facilitate gathering data on either premiums earned or claims incurred by policy form with respect to insureds over 65. Again, our experience with the policy form issued solely to persons over that age (P-27) does provide total premium and benefit figures as reported to the State insurance department each June 30. (This experience is attached as table II.)

IV. EXCLUSIONS AND LIMITATIONS

Detailed information contained in the exhibit referred to in question II ("The Modern Answer") specifically covers exclusions, limitations, and waiting periods for all policy forms.

V. ADVERTISING

Radio and printed advertising material directed specifically at persons over 65 has been bound separately as an enclosed exhibit for convenience.

VI. UNDERWRITING

A. Initial issuance, impaired risks

We do not have and cannot accurately estimate any relative figures on persons rated as impaired risks over 65 in comparison with younger applicants.

B. Administrative directives

You will note that there are no special instructions pertaining to overage applicants in the field office bulletins included with the exhibit material titled, "The Modern Answer."

C. Reunderwriting

1. Riders or waivers

All riders or restrictive riders are included in the exhibit "The Modern Answer" previously referred to.

2. Riders or waivers issued

3. Cancellation and termination

Again, the company's recordkeeping procedure provides no basis for making figures available and no base for a valid estimate, particularly since rewriting is not done on the basis of age.

4. Administrative directive to claims personnel

Enclosed as a separately bound exhibit is the company's entire catalog of directives and instructions for reunderwriting, entitled "Postclaim Underwriting."

VII. ATTRITION

A. Number of policyholders signed up during 1961, 1962, 1963

B. Those no longer insured for reasons other than death

C. Those no longer insured who received benefit

D. Reinstatement

Company recordkeeping again makes impractical any valid estimates of over 65 policyholders in the categories questioned. The same statistical method used to accurately estimate an answer to question I could be applied to question IV, A only, but would not be applicable for the other parts of the question.

However, the company's experience with its policy form written solely for over-65 persons (P-27), used previously for illustrative purposes, might again be useful.

IN FORCE

Year	Issued	Dec. 31, 1961	Dec. 31, 1962	Dec. 31, 1963
1961	76,764	66,654	49,804	41,130
1962	77,631		64,834	48,446
1963	62,280			50,364

These figures are raw and do not take into account the accepted level of persistency seen in all policies, or mortality. Application of the 1958 CSO mortality tables for the age group in question to the above would account for attrition by death of approximately 14,317 insureds. Normal persistency rate for those over 65 is believed to run higher than the average for all insured though, again, no firm estimates can be made.

Nonetheless, even among this identifiable example group of former over-65 policyholders it is impossible to determine how many had received benefits.

While no statistical correlation can be made with the above figures, it is worth noting that they have been drawn from the same policy form experience (P-27) instanced in answer to question III, B, with table II revealing a 1963 loss ratio of 76 percent for 1961 policies.

VIII. RISKS, CAPABILITY OF PRIVATE HEALTH INSURANCE: PREMIUM PROJECTION

Since this company entered the health insurance field it has purposefully designed coverage and premium patterns to provide health protection to large numbers of people, at all ages, at a price within reach.

We were the first private company to offer the convenience and budgeting ease of monthly premium payments. This practice continues. As a result, our policies have had appeal to middle and lower income groups.

Over a relatively few years we have been part of the growth of a new service industry which arose in answer to need and demand with, initially, very little available data for projecting claim-premium ratios.

Blue Cross organizations, originally specializing in group coverage, left millions unprotected while at the same time creating a growing awareness of and demand for protection among those not eligible for group protection. Against this background, early policies in the field were limited in protection and were cancelable, following generally accepted underwriting principles correlating premium cost to the insured risk.

Accumulated experience led us to move from cancelable policies to those renewable at the option of the company. This advance in policy form enabled many thousands to maintain their health insurance, without change in benefit or cost, through a predetermined renewal date.

More recently, still more extensive experience has evolved the guaranteed renewable policy form, with the reserved right to adjust premiums on a class basis. First, many such policies were renewable only to certain ages—usually 50 to 65—but now many are renewable for life, again with the reserved right to adjust premiums.

This company issues such policies and is currently developing new basic, major medical and hospital disability policies. A recent policy provides paid-up coverage at age 65.

Parallel with the pattern of developing ever-increasing coverage to an ever-broadening segment of the population and to an ever-higher age level, has been our effort to keep in mind the appeal to those of limited means by standardizing the risks at the outset.

The result—no increase in premium rate for our policies until 1963. At that time, an across the board percentage increase was made, regardless of age, on policies issued prior to 1955.

This pattern of evolution has been a business philosophy, as well as a policy. As was said by an official of the company in an address at a recent accident and health industry meeting: "Our general objective in underwriting at all ages has been to obtain a body of insured lives in each premium class whose individual prospects of suffering an insured loss do not differ widely from the norm for that class. To achieve this we must consider antiselection by declining to insure or by offering special treatment to the individual who presents a risk appreciably greater than that which the standard premium was designed to cover."

This history and the company philosophy which underlies it must color our answer. We can be realistic and practical despite the relatively short span of our experience with over-65 insurance.

There simply does not exist sufficient information to document a definite conclusion regarding comprehensive insurance of persons over 65 for the indefinite future. But we do have sufficient experience to come to some tentative conclusions.

We know health costs are rising. We know insurance administrative costs are rising. We know enormous strides have been taken in private insurance in the last few years. We know millions of elderly people have been relieved of the nagging worry of their future health needs.

While we also know we have not got the answer for everyone, we believe progress will continue.

And we also know there are realistic limitations, quite apart from what one company or an industry can do, which will affect the individual's opportunity or ability to continue or obtain health insurance coverage when he reaches 65.

We take considerable pride in our role in the evolution of this business. Since 1945, we have made a constantly widening variety of protective policies available to an increasing percentage of persons to age 80 and above with the valuable advantage of monthly budgeted premiums.

We have also developed a plan of mass marketing, predicated on direct mail and media advertising, carefully planned to bring interested applicants to State licensed local resident agents.

Basic renewable coverage to impaired risks, with limited coverage for particular conditions, has permitted us to afford valuable protection to elderly persons who would normally otherwise be totally uninsurable. Supplementary coverage, such as weekly indemnity during hospitalization, guaranteed renewable medical coverage now under study and other projected refinements—made scientifically and not for pure competitive reasons—will, in our view, continue to make private health insurance more attractive to the elderly.

In the health insurance area, and with particular regard to the elderly, we confidently believe we can continually offer health coverage, providing the greatest good to the greatest number, within their economic reach, consistent with the welfare of the company and justice to other policyholders.

33-420—64—pt. 4A——2

Beyond that, we cannot go in good conscience and on the basis of experience thus far accumulated.

Respectfully submitted.

EDWARD J. KELLY, *First Vice President.*

TABLE 1.—*Number of persons age 65 and over, by plan*

Plan	In force as of—		
	Dec. 31, 1961 [1]	Dec. 31, 1962 [1]	Dec. 31, 1963 [1]
GR-702	1,285	1,176	869
GR-706	----------	12,824	33,079
GR-708	----------	121	242
GR-709	----------	16,589	43,255
GR-710	----------	7,379	17,702
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P-19	1,503	1,361	1,213
P-27	71,375	119,081	143,444
P-33	1,018	869	831
P-39	15,602	15,719	14,391
P-45	190	162	119
P-55	73,167	71,613	64,277
P-56	1,284	1,676	1,664
P-62	950	2,985	2,674
P-65	101,634	72,770	65,835
P-69	2,419	24,040	21,874
P-72	3,289	2,560	2,260
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P-89	181,490	163,991	147,027
OBS	9,167	9,333	8,609
NC-701	92	119	186
Total	1,100,861	1,121,982	1,100,344

[1] Dec. 31, 1961, in-force was based on manual records, and Dec. 31, 1962, and Dec. 31, 1963, in-force on computer records.

TABLE 2.—*P-27 experience (incurred basis)*

Issue year	Year of experience		
	1961	1962	1963
1960:			
Premiums	$412,687	$319,019	$267,533
Claims	$179,114	$208,041	$202,617
Loss ratio (percent)	43	65	76
1961:			
Premiums	$2,842,359	$4,273,048	$3,403,532
Claims	$889,848	$2,339,090	$2,264,292
Loss ratio (percent)	31	55	67
1962:			
Premiums	----------	$3,116,726	$4,247,586
Claims	----------	$1,275,673	$2,552,003
Loss ratio (percent)	----------	41	60
1963:			
Premiums	----------	----------	$2,512,120
Claims	----------	----------	$978,885
Loss ratio (percent)	----------	----------	39

MARCH 11, 1964.

Mr. JOHN MACARTHUR,
President, Bankers Life & Casualty Co.,
Chicago, Ill.

DEAR MR. MACARTHUR: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, Mr. Constantine, of the subcommittee staff, at my direction, called on you some 2 weeks ago to discuss certain questions on an informal basis. The attached list of questions includes some modifications developed as a result of your meeting with Mr. Constantine.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon it is our intention to ask you to testify on the efforts of your organization to meet the health insurance needs of our older Americans.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA, *U.S. Senate,*
Chairman, Subcommittee on Health of the Elderly.

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies. (Classified by group and individual.)

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 or over: by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

III. Experience:

A. Premiums earned by policy form (described in II–A).

B. Claims incurred by policy form (described in II–A).

IV. Exclusions and limitations (including waiting periods) on conditions covered (for each form described in II–A).

V. Copies of all advertising and promotional literature principally directed toward older people and all press releases issued pertaining to the mass enrollment programs.

VI. Underwriting:

A. Initial issuance of individual policies to persons age 65 and over (exclusive of mass enrollment policies)—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65-and-over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims (information on policy forms described in II–A):

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating-up of policies where age or claims experience is a factor.

VII. Attrition:

A. Number of different persons signed up during calendar years 1960, 1961, and 1962 (with breakdown of totals as outlined in the note to question II–C).

B. Of those who (during the above years) are no longer policyholders, number

who are no longer insured for reasons other than death (specify reasons: lapses, terminations, cancellations, etc.).

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65-and-over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

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2. CONTINENTAL CASUALTY CO.

CONTINENTAL CASUALTY CO.,
Chicago, Ill., April 23, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging, U.S. Senate,
Washington, D.C.

MY DEAR SENATOR MCNAMARA: As mentioned in my previous letter of April 17, I am forwarding herewith the response to the list of questions specifically directed to the Golden 65 program.

Also enclosed is a revision of the first page of our response to the general questionnaire for Golden 65 previously forwarded you. In II-C some of the figures opposite the policies or combinations were transposed. This occurred on the second, third, and fourth lines.

We are presently preparing the statements for submission to your subcommittee and will submit 60 copies as requested.

Very truly yours,

RAYMOND M. DEFOSSEZ.

Enclosures.

ANSWERS TO SPECIFIC QUESTIONS ON CONTINENTAL CASUALTY CO. GOLDEN 65 PROGRAM

1. The major national campaign of 1963 resulted in the issuance of 143,854 policies to 105,460 persons:

Combinations of policies issued:	*Number insured*
65-Plus only	26,548
10,000 Reserve only	32,003
5,000 Medical Only	17,319
10,000 Reserve and 65-Plus	6,153
10,000 Reserve and 5,000 Medical	9,762
65-Plus and 5,000 Medical	4,871
65-Plus, 10,000 Reserve and 5,000 Medical	8,804
Total	105,460
Policy:	
65-Plus	46,376
10,000 Reserve	56,722
5,000 Medical	40,756

2.

	Earned premiums	Incurred claims evaluated as of January 1964
65-Plus:		
1957	$117,726	$61,049
1958	891,058	577,750
1959	10,595,472	6,569,303
1960	13,447,915	10,675,134
1961	13,410,076	11,269,778
1962	13,571,395	11,799,857
1963	14,563,353	13,158,573
5,000 Reserve:		
1960	2,129,948	1,314,236
1961	6,590,694	6,107,738
1962	5,545,418	5,613,905
1963	2,965,004	3,070,247
10,000 Reserve:		
1962	3,372,483	3,478,070
1963	9,857,582	9,048,105
5,000 Medical:		
1962	1,065,979	133,248
1963	3,155,597	845,570

3. We have had 3,626 claims filed through March 31, 1964 for the period July 1 through December 31, 1963, by persons who enrolled as a result of the June 1963 advertising campaign. Past experience has shown that additional claims chargeable to this period will be reported in subsequent months.

The total dollars of claims incurred for the same 6-month period is estimated to be $1,009,307.

4. The necessity for a rate increase for 65-Plus, 5,000 Reserve and 10,000 Reserve was first acknowledged in late October 1963. Premium increases were not planned when advertising was first placed for the June 1963 campaign.

5. As a consequence of the adjusted estimates of 1962 loss experience as viewed on July 29, 1963, the Actuarial Department first began close scrutiny of 1962 results suspecting that this loss experience might have been inaccurately evaluated in earlier analyses. By October 1963, it was apparent that the July 29 analysis was substantially correct and this, in addition to the rising loss ratios developing for 1963 experience, was responsible for the rate increases which were recommended for the 65-Plus, 5,000 Reserve and 10,000 Reserve programs. These increases were recommended in order to maintain the programs on a self-sustaining basis.

6. On the basis of our previous experience with 65-Plus, we anticipate that the revised rates should prove adequate for about 5 years, as did the former rates. The rates for 10,000 Reserve are more affected by inflation, and may require much earlier review, but they should prove adequate for at least 2 to 3 years.

7. The attached exhibit I depicts the 1962 loss experience for the 65-Plus, 5,000 Reserve and 10,000 Reserve programs as it appeared at successive periods in 1963. Also shown is 1963 loss experience as evaluated in July and October 1963.

8. According to information now available, it is estimated that 4.2 percent of existing in force policies (including 5,000 Medical, 65-Plus, 10,000 Reserve and 5,000 Reserve) terminated because of the rate increase.

No data are available which enable us to determine the number of policyholders which terminated since a lapsed policy may be only one of three held by the policyholder or the only one held by the policyholder. Furthermore, in order to derive the data above, it was necessary to estimate the terminations in excess of the average terminations normally experienced from all other causes. The normal terminations for business inforce for 6 months or more, and the figure used for this estimate, is approximately 1 percent per month.

EXHIBIT I

1962 loss experience

	Evaluated as of—			
	January 1963	April 1963	July 1963	October 1963
65-Plus:				
Earned	$13,571,395	$13,571,395	$13,571,395	$13,571,395
Incurred	$11,734,996	$11,678,254	$11,822,146	$11,802,359
Loss ratio	.865	.861	.871	.870
5,000 Reserve:				
Earned	$5,545,418	$5,545,418	$5,545,418	$5,545,418
Incurred	$5,641,819	$5,589,313	$5,627,095	$5,619,237
Loss ratio	1.017	1.008	1.015	1.013
10,000 Reserve:				
Earned	$3,372,483	$3,372,483	$3,372,483	$3,372,483
Incurred	$2,529,362	$2,782,512	$3,490,000	$3,498,562
Loss ratio	.750	.825	1.035	1.037

1963 loss experience, excluding new business written, June 1963

	Evaluated as of—	
	July 1963 (5 months)	October 1963 (9 months)
65-Plus:		
Earned	$5,651,058	$9,885,066
Incurred	$5,307,000	$9,443,266
Loss ratio	.939	.955
5,000 Reserve:		
Earned	$1,458,765	$2,340,792
Incurred	$1,574,572	$2,599,307
Loss ratio	1.079	1.093
10,000 Reserve:		
Earned	$3,024,869	$5,305,298
Incurred	$3,674,940	$6,248,206
Loss ratio	1.215	1.178

CONTINENTAL ASSURANCE CO.,
Chicago, Ill., April 17, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
Special Committee on Aging, U.S. Senate,
Washington, D.C.

MY DEAR SENATOR MCNAMARA: The four attachments to this letter and the files contained in the carton forwarded herewith are in response to the list of questions submitted with your letter of March 13, 1964, to Mr. Edwin H. Forkel.

Attachment I covers our individual and association franchise lines. Attachment II covers our Golden 65 program. Attachment III covers our group and mass enrollment programs other than Golden 65. Attachment IV answers questions VIII–A and VIII–B for all lines of business.

In each instance where data was available, we have supplied detailed information. In those instances where data was not readily available but reliable estimates could be prepared, they have been furnished. Only where data was not available and reliable estimates could not be supplied was the response negative.

The material in response to the list of questions specifically directed to the Golden 65 program is still in preparation. We should be able to forward it to you during the coming week.

As you can appreciate the compilation of data in reply to both lists of questions has necessitated a considerable amount of time, effort, and expense. If you have any questions concerning the material forwarded thus far, please let me know.

Sincerely yours,

RAYMOND M. DEFOSSEZ.

ATTACHMENT I

INDIVIDUAL AND ASSOCIATION FRANCHISE LINES

I. Total number of different persons insured against items of medical expense. (See exhibit A.)

A. Available data concerning other health insurance coverage of overage policyholders. Data are available for the individual lines only.

Data are only on any other coverage and cannot be broken down to indicate which coverage duplicates that being applied for.

Year	Number indicating other coverage	Percentage indicating other coverage (percent)
1963	13,469	42.4
1962	12,102	42.9
1961	16,426	44.3

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 and over. See exhibit B for a summary of major benefits by policy form and enclosed folders containing copies of these forms currently sold to persons 65 and over.

These also contain:

(1) Policy form variations by State.
(2) Circulars, brochures, and advertising pieces.
(3) Underwriting bulletins.
(4) Rates.
(5) Exclusions and limitations (specified in the policy).

B. Monthly (and/or annual) premium. See brochures and/or rate sheets in enclosed folders on policy forms and exhibit C for association franchise.

C. Number of policyholders and dependents on each form who are age 65 and over. See exhibit A.

III. Experience:

Data are not available on insureds age 65 or over for the individual lines. This is because the majority of these forms are available to persons both under and over age 65. Even those forms designated as overage are sold to persons age 60 and over. For association franchise forms experience is available and is given in exhibit C.

IV. Exclusions and limitations: See enclosed folders and policy forms.

V. Advertising and promotional literature: See enclosed folders on policy forms. Not all literature included is directed exclusively to overage persons.

VI. Underwriting:

A. Initial issuance to persons age 65 and over. See exhibit C.

B. Copies of all administrative directives relating to field underwriting. See enclosed folders on policy forms.

C. Underwriting subsequent to policy issuance.

1. Copies of all restrictive riders or waivers employed. See folder entitled "Restrictive Riders or Waivers."

2. Number of riders or waivers issued. See exhibit E.

3. Cancellation and termination. See exhibit E. No data are available by type of policy.

4. Administrative directives to claims personnel. See folder entitled "Postclaim Underwriting—Age Reviews."

VII. Attrition:

A. Number of different persons signed up by calendar year. See exhibit F.

B. Number no longer insured for reasons other than death. See exhibit F.

C. Number no longer insured for any reason who received benefits. See exhibit F.

D. Number reinstated. No data available.

EXHIBIT A

Overage insureds and dependents by policy form

Form	Type	1963	1962	1961
DP-1543	Hospital	3,286	3,464	3,578
IP-7472	do	35,730	37,266	38,410
IP-7473	do	9,477	9,562	9,941
DP-8502	do	10,652	11,145	12,540
DP-8503	do	15,180	17,381	18,925
AP-8701	Catastrophe hospital	4,287	4,791	5,436
AP-8715	do	1,149	1,287	1,427
RP-9372	Hospital		[1]	
RP-9372	do		[1]	
CP-9962	do	12,503	12,691	12,428
SSP-11070	Substandard hospital	9,655	9,197	8,932
AP-11704	Catastrophe hospital	19,099	16,357	16,884
AP-11856	Catastrophe	4,319	4,254	4,183
SSP-15167	Substandard catastrophe hospital	643	591	517
DP-16461	Hospital	454	379	303
AP-16921	Catastrophe hospital	405	312	256
SSP-16950	Substandard hospital (60 and over)	174	213	207
AP-17025	Hospital	767	776	679
AP-17026	Hospital (age 60 and over)	186	181	176
IP-18528	Hospital	9,801	5,606	1,431
DP-18596	do	4,257	2,192	187
DP-20677	Surgical-medical	1,413	239	[2]
DP-21601	Weekly indemnity hospital	1,162	98	[2]
AGP-10503				
AGP-15152				
AGQ-15269	Hospital	656	622	383
AGP-15764				
AGQ-18528				
AGQ-20586				
	Total [3]	145,255	138,604	136,823
	Other [4]	37,839	42,323	40,620
	Total [5]	183,094	180,927	177,443

[1] Not available.
[2] Not sold.
[3] Includes both insureds and dependents.
[4] Includes both insureds and dependents on forms no longer available for issue.
[5] Includes both insureds and dependents. Persons covered for hospital, surgical, or miscellaneous expense on disability income forms are not included.

NOTE.—The data shown in this exhibit are the result of some extrapolation and estimation but are believed to be as accurate as our records allow.

EXHIBIT B

Summary of coverage

Form	Hospital R. & B.	Surgical	Miscellaneous	Medical
DP-1543	Available in policy	Available by rider	Available in policy	Not available.
IP-7472	do	do	do	Available by rider.
IP-7473	do	do	do	Do.
DP-8502	do	do	do	Not available.
DP-8503	do	Not available	do	Do.
AP-8701	do	do	do	Do.
AP-8715	do	do	do	Do.
RP-9372	do	Available by rider	Available by rider	Available by rider.
RP-9373	do	do	do	Do.
CP-9962	do	do	Available in policy	Not available.
AGQ-10503	do	Available in policy	do	Do.
SSP-11070	do	Available by rider	do	Do.
AP-11704	do	Available in policy	do	Available in policy.
AP-11856	do	do	do	Do.
AGP-15152	do	do	do	Not available.
SSP-15167	do	do	do	Do.
AGQ-15269	do	do	do	Do.
AGP-15764	do	do	do	Do.
DP-16461	do	do	do	Available in policy.
AP-16921	do	do	do	Do.
SSP-16950	do	Available by rider	do	Not available.
AP-17025	do	do	do	Do.
AP-17026	do	do	do	Do.
AGQ-18044	do	Available in policy	do	Available by rider.
IP-18528	do	Available by rider	Not available	Do.
DP-18596	do	do	Available in policy	Do.
AGQ-20586	do	Not available	Not available	Not available.
DP-20677	Not available	Available in policy	do	Available in policy.
DP-21601	Available in policy	Not available	do	Not available.

EXHIBIT C

Association franchise rate and experience data

ANNUAL PREMIUMS

Form	Insured	Insured and spouse
AGQ-10503	$60.00	$140.00
AGP-15152	106.00	212.00
AGQ-15269	75.00	150.00
AGP-15764	79.20	158.40
AGQ-18044	110.00	220.00
AGQ-20586	28.00	56.00

EXPERIENCE ON ALL THE ABOVE FORMS

Year	Earned premium	Incurred losses
1963	$66,762	$48,519
1962	53,449	35,649
1961	41,738	28,978

EXHIBIT D

	1963	Percent	1962	Percent	1961	Percent
Total applications written	221,619		215,318		208,893	
Total hospital, surgical, catastrophe applications written	102,794		92,703		109,280	
Overage hospital, surgical, catastrophe	32,268		28,624		37,539	
Waivered, rated	11,577		10,240		14,953	
Percentage to total overage hospital, surgical, catastrophe		35.9		35.8		39.8
Standard	20,691		18,384		22,586	
Percentage to total overage hospital, surgical, catastrophe		64.1		64.2		60.2
Underage hospital, surgical, catastrophe	70,526		64,079		71,741	
Waivered, rated	9,753		8,642		10,520	
Percentage to total underage hospital, surgical, catastrophe		13.8		13.6		14.3
Standard	60,773		554,437		61,221	
Percentage to total underage hospital, surgical, catastrophe		86.2		86.4		85.7

EXHIBIT E

Underwriting subsequent to policy issuance

	1963	1962	1961
A. Due to the filing of claims:			
Total overage hospital, surgical, catastrophe claims received	22,442	22,160	22,246
I. Number offered waivers or substandard	5,610	5,540	5,562
Number of these who had received benefits	(1)	(1)	(1)
II. Number canceled or nonrenewed	898	886	890
Number of these who had received benefits	884	873	877
B. Due to age:			
Total overage hospital-surgical catastrophe applications reviewed	6,377	6,966	8,666
I. Number of these nonrenewed	1,913	2,090	2,600
(All were offered rewrite to overage hospital) Number of these who had received benefit	1,664	1,818	2,262
C. Total:			
Number canceled or nonrenewed	2,811	2,976	3,490
Number of these who received benefits	2,548	2,691	3,139

[1] Not available.

EXHIBIT F

	1962	1961	1960
Total overage hospital, surgical, catastrophe applications	28,624	37,539	41,103
Basic hospital only	16,159	21,133	23,262
Catastrophe only	9,248	12,088	13,144
Combination basic and catastrophe	3,158	4,240	4,590
Miscellaneous (hospital, surgical only)	59	78	107
Number no longer insured for reasons other than death	7,843	15,390	18,579
Lapsed	7,528	14,790	18,373
Nonrenewed	229	450	575
Canceled	86	150	206
Number no longer insured for any reason who received benefits	1,717	4,692	7,522

ATTACHMENT II

REVISION—GOLDEN 65

I. Total number of persons holding active policies at the end of each calendar year:

Plan	1961	1962	1963
65-Plus	174,602	181,052	194,708
5,000 Reserve	90,672	42,062	28,884
10,000 Reserve	(1)	66,311	106,245
5,000 Medical	(1)	39,613	64,669
Total	265,274	329,038	394,506

[1] Not issued.

Numbers of those persons holding one policy only and those persons holding each of the various combinations of policies, are available at the end of 1963 only, and are submitted in reply to II–C.

A. Data concerning other health insurance coverages held by Golden 65 policyholders are not available. Such information has not been requested by the company.

II. Benefits and premiums:

A. See exhibit A.

B. Monthly premium charged for each type of policy form described in II–A;

Plan	1961	1962	1963	1964 [1]
65-Plus	$6.50	$6.50	$6.50	$8.00
5,000 Reserve	7.00	7.00	7.00	9.50
10,000 Reserve	(2)	9.50	9.50	12.50
5,000 Medical	(2)	5.00	5.00	5.00

[1] Policyholders on 3 of our plans were notified in December 1963 of a nationwide rate increase effective in the 1st quarter of 1964.
[2] Not issued.

C. Numbers of those persons holding one policy only and those persons holding each of the various combinations of policies are available as of the end of calendar year 1963 only.

Policies or combinations of policies:	*Number of policyholders at Dec. 31, 1963*
65-Plus only	101,702
10,000 Reserve only	35,045
5,000 Medical only	6,053
5,000 Reserve only	9,246
65-Plus and 10,000 Reserve	27,432
65-Plus and 5,000 Reserve	18,376
65-Plus and 5,000 Medical	13,586
10,000 Reserve and 5,000 Medical	11,276
5,000 Medical and 5,000 Reserve	142
65-Plus, 10,000 Reserve and 5,000 Medical	32,492
65-Plus, 5,000 Reserve and 5,000 Medical	1,120
Total	256,470

Numbers of active policies held at the end of each calendar year are submitted in reply to I.

III. Experience:

Plan	A. Premiums earned	B. Claims incurred
65-Plus:		
1961	13,410,076	11,269,778
1962	13,571,395	11,799,857
1963	14,563,353	13,158,573
5,000 Reserve:		
1961	6,590,964	6,107,738
1962	5,545,418	5,613,905
1963	2,965,004	3,070,247
10,000 Reserve:		
1962	3,372,483	3,478,070
1963	9,857,582	9,048,105
5,000 Medical:		
1962	1,065,979	133,248
1963	3,155,597	845,570

IV. Exclusions and limitations: See exhibit A.

V. Advertising, promotional literature, and press releases: See exhibit B.

VI. Underwriting:

A. There is no initial underwriting on Golden 65.

B. Administrative directives relating to field underwriting are not applicable to Golden 65 plans.

C. Underwriting subsequent to policy issuance or filing or payment of claims is not applicable to golden 65 plans.

1. Restrictive riders or waivers are not employed.
2. Restrictive riders or waivers are not employed.
3. No Golden 65 policy has been canceled or nonrenewed by the company.
4. Administrative directives to claims personnel relative to company policy on cancellation, ridering, nonrenewal, or rating-up of policies are not applicable to Golden 65 plans.

VII. Attrition:

A. Detailed information regarding the number of persons issued a policy or a combination of policies as opposed to the number of policies issued was not kept for years prior to 1963.

Total policies issued

Plan	1960	1961	1962
65-Plus	9,216	31,131	34,704
5,000 Reserve	57,722	61,980	423
10,000 Reserve	(1)	(1)	[2] 37,034
5,000 Medical	(1)	(1)	40,069

[1] Not issued.
[2] Does not include 33,874 conversions from 5,000 Reserve.

Combinations of policies issued:

	1963
65-Plus only	26,548
10,000 Reserve only	32,003
5,000 Medical only	17,319
10,000 Reserve and 65-Plus	6,153
10,000 Reserve and 5,000 Medical	9,762
65-Plus and 5,000 Medical	4,871
65-Plus, 10,000 Reserve and 5,000 Medical	8,804
Total	105,460

B. Annual counts for total reduction of in-force policies only are available:

Year:	*Total reduction of in-force policies*
1960	38,129
1961	47,911
1962	48,466

Information regarding the cause of lapse is not available. However, during 1961 we maintained counts of those policies no longer active due to reported deaths. These totaled 18,517. Since notification of death is not required, we have no means of knowing how many additional lapses were due to unreported deaths.

C. We have no available data with which to obtain the number of those no longer insured who had received a benefit under Golden 65 policies.

D. Reinstatement information is impossible to supply. It has been the policy of the company to be as lenient as possible regarding reinstatements. Once a reinstatement has been made, the reinstated record is indistinguishable from other in-force records.

VIII. A. and B. Responses to these questions are offered elsewhere in reference to all our 65 and over business.

ATTACHMENT III

COMPOSITE GENERAL GROUP

I. 1961, 300,487; 1962, 353,062; and 1963, 414,597.

I. A. No available data of any type.

II. A. See the enclosures for the respective component categories.

B. See the enclosures for the respective component categories.

C. These data are included in (I) above.

III.[1] A. 1961, $20,817,158; 1962, $27,722,698; and 1963, $33,594,690.

B. 1961, $16,598,407; 1962, $19,898,808; and 1963, $27,935,103.

IV. See the enclosures for the respective component categories.

V. See the enclosures for the respective component categories.

VI. A. There is no rating of impaired risks.

B. There have been no administrative directives issued relating to field underwriting of this coverage for age 65 and over applicants.

C. 1. There have been no restrictive riders or waivers employed.

2. There have been no restrictive riders or waivers employed.

3. There have been no cancellations or nonrenewals.

4. There have been no administrative directives issued to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating up of policies where age or claim experience is a factor.

VII. A. 1960, 4,682; [2] 1961, 50,568; [3] and 1962, 78,401.[3]

B. 1960, 855; [2] 1961, 19,027; [3] and 1962, 42,478.[3]

C. See the enclosures for the respective component categories.

D. See the enclosures for the respective component categories.

ATTACHMENT IV

ALL OVERAGE PROGRAMS—ANSWERS TO QUESTIONS VIII–A AND VIII–B

VIII–A

Every class of insureds has characteristics peculiar to itself and requires an underwriting approach tailored to these characteristics. The outstanding characteristic of the overage population are the much higher incidence of illness, frequent occurrence of spontaneous and rapid deterioration in health and the preponderance of chronic, disabling or semidisabling illnesses which endure with attendant costs for the balance of the individual's life. In the past, these characteristics have presented problems in the availability, permanence, and cost of health insurance coverage.

The private insurance industry has in recent years evolved two major approaches to deal with these problems. The needs of the present overage population can be served through the mass enrollment approach, which eliminates initial underwriting, provides permanence of coverage, and permits operating economies which hold the cost of providing insurance to a minimum. To meet the need for health insurance in the future, the insurance industry is developing programs of hospital insurance for overage risks which are designed to provide paid-up benefits at age 65 or to provide level premium guaranteed renewable coverage for the life of the

[1] Excludes category "All other general group cases."

[2] Excludes categories "American Association of Retired Persons," "National Retired Teachers Association," "National Association of Retired Civil Employees," and "All other general group cases."

[3] Excludes categories "National Association of Retired Civil Employees" and "All other general group cases."

insured at rates level from the younger issue age. This coverage is available to all persons through individual policies. Similar programs are being tested for group insurance with the tendency being to create special groups of retiring employees with coverage and rates similar to that of the active employees. Such programs also meet the requirements of availability and permanence of insurance, and substantially reduce or eliminate the problem of high premium rates at advanced ages.

VIII–B

Within the past year we have reviewed and revised where necessary, all our major overage rate structures. As a result, we do not anticipate that any additional revisions will be required in the near future.

MARCH 19, 1964.

Mr. EDWIN A. FORKEL,
President, Continental Casualty Co., Chicago, Ill.

DEAR MR. FORKEL: Senator McNamara would appreciate your making the following modifications in the questionnaire attached to his letter of March 13.

All data concerning the number of persons insured, or enrolled during a given period should be accompanied by figures indicating the number of persons under age 65 included in the total. For example, the Golden 65 program permits a spouse who is under age 65 to be insured along with the spouse over age 65. Additionally, one of your large mass enrollment programs—that of the AARP–NRTA—includes many persons under age 65. I am sure that you can appreciate our concern that the figures distinguish between age 65 and over and those below that age.

Thank you again for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director,
Subcommittee on Health of the Elderly.

MARCH 13, 1964.

Mr. EDWIN A. FORKEL,
President, Continental Casualty Co.,
Chicago, Ill.

DEAR MR. FORKEL: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, Mr. Constantine of the subcommittee staff, at my direction, called on officials of your company some 2 weeks ago to discuss certain questions on an informal basis. The attached list of questions includes some modifications developed as a result of that meeting and subsequent correspondence.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon it is our intention to ask you to testify on the efforts of your company to meet the health insurance needs of our older Americans.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

CONTINENTAL CASUALTY CO. GOLDEN 65 PROGRAM

1. How many different persons were issued policies as a result of the major national advertising effort of last summer to promote Golden 65? (Please break down total as per note in preceding question II–C.)

2. Would you indicate separately, the earned premiums and incurred claims for each of the options of the Golden 65 program, by calendar year since initial offering of each option.

3. During the period July 1 through December 31, 1963, how many different persons of those enrolled in your 65-Plus option, as a result of your advertising campaign, received a benefit? What was the total dollar amount of incurred claims during that 6-month period from those new policyholders?

4. When was a premium increase on one or more options of the Golden 65 first discussed and considered? Were you aware when the advertising was placed for the campaign of the summer of 1963 that a premium increase was planned or probable on segments of the Golden 65 program?

5. When did your underwriting and/or actuarial department first note and first indicate the necessity for or recommend a premium increase on one or more of the golden 65 options?

6. Are your new premiums based upon present costs of medical care or projected costs of care? If projected cost basis, how far projected?

7. Please attach significant correspondence or documents pertinent to the above questions.

8. How many policyholders have failed to pay their premiums, since the increase was announced?

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies. (Classified by group and individual.)

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms where initial issuance is available to persons age 65 or over: by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

NOTE.—With regard to your mass enrollment policies please provide breakdowns indicating persons covered for basic only, major medical only, and basic and major medical. For example, on "Golden 65" indicate number holding "65-Plus" only, number holding "5,000 Reserve" only, number holding "10,000 Reserve" only, and separate totals of persons for each of the various combinations of options held by policyholders.

III. Experience:

A. Premiums earned by policy form (described in II–A.)

B. Claims incurred by policy form (described in II–A).

IV. Exclusions and limitations (including waiting periods) on conditions covered (for each form described in II–A).

V. Copies of all advertising and promotional literature principally directed toward older people and all press releases issued pertaining to the mass enrollment programs.

VI. Underwriting:

A. Initial issuance of individual policies to persons age 65 and over (exclusive of mass enrollment policies)—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65-and-over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims (information on policy forms described in II–A):

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, nonrenewal and rating-up of policies where age or claims experience is a factor.

VII. Attrition:

A. Number of different persons signed up during calendar years 1960, 1961, and 1962 (with breakdown of totals as outlined in the note to question II–C).

B. Of those who (during the above years) are no longer policyholders, number who are no longer insured for reasons other than death (specify reasons: lapses, terminations, cancellations, etc.).

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65-and-over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

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3. FIREMAN'S FUND INSURANCE CO.

FIREMAN'S FUND INSURANCE CO.,
San Francisco, Calif., May 6, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: With reference to my letter of April 17 acknowledging yours of March 31 concerning Fund 65 Plan—Plus $10,000 Plan, the following responses are submitted to your seven listed questions and request for material.

1. Attached are the following items:

Item A. Initial enrollment newspaper announcement (February 1, 1959).

Item B. Initial enrollment question and answer booklet (February 1, 1959).

Item C. Second enrollment newspaper announcement (July 1, 1959).

Item D. Payment card enrollment book mailer.

Item E. Third enrollment newspaper announcement (February 1, 1960).

Item F. Fourth enrollment general letter and newspaper mat (September 1, 1960).

Item G. Fifth enrollment staff letter and newspaper mat (February 1, 1961).

Item H. Sixth and seventh enrollment newspaper mat (October 1, 1961 and April 1, 1962).

Item I. Seventh enrollment staff letter and newspaper mat (April 1, 1962).

Item J. Tenth enrollment staff letter, question and answer booklet, newspaper mat (October 1, 1963).

Item K. Twelfth enrollment newspaper mat (April 1, 1964).

2. Fund 65 and Plus $10,000 are two separate coverages not optional plans. In order to buy the Plus $10,000 coverage, the insured must either already have the Fund 65 coverage or apply for both at the same time. Figures in the following answers are for fund 65 only since this gives number of insureds. In all instances, the figures reflect the number of people over age 65 since our plans do not allow the writing of applicants under that age

Item A. Total number of persons enrolled from inception (February 1, 1959 to March 1, 1964)? 78,351.

Item B. Total number of persons accepted for coverage during initial "open" period (February 1, 1959)? 24,465.

Item C. Total number insured immediately prior to and following each of the subsequent "open" periods?

Date:	*Number of new insureds*	Date:	*Number of new insureds*
July 1959	5,007	April 1962	6,835
February 1960	6,681	November 1962	4,385
September 1960	6,271	March 1963	5,315
February 1961	5,373	October 1963	4,500
October 1961	6,979	February 1964	2,540

Item D. Total number of persons insured as of March 1, 1964? 41,882.

3. Of the persons accepted for coverage during our initial open enrollment period, 10,325 were still insured under the program as of March 1, 1964.

4. The average age of the "fund 65" policyholder as of February 1, 1959 was 73.016 years; and as of March 1, 1964 was 75.746 years.

5. Please see attached exhibit I.

6. Please see attached exhibit II.

7. Our current premium which became effective August 1, 1963, anticipated that such premium structure would pay for benefits of the policy as of that date for the foreseeable future.

Very truly yours,

KENNETH T. KING, *Vice President.*

EXHIBIT I

	Premium earned	Losses incurred	Number of claims
1959:			
Basic	1,622,736	998,014	
Plus $10,000			
Total	1,622,736	998,014	4,200
1960:			
Basic	2,297,043	1,457,191	
Plus $10,000			
Total	2,297,043	1,457,191	7,183
1961:			
Basic	2,716,172	1,960,154	
Plus $10,000	191,435	193,148	
Total	2,907,607	2,153,302	9,138
1962:			
Basic	3,172,729	2,256,197	
Plus $10,000	1,089,816	1,262,754	
Total	4,262,545	3,518,951	12,374
1963:			
Basic	3,467,789	2,557,276	
Plus $10,000	1,921,690	2,832,934	
Total	5,389,479	5,390,210	15,286

EXHIBIT II

FUND 65 PLAN PLUS $10,000 PLAN

DEAR POLICYHOLDER: On February 1, 1959, the Fireman's Fund introduced its Fund 65 Plan to help defray the cost of illness and accident to our senior citizens. Later, recognizing the need for greater amounts of protection, we added the Plus $10,000 Plan. Policyholders have received more than $9 million in benefits under these plans in the 4½-year period that coverage has been available. We are justifiably proud of having been one of the first insurance companies to recognize these needs and to provide this protection.

However, during the past several years, costs of medical and hospital care have gradually and substantially increased and at a much higher rate than most other costs of living. The result has been a substantial increase in benefit payments.

These, together with other factors of increasing cost, create the necessity for raising the premium on the Plus $10,000 Plan effective August 12, 1963. Believing there is a real need and desire for this protection, we had no difficulty in concluding that this action was preferable to the alternative of curtailing existing coverage or eliminating the Plus $10,000 Plan from the program.

If you wish to keep your present Fund 65-Plus $10,000 policy, your new monthly premium, effective August 12, 1963, will be $15.75. If this is your desire, you should use one of the payment cards in the enclosed book to make your August 1963 payment and subsequent payments. Any advance payments you have made beyond August 12, 1963, which were received by us prior to June 15, 1963, have been credited in your new Fund 65-Plus $10,000 payment book at the rate of $15.75 per month. The first payment card indicates the amount and the due date of your next premium payment, provided that you have paid the July premium.

If you wish, you may participate in the Fund 65 Plan only at a cost (unchanged) of $6.50 per month. The coverage provided is that described under parts II and III in your present policy. If this is your desire, you should make your August

1963 payment by sending $6.50, together with the enclosed Fund 65 only election card. We will then send you a new policy and a new payment book which wil reflect any advance payments you have made.

Your current supply of return envelopes can be used to make this payment and subsequent payments. If you do not have return envelopes, please address your response to the post office box number shown on the payment coupons and the election card.

The effective date of coverage indicated in your present policy will not change regardless of whether you choose to keep your present Fund 65-Plus $10,000 policy or participate only in the Fund 65 Plan. This means the 6-month waiting period in your policy for preexisting conditions will not apply.

It is important that you make your decision without delay. If you do not pay either $15.75 to continue the Fund 65-Plus $10,000 program or $6.50 for the Fund 65 only Plan (unless you have advance premiums as outlined in the above paragraphs), you should understand that your coverage will expire under the terms of the policy on August 12, 1963, for nonpayment of premium.

Even with the increase in monthly premium, we believe thoughtful evaluation will indicate to you that the Fund 65-Plus $10,000 protection still represents the most outstanding value in the field of insurance for senior citizens.

Sincerely,

KENNETH T. KING, *Vice President.*

MARCH 31, 1964.

MR. KENNETH T. KING,
Vice President, Fireman's Fund,
San Francisco, Calif.

DEAR MR. KING: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"FUND 65 PLAN—PLUS $10,000 PLAN"

1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open enrollment" period; total number of persons insured immediately prior to and following each of any subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please break down these data to show subtotals indicating number of different persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured under the program as of March 1, 1964?

4. What was the average age of the "Fund 65" policyholder as of the end of your initial enrollment period? What was the average age as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

6. Please provide the details of any premiums and/or benefit changes which have been made in your program since its inception.

7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

4. MUTUAL OF OMAHA INSURANCE CO.

MUTUAL OF OMAHA INSURANCE CO.,
Washington, D.C., April 24, 1964.

Mr. JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly,
U.S. Senate, Washington, D.C.

DEAR MR. CONSTANTINE: Attached is our response to the questionnaire which has been prepared by our staff in Omaha.

Reference is made in the questionnaire to policy bulletins and certain other printed matter. As of this writing (5:05 p.m., Friday) I have not received the carton shipped to me from Omaha which is now being traced by the Air Express officials.

As explained to you previously by other officials of our company, we regret our inability to be more prompt in our reply to your questionnaire. As you have been previously informed, the officials of our company have been committed to sales meetings in various parts of the country and have been able to work on this survey only on week ends and the 1 or 2 days their busy schedule has allowed them to return to the general offices. Also, we had a very difficult time programing some of this information into our electronic system since it was already committed to regular business runs.

As soon as the answers to the remainder of the questions are made available to me, I will see that you receive them without delay.

Sincerely,

JAMES E. BARRETT,
Vice President.

I. Total policyholders (classified by group and individual) on persons age 65 and over as of year ending—

	Individual	Group [1]	Total
1961	1,022,423	[2]	[2]
1962	1,204,033	[2]	[2]
1963	1,279,351	1,689	1,281,040
TOTAL INDIVIDUALS COVERED BY ABOVE POLICIES			
1961	1,061,358	[2]	
1962	1,241,315	[2]	
1963	1,341,838	1,689	1,343,527

[1] See memorandum of Apr. 14, 1964, marked as exhibit No. 1.
[2] Not available.

I–A. Information and data concerning other insurance is requested and obtained only at the time of issuance of the policy contract from the application. No continuing record is maintained.

II. Benefits and premiums:

A. Policy forms issued.[1]

B. Monthly premium charged.[1]

C. Number of policyholders in force for each form described in "A" as of December 31, 1963. See exhibit No. 3.

III. Experience:

(Not yet available.)

IV. Exclusions and limitations on conditions covered.

See exhibit No. 2, included in reply to questions II–A, policy forms issued.

V. Copies of advertising:

(Not yet available.)

VI. Underwriting:

A. Policies issued during an open enrollment on nonselective forms are issued as applied for. None are rated or ridered. Those issued on a selective basis are considered upon the answers to the questions as asked in application. No record of comparison is available or kept on those rated or issued as impaired risks on either over or under age 65.

[1] See exhibit No. 2 listing policy forms and documented for information requested by separate presentation of bulletins giving rules, regulations, rates, etc., as requested.

B. See policy bulletins supplied in answer to question II, parts A and B.
C. Underwriting subsequent to policy issuance:
1. Copies attached: 1793–M, 2326–M.
2. No record is maintained.
3. No record is kept. The major portion of the business is issued with a renewal safeguard with no right to cancel on an individual policy.
4. The usual investigation is made in regard to payment of the claim in accordance with the terms of the policy contract.

VI. Attrition:

A. See exhibit No. 7. This covers years 1961, 1962, 1963. This covers policies issued on both the open enrollment (nonselective) and other policies available throughout the year on a selective basis.

B. No records are kept of the reason for terminations. All terminations are recorded just as a termination, regardless of reason.

C. No records kept.

D. No record of those that reinstate after the grace period has expired is maintained. A normal procedure, as on our regular business, is followed. That is, an offer to reinstate without penalty of a lapsed period is made at the end of 45 days from due date, and again at 65 days. No record of payments during this period is maintained as we do not record on our records a lapse until such efforts have been put forth to reinstate the coverage.

VII. Other:

A. There are unique risks involved in underwriting health insurance for the aged created primarily by the increased morbidity. The needs of these people have been obvious to the private insurance industry for a number of years. Continuous forward steps have been taken to solve them until today a wide selection of insurance coverages is available, from many sources, to each individual so that he can determine his particular need and adequately protect himself from financial loss.

Many other advances have occurred such as:

1. The entry of many insurance carriers into the field of providing hospital and medical care benefits for those 65 and over.
2. The provisions in regular policies that are sold for continuance during the entire lifetime of the insured.
3. Continuance of group insurance programs for life following retirement.
4. The mass marketing approaches now being used.
5. Programs of paid up at age 65 health insurance.

These, and many other innovations, are rapidly eliminating any problem of health insurance for the aged.

B. Mutual of Omaha is by its charter a mutual organization owned by its policyowners and dedicated to their service. When our board of directors authorized the senior age program, they directed that it be a break-even program.

We anticipate no different problems in the rates applicable to the over 65 age group of business than to the under 65 age group. All ages will be affected in the future by the same factors.

EXHIBIT No. 1

Re group survey of the aged.

Attached is the report sent to the Health Insurance Association of America as of December 31, 1963.

The completion of this report on an accurate basis for the group operation would be quite costly and time consuming as we do not maintain records on the majority of the certificateholders covered under our group policies. Where records are maintained, they are on a per-case basis and used daily for the administration under the policies. To remove them for this overall purpose would be detrimental to our workflow and policyholder service.

The figures contained in this report were determined by writing to the majority of our larger policyholders and requesting the information. The replies were tabulated and the count on groups of less than 500 lives were included in the State where the master policy was located. On cases with more than 500 lives the count was distributed in accordance with the 500 life rule.

As we did not do any sampling for ratios to apply against the total certificates in force there is a definite understatement made.

EXHIBIT No. 2

POLICY FORMS

76DV	54HO/FHO	3HSO
80DV	56HO/FHO	7HSO
84DV	57HO/FHO	11HSO
86DV	58HSO/FHSO	4HSO
37DO	65HO/FHO	8HSO
37DVO	68HO/FHO	12HSO
4DLO	70HO/FHO	3HO-3FHO-3DV
55-110	74HO/FHO	24HO/FHO
WSDO	2CLO/FCLO	26HO/FHO
22DV	2HRO	31HO/FHO-31DV-33DV-31DRO
41DV	16HO/FHO	55HO/FHO
64DO	16HSO/FHSO	6HMLO
59DRO	6HSO	8HMLO
59DV	10HSO	9HMLO
25HO/FHO	66HO	11CH
30HO/FHO	9HO-9FHO	15CH
36HO/FHO	27HO/FHO	50HO
38HV/FHV	29HSO	58HO/FHO
40HO/FHO	BOH	
52HO/FHO	8HO	

NOTE.—The above list does not contain several policy forms which are sold to people of all ages and on which no tabulation is made as to whether the policyowner is over 65 or under 65.

EXHIBIT 3

Number of policyholders in force as of Dec. 31, 1963

Form	*Policies in force*	*Form*	*Policies in force*
76DV	8,483	6HSO	4,563
80DV	1,649	10HSO	1,499
84DV	16	66HO	1,409
86DV	213	9HO-9FHO	396
37DO	229	27HO-FHO	925
37DVO	85	29HSO	38,593
4DLO	18	BOH	7,545
55-110	23,879	8HO	671
WSDO	11,839	3HSO	82,079
22DV	11	7HSO	1,167
41DV	1,333	11HSO	281
64DO	44	4HSO	205,961
59DRO	21	8HSO	6,324
59DV	193	12HSO	1,326
25HO/FHO	2,740	3HO-3FHO	88,763
30HO/FHO	87,673	3DV	22,405
36HO/FHO	11,279	24HO/FHO	168
38HV/FHV	1,667	26HO/FHO	249
40HO/FHO	14,788	31HO/FHO	4,057
52HO/FHO	53	31DV	6,459
54HO/FHO	935	33DV	5,363
56HO/FHO	12,585	31DRO	740
57HO/FHO	63	55HO/FHO	174
58HSO/FHSO	65	6HMLO	16,191
65HO/FHO	146	8HMLO	107
68HO/FHO	1,094	9HMLO	644
70HO/FHO	174	11CH	4,691
74HO/FHO	14	15CH	7,818
2CLO/FCLO	42	50HO	145,276
2HRO	36	58HO/FHO	2,179
16HO/FHO	43		
16HSO/FHSO	298	Total	839,731

NOTE.—The above listing of policies in force by form does not contain the policyholders on several forms where no tabulation is made as to age. Records are not maintained by distribution of age within policy form on this type of coverage.

EXHIBIT 4

Premiums earned per year

Form	1961	1962	1963
76DV	$37,020.87	$406.337.28	$742,692.87
80DV		42,237.38	146,902.17
84DV	35.71	821.84	1,397.40
86DV		8,067.32	19,754.73
37DO	17,754.70	20,800.39	12,442.42
37DVO	8,514.77	10,177.41	10,464.21
4DLO	992.10	1,231.65	1,463.83
55-110	2,601,435.77	2,208,567.67	1,842,661.49
WSDO	1,747,757.37	1,488,215.41	1,248,952.59
22DV	1,131.78	977.91	667.64
41DV	202,647.27	224,893.48	175,556.01
64DO	4,005.30	14,250.09	9,135.39
59DRO	1,316.80	1,471.28	1,951.29
59DV	28,493.76	30,898.86	24,093.86
25HO/FHO	196,366.81	240,232.84	252,593.21
30HO/FHO	5,323,540.26	7,286,058.66	8,853,617.69
36HO/FHO	769,798.57	1,024,236.19	1,229,432.51
38HV/FHV	83,539.45	115,896.91	145,678.04
40HO/FHO	1,044,432.54	1,329,667.04	1,463,936.89
52HO/FHO	2,039.31	2,603.66	2,923.37
54HO/FHO	58,114.52	77,645.72	95,815.34
56HO/FHO	225,635.65	396,179.48	548,573.17
57HO/FHO	1,270.87	1,779.00	2,590.43
58HSO/FHSO	2,201.16	6,332.57	5,753.93
65HO/FHO	2,265.41	5,103.82	7,004.24
68HO/FHO	11,154.47	36,812.97	55,181.41
70HO/FHO			−697.24
74HO/FHO			192.56
2CLO/FCLO	1,944.86	2,240.22	2,086.09
2HRO	3,549.14	4,484.14	4,079.59
16HO/FHO	4,032.17	4,117.50	4,155.94
16HSO/FHSO	41,918.87	40,828.66	37,279.35
6HSO	338,265.70	322,080.13	316,678.76
10HSO	43,935.21	45,783.91	47,274.83
66HO	39,088.73	57,895.84	71,832.35
9HO-9FHO	15,568.49	18,793.94	19,322.25
27HO-FHO	15,113.28	38,054.51	61,446.57
29HSO	1,443,445.46	2,368,940.91	3,047,837.17
BOH	737,941.42	630,459.61	550,498.19
8HO	46,440.40	44,700.76	47,070.18
3HSO	4,649,180.30	6,521,660.52	7,754,867.68
7HSO	61,250.16	82,510.98	102,050.29
11HSO	14,121.45	23,434.96	29,779.72
4HSO	16,792,620.62	19,129,308.57	20,838,704.13
8HSO	440,025.88	528,827.13	614,197.24
12HSO	114,193.12	131,787.68	147,125.74
3HO-3FHO	7,283,339.98	7,252,428.12	7,589,147.42
3DV	2,687,345.39	2,602,895.18	2,470,744.83
24HO/FHO	11,797.89	11,163.25	11,982.72
26HO/FHO	24,205.31	22,572.72	19,709.18
31HO/FHO	443,659.98	384,435.61	332,739.09
31DV	1,055,424.53	919,645.60	735,331.27
33DV	244,717.65	303,203.95	332,524.61
31DRO	52,210.14	63,341.69	64,662.88
55HO/FHO	10,160.04	12,762.34	14,349.44
6HMLO	1,404.00	82,123.37	223,966.55
8HMLO		401.50	1,306.30
9HMLO		−1.50	4,930.87
11CH	40,604.74	370,038.00	393,400.89
15CH		105,312.62	415,074.75
50HO	4,167,954.81	5,574,301.18	6,874,749.82
58HO/FHO	152,808.61	190,601.41	218,390.62

EXHIBIT 5

Claims incurred by year

Form	1961	1962	1963
76DV	$22,791.99	$179,164.86	$315,741.82
80DV		21,131.66	73,353.28
84DV	380.03	363.68	−363.73
86DV		2,961.79	14,113.26
37DO	4,969.96	8,324.60	5,003.96
37DVO	1,782.75	2,536.19	2,050.40
4DLO	−509.69	388.32	296.65
55-110	2,112,466.63	2,049,210.21	1,583,793.47
WSDO	1,337,335.07	1,215,000.24	1,020,940.55
22DV	−505.36	1,197.21	126.67
41DV	78,766.48	120,307.44	111,339.36
64DO	−85.47	1,885.99	3,464.24
59DRO	934.51	2,216.55	781.05
59DV	7,428.54	14,109.35	13,437.10
25HO/FHO	102,082.50	107,707.54	154,413.49
30HO/FHO	1,928,247.68	2,851,453.13	3,782,321.06
36HO/FHO	199,563.72	366,337.27	489,564.47
38HV/FHV	32,425.25	33,766.13	57,602.97
40HO/FHO	332,850.18	468,364.17	588,030.18
52HO/FHO	403.58	1,513.73	433.71
54HO/FHO	27,212.61	39,876.10	53,453.32
56HO/FHO	99,129.10	148,717.63	216,038.36
57HO/FHO	700.88	444.66	1,820.61
58HSO/FHSO	613.56	3,532.36	3,539.68
65HO/FHO		900.16	2,833.29
68HO/FHO	6,686.15	10,793.49	16,436.63
70HO/FHO			
74HO/FHO			722.89
2CLO/FCLO	274.88	1,619.63	292.64
2HRO	1,608.54	2,332.98	2,499.94
16HO/FHO	2,289.15	3,169.36	3,512.04
16HSO/FHSO	15,136.61	17,957.75	19,576.18
6HSO	188,517.48	223,880.57	216,814.57
10HSO	23,437.07	26,867.89	26,910.15
66HO	17,503.43	24,277.38	32,446.86
9HO-9FHO	6,675.01	9,066.12	12,717.71
27HO-FHO	4,976.59	12,263.17	32,227.38
29HSO	707,793.81	1,320,535.72	1,868,679.74
BOH	454,271.71	396,800.21	359,824.56
8HO	11,731.06	15,855.23	19,547.71
3HSO	2,315,799.90	3,356,445.89	4,265,217.77
7HSO	36,127.58	42,412.63	51,944.58
11HSO	6,103.76	12,083.72	13,917.09
4HSO	13,150,708.23	15,292,585.83	17,748,412.39
8HSO	349,930.78	407,783.30	462,136.23
12HSO	82,100.35	101,210.45	123,671.13
3HO-3FHO	4,884,141.67	5,117,894.85	5,321,065.79
3DV	1,707,977.26	1,801,963.80	1,784,061.79
24HO/FHO	5,116.28	3,793.71	6,833.01
26HO/FHO	14,224.77	18,292.61	14,022.05
31HO/FHO	178,001.42	182,151.18	182,242.16
31DV	435,455.79	438,627.17	436,646.46
33DV	96,954.77	112,206.36	170,812.63
31DRO	31,174.82	22,729.40	46,733.41
55HO/FHO	6,691.85	6,883.37	5,239.68
6HMLO	4,010.20	49,764.32	90,322.16
8HMLO		2,131.45	−456.46
9HMLO			6,344.64
11CH	12,650.00	135,407.46	295,679.80
15CH		21,947.22	171,748.36
50HO	3,460,044.49	3,635,918.83	5,751,164.15
58HO/FHO	41,252.42	53,627.95	68,634.90

EXHIBIT No. 6

ELIMINATION RIDER

This rider is attached to and made a part of Policy No. _____ and is subject to all provisions of the policy which are not in conflict with the provisions of this rider.

The effective date of this rider is _____.

In consideration of the company's continuing the policy in force after the effective date of this rider and not exercising its then known rights to rescind the policy, it is understood and agreed that none of the benefits provided in the policy shall accrue for any loss sustained by _____ resulting from _____

_____

_____

_____

Signature of the insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

RIDER FORM 2326M, ELIMINATION RIDER; RIDER FORM 2327M, DEPENDENT ELIMINATION RIDER

BRIEF DESCRIPTION

1. These are new riders to be used with any applicable policy or certificate in lieu of rescission.
2. Rider form 2326M eliminates coverage for a specific condition for the insured or other covered person.
3. Rider form 2327M removes a dependent and may be used, subject to benefits department instructions, even though the insured's coverage cannot be rescinded.
4. Copies of the riders appear on the reverse side of this bulletin.

UNDERWRITING RULES

1. Rules governing the use of these riders are stated in detail in benefits department bulletins. Note that special instructions apply when the riders are used on forms other than regular individual policies, such as association group certificates.
2. The effective date of the rider is the date it is signed.
3. The riders are to be signed in duplicate, the original for the application file and the duplicate for the insured.

HOME OFFICE PROCEDURE

1. Approval notifications to be given separately.
2. Rider code: 2326M—Elimination. 2327M—Elimination.
3. Keypunch code: 2326M—C26. 2327M—C27.

G. A. LEBENS.

ELIMINATION RIDER

This rider is attached to and made a part of Policy/Certificate No. _____ and is subject to all provisions of the policy/certificate which are not in conflict with the provisions of this rider.

The effective date of this rider is _____.

In consideration of the company's continuing the policy/certificate in force after the effective date of this rider and not exercising its then known rights of rescission it is understood and agreed that none of the benefits provided in the policy/certificate shall accrue for any loss sustained by _____ resulting from _____
_____

_____
Signature of the insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

DEPENDENT ELIMINATION RIDER

This rider is attached to and made a part of Policy/Certificate No. _____ and is subject to the conditions, exceptions and limitations of the policy/certificate not amended herein and to any further conditions, exceptions and limitations stated in this rider.

The date of this rider is _____.

In consideration of the company's continuing the policy/certificate in force and waiving its then known rights of rescission on account of the insured's material misrepresentation in the application, relating to _____, a copy of which application is attached to and made a part of the policy/certificate, it is understood and agreed that in lieu of such rescission, such dependent is hereby removed from the policy/certificate effective the date of the policy/certificate. All premiums paid for such dependent (less any benefits paid under the policy/certificate for such dependent) are hereby returned to the insured.

This rider shall be null and void unless it is signed by the insured.

_____
Signature of the insured

MUTUAL OF OMAHA INSURANCE CO.,
V. J. SKUTT, *President.*

EXHIBIT 7

Number of policies issued by year

Forms	Year		
	1961	1962	1963
76DV	2,243	5,558	4,731
80DV		1,052	1,186
84DV	6	16	11
86DV		164	148
37DO	90	59	40
37DVO	32	13	11
4DLO	12	5	7
55–110	351	350	276
W8DO	365	356	317
22DV	2	1	7
41DV	1,154	165	1
64DO	46		
59DRO	17	7	4
59DV	208	7	
25HO/FHO	846	724	525
30HO/FHO	27,885	32,749	26,984
36HO/FHO	3,681	4,584	3,737
38HV/FHV	577	566	597
40HO/FHO	5,505	4,860	3,529
52HO/FHO	21	17	16
54HO/FHO	422	345	351
56HO/FHO	5,154	5,423	5,423
57HO/FHO	19	26	21
58HSO/FHSO	79	40	19
65HO/FHO	77	59	78
68HO/FHO	546	536	570
70HO/FHO			174
74HO/FHO			14
2CLO/FCLO	28	11	5
2HRO	39	16	20
16HO/FHO	10	19	3
16HSO/FHSO	109	60	7
6HSO	641	618	564
10HSO	372	255	262
66HO	691	581	525
9HO-9FHO	129	80	29
27HO-FHO	414	435	447
29HSO	17,638	17,711	13,965
BOH	1,082	897	1,241
8HO	99	196	184
3HSO	32,685	30,973	27,833
7HSO	399	359	417
11HSO	116	98	125
4HSO	41,547	91,286	41,961
8HSO	1,130	2,487	1,592
12HSO	231	531	210
3HO-3FHO	1,741	2,093	1,466
3DV	367	313	203
24HO/FHO	42	24	45
26HO/FHO	20	8	2
31HO/FHO	361	69	19
31DV	3,540	42	4
33DV	2,388	2,115	1,795
31DRO	401	329	227
55HO/FHO	85	80	61
6HMLO	1,050	8,385	8,981
8HMLO		40	79
9HMLO		2	663
11CH	3,092	3,310	847
15CH		4,086	6,174
50HO	33,244	75,339	38,911
58HO/FHO	765	937	506
Total	193,794	304,467	198,150

NOTE.—The above listing of policies issued by form does not contain the policyholders on several forms where no tabulation is made as to age. Records are not maintained by distribution of age within policy form on this type of coverage.

MUTUAL OF OMAHA INSURANCE CO.,
Omaha, Nebr., May 22, 1964.

Hon. PAT MCNAMARA,
U.S. Senator, U.S. Senate Building,
Washington, D.C.

DEAR SENATOR MCNAMARA: Attached you will find the information which we indicated was not yet available in the answers to the questionnaire which you furnished us.

In answer to question No. 5, we have attached representative copies of our advertising.

Cordially yours,

A. M. HANSEN,
Vice President.

OMAHA, NEBR., *March 19, 1964.*

Mr. V. J. SKUTT,
President, Mutual of Omaha,
Benefit Health & Accident Association.

DEAR MR. SKUTT: Senator McNamara has asked me to write to you in connection with his letter of March 11.

Would you be kind enough to modify the questionnaire to reflect the following changes:

Question I, "total policyholders (classified by group and individual)" should read, "total number of different persons insured against items of medical expense—exclusive of holders of disability insurance policies (classified by group and individual)."

In question No. VI, where reference is made to policyholders, it should be understood that the intent of the question is to determine persons. That is, if the individual has two or more policies he should not be counted as two policyholders but rather as one person.

As a general rule it would be appreciated if you would subtract from all totals those persons who are under age 65 and who are enrolled in one of your "senior security" contracts by virtue of having a spouse age 65 or over.

Thank you for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly.

MARCH 11, 1964.

Mr. V. J. SKUTT,
President, Mutual of Omaha, Benefit Health & Accident Association,
Omaha, Nebr.

DEAR MR. SKUTT: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings Mr. Constantine, of the subcommittee staff, at my direction, has been in touch with your Mr. Chamberlain to discuss certain questions on an informal basis.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon, it is our intention to ask you to testify on the efforts of your organization to meet the health insurance needs of our older population.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

PLEASE PROVIDE INFORMATION AS OF END OF EACH OF LAST 3 CALENDAR YEARS FOR PERSONS AGE 65 AND OVER (EXCEPT WHERE OTHERWISE INDICATED)

I. Total policyholders (classified by group and individual).

A. Available data (of any type) concerning other health insurance coverage held by your policyholders—commercial and/or Blue Cross.

II. Benefits and premiums:

A. Policy forms issued, by principal benefits (hospital daily room and board indemnity; allowances for hospital extras; allowances for physicians' services; surgical schedule) noting changes made during each year.

B. Monthly premium charged for each type of policy form described in A (please note all changes made during each year).

C. Number of policyholders for each policy form described in A.

III. Experience:

A. Premiums earned by policy form.

B. Claims incurred by policy form.

IV. Exclusions and limitations (including waiting periods) on conditions covered for each of the policies currently available.

V. Copies of all advertising and promotional literature directed toward older people.

VI. Underwriting:

A. Initial issuance of individual policies—percent rated as impaired risks and comparison with persons under age 65 rated risks.

B. Copies of all administrative directives to agents and/or brokers relating to field underwriting of individual policies for 65 and over applicants.

C. Underwriting subsequent to policy issuance or filing or payment of claims.

1. Copies of all restrictive riders or waivers employed.

2. Number of riders issued and number of those to whom riders or waivers were issued who received or filed for a benefit.

3. Cancellation and/or number terminated (nonrenewal) by type of policy and indicating how many of these had received a benefit.

4. Copies of administrative directives to claims personnel relative to company policy on cancellation, ridering of policies, non-renewal and rating-up of policies.

VI. Attrition:

A. Number of policyholders signed up during calendar years 1960, 1961, and 1962.

B. Of those who (during the above years) are no longer policyholders, number who are no longer insured for reasons other than death (specify reasons: lapses; terminations; cancellations; etc.)

C. Of all those no longer insured (including deaths) how many received a benefit?

D. How many were reinstated?

VIII. Other:

A. What are the unique risks involved in underwriting health insurance for the aged and to what extent do you believe these can be met by private health insurance?

B. Do you anticipate that premium increases will be necessary on some or all of your policies for the 65 and over population during the next 2 years? Please elaborate, indicating, where appropriate, the percentage increase anticipated and the reasons therefor.

APPENDIX B

RESPONSES TO SUBCOMMITTEE QUESTIONNAIRES RECEIVED FROM "STATE 65" INSURERS:

1. CONNECTICUT "65"
2. MASSACHUSETTS "65"
3. NEW YORK "65"
4. TEXAS "65"

1. CONNECTICUT "65"

ASSOCIATED CONNECTICUT HEALTH INSURANCE COS.
Hartford, Conn., April 15, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
U.S. Senate,
Senate Office Building, Washington, D.C.

DEAR SIR: In accordance with the request in your letter of March 10 addressed to the Associated Connecticut Health Insurance Cos. which I acknowledged under date of March 20, I am pleased to enclose herewith a memorandum covering the seven questions forwarded with your letter of March 10, together with the material requested. To the extent that it has been possible and practical to do so, the answers given are full and complete.

Sincerely yours,

WILLIAM N. SEERY,
Chairman, Executive Committee.

ANSWERS TO QUESTIONS RECEIVED WITH LETTER OF MARCH 10, 1964, FROM HON. PAT MCNAMARA, U.S. SENATOR, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE ELDERLY

Question 1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

Answer 1. Herewith are the following items:

A. Question and answer leaflet used in connection with open enrollment period.
B. Sales folder used in connection with second open enrollment period.
C. Sales folder used in connection with third open enrollment period.
D. Sales folder currently in use.
E. Enrollment booklet provided for each person insured.
F. Enrollment booklet amendment effective November 1, 1962.
G. Enrollment booklet amendment effective January 1, 1964 (form 651-2).
H. Current enrollment booklet for each person becoming insured.
I. Copies of newspaper advertisements.
J. Copies of scripts for radio and television.

Question 2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open" period, total number insured immediately prior to and following each of the two subsequent "open" periods; and total number of persons insured as of March 1, 1964 (please break down these data to show subtotals indicating numbers of persons in each of your various coverage options).

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those under age 65.

Answer 2. A. The total number of individuals enrolled at any time, up to March 1, 1964, is 35,166.

B. The total number of individuals accepted for insurance during the initial open enrollment period was 21,849, broken down as follows:

Option 1: (648 under 65)	13,770	Option 3: (42 under 65)	2,225
Option 2: (208 under 65)	4,891	Option 4: (33 under 65)	964

C. The total number insured as of April 1, 1962, preceding the second open enrollment period was 19,848, broken down by option as follows:

Option 1	13,222	Option 3	1,988
Option 2	3,824	Option 4	814

D. The total number insured as of May 1, 1962, after the second open enrollment period was 25,577, broken down by option as follows:

Option 1	17,153	Option 3	2,893
Option 2	4,488	Option 4	1,043

E. The total number insured as of October 1, 1962, before the third open enrollment period was 24,581, broken down by option as follows:

Option 1	16,552	Option 3	2,801
Option 2	4,216	Option 4	1,012

F. The total number insured as of November 1, 1962, after the third open enrollment period was 27,017, broken down by option as follows:

Option 1	18,456	Option 3	3,009
Option 2	4,476	Option 4	1,076

G. The total number insured on March 1, 1964, was 25,479, broken down by option as follows:

Option 1 (642)	18,076	Option 3 (38)	2,720
Option 2 (141)	3,787	Option 4 (22)	896

NOTE.—The number of those under 65 as indicated in B and G above is not significant. A count on those under 65 is not available with respect to C, D, E, and F without undue time and expense being involved.

Question 3. How many of those persons accepted for coverage during your initial open period were still insured under the program as of March 1, 1964?

Answer 3. Of the 21,849 original insured members, there are 15,619 who remain insured, broken down by option as follows:

Option 1	10,191	Option 3	1,510
Option 2	3,338	Option 4	580

Question 4. What was the average age of the "Connecticut 65" policyholders as of end of your initial enrollment period? What was the average age as of March 1, 1964?

Answer 4. The average age of those insured as of October 1, 1961, was 74.6 years. The average age of those insured as of March 1, 1964, was 74.1 years.

Question 5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

Answer 5. A. The following is the earned premium by option and the incurred claims from October 1, 1961, to March 1, 1964:

	Earned premium	Incurred claims
Option 1	$4,843,986	$4,709,037
Option 2	902,986	666,135
Option 3	1,293,791	1,358,256
Option 4	399,332	351,567
Total	7,440,095	7,084,995

B. In the period from October 1, 1961, to March 1, 1964, claim payments have been made to 8,670 different individuals.

C. The following is a count of 1963 claims broken down by option:

Option 1	3,694	Option 3	801
Option 2	722	Option 4	263

Question 6. Please provide the details of any and all premium and/or benefit changes made to date in your program.

Answer 6. Amendment effective January 1, 1964 (form 651–2 included as item G with answer 1) covers all premium and/or benefit changes made to date. These include a limitation of $1,000 per calendar year for the "covered" expense of registered graduate nurses under the $10,000 maximum major medical expense benefits and a similar limitation to $750 per calendar year with respect to the $5,000 maximum major medical expense benefits. Premium rates were increased from $10 to $11 for option 1, from $17 to $19 for option 3, and from $14.50 to $15.50 for option 4. For future enrollees a modification was made with respect to benefits in certain instances where medical or surgical care, treatment, diagnosis, or consultation was provided in connection with an injury or sickness during the 90 consecutive days immediately preceding the effective date of coverage.

Question 7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

Answer 7. Herewith is a copy of a statement by Mr. W. N. Seery, vice president of the Travelers Insurance Co., to the Insurance Committee of the Connecticut General Assembly on March 7, 1961. This statement describes the purposes and aims of the program.

Also enclosed is a statement by Mr. Seery as chairman of the Executive Committee of Connecticut 65 at a public hearing called by Commissioner Alfred N. Premo of the Connecticut State Insurance Department on October 23, 1963. This statement and the exhibits with it describe the progress and situation of Connecticut 65 at that time. Following the hearing the modest changes in premium rates and benefits indicated in answer 6 above were made effective.

Additional information with respect to the number of people insured is included in answers 2 and 3 above. The claim and premium figures in answer 5 above include claims and premiums to March 1, 1964, as requested.

A new insurance program requires analysis and study of a continual nature and adjustments are to be anticipated as the need arises. It will be noted from the statement on October 23, 1963, that claim rates have somewhat exceeded our anticipations. Steadily increasing medical and hospital rates are also having their effect and are expected to continue in the future. However, at this point the Executive Committee of Connecticut 65 has made no decisions as to any further premium or benefit adjustments.

CONNECTICUT 65,
ASSOCIATED CONNECTICUT HEALTH INSURANCE COS.,
Hartford, Conn., March 20, 1964.

HON. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly, U.S. Senate, Washington, D.C.

DEAR SIR: We have for acknowledgment your letter of March 10 addressed to the Associated Connecticut Health Insurance Cos., and requesting certain information relative to Connecticut 65. We are reviewing our records and the full reply will be sent to you later.

Sincerely yours,

WILLIAM N. SEERY,
Chairman, Executive Committee.

MARCH 10, 1964.

PRESIDENT, ASSOCIATED CONNECTICUT HEALTH INSURANCE CO.,
Hartford, Conn.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"CONNECTICUT 65"

1. All literature describing benefits and premiums, including scripts and "tearsheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open" period; total number insured immediately prior to and following each of the two subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please break down these data to show subtotals indicating numbers of persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those under age 65.

3. How many of those persons accepted for coverage during your initial "open" period were still insured under the program as of March 1, 1964?

4. What was the average age of the "Connecticut 65" policyholders as of the end of your initial enrollment period? What was the average age as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

6. Please provide the details of any and all premium and/or benefit changes made to date in your program.

7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

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2. MASSACHUSETTS "65"

MASSACHUSETTS 65,
HEALTH INSURANCE ASSOCIATION,
Boston, Mass., April 22, 1964.

Senator PAT MCNAMARA,
U.S. Senate, Special Committee on Aging,
Subcommittee on Health of the Elderly,
Washington, D.C.

DEAR SENATOR MCNAMARA: Enclosed are the answers to the questions contained in your letter of March 10, 1964:

1. Exhibit I lists the attached items of literature requested.

2. The total number of persons enrolled in the program from inception to March 1964 is shown on the attached exhibit II.

3. The number of persons continuously insured since the original enrollment is not readily available. This information can be secured, if necessary, by a special run of our records.

4. The average age of the Mass 65 policyholder as of the initial enrollment period was 73.5 years. Exhibit III shows our most recent statistics available of the breakdown by ages.

5. Annual statement highlights, exhibit IV. Exhibit V shows the close correlation between the geographical distribution of the aged population and the Mass 65 enrollment.

6. There have been no rate changes since the inception of the program. Several benefit changes, all of which have been liberalizations, have been incorporated in the attached certificates of insurance.

7(*a*). No changes in the benefits provided by our plan are currently anticipated.

7(*b*). The initial premium rates assumed 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 continuance of the initial premium rate for the policy year through December 31, 1964, at which time there will be a further review of accumulated claim experience.

The favorable claim experience to date has been achieved through the wholehearted cooperation of the 46 sponsoring companies and the entire medical profession.

Sincerely yours,

HERBERT S. WOODS, *General Manager.*

EXHIBIT I

(*a*) Sales folder used in connection with first "open" enrollment period.
(*b*) Sales folder used in connection with second and the current "open" enrollment periods.
(*c*) Letter for occupant mailing, influence group, inquiries, and letter to participants.
(*d*) Copies of newspaper advertisements.
(*e*) Agent-broker sales kit.
(*f*) Newsletters to members, agents-brokers, doctors, and hospitals.
(*g*) Copies of radio scripts.
(*h*) Certificates of insurance, plans 1 and 2.
(*i*) Benefit summary chart, plans 1 and 2.
(*j*) Hospital manual.

EXHIBIT II

(*a*) The total response during initial enrollment period was 49,893. This represented 8.7 percent of the aged population in Massachusetts and a much larger percentage of the effective market. After eliminating returns permitted under the 10-day free-look provision, duplicate applications, etc., the initial enrollment figure proved to be 43,383. This figure which exceeds by a considerable margin the original expectations is divided between the two plans, as follows:

Plan I	32,728
Plan II	10,655
Total	43,383

(*b*) At the time of the April 1963 and March 1964 enrollments there were the following numbers insured:

April 1963 (including 941 new enrollees during open enrollment period):	
Plan I	31,269
Plan II	11,401
Total	42,670
March 1964 (including 1,305 new enrollees during March enrollment period):	
Plan I	26,969
Plan II	11,138
Total	38,107

(*c*) The enrollment activity can be summarized as follows:

Number of enrollees Dec. 31, 1962		43,383
April 1963 and March 1964 enrollees	2,246	
Other enrollees	3,609	
		5,855
Total		49,238
Less deaths	4,247	
Other terminations	6,884	
		11,131
Present number of enrollees		38,107
Less 3.2 percent under age 65		−1,219
Total		36,888

EXHIBIT III

Mass 65 distribution by ages

Age	Males	Females	Total	Age	Males	Females	Total
50 [1]		5	5	77	621	1,109	1,730
51 [1]	1	12	13	78	573	1,068	1,641
52 [1]		17	17	79	512	954	1,466
53 [1]		22	22	80	465	937	1,402
54 [1]		21	21	81	366	738	1,104
55 [1]	1	34	35	82	340	792	1,132
56 [1]	1	49	50	83	325	609	934
57 [1]	2	60	62	84	270	606	876
58 [1]	3	75	78	85	239	452	691
59 [1]	3	90	93	86	188	383	571
60 [1]	3	91	94	87	196	351	547
61 [1]	7	120	127	88	127	240	367
62 [1]	10	205	215	89	90	175	265
63 [1]	17	242	259	90	85	184	269
64 [1]	35	302	337	91	48	96	144
65	1,036	1,455	2,491	92	48	92	140
66	1,153	1,600	2,753	93	18	56	74
67	1,001	1,611	2,612	94	19	30	49
68	987	1,486	2,473	95	11	19	30
69	972	1,507	2,479	96	9	17	26
70	903	1,569	2,472	97	6	16	22
71	913	1,387	2,300	98	2	5	7
72	859	1,503	2,362	99	5	9	14
73	821	1,429	2,250	100 and over	22	17	39
74	825	1,480	2,305	Unknown	9	4	13
75	712	1,316	2,028				
76	675	1,202	1,877	Total	15,534	27,849	43,383

[1] Dependent spouse of enrollee age 65 or over.

EXHIBIT IV

Massachusetts 65 Health Insurance Association 1st policy year highlights

		Percent of premium
Premiums paid by Massachusetts 65 subscribers	$6,442,137	100
Claims incurred by 11,358 claimants	5,475,532	85
Net cost of operating Massachusetts 65	449,379	7
State premium taxes (estimated)	129,000	2
Developmental, promotional, and acquisition costs charged to the 1st policy year	388,226	6

EXHIBIT V

Geographical distribution by County

[Percent]

County	1960 census, population 65 and over	Mass 65 enrollees	County	1960 census, population 65 and over	Mass 65 enrollees
Barnstable	1.6	2.7	Middlesex	21.8	23.9
Berkshire	2.8	2.3	Nantucket	.1	1.9
Bristol	8.0	3.8	Norfolk	8.8	14.3
Dukes	.2	.2	Plymouth	4.9	4.7
Essex	12.1	11.0	Suffolk	16.8	14.0
Franklin	1.3	.9	Worcester	11.8	9.4
Hampden	7.9	9.0			
Hampshire	1.9	1.9	All counties	100.0	100.0

MASSACHUSETTS 65 HEALTH INSURANCE ASSOCIATION,
Boston, Mass.

YOU MUST ACT PROMPTLY TO TAKE ADVANTAGE OF THIS REMARKABLE NEW MAJOR MEDICAL PLAN

There are only 10 days left for you to get in on Mass 65, the wonderful new health insurance plan for Massachusetts residents 65 and over. Applications can be accepted only through October 31.

If you are 65 or over, or if you are financially responsible for somebody who is, you still have time to apply for this protection if you haven't already done so.

As you will recall from the descriptive folder recently mailed to you, Mass 65 pays up to a lifetime maximum of $10,000 for major medical health insurance coverage. It's practically like having a special emergency fund from which you can draw up to $5,000 in any one year to pay the big medical bills that usually result from a major accident or serious illness.

Mass 65 begins paying benefits when most basic hospital and surgical plans leave off. It helps pay big bills from your doctor, the hospital, or a convalescent nursing home. And it's easy to take advantage of this plan designed exclusively for Massachusetts residents 65 and over. There's no medical exam required * * * no health questions asked.

When you have the protection Mass 65 gives you, you can enjoy new peace of mind * * * lessen your worries about the impact of a serious or prolonged illness or crippling injury. Even if your expenses run into thousands of dollars, and this is not at all unusual, you will be helped substantially in meeting the really staggering bills that can be incurred.

Mass 65 major medical protection is the type of coverage that people 65 and over have always needed most, yet have often found extremely difficult to obtain. And now it's available, at low cost, for everybody in Massachusetts 65 and over.

But you must not delay. The initial enrollment period for Mass 65 ends October 31, no applications can be accepted after that date. So please call or see your agent or broker today * * * before time runs out. He'll gladly answer any questions you might have about the plan, and will help you enroll.

Sincerely yours,

A. M. WILSON,
Chairman, Executive Committee.

MASSACHUSETTS 65 HEALTH INSURANCE ASSOCIATION,
Boston, Mass., October 1962.

DEAR SIRS: May we ask your cooperation in supporting the new Massachusetts 65 plan?

Will you help us spread the good news about Massachusetts 65—the new major medical health insurance plan for Massachusetts residents 65 and over? The support of prominent people like yourself will help us substantially in making this first enrollment period in October successful.

You've probably already heard and read a great deal about Massachusetts 65 and the voluntary association of leading insurance companies behind it. The plan has received widespread and enthusiastic coverage and commentary in the press, radio, and TV.

This is not surprising, for Massachusetts 65 presents a dramatic answer to the critical need of older people in Massachusetts for low-cost major medical health protection, at a time they can most benefit—when a serious accident or prolonged illness incurs medical and hospital bills that can run into thousands of dollars.

As the enclosed folder about Massachusetts 65 points out, expenses of this extent go far beyond the coverage normally provided by basic hospital-surgical insurance. Yet major medical protection is the type of health insurance people 65 and over have often needed most, yet have usually found most difficult to secure without having to take a medical exam.

Massachusetts 65 offers benefits that extend up to $10,000 over a person's lifetime * * * for medical and surgical bills, for care in a hospital or convalescent home or even in the individual's own home. The plan was designed exclusively for Massachusetts residents 65 and over, and was actually made possible only through passage of a special State law.

If you'd like to cooperate in getting across the important story of Massachusetts 65, you can do so by making copies of the enclosed folder available to those in your community who might benefit from the plan. We'll gladly send you as many folders as you wish—just fill in and return the slip accompanying this letter in the postage-paid envelope provided.

And thanks for your help.

Sincerely yours,

A. M. WILSON,
Chairman, Executive Committee.

MARCH 10, 1964.

PRESIDENT, MASSACHUSETTS 65,
Boston, Mass.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
U.S. Senate,
Chairman, Subcommittee on Health of the Elderly.

1. All literature describing benefits and premiums, including scripts and tearsheets used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total number of persons accepted for coverage during initial "open enrollment" period, total number of persons insured immediately prior to and following each of any subsequent "open" periods; and total number of persons insured as of March 1, 1964. (Please breakdown these data to show subtotals indicating number of different persons in each of your various coverage options.)

NOTE.—For this and subsequent questions, provide data, to the extent possible, distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured under the program as of March 1, 1964?

4. What was the average age of the policyholder as of the end of your initial enrollment period? What was the average age as of March 1, 1964?

5. Please provide all data available relating to premiums earned, claims incurred, utilization, etc., for each of the various options and types of coverage.

6. Please provide the details of any premiums and/or benefit changes which have been made in your program since its inception.

7. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

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3. NEW YORK "65"

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.*

Answers to questions outlined in letters of March 10 and 17, 1964, from Subcommittee on Health of the Elderly under the chairmanship of the Honorable Pat McNamara:

Question 1. All literature describing benefits and rates, including scripts and tearsheets used in promotion.

Answer 1. The following material is enclosed:

Initial open enrollment—October 15 to November 15, 1962—Exhibits

1. New York 65 filmstrip and record.
2. Proofs of four newspaper ads.
3. Sales aids kit (agents-brokers).
4. Talk for community groups.
5. Kit for hospital administrators.
6. Insureds enrollment packet.

Second open enrollment—June 1–15, 1963

7. Proof of newspaper ad.
8. Sales aids kit (agents-brokers).
9. Two TV scripts.
10. Inquiry letter.

Special enrollment opportunities

11. Agent-broker kit, February 1963.
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–Nov. 15, 1962)	107,404
Interim enrollments (see folder entitled "Special Enrollment Opportunities in New York 65" for eligibility requirements)	1,734
2d "open" enrollment (June 1–15, 1963)	[1] 33,552
Total applications	142,690

[1] In addition, 702 persons who already had some coverage with New York 65 took this opportunity to add additional coverage, as follows:

Basic added	281
Major medical added	421
Total	702

The distribution by plan is as follows:

	Initial open enrollment	Interim enrollments	2d 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

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

Answer 2. (*b*) Total aged persons insured as of March 1, 1964:

Basic	41, 741
Major medical	41, 882
Combination	26, 512
All plans	110, 135

Answer 2. (*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" enrollment
Basic	37, 534	33, 214
Major medical	39, 564	34, 763
Combination	24, 346	21, 054
All plans	101, 444	89, 031

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. 2
Major medical	71. 8	71. 3	71. 5
Combination	75. 9	75. 7	75. 8
All plans	73. 7	73. 4	73. 5

NOTE.—The average age of persons who enrolled during our 2d "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

NOTE.—We believe that the average age of those insured as of Mar. 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

NOTE.—These figures relate to the period from Oct. 15, 1962, through Dec. 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 two 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.

NEW YORK 65,
HEALTH INSURANCE ASSOCIATION,
New York, N.Y.

DEAR ———: We were sorry to note that the premium payments on the above certificate have stopped. Since you did not take advantage of the offer to reinstate the insurance, as outlined in our last letter, it has now lapsed.

Could you please let us know why you dropped this valuable insurance? This will involve only a few minutes of your time and your answers will help us to provide better service for more people. Your reply will be treated as confidential and your name will not be used in any way.

Please check one or more of the reasons listed below:

[ ] Unsatisfactory experience with a claim.
[ ] Bought other health insurance protection.
[ ] Benefits too limited.
[ ] Moved out of New York State (insurance could have been continued).
[ ] Did not receive offer to reinstate the insurance.
[ ] Other (please explain)_____

_____

_____

Please add any other comments you may care to make on the back of this letter.

A postage-paid, self-addressed envelope is enclosed for your convenience in replying.

Thanks in advance for your help.

Sincerely,

FRED MALLEY,
Executive Director.

Enclosure.

MARCH 17, 1964.

Mr. MORTON D. MILLER,
President, New York 65 Health Insurance Association,
New York, N.Y.

DEAR MR. MILLER: This is by way of supplement to Senator McNamara's request for information on the New York 65 program. It would be appreciated if you would also provide the Subcommittee on Health with the results of your mail survey of "several thousand recent terminations" designed to determine the principal reasons for such termination and their relative frequency.

Thank you for your cooperation.

Sincerely,

JAY B. CONSTANTINE,
Staff Director, Subcommittee on Health of the Elderly.

MARCH 10, 1964.

PRESIDENT,
New York 65 Health Insurance Association,
New York, N.Y.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would forward your responses to the attached questions and

requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

NEW YORK "65" PROGRAM

1. All literature describing benefits and rates, including scripts and "tear-sheets" used in promotion.

2. Total number of different persons enrolled in program from inception to March 1, 1964; total aged persons insured as of March 1, 1964; 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.)

3. How many of those persons accepted for insurance during your initial "open" enrollment period (November 1963) were still insured under the program as of March 1, 1964?

4. What was the average age of the 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?

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).

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. Explain fully.

NOTE.—To extent possible, provide all data for persons age 65 and over, excluding spouses who are under age 65.

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4. TEXAS "65"

TEXAS 65 HEALTH INSURANCE ASSOCIATION,
Dallas, Tex., April 17, 1964.

Hon. PAT MCNAMARA,
Chairman, Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: In compliance with your request, we are sending you under separate cover copies of our health insurance certificates, master policy, and all literature describing the benefits and premiums, including both radio and TV scripts and "tear-sheets" used in the promotion of our initial enrollment last October by the Texas 65 Health Insurance Association. This is in line with question 1 of your questionnaire.

In question 2 you asked for the total number of persons enrolled during the initial "open enrollment." Also, total number of different persons insured as of March 1, 1964. For this and subsequent questions, you asked that we provide you data distinguishing between persons age 65 and over and those persons under age 65. I explained to Mr. Jay Constantine that we did not carry a breakdown between persons age 65 and over and those persons unher age 65; consequently, we were unable to provide this data for the initial enrollment. The number of certificates issued during the initial enrollment broken down by plan is as follows:

Plan I	12,031
Plan II	26,425
Plan III	7,710
Total	46,166

We are in a position to give you the two age groups, that is, persons age 65 and over and those persons under age 65 insured as of March 1, 1964, by plan which is as follows:

	Plan I		Plan II		Plan III		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under age 65	519	4	594	3.2	263	3.1	1,376	3.5
Over age 65	12,396	96	17,726	96.8	8,158	96.9	38,280	96.5
Total	12,915	------	18,320	------	8,421	------	39,656	------

You will observe a large decrease in the number of persons covered under plan 2 with a slight increase under both plan 1 and plan 3. This is due to the fact that on February 14, 1964, we wrote all of the persons insured under plan 2, which is our major medical plan, giving them the opportunity to change to plan 1, our basic hospital plan, or change to plan 3, the combination basic hospital and major medical plan, providing they had no other basic coverage and the request for change was received in our office on or before March 2, 1964. This change was made effective March 1, 1964. We took this action in order that these people fully understood the type of health insurance protection they had with the opportunity to make this change if it better fitted their needs.

In answer to your third question, we wish to advise that the initial enrollment was from October 1–31, 1963, with the coverage going into effect on November 1, 1963. The number of persons still insured as of March 1, 1964, is as follows:

	Plan I		Plan II		Plan III		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Under age 65	499	4	573	3.2	253	3	1,325	3.4
Over age 65	12,127	96	17,387	96.8	7,934	97	37,448	96.6
Total	12,626	------	17,960	------	8,187	------	38,773	------

In answer to question 4, the average age of the Texas 65 certificate holder as of the end of our initial enrollment period was 73.

In establishing the premium rates for Texas 65, we anticipated costs in our calculations from a period of 2 years from the initial enrollment. We are enclosing copy of letter from Mr. Harvey Galloway, Jr., of our actuarial subcommittee, to Mr. H. Lewis Rietz, president of the Texas 65 Health Insurance Association, to substantiate our rate calculation that is self-explanatory.

In question 6 you have asked whether or not any premium and/or benefit changes are anticipated or will be required within the next 2 years. You can readily appreciate the fact that the Texas 65 Health Insurance Association has been in existence less than 6 months. Our experience is too young at the present time, but it is not unfavorable. We do not, however, anticipate making any changes during the next 2 years.

Sincerely,

CHARLES M. BARRY, *Administrator.*

EXHIBIT X

SOUTHLAND LIFE INSURANCE CO.,
Dallas, Tex., July 25, 1963.

Subject: Rate Basis Consideration for Texas 65.

Mr. H. LEWIS RIETZ,
Executive Vice President,
Great Southern Life Insurance Co.,
Houston, Tex.

The purpose of this report is not to give an exact basis for the rate computations for the Texas 65 plans but in general terms to indicate some of the considerations and data used.

BACKGROUND

From the offset it was apparent that our task would not be a particularly easy one due to the small amount of data compiled on senior citizens, particularly in the major medical area. It then became apparent that some of the information available for base type benefits was not particularly applicable due to the time and locality of exposure. Fortunately three other States had met this situation and at least one of them had provided some experience results prior to our arriving at our final rates. Although the Connecticut results were not conclusive, it was somewhat informative to discuss the Connecticut experience situation with some of the responsible people in Connecticut and to determine how the experience had deviated from the underlying experience which was used for the rate computation. Mr. Pettengill of the Aetna advised that the basic data used in the Connecticut plan was from the retired Federal employees group plan and that the Connecticut experience was considerably higher than that derived under the retired Federal employees plan. In fact, at one time he indicated that the cost was 50 percent higher than would be anticipated from reviewing the retired Federal employees group experience. Apparently the Connecticut people must have anticipated some additional losses because the final Connecticut results did not appear this far out of line. The State which offered the most information concerning rates was New York. Fortunately we had access to a very complete written report to the New York insurance department regarding the rate mechanism for the New York 65 Plan. This memo served as a starting point for our deliberations.

One of our earlier problems was generated when we started to compare the utilization differences by area since most of the experience available was on exposure in the Northeast or in the Nation as a whole. The annual reports for the Transaction of the Society of Actuaries indicated a higher claim cost in Texas than for the Nation as a whole in both hospital and surgical benefits. The latest group major medical paper written by Pettengill & Burton indicates this higher claim cost extends into the major medical area as well as base type benefits. Mr. Pettengill offered to have some of his people make a special study comparing Texas with Connecticut under the retired Federal employees plan. There were some obvious biases and the size of the data indicated that the results could not be too meaningful for rate purposes. However, the relationships derived in the study indicated that the higher claim utilization for Texas under normal group operations also carried over into the senior citizen area.

Mr. John Winters of the Texas Department of Public Welfare gave us quite a bit of data which had been derived from the old-age assistance program in Texas during the year 1962. Since this program covered approximately 225,000 people 65 and over in Texas, the results should have been meaningful. However, we tended to distrust the results for several reasons:

(1) The old-age assistance benefits were payable to low-income people in Texas who were receiving State money for subsistence. It could be argued that the health needs of these people would not be the same as the health needs for people who would buy our product.

(2) The old-age assistance plan is constructed to discourage normal lengths of hospital confinement. The benefits are cut in half at the end of 15 days and at the end of each 15-day period, the doctor must give written certification that the continued confinement is necessary for the health and well-being of the patient. We collected data on about 6,400 claims which had been settled in November 1962 concerning the length of hospital confinement. This data indicated that the above-mentioned biases were operating to a very great extent to reduce the average length of confinement. The average length of confinement generated under the old-age assistance plan was about 60 percent of the average length of confinement shown for age 74 in a report on the problem of

continuation of medical care benefits for the aged in New York State, voluntary health insurance and the senior citizen. The annual rate of hospitalization under the old-age assistance plan was almost double the rate indicated in the New York report. Age 74 for the New York study data was used for comparative purposes as the average age for the old-age assistance plan is approximately 74.

METHOD AND ANTICIPATED RESULTS

Using our best estimate of the area variations and all the data mentioned above, the latest articles on the group hospitalization from the Transaction of the Society of Actuaries, plus the anticipated selection against the plans, the actuarial subcommittee derived rates which we anticipated would produce an 83 percent loss ratio. However, subsequent changes have modified this position to the point where a first-year loss ratio in the neighborhood of 85 percent is expected. This loss ratio is somewhat lower than we feel we need for a going plan, however, we feel that some margin for fluctuation is necessary as well as some allowance for the amortization of acquisition expenses. We also need some allowance for the increase in claim cost due to the force of inflation which should be at an annual rate of 3 to 5 percent.

The actuarial subcommittee does not feel that the proposed rates are inadequate but it does feel they are close enough that we will have to anticipate a rate increase at least by the end of the second year of plan operation and presumably about every second or third year thereafter.

Due to the nebulous nature of the data in this experimental area, it should be obvious that the actuarial subcommittee cannot make any guarantee as to the adequacy of the proposed rates. We can simply say that this is our best estimate of the rate situation.

PROPOSED MONTHLY RATES

Texas 65 basic plan	$9
Texas 65 major medical plan	10

Sincerely,

HARVEY GALLOWAY, Jr.

MARCH 10, 1964.

PRESIDENT,
Texas 65, Dallas, Tex.

DEAR SIR: As you may know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, it would be very much appreciated if you would foward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Jay Constantine of the subcommittee staff, to cooperate fully with you in the event that you desire further clarification of the information requested.

Thank you for your cooperation.

Sincerely yours,

PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly.

"TEXAS 65"

1. Copies of policies, and all literature describing benefits and premiums, including scripts and "tear-sheets" used in promotion.

2. Total number of different persons enrolled during initial "open enrollment" period. Total number of different persons insured as of March 1, 1964. (Please breakdown these data to show subtotals indicating number of different persons in each of your various coverage options.)

Note.—For this and subsequent questions, provide data distinguishing between persons age 65 and over and those persons under age 65.

3. How many of those persons accepted for coverage during your initial "open enrollment" period were still insured as of March 1, 1964?

4. What was the average age of the "Texas 65" policyholder as of the end of your initial enrollment period?

5. In establishing premiums for "Texas 65" were anticipated costs rather than then-current costs used in your calculations? If so, how far ahead were costs projected and anticipated?

6. Advise whether any premium and/or benefit changes are anticipated or will be required during the next 2 years. Explain fully.

APPENDIX C

RESPONSE TO QUESTIONNAIRE AND SUPPLEMENTAL MATERIALS SUPPLIED TO SUBCOMMITTEE BY HEALTH INSURANCE ASSOCIATION OF AMERICA:

1. EXPLANATION OF METHODOLOGY. (Provided to Subcommittee in May 1964.)
2. ESTIMATE OF EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED AS OF DECEMBER 31, 1962.
3. THE EXTENT OF INSURANCE COMPANY COVERAGE FOR THE MEDICAL EXPENSES OF THE SENIOR CITIZEN AS OF JULY 1961.

MARCH 6, 1964.

HEALTH INSURANCE ASSOCIATION OF AMERICA,
New York, N.Y.

GENTLEMEN: As you know, the Subcommittee on Health of the Elderly has announced that it will hold public hearings on the subject of Blue Cross and other private health insurance coverage for older Americans.

In connection with the preparations for those hearings, Mr. Constantine, of the subcommittee staff, at my direction, called on you some 2 weeks ago to discuss certain questions on an informal basis. The attached list of questions includes some modifications developed as a result of your meeting with Mr. Constantine as well as notations indicating which of the items requested were turned over to him at the meeting.

It would be very much appreciated if you would forward your responses to the attached questions and requests for material as soon as possible. I have asked Mr. Constantine to cooperate fully with you in the event that you desire further clarification of the information requested.

At such time as specific dates for the hearings are decided upon it is our intention to ask you to testify on the efforts of the health insurance industry to meet the health insurance needs of our older population.

Thank you for your cooperation.

Sincerely,

PAT MCNAMARA,
U.S. Senator.

HEALTH INSURANCE ASSOCIATION OF AMERICA

Specific items requested:

1. Copy of memorandum (and attached study) dated October 15, 1962, from Mr. Robbins to Mr. Follman on the subject of "Health Insurance Benefits Paid to Persons 65 and Over."

2. "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of July 1961" (and any similar studies for subsequent dates).[1]

3. "Report of the Special Committee on Continuance of Coverage, June 1960" (and any similar studies for subsequent dates).[2]

4. List of the 90 insurance companies providing data for the study requested in item 2 above. List of the other 130 companies surveyed which could not provide "data of the type requested."

5. List of the 308 member companies of the HIAA surveyed for the study "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962," noting which of those companies comprised the 123 able to "provide the kinds of data called for by the survey."

6. Copies of the several questionnaires used in conducting the above surveys.

Questions:

1. In calculating the number of aged persons covered by private health insurance as of December 31, 1962, you project a figure on the basis of replies received from 123 insurers who, according to HIAA, "write over 70 percent of the health insurance premiums in the United States."

(*a*) Does the 70-percent figure include disability income premiums?

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[1] Given to Mr. Constantine on Feb. 19, 1964, along with "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen, as of Dec. 31, 1962," and "An Estimate of the Extent of Private Health Insurance Coverage of the Aged, as of Dec. 31, 1962."

[2] Given to Mr. Constantine on Feb. 19, 1964.

(*b*) Assuming that Prudential and Metropolitan are included among the 123 insurers who provided "the kinds of data called for by the survey," what percentage of "health insurance premiums in the United States" did each of these companies write and what percentage of the total aged with health insurance (of the 123 companies reporting) did each of these companies report?

2. With reference to continuation of health insurance coverage at retirement, do you have any data indicating the extent to which benefits are reduced and employer contribution, if any, terminated or reduced for individuals offered conversion or continuation privileges? Do you have any data on length of prior service (or eligibility for pension) as a condition affecting eligibility for conversion or continuation and/or extent of employer contribution? Please provide such data, if available.

3. During the past 3 years, have you undertaken any surveys or prepared any reports, studies, or memoranda on the subject of the quality of health insurance coverage available to or held by persons 65 years of age or over, and/or the extent to which health insurance meets: the total private health expenditures, of the elderly; the expenditures of insured elderly; and the expenses of items against which insurance is held? Please provide any and all relevant material.

4. What is your estimate of the number of noninstitutionalized aged persons holding some form of health insurance (exclusive of disability income coverage) as of December 31, 1963? Please explain the bases for such estimate.

HEALTH INSURANCE ASSOCIATION OF AMERICA,
Washington, D.C., April 20, 1964.

Hon. PAT MCNAMARA,
Chairman, Subcommittee on Health of the Elderly,
Special Subcommittee on Aging, U.S. Senate, Washington, D.C.

DEAR SENATOR MCNAMARA: In response to your letter of March 6, and the questions and requests for the documents enclosed with your letter, we submit the following information.

A. SPECIFIC ITEMS REQUESTED

1. Copy of memorandum (and attached study) dated October 15, 1962, from Mr. Robbins to Mr. Follmann on the subject of "Health Insurance Benefits Paid to Persons 65 and Over."

We advised Mr. Constantine when he visited us on February 19, 1964, that we do not have a copy of the cited memorandum. To the best of our recollection, the requested memorandum refers to an internal unpublished review by a staff member, made some 18 months ago, of then available source material pertinent to an evaluation of the relationship between health insurance benefits paid to aged policyholders and the expenditures of such policyholders for items of health care against which they are insured. The memorandum concluded that insurance companies do not routinely maintain statistics bearing upon either the numerator or the denominator of the cited relationship inasmuch as such data are not required for the day-to-day underwriting of the business. It was found that the only data available consisted of statistics developed from household interview surveys conducted by or on behalf of the U.S. Department of Health, Education, and Welfare and the Health Information Foundation.

In view of the fact that actual insurance experience could not be obtained, and since the statistical data developed by the other sources cited were not deemed to be sufficiently conclusive for examination of this subject, the matter was not pursued, and the memorandum was not retained.

2. "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of July 1961" (and any similar studies for subsequent dates).

As indicated in your letter, this study was given to Mr. Constantine on February 19, 1964. On that date, Mr. Constantine was also given all subsequent studies of a similar nature. These studies document, among other things, the significant growth in the extent of insurance company coverage of senior citizens.

The studies also contain an indication of the level of benefits held by the insured aged almost 3 years ago (mid-1961). Although these data are out of date, they do indicate, as an example, that at that time about a fourth of the people insured by insurance companies held major medical or comprehensive

policies. These policies are especially designed to help offset the more serious medical expenses resulting from severe or prolonged illness or injury, whether occasioned in or out of the hospital. Included in the coverage is protection against expenditures for hospital care, surgery, physician services, nursing care, prescribed drugs, and in some instances skilled nursing home care. Since the conduct of this survey, there have been such developments as the State 65 plans in Connecticut, Massachusetts, New York, Texas, and California, and other major medical plans offered to the aged by individual companies. It is logical to assume, therefore, that the extent to which senior citizens have major medical benefits has undoubtedly increased since mid-1961.

3. "Report of the Special Committee on Continuance of Coverage, June 1960" (and any similar studies for subsequent dates).

As indicated in your letter, this study was given to Mr. Constantine on February 19, 1964. All subsequent studies of a similar nature were presented in item 2 above.

This study provides information, among other things, on the extent to which group retiree benefits were available at the end of 1959. For example, at that time, more than one half of the actively employed insured population held this type of retiree benefit protection. Data are also present in the study with respect to the growth in the number of companies which offer guaranteed renewable policies, and there is information with respect to the absence of any significant problems concerning cancellation and nonrenewal of individual health insurance policies.

4. List of the 90 insurance companies providing data for the study requested in item 2 above. List of the other 130 companies surveyed which could not provide "data of the type requested."

A list of the 90 companies which provided data for the study cited in item 2 above is attached (exhibit 1). This study was conducted among all member companies of the Health Insurance Association. At the time of the survey, at least 220 member companies offered insurance coverage to persons at ages 65 and over. Of these, 130 could not provide statistics on the extent to which they insured such aged persons. In some instances, group health insurance records are not kept routinely on an age basis; some could not free the necessary personnel to compile the requested statistics and for other related reasons of an administrative nature. A list of the 130 companies is also attached (exhibit 2).

5. List of the 308 member companies of the HIAA surveyed for the study "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962," noting which of those companies comprised the 123 able to "provide the kinds of data called for by the survey.'

A list of the 308 member companies of the association, mentioned in item 5, is attached (exhibit 3). A list of the 123 companies which were able to provide data for the study mentioned in item 5 is also attached (exhibit 4). The committee may also be interested in a listing of some of the larger writers of health insurance which either could not provide data for the survey, or as nonmember companies, were not asked to participate in these surveys. Such a listing is attached for your information (exhibit 5).

6. Copies of the several questionnaires used in conducting the above surveys.

Copies of the questionnaires used in the surveys referenced above are attached (exhibits 6 and 7).

B. QUESTIONS

1. In calculating the number of aged persons covered by private health insurance as of December 31, 1962, you project a figure on the basis of replies received from 123 insurers who, according to HIAA, "write over 70 percent of the health insurance premiums in the United States."

1a. Does the 70-percent figure include disability income premiums?

The premiums written by the 123 companies which reported on the number of the aged they insured as of December 31, 1962, includes their total U.S. health insurance premiums, including both their hospital-surgical-medical business as well as their loss of income or disability insurance business. Total health insurance premiums were used in this instance as a basis for projection, inasmuch as the survey did not provide separate data on hospital-surgical-medical pre-

miums. The source used for this premium information was the Spectator Health Insurance Index. This document is a trade magazine, published annually, and is in general use within the insurance business as well as by nonbusiness organizations, for reference purposes. The statistics compiled by the Spectator magazine statisticians are essentially developed from the individual annual statements of insurance companies and other insuring organizations.

The 70 percent is the proportion of the total health insurance premium volume written by all insurance companies. It does not include other types of health insurers.

Inasmuch as disability premium income is included in the premium of both the reporting and nonreporting companies, the use of the total premium provides the most reliable basis for projection.

1b. Assuming that Prudential and Metropolitan are included among the 123 insurers who provided "the kinds of data called for by the survey," what percentage of "health insurance premiums in the United States" did each of these companies write and what percentage of the total aged with health insurance (of the 123 companies reporting) did each of these companies report?

In 1962, the Metropolitan Life Insurance Co. wrote 9.1 percent and the Prudential Insurance Co. wrote 6.1 percent of the total U.S. health insurance premium (including disability income premium). As previously indicated, data on premiums have been obtained from the Spectator Health Insurance Index.

Statistics concerning the extent to which each of these two companies have aged persons insured, however, is an item which we do not feel privileged to supply. All our surveys, no matter what the subject, carry an assurance of individual company anonymity. We believe that it is customary for trade associations, no matter what the field, to function in this manner, for, from an individual company's competitive standpoint, they would not long receive company cooperation in their studies.

2. With reference to continuation of health insurance coverage at retirement, do you have any data indicating the extent to which benefits are reduced and employer contribution, if any, terminated or reduced for individuals offered conversion or continuation privileges? Do you have any data on length of prior service (or eligibility for pension) as a condition affecting eligibility for conversion or continuation and/or extent of employer contribution? Please provide such data, if available.

Any data that the association has collected on this subject appears in the study given to Mr. Constantine on February 19, 1964, and referred to in item 3 above. See, for example, tables 12, 12a, 13, 13a, 14, and 14a of the cited study. To the extent that the information requested is not contained in that study, it has not been gathered by this association.

3. During the past 3 years, have you undertaken any surveys or prepared any reports, studies or memorandums on the subject of the quality of health insurance coverage available to or held by persons 65 years of age or over, and/or the extent to which health insurance meets: the total private health expenditures, of the elderly; the expenditures of insured elderly; and the expenses of items against which insurance is held? Please provide any and all relevant material.

With the two exceptions noted below, this association during the past 3 years has undertaken no survey, and has prepared no reports or studies or memorandums based on its own findings, on the general subject matter of question 3. The two exceptions are (*a*) tables 2–6 of the study mentioned in item 2 above and given to Mr. Constantine on February 19, 1964; and (*b*) the staff review mentioned in item 1 above which was discarded as inconclusive.

4. What is your estimate of the number of noninstitutionalized aged persons holding some form of health insurance (exclusive of disability income coverage) as of December 31, 1963? Please explain the bases for such estimate.

The association does not as yet have an estimate of the extent to which the noninstitutionalized aged were insured as of December 31, 1963.

Yours very truly,

ROBERT R. NEAL,
General Manager.

1. METHODOLOGY EMPLOYED BY THE HEALTH INSURANCE ASSOCIATION OF AMERICA IN DEVELOPING ITS ESTIMATE WITH RESPECT TO THE EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED

By means of a questionnaire survey with regard to aged persons covered at the end of 1962, member companies of the association were asked to report on the extent to which they insured persons at ages 65 and over for hospital expenses, surgical expenses, regular medical expenses and major medical expenses. Of the 312 member companies in the association at the time of the survey, 123 were able to provide statistics with respect to the extent of health insurance coverage of persons at ages 65 and over.

The 123 companies which reported data indicated that they insured 4.8 million persons at ages 65 and over for either basic hospital expense coverage or comprehensive major medical expense coverage. It is to be noted that these companies reported additional persons with surgical expense coverage, regular medical expense coverage, and supplementary major medical coverage. Such additional persons were not counted by the association in its total of 4.8 million, since it was assumed that these people had already been included as having basic hospital expense coverage with either some other insurance company or other type of insurer. It was also assumed that persons with supplementary major medical expense coverage were already included among the 4.8 million with basic hospital expense coverage.

The 123 companies which reported a total of 4.8 million persons at ages 65 and over with some form of insurance company coverage wrote about 70 percent of the U.S. health insurance premiums in 1962 (including both disability income premiums as well as hospital-surgical-medical expense premiums). The methodology employed in the regular annual survey of the association with respect to persons insured at all ages entails projecting numbers covered by reporting companies to a grand total for all insurance companies, based on the relationship of premiums written by reporting companies to the total U.S. written premiums for health insurance by all companies. Had this methodology been employed for the association survey of aged policyholders, the result would have been an estimated 6.9 million aged persons insured by insurance companies (i.e., 4.8/7).

To avoid the possibility of any overstatement with respect to its estimate as to the extent to which insurance companies covered persons at ages 65 and over, and to eliminate duplication of coverage within the insurance business, the association did not use the foregoing methodology for projecting reported enrollment statistics to a grand total. If the nonreporting companies writing 30 percent of the premium had the same proportion of persons at ages 65 and over as had the reporting companies, they would have covered 2.1 million people. Rather than use this 2.1 million or a figure even higher, it was assumed that it would be conservative to use 1.3 million for nonreporting companies. As it turned out, this figure was too conservative, for one of the nonreporting companies later reported that it alone insured 1.1 million aged persons.

The 1.3 million, when added to the total insured by reporting companies of 4.8 million, yields a net total for insurance companies of 6.1 million persons with some form of health insurance coverage at ages 65 and over.

The foregoing statistics, prepared in April 1963, are contained in the survey report entitled "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962." Subsequent to the preparation of this survey memorandum, specifically in early April 1964, the association was informed by the Continental Casualty Insurance Co. that it had found an error in the statistics which it had submitted to the association in past surveys concerning the insured aged population. This company informed the association that in the process of preparing data for a more current survey of the aged as of the end of 1963, it had found some duplication among the statistics previously furnished to the association. The revised figures furnished to the association by this company results in a reduction of 370,000 persons from the reported insurance company total of 4.8 million cited in the foregoing paragraphs of this memorandum. At about the same time, in April 1964, the association received data from the Bankers Life & Casualty Co. concerning the extent to which that company insured persons at ages 65 and over. That company, not being a member of the association, had not been requested to furnish data for the various association surveys. The company reported that it insured approximately 1.1

million persons at ages 65 and over. Upon inquiry to this company by the association, it was determined that 763,000 of the 1.1 million persons which they reported as insured, had coverage which met the definition of the association count of persons with some form of health insurance coverage with insurance companies.

The net effect of the reduction in persons insured by the Continental Casualty Co. together with the now available information of persons insured by the Bankers Life & Casualty Co. was to increase the reported enrollment by insurance companies from 4.8 to 5.2 million persons insured as of December 31, 1962. In other words, rather than reported statistics from 123 companies which wrote about 70 percent of the premiums in the United States, the association now had "reported data" from 124 companies which wrote 73 percent of the U.S. premiums in 1962.

Again, rather than assume that the reported statistic of 5.2 million should be projected to a total on the basis of all of the remaining 27 percent of the U.S. premium, the association chose to be conservative. If the nonreporting companies writing 27 percent of the premium had the same proportion of persons at age 65 and over as had the reporting companies they would have covered 1.9 million persons. Rather than use the 1.9 million figure, it was assumed that it would be conservative to use about half, or 0.9 million. This figure, when added to the 5.2 million cited above, yields 6.1 million found to be appropriate at the time of the association's survey in April 1963.

Documentation of the sources of enrollment statistics of the aged, for other insurers, are contained in the association's document "An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of December 31, 1962" dated July 1963. As indicated in reference 3 of that memorandum, the Blue Cross enrollment data concerning the extent to which that organization insures persons at ages 65 and over were reported by a Blue Cross executive at an annual meeting of the American Optometric Association in Chicago, Ill., on July 2, 1963. Subsequently, this statistic on Blue Cross enrollment; namely, 5.3 million persons insured as of the end of 1962, appeared in "Blue Cross-Blue Shield Nongroup Coverage for Older People," Research Report No. 4, Social Security Administration, U.S. Department of Health, Education, and Welfare. Reference 4 and 5 of the July 1963 association memorandum contains documentation for the sources of the estimate as to the extent to which other insurers provide coverage to the aged. As indicated, it was estimated that such organizations insured 400,000 persons at ages 65 and over as of the end of 1962.

Unlike its regular annual survey with respect to the total population, the survey concerning coverage of the aged population did not measure the extent of duplicate coverage as between insurance companies and/or insurance companies and other insurers. The usual methodology employed in eliminating such duplicate coverage is outlined on pages 12 through 16 of the memorandum entitled "The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1962" (sources of data and methods of compilation). As indicated on these pages, various factors are utilized to eliminate duplication of coverage within the insurance business and between the insurance business data and those having coverage provided by other insurers. The net effect of the application of all these factors is to reduce the grand total by approximately 13 percent.

To eliminate the duplicate coverage in the association's estimated count of persons covered at the upper ages, the association assumed that the same extent of duplicate coverage existed among the aged as for the total population. It subtracted an additional one and a half million persons (13 percent) from its estimated enrollment total for insurance companies (6.1 million), for Blue Cross (5.3 million), and for other insurers (0.4 million). The net total thus obtained was 10.3 million persons at ages 65 and over or approximately 60 percent of the noninstitutional aged population.

In connection with the association's use of 13 percent as a factor for eliminating duplication of coverage, it is interesting to note that Dr. Forest Linder, Director of the U.S. National Center for Health Statistics, reported during the course of his appearance before the Senate Subcommittee on Health of the Elderly on April 27, 1964, that the U.S. National Health Survey found duplication of coverage among the aged at this same level. It is also of interest to note that, upon questioning, Dr. Linder stated that it was his opinion that the proportion of 60 percent estimated by the association was not inconsistent with the 54 percent insured among the aged as estimated by the U.S. National Health Survey, and that such a difference could result entirely from differences in survey techniques.

The survey which the association conducted with respect to the aged population insured by insurance companies as of December 31, 1962, did not request information with respect to the size of the room and board benefit held in policies covering aged persons. Such information had been obtained in a July 1961 survey and it was felt to be too expensive to re-request at this time. This being the case, there was no way of determining the extent to which aged persons held policies of $30 a day, $20 a day, $10 a day, $5 a day, etc. Should the association have wanted to do so, therefore, it could not have eliminated aged persons with policies paying $5 a day or less from its estimated count, since it did not have such information available.

With respect to the total population, however, the association obtains, in its survey of individual policy enrollment, a measurement as to the extent to which persons at all ages have policies which provide room and board benefits for $5 a day or less. During 1962, among persons at all ages, of the 345 companies which reported in the survey, only 23 indicated some coverage in force with room and board benefits of $5 a day or less. Of these 23, 17 indicated that policies of $5 a day or less represented less than 1 percent of their total individual business in force. Of the other six companies, only one reported to the association in its survey of coverage on the aged. This company reported that it insured slightly over 14,000 persons at ages 65 and over at the end of 1962. As indicated heretofore, it is not known as to the extent to which any or all of the aged persons insured by this one company have policies which pay $5 a day room and board benefits or less. It will be noted, however, that even in the unlikely event that all 14,000 had policy benefits at such a level, the exclusion of this amount would have little effect upon the association's estimate of 6.1 million persons insured with insurance companies at the end of 1962.

2. An Estimate of the Extent of Private Health Insurance Coverage of the Aged as of December 31, 1962

Health Insurance Association of America, Chicago, New York, and Washington

EXTENT OF PRIVATE HEALTH INSURANCE COVERAGE OF THE AGED, DECEMBER 31, 1962

As of the end of 1962, the Health Insurance Association of America estimates that 60 percent of the noninstitutionalized aged population had some form of private health insurance coverage.

This estimate is based upon an analysis of the following: (1) recent surveys of the extent of aged policyholders, conducted by private insurers; (2) the trend in the proportion of the aged population covered by private health insurance as evidenced in household interview surveys; and (3) other relevant statistics developed within the private health insurance business.

Recent surveys of aged policyholders

A survey of the Health Insurance Association of America [1] indicated that slightly over 6 million persons 65 years of age and older held some form of health insurance coverage with insurance companies as of December 31, 1962. This total represented about 1¼ million more persons than the 4¾ million covered by insurance companies as of July 1961. It was 2½ times the 2.3 million aged persons with insurance company coverage at the end of 1958.

A study conducted by the Blue Cross Association [2] indicated that 5.1 million aged persons were enrolled in Blue Cross plans as of November 1961. More recently, a Blue Cross spokesman has stated that 5.3 million aged persons are "currently" enrolled under Blue Cross programs.[3]

Other studies [4 5] have shown that the so-called independent plans, that is plans not affiliated with either the Blue Cross, or underwritten by an insurance company, covered about one-half million aged persons in 1961.

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[1] "The Extent of Insurance Company Coverage for the Medical Expenses of the Senior Citizen as of December 31, 1962," Health Insurance Association of America, April 1963.

[2] "Financing Health Care of the Aged," pt. I, p. 127, Blue Cross Association and American Hospital Association, January 1962.

[3] H. Pierce, vice president, Blue Cross Association, presented at annual meeting of American Optometric Association, Chicago, Ill., July 2, 1963.

[4] Testimony with respect to H.R. 4222 by H. Lewis Rietz before House Ways and Means Committee, July 1961 (vol. 2, pp. 852 and 853).

[5] "Health Statistics from the U.S. National Health Survey, Interim Report on Health Insurance, Series B-26," Department of Health, Education, and Welfare, 1960.

If the extent of duplicate coverage among the aged is assumed to be similar to that which exists for the total civilian population,[6] then an estimated 10.3 million persons 65 years of age and older were covered by some form of private health insurance at the end of 1962. This represents 60 percent of the total noninstitutionalized aged population.

Trend in the proportion of the aged covered

Presented in the following table is an indication of the recent trend in the proportion of the aged covered by private health insurance.

Percent of the noninstitutionalized population at ages 65 and over with private health insurance

Date of survey:	*Percent insured*
March 1952 [1]	26. 3
July 1953 [2]	31. 0
September 1956 [3]	36. 5
Spring 1957 [4]	38. 6
Spring 1958 [5]	43. 0
Fall 1959 [6]	46. 1
July 1961 [7]	53. 0
December 1961 [7]	55. 0

[1] I. S. Falk and A. W. Brewster, "Hospitalization and Insurance Among Aged Persons," Bureau Rept. No. 18, Social Security Administration, April 1953.
[2] O. W. Anderson and J. J. Feldman, "Family Medical Costs and Voluntary Health Insurance," McGraw-Hill Book Co., 1956, p. 107.
[3] Research and Statistics Note No. 13, Social Security Administration, May 21, 1958.
[4] Progress in Health Services, vol. 8 (January 1959), Health Information Foundation.
[5] Progress in Health Services, vol. 8 (May 1959), Health Information Foundation.
[6] Interim Report on Health Insurance, series B-26, HEW, 1960.
[7] Ibid.

It will be observed that during a 9-year period from 1952 to 1961 the proportion of the aged with health insurance has more than doubled. It is of further interest to note the relatively greater increases during the more recent period covered by the table.

The table also illustrates the relatively more rapid rate of growth of health insurance among the aged population as compared with the total civilian population. At the beginning of the period depicted, 1952, 59 percent of the total civilian population was insured and this increased by 17 percent to an estimated 76 percent by the end of 1962. For the total noninstitutionalized aged population, the proportion insured more than doubled during this period, increasing from 26 percent to about 60 percent. It should be noted further that the 26 percent insured in 1952 represented 3.4 million of the then 13 million aged persons. The 60 percent insured today consists of 10.3 million people or more than three times the number of aged insured in 1952.

Recent relevant statistics within the business

During the last 5 years, there have been a number of significant developments within the private health insurance business which portend a further rapid extension of insurance coverage among senior citizens. Evaluations of these developments have to be considered, separately, for (1) those persons presently at ages 65 years or older and (2) for those persons who will reach this age group in the future.

For persons currently 65 years of age and older, the following statistics are relevant:

(1) Through a development of the last 4 years, a mass enrollment approach whereby all persons 65 years of age and older in a given State can be insured regardless of present or past condition of health, well over 1 million aged persons have become insured.

(2) In 1961 and 1962 residents of Connecticut, Massachusetts, and New York became eligible for enrollment in State 65 plans written by insurance companies through voluntary associations. These plans provide both basic and major medical insurance to residents of a State, and are open for enrollment regardless of past or present health status. To date, in excess of 200,000 aged people have been enrolled. There are indications that similar approaches will soon be introduced in other States.

[6] "The Extent of Voluntary Health Insurance Coverage in the United States," Health Insurance Council, annual.

(3) Groups of retired people, such as the American Association of Retired Persons, can acquire health insurance protection, and thus have the advantages of the group insurance approach.

(4) In 1961, retired civil service employees of the Federal Government were offered health insurance protection. This could eventually add 400,000 aged persons to the rolls of health insurance. In addition, State governments, such as New York, have made similar health insurance protection available to their retired civil service employees in the past few years.

(5) In 1961, 4.1 million aged persons and their dependents received money income from employment.[7] For those of these 4 million aged who are employed in industries where there is group insurance, these persons currently have health insurance protection with all or a larger portion of the premium paid for by the employer. Although it cannot be definitely established as to the exact number of these who are so protected, it is known that in excess of three-quarters of the total working population and their dependents are insured through the group insurance mechanism.[8]

(6) In addition to the mass enrollment approaches discussed under (1) and (2) above, the current aged population has access to the new issuance of individual policies. There are currently at least 170 insurance companies that will issue new health insurance policies to persons 65 years of age and older. Of these, at least 38 companies offer policies to the aged which are guaranteed renewable.

With respect to those persons presently under 65 years of age, who will over the next several years become senior citizens, there have been an equally significant number of developments relative to health insurance coverage as follows:

1. There is a growing practice within the private health insurance business for group plans to provide for a continuance of the health insurance protection offered to active employees after they retire. In most of such plans that are presently being written, the employer pays for or prefunds the premium cost for continuing the coverage on his pensioners or retirees. The following statistics are relevant to this trend:

(*a*) A survey conducted by the New York State Insurance Department [9] indicated that among all insurance companies licensed to do business in New York State all group plans providing for continuation of coverage after retirement had the provision included in the policy during or subsequent to 1954.

(*b*) A study conducted by the Health Insurance Association [10] indicated that in 1952, only 24 percent of group plans surveyed had provision for continuation of the coverage after retirement whereas by 1956, 48 percent of these plans had had this provision added to the policy.

(*c*) A survey conducted by the U.S. Bureau of Labor Statistics in 1958 [11] indicated that 68 percent of the group insurance plans surveyed provided benefits for retired workers as compared with 54 percent in late 1954. This study indicated further that in all but 3 of the 92 group plans surveyed the employer pays all or a very large portion of the premium.

(*d*) Insurance company witnesses [12] before the Senate Subcommittee on the Aged and Aging indicated that under group insurance plans insured through their companies, anywhere from 45 to 60 percent will have the coverage continued after retirement and that for about 70 percent of those so protected the coverage will be provided without any contribution on their part.

(*e*) A study [13] conducted among a sample of group insurance policies issued in 1960 indicated that 68 percent of the employees covered under such policies will have the right to retain their benefits upon retirement.

2. Another recent development which will afford protection to the future retirees concerns the availability of the right to convert group coverage to an individual policy at time of retirement. Most insurers which write group insurance today make this benefit available and its growth has been rapid

3. At least 61 insurance companies offer individual policies which are guaranteed renewable for life. This means that an individual can purchase health insurance at a relatively young age, when the premiums are relatively smaller, and continue to pay this relatively small premium into advanced ages. At least six insurance

[7] Research and Statistics Note No. 7, 1961, Social Security Administration.
[8] Ibid.
[9] "Voluntary Health Insurance and the Senior Citizen," New York State Insurance Department, 1958
[10] Trend in Medical Care Benefits Provided to Active Employees and at Retirement Through Group Insurance Plans.
[11] Monthly Labor Review, vol. 81, No. 11, pp. 1243–1249, November 1958.
[12] Testimony of Morton D. Miller of the Equitable Life Assurance Society and Richard R. Shinn of the Metropolitan Life Insurance Co. before the Senate Subcommittee on the Problems of the Aged and Aging, Apr. 13, 1960.
[13] Health Insurance Institute, May 1961.

companies issue such guaranteed renewable coverage which becomes paid up at age 65, thus enabling the policyholder to prepay his protection.

4. Apart from the specific development of new techniques for insuring the future aged, it might also be observed that those persons reaching senior citizen status in future years emerge from a cohort of the population which has been subjected, during the last 10 years, to a considerable growth of health insurance coverage. Specifically, at the beginning of 1947, only 30 percent of the total population had some form of health insurance protection whereas currently this proportion has reached 76 percent. This is further illustrated in the following two analyses:

(1) A 1952 survey by the Social Security Administration [14] indicated that 26 percent of persons 65 years of age and older were insured. For those 65 to 69 the percentage was 36 percent; for those 70 to 74 it was 25 percent; and it was 15 percent for those 75 years of age and older. In 1947, when the above cited 65 to 69 cohort was 60 to 64, only 30 percent of the entire population was insured. It is unlikely that the people in the age group 60 to 64 were covered to the same extent. Yet 5 years later, these same people were 36 percent covered. Similarly, the people who were 70 to 74 years of age in 1952, were 60 to 64 in 1942. At the beginning of 1942 only 12 percent of the population had acquired voluntary health insurance. Thus, the percentage of this age group insured in 1952, about 25 percent, represents a substantial increase over the average extent of coverage at the time when these same people were in the 60 to 64 age bracket. Finally, those who were aged 75 and over in 1952 were 60 and over in 1937, at which time health insurance coverage in this country was almost negligible, covering fewer than 5 percent of the total population. The 15 percent of this age group covered in 1952 must, therefore, represent protection almost entirely acquired after age 65.

(2) In the fall of 1959, the Department of Health, Education, and Welfare estimated that 46.1 percent of the aged had health insurance.[15] Of those 65 to 74 years of age, the percent insured was 53.2 percent, and it was 32.5 percent for those 75 years of age and older. In 1949, when the above cited 65 to 74 cohort was 55 to 64, only 45 percent of the total population had health insurance. Even if people in this age group were insured to the same extent, within 10 years their coverage had increased to 53 percent. Similarly, when those 75 and over in 1959 were 60 and over in 1944, only 23 percent of the total population were insured. Thus, more than a third of the coverage among this group in 1959 (32 percent) must represent insurance acquired after age 65.

The examination of the increasing trend in the proportion of the aged protected by health insurance during 1952 to 1961, together with consideration of the other recent developments noted in the foregoing section of this memorandum, indicates that the current HIAA estimate to the effect that 60 percent of the noninstitutionalized aged were insured at the end of 1962, is statistically reliable.

According to the Social Security Administration,[16] 14 percent of the aged population are currently receiving old-age assistance benefits and are, therefore, eligible to obtain governmental help in meeting medical care costs. To this proportion should be added the aged who are receiving medical care assistance under the Kerr-Mills law. Since few, if any, of the aged in these categories have health insurance, the aforecited 60 percent of the total noninstitutionalized aged with private insurance coverage when added to the at least 14 percent eligible for medical care under OAA and MAA, means that about three-fourths of the aged presently have a means for meeting medical care costs either through private health insurance or present governmental programs.

EXHIBIT 7

INSTRUCTIONS FOR PART I, INDIVIDUAL AND FAMILY POLICIES

1. Information reported is to be based on an actual analysis of individual policies in force in the United States on December 31, 1962, and which provide hospital, surgical, regular medical, or major medical expense coverage. Where an actual analysis is not possible, representative samples or other appropriately qualified estimates will be acceptable. Where samples are used, however, data should be expressed in terms of totals based on the samples utilized.

2. Exclude special-risk, limited accident, polio, and other such policies not providing medical expense benefits for both accidents and illness. Franchise and

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[14] Social Security Bulletin, November 1952.
[15] Ibid.
[16] Social Security Bulletin, June 1961.

blanket policies should be included in part I unless reported in part II. Kindly indicate by footnote the part in which you have included your franchise and blanket coverages. Coverage under mass enrollment plans and conversions from group policies should also be shown in part I.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home and office visits. Distribute this total in line 3, however, as between categories shown in lines (*a*) and (*b*).

(*d*) *Major medical expense, supplementary.*—Include only the major medical expense or catastrophic coverage policies which may be superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. Include only policies written on a direct basis. Reinsurance assumed from other companies should be excluded, while reinsurance ceded to other companies should not be deducted. Do not include participation in State 65 association plans. Such data will be obtained direct from the association.

5. In the event that individuals are covered for hospital-surgical-medical expenses by rider to a loss of income policy, such persons should be included for purposes of this questionnaire.

6. Please note that persons with a policy providing hospital, surgical, and regular medical expense benefits should be entered in each of the appropriate lines of part I.

PART I

Number of people 65 years of age and older covered under individual and family health insurance policies, as of Dec. 31, 1962

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

INSTRUCTIONS FOR PART II, GROUP POLICIES

1. Information reported is to be based on actual analysis of group policies in force in the United States on December 31, 1962, and which provide hospital, surgical, medical, or major medical expense coverage. An actual analysis should be made and reported for all policies covering 500 or more employees. For smaller groups, analyze and report on all policies or use a sample by taking from either a numerical or alphabetical file (*a*) at least every 10th policy covering between 50 and 499 employees, and (*b*) at least every 20th policy (with a minimum sample of 100 policies) covering less than 50 employees. When a sample is used, the results entered in the tables should be the totals for your entire business as estimated from the sample. Other appropriate estimating procedures, where necessary, will be acceptable.

Exclude special-risk blanket coverages (e.g., polio, limited accident, volunteer firemen, schoolchildren). Other franchise and blanket coverages should be excluded if reported in part I.

2. Include only coverages written on a direct basis—reinsurance accepted from other organizations should be excluded, while reinsurance ceded to other organizations should be included. For coverages jointly underwritten by your organization and one or more other organizations on a coinsurance basis, the figures included should be a fractional part of the individuals so underwritten, the fraction used being the proportion of the total coverage under such cases which is underwritten by your organization. Do not include participation in State 65 Association plans. Such data will be obtained direct from the association.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Do not include, however, the extra hospitalization coverage provided in addition to weekly indemnity in policies issued under the California UCD law, if the benefit is only the minimum required by law ($12 for 20 days).

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home, and office visits.

(*d*) *Major medical expense* (*supplementary to basic plans*).—Include only the major medical expense or catastrophic coverage policies which are superimposed on basic hospital, surgical and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive* (*no basic plans*).—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. The following instructions apply with respect to the basis for reporting individuals: Include under each benefit classification the total number of individuals for whom such coverage is provided. Individuals with several kinds of coverage should be counted under each of the appropriate classifications.

5. It is recognized that some of the data for tables 1 and 2 may, in some instances, have to be obtained from your policyholders. The importance of this survey is such as to warrant such a procedure wherever possible. If such proves not to be practicable, qualified estimates will be acceptable.

PART II

TABLE 1.—*Number of actively employed individuals and dependents 65 years of age and older insured under group health insurance policies, as of Dec. 31, 1962*

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In-hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

TABLE 2.—*Number of retirees and retirees' dependents 65 years of age and older insured under group health insurance policies, as of Dec. 31, 1962*

Type of coverage	*Total*
1. Hospital expenses, total	
2. Surgical expenses, total	
3. Regular medical expenses, total	
(*a*) In-hospital only	
(*b*) Home, office, and hospital	
4. Major medical expenses, supplementary	
5. Major medical expenses, comprehensive	

3. THE EXTENT OF INSURANCE COMPANY COVERAGE FOR THE MEDICAL EXPENSES OF THE SENIOR CITIZEN AS OF JULY 1961

A Survey of Member Companies of the Health Insurance Association of America

TABLE OF CONTENTS

I. HIGHLIGHTS OF SURVEY

(1) As of July 1961, there were at least 220 member companies of the Health Insurance Association of America which offered health insurance coverage against the costs of medical care to the senior citizen (persons age 65 and older). This survey was conducted to determine the extent and quality of these coverages written by these companies. Of the 220 companies, 90 responded to the survey. The remainder were unable to provide data of the type requested.

(2) The 90 companies reported a total in-force of 3.6 million persons 65 years of age or older with some form of medical expense insurance in mid-1961. Since the health insurance premium volume of these companies is about two-thirds of the total health insurance premium volume in the United States, it is estimated that, among all insurance companies in the United States, there were about 4¾ million senior citizens covered as of mid-1961.

(3) A previous survey by the association indicated about 2.3 million aged with insurance company coverage at the end of 1958. Thus, in the last two and a half years, the number of aged persons covered by insurance companies is estimated to have more than doubled.

(4) Of the aged covered, 47 percent were insured under group policies and 53 percent under individual and family policies.

(5) Of the senior citizens with hospital expense coverage, 88 percent also had surgical expense insurance and 30 percent had coverage for regular medical expenses. Almost three-fourths of a million, 730,000 aged persons, were covered by major medical expenses insurance policies as of July 1961. Major medical policies provide coverage for all usual, customary, and necessary medical expenses in and out of the hospital including surgery, physicians services, prescribed drugs, nursing care, and appliances, subject to stated deductible, coinsurance, and maximum amounts.

(6) Of the aged with hospital expense insurance almost one-third had policies with daily hospital room and board benefits of $15 a day or more. About a fifth (18 percent) had benefits of from $11 to $14 per day and the remainder (53 percent) were covered for $10 a day or less.

(7) The nationwide average daily room and board charge in hospitals in 1960 was $17. Based on this average, almost one-third of the insureds would have the room and board portion of their hospital bill met in full or practically in full; 18 percent would have between 65 percent to 82 percent of the bill covered; and 53 percent would be covered for about half the room and board charge.

(8) Twenty-seven percent of the aged with hospital expense coverage had ancillary hospital expense benefits of $500 or more and an additional 21 percent had benefits of between $200 and $499. The remaining 52 percent were covered for ancillary hospital expenses up to $200. This coverage provides benefits for such hospital expenses as the operating room, anesthesia, and drugs.

(9) According to data developed by the Society of Actuaries, a $200 ancillary hospital expense benefit will provide full reimbursement of all hospital ancillary expenses in at least 80 percent of all confinements.

(10) More than two-fifths of the insured aged had hospital expense benefits of over 70 days per year. About a quarter had coverage for from 32 to 70 days per year. The remaining third had policies providing for 31 days, and in a few instances, for less than 31 days per year.

(11) According to U.S. National Health Survey data, two-fifths of the aged are discharged from hospital after a week or less; 70 percent after 2 weeks or less; and 91 percent after 30 days or less. Less than 10 percent of the aged spend 31 days or more in hospital. Based on these averages, all but a small proportion of the insureds would have sufficient benefit days to provide coverage for their entire hospital stay.

(12) More than half of the aged with surgical expense insurance (53 percent) have maximum surgical benefits of over $200. The remainder have such benefits for $200 or less (most usually $200).

(13) About a third of the aged with regular medical expense insurance have coverage for physicians visits in home, office, and hospital. The remaining two-thirds have coverage for nonsurgical physicians visits while hospitalized.

(14) As of mid-1961, several insurance companies were making available coverages which specifically include the cost of skilled nursing home care. Although the survey did not obtain data with respect to the total number of aged covered for such care, it is known that the predominant coverage is $7.50 a day for 31 days and $5 a day for the next 90 days in nursing homes.

(15) Four-fifths of the 730,000 aged persons with major medical insurance are covered by group policies. The remainder have individual and family coverage. Of those insured under group policies, 70 percent have the supplementary and 30 percent the comprehensive type of major medical coverage. These policies are written with maximum amounts up to $15,000, subject to deductibles and coinsurance.

(16) More than four-fifths of the aged covered under individual and family policies for hospital and surgical expenses have policies which are either guaranteed renewable or under which the company has voluntarily relinquished its right to nonrenew the policy because of any change in the physical condition of the insured.

(17) Upon retirement, more than one out of every two aged currently employed and insured under a group insurance policy have the right either to convert to an individual policy or to continue their coverage as a member of the group.

(18) Since July 1961, there have been such developments as the Connecticut 65 plan, the Federal Government retiree plan, and others, which portend a further extension of the coverages held and available to the aged.

II. BACKGROUND AND PURPOSE

In December 1957, the board of directors of the Health Insurance Association of America appointed a special committee on continuance of coverage.

In October 1958, that committee recommended a special meeting of the association to be held in New York City in December 1958. At that meeting, the following recommendations of the committee were adopted by the member companies of the Health Insurance Association of America:

1. Insurers offering individual and family coverage of the cost of health care under contracts which are renewable at the option of the insurer should continue to accelerate their progress in minimizing the refusal of renewal solely because of deterioration of health after issuance.

2. Every insurer offering health care coverages should, among the types of insurance contracts it offers, promptly make available to insurable adults policies which are guaranteed renewable for life.

3. Every insurer should develop sales programs designed to encourage the sale of permanent health care insurance where the need for this type of coverage exists.

4. Every insurer offering individual and family hospital, surgical, and medical care coverages should promptly take steps if it is not presently doing so to offer insurance coverage of persons now over age 65.

5. It is essential that adequate voluntary health insurance be available to broad classes of physically impaired people. Initial insurance underwiting standards essential to fulfilling the first two of these recommendations increase the need for insurance for the physically impaired. Otherwise, in the future, these people may be deprived of insurance coverage. It is recommended that each company carefully consider how to contribute to the achievement of this objective.

6. Every insurer writing coverage on a group basis should develop and aggressively promote soundly financed coverages that will continue after retirement.

7. Every insurer offering coverage on a group basis should encourage the inclusion in the group contract of the right to convert to an individual contract on termination of employment.

It is the purpose of this survey to determine the extent and quality of coverages against the costs of medical care presently covering senior citizens and to measure the accomplishments of member companies as respects such coverages since the adoption of the aforecited recommendations. Specifically, the survey develops data on the extent and quality of insurance company coverage for the medical care expenditures of persons 65 years of age or older with measurement taken as of July 1, 1961. Along with this current measurement, there is presented an indication of the recent trend with respect to such data.

III. SCOPE AND METHODOLOGY OF STUDY

The survey was conducted by mail among the 282 member companies of the Health Insurance Association of America by means of a questionnaire (see appendix B). Survey forms were distributed in June with responses requested by the end of September 1961. Of the 282 members, at least 220 made medical expense coverage available to persons 65 years of age and older. As of the date of this analysis (December 1961), 152 member companies had responded.

Among the 152 respondents, 43 were necessarily excluded from participation in the survey for one of the following reasons: the company did not write medical expense insurance for persons 65 or over (32 companies); the company wrote reinsurance only (4 companies); or the company did not write insurance in the United States (7 companies). There were, therefore, 109 member companies which reported writing medical expense insurance for the senior citizen on a direct basis in the United States. Of these 109, however, 19 could not supply data in sufficient detail to be usable for purposes of the study.

The results of the study are based, therefore, upon statistics provided by 90 member companies of the Health Insurance Association of America. Since certain of these companies write group insurance only, or individual insurance only, the total respondents for various sections of the survey (see questionnaire in appendix B) differ. The adequacy of the response rate for the several sections may be adjudged from the data presented below.

Responses to survey

	Number of companies	Percent of total U.S. premium
Total	90	66.0
Pt. I, individual	70	42.7
Pt. II, group:		
Table 1	63	59.7
Table 2	55	62.8

It will be noted that respondents to the survey write approximately two-thirds of the health insurance premiums in the United States. The sample, is therefore, deemed to be statistically valid and representative of the total U.S. business.

IV. ANALYSIS OF RESULTS, JULY 1961

(*A*) *Extent and type of coverage*

As of July 1, 1961, the 90 respondents to the survey reported 3.6 million persons 65 years of age or older with some form of medical expense insurance coverage. Since the health insurance premium volume of these companies is approximately two-thirds of the total health insurance premium volume in the United States, the complete extent of medical expense coverage by insurance companies, among

senior citizens in the United States, is estimated to have numbered about 4¾ million persons as of mid-1961.[1] [2]

It is of interest to compare the total of 4¾ million aged persons covered as of July 1961 with data obtained in a previous survey by the association. Although the statistics are not entirely comparable, since there were several different companies responding in each survey, the trend depicted is noteworthy. In the prior survey, data indicated 2.3 million aged covered at the end of 1958.[3] In a space of 2½ years, therefore, the number of aged persons covered by insurance company respondents to the association's survey is estimated to have more than doubled.

Among the aged persons insured as of July 1961, 47 percent were covered by group insurance and 53 percent by individual and family policies (see table 1, app. A).

Of those with hospital expense protection, 88 percent also had surgical expense protection and 30 percent had additional protection for regular medical expenses. A fifth of the aged with insurance company coverage, 730,000, had major medical expense policies.

Among the 730,000 persons with major medical expense coverage, 81 percent are protected under group policies and 19 percent have individual and family policies. Of those with group major medical expense coverage, 70 percent have such coverage superimposed upon a basic hospital-surgical policy and 30 percent have comprehensive plans which usually have deductibles of $25 or $50. The pertinent numbers are presented below.

Number of aged persons with major medical insurance, July 1961

Total	730, 140
Individual	135, 328
Group	594, 812
Supplementary	409, 529
Comprehensive	185, 283

The above noted aged persons with major medical expense policies have coverage in amounts up to $15,000 subject to deductibles and coinsurance. Benefits are paid for all the usual, customary, and necessary medical care expenditures both in and out of hospital, subject to deductible, coinsurance, and maximum amounts. Benefits include the costs of surgery, physicians services, prescribed drugs, nursing care, and appliances.

It is of interest to compare the proportions of the aged with hospital expense protection who also have surgical and regular medical with comparable data for the total population at all ages. Of persons covered by insurance companies for hospital expenses as of January 1961 (79 million), 75 million or 95 percent had protection for surgical expenses—a proportion only slightly higher than that among the aged. Although the proportion who also have regular medical expense coverage among the total population (52 percent) is considerably higher than the 30 percent among the aged, the latter proportion is significantly high in view of the fairly recent development of health insurance coverage for the aged. Ten years ago only 23 percent of the total population covered by insurance companies for hospital expenses also had coverage for regular medical expenses.

Additional data with respect to the extent and type of coverage of aged persons, as between group and individual insurance, may be found in table 1.

(B) Quality of coverage

(1) Hospital expenses

As indicated in table 2 (app. A), about one-third (29 percent) of the aged persons with hospital expense insurance had policies which provide daily hospital room and board benefits of $15 a day or more. About a fifth (18 percent) had benefits of $11 to $14 per day. The remainder, slightly over half (53 percent), were covered for $10 a day or less.

[1] In testimony before the Committee on Ways and Means, House of Representatives, in July 1961, the association estimated that 9 million aged were covered—4 to 4¼ million by insurance companies, 4½ million by the Blue Cross, and one-half to three-fourths million by other plans. In light of the current study, these estimates were probably understated.

[2] Data with respect to the extent of duplicate coverage among the aged were not obtained in this survey. The factors used to eliminate such duplicate coverage, therefore, were similar to those for the total population. These are shown in the regular annual survey of the Health Insurance Council, "The Extent of Voluntary Health Insurance Coverage in the United States."

[3] These data are based on reported statistics projected to a total. This was accomplished in a similar manner as the data for mid-1961, i.e., reported premium against total U.S. premium.

Two points are worthy of note with respect to these findings:

(1) The average daily room and board charge in non-Federal short-term hospitals in the United States in 1960 was $17.[4] In terms of this nationwide average, 29 percent of the aged insureds would have their daily room and board charges covered in full or practically in full; 18 percent would have between 65 to 82 percent of the bill covered; and the remainder would have, on the average, slightly over half the bill covered.

(2) The nationwide average hospital room and board charge varies significantly by geographical area in the United States. Thus, in States like Mississippi and Arkansas, as examples, where the average daily bed charges are $10[4] and $11[4] respectively, a daily hospital room and board insurance benefit of $10 a day would about cover the entire cost.

In addition to the daily room and board benefit, the aged insureds had benefits for ancillary hospital expenses in amounts up to $500 or more. Of the total, 27 percent had benefits for $500 or more; 21 percent had benefits of between $200 and $499; and 52 percent were covered for amounts up to $200. (See table 2.)

With respect to the foregoing, it is of interest to note that a $200 ancillary expense benefit will provide full reimbursement of all hospital extras in at least 80 percent of hospital confinement.[5]

More than two-fifths of the insureds (41 percent) had hospital expense coverage for more than 70 days per year. An additional 25 percent had benefits providing coverage for 32 to 70 days per year. The remaining third (34 percent) had policies which provided benefits for 31 days, and in a few instances, for less than 31 days.

An evaluation of the relative effectiveness of these findings may be obtained from a review of U.S. National Health Survey data.[6] According to this material, 41 percent of persons 65 and over are discharged from hospitals after stays of a week or less. An additional 31 percent are discharged after 1 to 2 weeks and about 19 percent spend from 15 to 30 days in hospital. Less than 10 percent of the aged stay in hospital for more than 31 days. Based on these data, all but small proportion of the aged insured would have sufficient benefit days to provide coverage for their entire hospital stay.

(2) Surgical expenses

A distribution of the aged persons with surgical expense insurance, by level of the coverage, is presented in table 3, appendix A.

Of the total, 10 percent had maximum surgical benefits of $300 or more and 43 percent had benefits of between $201 and $300. The remaining 47 percent had benefit maximums of $200.

(3) Regular medical expenses

As indicated in table 4 (app. A), two-thirds of the insured aged with coverage for regular medical expenses had such coverage in hospital only. The remaining third had coverage for physicians visits in home, office, and hospital.

The foregoing distribution is not too dissimilar from that which exists for the total insured population. Thus, a recent analysis by the Health Insurance Institute[7] among a sample group insured cases indicated that of those with regular medical expense coverage, 77 percent had coverage for in-hospital physicians visits and 23 percent for visits in home, office, and hospital.

(4) Nursing home expenses

The current survey did not measure the extent of insurance company coverage with respect to nursing home care. It is known, however, that as of mid-1961, several large insurance companies were making available coverages which specifically include the cost of skilled nursing home care. The predominant of such coverages is for $7.50 per day for the first 31 days in a nursing home and $5 per day for the next 90 days.

Additional data on the level of coverage among aged persons by type of coverage, as between group and individual insurance, may be found in tables 2–4.

[4] "Daily Service Charges in Hospital, 1960," American Hospital Association.
[5] "A Reinvestigation of Group Hospital Expense Insurance," Transactions of the Society of Actuaries, vol. XII, 1960.
[6] "Hospitalization, Patients Discharged from Short Stay Hospitals, United States, July 1957–June 1958," series B–7, Department of Health, Education, and Welfare.
[7] "Source Book of Health Insurance Data, 1961," Health Insurance Institute.

(C) Continuance of coverage

(1) Individual and family policies

As indicated in table 5 (app. A), over a fourth of the aged covered under individual and family policies for hospital and surgical expenses (27 and 28 percent respectively) had policies which are guaranteed renewable. An additional 54 percent of the aged covered for these two categories of expense had policies subject to nonrenewal under which the companies have voluntarily relinquished their right to nonrenew the policy because of any change in the physical condition of the insured. In less than a fifth of the individual policies for hospital and surgical expense (19 and 18 percent respectively) had there been no such voluntary action.

Of the aged insured under individual policies for regular medical expenses, 8 percent had guaranteed renewable policies and 92 percent had policies subject to nonrenewal. For a third of the latter, however, companies have voluntarily relinquished their right to nonrenew the policy because of any change in the physical condition of the insured.

Practically all aged persons covered for individual and family major medical insurance were covered by policies under which the company might refuse renewal. For more than three-quarters of these (77 percent), however, companies have voluntarily relinquished their right to nonrenew because of any change in the physical condition of the insured.

(2) Group policies

Table 6 (app. A) provides a distribution of the actively employed aged currently insured under group policies with an indication of the extent to which such coverage would continue after retirement. More than one out of every two had the right to continued coverage either as part of the group or by means of individual conversion.

V. CERTAIN DEVELOPMENTS SINCE JULY 1961

There have been several significant developments during the past few months which should further affect both the extent and quality of coverage among the aged. Two are particularly worthy of note.

In July 1961, retired employees of the Federal Government who retired prior to July 1, 1960, became eligible for health insurance coverage on a group basis written by insurance companies. Under the uniform Government program the benefits may be basic hospital and surgical expense coverage, major medical expense coverage (including hospital, surgeon, physicians, nursing home, drugs and nursing care) up to $5,000, or both. During the first month of this program, about 237,000 of an estimated 400,000 retirees acquired protection under this program.[8]

Federal employees who retired after July 1, 1960, are eligible for more liberal benefits under the Federal Employee Health Benefits Act of 1959.

In October 1961, residents of Connecticut aged 65 and over (and spouse, if 55 or older) became eligible for enrollment in the Connecticut 65 extended health insurance program. This plan, which is available without physical examination, provides lifetime benefits to $10,000 after a $100 deductible. It covers all medical expenses in and out of hospital. By the end of the first month enrollment period under this program, about 22,000 senior citizens were enrolled. Of these, 14,000 chose the $10,000 major medical plan only; 5,000 selected the $5,000 major medical plan only; about 2,000 selected a combination of the $10,000 major medical with additional basic plan benefits; and about 1,000 selected the $5,000 plan plus basic coverage. Of additional interest is the fact that 30 percent of the newly covered senior citizens were enrolled by someone other than themselves, usually their son or daughter. Similar programs are under consideration in other States.

In addition to the foregoing, companies continue to experiment with new forms of coverage for the aged. For example, in July 1961, a large insurance company introduced a new program of health insurance policies designed specifically for aged persons. Under these policies, major medical benefits are available up to $10,000 subject to a $50 deductible. These policies can be purchased by a relative of the senior citizen.

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[8] U.S. Civil Service Commission.

APPENDIX A

STATISTICAL TABLES

TABLE 1.—*Extent of health insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by type of coverage, July 1961*

Type of coverage	Total	Group	Individual and family
Hospital expense	3,615,140	1,715,169	1,899,971
Surgical expense	3,185,937	1,711,249	1,474,688
Regular medical expense	1,098,878	951,646	147,232
Major medical expense	730,140	594,529	135,328

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 2.—*Extent of hospital expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Daily hospital room and board benefit:						
$15 and over	1,049,478	29	696,489	41	352,989	19
$11 to $14	657,440	18	502,149	29	155,291	8
$10 or less	1,908,222	53	516,531	30	1,391,691	73
Maximum duration of stay:						
71 days and over	1,489,758	41	576,340	34	913,418	48
32 to 70 days	901,557	25	568,500	33	333,057	18
31 days or less	1,223,825	34	570,329	33	653,496	34
Ancillary hospital expense benefit:						
$500 and over	985,950	27	562,176	33	423,774	23
$200 to $499	749,077	21	520,108	30	228,969	12
Less than $200	1,880,113	52	632,885	37	1,247,228	65

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 3.—*Extent of surgical expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Maximum surgical benefit:						
More than $300	319,116	10	268,671	16	50,445	4
$201 to $300	1,366,071	43	744,366	43	621,705	42
$200 or less	1,500,750	47	698,212	41	802,538	54

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 4.—*Extent of regular medical expense insurance among persons 65 years of age and older by 90 insurance companies,* [1] *by quality of coverage, July 1961*

	Total		Group		Individual and family	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Physicians visits:						
Hospital, home, and office	366,047	33	347,249	36	18,798	13
In-hospital only	732,831	67	640,397	64	128,434	87

[1] These companies write ⅔ of the U.S. health insurance premiums.

TABLE 5.—*Extent of health insurance under individual policies among persons 65 years of age and older by 70 insurance companies,[1] by type of coverage and renewability provision, July 1961*

Type of coverage	Guaranteed renewable		Subject to cancellation and nonrenewal			
			With voluntary restriction on right to cancel		With no voluntary restriction on right to cancel	
	Number	Percent of total	Number	Percent of total	Number	Percent of total
Hospital expense	512,729	27	1,021,461	54	365,781	19
Surgical expense	408,986	28	789,773	54	275,929	18
Regular medical expense	11,708	8	46,826	32	88,698	60
Major medical expense	344	1	104,617	77	30,367	22

[1] These 70 companies write 43 percent of individual health insurance premiums.

TABLE 6.—*Extent of health insurance under group policies among actively employed persons and dependents 65 years of age and older by 63 insurance companies,[1] by type of coverage and continuance provision, July 1961*

Type of coverage	Total	With right to convert on retirement		With right to continue under group on retirement		Percent with 1 right or the other
		Number	Percent of total	Number	Percent of total	
Hospital expense	922,645	332,692	36.1	292,914	31.7	54.2
Surgical expense	921,868	328,792	35.7	306,102	33.2	56.4
Regular medical expense	574,856	140,111	24.3	195,439	33.9	49.7
Major medical expense	391,365	74,686	19.2	136,498	35.0	47.5

[1] These 63 companies write 60 percent of the group health insurance premiums.

APPENDIX B

QUESTIONNAIRE

EXHIBIT 6

INSTRUCTIONS FOR PART I, INDIVIDUAL AND FAMILY POLICIES

1. Information reported is to be based on an actual analysis of individual policies in force in the United States on June 30, 1961, and which provide hospital, surgical, regular medical, or major medical expense coverage. Where an actual analysis is not possible, representative samples or other appropriately qualified estimates will be acceptable. Where samples are used, however, data should be expressed in terms of totals based on the samples utilized.

2. Exclude special-risk, limited accident, polio and other such policies not providing medical expense benefits for both accidents and illness. Franchise and blanket policies should be included in part I unless reported in part II. Kindly indicate by footnote the part in which you have included your franchise and blanket coverages. Coverage under mass enrollment plans and conversions from group policies should also be shown in part I.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Indicate total number of persons 65 and over covered for hospital expenses opposite line 1. Please show distribution of this total, by amount of daily hospital room and board benefit, in appropriate lines a, b, and c. For example, if you insure 100 aged persons for hospital expenses, of whom 75 have policies which pay $10 a day or less in hospital, 20 pay $12 a day, and 5 pay $20 a day, insert 100 in line 1, 75 in line a, 20 in line b, and 5 in line c.

Similarly, distribute total in line 1 by maximum duration of hospital benefits in lines d, e, and f and by maximum ancillary hospital expenses in g, h, and i.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident. Please show distribution of total number covered for surgical expenses in line 2, by maximum surgical benefit provided, in appropriate lines j, k, and l.

(*c*) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i.e., exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home, and office visits. Distribute this total in line 3, however, as between categories shown in lines m and n.

(*d*) *Major medical expense, supplementary.*—Include only the major medical expense or catastrophic coverage policies which may be superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(*e*) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (*d*) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. For each type of coverage; e.g., hospital expenses, the total shown in column (A) should be distributed by type of renewability provision in columns (B), (C), and (D).

5. Include only policies written on a direct basis. Reinsurance assumed from other companies should be excluded, while reinsurance ceded to other companies should not be deducted.

6. In the event that individuals are covered for hospital-surgical-medical expenses by rider to a loss of income policy, such persons should be included for purposes of this questionnaire.

7. Please note that persons with a policy providing hospital, surgical, and regular medical expense benefits should be entered in each of the appropriate columns of part I.

PART I

Number of people 65 years of age and older covered under individual and family health insurance policies, as of June 30, 1961

Type of coverage	Total	Type of renewability provision		
		Guaranteed renewable	Subject to cancellation or nonrenewal	
			With voluntary restriction on right to cancel or nonrenewable	Other
	(A)	(B)	(C)	(D)
1. Hospital expenses, total				
(a) $10 a day or less				
(b) $11 to $14 a day				
(c) $15 a day or more				
(d) 31 days a year or less				
(e) 32 to 70 days a year				
(f) Over 70 days a year				
(g) Less than $200 ancillary expenses				
(h) $200 to $499				
(i) $500 and over				
2. Surgical expenses, total				
(j) $200 or less				
(k) $201 to $300				
(l) More than $300				
3. Regular medical expenses, total				
(m) Inhospital only				
(n) Home, office, and hospital				
4. Major medical expenses, supplementary				
5. Major medical expenses, comprehensive				

INSTRUCTIONS FOR PART II, GROUP POLICIES

1. Information reported is to be based on actual analysis of group policies in force in the United States on June 30, 1961, and which provide hospital, surgical, medical, or major medical expense coverage. An actual analysis should be made and reported for all policies covering 500 or more employees. For smaller groups, analyze and report on all policies or use a sample by taking from either a numerical or alphabetical file (*a*) at least every 10th policy covering between 50 and 499 employees, and (*b*) at least every 20th policy (with a minimum sample of 100 policies) covering less than 50 employees. When a sample is used, the results entered in the tables should be the totals for your entire business as estimated from the sample. Other appropriate estimating procedures, where necessary, will be acceptable.

Exclude special-risk blanket coverages (e.g. polio, limited accident, volunteer firemen, schoolchildren). Other franchise and blanket coverages should be excluded if reported in part I.

2. Include only coverages written on a direct basis—reinsurance accepted from other organizations should be excluded, while reinsurance ceded to other organizations should be included. For coverages jointly underwritten by your organization and one or more other organizations on a coinsurance basis, the figures included should be a fractional part of the individuals so underwritten, the fraction used being the proportion of the total coverage under such cases which is underwritten by your organization.

3. The following instructions apply with respect to benefit classifications:

(*a*) *Hospital expense.*—Include all coverage which provides or pays hospital benefits for confinement due to both sickness and accident. Do not include, however, the extra hospitalization coverage provided in addition to weekly indemnity in policies issued under the California U.C.D. law, if the benefit is only the minimum required by law ($12 for 20 days). See instructions to part I for distributions by scope of benefit.

(*b*) *Surgical expense.*—Include all coverage for surgical charges incurred due to both sickness and accident. See instructions to part I for distributions by scope of benefit.

(c) *Regular medical expense.*—Include coverage (except major medical expense) for any type of nonsurgical medical expense where the benefit is payable in event of both accident and illness without limitation as to the type of sickness or accident (i. e. exclude accident only, polio, etc.). This category is intended to include medical expense coverages that cover physicians' hospital calls only as well as those that cover hospital, home and office visits. See instructions to part I for distributions by scope of benefit.

(d) *Major medical expense (supplementary to basic plans).*—Include only the major medical expense or catastrophic coverage policies which are superimposed on basic hospital, surgical, and/or medical coverages (whether the latter are written by your company or not) and which provide payments to cover essentially all types of expense, whether hospital, surgical, or medical, and which are characterized by a high overall maximum on the amount payable and a deductible amount which is not covered. Policies with high maximum amounts and deductible provisions which cover only hospital expense should not be included under major medical expense, but rather under hospital expense. Do not include policies which cover only accidents or specified diseases (polio, etc.).

(e) *Major medical expense, comprehensive (no basic plans).*—Include those major medical expense policies which meet the definition under (d) but are written on cases where no basic hospital, surgical, or medical coverages exist. In most instances, policies in this category are written with deductible amounts of $250 or less.

4. The following instructions apply with respect to the basis for reporting individuals:

Include under each benefit classification the total number of individuals for whom such coverage is provided. Individuals with several kinds of coverage should be counted under each of the appropriate classifications.

5. It is recognized that some of the data for tables 1 and 2 may, in some instances, have to be obtained from your policyholders. The importance of this survey is such as to warrant such a procedure wherever possible. If such proves not to be practicable, qualified estimates will be acceptable.

PART II

TABLE 1.—*Number of actively employed individuals and dependents 65 years of age and older insured under group health insurance policies, as of June 30, 1961*

Type of coverage	Total	With right to convert on retirement	With right to continue under group on retirement
1. Hospital expense, total			
(a) $10 a day or less			
(b) $11 to $14 a day			
(c) $15 a day or more			
(d) 31 days a year or less			
(e) 32 to 70 days a year			
(f) Over 70 days a year			
(g) Less than $200 ancillary expenses			
(h) $200 to $499			
(i) $500 and over			
2. Surgical expense, total:			
(j) $200 or less			
(k) $201 to $300			
(l) More than $300			
3. Regular medical expense, total			
(m) In-hospital only			
(n) Home, office and hospital			
4. Major medical expense, supplemental			
5. Major medical expense, comprehensive			

TABLE 2.—*Number of retirees and retirees' dependents insured under group health insurance policies, as of June 30, 1961*

Type of benefit	*Number of individuals*
1. Hospital expense, total	
(*a*) $10 a day or less	
(*b*) $11 to $14 a day	
(*c*) $15 a day or more	
(*d*) 31 days a year or less	
(*e*) 32 to 70 days a year	
(*f*) Over 70 days a year	
(*g*) Less than $200 ancillary expenses	
(*h*) $200 to $499	
(i) $500 and over	
2. Surgical expense, total	
(*j*) $200 to less	
(*k*) $201 to $300	
(*l*) More than $300	
3. Regular medical expense, total	
(*m*) In-hospital only	
(*n*) Home, office, and hospital	
4. Major medical expense, supplementary	
5. Major medical expense, comprehensive	

(Part 4B, separately printed, containing appendixes D, E, F, and G, completes the publication of these hearings.)

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