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ABSTRACT

This report reviews certain aspects of the effectiveness of the Public Law 96-265 provisions (Section 1882 of the Social Security Act) designed to protect the elderly against substandard and overpriced health insurance policies supplementing Medicare. This document on Medigap policies includes an executive summary and five chapters. Chapter 1 looks at the Medicare program; the Baucus Amendment; state regulation of insurance industry; the Medigap market; and the objectives, scope, and methodology of the report. Chapter 2 examines state regulatory programs, almost all of which met minimum federal standards. Chapter 3 discusses the policies reviewed by the General Accounting Office, which generally met standards. Chapter 4 explains loss ratio and presents findings that loss ratio experience of Medigap policies is mixed and generally not used by states to evaluate premiums. Chapter 5 examines federal and state efforts to curb sales abuse through education and penalties. Because the report found that Section 1882, when combined with state efforts, appeared to be meeting its objectives of protecting the elderly against substandard Medigap policies and providing them with information on how to select Medigap policies, no recommendations for change are included. Four tables and one figure are included; Company-Wide Loss Ratio Experience for Medicare Supplemental Insurance is appended. (NB)

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Human Resources Division

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October 17, 1986

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Honorable Willis D. Gradison, Jr.
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

This report is in response to your February 25, 1986, request to review certain aspects of the effectiveness of the Public Law 96-265 provisions designed to protect the elderly against substandard and overpriced health insurance policies supplementing Medicare. The law set minimum standards for policies that insurers must meet to market them as Medicare supplementals and created a voluntary certification program for such policies.

As requested by your office, we did not obtain comments on this report. Unless you publicly release its contents earlier, we plan no further distribution of this report for 30 days. At that time, we will send copies to Senator Max Baucus, the Secretary of Health and Human Services, and other interested parties and make copies available to others on request.

Richard L. Fogel
Assistant Comptroller General

Purpose

Medicare pays much of the health care costs of the elderly, but they are responsible for deductibles and coinsurance, which sometimes represent large out-of-pocket costs. Almost from the beginning of Medicare, private insurers have offered policies—called Medigap policies—that supplement Medicare benefits.

In 1980 the Congress amended the Social Security Act to provide standards for policies that are marketed as Medigap insurance. In February 1986, the Chairman and Ranking Minority Member, Subcommittee on Health, House Committee on Ways and Means, requested GAO to determine if the law's objectives were being achieved. These objectives are to protect the elderly from policies that do not provide a minimum level of benefits at a reasonable price and from deceptive advertising of policies and to give the elderly information to enable them to select among policies.

Background

Section 1882 of the Social Security Act, added by Public Law 96-265, June 9, 1980, established standards for Medigap policies requiring that they provide at least a minimum level of benefits coverage and include certain provisions. The law also set minimum expected levels of benefit payouts—called loss ratios. Medigap policies sold to individuals must have an anticipated return to policyholders as benefits of at least 60 percent of the premiums collected, and this minimum loss ratio was set at 75 percent for policies sold to groups. Section 1882 also established federal criminal penalties for engaging in abusive sales and marketing practices for Medigap policies.

The statute incorporated by reference the Medigap standards contained in a model regulatory program developed by the National Association of Insurance Commissioners and set forth two procedures for determining whether insurance policies meet the federal standards. First, if a state has adopted laws and/or regulations that are at least as stringent as the association's model and the federal loss ratio requirement, policies regulated by the state are deemed to meet the federal requirements.

Second, the statute established a voluntary certification program under which insurance companies could market policies as Medigap insurance in states that do not have laws and regulations equivalent to the association's model. Insurers can submit policies and supporting documentation to the Secretary of Health and Human Services (HHS). If the Secretary

determines that a submitted policy meets federal requirements, it is certified and can be marketed as Medigap. Only two policies have been submitted to the Secretary, and neither had been certified as of September 1986.

To evaluate if policies being marketed as Medigap insurance meet the requirements of section 1882, GAO visited nine states and the District of Columbia that had laws and/or regulations at least as stringent as the association's model and two states that did not. GAO reviewed 142 policies for compliance with the federal standards and obtained loss ratio data for 394 individual and 4 group policies sold by 92 commercial firms and 13 Blue Cross/Blue Shield plans. Premiums collected nationwide on these 394 individual policies totaled over $2.1 billion in 1984. The total estimated Medigap market in that year was about $5 billion.

Other types of health insurance sold to the elderly—such as hospital indemnity, dread disease, and nursing home insurance—are not technically Medigap policies and do not fall under section 1882. They were not covered by GAO's review.

Results in Brief

Section 1882 has encouraged state adoption of Medigap insurance regulatory programs at least as stringent as the association's model, and only four states had not done so as of September 1986. This, in turn, has resulted in more uniform regulation of Medigap insurance and increased protection for the elderly against substandard and overpriced policies.

Medigap policies sold by commercial insurers that had more than $50 million in premiums and Blue Cross/Blue Shield plans generally met the loss ratio requirements of section 1882. However, over 60 percent of the commercial insurance policies with premiums under $50 million in 1984 did not meet those requirements. The loss ratio for all individual policies studied meant that about 60 cents of every premium dollar was returned as benefits or added to reserves.

Many Medigap policies covered more than the minimum required benefits. Differences in benefit coverage and loss ratios among policies illustrate the importance of comparison shopping. To assist the elderly, the federal and state governments have made available information useful in shopping for Medigap insurance.

Abuses still occur in the sale of Medigap policies. But many states have attempted to prevent abuse through such actions as monitoring sales

and advertising practices and revoking or suspending insurance agent licenses and issuing cease and desist orders to insurers.

GAO's Analysis

When section 1882 was enacted, 9 states had laws and regulations pertaining specifically to Medigap insurance; currently, 46 states, Puerto Rico, and the District of Columbia have laws and regulations that meet the section's minimum requirements. Thus, the states are primarily responsible for assuring that the federal standards for marketing Medigap insurance are met. (See p. 14.)

Policy Review

GAO compared a sample of 142 policies with the association's minimum standards. In GAO's opinion, 49 of them did not meet all of the standards for coverage. Forty of those policies fell short on only one standard. The most frequent shortcoming concerned the Medicare blood deductible—28 policies failed that standard, because they would not pay the full cost of the first three pints of blood, which Medicare does not cover. The identified shortcomings were relatively minor problems. (See pp. 21-24.)

On the other hand, 137 of the 142 policies exceeded the minimum standards in some respect. Seventy-eight of them would cover the $492 part A deductible for inpatient services, and 63 would pay the $75 annual part B deductible for physician and medical supplier services. Sixty-seven policies would cover the part A coinsurance for the 21st through 100th day of necessary skilled nursing care. (Medicare pays the full cost for the first 20 days.) (See pp. 22-23.)

Loss Ratios

The loss ratios of most policies were below the section 1882 targets; however, the loss ratios of the policies of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Company were generally above the targets. (See p. 28.) These are the policies most commonly purchased. The Blue Cross/Blue Shield individual policies GAO reviewed had 1984 premiums of $776.6 million and an aggregate loss ratio of 81.1 percent; the commercial individual policies included in GAO's analysis had nationwide 1984 premiums of $1.3 billion, and Prudential (with a 1984 loss ratio of 77.9 percent) had almost 25 percent of that business. (See app. I.)

For the 376 individual policies of commercial insurers studied, the loss ratio was 60.2 percent for 1984. In other words, $770 million in benefits were returned for the $1.3 billion in premiums paid. Thus, for every

$1 in premiums, 60 cents was returned as claims payments or used to increase reserves, and 40 cents represented administrative and marketing costs and profits. The same figures for the Blue Cross/Blue Shield plans studied are 81 cents in benefits to 19 cents in costs and profits.

The loss ratio provision of section 1882 is a target to strive for, not a requirement for actual performance. Thus, according to HHS's interpretation of the law (which GAO finds reasonable), states are not required to monitor loss ratio experience.

Monitoring of Sales and Advertising

Penalties for Medigap sales abuse generally have been the prerogative of the states because they are primarily responsible for regulating the insurance industry. All states GAO visited have a formal complaint system, within either the state insurance department or the state department of elderly affairs. State actions to stop abuses have included fines, cease and desist orders, and the revocation and suspension of agent licenses. All states GAO visited also monitor the advertising practices of insurance companies. Generally, the states rely on the public to alert state officials to problems, through the established complaint system. (See p. 34.)

Information Activities

HHS and the association jointly published the Guide to Health Insurance for People With Medicare, which contains much helpful advice for anyone shopping for Medigap insurance. Florida and Washington have published a shopper's guide for Medigap insurance, and a Maryland official told GAO the state was developing such a guide. These guides give the elderly valuable information to help them obtain Medigap insurance. (See pp. 32-34.)

Recommendations

Section 1882, when combined with state efforts, appears to be meeting its objectives of protecting the elderly against substandard Medigap policies and providing them with information on how to select Medigap policies. Thus, GAO is making no recommendations.

Agency Comments

GAO sought the views of federal and state agency officials during its work. Their views are incorporated in the report where appropriate.

Contents

Abbreviations

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NAIC	National Association of Insurance Commissioners

Introduction

On February 25, 1986, the Chairman and Ranking Minority Member, Subcommittee on Health, House Committee on Ways and Means, requested that we review compliance with federal standards regarding Medicare supplemental insurance policies sold by the private sector to the elderly. These policies— often referred to as Medigap insurance— are designed primarily to pay deductible and/or coinsurance amounts for hospital, medical, and surgical expenses covered by Medicare. The requesters asked us to compare policies with the federal minimum standards for Medigap insurance and to develop information on legal sanctions imposed for abuses in the sale of such insurance.

The Medicare Program

Medicare is a federal program that pays much of the health care costs for eligible persons—almost all persons 65 and older and some disabled persons. Medicare was established by title XVIII of the Social Security Act and became effective on July 1, 1966. The program provides two basic forms of protection:

Part A, Hospital Insurance, is financed primarily by Social Security payroll taxes. It covers inpatient hospital services, posthospital care in skilled nursing facilities, and care provided in patients' homes and by hospices. Part A benefits are paid on the basis of benefit periods. A benefit period begins when the beneficiary receives Medicare-covered services in a hospital and ends when he or she has been out of a hospital or skilled nursing facility for 60 consecutive days. For any benefit period, part A pays for all covered services for the first 60 days of inpatient hospital care except for the inpatient deductible ($492 in 1986) and the first three pints of blood used. For the next 30 days, the beneficiary is responsible for coinsurance equal to one quarter of the deductible amount per day ($123 per day in 1986). Every person enrolled in part A also has a 60-day, nonrenewable, lifetime reserve for inpatient hospital care that can be drawn from if more than 90 days are needed in a benefit period. When reserve days are used, the beneficiary is responsible for coinsurance equal to one-half of the deductible amount per day ($246 per day in 1986). For medically necessary inpatient care in a skilled nursing facility, after a hospital inpatient stay of at least 3 days and within 30 days of discharge from the hospital, part A pays for all covered services for the first 20 days in a benefit period. For the next 80 days, the beneficiary is responsible for one-eighth of the hospital deductible each day ($61.50 per day in 1986), and part A pays the remainder. Part A pays the entire cost of all medically necessary home health visits, and it pays for hospice services for beneficiaries who have a terminal illness and elect hospice care.

Part B, Supplementary Medical Insurance, is a voluntary program financed by enrollee premiums and federal contributions. Enrollee premiums currently account for 25 percent of total part B costs. Part B covers physician services and many other health services, such as laboratory and physical therapy services. For each calendar year, the beneficiary is responsible for the first $75 of approved charges (the part B deductible), after which the program pays 80 percent of approved charges for covered services during the rest of the year. The beneficiary is responsible for 20 percent of the approved charges (the part B coinsurance), plus any charges in excess of the Medicare-approved charge on claims for which the physician or supplier does not accept assignment.[1]

The Baucus Amendment

Public Law 96-265, enacted in 1980, added section 1882 to the Social Security Act. This provision is commonly referred to as the Baucus amendment after Senator Max Baucus, the amendment's chief sponsor in the Senate. This law was a response to marketing and advertising abuses in the sale of Medigap insurance to the elderly. Many abuses were detailed in hearings before the House Select Committee on Aging in 1978 and summarized in published hearings and a committee staff study.[2]

The Baucus amendment defines minimum standards for policies that must be met before companies can market them as Medigap policies. The standards are contained in a model regulation approved by the National Association of Insurance Commissioners (NAIC) on June 6, 1979, and incorporated in section 1882 by reference. These standards (1) require such policies to cover Medicare's coinsurance amounts within certain limits; (2) require that purchasers of a policy have a "free look" period, during which they may return an unwanted policy for cancellation and receive a full refund of any premium paid; (3) standardize many of the terms used in policies; (4) limit the period for which coverage may be denied for preexisting conditions; and (5) require cancellation and termination clauses to be prominently displayed. The standards for Medigap policies apply only to those sold to persons who qualify for Medicare by

[1]When physicians and suppliers accept assignment, they agree to accept Medicare's determination of a reasonable charge as payment in full and not to bill beneficiaries for charges in excess of the determined reasonable charge.

[2]Abuses in the Sale of Health Insurance to the Elderly, hearings before the House Select Committee on Aging, Committee Publication 95-165, November 28, 1978, and Abuses in the Sale of Health Insurance to the Elderly in Supplementation of Medicare: A National Scandal, a staff study of the House Select Committee on Aging, Committee Publication Number 95-160, November 28, 1978.

reason of age. In addition, the Baucus amendment established loss ratio targets for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

Because insurance regulation has historically been a state responsibility, the Baucus amendment relies primarily on the states to enforce the Medigap standards. Federal responsibilities involve determining whether state laws and regulations are equivalent to the Baucus amendment standards and certifying policies on a voluntary basis in states that do not have equivalent laws and regulations. In the McCarran-Ferguson Act (Public Law 79-15), enacted in 1945, the Congress expressed its desire that the states continue to have primary responsibility for regulating the insurance industry. When the Baucus amendment was enacted, nine states had rules and regulations specifically governing Medigap policies.

The amendment established the Supplemental Health Insurance Panel, consisting of the Secretary of Health and Human Services (HHS) and four state insurance commissioners or superintendents of insurance appointed by the President. The panel is responsible for reviewing each state's insurance regulatory program and certifying those that meet the minimum standards contained in the Baucus amendment. In states that do not obtain panel certification, insurers may submit their policies to the Secretary of HHS for approval. HHS's Health Care Financing Administration (HCFA), which administers Medicare and supports the panel, has reported that only two insurers had submitted policies to the Secretary and neither had been approved as of September 1986.

Finally, the Baucus amendment contains federal sanctions, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain the Secretary's certification, (2) posing as a federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

State Regulation of Insurance Industry

Regulating the insurance industry has traditionally been a state function, accomplished through the office of the state insurance commissioners. The state commissioners are linked through NAIC for the

purposes of discussing common problems, standardizing the annual reporting of financial information by insurance companies, and developing model legislative acts for adoption by the individual states.

State regulatory processes and procedures generally include

- prior approval of policies after a review of such features as policy readability and standardization of policy terms,
- premium rate control, and
- monitoring of unfair or deceptive acts through unfair trade practice regulations.

Health and accident insurance, of which Medigap is a part, is regulated through the same mechanisms mentioned above, except that premium rates are not directly regulated. Most states require premium rates for health and accident policies to be filed with the state and will disapprove any policy whose benefits provided are not considered reasonable in relation to the premiums charged. The requirement for a reasonable relationship between premiums and benefits paid (claims incurred) led NAIC to develop loss ratio benchmarks. A loss ratio is stated as a percentage. For example, a policy earning $1 million on premiums and incurring claims of $600,000 has a loss ratio of 60 percent.

The Medigap Market

The major sources of Medigap insurance are Blue Cross/Blue Shield plans and commercial insurance companies. The Blue Cross and Blue Shield Association told us that, nationwide, the premiums for its Medicare complementary insurance sold to individuals totaled about $3.7 billion[3] in 1984. Earned premiums of commercial Medigap insurance for 1984 totaled over $1.2 billion. These policies were sold by over 90 different companies, but the following three companies accounted for over 50 percent of the earned premiums:

[3]This figure includes Medigap policies plus some other policies sold to complement Medicare. The association could not provide data solely for Medigap policies, but an association representative told us most of these premiums would be for plans that meet or exceed Baucus amendment standards.

Table 1.1: Companies Selling the Most Medigap Insurance

Dollars in millions

	1984 earned premiums
Prudential Insurance Company	$304
United American Insurance Company	188
Bankers Life and Casualty Company	166
Total	**$658**

Other forms of health insurance sold to the elderly include limited benefit plans, such as hospital indemnity and dread disease (primarily cancer) coverage. These forms of insurance are not technically Medigap policies, although they may cover some gaps in Medicare's coverage, and thus are in a class of health and accident insurance plans outside the scope of the Baucus amendment. Hospital indemnity policies pay a fixed amount for each day the insured is in a hospital up to a designated number of days. Dread disease policies provide benefits only if one is stricken with the covered disease, such as cancer. Other policies may cover only certain services or charges, such as required skilled nursing care furnished in a skilled nursing facility. We did not obtain data on the size of the market for such plans, and such policies are not included in the scope of our review.

Objectives, Scope, and Methodology

The Chairman and Ranking Minority Member, Subcommittee on Health, House Committee on Ways and Means, asked us to evaluate certain aspects of the Baucus amendment. Specifically, we were asked to compare a sample of Medigap policies with the minimum standards and requirements in the law. Also, the requesters sought information on legal sanctions imposed under the Baucus amendment for abusive sales practices.

We did our work at HCFA headquarters in Baltimore; the HCFA regional offices in Atlanta, Boston, Denver, New York, Philadelphia, San Francisco, and Seattle; and in the states of Arizona, California, Colorado, Florida, Maryland, Massachusetts, Missouri, New Jersey, Pennsylvania, Rhode Island, and Washington plus the District of Columbia. We selected these jurisdictions judgmentally in order to include states with a substantial population of Medicare beneficiaries (those states had about 30 percent of the beneficiaries), areas that are the home of trusts or groups that market Medigap policies nationwide, and state regulatory programs that have not been certified by the panel (that is, Massachusetts and Rhode Island).

In the states visited, we did our work at the state insurance department, where we collected data maintained on the premiums collected and claims paid for all policies that we could identify as Medigap insurance and for which data were available. A total of 398 policies were covered by the data, which we used to compute nationwide loss ratios for those policies. In addition, in all states except Missouri, we selected all Blue Cross/Blue Shield Medigap policies, the five commercial Medigap policies with the highest value of earned premiums in 1984 (the latest year for which data were available), and a sample of all other Medigap policies for detailed review of the coverage offered. We reviewed the selected policies (a total of 142) to determine if they met the minimum standards. In Missouri and the District of Columbia, our review focused on policies sold nationwide through trusts or groups. (See app. I for a list of all insurance companies for which data are included in this report.)

We contacted state insurance departments, offices of aging, consumer affairs offices, and/or offices of attorneys general as appropriate to obtain data on complaints and prosecutions of cases of marketing abuse or illegal sales practices.

At HCFA headquarters and the regional offices, we obtained data on complaints about the marketing of Medigap policies. At headquarters, we also reviewed HCFA's files on the operations of the Supplemental Health Insurance Panel in certifying states and HCFA's actions to verify that state regulatory programs continue to meet the Baucus amendment standards.

Our fieldwork was performed from March through July 1986 in accordance with generally accepted government auditing standards. As requested by the Subcommittee office, we did not obtain written comments from the federal and state agencies involved. However the views of responsible federal and state officials were sought during our work and are incorporated in the report where appropriate.

Almost All State Regulatory Programs Meet Minimum Federal Standards

The Supplemental Health Insurance Panel, established by the Baucus amendment, reviewed state regulatory programs and then certified 46 states, the District of Columbia, and Puerto Rico as having Medigap regulatory programs that met minimum federal standards. The Baucus amendment encouraged states to adopt the minimum standards. As of September 1986, about 90 percent of the nation's population lived in jurisdictions with regulatory programs that meet Baucus amendment standards, up from 35 percent in states with Medigap regulatory programs when the law was enacted in 1980.

Certified Regulatory Programs Meet Minimum Standards

The Supplemental Health Insurance Panel is responsible for reviewing state regulatory programs and certifying those that incorporate standards equal to or more stringent than those contained in the NAIC model regulation and meet the loss ratio requirements of the Baucus amendment. In a university study in 1979, before the Baucus amendment was enacted, only nine states were identified as having minimum standards governing Medigap policies.

The panel was assisted in its work by HCFA staff, who reviewed the laws and regulations of the states and compared them with the NAIC model. The staff prepared recommendations of approval or nonapproval for the panel's consideration. The panel held its first meeting in December 1980.

The panel had approved 10 state regulatory programs by November 1981, but other states had to enact legislation or adopt regulations to bring their program into compliance with the minimum standards. By July 1982, the panel had certified 30 additional states. Five more states and the District of Columbia and Puerto Rico were certified by January 1984. Finally, New Jersey was certified in 1985. Thus, as of September 1986, the panel had certified 46 states plus the District of Columbia and Puerto Rico.

In support of the panel, HCFA has established a procedure to obtain annual updates from the states on their continued compliance with the Baucus amendment. HCFA does this through annual recertification letters to the states. In those letters, a state official responsible for administering the state's regulatory program is asked to sign an attestation that no substantive changes were made in the state's regulatory program that would cause it to lose its certification.

We reviewed HCFA's annual recertification files. In the 1984 file, we could not locate recertification letters from Alaska and Utah, but those states did submit such letters in 1985. In the 1985 file, we could not locate recertification letters from Tennessee, Montana, Washington, and the District of Columbia; however, each of them attested in 1986 that there were no changes to their regulatory programs. By August 1986, HCFA had received recertification letters from all but five states. A HCFA representative told us that follow-up letters had been sent to those five states, requesting a reply by September 30, 1986.

Some State Regulations Are More Restrictive Than Minimum Standards

Some of the certified states we visited have adopted more restrictive requirements than those in the Baucus amendment. For example:

- In Pennsylvania, insurers must offer coverage of the part A deductible (the NAIC model does not require coverage of this deductible), and the maximum part B deductible under Medigap policies is $75 per year (the model allows for a maximum part B deductible of $200).
- In Maryland, all Medigap policies must cover the part A deductible. Also, insurers must offer coverage of the part B deductible, either in the policy or through an optional rider. In 1986, Maryland amended its statute to require Medigap policies to pay up to $100 for an annual low dose mammograph for the detection of occult breast cancer.
- Washington and New Jersey require anticipated loss ratios of 65 percent for individual policies instead of the 60 percent required by the Baucus amendment.
- Both Colorado and Washington require a 30-day "free look" period for all policies during which the policyholder can cancel and obtain a return of premium. The NAIC model sets a 10-day period for policies sold directly by agents.

States Not Certified by the Panel

Massachusetts, New York, Rhode Island, and Wyoming have not received panel certification. To obtain information on regulatory programs of these noncertified states, we reviewed documents available through HCFA on why the states were not certified, and we visited Massachusetts and Rhode Island. According to these documents, the regulations of the noncertified states did not include many of the minimum standards, but some contained features that exceed the NAIC model in some respects.

Massachusetts' regulatory program did not meet three of the Baucus amendment standards. Massachusetts (1) does not require insurers to

pay the blood deductible;[1] (2) does not require coverage for an additional 365 days of 90 percent of part A expenses after the beneficiary's Medicare coverage is exhausted (Massachusetts requires payment of 100 percent of part A expenses for a total of 365 days); and (3) allows the insurer to exclude coverage for some part B services, such as durable medical equipment, doctor's charges outside of a hospital, medical supplies, ambulance services, and dental services outside of a hospital.

In other respects, Massachusetts requires coverage at least equal to that required under the NAIC model regulation, and in some areas the state's standards are higher than the model. For example, Massachusetts requires policies to meet an anticipated loss ratio of 65 percent and to cover the part B coinsurance without a dollar limit, whereas the model allows a $5,000 annual limit.

New York State regulations did not meet three of the minimum standards. Specifically, New York's regulations did not (1) require insurers to supplement part B expenses when the beneficiary is not hospitalized, (2) require delivery of a buyer's guide, and (3) require a receipt for the outline of coverage. New York regulations require policies sold to individuals over age 65 to meet an anticipated loss ratio of 65 percent, which is more restrictive than the Baucus amendment target.

Wyoming failed to meet two minimum standards. The state's regulations (1) allowed the sale of part A only and part B only supplemental policies and (2) allowed reasonable charges to be based on the insurer's determination rather than on Medicare's reasonable charge determination.

Rhode Island did not meet the Baucus amendment standards in several respects. The state's regulations did not meet the minimum standards concerning (1) payment of the Medicare part A coinsurance, (2) the limits on coverage of preexisting conditions, and (3) definitions of many standard terms. Also, the Rhode Island regulations did not cover group policies.

Conclusions

Since the enactment of the Baucus amendment, all but four states have adopted the NAIC model regulation for Medigap policies. We believe the amendment was effective in encouraging the states to bring a degree of

[1]Under Medicare, the beneficiary is responsible for the cost of the first three pints of blood or may arrange for the replacement of the first three pints.

standardization to their regulatory programs for Medigap insurance. Nevertheless, state regulatory programs for these policies are not identical. Several states have standards that exceed the minimum federal requirements, and as discussed in the next chapter, Medigap policies provide varying degrees of coverage.

Policies Reviewed Generally Met Standards

This chapter discusses compliance with the Baucus amendment standards except for those related to loss ratios, which are discussed in chapter 4. We reviewed a sample of 142 Medicare supplemental policies and found that in nearly all cases they met the minimum standards provided for in the Baucus amendment.

A number of Medigap policies also provide coverage beyond what is required. For example, 78 of the 142 policies provided coverage for Medicare's $492 hospital deductible, and 63 of the 142 covered the $75 part B deductible.

Few, if any, of the policies provide coverage that could be termed catastrophic, and coverage is usually limited to the same services that Medicare covers.

The Minimum Standards

For a policy to be marketed as a Medigap policy, the NAIC model regulation requires the following:

- Conditions for renewability must be stated on the first page of the policy.
- If a policy is sold as "noncancellable" or "guaranteed renewable," it must provide coverage for the insured's spouse after coverage of the insured ends if premiums are paid.
- A policy that is terminated must continue coverage for illnesses or accidents that occurred while the policy was in force, except that such coverage may be predicated on the continuous total disability of the insured, limited to the duration of a stated benefit period, or limited to the payment of maximum benefits.
- The purchaser must be allowed a "free look" period during which the purchaser may return the policy and get a full refund of any premium paid; this period must be at least 10 days for policies sold through agents and at least 30 days for policies sold through the mail.
- The coverage in the policy must automatically change as Medicare's deductibles and coinsurance requirements change.
- The policy may not define preexisting conditions more restrictively than as a condition that was diagnosed or treated within 6 months before the effective date of the policy, and benefits may be denied for preexisting conditions for no more than 6 months from the effective date of the policy.
- The policy must cover treatment for accidents and illnesses equally.

- Terms used in the policy, such as physician, hospital, sickness, and accident, may be defined within certain limits, and Medicare must be defined in the policy.
- The policy must cover all of the Medicare part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 91st through 150th day while the beneficiary uses his or her lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted his or her Medicare benefits.
- The policy must cover the Medicare part B coinsurance, but this may be subject to a deductible of $200 and a maximum benefit of $5,000 per year.
- The policy must cover the parts A and B blood deductibles.
- The policy must have an outline of coverage, which shows what Medicare covers, what the beneficiary is responsible for, and what the supplemental policy covers.

In addition, the NAIC standards include a requirement that insurers give beneficiaries a buyer's guide. This guide must be given to the beneficiary at the time he or she applies for insurance or, in the case of policies sold through the mail, at the time the policy is delivered to the beneficiary. HCFA and NAIC have jointly developed a guide that describes Medicare, Medigap, and other health insurance plans.

Table 3.1 compares hospital and physician benefit coverage for payments by Medicare, the amount the beneficiary is responsible for, and the minimum coverage required of Medigap insurance.

Table 3.1: Schedule of Benefit Coverage Provided by Medicare and Required by Medigap Minimum Requirements

Service	Benefit	Medicare pays[a]	Beneficiary is responsible for[a]	Minimum requirement for Medigap insurance
Medicare (Part A): Hospital Insurance-Covered Services per Benefit Period				
Hospitalization—semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but the $492 deductible	$492	None
	61st to 90th day	All but the $123 a day coinsurance	$123 a day	$123 a day
	91st to 150th day	All but the $246 a day coinsurance	$246 a day	$246 a day
	Beyond 150 days	Nothing	All charges	90 percent of covered charges up to 365 days
Posthospital skilled nursing facility care—in a facility approved by Medicare if the beneficiary has been in a hospital for at least 3 days and enters the facility within 30 days after hospital discharge	First 20 days	100 percent of costs	Nothing	None
	Additional 80 days	All but $61.50 a day	$61.50 a day	None
	Beyond 100 days	Nothing	All charges	None
Home health care	Unlimited visits as medically necessary	Full cost	Nothing	None
Hospice care	Two 90-day periods and one 30-day period	All but limited coinsurance for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care	None
Blood	Blood	All but first 3 pints	First 3 pints	First 3 pints
Medicare (Part B): Medical Insurance-Covered Services per Calendar Year				
Health expenses—physicians' services, outpatient health services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for health services in or out of the hospital	80 percent of Medicare-approved amount (after $75 deductible)	$75 deductible plus 20 percent of balance of approved amount (plus any charge above approved amount on unassigned claims)	All Medicare- approved charges not covered by Medicare. This benefit may be limited to $5,000 per year and may be subject to an annual deductible of $200.
Home health care	Unlimited visits as medically necessary	Full cost	Nothing	None
Outpatient hospital treatment	Unlimited as medically necessary	80 percent of approved amount (after $75 deductible)	$75 deductible plus 20 percent of balance of approved amount (assignment is required)	Same as for health expenses
Blood	Blood	80 percent of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20 percent of approved amount (after $75 deductible)	Same as for health expenses, plus first 3 pints
Clinical laboratory	Unlimited as medically necessary	Full cost (on assigned claims)	Nothing on assigned claims. Difference between Medicare payment and charges on unassigned claims	Same as for health expenses (on unassigned claims)

[a]Based on calendar year 1986 Medicare deductible and coinsurance amounts.

As can be seen in the table, Medigap policies are not required to pay some items, such as the part A deductible. Also, under part B, a Medigap policy may have its own deductible of up to $200 per year and may also limit benefits to $5,000 per year. As discussed below, some policies provide coverage beyond these minimum requirements.

A person who is shopping for Medigap insurance should be aware of the coverage options available. The buyer's guide jointly published by HCFA and NAIC includes a table similar to the one above plus other helpful hints for Medicare beneficiaries shopping for health insurance. Also, each Medigap policy must contain an outline of coverage, in a format similar to the table above, which describes the coverages of the policy. Comparing policies and reading the buyer's guide should give a Medicare beneficiary considerable information to help in choosing a policy. In addition, as discussed in chapter 5, we found that several states publish their own shopper's guides for Medigap insurance sold there.

Policies Reviewed by GAO

We reviewed 142 policies to determine whether the provisions and coverage of each were in compliance with the Baucus amendment standards listed above. From the 398 policies on which we obtained earned premium and incurred claims data, we selected 142 policies, which included in each state the five commercial policies with the highest earned premiums in 1984, all Blue Cross/Blue Shield plans in the state, and a random selection of other policies. Our objective was to select policies that would cover most of the business (the Blue Cross/Blue Shield plans and high-volume commercial policies) plus some lower volume policies.

Although the basic purpose of our review was to determine compliance with Baucus amendment standards, we also noted policy coverages that exceed the minimum standards.

Minor Shortcomings Noted in Certain Policies

In our opinion, 49 of the 142 policies we reviewed did not meet all of the federal standards. Generally, the policies fell short on one of the standards, as shown in table 3.2.

Table 3.2: Medigap Policies That Did Not Meet All NAIC Standards

Policies met all but	Number
1 standard	40
2 standards	7
3 standards	2
Total	49

In our opinion, most of the shortcomings were relatively minor. For example, 28 policies failed the blood deductible standard; these policies said they would cover 80 to 90 percent of the charges for the first 3 pints of blood rather than the required 100 percent or they were silent about coverage of blood.

In addition, 48 states (all but California and Wisconsin) have adopted another of NAIC's model laws, the "Uniform Individual Accident and Sickness Policy Provision Law," or laws substantially similar to that model law. This law provides that all policies sold in the state must comply with the state's statutes. If a provision in a particular policy conflicts with the state's laws, the effect of this model law is to change the policy to comply with state law. Thus, in the 44 certified states that have also adopted the NAIC uniform provision law, policies are required to meet the NAIC model regardless of the provisions of the policy itself. However, in case of a dispute between the beneficiary and the insurance company, the beneficiary may have to seek the aid of the state's insurance department or sue in the state's courts to obtain enforcement of this requirement.

Standards Exceeded in Some Areas

Of the 142 policies, 137 exceed in some respect the minimum benefits required by the Baucus amendment. These policies may (1) provide "first dollar" coverage, paying for Medicare deductibles under parts A or B; (2) provide some coverage for extreme expenses because they have no maximum dollar limit on benefits; and (3) cover services or charges not covered by Medicare. These extra benefits are discussed below.

The minimum standards do not require Medigap policies to cover the part A deductible ($492 per benefit period in 1986 for in-hospital care) or the $75 per year part B deductible. Of the 142 policies we examined, we identified 78 that cover the hospital deductible and 63 that cover the part B deductible.

Medigap policies are required to pay 90 percent of the in-hospital daily costs for up to 365 days, after the beneficiary's Medicare benefits are exhausted. This type of coverage could be considered a limited form of "catastrophic" health insurance. The policies we reviewed generally do not provide coverage beyond the 365-day requirements, but 61 of the policies exceeded the minimum requirements by covering 100 percent of these daily hospital costs. However, few Medigap beneficiaries would use this benefit. HCFA data show that only 0.6 percent of persons aged 65 years and greater hospitalized during 1984 used any of their lifetime reserve days. HCFA estimates that since the beginning of Medicare, about 0.3 percent of all enrollees exhausted their 60 lifetime reserve days, at which point this benefit would apply.

Six policies paid more or permitted payment of more than the required 20-percent part B coinsurance. Four of the six policies paid from 24 to 30 percent of the Medicare-approved charge for part B services, and two policies paid some portion of the difference between a supplier's charge for a service and the Medicare-approved amount for that service.

Fifteen policies provided coverage for private duty nursing, which is a service not covered by Medicare. Sixty-seven of the Medigap policies we reviewed covered the part A coinsurance ($61.50 per day in 1986) for the 21st through 100th day of necessary skilled nursing care, which is not required by the minimum benefit standards.

Conclusions

A Medicare beneficiary can buy Medigap insurance in the certified states with reasonable assurance that the policy either meets the minimum benefit standards of the NAIC model regulation or is required by state law to be in compliance with the standards. However, an individual may still face significant out-of-pocket costs even if he or she has a Medigap policy, because such policies are not required to pay the deductibles under parts A or B, may limit coverage of part B coinsurance to $5,000 per year, usually do not cover any costs that exceed Medicare's approved charges, and usually do not cover services (such as nursing home care) that are not covered by Medicare.

We also noted that many Medigap policies provide at least some coverage beyond the minimum requirements.

Loss Ratio Experience of Medigap Policies Mixed, and Generally Not Used by States to Evaluate Premiums

The actual loss ratio experience of many individual policies did not meet the target loss ratios of the Baucus amendment, but the actual loss ratios of the policies with the largest volumes of earned premiums were above the targets. However, loss ratios for a particular year can be difficult to interpret for a number of reasons. For example, a new policy may have a low loss ratio, but the ratio may rise as the policy matures. Also, policies that experience a high turnover in policyholders may have a low loss ratio because of such factors as the 6-month exclusion for new policyholders for treatments associated with preexisting conditions.

The loss ratio in the Baucus amendment is the "expected" ratio between premiums and benefits paid, not a ratio that must actually be met. Thus, if the insurer demonstrates to the state that it anticipates paying out enough in benefits to meet the specified loss ratios, it has met the loss ratio requirement. Accordingly, HHS believes the states are not required to evaluate whether the actual loss ratio experience of Medigap policies complies with the target. We believe that HHS's interpretation is reasonable.

Appendix I lists the annual earned premiums and loss ratios for Medigap insurance for 98 commercial firms and 13 Blue Cross/Blue Shield organizations that issued the 398 policies covered by our review. The loss ratio data cover the period 1982-84. The commercial company information is nationwide data for policies for which data were available, whereas the Blue Cross/Blue Shield data are statewide. The 92 commercial companies for which the 1984 loss ratio was obtained had an aggregate loss ratio for 1984 of 60.2 percent. This loss ratio was substantially influenced by the experience of the Prudential Life Insurance Company, which had nearly one-fourth of the earned premium amount and a loss ratio of 77.9 percent. The 13 Blue Cross/Blue Shield organizations had an aggregate loss ratio of 81.1 percent during 1984.

Explanation of Loss Ratios

The loss ratio for a policy represents the percentage of premiums collected that are paid in benefits; it is computed by dividing the amount of incurred claims by the amount of earned premiums for the reporting period. The result of this computation is usually expressed as a percentage. Incurred claims include not only paid claims but also reserves for claims for services enrollees received during the period that have not yet been settled by or reported to the insurer. The earned premium for the period for which a loss ratio is computed is an estimate of (1) the portion of total premiums assumed to have been used for incurred claims plus (2) the portion of earned premium that is available for

profit, paying dividends, and such expenses as administration, sales commissions, and advertising.

Loss ratios, which are used in the insurance industry as a method of interpreting the amount of benefits returned to policyholders, are sometimes considered a way of measuring the policy's value. Generally, state regulators told us that loss ratios must be interpreted with care and that a loss ratio that falls below the minimum required should mark the beginning of research to determine the reasons for the variance from the target.

In addition, several state insurance department staffs told us that loss ratios are useful only when dealing with "mature" policies, but they have different opinions on whether a mature policy is one that has been in force for 2, 3, or 4 years. Factors that can affect the maturity of a policy are the 6-month waiting period for claims involving treatment for preexisting conditions and the expectation that policyholders will need more medical services as they grow older and thus will submit more claims the longer they hold a policy.

Loss Ratio Experience Generally Not Evaluated by States

The Baucus amendment requires an "expected" loss ratio of 60 percent for policies sold to individuals and 75 percent for policies sold to members of groups. The states we visited all had requirements for Medigap policies to have an anticipated loss ratio at least equal to the Baucus amendment targets. When companies apply for policy approval from the state insurance commissioner, the states require companies to include with the application their actuarial estimates for the policy's anticipated loss ratio.

HHS has interpreted the amendment as not requiring state regulators to monitor the actual loss ratios of Medigap policies, but we collected data submitted by insurance companies to the state insurance departments and computed loss ratios for 394 individual and 4 group Medigap policies. The loss ratios of 254 of the policies were below the targets.

Regarding loss ratios, the Baucus amendment provides:

"The Secretary shall certify . . . any medicare supplemental policy or continue certification of such a policy, only if he finds that such policy-

"(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and

practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies.

"For purposes of paragraph (2), policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies."

The amendment further provides that a state program must meet the same requirements in order to be certified.

On May 6, 1985, in response to an inquiry from Senator Baucus concerning the Medigap legislation, the Secretary of HHS interpreted this provision as follows:

"The statute requires that a Medigap policy have a minimum anticipated loss ratio. It does not require that actual loss ratio experience be compared with what was anticipated. The Panel certified States on the basis that a minimum anticipated loss ratio was required. Consequently, there is not much information available about problems in ascertaining loss ratios or on the impact the Medigap program has had on policies that had lower loss ratios than that required." (Emphasis supplied.)

Thus, according to HHS, the states are not required to compare the loss ratio experience of Medigap policies with the standards for these ratios. We found several states that, on their own, require insurance companies to furnish actual earned premium and incurred claims information.

Of the states we visited, Colorado, Maryland, Missouri, and Pennsylvania were collecting data that would allow them to monitor the loss ratios of Medigap policies.

Missouri monitored insurers doing business in that state, including certain insurers who market policies nationwide through a trust arrangement within Missouri. In April 1986, Missouri wrote to 38 insurers whose loss ratios were below the targets, telling them that their loss ratios were too low and instructing them to lower their premiums accordingly. Five insurers lowered their premiums. The other 33 insurers responded, and as of September 1986 the state had contracted with an actuarial consultant to study those responses.

Colorado, Maryland, and Pennsylvania have been collecting data on loss ratios, but as of August 1986, state officials had not concluded that action was necessary. Colorado analyzed loss ratios for Medigap policies

and found that the policies had average statewide loss ratios of 54 percent and 58 percent for 1983 and 1984, respectively. As of June 1986, however, the state had not requested explanations from companies whose loss ratios were below the standards. Maryland requires insurance companies doing business in the state to report annually their experience on policies sold to Maryland residents. If the company has so few policies in force in the state that a statewide loss ratio is not credible, the company may submit data on its nationwide experience. Maryland requires data covering 5 years' experience, and Pennsylvania requires 4 years' experience.

The state of Washington plans to begin a loss ratio monitoring program in late 1986 for all health and accident insurance.

We obtained nationwide financial information on 398 policies for which 1984 premium and claims information was reported by 92 commercial firms and 13 Blue Cross/Blue Shield plans. Using the data available from the states,[1] which varied from 1 to 5 years' experience, we computed a cumulative loss ratio for each policy. The four policies with earned premiums in 1984 of over $100 million had loss ratios that exceeded the target. Generally, the policies that were not meeting the loss ratio targets established in the Baucus amendment had less business, as shown in table 4.1.

[1]Data concerning policies sold by Prudential, National Home Life, and Colonial Penn were not available through the states we visited; those data were obtained through a private association. The data were also reported to us on an aggregate basis for each company's Medigap business, not on a policy-by-policy basis.

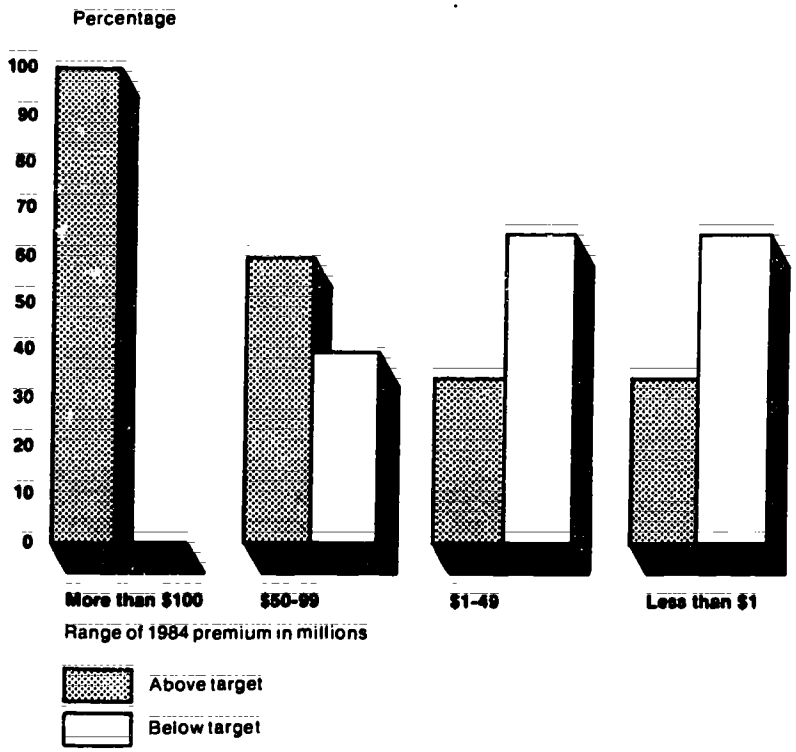
Table 4.1: Loss Ratio Experience of Selected Medigap Insurance Policies

Range of 1984 earned premium	Type	Number of policies with cumulative loss ratios: Above target	Below target
Over $100 million	Individual:		
	Commercial	1	0
	Blue Cross/ Blue Shield	3	0
$50-99 million	Individual:		
	Commercial	1	2
	Blue Cross/ Blue Shield	2	0
$1-49 million	Individual:		
	Commercial	39	89
	Blue Cross/ Blue Shield	10	2
	Group	1	1
Under $1 million	Individual:		
	Commercial	86	158
	Blue Cross/ Blue Shield	1	0
	Group	0	2
Total		**144**	**254**

The total 1984 earned premiums for the 144 policies whose loss ratios were above the target was about $1.4 billion; for the 254 policies whose loss ratios were below the target, the 1984 earned premiums totaled about $650 million.

The percentages of policies whose loss ratios were above and below the Baucus amendment targets, grouped according to volume of 1984 earned premium, are shown in figure 4.1.

Figure 4.1: Cumulative Loss Ratios for Medigap Policies by Amount of 1984 Earned Premiums



In appendix I, the loss ratios of the companies that sold the 398 policies plus six additional companies that reported premium and claims information for years before 1984 are presented on a company-wide basis for all policies for which data were available. Overall, the aggregate loss ratios for the commercial companies ranged from 59.2 to 65.3 percent in 1982-84; for Blue Cross/Blue Shield plans, the range of aggregate loss ratios was 81.1 to 93.7 percent. The cumulative loss ratios of individual commercial policies for which we had 3 or more years of data ranged from 18.6 to 85.3 percent. For Blue Cross/Blue Shield individual plans, the cumulative loss ratios ranged from 58.1 to 111.8 percent.

States to Receive Data That Can Be Used to Monitor Loss Ratio Experience

An NAIC committee prepared a revised standard Medigap reporting form for calendar year 1985 and later. NAIC recommends its reporting forms but does not have the authority to require their use; nevertheless, a representative of the industry told us that NAIC forms usually become the industry-wide standard. These reports are due from the insurance companies by June 30 of the year following the year the data cover. The

new Medigap form calls for loss ratio data to be reported for the "last completed calendar year" and "last three calendar years." The new form also requires loss ratio data for "Experience in Reporting State" and "United States Totals." The impetus to develop and implement this reporting form came from the states.

When we completed our work at the states in June 1986, they had not yet received data reported under this new framework, but the first annual reports on the new form were due on June 30, 1986. Regulatory officials in the states we visited believed that historical data are necessary for the states to adequately monitor loss ratio experience.

Conclusions

State insurance regulatory officials told us that loss ratios are a useful tool in analyzing insurance policy performance, but caution that they are only a step in any analysis. Loss ratios must be interpreted with care because of the factors that may affect the computations. Early policy experience may result in a relatively low loss ratio because of waiting periods for certain conditions when the policy will not cover services. Also, new policyholders may be relatively healthy and file few claims, so a policy experiencing substantial amounts of new business may experience a relatively low loss ratio. Thus, loss ratios should be viewed over the time that represents "mature" experience. State officials could not give us a clear definition of mature experience, but the new NAIC reporting form requests data covering 3 years' experience.

The Baucus amendment established loss ratio targets of 60 percent for individual Medigap policies and 75 percent for group Medigap policies. According to HHS, there is no requirement for the states to determine whether policies meet these targets. Beginning with data covering calendar year 1985, the states should receive standardized loss ratio information, which will aid them in monitoring loss ratio experience, if they choose to do so.

We computed loss ratios from data available in the states and through a private association. The loss ratios of 254 of the 398 policies we reviewed were below the targets, and these policies had about $650 million in earned premiums in 1984. Generally, the policies offered by commercial firms with high volumes of earned premiums and Blue Cross/Blue Shield plans had loss ratios that exceeded the targets.

Loss ratios reflect the combined experience of all policyholders, but the purchase of a policy is a highly individual transaction. A relatively high

loss ratio indicates that the policyholders as a group are getting a fair return on their premiums but does not promise any particular return to an individual.

As discussed in chapter 3, the extent of benefits provided under Medigap insurance varies among policies. This, combined with the wide differences in loss ratios discussed in this chapter, indicates to us that it is important for beneficiaries to shop for Medigap policies in order to obtain the best return on their premium payments. Chapter 5 discusses some of the assistance available to beneficiaries when they are looking for a Medigap policy.

State and Federal Agencies Have Tried to Curb Sales Abuse Through Education and Penalties

The purchase of Medigap insurance can be a complicated transaction because policy provisions, benefits, and loss ratios vary among policies that meet the minimum standards. HCFA and the states have made various efforts to aid and educate the elderly to make informed insurance purchase decisions. Sales abuses continue, but the states have taken some actions to deal with them through monetary penalties, cease and desist orders issued by state insurance commissioners, and the revocation and suspension of agent licenses. There have been no federal convictions under the Baucus amendment; however, the Postal Service has investigated Medigap insurance sale abuses under the mail fraud statutes. A June 1986 report[1] by the House Select Committee on Aging concluded that the states have done a good job in implementing regulatory improvements, but the report notes that abuses persist in the sale of Medigap insurance.

Generally, federal and state agencies initiate actions in response to complaints about advertising or sales practices. Federal agencies tend to emphasize educational activities, to help people make informed choices. While also supporting efforts to inform elderly persons about the options available to them, the states have been the primary enforcement arm against advertising and sales abuses.

Federal Efforts

To educate Medicare beneficiaries about purchasing private health insurance, HCFA and NAIC publish the Guide to Health Insurance for People With Medicare. The guide includes suggestions to make purchasers aware of and to protect themselves from misrepresentations and abusive sales practices. The guide is made available, without charge, through Social Security offices, and it is published in English and Spanish.

HCFA also conducts a nationwide educational program for volunteers who assist Medicare beneficiaries considering the purchase of Medigap policies. HCFA distributes its Medicare and Private Health Insurance Training Text to course participants as an instructor's guide.

The Social Security Administration district offices, as a contact point with the elderly, may receive questions or complaints from Medicare beneficiaries. These district offices record complaints and refer them to HCFA regional offices.

[1]Catastrophic Health Insurance: "Medigap Crisis," a report by the Chairman, Subcommittee on Health and Long-Term Care, House Select Committee on Aging, June 1986.

HCFA's regional offices have been involved with settling complaints from consumers about possible misrepresentation and other misleading sales practices of companies and agents. HCFA refers these complaints to the appropriate state insurance departments or to the HHS Inspector General for disposition. During fiscal years 1982-84, HCFA received 63 complaints of misrepresentation or sale of policies duplicating coverage under another policy. HCFA referred 8 complaints to the HHS Inspector General and 25 to the various state insurance departments for follow-up action. HCFA reviewed and closed the other 30 complaints for lack of evidence. In fiscal year 1985, HCFA received another 17 complaints. HCFA closed 13 of the complaints because of a lack of evidence; the other 4 were referred to state insurance departments.

In 1982, HCFA cooperated with the U.S. attorney and the Federal Bureau of Investigation in charging four insurance agents in Pennsylvania with representing themselves as federal employees while persuading elderly people to buy medical insurance. The Baucus amendment provides sanctions for posing as a federal agent to sell Medigap policies. The charges against these individuals were dropped because of difficulties in proving that they represented themselves as government agents, but the state of Pennsylvania later penalized one of them by suspending his license to sell insurance.

The Postal Inspection Service also takes preventive measures against insurance fraud through a consumer protection program directed at educating the elderly about potential mail fraud schemes. According to the Service, many of its 100 inspectors assigned to crime prevention duties make presentations to various senior citizen groups, and pamphlets on the topic are provided at no cost. The Service also has investigated insurance fraud cases directed against the elderly, although as of June 1986 there were no current investigations aimed specifically at Medigap insurance.

Many States Support Efforts to Aid and Educate the Elderly With Medigap Insurance Decisions

All the state insurance departments that we visited, except Rhode Island's, had a consumer protection division to help elderly citizens understand the sometimes confusing language of health insurance policies and a group of investigators to handle complaints received from the public. In Rhode Island, complaints about Medigap insurance are referred to the state's department of elderly affairs.

Some examples of state services to assist the elderly in making Medigap insurance decisions are

- shopper's guides that compare prices and coverages,
- education programs available for presentation at senior citizen meetings, and
- networks of counselors to help the elderly with insurance decisions.

The state of Washington has a program that is centered on the senior health insurance benefits advisors and includes a comparative shopper's guide. The advisors train senior citizens and other volunteers to be aware of the variety of medical protection services available to the elderly. These trained volunteers serve as advisors for seniors in their communities. The office of aging staff in New Jersey said they trained people to counsel senior citizens in a program similar to that of Washington.

In Arizona the state Association of Life Underwriters created the Senior Citizens Health Insurance Counselors program. This program was a response to the negative image given the industry as a result of the state's "sting" operation, concluded in 1980, which demonstrated that agents had misrepresented the insurance they were selling. The objective of the program, which is financially supported by the state, is to train volunteers to counsel senior citizens needing assistance in making intelligent decisions about purchasing Medigap or other insurance.

Florida officials issued a shopper's guide, and they conduct Medigap workshops at senior citizen association meetings and condominium complexes. They credit these efforts with creating a better informed population who are able to make good choices of coverage. They also said that they have received fewer complaints about Medigap insurance since these efforts have been in force.

Maryland officials told us they were assembling a shopper's guide for Medigap insurance available in that state.

Investigation and Sanctions

All of the states we visited had established rules and regulations governing advertising practices and sales of insurance by agents, and they monitor advertising and sales practices. All of them also had a formal insurance complaint handling system, either through the state's departments of insurance or elderly affairs, that included recording complaints, investigating the facts, and attempting to resolve the problems. Generally, the states respond primarily to complaints from the elderly or their representatives. That is, the states are usually not aware of problems unless they are brought to the attention of state officials.

Pennsylvania had records on the number of complaints about Medigap insurance received and the disposition of those complaints for the period July 1, 1984, through March 31, 1986, and Washington had records for the period January 1, 1985, through March 31, 1986. Pennsylvania received 445 complaints, and the state's investigators considered 234 to be justified. Of the 504 complaints that Washington received, its investigators considered 239 to be justified. In both states, most of the justified complaints dealt with questions regarding premium refunds, disputed claim amounts, and claim delays. In Pennsylvania, 29 of the justified complaints concerned misleading advertising and agent misrepresentation; in Washington, 32 were about those problems. In the other states visited, either we could not separate complaints about Medigap policies from complaints about other forms of insurance, or we could not readily identify the number of complaints received and their disposition for a recent time period.

Although time did not permit us to catalog all actions taken by the states, the following are examples of actions taken during 1985 and 1986:

1. Several states have acted to stop the use of mailings that were considered misleading. For example:

- The Washington state insurance commissioner's office issued a cease and desist order in January 1986. The order directed two groups to stop mailing information that attempted to deceive senior citizens. The groups involved were the "Senior Security Benefit Service" and the "National Senior Advisory Center." Both had the same Washington, D.C., address. The official-looking envelopes used, as well as the names and addresses of the groups, led the state office to conclude that they were deceiving people into thinking they were official government mailings, when the mailings were actually insurance marketing forms.
- An agreement and consent order in February 1985 between an insurance company and the Pennsylvania insurance commissioner called for the payment of a $50,000 settlement to the state. The Pennsylvania insurance department complained that the company's mail solicitations were misleading and deceptive. The Massachusetts state division of insurance issued a cease and desist order against the same insurance company for a deceptive mail solicitation. The state complained that the company's mailing suggested the purchase of the insurance was required by federal law. Florida also fined this company $5,000 for deceptive mailings.

2. In March 1986, the state of Florida fined an insurance company $25,000. This company was not renewing policies but rather offered policyholders a new policy that started a new 6-month waiting period for benefits.

3. Some states have dealt with insurance agent misrepresentation cases through fines and/or license revocation. For example, an agent in Pennsylvania was fined for falsely representing himself as a Medicare official. This was not a first offense. In Florida, agent licenses have been revoked for Medigap sale abuses, according to state officials, but the number of revocations was not readily available. During 1984, Arizona suspended or revoked the licenses of 15 insurance agents for violations involving the sale of Medigap insurance.

4. In June 1986, Maryland completed an investigation and received agreement from an insurance company to notify its agents that they were not to use unfair or high-pressure sales tactics or to misrepresent themselves as agents of another company or Medicare. This investigation grew out of consumer complaints that the company's agents sold Medigap and other health policies that were essentially duplicative because the policyholders already were covered by other insurance.

In June 1986 hearings before the House Select Committee on Aging, Minnesota's attorney general testified on current sales abuses and actions taken by that state to stop abuses in the sale of Medigap insurance. Those actions included

- enforcement of state law through criminal prosecutions and revocations of agent licenses,
- direct assistance to senior citizens in solving their insurance problems,
- public education to inform consumers of factors to be considered when buying insurance and how to guard themselves against fraud, and
- enactment of legislation that prohibits the overselling of insurance coverage.

Conclusions

HCFA and many of the states we visited have acted to educate the elderly about Medicare and the various insurance plans that can be purchased to supplement Medicare coverage. These actions include shoppers' guides, informational presentations, and networks of counselors. We believe these actions can do much to help the elderly make an informed purchase. The states we visited also have laws against misleading advertising, and they monitor insurance advertisements.

Federal and state agencies have also brought legal action against agents and companies who have been accused of misleading and unfair sales practices, when such cases are brought to their attention. Generally, sales abuse cases have been investigated and prosecuted under state laws, in keeping with the states' traditional role in regulating the insurance industry. These prosecutions have resulted in sanctions that include cease and desist orders, license revocations, and fines.

While these state and federal actions do not ensure that purchasers will not make poor choices or that purchasers will not be cheated, we believe that state and federal agencies are trying to educate and protect the elderly purchasers of Medigap insurance.

Company-Wide Loss Ratio Experience for Medicare Supplemental Insurance

Company	1984 Earned premium	1984 Incurred claims	1984 Loss ratio
Individual plans			
Prudential Life Insurance Co.	$304,323,322	$237,116,883	77.9
United American	188,419,001	88,644,634	47.0
Bankers Life and Casualty Co.	166,380,032	97,335,407	58.5
Standard Life & Accident	51,861,545	29,858,646	57.6
Mutual of Omaha	49,587,505	25,842,627	52.1
Globe Life & Accident	47,304,691	24,776,196	52.4
National Home Life	45,815,618	26,772,067	58.4
Reserve Life	35,193,338	29,953,640	85.1
Pyramid Life Insurance	28,497,139	18,557,828	65.1
National Foundation Life	21,961,690	11,894,278	54.2
Pioneer Life Insurance of Ill.	21,707,056	12,929,321	59.6
Certified Life Insurance	20,663,005	11,417,497	55.3
National States Insurance	19,894,615	9,822,195	49.4
Colonial Penn	18,255,929	12,075,496	66.1
Federal Home Life	17,258,098	8,896,014	51.5
Mutual Protective Insurance	15,927,844	6,659,314	41.8
American General Life and Accident	14,552,170	7,961,996	54.7
Medico Life Insurance	14,205,861	5,518,723	38.8
Equitable Life & Casualty	13,999,566	5,063,557	36.2
Physicians Mutual	12,581,102	7,069,959	56.2
Assoc. Doctors Life & Health	11,914,458	4,273,285	35.9
New York Life	10,237,255	6,539,723	63.9
Continental Casualty Co.	9,812,005	2,814,031	28.7
Central States Health & Life	9,195,714	4,393,214	47.8
Guarantee Trust Life Insurance	9,003,132	4,767,036	52.9
First National Life	8,282,260	5,656,607	68.3
Great Republic Life Insurance	6,492,826	3,382,189	52.1
Union Bankers Insurance	6,251,551	3,465,863	55.4
National Casualty	5,242,158	3,510,828	67.0
Montgomery Ward Life	4,814,166	(2,736,753)	−56.8
Liberty National Life Insurance	4,743,538	2,828,693	59.6
Georgia Life & Health	4,501,638	3,137,387	69.7
American Republic	4,475,029	2,207,974	49.3
Golden Rule	4,129,502	2,253,680	54.6
Holiday Life Insurance Co.	4,110,000	10,163,000	247.3
Lumbermans	3,990,943	1,232,551	30.9
Investors Insurance	3,965,730	2,328,071	58.7
Mennointe Mutual Aid	3,645,858	3,073,739	84.3

1983 Earned premium	1983 Incurred claims	1983 Loss ratio	1982 Earned premium	1982 Incurred claims	1982 Loss ratio	Cumulative loss ratio
$173,890,068	$140,167,705	80.6	$2,712	$264	9.7	78.9
112,718,299	57,196,513	50.7	64,772,723	33,069,129	51.1	48.9[a]
135,241,333	85,263,885	63.0	102,988,402	63,953,885	62.1	60.9
14,584,107	9,249,431	63.4	4,712,057	2,607,953	55.3	58.6
25,332,634	12,819,929	50.6	2,741,299	970,538	35.4	51.0
30,834,268	19,337,895	62.7	10,963,685	4,434,753	40.4	54.5
36,206,993	23,268,877	64.3	21,275,670	13,846,514	65.1	61.8
39,733,249	40,225,130	101.2	22,615,217	13,053,678	57.7	85.3
16,071,227	10,769,614	67.0	9,369,000	6,682,172	71.3	66.8
9,880,913	3,158,142	32.0				47.3
22,122,484	14,117,330	63.8				61.7
18,272,934	11,202,183	61.3				58.1
						49.4
15,279,419	11,934,810	78.1	13,230,320	13,049,702	98.6	79.2
12,254,566	5,892,054	48.1	251,186	102,657	40.9	50.0
12,538,054	6,293,650	50.2	2,463,435	789,737	32.1	44.4
						54.7
8,241,384	3,667,200	44.5	1,954,158	587,762	30.1	40.1
						36.2
10,097,716	6,120,884	60.6	7,145,693	4,223,390	59.1	58.4
7,445,337	2,389,193	32.1	3,998,231	841,333	21.0	32.1
5,676,360	3,031,735	53.4	2,185,754	885,013	40.4	57.8
2,897,283	4,405,783	152.1	1,830,954	1,601,359	87.5	60.7
16,942,120	11,017,301	65.0	3,113,499	1,551,268	49.8	58.0
						52.9
3,799,767	1,932,776	50.9				62.8
6,447,222	3,345,588	51.9				52.0
4,431,324	2,241,189	50.6	116,749	12,959	11.1	53.0
4,421,541	1,814,467	41.0				55.1
8,446,987	5,979,369	70.8	6,491,691	5,546,982	85.4	44.5
2,269,663	1,480,481	65.2				61.4
4,842,659	1,699,416	35.1				51.8
3,500,216	1,935,858	55.3	2,285,527	1,336,073	58.5	53.4[a]
1,532,127	1,421,588	92.8	99,953	48,736	48.8	64.6
						247.3
						30.9
220,786	55,807	25.3				56.9
22,793	18,948	83.1				84.3

Company	1984 Earned premium	1984 Incurred claims	1984 Loss ratio
Bankers Commercial Life	$3,645,289	$1,743,345	47.8
World Insurance	3,540,470	2,501,914	70.7
Gerber Life Insurance	3,303,015	1,447,855	43.8
Bankers Multiple Life	3,064,199	2,087,707	68.1
State Farm Mutual Auto	3,049,747	2,251,491	73.8
Transport Life	2,640,508	1,561,739	59.1
American Integrity Insurance	2,625,204	659,524	25.1
Academy Life Insurance	2,536,465	1,676,947	66.1
Life/Health Ins. Co. of America	2,504,503	805,589	32.2
Directors Life Insurance	2,461,242	1,080,735	43.9
George Washington Life	2,414,101	865,166	35.8
Acceleration Life Ins.	2,385,415	790,558	33 1
American Income Life	2,330,730	1,348,368	57.9
Life & Casualty Ins. Co. of Tenn.	2,198,105	990,236	45.0
Columbia Life	1,884,736	1,045,750	55.5
Benefit Trust Life Insurance	1,866,928	997,771	53.4
American National Insurance	1,845,871	1,018,268	55.2
Industrial Life Insurance	1,723,979	812,881	47.2
Intercontinental Life	1,707,532	793,059	46.4
Grange Mutual Life	1,339,545	1,139,072	85.0
Lutheran Brotherhood	1,071,881	500,466	46.7
First Farwest Life Insurance	629,381	351,299	55.8
Time Insurance	593,820	246,741	41.6
Professional Insurance Corp.	593,263	316,139	53.3
Statesman Life Insurance Co.	569,020	146,756	25.8
Guarantee Reserve Life	505,579	338,925	67.0
Guardian Life Ins. Co. of America	465,970	449,872	96.5
Liberty Life Insurance	386,200	12,847	3.3
American General Life Ins. of Delaware	361,597	162,326	44.9
Marquette National Life	342,929	183,315	53.5
Amalgamated Labor Life	276,825	151,950	54.9
Public Savings Life Insurance	267,049	94,976	35.6
Central National Life Ins. Co.	175,205	66,757	38.1
Empire Life Insurance	159,716	88,057	55.1
United Equitable Insurance	152,173	90,320	59.4
Colonial Penn Franklin	143,890	100,936	70.1
National Sec. Gen.	118,745	124,923	105.2
Union Labor Life	95,231	10,037	10.5
National Health Insurance	84,610	5,873	6.9

1983 Earned premium	1983 Incurred claims	1983 Loss ratio	1982 Earned premium	1982 Incurred claims	1982 Loss ratio	Cumulative loss ratio
$3,004,929	$1,338,067	44.5	$1,872,820	$686,749	36.7	44.2
1,571,786	1,248,509	79.4	249,310	144,874	58.1	72.7
1,373,475	490,084	35.7				41.4
2,825,963	2,912,728	103.1				84.9
265,215	173,016	65.2				73.1
791,609	419,228	53.0				57.7
1,175,011	140,057	11.9	624,235	22,739	3.6	18.6
2,723,355	2,087,086	76.6				71.6
1,087,847	167,945	15.4	87,746	2,062	2.3	26.5
2,163,353	1,823,970	84.3				62.8
1,795,756	313,874	17.5	154,501	11,796	7.6	27.3
1,025,155	290,138	28.3	10,720	4,489	41.9	31.7
574,290	261,915	45.6	174,549	47,333	27.1	53.8
						45.0
3,230,476	1,356,595	42.0	890,757	452,199	50.8	47.5
731,403	412,971	56.5	118,210	65,762	55.6	54.4[a]
1,429,432	722,451	50.5				53.1
1,562,406	931,961	59.6				53.1
1,419,644	650,039	45.8				46.1
227,839	277,074	121.6				90.4
						46.7
739,753	423,488	57.2				56.6
231,870	34,324	14.8				34.0
376,151	204,843	54.5	213,555	138,167	64.7	55.7
						25.8
293,283	174,103	59.4	10,758	3,950	36.7	63.9
						96.5
						3.3
						44.9
357,726	259,535	72.6				63.2
315,200	214,258	68.0				61.9
73,118	17,477	23.9				33.1
						38.1
180,691	130,294	72.1				64.1
503,587	193,276	38.4				43.2
						70.1
198,285	64,610	32.6	1,142	547	47.9	59.7
						10.5
904	0	0.0				6.9

Company	1984 Earned premium	1984 Incurred claims	1984 Loss ratio
Mass. Indemnity & Life	$77,791	$40,067	51.5
Aid Assoc. for Lutherans	76,036	35,316	46.4
Allstate Life	49,012	18,485	37.7
Hartford A & I Co.	42,299	34,984	82.7
Golden State Mutual Life	32,912	19,610	59.6
Midsouth Insurance Co.	32,129	6,233	19.4
Farm & Home Life Insurance Co.	24,207	3,090	12.8
Mutual Life of New York	16,484	5,928	36.0
First United Life	16,331	20,401	124.9
Great American Reserve	13,544	0	0.0
Bus Men Assur Co. of America	12,452	(99)	−0.8
MML Bay State Life	8,244	4,651	56.4
Providers Fidelity Life	6,760	2,711	40.1
Hartford Life Insurance	2,430	(2,575)	−106.0
Hartford Life & Accident Insurance	221	(13)	−5.9
American Guaranty Life Ins.			
Constitution Life Ins. Co.			
Cosmopolitan Life			
Peninsular Life			
Pennsylvania Life			
Union Fidelity Life Insurance			
Total	**$1,279,668,410**	**$770,706,675**	**60.2**
Individual Blue Cross/Blue Shield plans			
BC/BS MEDEX - MA	$180,774,913	$177,302,845	98.1
PA Blue Shield	178,659,515	154,581,402	86.5
Blue Cross/Blue Shield - FL	148,000,000	92,000,000	62.2
Blue Cross of Phila. - PA	69,401,471	54,842,464	79.0
Blue Shield of CA	58,421,769	39,739,016	68.0
Blue Cross/Blue Shield - COLO	28,673,365	16,559,636	57.8
Blue Cross of CA	25,373,446	14,743,665	58.1
Blue Cross of Northeast - PA	24,677,700	20,975,160	85.0
BC/BS Maryland	24,220,387	21,497,409	88.8
Capital Blue Cross - PA	23,182,873	25,533,872	110.1
Blue Cross of Lehigh - PA	8,011,494	6,503,743	81.2
Inter County Hosp. Plan - PA	7,149,500	5,869,300	82.1
Blue Cross of Western PA	67,550	58,508	86.6
Total	**$776,613,983**	**$630,207,020**	**81.1**

1983 Earned premium	1983 Incurred claims	1983 Loss ratio	1982 Earned premium	1982 Incurred claims	1982 Loss ratio	Cumulative loss ratio
						51.5
						46.4
$30,639	$12,513	40.8				38.9
						82.7
35,111	13,450	38.3				48.6
9,546	453	4.7				16.0
						12.8
18,191	4,328	23.8				29.6
						124.9
						0.0
						−0.8
13,357	10,435	78.1				69.8
						40.1
1,813	3,801	209.7				28.9
185	51	27.6				9.4
7,640,914	5,850,807	76.6				76.6
			$920,161	$747,991	81.3	81.3
5,745,502	4,217,572	73.4				73.4
928,474	692,305	74.6				74.6
3,597,937	1,292,615	35.9				35.9
15,869	11,088	69.9				69.9
$816,482,883	**$533,298,070**	**65.3**	**$289,940,419**	**$171,524,515**	**59.2**	
						98.1
$139,245,335	$139,845,027	100.4	$113,935,355	$109,036,823	95.7	93.4
128,000,000	106,000,000	82.8	101,000,000	78,000,000	77.2	73.2
57,229,363	57,383,371	100.3	41,243,912	45,870,826	111.2	94.2
49,316,985	36,706,916	74.4				71.0
29,020,610	15,838,193	54.6	20,355,669	17,524,695	86.1	64.0
						58.1
18,844,262	22,589,338	119.9	13,862,596	15,575,201	112.4	103.1
20,897,075	20,917,600	100.1	17,206,984	17,231,534	100.1	95.7
21,150,228	23,094,913	109.2	15,066,655	17,796,568	118.1	111.8
6,155,344	6,719,419	109.2	4,117,746	5,321,156	129.2	101.4
						82.1
59,724	58,951	98.7	51,261	50,538	98.6	94.1
$469,918,926	**$429,153,728**	**91.3**	**$326,840,178**	**$306,407,341**	**93.7**	

Company	1984 Earned premium	1984 Incurred claims	1984 Loss ratio
Group plans			
Blue Cross/Blue Shield - COLO	$2,582,045	$1,708,322	66.2
Bankers Life and Casualty Co.	1,410,088	874,048	62.0
United Equitable Insurance	848,152	311,113	36.7
Union Fidelity Life Insurance			
Total	**$4,840,285**	**$2,893,483**	**59.8**

1983 Earned premium	1983 Incurred claims	1983 Loss ratio	1982 Earned premium	1982 Incurred claims	1982 Loss ratio	Cumulative loss ratio
$3,659,666	$2,874,491	78.5	$3,719,634	$3,283,637	88.3	79.0
						62.0
						36.7
48,926	29,275	59.8				59.8
$3,708,592	**$2,903,766**	**78.3**	**$3,719,634**	**$3,283,637**	**88.3**	

[a]Cumulative loss ratio is based on more than 3 years' experience data.

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