Appendix F.—Supplementary Medical Insurance for Medicare Beneficiaries

Background

Elderly people have a disproportionate share of all personal health expenditures. Persons aged 65 and over are only about one-fifth as numerous as those aged 19 to 64, but their total personal health care expenditures are more than half as large as the total for the population aged 19 to 64. Although the aged represent only about 11 percent of the population, they account for over 29 percent of all personal health expenditures (131).

These figures reflect the more frequent illnesses of the aged and the greater expenses involved in their care, which occurs primarily in a hospital setting. Aged persons are more than four times as likely to have their activity limited by chronic health conditions than are those under 65. The aged are hospitalized at 2% times the rate for persons under age 65, and their average length of stay is almost twice that of other persons (261).

The response of Congress to these needs was the enactment of the Social Security Amendments of 1965, establishing the Medicare program and Medicaid program. As enacted, the Medicare program contained two parts: a hospital insurance program (Part A) and a supplementary medical insurance plan (Part B).

The hospital insurance program provided protection against the costs of inpatient hospital services, post-hospital extended care, post-hospital home health services, and outpatient hospital diagnostic services for beneficiaries under the Social Security and Railroad Retirement systems when they reach age 65. Each of these benefits was accompanied by deductibles and/or coinsurance payments by which the beneficiary shared in the costs of health services provided. Limitations on covered services were specified. In addition, Congress included provision for increases in deductible amounts for inpatient hospital and outpatient hospital diagnostic services to keep pace with increases in hospital costs.

Medicare and "Gaps" in Coverage

By design then, Medicare does not cover all health care expenses incurred by the elderly. As it evolved through the legislative and policymaking process in the 1960's, Medicare assumed many of the characteristics of private health insurance at that time, focusing on the payment of medical bills during periods of acute illness. Medicare, however, was intended to serve as a core health insurance program which the elderly poor could augment with Medicaid; other senior citizens, depending on their individual needs and resources, could augment Medicare through private health insurance.

Despite increased Federal spending over the years for both Medicare and Medicaid, for several reasons a growing number of senior citizens have turned to private health insurance for protection. For example, the Medicare cost-sharing requirements have risen at a much faster pace than cost-of-living increases provided to the elderly by Social Security. In addition, medical services reimbursed by Medicare are geared more toward episodic, short-term, acute illness than toward chronic, long-term disorders prevalent in the elderly population. Besides deductibles and coinsurance provisions, Medicare also does not pay for catastrophic, custodial, dental, or eye care. Therefore, there are important "gaps" in Medicare's coverage for the elderly.

These problems were further compounded by health care costs that generally outpaced inflation in other sectors of the economy, and a 15-percent decrease in this time period in the number of physicians who accepted Medicare patients on "assignment" (i.e., the physician agrees to accept full payment from Medicare for their services. When the physician does not accept assignment, the elderly patient is responsible for the difference between what Medicare will pay and what the doctor charges for a particular service).

By the mid-1970's, Medicare coverage had eroded to only 38 percent (compared with 50 percent in 1969) of the health care costs of the elderly. Fearful of the financial hardships of poor health, and confused by a complex benefit structure (see table F-1) that left "gaps" in their coverage, the elderly increasingly purchased supplemental, or "Medigap," insurance policies. By 1977, approximately 66 percent of the elderly population—15 million of the Nation's 23 million senior citizens—had at least one health insurance policy to supplement their Medicare benefits (267).

Private Health Insurance and Its Problems

As evidenced by the discussion in the preceding section, the elderly had a legitimate concern regarding Medicare and its ability to adequately address their financial needs during times of illness. The result was a profusion of Medicare supplemental or Medigap policies that, because of the complexity of Medicare ben-

Table F-l.—Medicare Benefits and Limitations, 1981

Kind of care	Medicare pays	Patient must pay	Comment
Part A—hospitalization	Days 1430	Initial deductible ($204)	Adjusted annually
	Days *60-90*	Daily deductible ($51)	Adjusted annually
	Days 90-150	Daily deductible ($102)	Adjusted annually
	After 150 days-no coverage	For *all* care	Reserve days (60) usable only once
			Care must be under doctor's orders and only be available in hospital
Part A—psychiatric hospitalization	Days 1-90	Initial and daily deductible	Only 190 days of care available in lifetime
	After 190 days-no coverage	For all care	
Part A—nursing homes skilled nursing care	Days 1-20 total	Nothing	Must be in Medicare certified skilled nursing facility (SNF)
	Days 20-100	Daily deductible ($25.50)	All five provisions must be met for reimbursement (including prior hospitalization)
	After 100 days-no coverage	For all care	No coverage for custodial care
			No coverage for private duty nursing or first 3 pints of blood
Part A—home health care	100 visits in 12-month period	For most other home health care	Patient must meet six conditions (including prior hospitalization or SNF care)
	Total cost of care for part-time skilled nursing, physical therapy and several other services		Does not cover full-time nursing care at home, drugs, meals and homemaker services
			Must be confined to home and be under doctor's orders
Part B—home health care	100 visits in a calendar year	$60 (Part B yearly deductible) and all noncovered services provided	Patient must meet four conditions to obtain reimbursement (including must be confined to home and be under doctor's orders)
			Does not require prior hospitalization
			Can provide coverage *after* 100 visits under Part A
Part B—physician and other medical services	Cost of care: except	Initial deductible ($60/yr) and 20% of all charges above $60 (determined to be reasonable and covered by Medicare in a calendar year)	Pays for doctors services, outpatient hospital care, outpatient physical therapy and speech pathology services, and other services
			Reasonable charge is *lowest* of customary, prevailing, or actual charge
Outpatient mental illness	$250/yr	All cost above $250	
Ambulance transportation	Most	All other costs	Available only when other forms of transport would endanger patient's health
Drugs	If drugs must be administered	All other drugs	
Immunizations	If required for treatment and ordered by physician	All other times	
Dental care	Jaw surgery and setting fractures only	All other costs	
Dentures	Nothing	Total cost	
Hearing and eye exams	Nothing	Total cost	
Eyeglasses and hearing aids	Nothing	Total cost	
Routine physical exams	Nothing	Total cost	
Most routine foot care	Nothing	Total cost	
Chiropractor's services	Manual manipulation of spine	All other costs	
Prosthetic devices	Most	All other costs	
Blood	Most	For first 3 pints	Some coverage under both Part A and Part B
Medical supplies	Dressings, splints, and casts	All other costs	

SOURCE: T. Van Eliet, *Medigap: State* Responses *to* Problems *With Health Insurance for the Elderly* (Washington, D. C.: Intergovernmental Health Policy Project, George Washington University, Oct. 30, 1979).

efits, were infinitely varied, with many options regarding policy benefits and price. **Comparison shopping among the options,** however, was confusing to many senior citizens, with premium rate structures sometimes "unfathomable" (140).

Private health **insurance policies marketed to the elderly have concentrated on the cost sharing for** covered services, often not including open-ended or catastrophic expenses, and have generally fallen into three categories:

- Medicare supplemental policies, generally referred to as "wraparound" coverage, usually pay some or all of Medicare's deductibles and copayments. Some policies may also pay for some services not covered by Medicare.
- Indemnity policies usually pay a fixed amount of money for each day of hospitalization. Some indemnity policies are attractive to the elderly because they pay in addition to other insurance held by the policyholder, providing extra income in times of illness. However, benefits are not structured to reflect the actual charges for an inpatient stay in a hospital.
- Limited policies or "dread disease" policies are another form of indemnity insurance. These policies provide benefits for only a single disease, such as cancer, or a group of specified diseases, and most benefits are keyed to hospitalization. Many States have banned limited or dread disease policies, which generally have a low rate of return to elderly policyholders.

Serious problems in the private insurance marketplace surfaced in a series of congressional hearings in 1978 on Medigap issues, and also in a report by the Federal Trade Commission (FTC) in July of that same year. Widespread company and individual agent abuses and problems in the sale of health insurance to the elderly population were noted by investigators. The following were identified (267):

- lack of policy standardization (complicating comparison shopping);
- the purchase of duplicate/excessive coverage (in most cases, worthless to the holder);
- lack of policy clarity (small print, numerous exclusions, policy riders, and a plethora of medical and legal terminology);
- low loss ratios (i.e., the percentage of premiums returned to the policyholders in the form of benefits), documented in table F-2, for preexisting conditions;
- clauses for preexisting conditions;
- claims-handling disputes;
- mail order insurance fraud; and
- deception, fraud, and high-pressure sales techniques by insurance agents o-n a widespread and nationwide basis.

At least 23 percent of those who purchase Medicare supplements were thought to have some duplicative insurance coverage.

It was further revealed that States had done little or nothing about these problems. Inadequate laws, regulations, and resources (i.e., money and personnel) kept many States from aggressively disciplining companies and agents engaged in fraudulent practices (267). In testimony before the House Select Committee on Aging (262), only 11 States reported having fined or disciplined companies for health insurance abuses. In cases when fines were issued, they tended to be minimal.

Table F-Z.—Returns on All Insurance as Compared With Medicare Supplemental Policies, Selected Companies, 1977

Company	Percent return on all insurance	Percent return on Medicare supplements
Mutual Protective Insurance	35	22
Medico Life	28	25
Mony	66	28
New York Life		28.7
American United Life	83	28.9
National Casualty Co.	59	30
American Progressive	*47*	*33*
National Security Insurance	21	35
Reliable	37	36
Constitution Life	78	37
Old American	45	38
Pioneer Life of Illinois	40	39
Liberty National Life	46	40
Pacific Mutual	65	40
Businessmen's Insurance	99	43
American Exchange Life	43	44
Commercial State Life	51	17
Union Bankers	53	48
Country Life	71	49
Aid to Lutherans	44	50
All American Casualty	87	52
Continental National America	82	55.4
Bankers Life & Casualty	67	57
Guarantee Reserve Life	62	57
American National	81	57.5
American Variable Annuity	65	63
Chesapeake Life	90	65
Guardian life Insurance	82	66
Mutual Benefit Life	72	70
Banker's (Iowa)	82	75
Home Life	76	77
Nationwide	79	78
Durham Life	67	79
Life of Virginia	78	82
Metropolitan		63
National Life and Accident	59	85
Provident Mutual	79	88
Blue Cross/Blue Shield	—	91

[a]Figures in this column estimated.

SOURCE: T. Van Eliet, *Mad/gap: State Responses to Problems With Health Insurance for the Elderly* (Washington, D. C.: Intergovernmental Health Policy Project, George Washington University, Oct. 30, 1979).

Interim State and Federal Responses

Every State had in place in 1978 an unfair trade practices act applicable to the business of insurance. Regulation of the industry has been, in fact, almost exclusively the responsibility of the States by virtue of the McCarran-Ferguson Act of 1945 (ch. 20, 59 Stat.). The act excluded the "business of insurance" from the Sherman, Clayton and the FTC acts, and left regula-

tion of the industry to State law. In place, then, were laws and regulations to prohibit fraud, abuse, or misrepresentations in the marketing of Medicare supplementary insurance.

As previously discussed, though, congressional hearings revealed the shortfall of many State laws, regulations, and their attendant enforcement. The hearings heightened Federal interest, and further Federal involvement was advocated on several points. First, the Federal Medicare program created the Medicare supplementary insurance business. Secondly, the area merited consideration in terms of whether there was a special need for consistency in regulatory approaches such as disclosure, standardization, and labeling. Different systems in every State would impose added costs of compliance on insurers and might confuse consumers, many of whom move at or after retirement. Lastly, many plans were sold by mail, and some States could not enforce Medicare supplementary regulations against mail order insurers not licensed in their States (64,262).

Several bills were introduced in the 96th session of Congress addressing some of the problems surrounding the marketing of Medicare supplements. Generally, the legislation proposed to increase the Federal Government's role in monitoring and controlling the private health insurance marketplace (267).

The States collectively took initiative in this area as well. The National Association of Insurance Commissioners (NAIC), a voluntary association of the chief insurance regulatory officials of the States, has traditionally played an important role in developing and revising State insurance statutes and regulations. In **1978,** NAIC established a task force to study the marketing of health insurance to the elderly (236). As a result of the study, NAIC promulgated standards in June ***1979*** as safeguards for insurance purchasers in the "Model Regulation To Implement the Individual Accident and Sickness Insurance Minimum Standards Act" (236). The model covered standards for policy provisions, minimum standards for benefits, loss ratio standards, disclosure standards, and administrative procedure standards.

Primarily on the basis of two provisions contained in the NAIC model law, Congress added section 1882 to title XVIII of the Social Security Act. Enacted on June 9, 1980, the statute (the Social Security Disability Amendments of 1980, Public Law 96-265) was an effort to create an incentive for States to upgrade their regulation of Medicare supplement health insurance policies. Basically, the law is fourfold. It provides for: 1) the creation of the Supplementary Health Insurance Panel, 2) the establishment of a Voluntary Certification Program, 3) creation of criminal penalty provisions, and 4) a study of the Medigap regulations (248).

The New Federal "Medigap Law"

As originally proposed, under section 1882, the Secretary of the Department of Health and Human Services (DHHS) would have determined whether individual State programs met or exceeded the standards contained in NAIC'S June 1979 Model Regulation. However, recognizing the traditional role of the States in regulating the business of insurance, Congress amended its original proposal to give recognition to the expertise in insurance existing at the State level. In its final form, section 1882 established the Supplementary Health Insurance Panel, composed of four State Insurance Commissioners appointed by the President and chaired by the Secretary of DHHS, as the body responsible for determining whether State Medicare supplemental insurance regulatory programs meet or exceed the minimum standards set forth by the act. A provision was also added requiring the panel to report to Congress by January 1, 1982, those States unlikely to have in place by July 1, 1982, a program that meets or exceeds the minimum standards.

On November 6, 1980, Commissioners William H. L. Woodyard 111 of Arkansas, Joseph C, Mike of Connecticut, Roger C. Day of Utah, and Susan M. Mitchell of Wisconsin were appointed to serve on the Supplementary Health Insurance Panel. Tera S. Younger, Director of the Bureau of Program Operations in the Health Care Financing Administration (HCFA), is the designated representative of the Secretary and serves as the panel's chairperson.

The panel has reviewed the laws and regulations governing Medicare supplemental insurance in each State and the District of Columbia. These reviews were conducted in open meetings, and each State was invited to speak on behalf of its own program. During the review, a vote was taken to render an advisory opinion on the program, approve the program, or approve the program subject to certain conditions. Table F-3 summarizes the minimum Federal standards used by the panel in making its determinations of individual State compliance.

Advisory opinions were rendered at the request of a State so that it could determine where its program stood in comparison to the minimum standards, without having the panel formally act on the regulatory program. Advisory opinions were also issued in instances where a State's regulatory program required an extensive overhaul to bring it into compliance and the State wished the panel's guidance.

Programs approved by the panel meet or exceed the Federal minimum standards. A program approved conditionally by the panel was one in which there was general compliance with the Federal minimum standards, but some deficiencies existed, or complying

Table F-3.—Federal Standards for State Regulation of Medicare Supplementary Insurance

Minimum Federal Standads
6 months or less limitation of preexisting condition
Applies to group and individual policies
Loss-ratio requirements:
75 percent group
60 percent individual
Equivalent definitions as contained in NAIC model of:
Hospital
Medicare
Benefit period
Accident
Physician
Nurse
Skilled nursing facility
Sickness
Medicare eligible expenses
Automatically changes Medicare cost-sharing amounts
Limitations of benefits do not extend beyond June 1979 NAIC model
Requires policy or combination of policies to cover both Part A and Part B minimums
Requires coverage of Part A hospital coinsurance from 61 to 90 days
Requires coverage of Part A hospital coinsurance during lifetime reserve days
Requires coverage of 90 percent of Part A expenses after exhaustion of lifetime reserve to a lifetime minimum of 365 additional days
Requires coverage of 20 percent of eligible expenses under Part B regardless of hospitalization subject to $200 deductible and maximum of $5,000 per calendar year
Free-look provision-refund **available** within 10 days of policy delivery and 30 days for direct response
Delivery of buyer's guide and written receipt at time of application. Direct response by the time policy is delivered
Outline of coverage requirements
Replacement requirements
Prohibits use of terms "Medicare Supplement," "Medigap" and words of similar import unless the policy meets these minimum standards

SOURCE: Department of Health and Human Services, Health Care Financing Administration, "The Supplemental Health Insurance Panel's Report to the Committee on Finance of the Senate and the Committees on Energy and Commerce and Ways and Means of the U.S. House of Representatives," unpublished, Baltimore, Md., Feb. 2, 1982.

legislation or regulations were prepared but were not yet in effect. States with conditionally approved programs were asked to modify them in a manner specified by the panel to achieve compliance. Once the modification was accomplished, the condition was removed and full approval was granted.

A State program was judged not expected to be in compliance with the standards only after the panel had issued an advisory opinion or a conditional approval and the State had declined to make the changes necessary to achieve compliance.

On the basis of the results of these reviews, the panel determined that the programs of 45 States and jurisdictions were expected to meet the Federal minimum standards by July 1, 1982. Ten were not expected to comply by that date. A listing of the status of each State program is found in table F-4.

Of the 45 States that the panel expected to be in compliance by July 1, 1982, 22 require modifications to, or finalization of, their Medigap regulatory programs

Table F-4.—State Compliance With Federal Minimum Standards for Supplementary Health Insurance

States expected to meet the Federal mininum standards by July 1, 1982

A. States approved:

1. Alabama	13. Nebraska
2. Alaska	14. New Hampshire
3. Arizona	15. North Carolina
4. Arkansas	16. North Dakota
5. Colorado	17. Oregon
6. Florida	18. Tennessee
7. Georgia	19. Texas
8. Indiana	20. Utah
9. Iowa	21. Vermont
10. Kansas	22. Virginia
11. Mississippi	23. West Virginia
12. Montana	

B. States conditionally approved or given advisory opinions which are expected to be in compliance by July 1, 1982. The panel will continue to review the progress of these States to assure they finalize their programs or make the required modifications:

1. Connecticut	11. Minnesota
2. District of Columbia	12. Missouri
3. Hawaii	13. New Mexico
4. Idaho	14. Nevada
5. Illinois	15. Ohio
6. Kentucky	16. Oklahoma
7. Lousiana	17. South Carolina
	18. South Dakota
9. Maryland	19. Washington
10. Michigan	20. Wisconsin

C. States from which the panel has not received a formal submittal but which are expected to be in compliance by July 1,1982. The panel will continue to review the progress of these States to assure they finalize their programs:

1. Delaware
2. Puerto Rico

States not expected to meet the Federal minimum standards by July 1, 1982

A. States conditionally approved or given advisory opinions which are not expected to be in compliance by July 1, 1982:

1. California	4. Pennsylvania[a]
2. Massachusetts	5. Rhode Island
3. New Jersey	6. Wyoming

B. States from which the panel has not received a submittal but which are *not* expected to be in compliance by July 1, 1982:

1. New York	3. Virgin Islands
2. Guam	4. American Samoa

[a]Pennsylvania's regulation is effective Sept. 20, 1982. The panel recommends that the Federal Voluntary Certification Program not be implemented in Pennsylvania.

SOURCE: Supplemental Health Insurance Panel, "Report to the Committee on Finance of the Senate and to the committees on Energy and Commerce and Waya and Means of the House of Representatives," Department of Health and Human Sewlces, Washington, D. C., Feb. 2, 1982.

before they will fully comply. The panel intends to conduct a continuing review of these States to monitor their progress and confirm their ultimate compliance. A continuing review of those States which are not now expected to have a program which meets the Federal minimum requirements will also be conducted. This will enable the panel to provide timely consideration to any State which may decide to adopt the minimum standards at some future date (59).

On July 1, 1982, the Medigap Operations Staff (MOS) in HCFA was to implement the Voluntary Certification Program in those States and territories not yet having a panel-approved regulatory program. This program will allow insurers to submit Medigap policies for review. It will then be determined whether these policies meet or exceed certain loss-ratio requirements set forth by law and the minimum requirements prescribed by NAIC. If certification is granted by the Secretary of DHHS, the insurers will be given permission to place a Federal emblem on these policies. MOS will review these policies yearly to determine whether they should be recertified.

In regard to the criminal penalty provisions included in the law, the HCFA Regional Offices (ROS), the Office of Inspector General, the Department of Justice, the State Insurance Departments, and MOS are all working together to implement and monitor these penalties. Quarterly, ROS are required to submit a report to MOS outlining complaints received and actions taken concerning Medigap abuses.

Section 1882(f)(2) of the law required the Secretary of DHHS to submit a report to Congress no later than July 1, **1982,** and periodically thereafter, evaluating the effectiveness of the Voluntary Certification Program and the criminal penalties established under this section of the law. MOS will be responsible for preparing this report as well as developing and giving DHHS recommendation as to whether or not the certification program and criminal penalties should be continued (248).

In compliance with Medigap legislation, HCFA'S Office of Research and Demonstrations in January 1982 began a study of the comparative effectiveness of State approaches to Medigap regulation. The study, to be conducted in six States, will be used to address whether a mandatory Federal regulatory program is needed to assure marketing of appropriate types of Medicare supplemental policies, whether there are ways in which State regulations can be enhanced, and whether there is a need for standards for other types of policies sold to Medicare beneficiaries. The six States, representative of the regulatory spectrum, selected as survey sites are Florida, New Jersey, Wisconsin, California, Washington, and Mississippi.

As an addition to this study, the National Center for Health Services Research, in cooperation with HCFA, will conduct a supplemental survey to determine the preference and willingness to pay for longterrn care insurance **(117).**

Types of State Regulatory Action

As of early 1979, only a few States such as Wisconsin had taken truly comprehensive action aimed at alleviating Medigap abuses. Over the last few years, though, States have passed meaningful new initiatives to curb abuses. New Jersey, for example, has banned all cancer insurance policies. Massachusetts has established its own dread disease lists, and has set rigorous standards for such policies. Most States have implemented regulations focused either on the insurance provider or on affecting consumer behavior, such as establishing a particular minimum standard (e.g., loss ratios) or strengthening disclosure requirements. The State experience is summarized below in broad areas of needed Medigap reform.

Standardization of Coverage

Several States have taken steps to classify and standardize the kinds of Medicare supplements that can be sold in a State. These steps can help to establish minimum levels of coverage provided by a policy and make it easier for the purchaser to shop for or compare similar policies.

The rationale for the standardization approach is that consumers are unable to choose intelligently among policy forms if the choices available are too numerous and varied. By allowing only a limited number of standard policies, the regulator hopes to enhance price competition by holding other product variables more or less fixed. The standardization approach implicitly assumes that there is a limit to the value of having free competition with regard to insurance product design because consumers have difficulty choosing intelligently among a large number of products with differing configurations.

Each State has taken a different approach, California has established three classes of Medicare supplements: in-hospital expenses only, in- and out-of-hospital expenses, and catastrophic Medicare supplementary coverage. A policy must be appropriately labeled, but no attempt is made to "grade" the policies within a category.

Wisconsin, generally considered a leader in its innovative approaches to the regulation of Medicare supplements, has four clearly defined categories of Medicare supplement insurance and minimum levels

of coverage for each category. The policies carry a clear designation of the category on the first page of the policy. Each policy also contains a "caption" which explains the four classes of coverage. All policies approved for sale in Wisconsin must adhere to the standards for one of the four classes of coverage.

In regulations filed in September 1979, Massachusetts established three separate classes of Medicare supplement policies. Unlike Wisconsin or California, however, Massachusetts strictly limits each class of policy as to benefits. Each insurer must offer the exact benefit package which defines a certain class of policy—no more and no less.

Minimum Standards

Many States have specific laws or definite portions of their minimum standards laws that affect the sale of Medicare supplements. These laws vary considerably in their approach, scope, and focus of their provisions.

The thrust of the minimum standards approach is to assure that policies offered for sale provide coverage which is "meaningful" in relation to the purposes for which it is to be sold. Prospective purchasers cannot be expected to recognize all of the health risks they face or to be able to put probability, severity, or cost valences on each risk. A policy that appears to be very complete and generous in its coverage may, in fact, be quite limited when measured by reference to the actual risks the insured faces.

Some of the States with noteworthy minimum standards for Medicare supplements include California, Illinois, Massachusetts, Michigan, Pennsylvania, and Wisconsin. California and Wisconsin are often cited as having some of the most comprehensive minimum standards. Several States also enacted legislation authorizing or directing the insurance commissioner to promulgate minimum standards for Medicare supplements.

Regulation of the Economic Value of Policies

Another approach, diametrically opposed in theory to standardization, is to regulate the economic content of policies by controlling the price which insurers can charge for them. This may take the form of direct rate regulation or its indirect counterpart, regulation of policy loss ratios (i.e., the percentage of premiums returned to the policyholders in the form of benefits).

Many States have now imposed loss-ratio requirements on Medicare supplement policies, some higher than the "benchmark" of 60 percent set by Public Law **96-25** for policies sold to individuals. Minimum Medicare supplement loss ratios range from a low ratio of **60** percent to a high minimum loss ratio of **70** percent for group policies in Connecticut.

There is controversy as to whether loss-ratio information is a useful tool for consumers to employ in comparing policies. The prevalent thinking is that the complexities of loss ratio analysis are too great for laymen to make intelligent use of such ratios as an index of economic value. Loss-ratio monitoring, then, in most of the States in which it is used, has application only as between the insurers and the regulators; it is a regulatory tool rather than a device for improving consumer choice. It might be noted, however, that until mid-1981, Wisconsin included loss-ratio information among the data that it periodically publishes for use by prospective purchasers of Medicare supplementary insurance.

Disclosure Requirements

A predominant approach to Medigap regulation is the provision of information to consumers, either directly or indirectly. Many States have improved their disclosure requirements in an attempt to give the consumer every opportunity to make an "informed" choice. At least nine States mandate the use of a form that outlines benefits and gaps in coverage. Several of these States, including California, Colorado, and Pennsylvania, require the use of this form for all types of health insurance sold to the elderly. Washington, Oregon, and New Mexico require a disclosure form only for Medicare supplements.

The States vary considerably in their disclosure requirements. For example, disclosure forms differ in their structure, content, and use. California is unique in that it requires the use of a separate disclosure form for each of its three categories of Medicare supplements, as well as hospital indemnity and dread disease policies. States such as Colorado and Connecticut, as part of their disclosure requirements, attempt to warn applicants if the sale of any new insurance replaces or adds to existing coverage. Most States (e.g., Montana, New Mexico, Oregon) require delivery of the disclosure form no later than at the time of delivery of the policy. At least one, Wisconsin, is known to mandate the use of a disclosure form at the time of sale.

Very few States require the use of consumer information pamphlets—e.g., Wisconsin at the time of sale and Michigan at the time of delivery. About half of the States do have consumer information pamphlets available for senior citizens. These brochures are normally made available upon request to those over **65** or through general distribution channels. In addition, NAIC and HCFA have prepared a brochure on private health insurance sold to the elderly that is available to all Medicare beneficiaries **(233,267).**

Through its regional offices and with State insurance departments, HCFA also conducts a nationwide training program for volunteers to assist Medicare beneficiaries wishing help in considering the purchase of private health insurance to supplement Medicare coverage. As of October 1981, HCFA had conducted over 275 Medigap training sessions, for over 13,000 individuals in every State. HCFA'S Office of Public Affairs is presently preparing a public service campaign to acquaint Medicare beneficiaries and other affected individuals of the Medigap law and State regulatory programs concerning Medicare supplements. This campaign will be nationwide in scope and provide all entitled beneficiaries with information to help them with their decision to purchase private supplemental health insurance (131).

Strict Enforcement

Even before the Medigap "scandals" of the late 1970's, most States had on their books general laws prohibiting fraudulent or unethical sales practices and unfair or deceptive advertising. They had also had authority to revoke licenses or impose other disciplinary measures on companies or agents found guilty of unethical or unprofessional conduct. Thus, some States reacted to the Medigap issue by simply stepping up their investigatory and disciplinary actions, communicating unequivocally to the insurance industry that abuses will not be tolerated,

Several States, either spontaneously or under pressure from media publicity, have launched substantial investigations to uncover and punish Medigap abuses. At times, these campaigns have focused on particularly abusive companies; in other cases, they have been directed at individual agents. Fines, reprimands, and revocation or suspension of licenses, have been the regulatory weapons employed. Kansas has augmented its strict enforcement policies in recent years with a relatively sophisticated computer system for tracking and analyzing complaint, investigation, prosecution, and sanction data (233).

Conclusion

The last 5 years have been a period of extensive change in the buying, selling, and regulating of Medigap policies. How effective these changes have been, though, is still largely speculative.

The Federal role—for all its hearings, reports, and organizational structure—still represents a basically voluntary approach to the Medigap problem. Sen. Max Baucus (D-Mont.) has stated that the best possible effect of Federal voluntary efforts "would be a much better informed Medicare consumer . . . (that would) make it easier for buyers to identify good insurance policies and make better comparisons before buying." The American Association of Retired Persons, however, has warned that because the program is voluntary, there is potential for abuse (131). It urged consideration of future mandatory certification requirements with set standards for comparison if present efforts are less than adequate.

States, the traditional regulators in the insurance area, have passed new legislation and implemented new regulations to curb established patterns of abuse. The priority given to such enforcement in each State is not known. It is clear, however, that relying on a State-by-State approach can be expected to result in a diverse approach to the problems, with a corresponding variation in results.

A recent study by Arthur D. Little (9) identified the population 62 years and older and Medicare recipients as demonstrating the lowest level of knowledge of any demographic group in several categories of health insurance information, including cost of coverage and continuance provisions. The study concluded that the population 62 or over and Medicare recipients demonstrated poor knowledge of conditions of coverage for Medicare supplementary policies, that this group could generally not select the policy that provided them with better financial protection, and that a "substantial proportion" believed that more than one supplementary policy is needed to cover the gap in Medicare. The development of health insurance education/information materials and programs for this population remains an important need.

It should finally be noted that the heart of the Medigap problem probably remains with the Federal Medicare program itself. Medicare's complex benefit structure confuses many a consumer, while the continued increase in its deductible and coinsurance clauses worries many a consumer. By paying only about 38 percent of the health care costs of a largely fixed-income group, the Medicare program has understandably continued to generate a market for multiple varieties of supplemental insurance. These supplemental polices have, at the same time, mostly concentrated on the cost sharing for covered services. Even if new regulatory and consumer information strategies alleviate recent Medigap problems, open-ended or catastrophic expenses may pose a substantial problem for elderly people.

The Medigap experience, from a policy perspective, can be used by proponents of greater plan competition as an argument for uniform, standard, simple, yet fairly comprehensive benefit packages for health care consumers, especially the aged. Advocates of greater

competition in health care—including proponents of both greater patient cost-sharing measures and greater competition among plans—can also point to Medigap problems as a lesson for avoiding two levels of health insurance that only serve to increase system complexity and cost. Even under the most benign of intentions, complex base plans such as Medicare may result in interacting with and ultimately subsidizing supplemental plans.