Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

THE IMPACT OF OBRA 1990 ON STATE REGULATION OF MEDIGAP INSURANCE

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EXECUTIVE SUMMARY

PURPOSE

To determine the impact of the Omnibus Budget Reconciliation Act of 1990 on State regulation of Medigap insurance and on related consumer education.

BACKGROUND

The Medicare Program and Medicare Supplemental or "Medigap" Insurance

Congress established the Medicare program in 1965 under title XVIII of the Social Security Act. Medicare consists of two separate insurance programs, hospital insurance (part A) and supplementary medical insurance (part B). It provides payment for certain medical services for persons at least 65 years of age or under 65 if disabled, including those afflicted with end-stage renal disease. In 1993, Medicare covered about 32.1 million aged and 3.4 million disabled beneficiaries. The Health Care Financing Administration (HCFA) manages the Medicare program.

Medicare covers about 75 percent of the actual cost of medical care provided to beneficiaries. Beneficiaries are responsible for deductibles and coinsurance amounts under both parts A and B, as well as services and items that Medicare does not cover. Almost three-quarters of aged Medicare beneficiaries have private health insurance, including Medicare supplemental, or "Medigap," to cover some of their expenses.

Regulation of Medigap Insurance

The States were solely responsible for regulating Medigap until 1980, when Congress responded to numerous reports of abuses in the marketing of Medigap insurance. Legislation established minimum Federal standards for Medigap policies by adopting model standards developed by the National Association of Insurance Commissioners (NAIC). At the time of our fieldwork, the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) contained the most recent amendment to the Medigap statutes. It required the standardization of Medigap policies, Federal and State action to curb abuses in the marketing of Medigap policies, and the education of consumers. The States' insurance departments and information, counseling, and assistance (ICA) grantee programs are responsible for regulation and education.

DEVELOPMENTS SINCE ISSUANCE OF THE DRAFT REPORT

On October 31, 1994, Congress passed the Social Security Act Amendments of 1994. Effective January 1995, the amendments clarify that a six-month open enrollment period applies to all beneficiaries who are age 65, including those who had been entitled to Part B benefits prior to age 65 due to end-stage renal disease or disability. The legislation also amends the anti-duplication provision to allow some Medigap

RECOMMENDATIONS

We recommend that HCFA:

1. implement plans for direct regional office assistance to ICA grantees;

2. a. consider expanding the Complaints Database System to reflect received, closed, and pending Medigap complaints;

   b. direct State insurance departments to furnish key required data, such as policy type, for each reporting period;

   c. clarify instructions to assure uniform reporting of data by States; and

3. work with NAIC and State insurance departments to encourage States to adopt consumer safeguards exceeding the minimum standards, including open enrollment for the disabled and community rating of premiums.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on the draft report, HCFA concurred fully with the report's recommendations. The HCFA described actions they already have taken or plan to take to (1) provide regional office support to ICA grantees, (2) obtain key required data, (3) clarify reporting instructions, and (4) pursue a legislative proposal to mandate the use of community rating for Medigap policies. They do not, however, plan to request Office of Management and Budget clearance for expanded data collection at this time. The HCFA noted that the Social Security Act Amendments of 1994 address issues surrounding open enrollment for the disabled and the anti-duplication provision. The full text of HCFA's comments appears in appendix C. In response to HCFA's comments, we have made technical corrections to reflect the passage of the Social Security Act Amendments of 1994 and actions taken by HCFA.

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PURPOSE

To determine the impact of the Omnibus Budget Reconciliation Act of 1990 on State regulation of Medigap insurance and on related consumer education.

BACKGROUND

The Medicare Program

Congress established the Medicare program in 1965 under title XVIII of the Social Security Act to provide health insurance for the elderly and disabled. It consists of two separate but complementary insurance programs, hospital insurance (part A) and supplementary medical insurance (part B). Although part A is called hospital insurance, it also covers services furnished by skilled nursing facilities, home health agencies, and hospices. Part B covers a wide range of medical services and supplies, including physician services and durable medical equipment. In 1993, Medicare covered about 32.1 million aged and 3.4 million disabled beneficiaries. The Health Care Financing Administration (HCFA) manages the Medicare program.

Why Beneficiaries Might Need Insurance Coverage Supplemental to Medicare

Medicare does not cover all health services or all costs. Beneficiaries are responsible for deductibles and coinsurance under both parts A and B, as well as services and items that Medicare does not cover. For example, when physicians accept the Medicare-approved amount for part B services as payment in full (assignment of benefits), Medicare covers only 80 percent of this amount, excepting mental health services. For mental health services, Medicare covers 50 percent of approved charges, and beneficiaries are responsible for 50 percent. Beneficiaries also may have to pay amounts above those approved if they receive covered services from physicians who do not accept assignment.

While Medicare covers most of the cost of medical care provided to beneficiaries, almost three-quarters of aged beneficiaries buy private health insurance for greater protection. These plans typically provide coverage for some or all of the deductible and coinsurance amounts for Medicare-covered services. They are known as "Medigap," because they fill the gaps in Medicare benefits. Sometimes they also cover items or services excluded by Medicare, such as preventive health care or most outpatient prescription drugs.

Despite the national extent of Medigap insurance coverage, Medigap policies account for a small portion of total premiums for health insurance products sold. According to the National Association of Insurance Commissioners (NAIC), Medigap insurance premiums represented less than three percent of those written nationally in 1992. The

1992 State-reported premiums for Medigap insurance were $11.8 billion. The total premiums written nationally by Property and Casualty and Life/Health insurance companies, excluding Blue Cross and Blue Shield plans not organized as insurers, were $443.5 billion.

Regulation of Medigap

The States were solely responsible for regulating Medigap until 1980, when Congress responded to numerous reports of abuses in the marketing of Medigap insurance. The "Baucus Amendment" established minimum Federal standards for Medigap policies by adopting model standards developed by NAIC. The amendment gave States the opportunity to adopt the Federal standards as part of their regulatory programs for Medigap insurance. The Baucus amendment, however, lacked the enforcement power to assure that States adopted the Federal standards.

Repeal of the Catastrophic Coverage Act of 1988 was the greatest stimulus to further Congressional action to regulate Medigap insurance. That legislation would have filled some major gaps in Medicare by limiting beneficiaries' out-of-pocket expenses and by increasing coverage. As a result, during the Medicare Hearings of 1990, the Subcommittee on Medicare and Long-term Care of the Senate Committee on Finance concluded that "several specific problem areas exist [with Medigap insurance] and must be urgently addressed by Congress. These are consumer confusion, duplication of coverage, failure to comply with ratio standards, and continued abuses in sales and marketing practices."

These concerns caused Congress to enact new Medigap statutes as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). These statutes provided for the simplification and standardization of Medigap policies and mandatory compliance. They sought to:

- set minimum standards for Medigap policies and prohibit insurers from offering beneficiaries more than ten different benefit packages, effective July 30, 1992;
- minimize inappropriate sales and marketing of Medigap policies; and
- educate and counsel consumers who wish to purchase Medigap insurance.

The efforts to realize these goals required an unusual collaboration among the Federal government, NAIC, and States, following passage of the legislation on November 5, 1990. The OBRA 1990 altered the Federal role in the regulation of Medigap policies. As of the effective date (July 30, 1992, with some exceptions), OBRA 1990 restricted insurers from issuing any Medigap policy in any State unless the State has an approved regulatory program or the Secretary of Health and Human Services certifies that the policy meets the revised standards. The statute called for NAIC to revise its model regulation for Medigap policies to meet the OBRA 1990 requirements by August 5, 1991. The revised NAIC standards were to become

effective in all States within the following year. The OBRA 1990 also provided for grants from HCFA to the States to establish an information, counseling, and assistance (ICA) program to educate consumers.

Beginning July 30, 1991, NAIC, HCFA, and States began to implement the statute. The NAIC adopted implementing standards, and most States passed new authorizing legislation. The HCFA reviewed and approved:

- virtually all Medigap regulatory programs of 48 States, the District of Columbia, Puerto Rico, and the Virgin Islands. Two States needed extensions for their legislatures to act. This action was authorized by statute when State legislatures could not meet in time to comply with the mandates of OBRA 1990. The HCFA approved Montana's program on July 3, 1993, and Oregon's program on March 11, 1994; and

- most State applications for ICA grants to educate consumers, providing funds ($8.99 million in FY 1994) to States and territories for this purpose. Mississippi received funding in FY 1994, the last of the 53 States and territories to get approval. State Insurance Departments (SIDs) administer the programs in 17 States, and State Offices on Aging conduct the program in 36 States.

The Minimum Standards and the Ten Standard Medigap Policies

Provisions of the 1990 Medigap amendments included the standardization of Medigap policies, guaranteed renewability, higher loss ratio requirements, required refunds or credits if the policies do not meet loss ratio requirements, and prohibition against virtually any sale of duplicative health insurance coverage to Medicare beneficiaries. Each State may determine whether insurers may sell some or all the ten benefit plans in that State, but all Medigap insurers must make Plan A available to beneficiaries if they sell any of the plans. States may not authorize the sale of more than these ten Medigap plans. The complete minimum standards for Medigap policies appear in appendix A.

Massachusetts, Minnesota, and Wisconsin adopted stringent Medigap standardization requirements before passage of OBRA 1990 and applied to HCFA to waive NAIC standardization requirements. Since the statute permitted such waivers, HCFA granted all three waiver applications. As a result, policies must conform to those States' unique standardization requirements rather than to the ten standardized benefit packages.

State Reporting of Medigap Complaints

The OBRA 1990 called for SIDs to receive consumer inquiries and complaints about the availability and marketing of Medigap policies. State reporting of consumer Medigap complaint data evolved as a means to gauge the extent of complaint activity, but HCFA had no means for collecting the information. As an interim measure,

HCFA has utilized NAIC's Complaints Database System which contains data on all lines of insurance from each State. The HCFA asked NAIC to modify the system in early 1993 to incorporate data specific to Medigap complaints. Since then, NAIC has been providing HCFA with quarterly complaint data updates. (See appendix B for NAIC's data collection fields and the characteristics of closed Medigap complaint cases reported for 1993.)

DEVELOPMENTS SINCE ISSUANCE OF THE DRAFT REPORT

On October 31, 1994, Congress passed the Social Security Act Amendments of 1994. Effective January 1995, the amendments clarify that a six-month open enrollment period applies to all beneficiaries who are age 65, including those who had been entitled to Part B benefits prior to age 65 due to end-stage renal disease or disability. The legislation also amends the anti-duplication provision discussed on page 16 of this report. The HCFA is working with NAIC and the States to incorporate required changes into the NAIC model regulation and State legislation.

METHODOLOGY

We obtained the views of 156 respondents from all States and other organizations on the impact of OBRA 1990 on Medigap insurance regulation and consumer education. In this report, "States" refers to the States, territories, and the District of Columbia. We asked each respondent to answer a survey consisting of five core questions. We asked insurance commissioners two additional questions.

To supplement information from the survey, we asked respondents from 16 sample States in-depth questions about their procedures and how OBRA 1990 has affected their workloads. We selected these States purposively to represent a geographically diverse mix of States with large, medium, and small Medicare beneficiary populations. The sample States include 11 ICA programs run by State Offices on Aging and the remainder run by SIDs. The States are Arizona, California, Colorado, Delaware, District of Columbia, Florida, Illinois, Maryland, Mississippi, Nevada, New York, Oregon, Pennsylvania, Texas, Utah, and Washington.

Besides State regulators, we contacted insurance industry and consumer groups. Insurer organizations include the Health Insurance Association of America, eight Blue Cross and Blue Shield plans in four States, and the Prudential Insurance Company. We contacted the following advocacy organizations: the American Association for Retired People, the Consumers Union, United Seniors Health Cooperative, Action for Older Persons, Mass Home Care, Provenant Health Insurance Counseling for Seniors, and an independent consultant from California.

The following table displays the respondent groups, the number contacted, the number responding, and the methods used to contact them.

Respondent Groups		Number Contacted	Number Responding	Contact Method
Insurance Commissioners		55	54	mail and telephone
16 Sample States	Policy Approval Staff	16	16	9 in-person and 7 telephone
	Complaint Resolution Staff	16	16	9 in-person and 7 telephone
	ICA Program Coordinators	16	16	9 in-person and 7 telephone
Remaining ICA Program Coordinators		37	36	mail and telephone
Consumer Advocates		7	7	mail and telephone
Insurer Organizations		10	10	mail and telephone
NAIC		1	1	mail and telephone
TOTAL		**158**	**156**	

Our findings represent all the opinions expressed by respondents. When respondents lacked enough experience or knowledge to respond to a specific question, we excluded them from the statistical results related to that question. On the other hand, we have included and described responses other than the choices available in the statistical results as appropriate.

We also obtained and reviewed:

- SID documents describing regulations, policies, and procedures for the review and approval of Medigap policies, market conduct, and complaint investigation and resolution;
- SID and NAIC documents describing the collection and disposition of Medigap complaint data;
- NAIC and State complaint data, including the NAIC Complaint Database System for cases closed in calendar year 1993; and
- examples of educational information regarding Medigap insurance disseminated by HCFA, NAIC, SIDs, ICA grantees, and other advocacy organizations.

We conducted this inspection according to the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

AN OVERVIEW OF SAMPLE STATES' MEDIGAP REGULATION AND EDUCATION

The following is a summary of the 16 sample States' Medigap policy and market conduct review, education, and complaint resolution activities. The States use similarly structured procedures to conduct reviews, to educate consumers, and to resolve complaints. They did not specifically create these procedures to regulate Medigap insurance, but they have applied procedures that have been in use for years and address all other lines of insurance.

State insurance department respondents described their procedures for reviewing and approving Medigap policies, for reviewing market conduct, for educating consumers, and for resolving consumer complaints. They also provided detailed written procedures and the State regulations from which those procedures were drawn. State ICA grantees also provided descriptions of their consumer education programs. Our evaluation of those documents confirmed States' use of structured procedures to regulate Medigap insurance and resolve complaints.

Medigap Policy Review

Sample States have similar procedures for the submission, review, and approval of Medigap policies. Typically, States require the insurer to submit policy forms, proposed rate material with an actuarial justification, and advertising material. Some States require certificates attesting to compliance with all State laws, actuarial rules for rates and loss ratios, and readability. Usually, an analyst or attorney reviews the proposed policy language and an actuary reviews the proposed rates before States grant approval. If a policy is disapproved, the company typically has up to 60 days to make necessary corrections and resubmit.

Before any policies may be offered to consumers, most SIDs require review and approval of both policies and premium rates. According to SID respondents in these States, regulators perform thorough reviews to assure that policies correspond to one of the ten standard types, required forms and disclosure statements are used, and rates are appropriate. Most sample States require insurers to submit Medigap policies and premium rates for approval before marketing the policies to consumers. Four of these States, however, have a "deeming" provision. The "deeming" provision means that insurers may assume approval of proposed policies and rates unless the SID explicitly disapproves them within a given number of days. In practice, States usually approve or disapprove filings within the specified period.

A few States use other methods for reviewing policies and rates. In one sample State, insurers may "file and use" policies or rates by attesting that all requirements are met, subject to heavy fines and possible loss of licensing if facts establish otherwise. In another State, insurers must wait for review and approval for proposed policies, but may file proposed rates and use them immediately.

Sample States vary in whether they review marketing materials to assure they are accurate. Half require review and approval of marketing materials before insurers may use them, while two deem proposed materials approved unless they explicitly disapprove them within a given number of days. However, six States neither require prior nor deemed approval of all marketing materials. These States rely on consumer complaints to identify problems. A respondent from one of these States said:

> [We utilize] reactionary monitoring. Once there is a complaint made, we investigate. Mostly, we assure that insurers and agents don't use the abusive marketing or sales practices of the past through the complaints system. An agent or company will complain about another's practices. If we find advertising that has technical violations, we refer it to the legal division.

Market Conduct Exams

During market conduct exams, States review insurance company records to check for compliance with State laws and standards. Most SIDs in the sample States perform market conduct exams on a cause basis, if they have received complaints or other information to warrant an extensive review. All but three sample States rely on complaints to identify candidates for market conduct reviews, since most exams are very comprehensive and require substantial resources, especially if the number of companies in the State is high. During an exam, regulators review all lines of insurance, Medigap being one of the smallest. A respondent from a large sample State noted, "The complaint process is a major way we monitor performance. We follow-up on each complaint, and do a market conduct review of that company and its agents if necessary."

Several SIDs perform market conduct exams on a three-to-five-year basis, although some have only begun their first cycle. This practice is more typical of the smaller States with fewer companies to review. A respondent from a small State told us, "We perform market conduct exams primarily on domestic companies because we share the results of exams with other States. We have a three-to-five-year schedule for doing exams. We also target exams if we suspect problems."

Medigap Complaint Resolution

Each sample SID has staff devoted to complaint investigation and resolution, often within a consumer services unit. Usually these staff handle complaints about all lines of insurance, not just Medigap complaints. States obtain the complaints in writing where possible and promptly contact insurers and agents, as appropriate. Complainants are given periodic status on their complaints as well as on their final disposition.

Although day-to-day operation varies somewhat among sample States' complaint units, most discourage investigation by referring agencies, including ICA grantees. This is

rarely a problem, since the referring agencies lack investigative expertise and resources. Some SID complaint units do provide training to ICA grantee volunteers on recognizing problems and making appropriate referrals, usually in States where the SID is also the grantee.

The sample States are similar in how they manage Medigap complaints, although they differ significantly in the extent to which their complaint management information systems are automated. Several States, including both large and small ones, have sophisticated complaint management systems to process all complaints, including those involving Medigap. These States can count receipts, clearances, and pending workloads. However, only one of these States regularly produces complaint reports that permit detailed analysis of Medigap complaints. Others do not because the size of the workload is too small to make any analysis meaningful.

Whenever SIDs take disciplinary action against insurers and agents, including those few involved in Medigap cases, they publicize the results in detail. States frequently publish such cases in SID newsletters, which they share with other States, and NAIC's interstate electronic messaging system that connects all SIDs. This exposure assures the widest publicity among States and alerts those who may have the same insurers and agents operating in their jurisdictions.

Since June 1993, States have reported closed Medigap complaint data quarterly to NAIC's Complaints Database System. The NAIC, in turn, provides HCFA the data for review. For 1993, the sample States reported 1,374 complaints closed, representing about half the national total. Complaints from sample States are similar to those from the rest of the nation in both the reasons for complaints and their dispositions. (See appendix B for further details about Medigap complaints.)

Information, Counseling, and Assistance Programs

States are in various stages of launching their ICA programs to educate and counsel consumers. Most ICA grantees in the sample States contract with area aging or other agencies to set up a network to provide information and counseling. Since only a few paid staff positions are available, the program depends heavily on volunteers. The ICA providers recruit and train volunteers, develop newsletters and other information, establish toll-free numbers, and conduct outreach. Half the ICA grantees in the sample States have established information and counseling networks in all areas of their States, and six have networks in most areas. One State is set up only in some areas, and one, a recent grantee, has not yet set up its network. Several States mentioned the difficulty in establishing programs in rural areas, or in reaching minorities and other target groups. In the sample States, all but one of the ICA grantees have set up a toll-free number or will have one shortly.

All ICA grantees in the sample States are establishing outreach programs to inform those turning 65 about their health insurance options, including Medigap open enrollment. Grantees use a variety of outreach methods, including radio and television

public service announcements and programs, articles in ethnic and neighborhood newspapers, and presentations at senior centers and other sites. Eleven of the sample ICA grantees have implemented outreach programs, four have limited outreach, and one is just starting. Several grantees are negotiating agreements with regional HCFA and local Social Security offices to provide Medigap information in notices sent to current and expected Medicare beneficiaries. One State, for example, has arranged to get the state-wide Medicare carrier to put information about the ICA program into the mailing of the explanation of medical benefits sent to beneficiaries.

Most sample ICA grantees characterize their relationship and communication with the State insurance complaint division as "effective," but three located in State Offices on Aging believe the relationship is not effective. They cited political differences and different bureaucratic styles as factors resulting in less effective relationships between SIDs and ICA grantees, but otherwise these ICA grantee responses were similar to those of other respondents.

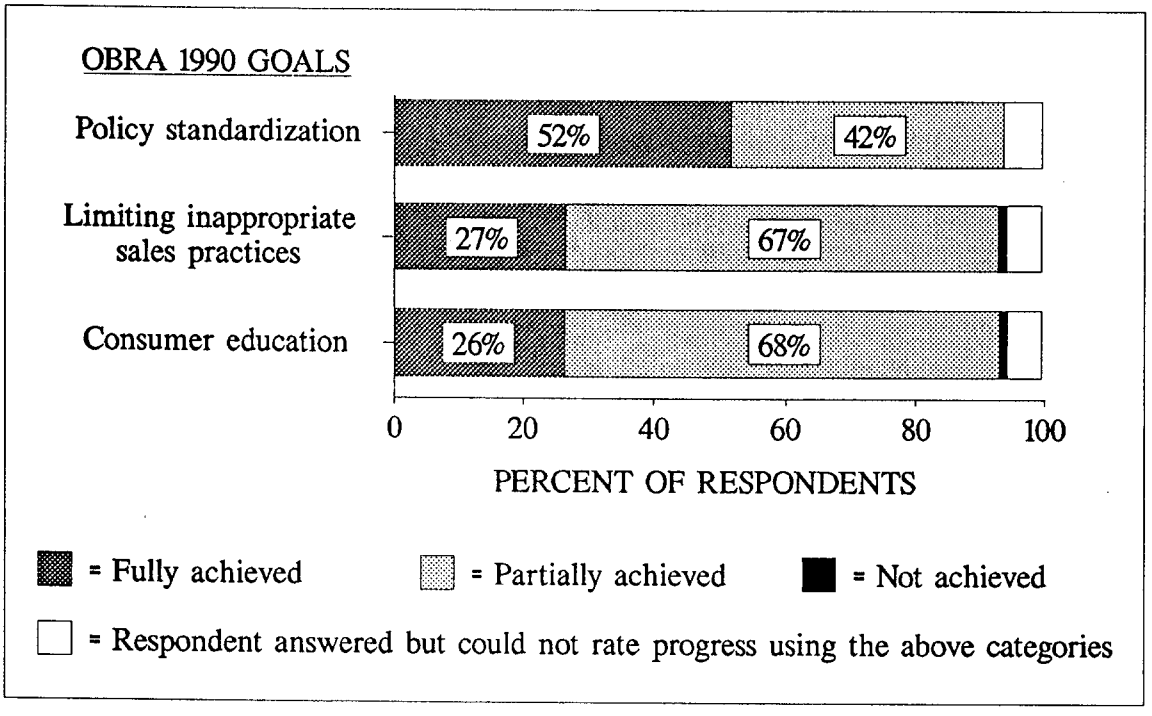
We also learned that NAIC enhances communication among ICA grantees through its sponsorship of "The Senior Counseling Letter." The North Carolina ICA grantee was instrumental in starting this quarterly publication and produced the first editions. Subsequently, NAIC has produced and distributed it to all grantees. The newsletter solicits submissions from State programs and incorporates them into each issue, reflecting their outreach activity, innovative practices, and relevant social and legal issues.

IMPLEMENTATION OF 1990 MEDIGAP REFORMS HAS SUBSTANTIALLY IMPROVED STATE REGULATION OF MEDIGAP INSURANCE

Most respondents believe States are well on the way to achieving the objectives of OBRA 1990 Medigap reforms in less than two years since implementation

The main goals of the OBRA 1990 Medigap provisions were to help consumers choose insurance that best fits their needs through (1) standardizing policies, (2) reducing inappropriate sales and marketing practices, and (3) educating consumers. As the following chart depicts, more than 90 percent of respondents believe each objective has been at least partially achieved and a majority said that standardization has been fully achieved. This response was consistent among the different groups of respondents.

RESPONDENTS' RATINGS OF PROGRESS TOWARD OBRA 1990 GOALS



Respondents agreed that OBRA 1990 has succeeded in simplifying the choices consumers have to make in buying Medigap insurance. They said standardizing benefits allows consumers to compare similar plans offered by different insurers. Some respondents cautioned, however, that choosing a Medigap policy remains challenging. Many consumers, they believe, lack sufficient understanding to make informed choices. They also were concerned that the ten standard plans may not

contain the best mix of benefits to meet consumers' needs. One consumer advocate noted that consumers' choices are easier, but not optimal:

> The passage of OBRA 1990 has absolutely made it easier for consumers to select, since they have only ten choices. Choosing from the wide range before could be confusing. However, the situation is not perfect, since none of the ten options may exactly fit consumer needs.

Respondents said instances of marketing abuse are much less prevalent since the implementation of OBRA 1990. Many respondents credited OBRA 1990 provisions, such as restrictions on commissions and detailed disclosure requirements, with decreasing inappropriate sales and marketing practices. Both SID and ICA grantee respondents told us that many recent consumer contacts have more to do with uncertainty about choosing a policy than with blatantly inappropriate marketing and sales practices. Yet 49 respondents, including those from 31 States, reported that some agents or insurers continue inappropriate practices in spite of the reforms. Other respondents fear that consumers continue to be vulnerable, because many still do not know what practices are inappropriate or how to avoid abuses.

Respondents believe consumer education is central to making informed choices easier for consumers and to preventing sales and marketing abuse. As described later in this report, many told us the ICA program is an important vehicle for educating consumers about choosing insurance to fit their needs. Two-thirds of respondents, however, believe this goal is only partially achieved, primarily because educational efforts have just recently begun and because education is an ongoing process. They believe improved and continued outreach is necessary to reach more consumers, especially minority and rural populations.

Many States have provided significant consumer safeguards by implementing standards exceeding the minimum standards required by OBRA 1990

Encouraged by NAIC, many States have adopted Medigap insurance standards exceeding those required by OBRA 1990. For example, approximately 75 percent of all States have adopted NAIC's recommendation to eliminate first-year sales commissions for all Medigap replacement policies. This action removed a major incentive for agents to sell consumers policies they do not need. Although the conference committee report accompanying OBRA 1990 reflected Congress's intent to prohibit first-year commissions for sales of policy upgrades, the final bill omitted this provision. The NAIC acceded to Congress's intent by adding a drafting note which encouraged States to modify their regulations accordingly. The NAIC advised, "If this phrase is removed, the payment of first-year commissions will not be allowed in any replacement sale. States will not jeopardize their approval by HCFA if they remove this language."

Several States have assured that agents will face severe consequences, including loss of licensure to sell insurance in that State, if they try to sell consumers Medigap policies

they do not need. As one SID staffer noted, "We require an agent certification that the consumer's current health coverage was reviewed and this new policy is appropriate to meet the consumer's needs." Legislation in other States prohibits agents from collecting more than one month's premium until consumers have examined their Medigap policies for 30 days. This motivates agents to return to see if consumers are satisfied with their policies.

A few States have adopted community rating of premiums as a consumer safeguard. Community rating of premiums eliminates automatic rate increases with age. States did this to respond to the increasing efforts of insurers to offer policies with premiums calculated by attained age. The cost of these plans increases automatically as the consumer grows older and is substantially higher in later years when consumers can no longer afford them. According to one respondent, community rating of premiums has eliminated both this problem and a major source of consumer complaints in his State.

At the time of our interviews, we found that some States had extended open enrollment to the disabled, something OBRA 1990 did not do. Many ICA and advocate respondents complained that the disabled could not take advantage of the open enrollment period available to beneficiaries first enrolling in Medicare Part B at age 65. Open enrollment gives beneficiaries six months in which insurers may not deny them coverage because of health problems. The recent amendments to the Social Security Act require that an open enrollment period be available to all beneficiaries aged 65, including those who had been enrolled in Medicare Part B prior to age 65 due to end-stage renal disease or disability. Some States had extended open enrollment to the disabled and required insurers to offer at least one policy to disabled Medicare beneficiaries, even before the federal amendments. Currently, some States, such as Oklahoma and Pennsylvania, exceed the legislative requirement by requiring open enrollment for disabled persons of any age.

Most States reported more efficient Medigap policy review since implementing OBRA 1990

Almost 60 percent of all insurance commissioners and 75 percent of sample State policy review staff said that their State's review and approval of Medigap policies is more efficient since implementing the OBRA 1990 Medigap provisions. Of those who provided comments, most explained that OBRA 1990 has streamlined their review process. One policy reviewer described a typical change in the process:

> We used to have a huge variation in policies submitted. We would have to decide in each case if the benefits justified the policy. Now the policies are all standard with the ten allowed models, and we don't have to decide about benefits to the individual. Our reviews are standardized and don't take the time they used to.

Most of the respondents who expressed different views said that their States already had efficient review procedures in place or that their review process did not change.

A few others reported that the review of the standard plans requires a more detailed and time-consuming review.

Consumer education programs are growing and essential

Many respondents believe that the ICA program not only is effective but also is important to achieving the OBRA 1990 consumer education objective. Forty-one respondents, including most advocates, volunteered their belief that the ICA program is vital to consumer education efforts. As one advocate explained, the ICA program provides accurate, unbiased consumer information about Medigap. Another consumer advocacy organization stated that "consumer education has been enhanced, especially with the increased number of staff and volunteers in the ICA grant program." Even some insurers recognized the importance of consumer education. For example, one insurer acknowledged that, through the ICA program, "at least consumers have somewhere to turn for help with difficult decisions."

Approximately one quarter of all respondents believe ICA programs need to address the consumer confusion resulting from the complexity of Medigap insurance and the Medicare program. These respondents emphasized the urgency to provide direct consumer education, counseling, and outreach, especially since there are always new groups of people eligible for Medicare.

Respondents in most States believe Medigap complaints have declined since the implementation of OBRA 1990

Most State commissioners and sample State complaint resolution staff said the number of Medigap complaints has decreased since OBRA 1990. However, only a few of the sample States knew what their actual complaint receipts and pending workloads were. A SID respondent who handles complaints in one State told us:

> We are getting fewer complaints each quarter. Prior to OBRA 1990, we used to get a lot of complaints about rates and doctor payments. Now [we get] very few about anything, although I can't give you any exact figures. The Medigap standardization has been so successful that we would like to see it extended to other kinds of health insurance.

Although respondents told us Medigap complaints generally have decreased, the number of complaints, they said, was never very large. Complaint resolution staff in the two sample States with the largest Medicare populations noted that the annual number of Medigap complaints is fewer than 500 out of more than 100,000 total complaints received for all insurance product lines. Other States made similar comments about the small size of their Medigap complaint workloads.

Some respondents reported that the types of complaints they receive have changed since the implementation of OBRA 1990. For example, there are fewer complaints about claims because policy coverage is now standard. In some States, the number of marketing-

and sales-related complaints has decreased due to OBRA 1990 restrictions on first-year sales commissions and duplicative policies. As discussed on page 11, many States have adopted more stringent standards than required by OBRA 1990. This action has also helped to decrease complaints. On the other hand, some respondents in different States told us that complaints have increased as consumers are more aware of their rights.

We reviewed data from NAIC's Complaints Database System for complaints closed in 1993 and found no apparent relationships between the regulation of Medigap insurance and the nature of complaints in the 16 sample States. Analysis of complaint data by the types of policy, rate, and marketing review sample States use made no clear connection with the number of complaints closed, the ratio of complaints per Medicare population, or the reasons for complaints. We did not draw distinctions in how sample States perform market conduct exams or resolve complaints, precluding analysis of variations in closed complaints. As noted in our discussion about this database below, having only closed complaints to analyze prevents any reasonable comparison of State activity, since the full size and nature of workloads is unknown.

MOST RESPONDENTS BELIEVE THE FEDERAL/STATE COLLABORATION TO IMPLEMENT OBRA 1990 WAS EFFECTIVE

Approximately 85 percent of all respondents believe that Federal/State collaboration to implement OBRA 1990 Medigap provisions has been effective. A consumer advocate reflected the views of many, saying, ". . . most of the problems which plagued Medigap were solved or minimized by the cooperation of States, the Feds, and NAIC." Even most insurers believe the process worked well. A national insurers organization "strongly supports and encourages the continued use of the [OBRA 1990 implementation process]."

A few respondents believe that collaboration was not effective or was problematic. The problems cited included consumer hardships resulting from the anti-duplication provision and the long delay in issuing Federal regulations. Ten who believe collaboration has worked well nevertheless mentioned the need for technical correction of the anti-duplication provision. Others cited problems with Federal responsiveness, such as not getting prompt answers to questions.

SEVERAL ISSUES WARRANT FURTHER ACTION

Respondent comments and our analysis of complaint data highlight three issues that warrant action by HCFA. These issues concern the ICA program, NAIC's Complaints Database System, and the anti-duplication provision.

Respondents questioned the adequacy of HCFA's role in promoting the ICA program; HCFA has plans to work more directly with State programs

While most respondents recognize the important role played by the ICA program, some believe that HCFA has not given it adequate priority. For example, one advocate believes that HCFA had no clear idea of what the ICA programs should do and only began to clarify Federal policy and program standards after the initial funding. A few ICA grantees said HCFA's failure to publish notices nationally about the role of the ICA program illustrates the low priority HCFA gives the ICAs. In a typical comment, one ICA grantee said each State has to approach the local Social Security office, Medicare carriers, and fiscal intermediaries for help to get information to beneficiaries. The grantee concluded that "a sincere commitment to successful ICA programs would have built these bridges up front."

The HCFA is aware of ICA grantee concerns and is acting to respond to them. For fiscal year 1994, HCFA distributed $242,108 among the ten HCFA regional offices for the support of ICA grantees in each region. Funds were used for travel, contracts, equipment purchases, and other materials and services. Additionally, Medigap coordinators in each region support State ICA programs by assisting in training staff and volunteers, providing technical support, assisting with publicity and outreach, and creating pamphlets and brochures.

The NAIC's Complaints Database System has the potential to be an effective analytical tool for HCFA; HCFA and NAIC are working on ways to improve it

The NAIC established the Complaints Database System in October 1991 as a central repository for closed consumer complaints against insurers and agents regulated by NAIC-member States. The system was designed primarily to facilitate market conduct examinations of companies and to identify national, regional, and State trends that may be observed from complaints analysis. State reporting of complaint data to NAIC is voluntary.

Although NAIC did not create the Complaints Database System to be a monitoring tool for HCFA, it has the potential to be an effective one. We identified several changes that could improve the usefulness of the database as an effective analytical tool. These changes involve data that the system currently does not collect as well as more consistent reporting of required data.

Since States do not report received and pending Medigap complaints, there is no way to determine the size of the complaint workload at any specific time. This negates the potential for identifying patterns of behavior among consumers, insurers, and agents that inform policy makers who seek to improve Medigap products and protect consumers. Looking only at closed complaints prevents any reasonable comparison of State activity, since it reveals nothing about investigations in progress.

Sample States differ in the date they use to close a complaint, when making a referral for disciplinary action. Nationwide in 1993, six States closed 38 complaints when they made referrals for administrative or law enforcement action. They closed the complaints because their final resolution could take months or years. On the other hand, one State is holding open more than 60 complaints until such final resolution. That State's average complaint processing time is almost nine months, the highest in the country. Such variations make the analysis of complaint processing time difficult and any results unreliable. The NAIC's instruction to States emphasizes using the date the complaint is referred for disciplinary action as the date the complaint is closed. However, the instruction leaves the choice of a closing date to the State.

Other changes address the incomplete reporting of policy type and consumer age data fields. Among the 16 sample States, 44 percent of data on the type of Medigap policy the consumer has are missing, as are 79 percent on the age of the policyholder. Such data would be crucial if Congress were to consider revising the number and type of Medigap policies to make available to Medicare beneficiaries of all ages.

Finally, sample States make excessive use of the "Other" code in recording complaint data. For example, in the 16 sample States 25 percent of complaint dispositions are coded "Other," as are 8 percent of data on the source of the complaint. The use of this category indicates a possible limitation in the definitions available for complaint disposition and source, varying interpretations by different staff of the case facts, or inappropriate coding when the best choice is not immediately evident. It should be noted that sometimes multiple dispositions result from one complaint, including the disposition "Other." (See appendix B for the data collection fields and the characteristics of closed Medigap complaints reported nationally for 1993.)

The HCFA has negotiated with NAIC to modify the Complaints Database System to incorporate changes that would strengthen its use as an analytical tool. Also, NAIC is in the process of analyzing the use of "Other" to determine whether the disposition codes need to be expanded to include additional common dispositions and reduce the use of the "Other" code.

Many respondents found the anti-duplication provision of OBRA 1990 hindered some beneficiaries from obtaining Medigap coverage; HCFA is working with NAIC and the States to incorporate clarified provisions into State law

While nationally respondents agreed that the anti-duplication provision has curtailed the sale of duplicative and unnecessary insurance, at the time of our interviews many maintained that it also unjustly penalized some consumers. The anti-duplication provision prohibited insurers from selling Medigap policies to a beneficiary if the insurer knew that the policy duplicates Medicare, Medicaid, or other health benefits to which the beneficiary is entitled. But the strict wording of the provision meant that many beneficiaries who needed Medigap coverage were not able to buy it because they already had long-term care, hospital indemnity, or employer group health insurance. Respondents pointed out these beneficiaries had a difficult choice: (1) to

forgo Medigap coverage or (2) to drop their current coverage, which generally costs them little or frequently contains more desirable benefits, such as extended prescription drug coverage. (See appendix A, page A-2, for a description of standard Medigap benefits.)

According to respondents, State regulators interpreted the anti-duplication provision differently, resulting in inconsistent enforcement. Some States followed the provision strictly, while others allowed concurrent coverage with limited benefit plans or long-term care insurance. For this reason, they considered duplication of policies to be continuing in their States. At the time of our interviews, respondents emphasized the need for technical correction or clarification from HCFA to aid them in interpreting the provision. Since then, the Social Security Act Amendments of 1994 have clarified that knowingly selling a duplicate Medigap policy to someone who already has Medigap coverage is not allowed, while selling a Medigap policy to someone who has other private health insurance is allowed as long as the Medigap policy pays benefits regardless of the other insurance. The HCFA is now working with NAIC and the States to incorporate these changes into State law.

APPENDIX A

THE OBRA 1990 MINIMUM MEDIGAP STANDARDS

- *Standardization of Medicare supplemental policies into no more than ten packages to assist beneficiaries in comparative shopping for a policy;*
- *Guaranteed renewability;*
- *Suspension of Medigap benefits and premiums during Medicaid eligibility (for up to 24 months if the beneficiary notifies the insurer within 90 days of the start of Medicaid eligibility. Medigap benefits will be renewed if the beneficiary notifies the insurer within 90 days after Medicaid eligibility ends);*
- *New and higher loss ratio requirements for individual policies (65 percent instead of 60 percent) and for group policies (75 percent) and required refunds or credits if the policies do not meet the loss ratio requirements;*
- *Pre-existing conditions limitation (pre-existing conditions may only be imposed in a replacement policy to the extent such conditions were not met under the original policy);*
- *Restrictions on medical underwriting (six-month open enrollment period for new Part B enrollees who are 65 or older);*
- *State assurances that they will maintain and make publicly available copies of all policy forms approved in the State, along with information on the policy premium and loss ratio data for the past three years;*
- *Implementation of a process for approving or disapproving premium increases and establishment of a policy, whereby insurance commissioners may hold public hearings prior to approval of a premium increase;*
- *Required filing in all States in which a policy is marketed (deemed approval of mail order policies is no longer permitted);*
- *Clarification that Health Maintenance Organizations are excluded from the definition of a Medicare supplement only when they are providing Medicare benefits pursuant to a Federal contract under section 1876 or 1833 or a demonstration authority; and*
- *Prohibition against virtually any sale of duplicative health insurance coverage to Medicare beneficiaries (including prescribed questions that must be asked and declarations made by both the buyer and seller on the policy application form).*

THE TEN STANDARD MEDIGAP POLICIES

	A	B	C	D	E	F	G	H	I	J
CORE BENEFIT: Coverage of Part A coinsurance amount ($174 per day in 1994) for the 61st through 90th day of hospitalization in each Medicare benefit period.	•	•	•	•	•	•	•	•	•	•
CORE BENEFIT: Coverage for the Part A coinsurance amount ($348 per day in 1994) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.	•	•	•	•	•	•	•	•	•	•
CORE BENEFIT: After all Medicare hospital benefits are exhausted, coverage for 100 percent of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime.	•	•	•	•	•	•	•	•	•	•
CORE BENEFIT: Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with Federal regulations.	•	•	•	•	•	•	•	•	•	•
CORE BENEFIT: Coverage for the coinsurance amount for Part B services (generally 20 percent of approved amount) after $100 annual deductible is met.	•	•	•	•	•	•	•	•	•	•
Coverage for the Medicare Part A inpatient hospital deductible ($696 per benefit period in 1994).		•	•	•	•	•	•	•	•	•
Coverage for the skilled nursing facility care coinsurance amount ($87 per day for days 21 through 100 per benefit period in 1994).			•	•	•	•	•	•	•	•
Coverage for the Medicare Part B deductible ($100 per calendar year in 1994).			•			•				•
Coverage for 80 percent of medically necessary emergency care in a foreign country, after a $250 deductible.			•	•	•	•	•	•	•	•
Coverage for at-home recovery. This benefit pays up to $1600 per year for short-term, at-home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.				•			•		•	•
Coverage for preventive health care. This benefit pays up to $120 per year for such things as a physical examination, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.					•					•
Coverage for 100 percent of Medicare Part B excess charges (difference between Medicare approved amount and actual charges).						•			•	•
Coverage for 80 percent of Medicare Part B excess charges (difference between Medicare approved amount and actual charges).							•			
Basic coverage for 50 percent of the cost of prescription drugs up to a maximum annual benefit of $1250 after the policyholder meets a $250 per year deductible.								•	•	
Extended coverage for 50 percent of the cost of prescription drugs up to a maximum annual benefit of $3000 after the policy holder meets a $250 per year deductible.										•

APPENDIX B

THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' STANDARD COMPLAINT DATA FORM AND THE CHARACTERISTICS OF MEDIGAP COMPLAINTS

The following pages include a copy of the National Association of Insurance Commissioners' (NAIC) Standard Complaint Data form and tables that summarize the characteristics of national Medigap complaints, including reason for complaint, disposition, type of Medigap policy, source of complaint, and age of insured. We calculated these statistics using NAIC's database of complaints that State insurance departments closed during calendar year 1993. This is the same database that NAIC routinely sends to the Health Care Financing Administration. In these tables, the total percents may not exactly equal the sum of individual percents because of rounding. We did not attempt to verify the data contained in the NAIC Complaints Database System.

NAIC STANDARD COMPLAINT DATA

FIELDS WHICH ARE SHADED ON THIS FORM SHOULD BE USED FOR REPORTING MEDICARE SUPPLEMENT COMPLAINT INFORMATION THROUGH THE CDS.

State: _____ State Complaint No.: _____ Date Opened: ___/___/_____ (M M D D Y Y Y Y) Date Closed: ___/___/_____ (M M D D Y Y Y Y)

COMPLAINT AGAINST

Entity Name: _____ NAIC Entity No.: _ _ _ _ _ _ _

CoCode: _____ AA / FEIN: ___-_____ Entity Type Code: _____ Function Code: _ _ _

SSN: ___-___-_____ DOB: ___/___/_____ (M M D D Y Y Y Y) Phone: (___) ___-_____

Address: _____ City: _____ St: _____ Zip: _____-_____

COMPLAINANT / INSURED INFORMATION

Complainant Zip Code: _____ Insured Age Group: 1 2 3 4 *Age Group Codes: 1 = < 25 2 = 25 to 49 3 = 50 to 64 4 = 65+*

Complainant Type Code: _____ *Complainant Type Codes: INS = Insured; BEN = Beneficiary; PRO = Producer; THP = Third Party; OTH = Other*

Medicare Supplement Policy Type Code: _____ *Standardized Medicare Supplement Benefit Plan Codes: "A" through "J", "O" or "P"*

TYPE OF COVERAGE

Select only one item from the first level of coverages listed; up to 3 may be selected from the second level.

AUTO

First Level

- 0105 Private Passenger
- 0110 Commercial
- 0115 Motorcycle
- 0120 Motorhome
- 0125 Other

Second Level

- 0130 Liability
- 0135 Physical Damage
- 0140 Medical Payments
- 0145 UM/UIM
- 0150 No-Fault / PIP
- 0155 JUA Related
- 0160 Other

FIRE, ALLIED LINES & CMP

- 0205 Fire, Allied Lines
- 0210 Commercial Multi-Peril
- 0215 Credit Property
- 0220 Other

- 0225 Liability
- 0230 Theft
- 0235 Fire - Real Property
- 0240 Personal Property
- 0245 Other

HOMEOWNERS

- 0305 Homeowners
- 0310 Farmowner/Ranchowner
- 0315 Mobile Homeowner
- 0320 Other

- 0325 Liability
- 0330 Theft
- 0335 Fire - Real Property
- 0340 Personal Property
- 0345 Other

LIFE AND ANNUITY

- 0405 Individual Life
- 0410 Group Life
- 0415 Annuities
- 0420 Credit Life
- 0425 Accelerated Benefits
- 0430 Other

ACCIDENT AND HEALTH

- 0505 Individual
- 0510 Group
- 0515 Credit
- 0517 Other

Second Level

- 0520 Accident Only
- 0525 Disability Income
- 0530 Health Only
- 0535 Medicare Supplement
- 0536 Medicare Select
- 0540 Long-Term Care
- 0545 Dental
- 0550 Hospital Indemnity
- 0555 Cancer / Dread Disease
- 0560 Other

LIABILITY

- 0605 General
- 0610 Products
- 0615 Professional / E & O
- 0620 Other

MISCELLANEOUS

- 0705 Workers' Compensation
- 0710 Fidelity & Surety
- 0715 Ocean Marine
- 0720 Inland Marine
- 0725 Title
- 0730 Mortgage Guaranty
- 0735 Damage Waiver
- 0740 Warranty Contract
- 0741 Federal Programs
- 0745 Other

REASON FOR COMPLAINT

Select up to three (3) items per category.

UNDERWRITING

- 0805 Premium & Rating
- 0810 Refusal to Insure
- 0815 Cancellation
- 0816 Nonrenewal
- 0820 Delays
- 0825 Unfair Discrimination
- 0830 Endorsement / Rider
- 0835 Group Conversion
- 0840 Continuation of Benefits
- 0841 Medicare Supplement: Refusal to Insure During Open Enrollment Period
- 0842 Medicare Supplement: Refusal to Insure After Open Enrollment Period
- 0845 Other

POLICYHOLDER SERVICE

- 1105 Premium Notice/Billing
- 1110 Cash Value
- 1115 Delays / No Response
- 1120 Premium Refund
- 1125 Coverage Question
- 1126 Access to Care
- 1127 Quality of Care
- 1130 Other

CLAIM HANDLING

- 1005 Unassistactory Settlement/Offer
- 1010 Post-Claim Underwriting
- 1015 Denial of Claim
- 1020 Coordination of Benefits
- 1025 Delays
- 1030 Cost Containment
- 1035 Other

MARKETING & SALES

- 0905 Misleading Advertising
- 0910 Agent Handling
- 0915 Misrepresentation
- 0920 Twisting
- 0921 Deceptive Cold Lead Advertising
- 0922 High Pressure Tactics
- 0923 Duplication of Coverage
- 0925 Delays
- 0930 Other

DISPOSITION

Select up to three (3) items.

- 1205 Policy Issued/Restored
- 1210 Additional Payment
- 1215 Refund
- 1220 Coverage Extended
- 1225 Claim Reopened
- 1230 Claim Settled
- 1235 No Action Requested / Required
- 1240 Referred to Proper Agency
- 1245 Advertising Withdrawn / Amended
- 1250 Underwriting Practice Resolved
- 1255 Delay Resolved
- 1260 Cancellation Notice Withdrawn
- 1265 Nonrenewal Notice Rescinded
- 1270 Premium Problem Resolved
- 1275 Apparent Unlicensed Activity
- 1280 Referred for Disciplinary Action
- 1285 Question of Fact
- 1290 Contract Provision / Legal Issue
- 1295 Company Position Upheld
- 1300 No Jurisdiction
- 1305 Insufficient Information
- 1310 Other

Rev. 11.09.92

TABLE 1: REASON FOR MEDIGAP COMPLAINTS

REASON FOR COMPLAINT	CODE IN DATABASE	NUMBER OF COMPLAINTS	PERCENT
Claim handling	1005 to 1035	1,080	34.8
Policyholder service	1105 to 1130	819	26.4
Marketing and sales	0905 to 0930	606	19.5
Underwriting	0805 to 0845	599	19.3
TOTAL NUMBER OF COMPLAINT REASONS		3,104	100.0

In this table, the total number of complaint reasons does not equal the total number of complaints (2,799), because 214 complaints contain 2 reasons, 41 contain 3 reasons, and 3 contain 4 reasons.

TABLE 2: DISPOSITION OF MEDIGAP COMPLAINTS

DISPOSITION OF COMPLAINT	CODE IN DATABASE	NUMBER OF COMPLAINTS	PERCENT
Company position upheld	1295	488	15.8
Refund	1215	468	15.1
Claim settled	1230	332	10.7
No action requested or required	1235	236	7.6
Contract provision or legal issue	1290	216	7.0
All 16 remaining dispositions (excluding those coded "other")	All remaining codes except 1310	792	25.6
Dispositions coded "other"	1310	560	18.1
TOTAL NUMBER OF COMPLAINT DISPOSITIONS		3,092	100.0

In this table, the total number of complaint dispositions does not equal the total number of complaints (2,799), because 269 complaints contain 2 dispositions and 12 contain 3 dispositions.

TABLE 3: COMPLAINTS BY TYPE OF MEDIGAP POLICY

TYPE OF MEDIGAP POLICY*	CODE IN DATABASE	NUMBER OF COMPLAINTS	PERCENT
Type A	A	179	6.4
Type B	B	102	3.6
Type C	C	80	2.9
Type D	D	26	0.9
Type E	E	5	0.2
Type F	F	165	5.9
Type G	G	9	0.3
Type H	H	12	0.4
Type I	I	37	1.3
Type J	J	18	0.6
Policies issued prior to OBRA 1990 and no longer offered in the State	P	694	24.8
Other	O	332	11.9
Missing data	Blank	1,140	40.7
TOTAL NUMBER OF COMPLAINTS		2,799	100.0

*For descriptions of these Medigap policy types, see appendix A.

TABLE 4: SOURCE OF COMPLAINT FOR MEDIGAP COMPLAINTS

SOURCE OF COMPLAINT	CODE IN DATABASE	NUMBER OF COMPLAINTS	PERCENT
Insured	INS	2,288	81.7
Third party	THP	168	6.0
Producer (agent, broker, solicitor, etc.)	PRO	48	1.7
Beneficiary	BEN	14	0.5
Other	OTH	280	10.0
Missing data	Blank	1	0.0
TOTAL NUMBER OF COMPLAINTS		2,799	100.0

For Medigap insurance products, the terms "insured" and "beneficiary" used in this table generally refer to the same thing--the person insured and eligible for benefits through the policy. In the NAIC Complaints Database System, however, States have the discretion to enter data according to their own definitions. Some States may consider a spouse covered under a joint Medigap policy to be a beneficiary rather than the insured, for data entry purposes.

TABLE 5: AGE OF INSURED FOR MEDIGAP COMPLAINTS

AGE CATEGORY	CODE IN DATABASE	NUMBER OF COMPLAINTS	PERCENT
Under age 25	1	9	0.3
25 to 49	2	11	0.4
50 to 64	3	17	0.6
65 and older	4	750	26.8
Missing data	Blank	2,012	71.9
TOTAL NUMBER OF COMPLAINTS		2,799	100.0

APPENDIX C

HCFA COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

FEB 24 1995

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "The Impact of the Omnibus Budget Reconciliation Act of 1990 on State Regulations of Medigap Insurance," (OEI-09-93-00230)

We reviewed the above-referenced report in which OIG expressed concerns about the Health Care Financing Administration's support for the information, counseling, and assistance grantee program, and the usefulness of the Medigap complaints data base system as an analytical tool.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this draft report. Please contact us if you would like to discuss our comments and response.

Attachment

IG	____
SAIG	____
PDIG	____
DIG-AS	____
DIG-EI	✓
DIG-OI	____
AIG-CFAA	____
AIG-MP	____
OGC/IG	____
EXSEC	✓
DATE SENT	2-27

Health Care Financing Administration's (HCFA's) Comments
on Office of Inspector General (OIG) Draft Report:
The Impact of the Omnibus Budget Reconciliation Act 1990
on State Regulations of Medigap Insurance
OEI-09-93-00230

OIG Recommendation

HCFA should implement plans for direct regional office (RO) assistance to information, counseling, and assistance (ICA) grantees.

HCFA Response

We concur with this recommendation. While a few of the ROs supported the ICA program from its inception, not all regions provided direct support. In response to comments at a meeting in Denver, in March 1994, by several of the ICA State representatives, HCFA took positive steps to involve all of the ROs. Beginning in late July 1994, HCFA made funds available to the ROs for ICA support activities. For fiscal year 1994, $242,108 was allocated to the ROs for travel, contracts, equipment purchases, and other materials and services in support of the ICA programs. There are Medigap coordinators designated in each RO in the Division of Medicare, usually in the beneficiary services area. These coordinators also work with the State Offices of Aging to develop responses to requests for information by beneficiaries. The ROs support the State programs by assisting in training staff and volunteers, furnishing technical support, assisting in publicizing the programs in the various media including TV, radio, newspapers, newsletters, and communicating through computer bulletin boards. The ROs also assist in the creation of various written materials including pamphlets and brochures.

OIG Recommendation

HCFA should consider expanding the complaints data base system to reflect received, closed, and pending Medigap complaints; direct State insurance departments (SID) to furnish key required data, such as policy type, for each reporting period; clarify instructions to assure uniform reporting of data by States.

HCFA Response

We concur with this recommendation. Our initial plans were to collect these types of complaints and the data base was designed to allow entry of these complaints. However, we had to rely on the National Association of Insurance Commissioners (NAIC) to provide data from their complaint data base system in the past, because we did not have approval from the Office of Management and Budget to collect complaints data (clearance was received December 1993 for closed complaints only). Therefore, we could not compel States to furnish this information.

In order to capture data on received, open, and pending complaints, we will have to revise the original clearance request to include these elements. Current staffing constraints preclude us from starting work on this activity at this time. We will keep you informed of our progress.

Additionally, we have discussed with NAIC the requirement for SIDs to furnish key data, and we have negotiated data collection requirements with them. NAIC has also agreed to ensure that States provide the required data for transmission to HCFA.

Finally, we have determined that a data dictionary is needed to clarify meanings of terms to ensure uniform reporting. We plan to develop the dictionary and negotiate its implementation with NAIC and the States.

OIG Recommendation

HCFA should work with the NAIC and SIDs to encourage States to adopt consumer safeguards exceeding the minimum standards, including open enrollment for the disabled and community rating of premiums.

HCFA Response

We concur with this recommendation. HCFA favors strengthening beneficiary safeguards with regard to Medigap insurance. We have supported technical amendments that were passed recently in the Social Security Act Amendments of 1994 (the Act). In part, these amendments require that, effective January 1995, the 6-month open enrollment period for Medigap policies begins with the first month that a beneficiary is age 65 or older and is enrolled for benefits under Part B. This clarifies that the open enrollment period applies to all beneficiaries who are age 65, including those who had been entitled to Part B benefits prior to age 65 as a result of end-stage renal disease or disability.

Beneficiaries who turned age 65 after the effective date of the original open enrollment provision (November 5, 1991) and who did not receive an open enrollment period because they were previously entitled to Part B will be given a one-time 6-month open enrollment period beginning January 1, 1995. Also, some States now require open enrollment for the disabled at any age (Oklahoma and Pennsylvania). We would support any State program that adopted such provisions.

Additionally, HCFA has also recognized the inequities associated with the use of attained-age rates in the Medigap market. We are also pursuing a legislative proposal to mandate the use of community rating for Medigap policies.

TECHNICAL COMMENTS

The text at the top of page 16 discusses proposed legislation for certain issues, including antiduplication. Those proposals have been enacted as the Act. You may want to update the report to reflect these amendments.

Also, the source of the data in the Tables found in Appendix B should be identified. Table 4 contains both "insured and beneficiary" as sources of complaints. The report should explain the distinction between them.