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MEDIGAP INSURANCE

Alternatives for Medicare Beneficiaries to Avoid Medical Underwriting

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Human Services Division

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United States Senate

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Ranking Minority Member
Committee on Commerce
House of Representatives

Although the Medicare program covers a substantial portion of its beneficiaries' health costs, it does require deductibles and coinsurance that can amount to thousands of dollars a year. As a result, over 75 percent of elderly beneficiaries—about 22 million people—obtain private insurance to help cover out-of-pocket costs. The most common type of Medicare supplemental coverage is individually purchased Medigap policies. Some Medigap policies also cover some items not covered by Medicare, such as prescription drugs and services received while out of the country. On occasion, beneficiaries decide to change Medigap policies and at that time may become subject to medical underwriting; that is, the insurer can take into account a person's health status or health history in deciding whether to sell a policy.

A provision in Public Law 104-18 (July 7, 1995) required us to study the extent to which individuals who have been continuously covered under Medigap are subject to having their health status and history affect whether they can obtain a new policy if they want to change policies. The statute also called for us to identify options for modifying the Social

Security Act's federal Medigap requirements to ensure that medical underwriting is not a problem in such cases.

To do this work, we reviewed the underwriting policies of the 25 largest Medigap insurers who, in total, write about 65 percent of the Medigap business. We also analyzed data from the Department of Health and Human Services' (HHS) Health Care Financing Administration's (HCFA) surveys of Medicare beneficiaries to estimate how many changed health plans over the 1991-94 period. In addition, we reviewed data maintained by the National Association of Insurance Commissioners (NAIC) on complaints about Medigap policies and discussed complaints and issues about medical underwriting with selected state insurance departments, consumer groups, and NAIC. We performed our work from October 1995 through July 1996 in accordance with generally accepted government auditing standards. (See app. I for details on our methodology.)

Results in Brief

During the 6 months after a person turns age 65 and enrolls in Medicare part B, federal law guarantees the opportunity to purchase a Medigap policy. After that, Medigap insurers are permitted to refuse to sell policies because of an applicant's health history or status, and insurers do exercise this option. Of the 25 largest Medigap insurers, 11 use medical underwriting to decide to whom to sell their policies, 5 sell some policies without checking health histories, and the remaining 9 offer their policies without checking applicants' health history or status.

Currently, all Medicare beneficiaries, regardless of their health history or status, have at least one alternative available to them to supplement their Medicare coverage after the 6-month guarantee period. Seven of the 10 policies offered through the American Association of Retired Persons (AARP) and issued by the Prudential Insurance Company of America are available without medical underwriting to AARP members, and AARP membership is open to all elderly Medicare beneficiaries. Depending on where beneficiaries reside, the local Blue Cross/Blue Shield plan may also offer Medigap policies without medical underwriting. While these alternatives are available today to people wishing to change Medigap policies without medical underwriting, there is no federal requirement that such alternatives be available in the future.

In lieu of purchasing a Medigap policy, another alternative available to some beneficiaries is enrollment in a health maintenance organization

(HMO) that has a Medicare risk contract.[1] HMOs often offer reduced, or no, cost-sharing for Medicare services and cover some additional services. Some HMOs charge a premium for the expanded coverage, while others do not. Medicare requires HMOs to have annual open enrollment periods and to accept beneficiaries on a first-come, first-served basis. However, when beneficiaries enroll in an HMO, they normally have to use the physicians, hospitals, and other providers on the HMO's panel. If a beneficiary chooses to leave an HMO and switch to fee-for-service care, the same alternatives to medical underwriting would be available as mentioned above for Medigap policyholders who choose to switch policies.

As a rule, Medicare beneficiaries do not switch private health plans, such as Medigap policies and employer-sponsored plans. HCFA's ongoing Medicare surveys show that 99 percent of beneficiaries who had private plans in 1991 and were still alive in 1994 had the same plan in 1994. About 1 percent of beneficiaries either switched plans, dropped plans, or made other changes during the 1991-94 period. Nevertheless, beneficiaries are affected by medical underwriting. For example, in 1995, one insurer received 83,000 applications after the 6-month open enrollment window had closed. These applications were subject to medical underwriting, and almost 1,100 beneficiaries were rejected for medical reasons.

Medicare beneficiaries have made few formal complaints to their state insurance departments about Medigap underwriting practices. The complaint data system maintained by NAIC included only 316 complaints for 1995 related to underwriting. It is not surprising that formal complaints are few because medical underwriting is permissible, and policyholders are usually informed of this at the informal telephone contact stage of the complaint process.

Because current alternatives for beneficiaries who want to change Medigap policies without being subject to medical underwriting are not required by federal law to be available, they might be discontinued in the future. If the Congress is concerned by this, the federal Medigap provisions could be amended to require that beneficiaries continuously enrolled in Medigap be given the opportunity to switch policies without being subject to medical underwriting.

[1]Risk-contract HMOs agree with HCFA to provide all Medicare-covered services in exchange for a fixed monthly payment for each beneficiary who enrolls in the HMO. The HMO retains as profit any Medicare payment in excess of its costs of treating beneficiaries while it suffers a loss if costs exceed payments.

Background

Medicare is a federal health insurance program that helps its beneficiaries pay for health services. The program does not cover every type of health service, and beneficiaries are responsible for deductibles and coinsurance. Medigap insurance, which is designed to supplement Medicare's benefits, is regulated by federal and state law. Insurers must meet federal and state requirements to market policies as Medigap insurance.

Section 1882 of the Social Security Act established federal requirements for the marketing, benefits, and performance of Medigap policies. Starting in 1992, Medigap policies were required to conform to 1 of 10 standardized sets of benefits, referred to as plans A through J. For example, standard policy A covers Medicare coinsurance; policy C covers Medicare coinsurance and inpatient deductibles; and policy J covers these cost-sharing components as well as several services not covered by Medicare, such as prescription drugs. These are the only Medigap plans that can be sold in most states.[2] Companies are not required to offer all 10 plans, and many do not. (See app. II for a description of the items covered under each of the 10 plans.)

The Omnibus Budget Reconciliation Act (OBRA) of 1990[3] authorized the Medicare SELECT program, a 3-year demonstration project in 15 states. Medicare SELECT policies combine certain managed care concepts with the 10 standard Medigap policies. SELECT policies require the insured to use the doctors and hospitals on the plan's provider panel or pay higher cost-sharing amounts. The SELECT program was extended to June 30, 1998, and expanded to all states by Public Law 104-18.

Federal law guarantees that, for a period of 6 months from the date a Medicare beneficiary both enrolls in Medicare part B and is age 65 or older, the beneficiary has a right to buy the Medigap policy of his or her choice regardless of any health problems the beneficiary may have. The Medigap open enrollment period at age 65 is also available to all disabled and kidney failure beneficiaries who have previously enrolled in Medicare part B. Thus, Medigap policies are required to be "guaranteed issue" during the 6-month period. Once the 6-month Medigap open enrollment period starts, it cannot be extended or repeated. Beneficiaries are informed of the 6-month open enrollment period when they enroll in Medicare.

[2]Minnesota, Massachusetts, and Wisconsin have waivers to the 10-plan requirement and operate their own programs that limit the number of policy types that can be sold. In each case, the state allows fewer than the federal limit.

[3]P.L. 101-508, Nov. 5, 1990.

Insurers who sell Medigap policies outside the open enrollment period are allowed to use medical underwriting. Prospective policyholders usually must complete an application form that includes several questions about their health and habits. A "yes" response to any question can trigger a rejection of the application.

Enrollment in an HMO with a Medicare risk contract can be viewed as a substitute for a Medigap policy. Like Medigap policies, HMOs often fill some of the gaps in Medicare coverage. In return for a fixed monthly payment from Medicare for each beneficiary enrolled, the HMO must provide or arrange for all services covered by Medicare. HMO enrollees generally must use the HMO's doctors and hospitals for all their care, except in emergencies. Services obtained outside the HMO network generally will not be paid for by either the HMO or Medicare. The HMO cannot reject an application because of bad health, except for permanent kidney failure. Some HMOs charge the beneficiary a premium for the benefits not otherwise covered by Medicare, while other HMOs do not.

Employer-sponsored retiree health insurance also acts as a Medigap policy for some Medicare beneficiaries. Although these plans generally provide benefits similar to those of Medigap policies, they are not regulated as Medigap insurance. Nor is limited-benefit insurance, such as hospital indemnity plans, long-term care policies, and cancer insurance, regulated as Medigap insurance.

Applicants for Medigap Insurance Are Often Subject to Medical Underwriting, but Alternatives Are Available

Medigap insurers are permitted to use medical underwriting after an individual's 6-month open enrollment period has closed, and many of them do. However, Medicare beneficiaries who wish to change Medigap policies have at least one alternative that does not involve medical underwriting and, depending on where they live, may have several alternatives. Although currently there are alternatives for Medigap policyholders to switch policies, federal law does not guarantee that those alternatives will continue in the future.

Under the Medicare SELECT program, NAIC's model regulation guarantees policyholders the ability to switch to at least the lowest-benefit Medigap plan if they decide to go back to a regular Medigap policy and if the SELECT insurer offers Medigap policies. Also, federal law requires risk-contract HMOs to offer an annual open enrollment during which all must be accepted in the order they apply up to the HMO's beneficiary enrollment limit.

Alternatives Available to Medigap Policyholders

Of the largest 25 Medigap insurers, 11 companies used medical underwriting for applicants who wished to purchase a Medigap policy after their 6-month open enrollment period expired. Five companies used medical underwriting for applicants for some policies, especially policies with prescription drug coverage, while offering other policies as guaranteed issue. The remaining nine companies offered all their policies as guaranteed issue. (See app. III for a list and selected characteristics of the 25 companies we reviewed.)

All 16 companies that used medical underwriting gathered information on applicants' medical history and health status on the Medigap application form. For example, applicants could be asked if they had had cancer. For 11 of the 16 companies, a "yes" response to any health question would lead to rejection of the Medigap application. The other five companies told us they would consider additional factors. For example, if an applicant indicated having had an illness during the last 5 years, one company would compare the illness with a list of deniable medical conditions before a determination was made.

Twelve of the 14 insurers that offered at least one policy as guaranteed issue were Blue Cross/Blue Shield companies, which had market areas generally limited to one state. Prudential, which sold its Medigap insurance through an arrangement with the AARP, offered 7 of the 10 Medigap standard plans as guaranteed-issue policies to AARP members, and membership was open to all elderly. Eleven of the 14 companies that sold at least one guaranteed-issue policy offered only the less comprehensive Medigap plans—those without prescription drug coverage—on a guaranteed-issue basis. The other three companies offered plans with prescription drug coverage. The various medical underwriting practices of the 25 companies are summarized in table 1.

Table 1: Medical Underwriting Practices of 25 Largest Medigap Insurance Companies

Insurer	Total	Medical underwriting applicable to all policies	Medical underwriting applicable to some policies	All guaranteed-issue policies
Blue Cross/Blue Shield	16	4[a]	4	8
Commercial	9	7	1	1[b]
Total	**25**	**11**	**5**	**9**

[a]One company offered some guaranteed-issue policies but at a higher premium rate.

[b]This company only sells Medigap policies in one state.

Six of the 16 companies that used medical underwriting were able to provide us with information on the number of applications they rejected. In 1995, the rejection rates for these companies ranged from 1 percent to 54 percent. The two highest rejection rates were from companies that required medical underwriting on policies with drug coverage but offered all other policies as guaranteed issue. One of the lower rejection rates, 2 percent, was reported by a company that requires underwriting for all policies. In 1995, this company received 83,000 applications from individuals whose 6-month open window had closed and rejected 1,096 applications for medical reasons. The reason most frequently cited by companies for rejecting an application was medical problems.

The majority of Medicare beneficiaries have policies issued before Medigap policies were standardized into 10 policy forms in 1992. These prestandardized policies can no longer be sold to new customers. Twelve of the 16 companies that submitted some or all of their applications to medical underwriting allowed their policyholders to switch from a prestandardized Medigap policy to a standardized Medigap policy without medical underwriting, if the benefits were comparable with or less comprehensive than those of the prestandardized policy. Two other companies allowed their prestandardized policyholders to switch into any standardized policy without medical underwriting. All 16 companies allowed a policyholder to switch from one standardized policy to a lesser-benefit standardized policy without medical underwriting. A switch to a policy that provided more benefits, in most cases, was subject to medical underwriting.

Medicare SELECT Policyholders Have Choices

Federal law requires insurers to offer Medicare beneficiaries who want to leave the Medicare SELECT program the option of purchasing a traditional Medigap policy. States have interpreted this requirement differently. However, the NAIC model regulations require SELECT insurers to offer a standard Medigap policy, if the insurer sells them, to those individuals who wish to drop their SELECT policy. The policy offered must have comparable or lesser benefits and must be available regardless of the individual's health. A recent report[4] on the Medicare SELECT program found that most of the original 15 demonstration states determined that offering the basic Medigap plan "A" meets this requirement.

[4]Research Triangle Institute, Evaluation of Medicare SELECT Amendments: Case Study Report (Baltimore, Md.: HCFA, HHS, Feb. 10, 1994).

Risk-Contract HMOs Offer Another Alternative

HMOs with Medicare risk contracts often have lower cost-sharing than the fee-for-service program—or no cost-sharing at all—and also often cover additional services. Thus, HMOs with Medicare risk contracts can be viewed as an alternative to Medigap insurance. However, by enrolling in an HMO, a beneficiary agrees to relinquish the right to choose providers of care. Also, if the beneficiary decides to return to the fee-for-service program, Medigap insurers can use medical underwriting to determine whether to sell the person a policy.

Under their agreements with Medicare, risk-contract HMOs must accept all eligible Medicare applicants in order of application, during an annual open enrollment period, except those enrolled in a hospice plan and those who have been diagnosed with permanent kidney failure. Medicare HMOs serve areas in 37 states and the District of Columbia, although they currently are concentrated in relatively few states. Over 45 percent of the 223 risk-contract HMOs are located in five states and enrolled over 65 percent of the 3.7 million Medicare HMO enrollees as of July 1996. Most other states had few risk-contract HMOs, and 13 states had no risk-contract HMO. While the availability to beneficiaries of HMOs across the country is far from uniform, risk-contract HMOs are available in states where a large number of Medicare beneficiaries reside.

Medicare Beneficiaries Seldom Change Health Plans

Most elderly Medicare beneficiaries do not replace their private health insurance coverage but many do add to existing coverage. HCFA's Medicare Current Beneficiary Survey data show that about 99 percent of the 19.5 million beneficiaries who had private insurance in 1991 and were alive in 1994 had the same plans in 1994. The remaining 1 percent of these beneficiaries either switched plans, dropped plans, or made other changes during the 1991-94 period. About 25 percent of the 19.5 million added plans to supplement those they had in 1991 (see table 2). In addition, over 1 million beneficiaries who did not have a private supplemental policy in 1991 had obtained one or more by the end of 1994. The data allowed us to compare only coverage by plan name, and we could not identify those instances in which the beneficiary switched coverage within the same plan. For example, we could not identify a case where a beneficiary switched from Medigap plan C to Medigap plan F if the plan name was Blue Cross/Blue Shield in both 1991 and 1994.

For purposes of HCFA's survey, private insurance included individually purchased plans (primarily Medigap policies); health plans from former employers; and other plans that might cover hospital, physician, or drug

charges. HCFA's survey excluded long-term care, hospital indemnity, and specified disease insurance from the private insurance category, but it is possible that beneficiaries reported these types of limited-benefit plans as individually purchased plans.

Table 2: Type of Private Health Insurance Plan Changes Made Between 1991 and 1994 by Medicare Beneficiaries Who Had Private Plans in 1991

Numbers are percentages

Type of private plan held in 1991	No change	Added policies	Other change[a]	Total private plans held in 1994
One Medigap policy[b]	32.2	8.2	.6	41.1
One employer-sponsored plan	28.9	11.8	.3	41.0
One unknown plan	2.2	.3	.1	2.5
Multiple plans	10.8	4.4	.3	15.5
Total	**74.0**	**24.7**	**1.3**	**100.0**

Note: Numbers may not add to totals because of rounding.

[a]Medicare beneficiaries either switched policies, dropped policies, or made multiple changes.

[b]Also includes other insurance that covers hospital and physician charges or prescription drugs.

Source: Derived by GAO from the computerized results of HCFA's 1991 and 1994 Medicare Current Beneficiary Survey.

Between 1991 and 1994, about 4.8 million beneficiaries added private health insurance plans to their existing coverage. Of these beneficiaries, about 4 million had only one policy in 1991; added coverage resulted in their owning multiple policies in 1994. Table 3 shows that in 1994 over 1.3 million beneficiaries had multiple Medigap policies and 1.4 million had multiple employer-sponsored plans. One reason why beneficiaries can be covered by multiple employer-sponsored plans is that both spouses can have plans that also cover the other spouse.

Table 3: Number of Medicare Beneficiaries Who Added Private Health Insurance Plans in 1992, 1993, or 1994 to the Plan They Had in 1991

Numbers in thousands

	Coverage added between 1991 and 1994			
Type of private plan held in 1991	**Medigap policy only**	**Employer-sponsored plan only**	**Combination of plans or other plan**	**Total multiple private plans held in 1994**
One Medigap policy	1,348	146	114	1,609
One employer-sponsored plan	639	1,401	254	2,294
One unknown plan	23	29	8	60
Total	**2,009**	**1,577**	**376**	**3,962**

Note: Numbers may not add to totals because of rounding.

Source: Derived by GAO from the computerized results of HCFA's 1991 and 1994 Medicare Current Beneficiary Survey.

Federal law prohibits an insurer from selling a beneficiary a second Medigap policy unless the beneficiary states in writing that he or she intends to cancel the first policy after the replacement policy goes into effect. Because so many beneficiaries reported purchasing Medigap policies when they already owned one, it appears that the law may not actually be preventing beneficiaries from owning multiple policies.

Few Medigap Underwriting Complaints Have Been Made

Since 1993, NAIC has maintained a central database of formal complaints made to state insurance departments. This system has a category for underwriting complaints but it does not break the category into components such as medical underwriting. According to NAIC's data, underwriting was the basis for 18 percent of the formal Medigap complaints to state insurance departments in 1994 and 1995.

In 1994, 3 out of a total of 391 Medigap complaints relating to underwriting cited "refusal to insure after open enrollment period" as the reason for the complaint; in 1995, 1 out of 316 gave this reason. According to NAIC data, over 50 percent of the underwriting complaints in both 1994 and 1995 cited premium and rating method concerns.

Insurance department officials from the 10 states with the largest Medicare populations said their departments received few Medigap complaints, and even fewer complaints relating to medical underwriting, in the last few years. Officials in five states attributed the current low

volume of Medigap complaints to the changes made under OBRA 1990, which increased consumer protections and required that Medigap policies be standardized. Several officials also commented that it is not surprising that few formal complaints about medical underwriting are made because that practice is permissible and people are told as much at the informal telephone contact stage.

The six consumer groups we contacted believed that Medigap medical underwriting practices resulted in some individuals' being unable to obtain or change coverage, but the groups did not have statistical data describing the magnitude of the problem. These groups noted that although Medigap medical underwriting after the 6-month open enrollment period was a matter of concern, Prudential offered a continuous open market for Medigap policies through its arrangement with AARP.

Legislative Option to Prevent Medical Underwriting

Because the current alternatives for avoiding medical underwriting are not required by law to be available, the situation could change in the future. One way to ensure that medical underwriting does not become a problem in the future would be to require Medigap insurers to offer policies with comparable benefit packages on a guaranteed-issue basis to individuals who have been continuously covered under Medigap. In this case, however, concerns might arise that because individuals can always buy a guaranteed-issue policy they might be encouraged to postpone purchase until they know they are likely to use the policy. However, if a condition for access to guaranteed-issue policies is continuous coverage under a similar policy, this concern is no longer an issue. Another potential problem is that individuals could seek to upgrade to more benefit-rich policies if they expected to use one of the new benefits. Again, this would not be a problem if insurers had to offer only policies with benefits comparable with the individual's current policy.

Employer-sponsored retiree health plans and HMOs with Medicare contracts can be viewed as substitutes for Medigap policies. Problems with maintaining Medicare supplement coverage can also occur if beneficiaries choose or are forced to change from these Medigap substitutes. We previously reported on potential problems in obtaining Medigap policies for those beneficiaries covered by employer-sponsored plans if their plan is terminated or benefits are downgraded.[5] Beneficiaries can be forced to discontinue HMO enrollment for such reasons as

[5]Health Insurance for the Elderly: Owning Duplicate Policies Is Costly and Unnecessary (GAO/HEHS-94-185, Aug. 3, 1994).

relocating to an area where no HMO participates in Medicare. Also, some beneficiaries want to discontinue HMO coverage but feel that they cannot do so. The HHS Office of Inspector General reported that, in 1994, 10 percent of beneficiaries who were enrolled in HMOs (almost 94,000 people) wanted to end their enrollment but felt that they could not because of financial reasons, which could include concern about the availability of a Medigap policy.[6] Beneficiaries with substitutes for Medigap who seek Medigap policies could be protected from medical underwriting under the legislative option discussed above if continuous coverage under a Medigap policy is defined to include enrollment in employer-sponsored health plans and in HMOs with Medicare contracts.

Conclusion

Most beneficiaries obtain private insurance to supplement Medicare when they become eligible for the program at age 65. Few beneficiaries subsequently decide to change their policies, and those that do have at least one alternative for changing without being subject to medical underwriting. However, these alternatives are not guaranteed by federal law, and it is possible that circumstances could change in the future. Federal Medigap law (section 1882 of the Social Security Act) could be amended to furnish such a guarantee to beneficiaries who have been continuously covered by Medigap. Such a change should not have any major effect because it would not alter beneficiary incentives for Medigap coverage.

Matters for Consideration by the Congress

If the Congress is concerned that the current alternatives available to Medicare beneficiaries who wish to change Medigap policies might not exist in the future, the Congress could amend federal Medigap law. Such an amendment could require insurers to offer Medicare beneficiaries who have been continuously covered by Medigap insurance guaranteed-issue policies with benefit packages comparable with those of the policy they currently hold. The Congress may also wish to consider extending this protection to beneficiaries whose employer-sponsored retiree health plans are terminated or curtailed and who must or choose to leave their HMOs.

In commenting on a draft of this report, NAIC representatives agreed with our factual presentation and our conclusions. NAIC did offer some technical suggestions, which we incorporated where appropriate.

[6]Office of Inspector General, HHS, Beneficiary Perspectives of Medicare Risk HMOs, OEI-06-91-00730 (Washington, D.C.: HHS, Mar. 1995).

We are sending copies of this report to NAIC, the Secretary of Health and Human Services, and other interested congressional committees and individuals. We will make copies available to others on request.

If you have any questions, please call me on (202) 512-6806 or Tom Dowdal, Assistant Director, on (202) 512-6588. Other contributors to this report are listed in appendix IV.

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Contents

Abbreviations

AARP	American Association of Retired Persons
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
NAIC	National Association of Insurance Commissioners
OBRA	Omnibus Budget Reconciliation Act

Scope and Methodology

Scope

We obtained from the National Association of Insurance Commissioners (NAIC) their computerized database of insurance companies' Medigap annual experience exhibits for 1994. The database identified 354 insurance companies and reported total earned premiums of $12.6 billion. We limited our review of medical underwriting to the 25 largest sellers of Medigap insurance. These companies had earned premiums of about $8.3 billion, or over 65 percent of the total. We did not test the accuracy of the database but our prior work has shown these databases to be highly accurate.

Methodology

To identify the extent to which medical underwriting is used in the Medigap market, we interviewed knowledgeable officials from the 25 largest sellers of Medigap insurance on their underwriting practices.

To determine how frequently Medicare beneficiaries change private health plans, we obtained access to the computerized results of round 1 and round 10 of the Health Care Financing Administration's (HCFA) Medicare Current Beneficiary Survey, a continuous, multipurpose survey of a representative sample of the Medicare population. Round 1 and round 10 interviews were conducted in the last 4 months of calendar years 1991 and 1994, respectively. These interviews captured baseline information on a sample of Medicare beneficiaries (12,677 in 1991), including information on supplemental coverage from private insurance and Medicaid. For purposes of HCFA's survey, private insurance included an individually purchased plan (that is, a Medigap policy); health plans from former employers; and other plans that might cover hospital, physician, or drug charges. HCFA's survey excluded long-term care, hospital indemnity, and specified disease insurance from this insurance category. We compared, by plan name, the private insurance that Medicare beneficiaries aged 65 and older had in 1991 with the plans these same beneficiaries had in 1994 and identified and analyzed differences. We did not verify the accuracy of the information in the computerized file.

To assess whether elderly Medicare beneficiaries are complaining about Medigap medical underwriting practices, we obtained from NAIC's complaint data system a computerized file of Medigap complaints in 1994 and 1995. The NAIC data system is developed from information provided by state insurance departments on closed complaints. We analyzed the data on the 2,110 Medigap complaints identified in 1994 and the 1,732 identified in 1995. We supplemented these data by interviewing officials from the insurance departments of the 10 states with the largest elderly populations

and by interviewing officials from 6 consumer/advocacy groups. We did not verify the accuracy of the information in the computerized file.

Sampling Errors

Data reported in tables 2 and 3 are derived from the computerized results of the Medicare Current Beneficiary Survey. Because these data are derived from a sample, each estimate has a sampling error associated with it. The size of the sampling error reflects the precision of the estimate: The smaller the sampling error, the more precise the estimate. We computed sampling errors for tables 2 and 3 at the 95-percent confidence level. This means that the chances are about 95 out of 100 that the actual number or percentage being estimated falls within the range defined by our estimate, plus or minus the sampling error. Tables I.1 and I.2 show the sampling errors for tables 2 and 3, respectively.

Table I.1: Point Estimates and Sampling Errors for Type of Private Health Insurance Plan Changes Made Between 1991 and 1994 by Medicare Beneficiaries Who Had Private Plans in 1991

Numbers are percentages

Type of private plan held in 1991	No change	Added policies	Other change	Total private plans held in 1994
One Medigap policy	32 ± 1.9	8 ± 1.0	0.6 ± 0.2	41 ± 2.2
One employer-sponsored plan	29 ± 1.9	12 ± 1.2	0.3 ± 0.1	41 ± 2.1
One unknown plan	2 ± 0.4	0.3 ± 0.2	0.1 ± 0.0	3 ± 0.5
Multiple plans	11 ± 1.0	4 ± 0.6	0.3 ± 0.1	15 ± 1.1
Total	**74 ± 1.6**	**25 ± 1.6**	**1 ± 0.3**	**100.0**

Note: Numbers may not add to totals because of rounding. Sampling errors are computed at the 95-percent confidence level.

Table I.2: Point Estimates and Sampling Errors for Number of Medicare Beneficiaries Who Added Private Health Insurance Plans in 1992, 1993, or 1994 to the Plan They Had in 1991

Numbers in thousands

	Coverage added between 1991 and 1994			
Type of private plan held in 1991	Medigap policy only	Employer-sponsored plan only	Combination of plans or other plan	Total multiple private plans held in 1994
One Medigap policy	1,348 ± 175	146 ± 54	114 ± 47	1,609 ± 195
One employer-sponsored plan	639 ± 122	1,401 ± 180	254 ± 74	2,294 ± 245
One unknown plan	23 ± 19	29 ± 23	8 ± 11	60 ± 32
Total	**2,009 ± 199**	**1,577 ± 199**	**376 ± 89**	**3,962 ± 295**

Note: Numbers may not add to totals because of rounding. Sampling errors are computed at the 95-percent confidence level.

In addition, other beneficiary estimates presented in the report have the following sampling errors:

- for the 19.5 million beneficiaries who had private insurance, the sampling error was ± .4 million;
- for the more than 1 million beneficiaries who did not have a private supplemental policy in 1991 but had at least one in 1994, the sampling error was ± .1 million; and
- for the 4.8 million beneficiaries who added private health insurance plans, the sampling error was ± .3 million.

Features of Standardized Medicare Supplement Plans

In 1991, the NAIC approved the following 10 standardized benefit combinations (plans A through J) for Medicare supplement policies. Forty-four states, the District of Columbia, Puerto Rico, and the Virgin Islands approved all 10 plans. Pennsylvania and Vermont approved seven; Delaware approved six; and Massachusetts, Minnesota, and Wisconsin had alternative simplification programs in effect and have waivers that exempt them from these standard plans. Benefits included in a plan are marked by "X."

Table II.1: Benefit Combinations of the Standardized Medicare Supplement Plans

Benefits	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Basic benefits[a]	X	X	X	X	X	X	X	X	X	X
Skilled nursing facility coinsurance			X	X	X	X	X	X	X	X
Part A deductible		X	X	X	X	X	X	X	X	X
Part B deductible			X			X				X
Part B excess charges[b]						X	X[c]		X	X
Foreign travel emergency			X	X	X	X	X	X	X	X
At-home recovery				X			X		X	X
Prescription drugs								X[d]	X[d]	X[e]
Preventive medical care					X					X

[a]Basic benefits pay the beneficiary's Medicare part B coinsurance (generally 20 percent of Medicare-approved charges after the $100 annual deductible), part A coinsurance for the 61st-90th day of a Medicare-covered hospital stay, part A coinsurance during the use of a beneficiary's 60 lifetime reserve days, eligible expenses after a beneficiary's hospital benefits are exhausted up to a lifetime maximum of 365 days, and parts A and B blood deductible (3 pints).

[b]Part B excess charges are the difference between the actual charge for a service or item and the Medicare-allowed charge for that service or item. Medicare prohibits charging more than 115 percent of the Medicare-allowed charge.

[c]This plan pays 80 percent of part B excess charges.

[d]Prescription drug coverage under plans H and I requires an annual deductible of $250; then the plan pays 50 percent of covered charges, up to a maximum plan payment of $1,250 per year.

[e]Prescription drug coverage under plan J requires an annual deductible of $250; then the plan pays 50 percent of covered charges, up to a maximum plan payment of $3,000 per year.

25 Largest Sellers of Medigap Insurance

Company	Total 1994 premiums	Standardized plans offered[a]	States marketed	Number of policies in force in 1995		Medical underwriting	Primary method for calculating premiums[b]
				Standard	Nonstandard		
Prudential Insurance Company of America	$2,525,855,458	A through J	Multiple	1,150,214	1,969,743	Yes[c]	Community
Bankers Life and Casualty Company	567,733,657	A through I	Multiple	237,668	202,526	Yes	Attained age
Empire Blue Cross and Blue Shield	555,536,690	A, B, and H	Single	284,639	119	No	Community
United American Insurance Company	519,636,376	A, B, C, D, F, and G	Multiple	198,984	180,318	Yes	Issue age
Blue Cross and Blue Shield of Massachusetts	464,472,437	Waiver[d]	Single	208,559	7,677	No	Community
Medical Service Association of Pennsylvania-Pennsylvania Blue Shield	365,244,297	A, B, C, and H	Single	513,314	0	No	Issue age
Blue Cross and Blue Shield of Florida, Inc.	305,529,121	A, B, C, D, and F	Single	94,762	137,565	No	Issue age
Blue Cross and Blue Shield of Illinois Health Care Service Corporation	254,696,911	A, B, D, E, and F	Single	122,797	167,471	No	Attained age
Blue Cross and Blue Shield of Virginia	203,832,750	A, B, C, F, I, and J	Single	32,217	93,711	Yes[e]	Issue age
Blue Cross and Blue Shield of North Carolina, Inc.	184,107,328	All except G	Single	55,308	85,267	Yes	Issue age
Mutual of Omaha Insurance Company	183,430,118	A, C, F, and I	Multiple	100,000	150,000	Yes	Attained age
Pioneer Life Insurance Company of Illinois	180,965,855	A, B, C, D, E, F, G, and I	Multiple	84,146	71,821	Yes	Attained age

(continued)

Company	Total 1994 premiums	Standardized plans offered[a]	States marketed	Number of policies in force in 1995		Medical underwriting	Primary method for calculating premiums[b]
				Standard	Nonstandard		
Blue Cross and Blue Shield of Indiana Associated Insurance Companies, Inc.	180,200,050	A, B, C, D, F, G, and H	Single	43,000	107,000	Yes[c]	Attained age
Blue Cross and Blue Shield of New Jersey, Inc.	179,058,000	A, C, F, and I	Single	33,167	158,485	Yes[c]	Community
Physicians Mutual Insurance Company	176,543,759	A through J	Multiple	105,372	58,690	Yes	Issue age
Blue Cross and Blue Shield of Alabama	165,647,335	A and B	Single	178,000	0	No	Issue age
Blue Cross and Blue Shield of Iowa-IASD Health Services Corporation	157,659,892	A, C, E, F, and J	Single	60,443	40,235	Yes[c]	Attained age
Blue Cross and Blue Shield of Michigan	155,410,958	A, C, and H	Single	39,201	148,158	No	Community
Blue Cross and Blue Shield of Connecticut, Inc.	154,283,955	A, B, C, D, F, and H	Single	20,193	128,979	Yes[c]	Community
Standard Life and Accident Insurance Company	151,782,693	A, B, C, and F	Multiple	45,000	60,000	Yes	Issue age
Blue Cross and Blue Shield of Tennessee	142,747,238	A through J	Single	33,250	124,150	Yes	Attained age
Blue Cross and Blue Shield of Kansas, Inc.	134,673,000	A, C, and F	Single	105,570	33,486	Yes	Attained age
Blue Cross of Western Pennsylvania	130,848,816	A,B,C, and H	Single	187,569	0	No	Issue age

(continued)

Company	Total 1994 premiums	Standardized plans offered[a]	States marketed	Number of policies in force in 1995		Medical underwriting	Primary method for calculating premiums[b]
				Standard	Nonstandard		
State Farm Mutual Insurance Company	126,533,729	A and C	Single	441	84,768	No	Attained age
American Family Life Assurance Company of Columbus, Georgia	124,216,026	A, B, C, F, and G	Multiple	55,075	46,500	Yes	Issue age

[a]Plan types may vary by state for companies marketing in multiple states.

[b]Insurance companies use three different methods to calculate premiums: issue age, attained age, and community (no age) rating. Under the issue age method, premium rates vary by the age at which the beneficiary first purchases a policy. Premiums will not rise as the beneficiary gets older. Under the attained age method, the premium is based on the beneficiary's current age and will increase as the beneficiary grows older. Under the community (no age) method, all beneficiaries pay the same premiums regardless of age.

[c]Company has some guaranteed issue plans.

[d]Massachusetts, Minnesota, and Wisconsin had alternative simplification programs in effect when OBRA 1990 was enacted and have a waiver that exempts them from the standardized policy requirement.

[e]Plans A and C can be purchased with or without medical underwriting, but without medical underwriting, they have higher premium rates.

Source: Derived by GAO from interviews held with officials of the 25 companies listed above and from NAIC's database of 1994 Medigap loss ratios as reported to NAIC by insurance companies.

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