S. HRG. 101-1254

MEDIGAP INSURANCE: STRENGTHENING FEDERAL STANDARDS

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

S. 2050, S. 2189, S. 2640, S. 2641, and S. 3020

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Medicare benefit package to include preventative services, just as we did for the 65 and under population. And we recommended major reforms in the Medigap insurance market.

I am pleased that virtually all of the Pepper Commission recommendations for Medigap reform are reflected in the bills that are before us today. I am particularly pleased that Senator Daschle's and Senator Riegle's bills both address simplification of Medigap policies. Almost 100 companies sell Medigap insurance in the small State of West Virginia—100. No wonder seniors have an incredibly difficult time sorting through all of these various policies and are often unable to make informed decisions.

Now I am very well aware of the need to preserve innovation and diversity in the insurance market. I also know that we are talking about a limited benefit package that is designed to fill in gaps in the Medicare program. That is what it does. It just fills in gaps—Medigap. There are only so many models, it would seem to this Senator, that in fact can be formed to provide this service and this product.

So working with my colleagues on the Finance Committee I am confident that we, in fact, will, and I believe this very strongly, will enact Medigap legislation and that we will do that this year.

At this time I would like to call on Senator Max Baucus of Montana for any comments he might wish to make. Then Senate Finance Committee staff could help me on who came in when, so that I do not violate protocol.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I will be very brief. This is obviously a very important hearing. I think the Medigap provisions adopted in the law a decade ago were very helpful. They went a long way to help reform some abuses that were then occurring in the sales of Medicare supplemental insurance. I remember 10 years ago when I looked at the record of many hearings held both in the House and the Senate, particularly hearings held by the late Senator Claude Pepper, I was astounded at the number of times in the hearings that he held, how often insurance policies were sold to people that were absolute rip-offs. I mean it was quite astounding.

That is what got me going on this issue. I then realized it made some sense to get a provision enacted in the law to reform some of the problems that were obviously occurring. I must tell you, Mr. Chairman, that was one of the first times I really cut my teeth in the legislative process, particularly in conference with the House on that provision. It was very rough going. It was heavy weather in trying to get those amendments adopted, but we finally did. They have gone a long way. They have been very helpful.

Now though, 10 years later, it is clear, particularly in view of the GAO study, that we have to refine those provisions further. It seems to me that there are several areas where improvement is needed.

One, obviously, is enforcement. It is clear that the States, and the Department of Justice, and HCFA, and all the relevant agen-

cies, just are not enforcing the provisions in the laws as well as they should. Maybe it is a lack of resources, maybe the provisions in law are not sufficiently clear. Whatever the reasons, the result is clear—namely, so far inadequate enforcement of the law.

Second, we have to avoid the problem of duplication. I think many policies are duplicative. That has to be addressed.

Which gets to the third area, the subject of Senator Pryor's bill—namely better consumer information. I thank the Senator for his bill. It is clear that Medigap policies are too complicated in many areas. We need to make sure that better information is available to make sense of these policies. And beyond that I believe some simplification is needed.

More standardization of policies I think would go a long way. I do not see any reason why the insurance industry cannot continue to sell policies, even policies that are more standardized. I think in many ways it would help the industry. It seems to me the more standardized, therefore the more simple they are and perhaps the more likely it is that a senior would want to buy the policy. I think that argument has a lot of merit.

And finally, I think we should address the loss ratios—60 and 75 might be a little bit low at this point. I am open on that subject. I have listened to various witnesses. But we should very much look at the propriety of present loss ratios—60 for individuals; 75 for group. Perhaps they can be adjusted as well.

But in any event, there is a lot of good legislation, a lot of very good bills introduced; and I look forward to the testimony and working with members of the committee so that we can act on Medigap reform this year, to further minimize abuses that do occur.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Baucus.

Senator Chafee?

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. I want to commend you for holding these hearings. The Medicare program is certainly complicated. I think we all know that. I sympathize with senior citizens who are wrestling with terms like "deductibles" and "coinsurance," "premiums," "covered services," "balance billing." So sometimes the whole thing seems incomprehensible.

Now many of us have seen, I suppose, a very high percentage of Americans have seen the television commercials in which celebrities ask Medicare beneficiaries if their current insurance polices are adequate and they are urged to send for information, "Write me and I will tell you how to do it." We can only guess the number of insurance agents that then visit the homes of those folks or the solicitations they receive through the mail.

And as a result, as you pointed out, Mr. Chairman, senior citizens often have duplicative policies, frequently they cannot afford them, or they have policies that do not adequately address their needs.

Now in 1980 we adopted the Baucus standards. I want to pay tribute to the Senator from Montana for bringing those up at that

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FRIDAY, SEPTEMBER 14, 1990

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG-TERM CARE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 2:04 p.m., in room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller IV (chairman of the subcommittee) presiding.

Also present: Senators Baucus, Pryor, Riegle, Daschle, Chafee, Heinz, and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-51, Aug. 27, 1990]

MEDICARE SUBCOMMITTEE TO HOLD HEARING ON MEDIGAP INSURANCE; PROPOSALS TO STRENGTHEN FEDERAL STANDARDS TO BE FOCUS

WASHINGTON, DC—Senator John D. Rockefeller IV (D., West Virginia), Chairman, announced Monday that the Subcommittee on Medicare and Long-Term Care will hold a follow-up hearing on issues relating to Medigap insurance. The hearing will focus on a number of bills that attempt to help beneficiaries make more informed choices when purchasing Medigap insurance policies and to moderate increases in Medigap premiums.

The hearing is scheduled for *Friday, September 14, 1990 at 10 a.m.* in Room SD-15 of the Dirksen Senate Office Building.

"Last February, this subcommittee held a hearing to try to pinpoint why so many senior citizens were seeing huge increases in their Medigap insurance premiums. At that hearing, we learned that repeal of the Medicare catastrophic law was just one of several reasons why premiums, on average, increased almost 20 percent or $ [illegible] a month this year. Other reasons cited were general health care inflation, increased utilization of services by the elderly, and higher than expected claims in prior years. The GAO also testified at that hearing that many of the Medigap policies they surveyed failed to meet minimum loss ratio standards established in 1980 as a result of legislation introduced by Senator Baucus," Rockefeller said.

"Since that hearing, several of my colleagues have introduced legislation to address many of the problems that were highlighted at that hearing. I am pleased to be holding this follow-up hearing to solicit further input on this vitally important issue," Rockefeller said.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA, CHAIRMAN OF THE SUBCOMMITTEE

Senator ROCKEFELLER. We will start the hearing. I expect that some of my colleagues on this committee will be coming for a subject as important as this. And I will say now, and then repeat when they come, that this hearing needs to be completed by 4:30; and, therefore, we will go to a 5-minute rule in terms of statements, not

for Dr. Wilensky. That will not apply to her. But there will be a 5-minute rule and there will also be a 5-minute rule on Senators questioning.

I am very happy to be holding about this followup hearing on Medicare supplemental insurance policies. It is a subject that is obviously troubling to a lot of members of the Finance Committee.

Last February, this subcommittee heard some very disturbing news, news that has in fact reinforced my commitment and the determination of some of my colleagues on this committee to resolve the serious problems that we seem to continue to encounter.

At our February hearing the GAO informed us that their survey shows that Medigap insurance premiums for 1990 are expected to increase by an average of 19.5 percent, which is bad enough as an average, but that ranges from 5 percent to over 52 percent—as much as 52 percent.

In my home State of West Virginia Blue Cross/Blue Shield, which has 60 percent of the Medigap market hiked their premiums by 27 percent; 36,000 West Virginia seniors are seeing their monthly premiums rise from $44.73 to the figure of $59.44, and that is a lot of money. Only about half of the premium hikes were, in fact, attributed to the repeal of the catastrophic health care bill. As you remember, that was the common wisdom. But, in fact, only about half of the increases were attributed to repeal of catastrophic. Other reasons cited were increased use of health services, medical inflation and higher than expected claims experience.

We heard that even though all but four States have voluntarily adopted the Baucus minimum standards, that were established in 1980 by my distinguished colleague from Montana, State enforcement varies widely; and Federal oversight, at least insofar as we can see, is virtually nonexistent.

The GAO testified that even though minimum loss ratio standards have been on the books for 10 years a significant number of Medigap policies continue to be sold that consistently fail to meet that minimum Federal standard. According to GAO surveys, 66 percent of commercial companies selling group plans had loss ratios below the required minimum standard of 75 percent—66 percent, two-thirds of them, came in below that. And one-third of them, of the commercial sellers, selling individual policies, came in below the required 60 percent. So something is amiss.

These trends are among the reasons that I am an original cosponsor of the Medigap legislation that has been introduced by Senator Daschle, by Senator Riegle, and by Senator Pryor.

Obviously, I am looking forward to all of our witness's comments. This is an extremely important and disturbing subject. Senator Chafee introduced a bill just last week.

I believe these bills will go a long way towards addressing the fraud and the abuses in the Medigap market that we heard about last February and will make sure that senior citizens are getting their money's worth from Medigap policies when they buy them.

As many of you know, the Pepper Commission recently released—and Senator Baucus is an esteemed member of the Pepper Commission—recently released its health care recommendations for people 65 years and older. We recommended vital protections for low-income seniors. We recommended improvements in the

time. The standards have done much to help the elderly in selecting the proper Medigap policies. I think as the Senator himself has acknowledged there is room for improvement now as we have moved through the last decade.

I think it is imperative that in improving these standards we are careful that we do not do more harm than good. I believe the Federal Government should play a role in monitoring the Medigap policies. But I think we have to be cautious about expanding that role. Everyone knows that the Federal Government does not have a great deal in terms of available resources now. We have to, I think, have extreme caution not to implement a system that will result in the Federal Government regulating the Medigap insurance industry in the States.

I find it difficult to believe that the seniors would be well served by that policy. I have introduced legislation which you have touched on, Mr. Chairman, S. 2030, which I believe maintains the integrity of the current law by leaving the regulation and enforcement of Medigap policies to the States. My language expands current law and allows the Federal Government to get in as a safety net.

States would be subject to some reporting requirements. This information would provide assurances to States of adequately enforcing the standards. In addition, my proposal through the annual report that has to be made to the Secretary of Health and Human Services provides the Secretary with an indicator of the policies and of the problems that are existing in the States.

The Secretary then would provide assistance to the States to bring the States into compliance. If the State refused to enforce its standards then the Secretary has the authority to revoke that State's ability to approve the policy.

A number of my colleagues in the Senate have introduced legislation on this issue—many on this committee. Specific provisions may differ, but I think we all agree we must revise the current Medigap standards. We have to address the problem of duplication of policies, consumer confusion, unsavory marketing techniques that are being practiced by a few bad apples.

I would like to commend the consumer organization you are going to hear from, the insurance industry which has come forward with some helpful information on this whole subject; and I think with this whole cooperation we can, as you say, enact this legislation. That is quite remarkable because we only have 3 weeks.

Thank you.

Senator ROCKEFELLER. Thank you, Senator Chafee.

Senator Pryor?

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, I want to thank you also. I join my colleagues in thanking you for this particular hearing. It has been a great pleasure to have worked with you, Mr. Chairman, and with Senator Baucus, and Riegle, and Daschle, Chafee, Heinz, and all who have put together what I think is a very good thrust on the Medigap front.

I am vitally concerned about all of this. But a specific concern that I have always had since the repeal of catastrophic is the ultimate potential for abuse and fraud against the elderly in sort of duping the elderly into believing that this policy is best or that policy is best.

I know that the Aging Committee which I have the privilege of chairing, about 8 weeks ago had a hearing just on these subjects. One of our star witnesses had to appear, not in person, but by satellite from his prison cell in Florida. He was a convicted Medigap insurance salesman. Senator Heinz was at this hearing and this fellow—the prison officials were afraid to let him come to the Aging Committee because the official was afraid he would sell all of us a Medigap policy. [Laughter.]

He was such a grand con artist. But this fellow testified from his cell. I think his salary—from commissions on Medigap policies, the year before he went to jail were something in the neighborhood of $300,000, from selling these policies. He told about how he was trained. How he was trained to once you get in the door, you do not walk out that door until you have that senior citizen committed.

Well the fellow found out about—they buy these cold leads from these companies. They buy a list. Well how do they get the list of people who are interested in this? Well, first, there are all kinds of groups like this. Here's one, the Association of Retired Americans. This is not AARP. This is the Association of Retired Americans. They are in Scottsdale, AZ.

They sent a letter to my constituent, Lillian Chapman. She is 77. She called us up and said, "It looks like a Government document. Am I supposed to fill this out? Am I going to be penalized? Am I going to lose my Social Security?" Well of course not. But had she sent this back to the person that distributed it to her, immediately she would have been called on by an insurance salesman. That company would have bought this list from this particular group. That is the cold lead issue. This is why I have gotten very involved in the consumer education issue that Senator Baucus referred to. And my legislation is just a part of this overall thrust.

I just think that time is of the essence because we are seeing a plethora of these types of situations and organizations in a feeding frenzy on the elderly. I think our State Insurance Commissioners are really going to have to go to bat and they are going to have to become much more aggressive and we are too. I think that these and other issues in this legislation, if we could pass it before we leave, I think we would truly be doing a service to the people.

Mr. Chairman, I have a statement I would like to place in the record. I yield back the balance of my time if I have any. I thank you very much.

[The prepared statement of Senator Pryor appears in the appendix.]

Senator ROCKEFELLER. Thank you, Senator Pryor.

Senator Riegle?

And Senator Heinz will be next.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you very much, Senator Rockefeller. I appreciate your leadership in this area. I want to just make a few opening comments.

Last February this committee found that current problems with the Medigap market place make it very difficult for seniors to purchase policies that they really need and they are all aware of that. There is a bi-partisan effort underway by members of this committee to try to fix the problem.

I introduced, as you have kindly mentioned, the Medigap Simplification Act of 1990. That bill now has 12 co-sponsors and would only cost $5 million a year for State hotlines to solve the problems that Senator Pryor and others have mentioned here today.

I am pleased that many groups who are here today have accepted my offer to work together. We have been working with consumer and aging groups, including Consumers Union, AARP, and Families USA, with State Insurance Commissioners, and insurers, including Blue Cross and HIAA.

My bill would simplify a complicated and confusing system. It would allow for price shopping, and it would ensure that reasonable products are sold. I think simplification would result in standard alternatives across all of the States so seniors can compare policies and get the most value for their money.

Senator Daschle has introduced his comprehensive proposal, S. 2640, which includes my proposal and I am also a co-sponsor of that legislation, as well as Senator Pryor's bill. Now, we are trying in further developing this bill, with the groups that I have just cited, to incorporate proposals that are important to the administration, such as a Medicare Select, a preferred provider organization (PPO) program.

We have come a long way since February. We now have a bill State Commissioners, insurers, and consumer aging groups all support. I will not go into it in detail except to say that the bill requires experts, including State Insurance Commissioners, together with consumer groups, insurers and Medicare beneficiaries to develop standards to simplify Medigap benefit packages.

Almost all States current use NAIC standards. Our bill would enhance those voluntary guidelines. And then, if standards are not developed by these experts, and I would expect that they would be, HHS would issue them only as a last resort.

We would rely on these experts to come up with the best structure, which would be a core set of benefits plus limited optional riders or low, medium or high benefit packages or some mixture. The bill would also provide grants for State toll-free hotlines to provide information about State Medigap policies, Medicare and Medicaid benefits, and would protect low-income seniors with Medicaid that do not usually need Medigap.

I would just conclude by saying to our witness, (Dr. Gail Wilensly) the reason that we have a lot of people on board is it is a good idea and we have kept a seat for you because we need to have you on board. So I am quite willing to see if we cannot work out any remaining refinements that may be needed. But we need some

standardized basic policies in place. We have to get it done. Seniors are being cheated left and right. There is no excuse for it.

So I want you to know that I want to work cooperatively with you, but no for an answer is not an answer, if I may say so respectfully.

Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Riegle.

Senator Heinz?

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM PENNSYLVANIA

Senator HEINZ. Mr. Chairman, I, too, want to thank you for this hearing on what is a very good subject. That makes the vote unanimous and deservedly so. I would ask unanimous consent that my entire statement be put in the record at this point.

Senator ROCKEFELLER. It will be.

Senator HEINZ. The other members have done an excellent job of laying out exactly what the problems are here, as has Senator Baucus, Senator Pryor, Senator Chafee, Senator Riegle and others. I must say that nobody has a more instructive or more entertaining hearing than my colleague on the Aging Committee, Senator Pryor. He has become the wizard of the master switch—turning on closed circuit television to show you the way things really are, whether it is the home of a lady who is suffering with a disability or in the prison cell of a convicted con artist.

You know, when we talk about hearing from the folks back home there is nobody who has a better record literally, as well as figuratively, than my chairman on the Aging Committee. David, keep it up. It is not only entertaining, it is informative.

Senator PRYOR. Thank you.

Senator HEINZ. In sum, of course, we learned a lot about how insurers, agents, and State Insurance Commissioners, all can contribute to the problems my colleagues have mentioned. But notwithstanding the excellent work that Max Baucus has done in this area over the years, and not because of any lack of work on his part, I think it would nonetheless be remiss not to place part of the blame on the doormat of the Federal Government.

After all, it is Congress and the administration, Gail, although you have not had a chance to mess anything up, that have created a Medicare program that is cumbersome, complicated, and inadequate in terms of covering the basic health care needs of many of our senior citizens. It is not surprising that into this morass of poor policy has stepped the insurance industry with their Medigap plans.

Absent major Federal legislation to reform our health care system, our role today is not to quash the Medigap market. I do not think any of us want to do that. But we do want to assure a better quality product. And the Daschle-Heinz Medigap Fraud and Abuse Prevention Act—S. 2640—would, we believe, do just that. Our bill would simplify the purchase of a Medigap policy by limiting the number of benefit packages available and standardizing the format, terminology and benefits contained in each package.

This would permit a true apples to apples policy comparison and encourage competition based on price and benefits. Further, S. 2640 would also improve loss ratios, require prior approval for rate increases, mandate policies be guaranteed renewable, and prevent the sale of Medigap coverage to Medicaid recipients. Incentives for agents to twist or churn coverage would be minimized by reducing the allowable sales commission for new policies to no more than 150 percent of the commission for a renewal. And agents would be precluded from selling duplicate coverage to a beneficiary.

Most important, Mr. Chairman, the Daschle-Heinz bill would make consumer education a priority through funds for State-sponsored health insurance counseling programs for Medicare beneficiaries, a concept developed by Senator Pryor and myself. The hearings we had in the Aging Committee made it clear that older Americans have at best a hazy grasp of the protections offered under Medicare and thus an uninformed approach to purchasing additional coverage through Medigap.

State counseling programs—and we are fortunate to have one in Pennsylvania—have proven invaluable to beneficiaries in an environment best characterized by the phrase, "caveat emptor"—"let the buyer beware."

Although insurers and agents do not support all of the provisions of S. 2640, they have expressed support of the bill's primary objectives and provisions. This hearing provides an excellent opportunity to focus on our areas of disagreement and learn how we might best meet the goals of the legislation without disrupting the stability of the Medigap market.

So I look forward to today's testimony and to working with our other colleagues in the days and weeks ahead to achieve a solution this year.

Senator ROCKEFELLER. Thank you, Senator Heinz.

[The prepared statement of Senator Heinz appears in the appendix.]

Senator ROCKEFELLER. And finally, my esteemed colleague, Senator Durenberger.

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Thank you, Mr. Chairman. Thank you, Max Baucus, the father of all of this. Thank you to Daschle-Heinz. Thank you to the people in Minnesota who enacted a bill almost exactly like this that is a model to everybody in the nation. They are living with it. It is doing well. And anything you hear that says this is not a good piece of legislation, John, well, it is working well in Minnesota. It works just like this and it is a very good bill. It has everything except the loss-ratio provisions.

And finally, thank you to Gail Shearer, who we are going to hear from today and to Lucia Devonaire of Families USA. I think of all of the people who contributed to the bill the authors I am sure would acknowledge, and to having that bill and to doing something about it, I think Gail at Consumers Union and Lucia at Families USA should have our gratitude for supporting all of this today.

[The perpared statement of Senator Durenberger appears in the appendix.]

Senator ROCKEFELLER. And now Dr. Gail Wilensky, who as you have heard me say before, I think is a superb HCFA Director in an impossible job, but probably not impossible for her. Dr. Wilensky?

STATEMENT OF HON. GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. WILENSKY. Thank you. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss Medicare supplemental insurance, or Medigap, and the Department's principles for reform should Congress decide to advance further legislation in this area.

I share your concern that the elderly and those who purchase Medigap insurance should be able to secure the best value for their money. We believe that the best way to protect these consumers is to give them more and better information, and to ensure a broad range of choice. We believe that States should retain the responsibility for Medigap regulation.

The Medicare Catastrophic Coverage Act, and its subsequent repeal, required a number of modifications in Medigap standards to conform with the changes in the Medicare benefits. These recent revisions in Medigap have been disruptive to the Medigap industry, confusing to beneficiaries, and burdensome to States. With that in mind, we need to ensure that further mandatory changes do not inhibit voluntary participation in the Medigap regulation program.

Before I describe my principles for Medigap reform, I would like to express my strong belief that our Medicare Select proposal should be included in any Medigap reform legislation. I was very pleased to hear from Senator Riegle that he has included it in his bill. Medicare Select gives older Americans access to another option in health care, one that has been available to consumers in the private sector for several years, the preferred provider organization.

Medicare Select would allow these managed care networks to link with supplemental insurance to provide wrap-around Medicare coverage. Premiums would be lower than those generally available for Medigap coverage. It is important to provide beneficiaries with the full range of health care options available in mainstream medicine. Our Medicare Select proposal should be passed even if Congress decided not to enact more fundamental changes in Medigap.

As Congress considers options for Medigap legislation, there are three important principals that we believe should be incorporated into any reform. First, we believe States should continue to bear the responsibility for regulation of Medigap policies. The regulation of health insurance has traditionally been the role of the States, rather than the Federal Government. Although we believe that it is appropriate to provide Federal oversight over States' regulatory activities, there should be no mandatory direct Federal regulation of Medigap policies.

In this regard we believe that it would be desirable to provide additional incentives to promote continued State participation in the voluntary Medigap program.

Second, we think that Medicare beneficiaries should be able to choose from a range of Medigap policies. Many bills before this committee would limit the number and the types of policies available to consumers. It is condescending to think that beneficiaries are unable to choose appropriate insurance coverage. Medicare beneficiaries can make informed choices regarding their Medigap coverage when given adequate information on Medigap policies.

Restricting choice through standardization is to me, personally, and the administration, unacceptable. There are other more reasonable means to ensure that the elderly can make informed decisions about the Medigap policies they purchase. Definitions of terminology could be made consistent to reduce consumer confusion. Insurers could be required to offer a policy limited to just the minimum benefit package. Insurers could also spell out the cost of the minimum benefit package separate from additional benefits.

Third, we believe that Medigap insurance should be accessible to as many Medicare beneficiaries as possible. We are aware that some beneficiaries are unable to find basic Medigap insurance and cannot afford the enriched insurance coverage that is now available. Any revision in Medigap regulation should allow seniors the option of buying catastrophic only coverage. At present such coverage is prohibited. We believe that seniors should have this choice.

Not only would this provide a lower cost option to seniors, it also addresses the fact that first dollar Medigap coverage increases health care utilization and, therefore, increases Medicare costs. Studies have consistently shown that co-insurance and deductibles reduce utilization without affecting quality.

Each of these three principles is consistent with the basic philosophy that I bring to HCFA—that beneficiaries should have a broad range of choice in receiving their health care and that they should have the information necessary to make informed decisions. Medicare beneficiaries should not be precluded from having the same options available to other consumers of health care.

We must keep Medicare moving on the same track as mainstream medicine and health insurance, not away from it. We believe that our Medicare Select proposal helps to accomplish this goal.

The administration shares your commitment to the individuals served by the Medicare program. As Medigap legislative proposals are debated, I urge you to consider our concerns and our priorities.

I would be pleased to answer any questions you have.

[The prepared statement of Dr. Wilensky appears in the appendix.]

Senator ROCKEFELLER. Thank you, Dr. Wilensky. Let me ask three.

And I might say for those of my colleagues who arrived after we began, a 5-minute rule will be invoked from this point forward for all witnesses and for all questions. If there appears to be time we can go to a second round.

We had a hearing on this in February, as you remember, and at that time we heard a little about one of your three principles. Al-

though the vast majority of States have adopted the Baucus standards, actual enforcement is very spotty. I wanted to know how your principles fit into this and what they do about it.

Dr. WILENSKY. We agree that there has been a problem with the Baucus standards. Although they are good standards, there is some concern that they may need to be strengthened. The standards set up an agreement between the States and the Federal Government, but they did not provide for any Federal monitoring or oversight that would occur thereafter. This has lead to some difficulties which could, and should, be changed.

Senator ROCKEFELLER. Would that be done by the Social Security Administration as some suggest?

Dr. WILENSKY. Well it could be. It could be done by the Health Care Financing Administration as well.

Senator ROCKEFELLER. Social Security is enormously overworked, wouldn't you think?

Dr. WILENSKY. That has been a concern.

Senator ROCKEFELLER. In other words, if you are going to have monitoring at the Federal level, and it does not exist now, it is going to have to be done by some group that is technically competent and has the capacity to do it.

Dr. WILENSKY. Well I think that may depend on how we define the monitoring. We believe it is important to have information available to the Federal Government to make sure that the agreement that has been entered into between the States and the Secretary actually occurs. The States could provide information to the Secretary that would, in fact, establish whether or not plans are meeting loss ratios and other provisions of the NAIC model.

We think that the notion of having oversight is good, so that if information is provided to the Secretary that States are not living up to the agreement that they have arranged, the Secretary or the State Health Insurance panel that has empowered the States to take over this obligation from the Secretary, could remove that right.

We do not think that direct intervention by the Department is necessary. Rather, that information could be provided back to the States to indicate whether the State is living up to the agreement that it has had with the Federal Government. That is the part that has been missing to date. We think it has, in fact, caused some difficulties.

Senator ROCKEFELLER. And again, as for the State, what makes you think that the States are suddenly going to get vigorous in their enforcement monitoring?

Dr. WILENSKY. Because it would be a requirement in order to continue the State's authority to deem that plans are meeting the Baucus standard or whatever the new standard is labeled. And strong incentives could be placed so that if the State did not have that right delegated to it, the insurance companies could be adversely affected, both in a monetary way and in terms of the policies that it could offer.

Senator ROCKEFELLER. Another question. Generally, seniors are prime targets for unscrupulous business practices. The suggestion has been made that you get a printed statement from the Medigap

insurance company certifying that the policy is okay, that the Agency is okay, the so-called labeling method.

Could you address yourself to my very fundamental concern that labeling, that a label is something that (1) an agent can very quickly explain away to a disadvantaged senior—disadvantaged, that is not economically, but just disadvantaged in terms of awareness of the product, and (2) that labels are routinely overlooked as a part of our national ethic.

Dr. WILENSKY. Okay. There are two pieces to the issue that you have raised. First, we believe that providing more consistent, better information so that seniors can easily understand what is in the policy and in any additions to whatever basic minimum is defined by law, is extremely critical. There has been absence. There has been a lot of different terminology used. Even people like myself who think they understand the insurance world relatively well have difficulty understanding what some of the policies cover.

So that I have no quarrel with you about the fact that information, necessary information so that people can make informed choices, has not been available.

Second, I think the issue of what to do ought to be viewed in two ways. If you had lack of compliance with the NAIC model, you could, in fact, make it onerous in selling a policy, first, by requiring a very visible notice on every page of the policy the fact that this is not in compliance with the standards established by the NAIC and second by requiring the individual to sign a form indicating that he understood that.

Senator ROCKEFELLER. I want to get to my third question. On page 9 of your testimony you stressed the need for insurers to be able to develop what you call innovative benefit packages and that any restriction on "type and number of Medigap policies that may be offered would deprive beneficiaries of the ability they currently have to select the benefit package that fits their individuals needs" and indeed this is one of your principles.

Dr. WILENSKY. Correct.

Senator ROCKEFELLER. You also go on to say that you would prefer no standardization at all.

Dr. WILENSKY. Of benefits?

Senator ROCKEFELLER. Yes.

Dr. WILENSKY. Now——

Senator ROCKEFELLER. Let me finish. I might agree with you if before we had not heard testimony that seemed to suggest that seniors are really having an extremely difficult time picking appropriate Medigap policies. Consumers are overwhelmed by these choices. I do not understand your reluctance about standardization.

Dr. WILENSKY. With all due respect to the Senators who I know have been very concerned and given great thought to the legislation that has been put forward, I think there has been some misplaced emphasis. What has been needed is consistent, uniform, standard information. That has not existed. It is very difficult for people to understand what is in a minimum benefit package and in particular what is included in any additions and how much that might cost.

It is far preferable to require consistent terminology and to require that information be provided on what additions are offered

and how much cast that adds to the minimum package rather than to limit choice. The Medicare Select proposal that we are advocating, a preferred provider organization arrangement, is not something that is currently permissible under the Baucus standard. Not because I think the standard was designed to exclude it, it simply is an innovation that did not exist at the time that the legislation was written. It is precisely this situation we want to prevent from happening.

When you put forward a limited number of standardized benefits, you probably will not anticipate innovative changes like PPO's or networks of physicians with primary care gatekeepers that are now being developed by the private insurance industry.

I think the problem has been lack of a standardized set of definitions and information on the implication of adding benefits to the minimum package. I personally believe it is condescending and paternalistic to the elderly to say you can only buy three or four sets of benefits because we say so.

I do not think that is the best way to respond to the very legitimate confusion that you have raised and that your colleagues have raised in their legislation.

Senator ROCKEFELLER. All right. My time is up. Dr. Wilensky, I thank you.

Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman.

Dr. Wilensky, are you familiar with the experience of some States that have, as I understand it, simplified policies—that is, requirements that reduce the number of policies that may be sold?

Dr. WILENSKY. I understand that there are three, I believe, such States that do that.

Senator BAUCUS. Wisconsin is one State; is that correct?

Dr. WILENSKY. Yes. Kansas is another and I am not sure which is the third.

Senator BAUCUS. I understand Minnesota is the third State.

Do you have enough knowledge of experience in those States to know the degree to which that is a good idea? Is it working in those States? Are seniors happy or less satisfied? Are insurers more or less satisfied? I am just curious about what you know about those States in experimenting with this new approach in standardizing benefits.

Dr. WILENSKY. There have been two different approaches that are used in the three States. I was incorrect in saying it was Kansas. Minnesota, Wisconsin, and Massachusetts are the three States that have taken two different approaches. One is a rider approach where they limit the number of riders that are available; and the second option in Massachusetts limits the whole package.

I am not aware of surveys about consumer satisfaction or surveys that particularly get at the point as to whether or not this is the best way to handle this problem.

Senator BAUCUS. How long have those States adopted those two different approaches? How long have they been in existence?

Dr. WILENSKY. I can find out for you.

[The following information was subsequently received for the record:]

Dr. WILENSKY. Three states, Minnesota, Wisconsin, and Massachusetts, currently allow Medigap insurers to offer only those combinations of benefits outlined in state regulations.

The Minnesota regulations have only been in effect since January 1, 1990, while in Wisconsin they have been in effect since January 1, 1989. The Massachusetts statute has been in place since 1980.

Dr. WILENSKY. Let me just add one other point, Senator. While I obviously have strong feelings about the Federal Government engaging in this type of restriction on what the elderly of this country can purchase as Medigap, I have somewhat less objection because of the level at which it is occurring if States do choose to do that.

Senator BAUCUS. Well that is the very Government we have, basically, when it comes to insurance. States set their own insurance regulations.

Dr. WILENSKY. That is correct.

Senator BAUCUS. I was just wondering, don't you think it makes sense for us to learn more about those States before we decide whether or not it is a good idea—that is, before we categorically reject standardization of benefits as a bad idea?

Dr. WILENSKY. Well I certainly have no objection to learning more about it. As I think you know, I am a researcher by background and you will rarely find me objecting to trying to find out more about something before we make a decision.

But I would counter by saying, we have, to date, not done anything like what I am suggesting, which is make a serious attempt to provide standardized terminology and standardized information so that it is clear, very clear, what it is you are buying, and what you get and what it costs you to add benefits. I think this would be incredibly valuable and it would seem to me a much more prudent next step rather than to say we will jump beyond that and assume that it cannot happen. We should not assume that people who are over 65 are incapable of making choices, even with good information, and therefore go to this limited benefit.

Senator BAUCUS. I am a little unclear as to what you mean by standardizing terminology. I mean how is that really going to help solve the problem. As I understand the problem—at least according to GAO and through seniors groups—a lot of it is lack of enforcement and the loss ratio for many policies that are sold and purchased are lower than the 60 percent for individual policies. And we also hear that people are confused about the wide variety of different benefits packages that people are confused.

Now when you say "standardized terminology" or "standardized information" I am not quite certain what that is and how that is going to help solve the problem.

Dr. WILENSKY. The difficulty is that there are sometimes technical terms or there are terms that are used to mean different things—what the coverage is, what the benefit is, what the deductible involves. The requirement should be that when you use a term, it is always, in every policy, used precisely the same way. And even more importantly, that when you add a benefit it is clearly defined what is covered by the benefit that was not covered previously and also what that benefit costs.

You and Senator Rockefeller have referenced the GAO report. While it is true that there are a number of plans that do not meet the minimum loss ratios, I think it is important to note—I do not want to minimize the problem—that it is a little misleading to concentrate on the number of plans. The fact of the matter is, 90 percent of the premium dollars covering individual policies and 96 percent of the premium dollars for group policies met the minimum loss ratios. What that means is that there are some plans out there that few people subscribe to that are not meeting the minimum loss ratios.

Senator BAUCUS. My time is about up here. I want to ask you another question.

How many different plans are there now being sold? And how many different combinations are there of benefits now being sold?

Dr. WILENSKY. I do not have any information like that.

Senator BAUCUS. Your rough guess? Just off the top of your head, rough guess?

Dr. WILENSKY. A couple hundred?

Senator BAUCUS. Nobody knows?

Dr. WILENSKY. I am sure people do.

Senator BAUCUS. Well if nobody knows, how can we—can you—say that the problem is not complexity of the proliferation of a great number of plans or a combination of benefits?

I mean it is a little hard for me to square those two statements, if you don't know how many plans are being offered or the number of combinations of benefits are available.

Dr. WILENSKY. The problem is lack of information on what you are buying and how much it costs to buy any additional benefit. I agree it has been a very bad problem and it is one for which we bear some responsibility, along with the Congress, in allowing to happen.

But I think the way to fix the problem is to require uniform information on what the benefit addition is and what it would cost the elderly. Then the elderly persons can decide, whether they want it or not.

Senator BAUCUS. Well with all due respect, I think the solution involves more than that. That is part of it, but I think there is more to it than that.

Thank you very much, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Baucus.

Senator Chafee?

Senator CHAFEE. Thank you, Mr. Chairman.

Dr. Wilensky, in the first part of your statement, the printed statement, you talked about the fact that co-insurance and deductibles have been built by Congress into the program in order to assist in reducing the costs. Then you go on to point out that those who have Medigap insurance, and therefore are paying for the insurance and not paying for the deductibles or the co-insurance, end up by using the Medicare program 24 percent more and that it thus results in Medicare outlays of approximately $17 billion a year.

So what? Why are you putting that in your testimony? What are you trying to tell us?

Dr. WILENSKY. I was trying to make the point that requiring that everyone have first dollar coverage if they have Medigap wraparounds, first, in my view, needlessly limits choice; second, in fact, imposes some costs on the Medicare system. There is a substantial amount of evidence that first dollar coverage leads to greater use. And since the Federal Government pays at the least 80 cents on the dollar, there is a cost to all of us who are funding this program when there is first dollar coverage.

I am not saying that it should not be available. It strikes me that if there are changes to be made in the minimum benefit package, one of the things that should seriously be considered is to allow the option of a catastrophic wraparound. That is simply not permitted under current law. You must begin in the front end. It would not only give seniors a choice but——

Senator CHAFEE. Under the Baucus standards?

Dr. WILENSKY. Yes.

Senator CHAFEE. I think you are right. First of all, I did not mean to say "so what." I should not have said that because this is extremely interesting. I personally have always felt that some copayment or deductible is useful and that it makes people think twice before casually embarking into a program. Now perhaps the word "casual" is not the correct word.

I also do not quite understand why an individual, if he or she so chooses, cannot have catastrophic coverage.

Dr. WILENSKY. Correct.

Senator CHAFEE. I think this should be a market basket situation, that an individual could go in and get the type of insurance that is best suited to his or her situation. I agree completely with your point that you are making, and I hope we can revise the regulations or the standards to achieve the goal that you have set forth. I think that makes sense.

You, in your testimony, stress the importance of assuring that the States have a role in the regulation of insurance. I agree with that. Many argue that the insurers should not be able to market policies unless they are certified either by the State or the Secretary of Health and Human Services.

In the States which do not adopt the Federal standards, the Secretary would be required to certify every insurance policy sold in that State. In effect, the Secretary becomes a regulator, if you would, of Medigap insurance.

Dr. WILENSKY. Correct.

Senator CHAFEE. Now are you equipped to handle that?

Dr. WILENSKY. I do not believe so. I think that the States have historically had much more experience regulating insurance than the Federal Government.

Senator CHAFEE. Well, I think so too. I appreciate the testimony you have given here. And particularly, I want to reiterate the point that Dr. Wilensky has made, Mr. Chairman, about the fact that I think we want to make sure that the elderly understand the policies. But I do not think we should look on every elderly person as lacking the competence to do what is best for him or her, and that situations vary. I think we ought to recognize that.

Thank you, Mr. Chairman.

Dr. WILENSKY. Senator Chafee, as I had mentioned to Senator Riegle, I would like to express my appreciation for your support of our Medicare Select proposal and also for the sentiments that you have just expressed.

Senator CHAFEE. Thank you.

Senator ROCKEFELLER. Thank you, Senator Chafee.

Senator Riegle?

Senator RIEGLE. Thank you, Mr. Chairman.

You say a lot of the right things but you do not quite get there. We have to get you there. I guess I would say to you, when the bill that I have developed and has now quite a broad list of co-sponsors, when it is supported by the State Insurance Commissioners, which it is, when it is supported by the Blue Cross/Blue Shield, HIAA, and consumer and aging groups who agree on the need for simplification, what is it that they are missing, and that you are seeing? Or what is it that they are seeing that you are missing that causes you to not be willing to join that kind of a consensus?

Dr. WILENSKY. I have been trying to make clear that while I believe there has been real confusion, and that we in the Government bear some responsibility, I believe that the way we should correct that is to force a standardization of information—to make it very clear what is in whatever minimum package we agree to, and to make it very clear what benefits are added to it, and what those additional benefits cost.

I think it is not proper to limit the number of benefit packages that are available. I understand what you are trying to——

Senator RIEGLE. No, we do not limit the number of benefit packages at all. We want a standardized package with add-ons or some other mechanism that can go with that, but that does not necessarily limit the number of packages.

Dr. WILENSKY. Okay, then I am mistaken about that. I thought there was a limit as to what was put on.

It may be that there are some particulars about the bill then that I have misunderstood.

Senator RIEGLE. Maybe it is just semantics. Because what we are looking for is, with the help of all of the professional parties at interest, which of course you are one as well, to try to achieve some basic package that is a starting point and that is uniform—and albeit with the definitions and the clarifications, the same things you talk about—and then you can have also add-ons or whatever NAIC decides. You can have add-ons to that of all types and sorts that would be understood and what have you, that people can decide they want or do not want as such.

But the problem now is—and, you know, older persons are every bit as smart, if not smarter than people of younger ages, but for many people as they get older, it gets tougher to figure these things out. These things are not simple. They are very complicated. They are very confusing. People are being fleeced out of, you know, hundreds of millions and billions of dollars. I mean we have some obligation to put a stop to the fact that people are having their money taken away from them by people who are really exploiting the situation.

To have a standard package or packages that the experts in the field agree on, I view that as common sense. I mean I do not under-

stand where the objection lies. I am just having a hard time understanding that.

Dr. WILENSKY. We would, obviously, be pleased to work with your staff to see whether we cannot come to some further agreement. It is my understanding that your legislation gives the NAIC a period of time--9 months—in order to come up with not only the minimum, which would probably be statutorily defined, but nine other benefit packages and nothing else could be marketed.

It is really that limitation, as opposed to insisting on a standardization of information or information about the costs of any additional benefits that is in question. It may turn out that, in fact, there are only 9 or 10 or 15 packages that are put forward. But it is not limiting the number that is important. It is limiting the kind of information that must be provided, including the cost of any additional component, that we think is critical.

Senator RIEGLE. On the question of how many variations or add-ons one wants to consider, I think that is an open question. I think that can be discussed. I think what is critical here is to have a standard package that is well thought out, well crafted, that is uniform, uniform across the 50 States, people can understand it and then they can decide from that point whether they want add-ons or what not, and then can do some kind of a cost benefit analysis beyond that point.

Dr. WILENSKY. I agree with that.

Senator RIEGLE. But I think this is one area where the Government has a constructive role to play without being intrusive. I mean what we are trying to do here is allow people to get good value, fair value, full value, without being bled dry by people who are taking advantage of the inherent confusion of the existing set-up. I really think we have to get this done.

I mean these are the kinds of reasons why people have governments, to try to, you know, have intelligent things done that can help them make these kinds of choices in a situation where they are not taken advantage of.

Dr. WILENSKY. No, Senator, I very much agree with the statement you have just made. I would be very pleased to be personally involved and to have my staff work with your group to suggest some modifications that would make us more comfortable.

Senator RIEGLE. I appreciate that. Because, you know, we are not locked in concrete. I want to try to find something that is going to work. So let me accept that offer and we will talk further.

Dr. WILENSKY. Great.

Senator RIEGLE. Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Riegle.

Senator Heinz?

Senator HEINZ. Mr. Chairman, there is one issue that underlies the consumer confusion about policies, and which has to be, I think, directly addressed. When we say, for example, as Dr. Wilensky did, that what is needed is to have a minimum benefit package plus individual options that can be added onto that for a price, the question is: Is the consumer in a very good position to judge what a well integrated package ought to look like? If they were presented under this scenario with what you might call a Chinese menu—where you get one from Column A, which is the basic bene-

fit, and then multiple choice from Column B—could they make a good choice?.

I want to ask you, Dr. Wilensky, what information, if any, do we have about an individual's ability to judge the value of benefits based on the way they are described and also whether consumers have the information they require about the probability of needing a particular kind of benefit that might sound very attractive—it might sound rather unattractive—depending on how it was described?

Dr. WILENSKY. Well I guess I feel, in some ways, at a little bit of a loss about the general philosophical statement that is implied. It strikes me that we can agree that there is a need for clear language about what the benefit actually is—it's prescription drugs or nursing services or something else, and very clear understandable language about what that additional benefit costs above the minimum. I cannot think of anyone who is going to be a better position than the elderly person and the elderly person's family, who normally helps the elderly person, to make these decisions.

It is precisely because I believe that given some information—clear, understandable, standardized information—about what you would be buying, and what it cost you to get that additional benefit, that there is no one better able to decide whether the additional benefit is worth the additional costs than the elderly person. I think the notion that the Government can make this decision, or the so-called "experts" can decide better than those over age 65, is incredibly condescending to our elderly population.

Senator HEINZ. My question though was really: What information do we have, as opposed to your opinion or my opinion, as to people's ability to make these distinctions?

Let me tell you why I ask. Many of us have been engaged in trying to figure out how to guard consumers of nursing home services, whether it is for a loved one or for themselves against substandard care. The bottom line is, it is hard even for an expert to figure out whether one nursing home is above average, average or well below average. It is very tough, even for a member of the HCFA staff. It takes us sometimes, you know, many years to conclude that one nursing home, indeed, does deliver substandard care and should be sanctioned or, in some cases, lose its eligibility for Medicare or Medicaid patients.

It is not unreasonable to ask the question: Do we have any information beyond just your and my opinion? So that is really what I am getting at.

Dr. WILENSKY. Well, I suspect that in the future, there will be a minimum benefit package that will have been developed by a consensus of experts. Some decisions then, are already limited in terms of the benefit package that is available for the elderly individual.

We normally allow choices for people to make purchases. I guess my response to you is that I am not aware of information that indicates that we either should not or do not allow people to make choices, or that we assume they make bad choices when they are given good information.

Senator HEINZ. The following question might be considered a cheap shot, although it is not intended as such: Do you know which Federal employee's health insurance package you have?

Dr. WILENSKY. Yes, of course.

Senator HEINZ. Can you tell us the benefits in it?

Dr. WILENSKY. I can tell you some of them.

Senator HEINZ. You are better than most of us. You know how complicated it is to figure out which is a more cost effective proposition—the high option or the low option.

Dr. WILENSKY. It is not described the way I am suggesting, which is to say, additional benefits that move away from the minimum benefit package would have an added cost. I certainly wish they would do that. It would make it much easier.

Senator HEINZ. It certainly would. There are other things that might make it easier as well.

My time has expired.

Senator ROCKEFELLER. Thank you, Senator Heinz.

Senator Durenberger?

Senator DURENBERGER. On the issue of coverage, I certainly do like the recommendation that we require a catastrophic option. Is there a simple way to design that and to describe that? And is there some standard definition which would put you in a position to say that taking either Prudential, which writes a lot of AARP insurers, or Blue Cross, which writes a lot of their own supplemental, that one of the current standard plans costs "X" number of dollars in catastrophic only would cost so much a month? Have you any idea what the comparative costs would be?

Dr. WILENSKY. Let me go back and answer your questions in a couple parts. A common definition of "catastrophic," was agreed upon by you gentlemen awhile ago. There are a number of definitions that one could come up with, but not an infinite number. There are a few that I think would do. The sense of my colleagues in the back is that a catastrophic package might cost only half of what a standard wraparound package would cost. We can try to provide some additional information about that.

[The following information was subsequently received for the record:]

One possible catastrophic benefit package would require the following changes to the current minimum benefit package:

- All hospital deductibles, after the deductible related to the first admission for the calendar year, would be covered. This replaces the current requirement that policies cover either all or none of the hospital deductible; and,
- Part B coinsurance amounts after a $500 deductible would be met. This replaces the current requirement that policies cover all Part B coinsurance after the $75 deductible is met.

The annual cost of this revised minimum benefit package would be $300, according to our actuaries. The cost of the current minimum benefit package is $580, a difference of 48 percent.

Dr. WILENSKY. I am told that a $500 deductible for Part B with one deductible per year would, for example, halve the cost of a premium. So, again, it depends on whether you look at the catastrophic definition you used in the catastrophic legislation or something slightly more lenient. But we believe it would have a significant impact on the premium costs to the elderly.

Senator DURENBERGER. You would be paying—that kind of a plan after the first $500 would be paying what?

Dr. WILENSKY. Everything else in Part B.

Senator DURENBERGER. Everything else that is covered under Part B.

Dr. WILENSKY. That is covered under Part B.

Senator DURENBERGER. All right.

Dr. WILENSKY. But again the minimum could be tailored to Medicare coverage, in which case it would kick in after a certain amount of money is paid on Part A or Part B. You could structure it so that it would pay on either—the exact issues that you struggled with in defining the catastrophic legislation.

Senator DURENBERGER. Would you favor a prohibition against coverage for the current deductible on Part B if we were to incorporate that in there, eliminating the coverage for the deductible?

Dr. WILENSKY. I would prefer that there be less coverage of Part B. I do not know that I would want to have a prohibition of covering the deductible.

Senator DURENBERGER. Why not?

Dr. WILENSKY. Basically, for the same reason that I've made some of my other statements. In general, I would prefer to have people be able to choose if they wish to pay for it. The problem with this, which has been an issue that economists have raised over the last 10 years that I have been aware of, is that first dollar coverage imposes costs on the rest of the system. People have suggested from time to time that if you have first dollar coverage you ought to have to pay a tax on it because of the impact that it imposes.

In general, I prefer to try to get people to do things or not do things through financial incentives rather than through outright prohibition. But the point that you are raising is that it does impact the cost to the rest of the system in a significant way.

Senator DURENBERGER. Do you or anyone in the front row have any of those examples if we did eliminate deductible coverage, as to what impact that might have on the premium costs?

Dr. WILENSKY. We would be glad to supply it for the record, Senator.

Senator DURENBERGER. Okay.

[The following information was subsequently received for the record:]

The premium for the current minimum benefit package, including all hospital deductibles, is $580 annually. The cost for the same package with only one hospital deductible for the first admission in a year would be approximately $420.

Senator DURENBERGER. My third question is, your Medicare Select proposal provides that minimum loss ratios for these managed care policies will be 10 percent lower than the minimums for other Medigap policies. If managed care promotes efficiency in health care delivery, why should these policies be expected to pay out less in benefits than non-managed care arrangements?

Dr. WILENSKY. The only issue we were trying to address is that there are administrative costs involved in this type of plan that are not part of other insurance plans. So we were trying to recognize

that. Whether the precise percent is correct or not, it is our best estimate with the advice that we had.

What we were trying to do is to have a comparable pay out for benefits. We believe there would be an additional administrative cost that these organizations would have to face and we were trying to compensate.

Senator DURENBERGER. So then if we are going to go back and revisit the tougher risk contract kinds of operations you would favor 110 percent of the AAPPC or some other?

Dr. WILENSKY. We have been trying hard to get you to consider 100 percent.

Senator DURENBERGER. Thank you.

Senator ROCKEFELLER. Thank you, Senator Durenberger.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

Dr. Wilensky, I find myself in agreement with many of the things that you have said this afternoon. Where I find myself in very stark disagreement is on an issue that has already been discussed at some length from a lot of different angles. That issue is simplification.

You were asked earlier about the States' experience with simplification; and you indicated correctly there are three States who have simplified their Medigap markets. Senator Durenberger's State is one. In fact, Minnesota has been a leader in this area. What we have found is that in Wisconsin there have been 12 percent fewer complaints since simplification has been enacted. We do not know the exact percentage in other States, but in all three cases the States have reported a fairly significant decrease in complaints.

Number two, nearly every consumer group, nearly every senior citizen group, has indicated they want simplification. They are not arguing that there ought to be the broad array of different policies on the market. So I guess when one looks at both the experience of the three States that have it and the broad array of users who want it, it is a pretty courageous stand you take as you argue for something other than what seems to be the writing on the wall.

Senator Riegle asked you what HCFA knows that these groups do not know, that these States do not know. I am not sure you had an opportunity to answer that question. But I would give you another opportunity if you want to take a shot at it.

Dr. WILENSKY. I would very much like to.

Let me first say that standardization of benefits does result in simplification. I have no question with that. And particularly compared to the chaos that exists, I am not in the least surprised that you would get 12 percent, or whatever percentage you mentioned, fewer complaints. It is relative to the situation.

Since we do not have an example where there is clear information about what you are buying and what it costs you if you buy above a certain package, it is not clear to me that you would not have 20 percent less frustration or whatever. I cannot tell you that you would. It would certainly seem to me that what is being proposed is a far more drastic step than what ought to be the next step.

Second is that while I am aware, maybe even painfully aware, that there is more support than I might have thought would occur for the standardization of benefits, I am not sure whether that includes AARP. That is obviously a large group. Their point of view would be important. Occasionally groups have been known to not speak as clearly on behalf of their members as they might.

As I have said to you, I think we have not done what we need to do for the elderly. I think we really have not served them as well as we could. We have not assured them that they could buy, with a minimum amount of effort, a Medigap package and know what they are buying and what it is costing. I think the way to correct that is to ensure that information exists and not to assume that competent, elderly people cannot make judgments if given the information.

Senator DASCHLE. Well let me pose a question in the form of a statement. I would like you to, if you could, respond to the three points I am about to make. You were asked how many different varieties of policies and plans are there today. And understandably, you could not give a specific answer. I think it is conventional wisdom that there are thousands. Given all the different provisions of every different plan, if you mix and match them up anyway you want to, you could come up with a combination of thousands. I do not think that anyone would dispute that.

The question I have with regard to that conventional wisdom is: How do you standardize information if you cannot standardize the packages? In other words, don't you by the very nature of offering this broad array of different choices necessitate a broad array of different terminology to define each of those choices? That is my first point.

The second point is enforcement. If I assume that your answer to the first question is "yes," then my next question is: How in the world would you enforce it in law? How do you enforce this if insurers say, "well, of course, the information is different because the policy is different?" And the policy may legitimately be different. So if insurers are going to define the nuance in that particular new policy they are going to have to do it with their own information. I see the light is on. That is the second point.

The third point I would make is——

Senator ROCKEFELLER. Take your time, Senator Daschle, because you did not have an opening statement. So take your time.

Senator DASCHLE. Thank you, Mr. Chairman.

The third point that I would make is that, insurance companies tell me that if you do what you are suggesting, that is, limit information, you are going to limit the number of policies offered. They indicate to us perhaps four to six different Medigap policies would be offered to beneficiaries. So you are accomplishing what you say you do not want to accomplish by standardizing language, if the experts are any guide. So why not do it anyway? Why not do it to begin with?

Could you respond to those three points.

Dr. WILENSKY. I will certainly try to do that.

Let me say that I agree with your conclusion that the result of requiring the information that we are talking about would limit or reduce the number of policy and plan options over what is current-

ly available. I think it would reduce them because it would be exceedingly difficult to try to make a convincing case as to why people might want to buy additional benefits relative to either a minimum or some standardized optional descriptions.

The point is that by not setting out ahead of time to define limited benefit packages in statute, but by requiring consistent terminology and consistent information to be provided about what happens when benefits are added on, you allow for changes to occur that you all might not think of today, or that today might not seem important, but in fact represent a legitimate change next year or 2 years from now.

Rather than have to go through the cumbersome process of redefining a new, acceptable benefit package, the information and the terminology should be standard and clear, as well as the cost of adding on to whatever minimum package you use. I really do hope you give some consideration to the catastrophic as a minimum. Then, if you have PPO's or networks of physicians or some other organizational arrangement that might not turn out to fit your five packages or eight packages or nine packages, you do not have to worry about altering or amending the legislation.

I really do not think that the way to solve the problem that all of us are concerned about is to arbitrarily limit the number of benefit packages that we allow to be sold, but instead to have standardization of the terminology used and to provide information, particularly on the cost of any additional benefit.

How do you go about monitoring it? Certainly a legitimate question. As I have indicated earlier, I think that we have all been remiss, that we have allowed, under the voluntary program, which I am not opposed to, this arrangement to go on. You have an agreement made between HHS and the States, and we in the Federal Government never look back to see how the States did. Did the States live up to the arrangement that they said they would? Did they, in fact, apply their rules in the way that they said they would?

I think it is important and I think it ought to be required that States report, on a periodic basis, information necessary for the Federal Government to make the determination that the States are carrying out the agreement that we entered into. The agreement itself is pretty good. You can argue about whether the loss ratios ought to be a little higher or whether we want to make some other changes, particularly the NAIC consumer protection changes that were included in the catastrophic coverage legislation and are required to be in place by December of this year.

I think we have made great strides toward having the elderly protected. The problem is, there is nothing in the current law that forces or even allows us to easily provide the kind of oversight that we should to ensure that the States actually carry out that agreement. That was in error and I think it is an error that could use some fixing, but I think there is a way to fix it.

Senator DASCHLE. Well you are quite an optimist, and I must say it just recalls the old story about draining the sea to find the submarines. You know, you first must find a way to drain the sea. That is not my problem. You know, you said you are in research. I think with any sales experience you would have to come to the con-

clusion that with the thousands of different packages will come thousands of different explanations which will come thousands of problems associated with describing each of those packages; and you are right back to where you started.

Dr. WILENSKY. I think not if you require consistent terminology. I know the NAIC will be up later. In the discussions I have had with the insurance industry, it seems it would not be difficult to develop consistent terminology. Now enforcing it is a different issue. I am a big believer in using financial incentives to get people to behave in the way that you would like.

States that do not engage in this agreement can have their insurance companies facing severe penalties. They might still be able to come into the Federal Government for certification, as they now are allowed to under the Baucus Amendment, but we could make it mighty expensive for them to do that. We could hit them with a very expensive certification fee in order to keep the States in this game, making sure that the States undertake the regulatory mechanism that they traditionally have under McCarran-Ferguson.

Senator DASCHLE. Well, I am confident about one thing, and I will end with this—whether we take it your way or whether we take it our way, I think we are going to end up with approximately the same thing. You are going to get a half a dozen or so policy options. You will be satisfied with that, because you said all you want to do is limit terminology. I will be satisfied with that because it simplifies the plan.

But I would just say that if experience is any guide, and it certainly seems to be in the three States that offer simplified plans today, if it is any indication as we talk to consumer groups what it is they find to be the most reasonable approach to solving the problem, we have a pretty good road map. I do not think I will ever persuade you, and you certainly will not persuade me. I appreciate your willingness to come this afternoon. Thank you.

Thank you, Mr. Chairman.

Senator ROCKEFELLER. Thank you, Senator Daschle.

Dr. Wilensky, thank you very, very much. As usual you have been on the stand for an hour and a half or so. But you do well. I happen to agree with Senator Daschle's closing when I think of the 96 companies in West Virginia offering—but that is another matter.

Dr. WILENSKY. Well I might have done well, but I didn't do well enough if I have not convinced you gentlemen. But thank you for the opportunity to appear before you.

Senator ROCKEFELLER. Thank you very much.

I would like to bring forward our next panel. Earl Pomeroy, commissioner of insurance, State of North Dakota and president of NAIC; also Alissa Fox, who is the senior Washington representative of Blue Cross/Blue Shield Association; Linda Jenckes, vice president of Federal affairs, Health Insurance Association of America; and Karl Hansen, Vita Insurance, who is in fact testifying on behalf of the National Association of Life Underwriters.

Earl Pomeroy, if you are ready, sir, we would like to start with you, remembering that the 5-minute rule applies for all of us.

STATEMENT OF EARL R. POMEROY, COMMISSIONER OF INSURANCE, STATE OF NORTH DAKOTA AND PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, BISMARCK, ND

Mr. POMEROY. Mr. Chairman, thank you. I am going to be very brief. I do have a plane to catch back to North Dakota. I am wondering if I might take questions upon completion of my opening statement and certainly upon exhaustion of the committee's inquiry in order to facilitate my plane departure. You can evaluate that.

Senator ROCKEFELLER. What time is your plane departure?

Mr. POMEROY. Ten minutes before 5:00.

Senator DURENBERGER. You can ride out with me, Earl, if you want.

Mr. POMEROY. Thank you, Mr. Chairman.

My name is Earl Pomeroy. I am testifying as president of the National Association of Insurance Commissioners, chairman of the NAIC's Medicare Supplement Task Force, and as the Insurance Commissioner from North Dakota.

I want to underscore the Insurance Commissioner's concern for meaningful consumer protection of the Medicare supplement market. As we speak about issues this afternoon we operate on a complete philosophical agreement that there needs to be effective regulation to make certain this market is well served and demonstrated abuses are effectively prohibited.

Now working together, Congress and the NAIC have accomplished through a very unique partnership a great deal over the past decade. I want to indicate what we have accomplished briefly, indicate what is on the drawing board at the NAIC, and then also reveal about how we feel about certain provisions of various legislative proposals introduced by Senators Pryor, Riegle, Daschle, and Chafee.

In 1980 Congress passed the Baucus Amendment to the Social Security Act imposing the voluntary certification method. This imposed effectively minimum standards in the Medicare supplement market. Minimum standards were developed by the NAIC and the imposition of these minimum standards had a very positive effect on the market place. Certainly a number of coverages that were illusory or ineffective disappeared from the market as no longer being in compliance with the minimum standards.

States virtually universally enacted standards which at least came up to the minimum Baucus standards. With the passage of the catastrophic care extensions Congress allocated to the NAIC the responsibility of coming up with the new minimum standards appropriate for the catastrophic reconfiguration of Medicare. We did that, Mr. Chairman; and within 1 year 49 States had passed the statutes and regulations necessary to meet the new minimum standards.

I cite that 49 State figure as very important. It shows how seriously States accept their responsibilities under the minimum certification, under the present Baucus legislation. The repeal of catastrophic represented yet another important chapter in the congressional NAIC effort to improve the consumer protections in this market. The repealing legislation authorized the NAIC not just to

redesign the minimum standards, but to enhance the consumer protections offered in the Baucus framework. The new protections that the NAIC brought forward include guaranteed renewability, limited aging commission structures, improved and clarified the required outline of coverage, imposed appropriateness of coverage requirements upon agents selling this coverage, clearly prohibited duplication of Medicare supplement coverage, and required company reporting of multiple policies.

These standards are presently being enacted State by State in order to reach certification. The 1990 NAIC Medicare Supplement Task Force is also an ambitious one. It includes standardization, examination of loss ratios, and evaluation of limited benefit policies. The task force has voted to move toward a standardized format in the Medicare supplement market. Presently we are trying to steer the course between affecting meaningful simplification through standardization while preserving optimal, meaningful consumer choice.

This is an extremely difficult line to draw and we are committed to incurring substantial research dollars surveying consumer preferences as we move the standardized format configurations forward.

We have done a great deal to strengthen loss ratio monitoring. At our meeting held earlier this week we voted to bring into the NAIC office a multi-State, representatives of several States, for purposes of evaluating the loss ratio data that we have achieved. As I told you in February, Mr. Chairman, we have also substantially improved the loss ratio reporting form which makes it much easier to enforce loss ratios. We are also looking at raising the individual loss ratio to 65 percent. I cannot indicate to you this afternoon that this is a step the NAIC as a whole will take. Eleven States have moved that way and it has not been demonstrated, at least to my satisfaction, that increasing the loss ratio from 60 to 65 percent resulted in any significant market dislocation.

Again, I am not certain whether the NAIC will move the model in that direction; but States are individually appearing to. There is a trend moving that way. We also are surveying limited benefit policies for purposes of identifying what is in this market and the loss ratios that are being realized.

There are several points of agreement and disagreement with the Federal proposals that are pending. We strongly support the Consumer Council provisions of the Pryor, Riegle and Daschle legislation. We endorse a clear prohibition of duplication. We acknowledge the legitimacy of moving toward a standardization format, although prefer doing it in a manner within the Riegle bill rather than the Daschle legislation. We acknowledge the importance of managed care. And to that end support the Medicare Select provisions of Senator Chafee's proposal.

We oppose the mandatory certification provision of the Daschle legislation in light of track record in meeting voluntary certification. I do not believe the need for this has been established. We strongly oppose the Senator Chafee proposal regarding ongoing HCFA monitoring of State performance.

While Dr. Wilensky indicated that HCFA does not want to regulate insurers, it appears to us that this proposal would have HCFA regulating States and State departments; and this is unacceptable.

Thank you, Mr. Chairman. I will be happy to answer any questions.

Senator ROCKEFELLER. Thank you, Mr. Pomeroy.

Senator Durenberger and I determined that your flight schedule is all right and we can go through the panel.

Mr. POMEROY. Sure. I will certainly defer to that determination, Mr. Chairman. [Laughter.]

Senator DURENBERGER. You are stuck riding with me.

Senator ROCKEFELLER. Ms. Fox?

[The prepared statement of Mr. Pomeroy appears in the appendix.]

STATEMENT OF ALISSA T. FOX, SENIOR WASHINGTON REPRESENTATIVE, OFFICE OF GOVERNMENT RELATIONS, THE BLUE CROSS AND BLUE SHIELD ASSOCIATION, WASHINGTON, DC

Ms. Fox. Thank you, Mr. Chairman. I am Alissa Fox of Blue Cross and Blue Shield Association. I appreciate the opportunity to present our views today on Medigap reform. The Blue Cross and Blue Shield Association supports the enactment of a meaningful Medigap reform bill this year.

The association supports most aspects of the various legislative proposals under consideration by the committee. We support efforts to strengthen enforcement of minimum loss ratios, raise the minimum loss ratio for individual policies to 70 percent, simplify Medigap benefits, fund State consumer counseling programs, assure that individuals buy only one Medigap policy, and foster the development of Medigap PPO's.

I would like to take this opportunity to outline concerns we have about some provisions contained in the bills. While we support the movement to simplify Medigap benefits we would like to see one important change. Legislation should provide NAIC greater flexibility to consider a range of approaches to simplification. We are concerned that the limit on the total number of options insurers could offer, which has been specified in two of the bills, would unduly constrain the NAIC and preclude some proposals, including ours, from being considered.

Also, in order to encourage worthwhile innovation we recommend that State insurance departments, rather than NAIC or HHS, should have the authority to approve innovative benefits.

I would like to describe the simplification proposal we have submitted for NAIC's consideration. Under our proposal the NAIC would specify a core benefit package that all Medigap insurers would be required to offer. This is consistent with the bills before you. The NAIC would also specify a limited number of standardized additional benefits that insurers could package with the core benefits as appropriate. These optional benefits would be precisely defined by NAIC. We have attached to our testimony an example of a chart that could be used by all insurers so that beneficiaries could compare policies.

We believe this approach offers several advantages. Consumers would be able to make comparisons across policies because all the variations in coverage and cost-sharing designs for a given benefit would be eliminated. Consumers would have access to more options and insurers could be more responsive to local consumer needs and competitive environments if they had the flexibility to design benefit packages.

We have concerns with two approaches that are currently under discussion. First, we are opposed to an approach that would require a minimum package with benefit riders that could be purchased separately at the beneficiary's option. Allowing beneficiaries to accept or reject specific benefits at the time of purchase would lead to serious adverse selection, resulting in higher premiums. In fact, our actuaries estimate that it would cost a consumer about 28 percent more if benefits were offered individually as riders. We also believe that riders could result in insurers dropping certain benefits, such as prescription drugs.

We also would not support a prepackaged approach under which insurers could offer a very limited number of prepackaged plans. It will be extraordinarily difficult for any entity to decide the appropriate content for a limited number of policies that will be sold nationally.

A second area of concern is direct Federal regulation of Medigap insurance. We favor maintaining the Baucus voluntary certification program that preserves State regulation of insurance. In our view, the entirely voluntary structure outlined in the Federal Baucus amendments has worked extremely well. We believe the Federal Government could play an important role in fostering more effective State regulatory programs, and we support provisions that would accomplish this.

Finally, we are very concerned about additional process requirements for State Insurance Commissioners, such as mandating public rate hearings. Such requirements would further tax limited staff and financial resources which we believe would be better channeled into enforcement activities.

Thank you for the opportunity to provide our recommendations.

Senator ROCKEFELLER. Thank you.

[The prepared statement of Ms. Fox appears in the appendix.]

Senator ROCKEFELLER. Linda Jenckes?

STATEMENT OF LINDA JENCKES, VICE PRESIDENT, FEDERAL AFFAIRS, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Ms. JENCKES. Thank you, Mr. Chairman. As always, it is a pleasure to be with you and the other members of the committee. I would like my entire submitted for the record and would like to highlight its contents for you now if I may.

Senator ROCKEFELLER. Please.

Ms. JENCKES. The HIAA shares the concerns of Members of Congress, consumers, and senior citizens groups who believe that despite vigorous State regulation of the private Medicare supplement industry some consumer problems do in fact persist and should be confronted.

Also, due to consumer confusion regarding coverage needs, seniors may be purchasing unnecessary policies. At the State level the industry has been working with the National Association of Insurance Commissioners and Commissioner Pomeroy to develop solutions to these market problems. Proposals currently before the committee would employ a variety of approaches to deal with problems in the Medicare supplement marketplace.

We appreciate the concerns of the sponsors of these proposals and have been, and hope to continue, working with you and your staffs to craft solutions to these problems.

After studying all the bills pending before committees of the Congress the Association has developed a set of legislative recommendations, many of which are very much like the provisions in some of your bills. We believe that our recommendations will effectively deal with problems in the Medicare supplement market. These HIAA supported reforms to be implemented within the current statutory frame work would improve the value of Medigap coverage and alleviate problems in the marketplace.

The reforms include: simplification of Medigap policies, guaranteed renewability of coverage, prohibiting the sale of Medigap policies to persons also enrolled in Medicaid, assuring that States have approved policies sold to their residents and the premiums charged for them and prohibiting the sale of duplicate Medigap policies. We support counseling for seniors on their health insurance needs and also limiting delays in coverage for pre-existing conditions.

There are provisions in various bills that we cannot support because we feel they would reduce the availability of coverage. Of particular concern to the HIAA are proposals which would have the Federal Government increase the minimum loss ratio requirements for individual and group Medigap coverage and which would expand the Federal role to cover types of health insurance not sold primarily to seniors which are indemnity or dread disease policies. We are concerned about proposals which would regulate agent commissions and limit medical underwriting as well.

I will highlight some of the specifics now. We would like to state our strong support immediately for Federal legislation to promote health insurance counseling and assistance to seniors. The Pryor, Kohl, Riegle, Daschle, and Chafee bills all have worthwhile consumer counseling and assistance provisions. Similarly, the establishment of toll-free hotlines called for by the Kohl, Riegle, Daschle and Chafee bills to assist seniors with health insurance questions or problems would be worthwhile and a cost effective initiative.

On increased civil penalties as contained in the Kohl, Riegle and Daschle bills, we do not oppose such increases. On the sale of duplicative coverages, the NAIC consumer protection amendments now being put into effect by the States deal effectively with the problem of seniors being sold more than one Medicare supplement policy and we support them. We also support similar Federal legislation specifically prohibiting the sale of duplicate Medicare amendments based on these NAIC recommendations. On approval of premium rates, the Kohl, and Senator Daschle, your bill, would require all States specifically to approve any premium increase for Medicare supplement insurance. We support this requirement. Virtually all

States presently have such a requirement for individual policies but may not require it for approval of group premium rates.

On simplification of Medicare supplement policies, I would like to respond to the question, Senator Daschle, that you asked before regarding the number of benefit options which are presently available. We just recently did a survey of our companies to determine how many additional benefits they were generally offering. We came to the conclusion—and this is attached to my statement and is included in the full statement—that it is approximately eight. However, there are different degradations of each. For example, on balance billing one company may offer 10 percent of its costs or 20 percent or 100 percent. Also, although eight are the most common, there are actually only four which are most typically offered.

[The following information was subsequently received for the record:]

TYPES OF ADDITIONAL BENEFITS OFFERED TO THE MINIMUM STANDARD MEDICARE SUPPLEMENTAL INSURANCE POLICY

Policies		Type of benefit	Covered persons	
No.	Percent		No.	Percent
19	59.3	Payment of greater than the Medicare allowable charge on Part B	257,227	9.6
16	50.0	Payment for additional SNF days during a Medicare certified SNF admission	2,623,615	98.5
11	34.3	Private Duty Nursing	2,611,505	98.1
8	25.0	Prescription Drug Coverage	591,717	22.2
9	28.1	Foreign Medical Care	81,500	3.1
5	15.6	Hospital services not covered by Medicare (e.g. private room) [1]	59,105	2.2
2	6.2	Immunizations [1]	13,500	0.5
2	6.2	Ambulance charges not covered by Medicare [1]	13,500	0.5

[1] Benefit not offered by more than one insurer.

At any rate, we are supportive of the concept of standardization but do not believe it is either advisable or necessary to limit consumers to choosing among a few prescribed alternative packages as contemplated in your and Senator Riegle's bill. If the goal is to simplify informed decision making by consumers, we believe it can best be achieved in a way which provides consumers a greater range of choices while allowing insurers greater latitude to design competitive benefit packages—not too dissimilar to the Blue Cross position.

Under the alternative system we have in mind, the Congress would require the NAIC to develop a list of standardized optional benefits and uniform language and formats to be utilized in Medicare supplement policies and outlines of coverage. Insurers would be permitted to select whichever of these individual standardized benefits they wish to offer in addition to the minimum benefit package, but would also have to offer prospective purchasers a policy containing only the minimum required benefits.

We feel that an improved outline of coverage, which is also attached to my statement, will help consumers in identifying the choices which are in their best economic interest.

On hospital and dread disease policies, we do not agree that Federal action is needed either to regulate the loss ratios or limit the sale of hospital indemnity policies to Medicare beneficiaries. Hospi-

tal indemnity policies are not Medicare supplements. Unlike Medigap policies these policies are unrelated to Medicare and they are marketed population-wide, not just to Medicare beneficiaries. Their loss ratios, benefits, outline of coverage, and marketing are controlled by States under a separate NAIC model regulation. We look forward to working with the NAIC in their oversight as to whether that regulation is effective.

We look forward to working with you on the other provisions in the bills which are contained in my full remarks.

Thank you.

Senator ROCKEFELLER. Thank you, Linda, very much.

[The prepared statement of Ms. Jenckes appears in the appendix.]

Senator ROCKEFELLER. Senator Daschle has just made a good observation. It is 10 minutes of 4:00, Earl. Karl, we are not going to forget you, but I think it would be important maybe to ask you a couple of questions and let you go. Because Friday afternoon is a little bit different than other places. Let me just do one or two.

Karl Hansen, who has not spoken yet, will testify right after you leave that although his organization initially opposed NAIC standards on limiting commissions to 200 percent, they have agreed to abide by NAIC standards and that the NALU is not "lobbying the State capitols to defeat it."

How often are NAIC standards overridden by State capitols? Are all the NAIC minimum standards subject to State discretion? Which NAIC standards most frequently are not adopted by States? How much discretion, in fact, do States have?

Mr. POMEROY. The Baucus partnership for the regulation of Medicare supplement has brought about a system where the States virtually comply with every aspect required for certification, and the indication of the HCFA panel which certifies whether a State complies or not, has deemed each of the major components of the Consumer Protection Amendments to be required and not discretionary in order to achieve certification.

Where we are finding the greatest resistance in terms of the legislation of the enactment of the consumer protection amendments is in the agent/commission area and I am pleased that it is not the life underwriters that are generating that opposition. It comes from, primarily, individuals engaged exclusively in the sale of health insurance to senior citizens. Frankly, the target group, which has caused a good deal of the problem, we are addressing generally.

So the minimum standards are taken seriously. There is very little discretionary room if a State is to achieve certification.

Senator ROCKEFELLER. Okay. Now I think I heard you say that if there was an increase in the loss ratio you do not think there would be a substantial affect on access to these policies.

Mr. POMEROY. Depending on what the increase is, Mr. Chairman.

Senator ROCKEFELLER. Sure. Obviously. But if it was as in the bills?

Mr. POMEROY. I think the adjustment in the bill, moving individual to 70 and group to 80 would definitely have an impact in terms of market access and availability; and I think would disrupt the market. I, personally, as a North Dakota Commissioner, I believe

taking the individual loss ratio requirement from 60 percent to 65 percent will cause no dislocation. Eleven States have taken that move. I know of no State that has taken individual up to 70 percent or group up to 80 percent. I believe there would seriously be problems in that area.

Senator ROCKEFELLER. You mean you believe because you are not sure, because nobody has done it yet or do you clinically, so to speak, believe that that would cause disruption?

Mr. POMEROY. I believe based upon information which has been presented to me as a regulator evaluating this. The North Dakota Department, nor the NAIC, neither have done an exhaustive study about the impact of 70 percent on the market, although I believe based upon my technical regulatory expertise and understanding of the market that there would be problems.

Senator ROCKEFELLER. That is interesting. Okay. Well I am glad I asked that question. I have one more before Senator Daschle.

Linda Jenckes indicated in her testimony that an increase in loss ratios for individual Medigap policies would largely eliminate the use of agents in marketing Medigap policies. Do you agree with this statement? Who is it that commonly purchases Medigap policies from agents—individuals in rural areas, low income individuals? What percentage of the Medigap market is in fact sold by agents?

Mr. POMEROY. I do not have specific data relative to the percentage of the markets sold by individual agents as opposed to group. I do know that individual agents play a major responsibility in providing effective access of the consumer to this product and that direct marketing efforts fall short of blanketing the universe of people that might be interested in purchasing this coverage.

I do not believe the experience in those States which have taken individual loss ratio requirement up to 65 percent have found the agent activity to tail off substantially. Even in rural areas the State of Minnesota, for example, has had a 65 percent loss ratio requirement since I believe 1983, possibly 1981. But in any event their market is difficult to distinguish relative to availability from the North Dakota market which is still at the 60 percent, although we are now in the process of moving to 65 percent.

Senator ROCKEFELLER. So again the 65 to 70 percent differential is a question in your mind on this matter also?

Mr. POMEROY. That is a question. But I think taking it from 60 to 65 is by my view a safe step. Moving beyond that I have some serious questions about the market implications.

Senator ROCKEFELLER. Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

Minnesota also has mandated level commissions. I would be interested in knowing whether there is any evidence, just as Senator Rockefeller has asked about loss ratios, on the basis of what we have been able to tell from Minnesota's experience, that there has been an unwillingness to sell Medigap policies in Minnesota because of the level commissions.

Mr. POMEROY. The NAIC Medicare Supplement Task Force has heard from the State of Minnesota specifically on this point. The department has represented to us that their market has not been unduly disrupted or even disrupted to a significant extent.

Senator DASCHLE. Our bill has, as you may know, mandates a 150 percent first year commission rate. Do you think that is unreasonable?

Mr. POMEROY. I believe a 150 percent first year commission rate is not unreasonable; frankly, as an individual regulator, I prefer it to the 200 percent in the NAIC model. On the other hand, the NAIC model—and there are commissioners that believe the NAIC model goes too far. There certainly is a good deal of resistance encountered in the States as we try and legislate the 200 percent.

So reasonable minds can differ on that point. But I do not personally have a problem with the 150 percent.

Senator DASCHLE. You heard Dr. Wilensky talk about simplification. Do you agree with her?

Mr. POMEROY. I do not agree with Dr. Wilensky on the issue of simplification, although there is no question about the sincerity of her views. The fact of the matter is that there are not an infinite variety of required coverages within this narrow market. There are about 10 major coverages afforded in a Medicare supplement policy and I believe that you can restrict in a fairly standardized way the market into offering those major coverages and reach the goal of standardization without unduly impinging upon consumer choice.

Senator DASCHLE. You must talk from time to time with the Commissioners from Minnesota, Wisconsin, and Massachusetts. As they have talked with you, either informally or in some of your meetings, have they given any indication that there is a problem with standardization as they have experienced it?

Mr. POMEROY. Yes and no. Generally speaking, all prefer standardization, believe their constituents are happy with it.

Now the business of achieving standardization is very technically difficult. Minnesota and Wisconsin each within the last year have undergone fairly substantial revisions to their initial standardization effort and in each instance they feel they have improved their legislation.

Each of the three formats is different from one another. Minnesota and Wisconsin are actively participating in the NAIC Task Force effort to arrive at a model standardization format. So it can be done. Doing it is tricky and the States that have done it are still learning how to improve upon this format.

Senator DASCHLE. Very good.

I have been in exactly the same position you are in right now, Mr. Pomeroy. You are going to my part of the country as our neighbor. I wish you well. There is nothing worse than getting to National at 4:00 on Friday afternoon. Good luck.

Mr. POMEROY. Thank you very much, Senator Daschle.

Senator ROCKEFELLER. That you, Earl, very much.

Mr. POMEROY. Thank you, Senator Rockefeller.

Senator ROCKEFELLER. Karl Hansen, please proceed. I am sorry to scoop part of your testimony.

STATEMENT OF KARL E. HANSEN, PRESIDENT, VITA INSURANCE ASSOCIATES, MOUNTAIN VIEW, CA, TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

Mr. HANSEN. Mr. Chairman, Members of the subcommittee, thank you for giving the National Association of Life Underwriters the opportunity to testify today. My name is Karl Hansen. I am president of Vita Insurance Associates in Mountain View, CA. In fact, I have not been to Florida in quite sometime. I just want to make that clear.

NALU, currently celebrating its centennial is a Federation of 1,000 State and local associations. The 138,000 members of these associations are sales professionals in life and health insurance and other related financial products.

We are especially pleased to testify before you on the issue of Medicare supplemental insurance. There has been much hyperbole over the past several months on this issue. You have heard testimonials from individuals who claim to have been improperly sold a multiple number of Medigap policies.

Let me state at the outset as emphatically as possible that NALU does not promote nor condone any of these abuses in the market place. Although there seems to be little objective evidence about how widespread these egregious practices have become, we want to join with you to help pass legislation that will terminate the elicit activities of these boiler room operations.

Over the past several weeks we have been working with Congressman Pete Stark, chairman of the Ways and Means Subcommittee on Health, to develop a package of reforms that protect and help consumers. We are pleased to inform you that NALU, along with the National Association of Professional Insurance Agents, the Independent Insurance Agents Association of America, and the National Association of Casualty and Surety Agents strongly supports Mr. Stark's new proposal.

Let me briefly outline the nature of the package. Although all of the details have yet to be worked out, we believe that it promises to be an excellent piece of legislation which deserves both congressional and industry support. It includes proposals first to standardize benefit packages, prohibit the sale of duplicative policies, establish a uniform calculation of loss ratios, codify pre-existing condition limitations, medical underwriting reforms, establish minimum loss ratios for dread disease and hospital indemnity policies, and envisions a role for the NAIC, each individual State, and the Department of Health and Human Services.

As I indicated at the outset, the details are still sketchy and we expect that a definitive package will be marked up in Mr. Stark's subcommittee very shortly.

As you know, numerous legislative initiatives have been introduced in the Senate. A key concern centers around efforts to further restrict agent compensation. One such provision would place further restrictions on first year agent commissions at 150 percent of the renewal rate. This is objectionable for a number of reasons. The NAIC has already revised its model to restrict first year commissions at 200 percent of renewals. Although we initially opposed the efforts by the NAIC to enact this provision we have agreed to

abide by their decision and NALU is not lobbying the State capitols to defeat it.

Although we strongly disagree with the prospect of curbing abuses through caps on agent commissions, we would ask you to give the NAIC model an opportunity to work.

Before leaving the issue of agent compensation let me make a few observations. Agents provide valuable personal assistance to the elderly, especially those in rural areas who might not have the same access to the choices in Medigap policies as those in urban areas. Agents spend countless hours answering complex problems about Medicare, explaining the advantages and disadvantages of certain policies and their benefits, and assisting senior citizens with both Medicare and Medigap claims.

Squeezing agent's sold policies out of the market will only encourage more direct sales of products. While these may be fine for some, seniors who need the assistance of an agent will find small comfort in an 800 telephone number. With the increasing complexity of health insurance in general, and Medicare specifically, senior citizens need more guidance not less.

Economically, reputable agents will be most adversely affected by limitations on the compensation they may receive. These same law abiding agents will have to choose between spending less time with their clients or selling other insurance products to other consumers. To penalize those agents and ultimately their clients by tacking on additional arbitrary restrictions on all agent commissions would be a disservice to the industry and consumers.

While we hope that you would favorably consider the Stark proposal we will be happy to work with you and your staff in drafting a bill that is acceptable to the Senate Finance Committee.

Thank you again for the opportunity to testify this afternoon. I would love to try to answer any questions you might have.

[The prepared statement of Mr. Hansen appears in the appendix.]

Senator ROCKEFELLER. Thank you very much, Mr. Hansen.

Ms. Jenckes, you have testified that HIAA is opposed to increasing minimum loss ratio standards. But Blue Cross/Blue Shield which currently underwrites Medigap insurance in 42 percent of the market—more so in West Virginia—favors increasing the minimum loss ratio standard. Can you explain the difference in this?

Ms. JENCKES. I will attempt to, Senator Rockefeller. Number one, 95 percent of the premium income is actually meeting the loss ratio standard as it presently exists. I would like to just start off with that point.

Number two, I think even though Blue Cross and Blue Shield does use agents, many more of our companies employ agents to sell their products. So, therefore, I think there is a difference in the way our product is marketed. They are also much larger in the group insurance business than are most commercial insurance companies with the exception of Prudential, who has the AARP case. So that individual loss ratio requirements have far more meaning for our general membership than I think it does for Blue Cross/Blue Shield.

Senator ROCKEFELLER. I am trying to find something here.

Karl, the AARP survey found that 24 percent of individuals with Medigap policies had two or more policies.

Mr. HANSEN. Right.

Senator ROCKEFELLER. And 37 percent said an agent never asked them if they already had a Medigap policy before attempting to sell another one. How do you respond to that?

Mr. HANSEN. Well we obviously do not condone the fact that some agents are not doing their proper job in presenting a Medigap contract. I think the only thing that I can say as an association is, we are promoting the education and the professionalism to try to do the job more properly.

In fact, in my own personal situation we make every effort to include the family—the son or daughter of the parent—in the Medicare supplement process because—in fact, I should share briefly with you the fact that even when we do this and we go through the process of need analysis and whatnot, and we establish a Medigap contract, in more than one case, just a matter of 2 or 3 years later, I have discovered that the senior citizen has purchased yet another Medicare supplement in addition to the one that we placed in force due to the mail and the television onslaught that they receive literally probably 8 hours a day on the TV. And the child who we had in the conversation of the sales process, you know, did not even realize that their own parent was paying for two Medicare supplements.

It is not a practice that we condone. In fact, in California we are working with the Commissioner, and we think we are making a lot of headway to restrict those licenses. And in the heavy abuse areas, they actually have the licenses of agents revoked.

Ms. JENCKES. Senator, it may be helpful to note that the new NAIC standards which were approved last December, which are just presently going into effect in the States now do require the applicant to answer that question on the actual policy form. And if they answer the question that they do in fact have other insurance they must agree to drop their existing insurance before they can purchase another policy or the agent and/or company may offer it.

Mr. HANSEN. I was not aware if that was just California law or national law. We actually do that in California.

Senator ROCKEFELLER. Okay. As I indicated in my opening statement, GAO estimates that the Medigap insurance premiums will go up between 5 and 50 percent this year; average, I think, what was it, 19.5 percent. Medicare, is going up only 11, maybe 12 percent. Why are Medigap premiums going up so much more?

Ms. JENCKES. Senator, our premiums directly reflect the increases in the costs of the Medicare program. When I testified as well as Blue Cross and Blue Shield earlier this year, we indicated that Medicare Part B costs were going up on a 16 percent compounded basis. You couple that with the fact that insurers had to once again for the second year in a row substantially modify their benefits, to meet the current NAIC standards and add it to the cost of the policy, as well as the general cost of inflation and utilization of the product and the cost of the product will naturally increase.

So I think you will find any price increases that we have very consistent with those of the Medicare program itself. We supplement its benefits. So as it goes up, our policies will go up approxi-

mately the same amount because we are picking up the Part B cost or 20 percent of the co-insurance amounts. We wish we could get it down. Perhaps the new Physician Payment Reform system that is underway will help, as well as some of fraud and abuse initiatives. Again, whatever direct costs Medicare has, we have as well in our policies.

Senator ROCKEFELLER. Karl?

Mr. HANSEN. Yes, I was going to mention that in those contracts that actually pay the difference between what Medicare allows and what the actual charge is, as Medicare continues on a rather conservative nature of increase in their benefits, that difference continues to expand. So those contracts that we consider to be the top end, comprehensive contracts are actually paying a larger, and larger, and larger bite of the total bill. Therefore, they are going up in cost rather dramatically.

It is not something any of us like to—believe me, I do not like to communicate to the client, "Here it goes again." But that is what is happening. It is a problem.

Ms. FOX. I would just add for Blue Cross/Blue Shield, our premiums went up on average 23 percent this year and about two-thirds of that reflected repeal of Medicare catastrophic, on average.

Senator ROCKEFELLER. GAO disputes that.

Ms. FOX. That is what our plans have reported to us. This is an average figure and there are variations in that.

Mr. HANSEN. The loss ratios did not go down dramatically. I think that is probably the best evidence in looking from year to year, that the premium increases in the Foster-Higgins Study that I was looking at, loss ratios have remained rather level in the years studied. So it would imply that the premium increases were in fact appropriate.

Believe me, I fight the insurance companies on this issue. You know, we do not like to pass on those increases to our consumer clients.

Senator ROCKEFELLER. Maybe I can come at it from a different angle. I am trying to crack that argument. I find it very hard to accept it. I cannot dispute your facts, but the mathematics does not seem to work out right to me. Medicare inflation is lower than what you are talking about. You are talking about 19.5 percent average increase for Medigap insurance; Medicare is 10 percent, literally 10 percent.

My time has run out. I am going to let Tom take a crack at it while I try to regroup.

Senator DASCHLE. I must say, Mr. Chairman, I do not think I would have any better success. I do think part of it is administrative costs. Medicare is able to avoid——

Senator ROCKEFELLER. Medicare administrative costs are 2 to 3 percent on this.

Senator DASCHLE. But I do not think health insurance companies can say that. I think their administrative costs are much higher than Medicare, as are their sales costs. Medicare does not have sales costs. But that is as good a shot as I have at guessing. I share your frustration.

We are not here to talk about catastrophic but, Alissa—I was going to start out with a positive note here. What I find frustrating

is that when we passed the catastrophic plan we did not see a commensurate decrease in premiums. We saw an increase that year too and it was attributed to other increases. We never see a decrease.

That is not a question. It is just a frustration I have.

Ms. Fox. I would just like to say that in 1989 some of our plans actually did decrease their Medigap premiums. However, an average Blue Cross and Blue Shield Plan Medigap rates increased an average of 8 percent.

Senator DASCHLE. Increase.

Ms. Fox. But there were quite a number of plans that did show an absolute dollar reduction from the prior year.

Senator DASCHLE. It is one of the more frustrating things that we have to contend with.

Ms. Fox. I would just add that on average our administrative costs run about 10 percent. It is larger than Medicare, which is about 3 percent.

Senator DASCHLE. Does that include sales?

Ms. Fox. Yes.

Senator DASCHLE. Administrative costs includes all of your overhead?

Ms. Fox. Yes.

Senator DASCHLE. On average?

Ms. Fox. Yes.

Senator DASCHLE. Okay. I think that is much lower than the industry average, substantially lower.

Let me just start out with what I was going to say. That is, we really do appreciate the cooperation we have had from all three of your organizations as we have begun drafting this legislation and considering how we can make it most practical. I must say it has been kind of a breath of fresh air to talk to groups affected and to have the kind of constructive suggestions we have gotten in all three cases. Not that we agree on everything, but certainly you have been very forthcoming and I, for one, appreciate that. I can give you a lot of cases where we deal with industries where that is not the case.

Linda, with regard to loss ratios, with what time we have, going over the history of the establishment of those things from the beginning, the impression I have is that they were a little arbitrary at first. We thought we would decide what was fair and we would rationalize on the basis of a few numbers. We have come up with those numbers and we are living by them. But I really do not know anybody who can give me a definitive analysis as to why those loss ratios ought to be the Bible.

Now we are arguing for a lot of reasons that they ought to be higher. But you seem to argue without equivocation that they just cannot be any higher. I have not heard any real convincing argument that on the basis of fact, rather than conjecture, they just cannot be higher. Are you prepared to elaborate at all on that?

Ms. JENCKES. Commissioner Pomeroy indicated that on the individual side some States are going to the 65 percent loss ratio of requirement—I was not aware that one State had it in since 1981—but most have done so just this past year. It is very difficult for me, therefore, to give you an impact statement on that amount.

When you look at loss ratios, and that is why we did the Foster-Higgins study which is attached to my testimony, I think you will see it is a unique management tool for the commercial insurance industry and for consumers, it is not an indication of value. What a consumer has to look at is cost of the product and the service of the company that they are using.

I think the best example, Senator Daschle, I can give you is, to compare two policies which have the same exact benefits and the same exact cost, one can have a 90 percent loss ratio and one a 60 percent. I would suggest to you that probably the one at 60 percent may be the better buy because there probably will not be a premium increase next year.

So when you look at loss ratios on behalf of the consumers, who we are all attempting to protect, I think there are other things that will help the consumer do better comparison shopping then looking at loss ratios. The idea that we proposed on the outline of coverage, which takes the existing Medicare supplemental minimum standards, and then breaks out any additional benefits in accordance with your simplification ideas, and puts a price on those two separate parts of the package, will help consumers line up three policies—a Blue Cross policy, a Prudential policy, and a Mutual of Omaha policy—and determine which one is the best value and the best buy for them.

I think if the loss ratio were on the policy the consumer would not know what that loss ratio means. But that is not to say that we do not feel they should be enforced. Every company should be meeting 60 percent for individual policies and 75 percent for group. If they are not, there is supposed to be a reduction in premium to the consumer.

Senator DASCHLE. I see my yellow light is on. Two questions real quick and then I will submit the other questions for the record for other witnesses.

You do support the refund provision in our bill? Do I understand that correctly?

Ms. JENCKES. Absolutely.

Senator DASCHLE. Okay.

And with regard to Medicare I assume your industry and I do not want to put words in your mouth—but it is my understanding that you do support the elimination of duplication.

Ms. JENCKES. That is correct.

Senator DASCHLE. And when it comes to Medicaid policies the AARP report which indicated that 51 percent of Medicaid recipients have a Medigap policy indicates the kind of pervasiveness of duplication. Would you support a provision which would eliminate Medigap coverage from Medicaid recipients?

Ms. JENCKES. Senator, that is difficult. We would never actively advocate that any Medicaid beneficiary purchase this type of policy. The difficulty is that there are several States—and I will provide the list for you—that actually purchase Medigap policies for their Medicaid recipients because they feel it is a better buy and is less costly to the State. So I think we have to examine why those States do it.

[The list follows:]

Based on a limited survey done by the American Public Welfare Association, New York, Minnesota, Oregon and Washington buy Medicare Supplemental insurance policies for their Medicaid beneficiaries. Georgia, Arkansas and Alabama are actively considering doing so as well.

Ms. JENCKES. Secondarily, there are a couple of States that prohibit us from asking the question as to whether or not you are on Medicaid. So conceptually, yes. I agree with you and industry does as well that this practice should be stopped; but I think we really have to examine what exists in the marketplace. We were very concerned about the AARP survey as well which indicated half of Medicaid beneficiaries had Medigap. Maybe they arrived at that number because of the fact that many of the States are buying these policies for the recipients.

So I think before we actually move we have to study why certain States are doing it. In concept, however, we are with you.

Senator DASCHLE. Thank you for your testimony. I am out of time. I know we have another panel.

Go ahead.

Mr. HANSEN. A small comment. I have many wealthy clients who have their parents spend down to Medicaid and then they want to buy a Medicare supplement contract on them. I mean wealthy clients. I come from a wealthy neighborhood.

Senator DASCHLE. Do you want to give us any names? [Laughter.]

Mr. HANSEN. I have a multi-millionaire that has six Medicare supplement contracts. I cannot talk him out of them. It is unbelievable. It is a fear situation, quite frankly. So it is a problem.

Senator ROCKEFELLER. The only way I can try and come back at this, Tom, is totally simplistic. First of all, if it went from 60 to 65 and 70 to 75 or 80, whatever, it is true that that would come out of profits, is it not?

Ms. JENCKES. No, Senator. When it comes to the components of a loss ratio for the commercial insurance industry you are looking at premium taxes; you are looking at cost of the sales force; you are talking about administration of the policy and a host of other things.

Second, when you look at a loss ratio, and we are delighted that the NAIC has finally standardized the requirements in all 50 States for a loss ratio standard, you cannot look at it for 1-year only because policies appreciate in value over time. They become more beneficial. When a policy first comes on the marketplace you may have a group of beneficiaries who buy that policy who are healthy and may not submit a claim on it for 2 or 3 years. In that case, the loss ratio that very first year is going to be very low because there have been no claims submitted against it. That is just one among a host of factors that would determine the level of a loss ratio. One of our largest Medicare supplemental underwriters indicated that the extent of their profit the last couple of years has been 2 to 3 percent.

Senator ROCKEFELLER. Let me come at it another way. You are paying 60 cents out of a dollar under the current situation for the individual. You raise your premiums to $1.20 or to $1.40.

Ms. JENCKES. Okay. I have to respond to that, that 60——

Senator ROCKEFELLER. In fact, I would like to get it, if possible, from at least two of you in writing. Just give me something verbal quickly now. But I would like to get it in writing.

Ms. JENCKES. When you look at the 60 cents on the dollar and apply it to a loss ratio, you are referring to costs for a year. A loss ratio, however, is calculated over the life of the policy. To get a more accurate reading, you have to look at it at a minimum of 3 years, which is what NAIC just did in its recent new regulation.

One of the major ingredients of a loss ratio, is that it is looking at the value of that product over time but I will put this in writing.

[The information appears in the appendix.]

Senator ROCKEFELLER. I am trying my best, Linda. I thank all of you very, very much—very, very much, and I am sorry that it has taken so long for us to get you up here. But then again, you are better off than the next panel.

Ms. JENCKES. Thank you.

Senator ROCKEFELLER. The next panel is Eric Shulman, who is director of legislation, National Council of Senior Citizens; Gail Shearer, policy analysis, Consumers Union; and Mr. Wayne Lindley, Health Insurance Counseling and Advocacy Program, California Department of Aging. We welcome you folks very much.

Eric, we will start out with you once you are ready.

STATEMENT OF ERIC SHULMAN, DIRECTOR OF LEGISLATION, NATIONAL COUNCIL OF SENIOR CITIZENS, WASHINGTON, DC

Mr. SHULMAN. Thank you, Senator Rockefeller. I appreciate the opportunity to be here to talk about this issue and I will summarize my testimony and ask that the testimony be introduced into the record.

Senator ROCKEFELLER. Of course.

Mr. SHULMAN. Mr. Chairman, the National Council feels that the current debate taking place in Congress over Medigap is just somewhat misdirected. While other congressional hearings and witnesses have focused mainly on consumer protections most seniors today are more concerned about how much their policy costs, how much their rates have gone up in the last 2 years, and what, if anything, Congress and the Administration can do about it.

This is not to demean the importance of these consumer protections. We believe that there have been accesses within the industry for many years and we do believe that these protections and measures included in the Daschle legislation are very important.

But I do want to reemphasize that we recently had our national convention in Chicago and I must say that of preeminent concern to our members has been the spate of Medigap increases since the repeal of catastrophic and, indeed, the continuing Medigap insurance premium increases over the last few years.

One reason that Medigap prices keep going up is that loss ratios are set low; and under current law they are voluntary targets. According to the GAO the private insurance industry is failing to meet even the Baucus standards of 60 percent. Excluding Prudential, other commercial policies had an average loss ratio of 59 percent. That means that insurance companies are returning an average of 59 cents on each dollar they take in.

NCSC feels strongly that loss ratios need to be increased and that the targets need to be made mandatory. Access to supplemental insurance will not be harmed and overall value of policies would be increased making them a better buy. The loss ratios for health insurance for those under age 65 average out to a little over 80 percent. The loss ratios for Medicare are 97 to 98 percent. If these insurers can meet these targets then Medigap can raise theirs to 70 percent.

There are other problems associated with the industry. Current Medigap laws are inadequate and poorly enforced. Premium increases consistently outpace the rate of medical inflation. Even when Congress expands Medicare benefits, agents use whatever means necessary to sell their policies and seniors afraid of facing their future penniless often buy more than one policy.

Even great abuse occurs when agents sell policies to Medicaid beneficiaries. Over 3 million seniors receive benefits through the Medicaid program. Since Medicaid covers out-of-pocket costs for seniors living below the poverty line there is no need for these people to spend their few meager dollars on Medigap. These problems are exacerbated by the fact that the law allows for little or no consumer participation when it comes to establishing premium rates. We allow consumer representation when it comes to pricing utilities and other forms of insurance, why not Medigap?

Only 16 States require that State Insurance Commissioners formally approve a premium increase for group policies before they take affect. Many rate increases, even if approved beforehand, take place without consumer representation or input. While a public hearing does not guarantee lower rates, it does provide an opportunity for advocates to turn up the heat on insurers and to make insurance commissioners, and indeed insurance companies, more accountable.

NCSC feels very strongly that a Federally mandated State prior approval requirement complete with public hearings be a part of the final package enacted by Congress.

There is a comprehensive solution to the problems of Medigap before you. NCSC supports and endorses S. 2640 and we appreciate Senator Daschle's efforts to improve the Medigap situation. Actually, Senator Daschle's bill is the only bill before you with a public hearing element in it. While NCSC feels that a hearing should be held on all rate increases, we understand the need for some type of triggering device so that insurance commissions are not overwhelmed. We support the provisions requiring higher loss ratios and feel that the approach of requiring rebates for policies that do not meet the minimum loss ratios is both innovative and necessary.

We also believe that only through a public hearing process will consumers again feel as if they have some control over a process which all too often seems to roll right over them. NCSC also supports the other provisions of S. 2640.

Finally, Mr. Chairman, NCSC firmly believes that only a comprehensive solution, such as that provided in S. 2640, will alleviate some of the pressures on the Medigap system. Unfortunately, Mr. Chairman, even with all of these protections we realize that it will not be possible to substantially slow or certainly halt large Medigap premium increases. While a public hearing will make insur-

ance companies more accountable, require them to do more of their work in the sunshine, State Insurance Commissioners more responsive, and it would give access to millions of consumers who have never had it, it will not put a halt to medical inflation and the tendency of physicians to overvalue procedures.

As you know, we believe that the only way to affectively halt medical inflation in the United States is to enact some form of national health care program. I want to just take this opportunity to thank you, Mr. Chairman, for both your leadership and dedication, your work with the Pepper Commission, and we would like to work with you in the future in moving toward that goal.

That concludes my testimony.

Senator ROCKEFELLER. Thank you very much, Mr. Shulman.

[The prepared statement of Mr. Shulman appears in the appendix.]

Senator ROCKEFELLER. Ms. Shearer?

STATEMENT OF GAIL E. SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON, DC

Ms. SHEARER. Thank you, Mr. Chairman. Consumers Union appreciates the opportunity to testify before you on the issue of private health insurance to supplement Medicare. We commend the leadership that the members of this subcommittee bring to this issue. We believe that Senator Daschle's proposal, which has been co-sponsored by many members of this subcommittee, incorporates the best provisions and assembles a comprehensive reform package that should serve as the basis for your deliberations.

We urge you to preserve what we view as the bill's most important principle—the principle of apples to apples comparisons. The bill should not allow companies to bundle the benefits however they want, because we believe this undercuts the goal of simplification.

The essential features of comprehensive Medigap reform are simplifying the market through standardization of benefits, encouraging State counseling programs, prohibiting the sale of duplicative Medigap policies, improving enforcement of loss ratio standards, increasing loss ratios and discouraging twisting by leveling sales commissions.

I will comment very briefly on a few of the bills that have been introduced in the Senate with regard to these features. First, S. 2189, Senator Pryor's counseling bill. This would establish a grant program, as you know, to provide health insurance information counseling and assistance to Medicare eligible individuals. We strongly support this bill because we believe that counseling programs have the potential to dramatically improve the performance of this market. The impressive track record of existing counseling programs lends strong support for this view.

As you know, though, we believe that counseling alone is not enough. We are very pleased that S. 2189 has been incorporated into S. 2640, the Medigap Fraud and Abuse Prevention Act.

Turning now to Senator Riegle's Medigap Simplification Act, the key feature of S. 2641 is the requirement that the NAIC or DHHS simplify the Medigap insurance benefit structure. The legislation

would require either a core benefit package with separately priced optional riders or a limited number of benefit packages. We strongly support this provision since we believe that simplification should be the centerpiece of Medigap reform.

In anticipation of the enactment of congressional legislation, the NAIC has established a working group to develop a model simplification regulation and we are participating actively in the NAIC's deliberations on how best to do this.

Like counseling, simplification alone does not solve the problems in this market, but it is a powerful tool that should be a central part of the comprehensive reform bill. We are pleased that the key provisions of S. 2641 have been incorporated into S. 2640.

I will turn now to that—S. 2640, Senator Daschle's Medigap Fraud and Abuse Prevention Act. This is a comprehensive bill that dramatically changes the way Medicare supplemental insurance would be regulated. The key provisions are simplification, a grant program for counseling, prohibition of duplicative policies, improved enforcement of loss ratios, flattening of agent commissions.

We strongly support this bill. It would dramatically change the private health insurance market to the benefit of senior citizens. It would lead to a less complicated market, improved value for premium dollars, increased price competition, reduced waste on the purchase of excessive policies, and it would curb agent abuses. In addition, it would provide senior citizens with a source of objective advice about their health insurance needs. S. 2640 provides all these benefits with a minimal price tag.

In conclusion, Consumers Union strongly supports the Medigap legislation introduced by Senators Pryor, Riegle and Daschle, each of which is co-sponsored by many members of this subcommittee. The keys to ending abuse in this market are simplification, one-on-one counseling, ending duplication, enforcing and increasing loss ratios, and leveling agent commissions.

We look forward to working with you to assure that Medigap reform is a reality this year. Thank you very much.

Senator ROCKEFELLER. Thank you, Ms. Shearer.

[The prepared statement of Ms. Shearer appears in the appendix.]

Senator ROCKEFELLER. Mr. Lindley?

STATEMENT OF WAYNE R. LINDLEY, STATE PROGRAM MANAGER, HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM, CALIFORNIA DEPARTMENT OF AGING, SACRAMENTO, CA, ACCOMPANIED BY TERRI KENNEDY, DIRECTOR, HICAP-RIVERSIDE, SAN BERNARDINO, CA

Mr. LINDLEY. Thank you, Mr. Chairman. We are pleased to be here today and be invited to talk about the merits and benefits of establishing a Federal grant program for State health insurance information counseling and assistance programs. I am accompanied by Terri Kennedy, one of our managers in California.

We support the concepts contained in Senator Pryor's bill, S. 2189, and our references today in the counseling programs would apply to the principles in that bill.

I would like to first make three points on the need for counseling. The first is—and I think it was mentioned by some other testimony here today—that the problems that we are facing in some of these areas are not just age specific. I think a lot of policy language, and the policies offered, and so forth are very complicated and hard to understand by any individual, any average individual of any age.

Second, the elderly are vulnerable in some areas, particularly to false and misleading insurance practices, for two very important reasons. One, Medicare is generally misunderstood as being complete in its coverage of acute illness and especially the long-term care needs. I think that has been fairly well documented in the last few years. The second is fear. Fear of long-term illnesses or custodial care nursing homes is more of a reality to the retired elderly than it is with younger generations. That leads in part to the purchase of excess insurance.

Third—and I think this is very important to understand, especially with the education and counseling components—is that laws and regulations and the enforcement of those laws and regulations are only two of the important parts of consumer protection. But by adding education and counseling that really get to the local level for seniors, we can have a triad approach that is really effective.

We see the counseling programs as an equally important partner in assisting the consumer. In addition, the counseling programs that we are aware of, and in particular our experience in California, are in a unique position to discover and document problems that need to be corrected through regulation and enforcement. We have a number of things going on in California now to provide data bases on the problems that seniors are facing.

Additionally, I would like to make a point on our cost efficiency. I would like to point out that the Health Insurance Counseling and Advocacy Program in California, otherwise known as HICAP, has last year counseled over 50,000 seniors. We also put on education forums for over 100,000 people throughout communities in California. So I think we really see an awful lot of the things that seniors are up against.

We reported last year savings from our program to the clients in the State an amount of $4,689,000. That is almost a $2 savings for every $1 spent in the program. Since late 1987 the HICAP has reported $10.7 million in savings. That does not count several years that we were providing services but were not documenting that savings.

Our statistics show that, in many instances, personal client savings can amount to several thousand dollars, with an average savings of around $900 per client. State counseling programs can also save time and expense for Federal programs. We have experienced this in a number of ways. For example, in Terri's area in Riverside in San Bernardio Counties, the Social Security Administration has made as many as 150 referrals a week to the local HICAP agency.

We also know that there is cost avoidance to many of the things we can do with education and counseling that will prevent people from having to spend down their resources early and becoming eligible for Federal and State programs.

There are currently 12 States that have independently developed counseling programs. But there are at least a dozen more States interested in starting programs immediately, provided the resources can be developed. State counseling programs are highly flexible and conform to the specific needs of the service population in each State.

And from the experience to date there are two critical keys to the success of these programs. First, they are sponsored by either the State regulatory agencies or consumer-type agencies under the auspice of the State Government. They are independent of the conflict of interest we see in other programs.

And second, they rely on volunteers to expand services beyond core professional staff. State counseling programs have the flexibility to meet many different demands surrounding the acute long-term care issues of interest to most seniors. This flexibility should not be restricted by Federal statute.

The status quo offers no answers for the tens of thousands of elderly consumers faced with serious decisions and problems involving health insurance. And into this vacuum will come dozens of insurance industry counseling programs and hundreds more local counseling services offered by financial planners and insurance specialists to add significantly to the existing confusion that the seniors face. There will be no stable or reliable place to go without some form of State counseling programs in our opinion.

The advantages of a State-administered counseling program are: (1) they can tap the resource networks of the regulatory system, aging services, and consumer advocacy groups; (2) by using trained volunteers that are supported by professionals, they are a cost efficient and far reaching entity assisting individual communities; (3) they provide an objective source of information without conflict of interest; (4) they are trusted, especially if locally trained, registered, and supervised peer volunteer counselors are used; and (5) they provide consistency by forming a nationwide network of consumer information and assistance tailored to the unique characteristics of each State.

Mr. Chairman, with your permission, I would like to enter into the record the HICAP performance report for last year.

Senator ROCKEFELLER. Of course.

Mr. LINDLEY. Thank you.

[The information appears in the appendix.]

[The prepared statement of Mr. Lindley appears in the appendix.]

Senator ROCKEFELLER. I thank all of you.

What was the question that I should have asked of the previous panel about penetrating this matter of loss ratios and how that would just be devastating? In other words, the cost of Medicare, and the cost of repeal of catastrophic, and all the rest of it was causing these premium price increases. I was trying to find the fallacy and I felt it was there somewhere, but I could not put my finger on it. Could you have helped me?

Mr. SHULMAN. I would just say, Senator, it seemed to me you asked the right questions. It was the answers that seemed to be unclear.

Senator ROCKEFELLER. No. I was not concerned about the question. I was concerned that I was not able to elicit an answer. I could not come around back at the answer in the way that I wanted. So maybe one of the three of you would just simply say your views on that.

Mr. LINDLEY. Mr. Chairman, could I have Terri Kennedy respond?

Senator ROCKEFELLER. Of course.

Ms. KENNEDY. I think that the problem that we see——

Senator ROCKEFELLER. In fact, I saw you shaking your head at one point.

Ms. KENNEDY. Yes. The problem that we found was that the excuse for the premiums going up was catastrophic. So logically if catastrophic is repealed why aren't they going down? Okay? That relates to the loss ratio. It is very simple in our minds. We cannot seem to get it clear in everyone else's.

Senator ROCKEFELLER. Well their logic would have been that people would have thought there was something there so that the fear of increase, rather than have gone down, would have doubled, right, so that people would be reaching out for more Medigap. But that certainly is a point.

Mr. SHULMAN. Although I can just recall that during the catastrophic fight that CBO came out with an analysis saying that Medigap premiums would drop by about $100 a year as a consequence of the implementation of the catastrophic.

Senator ROCKEFELLER. Yes, that is right. That statement was made, wasn't it?

Tell me what confuses seniors most about Medigap. It was an interesting by-play. In other words, everybody wants to say that seniors do not get confused more than anybody else; and yet I keep coming back to West Virginia with 96 companies out there trying to sell Medigap insurance policies.

Ms. Jenckes at one point said there are really only eight; and then she sort of said that within that eight there are only four. But my statistics for West Virginia say 96. Tom indicated thousands across the country. I suspect he is right.

What is it that confuses seniors? Give me examples of it. Help me understand it.

Ms. SHEARER. Can I start with that one?

Senator ROCKEFELLER. Sure.

Ms. SHEARER. Let me just make a point that did not come up earlier. That is that Dr. Wilensky talked about the concern of being condescending to the elderly.

Senator ROCKEFELLER. Yes, that is right.

Ms. SHEARER. One thing that did not come out was that for the most part people under 65 have the luxury of having their employers shop for their health insurance. It is not until they turn 65 and they retire that all of a sudden they are thrust into this horribly complicated decision without years and years of experience in many, many cases. So I do not think that that condescending argument holds up that well.

But just commenting on your question about what complicates people, I think in large part it is the fact that there are so many different policy benefits out there, and policy provisions are defined

in many different ways. Just turning to one example, the coverage of excess charges, there is no standard definition for excess charges.

I just would like to turn to one point that Dr. Wilensky made about the desire for a catastrophic policy. It is interesting that, I believe that her assumption would be that the catastrophic policy would be defined in one standard way. I believe that that principle can be extended to the way the Medigap market is today. I mean there is no cluster point. Benefits are all over the place. I think that we need a standard definition. We need consumers to be able to compare a limited number of policies.

People from AARP talk about a "kitchen table" test. It would make sense for you to be able to spread out on one small table the number of options that are available without having hundreds and hundreds of options on the market. I know this is a sort of rambling response.

Senator ROCKEFELLER. No, it was a very good one. It is the idea that somehow if there are 96, if you reduced it to 48, it would be impinging upon the free enterprise system. I mean I guess that is a factor. But the real point is, how can we give fair choices and allow seniors to make accurate choices, and as you say, by themselves or with an agent or with an agent who leaves a policy or with an agent who wants to sell a policy.

You know, I love the television ads about all the close and wonderful relationships, and I am sure that is true in a lot of cases. But that is the way they make their living. They have to sell policies. That puts pressures on seniors. And that, just by definition, if the senior is seeing a policy that he or she has not seen before and it offers something that is different, then the thought that, my gosh, I have something in which I am not covered, I had better get that, and nobody to counsel no.

A kitchen table would seem to me to be sensible.

Ms. SHEARER. The principle that we have endorsed is the concept of meaningful choice in this market place. We believe that you could take a limited number of packages, if you set the low one at the core basic minimum policy, you set the high one at basically a policy that incorporates everything available on the market place, and you define in between two midpoints, that we believe that consumers could live with that type of choice. What they do not need is frivolous variation and variation in definitions.

Senator ROCKEFELLER. It is the same thing that we ran into in the Pepper Commission, looking at standard health coverage insurance. It was very clear that there are about 700 different basic insurance polices out there, and that what you need is kind of a standard minimum. It is not necessarily a Cadillac; it might be a Chevrolet. You do not say that there cannot be Cadillacs but you have to have that standard one out there, that covers preventive, and hospital, and doctors, so that there is the certainty that you are getting a good buy and have a basic health benefit plan.

Then if you want to add on, people have the right to do that.

Plus, another concern on my part--I mean I was a Governor for 8 years and in our insurance department there were 18 people. They were overwhelmed. I did not exactly notice Gail Wilensky jumping up and down with the desire to monitor this program. Did

you? The only other choice would be Social Security and that would be a terrible choice because they are overwhelmed beyond belief.

Mr. LINDLEY. Mr. Chairman?

Senator ROCKEFELLER. Yes.

Mr. LINDLEY. If I could just also add one other thing about that question that you asked a minute ago. What we are finding also is that yes there may be a core of eight or whatever principle benefits and so forth, but a lot of the advertising, seniors get distracted by the advertising. If it is a highly competitive area, you are going to take a lot of liberty with the English language in the advertising.

Our experience shows that while there are some elderly who are extremely capable individuals who either because of their business in the past or because they dealt with family finances for years, but there are an awful lot of others—there are widows, there are all kinds of people—who have not had that experience, and they go immediately to the sales literature and are believing the sales literature to be contracts. And over and over again our experience is that when they get a claim denied, they are in shock. They did not realize that it was not covered in many cases.

Senator ROCKEFELLER. Yes.

Mr. LINDLEY. Of course, that applies a lot more to long-term care insurance, not just the Medigap any more.

Senator ROCKEFELLER. And if seniors have four, five or six Medigap policies, in and of itself, that describes that there is a problem, does it not? I mean there is just no excuse for that. There is just simply no excuse for that.

My last question and then we will end this. Would you think that loss ratio information would be helpful to seniors or is that not necessarily useful information?

Ms. SHEARER. I think that if all of the other things that are on the table were done that the provision of loss ratio information becomes less important. I am concerned about some of the misleading signals loss ratio information could possibly give. Just as the point was made earlier that a very high loss ratio could be a sign that the premium is going to increase the next year.

There are two sides for this one and I do not have strong feelings one way or the other. On the other hand, I think there is the argument to be made that consumers deserve to know what kind of value the typical purchaser of that policy is getting. But I do have some reservations about disclosure of loss ratio information as something that is going to solve all these problems.

Senator ROCKEFELLER. Yes. I think I would agree with that. It sounds good but the effect to be helpful may not be very much.

I guess it comes down to the fact that when people are purchasing Medigap insurance policies decisions they are feeling vulnerable because that is why they are looking for this kind of assistance. They are often—well, what, there are 9 million elderly Americans living all by themselves. Many of them have not had this experience before and they have to make these decisions and analyze these things quite apart from the persuasiveness of the agent and the goodwill of the agent, and then the television advertising. It is an overwhelming situation.

It just seems to me that Congress has a responsibility to simplify, to standardize, to monitor, to simply reach out and be helpful in what is obviously a very, very serious problem. As I said at the beginning, I think we are going to do that.

I thank you all very, very much.

This hearing is adjourned.

[The hearing was adjourned at 4:49 p.m.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF SENATOR TOM DASCHLE

Mr. Chairman, I would like to commend you for holding this hearing today. Earlier in the year, the Finance Committee held a hearing to learn about problem in the Medigap industry. I am pleased that we have this opportunity to meet again to discuss solutions to those problems. It is a timely hearing as well; as it becomes increasingly likely that negotiators at the budget summit will pare down Medicare spending, it is vital that we have strong consumer protections in place in the Medigap market.

Medigap insurance is big business. Three quarters of our nation's seniors, totalling about 25 million people, purchase Medigap to fill in the holes in Medicare coverage. It is a highly lucrative market as well. Medicare supplemental insurance has grown into a $15 billion industry that provides plans to seniors in all fifty states. My state of South Dakota alone has over fifty Medigap plans from which seniors can choose. In states like California, seniors can sort through nearly 200 complex and varying Medigap plans.

Few would debate the importance of Medigap insurance, since Medicare currently covers only 45% of senior citizens' health expenses. It is also evident that the majority of insurance companies and their agents provide high-value policies and service to their Medigap clients. Policies from companies like Blue Cross Blue Shield, for example, consistently meet loss ratios well above the current NAIC standards.

However, a minority of unscrupulous companies and agents take advantage of poor regulation of the Medigap industry. They lead our nation's seniors to buy multiple and duplicative policies of low value and frivolous differences. A growing body of evidence suggests that some of these agents employ high-pressure marketing techniques and prey on seniors' fears of catastrophic illness and financial dependency or ruin. As we learned at the previous Finance Committee hearing on Medigap, fraud in this industry is not a "fringe problem blown out of proportion," as some in the insurance business would lead us to believe. Millions of seniors every year are victimized by such egregious practices.

The examples of these abuses can be quite dramatic. Ruth Hotchkiss, an elderly woman from Humboldt, South Dakota, was pressured into buying 45 Medigap and life insurance policies over a twenty year period, even though she only needed one of each type of policy. For all this worthless extra coverage, she spent over half of her income. Millions of seniors find themselves in this same situation every year. An AARP study found that 25% of people owning Medigap own more than one policy., and five percent own three or more. At an average cost of $800 per policy, and with some policies costing as much as $1200 per year, this is clearly a serious problem for our nation's senior citizens.

As disturbing as the reports of seniors buying multiple policies are the results of an AARP study regarding Medicaid recipients and Medigap insurance. This study shows that 51% of low-income seniors who qualify for Medicaid purchase Medigap policies, despite the fact that in nearly every state, Medigap policies are 100% duplicative of the benefits offered under Medicaid. Considering these seniors' limited resources, there is no reason why Medicaid beneficiaries need or should be sold a superfluous insurance policy.

Medigap insurance was designed to give seniors a feeling of security and peace of mind. Unfortunately, it seems that these policies can cause seniors far more worries than they can alleviate.

I believe Congress can no longer sit back complacently while senior citizens are being victimized by fraud and abuse in the Medigap market. The time has come to take off the "velvet gloves" and crack down on the perpetrators of this fraud.

The bill that I have introduced with Senators Heinz, Riegle, Pryor, Durenberger and Rockefeller, a companion measure to Representative Wyden's bill, addresses the major problems plaguing the Medigap industry. The bill builds on the current guidelines set forth in the Baucus Amendments and closes some of the gigantic loopholes in them. It also provides new and stronger protections for beneficiaries, especially in the area of preventing the sale of duplicative policies. It raises loss ratios and establishes a system for ensuring that they are met. It limits the incentives that lead agents to "churn" customers. The bill also sets criminal and civil penalties for the violations of these new standards.

One section of the bill deals with two particularly troubling aspects of Medigap insurance—its high cost and its low value. A study by the General Accounting Office (GAO) found that 34% of companies selling individual policies and 67% of companies selling group policies failed to meet the current loss ratio standards for individual and group policies respectively. Despite this fact, many states have no formal mechanism for reviewing and approving rate increases. They simply rubber stamp approval of all rate requests, with obvious consequences for the quality of these policies.

Our bill would prevent unjustified rate increases and help to ensure high-value policies through a three-pronged approach. First, it raises loss ratios to 70% and 80% for individual and group policies respectively. Second, it requires states to approve rate increases prior to the date they go into effect. This would ensure that loss ratios are met and premiums are reasonable in relation to the benefits offered. Third, it requires companies to offer senior citizens a rebate if the policy they hold does not meet the minimum loss ratio in a given year.

Our bill also tackles the problem of 25% of senior citizens owning duplicative policies and 50% of Medicaid recipients purchasing unnecessary Medigap coverage. The bill would prohibit the sale of a Medigap policy to anyone who already owns a Medigap policy or receives Medicaid benefits. Further, it requires companies to suspend Medigap premiums and benefits for any period during which a customer is eligible for Medicaid. Premiums would be automatically reinstated if a beneficiary loses Medicaid eligibility.

Finally, our bill incorporates a provision authored by Senator Riegle that would simplify the market. It would require that NAIC, in consultation with representatives of consumers, insurers, and Medicare beneficiaries, develop simplified Medigap benefit packages and establish uniform format and standard terminology for Medigap policies. This provision will allow for "apples to apples" comparisons between policies and plans. It would also promote competitive rates.

Mr. Chairman, this is a comprehensive piece of legislation that is designed to attack the major problems in the industry. The ultimate goal of this bill is to ensure that Medigap policies are of high value, that a meaningful range of choices is available, and that seniors have the information they need to buy the policy that best suits their needs.

Over the last several months, I have worked with representatives from the insurance industry, agent organizations, senior and consumer groups to refine and improve my bill. I am pleased at the high degree of cooperation and compromise surrounding these discussions. We have narrowed our differences considerably, and there are only a few significant issues left to resolve. look forward to exploring those issues today.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

In 1980, shortly after I came to the Senate, many of us in Congress recognized that there were significant problems with the Medicare Supplemental policies insurers were selling to seniors to cover expenses not reimbursed through Medicare. That year, we wrote into law the Baucus Amendment to correct the perceived abuses that were found in the Medigap market.

Today, ten years later, it has become clear that the Baucus Amendment has not worked as we had anticipated. This year, the Senate has heard from people like Charlene Blackburn of Santa Cruz, California, an articulate former Assistant Dean of Students at the University of Oregon. Mrs. Blackburn was sold 14 different Medigap policies by the same agent for which she was paying thousands of dollars a year. Just one of those policies would have been sufficient to meet her needs—the other 13 served only one purpose, to line the agent's pockets.

This year, we heard from the General Accounting Office which reported that *one out of three* insurance companies selling individual Medigap policies failed to meet the minimum standards established by the Baucus Amendment requiring insurers to return a reasonable portion of each premium dollar in benefits to policyholders. GAO further reported that an astounding sixty-seven percent—two out of three—of the companies selling group Medigap policies failed to meet the Baucus Amendment requirements.

Consumer interest groups have described in detail the incredibly confusing array of Medicare Supplemental policies which defy useful cost comparisons. Accountants and actuaries cannot even figure out what really is the best Policy for the money; how can we expect the elderly to make such choices.

And what's even worse is that low-income seniors, the poorest of the elderly, are being ripped off by the Medigap insurers. A recent AARP study indicates that 50 percent of low-income seniors who qualify for Medicaid purchase Medigap insurance, despite the fact that Medigap coverage duplicates the benefits these individuals already receive under Medicaid. That is simply outrageous.

Something must be done to eliminate the continued marketing and sales abuses in the $15 billion Medigap market. That something is S. 2640, the Medigap Fraud and Abuse Prevention Act, that was introduced in May by Senator Daschle, my good neighbor from South Dakota, and that I have co-sponsored along with most of my colleagues here today.

This most important bill addresses the uneven enforcement of current law and establishes tough consumer protection standards. Specifically, the bill provides new and stronger policyholder protections, especially in the area of duplicative policy sales, raises the amount that insurers must pay out to policyholders in benefits, establishes a system for ensuring that the benefit payout standard is met, and limits incentives for agents to unnecessarily "churn" or replace existing Medigap policies. The bill also brings much needed simplification to all Medigap policies, making them more uniform, more understandable and easier to compare.

Many of the provisions of this bill were inspired by the trail blazing efforts of Minnesotans—particularly the Minnesota state legislature and the Minnesota Department of Commerce. I am extremely proud that Minnesota has set the standard for the nation over the past decade by adopting tough insurance reforms to standardize Medigap benefits, to ensure that even "uninsurable" seniors have a source for coverage, and to assure that policyholders get their money's worth. We have learned much from the Minnesota experience.

Today's hearing is especially timely given reports from the budget summit of tens of billions in cuts to Medicare over the next five years. These cuts are very likely to produce an even greater reliance on Medicare Supplemental insurance.

The Medigap Fraud and Abuse Prevention Act contains a number of controversial reforms that today's distinguished witnesses will discuss. I look forward to some healthy debate over the bill's benefit standardization provisions, the prior approval and public hearing requirement for premium increases, and the limits on commissions paid to agents. I would also like your thoughts on adding a requirement that states must promulgate a consumer cost comparison guide similar to the exceptional guide issued earlier this year by the Minnesota Commerce Department.

If we are able to eliminate the clear abuses in this market, we will have eased the anxieties of 15 million Americans who rely upon their Medicare Supplemental policies to protect them and their families against the often catastrophic costs of getting sick. And just maybe, we won't need to be back here again next year investigating the same problems.

PREPARED STATEMENT OF ALISSA T. FOX

Mr. Chairman, I am Alissa Fox, Senior Washington Representative for the Blue Cross and Blue Shield Association. I appreciate the opportunity to testify before your subcommittee on the subject of Medicare supplemental insurance.

Blue Cross and Blue Shield Plans underwrite benefits to supplement Medicare coverage for about eight and one-half million beneficiaries, approximately 42 percent of all beneficiaries with such coverage. About two-thirds of these beneficiaries—6 million people—have individual Blue Cross and Blue Shield coverage; the other two and one-half million are covered under group policies.

Our testimony today focuses on approaches to reforming the Medigap market, specifically those outlined in legislative proposals introduced by Senators Daschle, Riegle, Chafee and Pryor and cosponsored by several Members of the Finance Committee.

Blue Cross and Blue Shield Plans are committed to providing subscribers with coverage that meets their needs, exceptional value for their premium dollar, and the service they deserve. The Blue Cross and Blue Shield Association supports the enactment of a meaningful Medigap reform bill this year to assure that Medicare beneficiaries receive high-value Medigap policies and that they better understand the coverage options available to them.

APPROACHES TO REFORMING THE MEDIGAP MARKET

Notwithstanding increasingly rigorous regulation of Medigap insurance and the responsible conduct of most insurers in the Medigap market, problems do exist. Because Medicare beneficiaries often do not understand their Medicare benefits, they cannot always make well-informed choices about Medigap coverage. Also, some states lack adequate resources to enforce Medigap regulations with sufficient rigor. Finally, some seniors have been sold excessive coverage, a consequence of inappropriate marketing that should be precluded.

We share your concern about these issues. We also welcome this opportunity to take a hard look at marketing practices, standards, enforcement, and other matters—and to offer our views as to how to address these issues.

The Association supports many aspects of the various legislative proposals under consideration by the Committee. Specifically, we support efforts to:

- strengthen enforcement of minimum loss ratio requirements and raise the minimum loss ratio for individual policies to 70 percent in order to ensure that beneficiaries receive good value;
- simplify Medigap benefits so seniors can shop wisely;
- establish and support state consumer counseling programs to educate seniors about Medicare and Medigap; and
- assure that individuals purchase only one Medigap policy to provide adequate coverage of health care expenses.

Our detailed comments on the legislative proposals follow.

Simplification of Medigap Benefits

The Medigap reform bills introduced by Senators Riegle, Daschle and Chafee propose to simplify the choices facing seniors purchasing Medigap insurance. All three bills would do this by outlining parameters for the simplification of Medigap benefits, and leaving the design and definition of benefits within these parameters to the National Association of Insurance Commissioners (NAIC). We support the delegation of these responsibilities to the NAIC. We believe that the NAIC, because of its expertise and longstanding role in the regulation of insurance, can most effectively specify appropriate Medigap simplification standards. Indeed, this process is already underway and we have been working closely with the NAIC to develop policy in this area.

The bills before you would have the NAIC define a uniform stand-alone minimum benefit package that all Medigap insurers would be required to offer. The simplification proposal developed by Senator Riegle and included in both his and Senator Daschle's bills provides that the NAIC also would specify additional, optional Medigap benefits that insurers could offer. Both these bills would limit to ten the total number of Medigap benefit combinations the NAIC could develop, and require that the premiums for the additional, optional benefits be stated separately. In order for an insurer to offer a new or innovative benefit, a state would have to apply to the Secretary of HHS or the NAIC for a waiver to permit issuance of such a benefit for up to three years.

Under Senator Chafee's bill, the NAIC would be required to develop, in addition to the stand-alone core benefit package, an alternative minimum benefit package that has no first-dollar coverage and is significantly less expensive than the standard minimum package.

The Blue Cross and Blue Shield Association supports proposals designed to reduce consumer confusion in the Medigap market. However, we believe that beneficiaries should continue to have access to worthwhile policies that include the variety of benefits they want, and that insurers must be permitted to pursue cost-containment strategies and minimize adverse selection problems that could increase premiums. We are particularly concerned that an inflexible limit on the total number of options insurers can offer would preclude consideration of an alternative approach that we believe would responsibly and effectively achieve Congress' policy objectives. We have submitted our proposal to the NAIC working group convened to develop a draft model rule that includes simplification requirements.

Under our proposal, the NAIC would specify a core benefit package that all Medigap insurers would be required to offer. This is consistent with the simplification provisions in all the bills before you. Also, the NAIC would specify a limited number of *standardized additional* benefits that insurers could combine and package with the core benefits as they deem appropriate. The terms, nature and content of each of these optional benefits would be defined precisely by the NAIC. For example, if the NAIC established a prescription drug benefit with a $200 deductible and 20 percent coinsurance, any Medigap insurer offering a prescription drug benefit would have to offer it on these terms.

Medigap PPOs would be allowed under our proposal. In order to encourage worthwhile innovation, such as cost-containment designs, we recommend that state insurance departments rather than the NAIC or the Secretary of HHS, have the authority to approve these types of benefits.

Finally, the NAIC would establish a standard format and standard language that all Medigap insurers would be required to use, perhaps similar to the format we have included with our testimony for the record.

We believe this approach would offer the following important advantages:

- *Consumers would be able to make comparisons across policies* because the minimum benefit package and the additional benefits insurers could offer would be defined precisely and uniformly. All the variation in coverage and cost-sharing designs for a given benefit that currently make comparisons difficult would be eliminated.
- *Consumers would have access to more options* if insurers had flexibility to design benefit packages than they would if the number and structure of packages were limited by the NAIC. It will be very difficult for *any* entity to decide the appropriate content for a limited number of Medigap policies nationally.
- *Insurers could be more responsive to local consumer needs and competitive environments* if they had the flexibility to design benefit packages. In many cases, Blue Cross and Blue Shield Plans have included benefits, such as additional home-based services, at the request of local senior citizen advisory groups.

In our discussions with the NAIC, we have indicated that we would oppose any approach to simplification that provided for a minimum package with *benefit riders* that could be purchased separately at the beneficiary's option. Allowing beneficiaries to accept or reject specific benefits at the time of purchase would lead to serious adverse selection. Our actuaries estimate that it would cost a consumer roughly 28 percent more in premiums to purchase the most commonly marketed benefits as riders to a typical Blue Cross and Blue Shield core policy than it would if the very same benefits were sold as part of a benefit package. We also believe that an approach based on riders could result in insurers discontinuing their offer of certain benefits. In response to a recent survey, almost all of the Blue Cross and Blue Shield Plans that currently offer a prescription drug benefit indicated they would drop the benefit if they had to offer it as a rider.

We have also indicated to the NAIC that we would not support an approach under which insurers could offer only some number of "pre-packaged" benefit options specified by the NAIC. We believe that this approach would narrowly limit consumer choice that seniors exercise and value. Reform in this area must balance the need for simplification against the importance of worthwhile choice.

With respect to Senator Chafee's proposal that the NAIC develop both a minimum benefit package and an alternative "bare bones" minimum package as part of the simplification standards, we believe that state regulators should have the authority to choose which of these two core packages insurers in their states must offer.

Finally, we have two other concerns regarding aspects of the proposed simplification:

- We oppose the provision that would require separate pricing of benefits contained in a package. This would be confusing to consumers because the cost of a particular benefit will vary depending upon the other benefits with which it is packaged. We believe the standard format we have proposed would achieve the objective of facilitating comparisons across policies.
- As a general principle, we recommend that simplification requirements apply to new policies only. Widespread confusion and dissatisfaction would likely result if subscribers in existing policies were forced to switch to higher-priced policies or receive fewer or different benefits. We propose that insurers offer their subscribers the option, at renewal time, to purchase the minimum benefit package under the new simplification standards or, if available, a policy substantially equivalent to the one they hold.

Preventing Duplication

The Association supports the policies reflected in the bills before you, that Medicare beneficiaries need only one Medigap policy to provide adequate coverage of their health care expenses and that Medigap policies should not be sold to individuals entitled to Medicaid benefits.

We favor the approach proposed by Senators Riegle and Daschle, whose legislation would require that sellers provide potential subscribers with a Federal notice informing them that Medicare beneficiaries should purchase only one policy and that those eligible for Medicaid should not purchase Medigap insurance. We agree also that sellers should be required to obtain a signed statement from the potential customer indicating whether he or she has other Medigap coverage, or is receiving Medicaid. We are concerned, however, that this requirement be crafted carefully so that the obligation of the seller to assess the beneficiary's existing Medigap or Medicaid coverage is realistic; otherwise, agents may decline to sell worthwhile coverage rather than risk untenable personal liability.

Loss Ratios

Senator Daschle's bill would increase the minimum loss ratios from 60 to 70 percent for individual policies and from 75 to 80 percent for group policies. Senator Chafee's bill directs the NAIC to establish loss ratio standards for indemnity and dread disease policies.

We believe that loss ratios are an important indicator of value. They reveal the percentage of premium dollars that insurance companies return in benefits to consumers. The balance reflects administrative expenses, including marketing costs and agent commissions, and profit.

We support raising the minimum loss ratio requirement for individual Medigap policies to 70 percent. A 30 percent maximum for administrative costs seems to us a reasonable standard. However, we recommend maintaining the minimum loss ratio for group policies at 75 percent. We have found that most group policies are association-type groups that have administrative costs quite similar to the administrative costs associated with individual coverage.

While the Blue Cross and Blue Shield system has virtually no market in hospital indemnity and dread disease policies, we believe that the development by the NAIC of loss ratio requirements for these types of policies appears appropriate.

Senator Chafee's and Senator Daschle's bills seek to strengthen enforcement of loss ratio standards. We believe provisions of both their legislative proposals would go a long way toward accomplishing this objective. We support provisions that would have the NAIC develop standard procedures for the calculation, reporting, and review of loss ratios, and that would have insurers whose policies fail the loss ratio standards make premium credits necessary to bring them into compliance.

We believe that meaningful implementation and enforcement of loss ratio standards on a state-by-state and policy-by-policy basis is essential. Only in this way can consumers be assured of receiving valuable Medigap policies.

Public Hearings

Senator Daschle's bill would require that states hold public rate hearings before approving "significant premium increases." We are concerned that the establishment of additional process requirements for state insurance commissioners would further tax limited staff and financial resources which, we believe, would be better channel led into enforcement activities.

As an alternative to Senator Daschle's proposal, we suggest that public hearings be required for *any* premium increase for a policy that fails to meet or barely meets the minimum loss ratio standard.

Agent Commissions

We do not oppose proposals to limit agent commissions structures. Current NAIC model regulations limit first-year commissions to 200 percent of commissions paid for renewals, and require that commissions for subsequent years be level with second-year commissions. The model regulations also prohibit higher commissions for replacement than for renewal, unless the replacement policy is substantially richer. Senator Daschle's bill would limit first-year agent commissions to 150 percent of renewal commissions.

Many of our Plans use agents to sell Medigap policies. When our Plans use agents, they generally pay first-year commissions of around IS percent. In some cases, however, Plans pay a very minimal, one-time commission, such as $25 per sale. We recommend that any legislation restricting agent commission structures provide for a limited exception to accommodate such situations as these.

Consumer Education

We support proposals offered by Senators Pryor, Daschle, and Chafee to improve consumer information and education. We believe that beneficiary confusion about basic Medicare coverage is widespread, and that the confusion surrounding supplemental coverage cannot be dispelled until individuals understand their underlying benefits. Organized and well-funded education programs will be essential to assist beneficiaries in making smart choices about their Medigap coverage.

A number of Blue Cross and Blue Shield Plans have service representatives and outreach programs in their communities to help seniors understand their Medicare coverage and their supplemental insurance needs. In addition, we have worked closely with HHS and the NAIC to update and improve the consumers' guide to supplemental insurance coverage. However, we believe that more can and should be done to educate consumers making insurance purchases. We believe that the beneficiary counseling proposals will help to fill these needs.

The Role of the Federal Government, States and the NAIC

Senator Daschle's bill calls for a very significant change, namely, a departure from the current voluntary character of the Federal certification program for Medigap insurance. Under his proposal, the sale of policies that did not meet the new NAIC standards or, in the case of states that do not adopt the NAIC standards, receive the Secretary's approval, would be subject to a civil money penalty. Under Senator Chafee's bill, Federal oversight of state regulatory programs and of policies issued in states without federally-approved regulatory programs, would be significantly increased. However, the Federal certification program would continue to remain entirely voluntary.

In our view, the entirely voluntary structure outlined in the Federal Baucus Amendments has worked extremely well. Notably, since the NAIC first developed model standards for Medigap insurance, nearly all states—while retaining the authority to reject the NAIC standards and establish their own—have adopted the NAIC's regulations without being compelled to do so by law.

We favor maintaining a voluntary system that preserves state regulation of insurance, and recommend, as all the bills have proposed, that Congress continue to rely on the NAIC to develop standards that assure reasonable value and benefits in Medigap coverage, and on states to adopt and enforce them. We believe the appropriate role of the Federal Government is to assure more adequate enforcement by states. We do not believe additional penalties or a direct Federal regulatory role is necessary.

We recognize that, despite the generally excellent outcome of the current approach to regulating Medigap policies, some states have not adequately enforced the NAIC standards. Accordingly, we agree that additional measures are needed to ensure that consumers get good value for their premium dollars, understand their benefit options, and are protected against abusive marketing practices.

We believe that the Federal Government can play a critical role by strengthening the existing regulatory framework for Medigap insurance, imposing clear disclosure requirements, and providing for consumer education and counseling programs.

We support the provisions of Senator Chafee's bill that would: strengthen Federal review of state regulatory programs and enforcement; provide for Federal technical assistance to states whose regulatory programs the Secretary found in need of improvement; and provide for grants to states with approved programs to help strengthen their enforcement. Under Senator Chafee's legislation, states seeking continued Federal approval of their Medigap regulatory programs would be required to report annually to the Secretary of HHS concerning loss ratios and other matters specified by the Secretary. If a state failed to satisfy these requirements, the Secretary would be authorized to revoke approval of its regulatory program.

We recommend that the NAIC be given a reasonable period of time, such as the nine months proposed by Senators Riegle and Daschle, to revise its model act and regulations to include new standards in certain areas. Three months, as proposed by Senator Chafee, is too little time for the NAIC to deliberate and act on these important issues. As under current law, the Secretary of Health and Human Services would develop the standards within one year if the NAIC failed to act. While adoption of the standards by states would remain voluntary, we are confident that the states would adopt the model regulations, just as they have the current Medigap model regulations.

Under Senator Chafee's bill, insurers in states without approved regulatory programs would be required to pay an initial fee of $20,000 to obtain Federal certification of a Medigap policy. We are concerned that such fees would discourage insurers from seeking Federal certification of their policies.

Medicare Select

Senator Chafee's bill includes a managed care initiative, known as "Medicare Select," that would relax current Federal standards for Medigap insurance to encourage PPOs to become involved in this market. Under the proposed legislation, Medigap insurers, after state approval, could provide reduced supplemental coverage when subscribers obtain services outside the insurer's PPO network. This differential coverage would act as a financial incentive to Medicare beneficiaries to stay within the network and receive their services from its more efficient and lower-cost providers. The Medigap PPOs would be permitted to develop their own medical review operations, funded by offsets against the Federal appropriations for medical review performed by Medicare contractors.

We are supportive of this initiative which, we believe, would build on and facilitate innovative managed care arrangements that have been increasingly successful and popular in the private insurance market. Indeed, the Medicare Select concept is modeled on a Medigap PPO initiated by Blue Cross and Blue Shield of Arizona. As mentioned earlier, we believe Medigap PPOs should be exempt from benefit standardization.

However, we object to the proposal to fund PPO medical review contracts through offsets against the already strained Medicare contractor budget. We are especially concerned that a Medigap PPO is likely to have start-up costs to establish an effective medical review operation that are much higher on a unit cost basis than those of an efficient Medicare carrier reviewing a large volume of claims. We propose that Medicare Select operations have an independent source of funding, or that the total number of PPO medical review contracts that could be funded from the Medicare contractor budget be limited.

Medigap Regulation and HMOs

Senator Daschle's bill would exempt all HMOs with HCFA contracts from Medigap regulation. As part of the effort to improve public policy in the Medigap area, we believe it is appropriate to consider the application of standards to HMO products that provide Medicare and supplemental benefits to the elderly.

Because of their structure, and because of the important flexibility they allow for innovative benefit and health delivery designs, we do not believe it is necessary or appropriate to apply Medigap simplification requirements to policies issued under TEFRA HMOs, health care prepayment plans (HCPPs) under section 1833 of the Social Security Act, or Medigap PPOs.

In fact, because they are subject to extensive Federal regulation, we believe it would be appropriate, as Senator Daschle has proposed, to exempt TEFRA HMOs from the array of Medigap regulation under your consideration. On the other hand, we believe that HCPPs, which are subject to very limited Federal regulation, should be subject to premium and other standards such as those that apply to both Medigap insurance and TEFRA contracts.

State Approval of All Policies Sold in the State

We support the provision of Senator Daschle's bill that would require state approval of all policies sold in a state. The current Federal statute provides that under certain circumstances, a policy may be deemed to be approved in the state in which it is sold. The bill would eliminate the authority for deemed approval, and require state regulators to approve all policies sold in their states.

CONCLUSION

Blue Cross and Blue Shield Plans are committed to providing Medicare beneficiaries with Medigap benefits designed to meet their needs, excellent value for their premium dollars, and superior service. In our view, the voluntary character of the Federal regulations governing the Medigap market has worked extremely well, as demonstrated by the timely promulgation of model Medigap regulations by the NAIC, and the nearly universal adoption of them by the states.

The Blue Cross and Blue Shield Association supports efforts to ensure that Medicare beneficiaries receive high-value Medigap policies, help make informed choices, and receive protection from marketing abuses. We offer our continued assistance in promoting these efforts as Medigap reform legislation is considered.

MEDIGAP SIMPLIFICATION PROPOSAL

BLUE CROSS & BLUE SHIELD ASSOCIATION

STANDARD BENEFITS: (Defined by the NAIC)	POLICY A	POLICY B	POLICY C
CORE BENEFITS	X	X	X
OPTIONAL BENEFITS:			
1. Part A Deductible		X	X
2. Part B Deductible		X	X
3. Home Health			X
4. Balance Billing			X
5. Outpatient Prescription Drugs			X
6.			
7.			
TOTAL FOR CORE & OPTIONAL BENEFITS	$	$	$
INNOVATIVE BENEFITS: (Approved by the State Insurance Commissioner)			
1. ---------->			$
TOTAL PREMIUM	$	$	$

- *THE NAIC WOULD DEFINE A SET OF SPECIFIC CORE BENEFITS THAT MUST BE INCLUDED IN ALL POLICIES.*
- *THE NAIC WOULD DEFINE A SET OF ADDITIONAL BENEFITS INSURERS COULD COMBINE IN POLICY PACKAGES TO ALL OR SOME POLICIES. THE ACTUAL BENEFITS WOULD BE DEFINED e.g. A PRESCRIPTION DRUG BENEFIT WITH A $250 DEDUCTIBLE AND 25% COINSURANCE.*
- *INNOVATIVE BENEFITS COULD BE ADDED ONLY IF APPROVED BY THE STATE INSURANCE COMMISSIONER.*

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PREPARED STATEMENT OF KARL E. HANSEN

Mr. Chairman, members of the Subcommittee, thank you for giving the National Association of Life Underwriters (NALU) the opportunity to testify today. My name is Karl E. Hansen, CLU. I am President of Vita Insurance Associates in Mountain View, California.

NALU, currently celebrating its centennial, is a federation of 1,000 state and local associations. The 138,000 members of these associations are sales professionals in life and health insurance and other related financial products.

We are especially pleased to testify before you on the issue of Medicare supplemental insurance. There has been much hyperbole over the past several months on this issue. You have heard testimonials from individuals who claim to have been sold a multiple number of Medigap policies. Let me state at the outset, as emphatically as possible, that NALU does not promote nor condone any of these abuses in the marketplace.

Although there seems to be little objective evidence about how widespread these egregious practices have become, we want to join with you to help pass legislation that will terminate the illicit activities of these "boiler-room operations."

As you know, the National Association of Insurance Commissioners' (NAIC) Consumer Protection Amendments to the Medicare Supplement Model Act and Regulation, adopted in December 1989 and passed in a number of states, includes various new marketing restrictions and consumer protection safeguards. Ideally, we would hope that Congress could defer to the NAIC until the model has been enacted by all the states and a sufficient time has elapsed to see what happens before moving to pass Federal regulations. However, we are cognizant of congressional concerns to stop marketing abuses when they occur and we are willing to work with Congress to stop these fraudulent practices.

Over the past several weeks, we have been working with Congressman Pete Stark (D-CA), Chairman of the Ways and Means Subcommittee on Health, to develop a package of reforms to protect and help consumers. We are pleased to inform you that NALU, along with the National Association of Professional Insurance Agents, the Independent Insurance Agents Association of America, and the National Association of Casualty and Surety Agents, strongly supports Mr.Stark's new proposal.

Let me briefly outline the nature of the package. Although all of the details have yet to be worked out, we believe that it promises to be an excellent piece of legislation which deserves both congressional and industry support.

STANDARDIZATION OF BENEFIT PACKAGES

The proposal envisions that companies would be allowed to sell four different benefit packages, ranging from standard to comprehensive. Each package would provide for uniform language and format. There are several advantages to this approach. Consumers could choose from a limited number of products containing some format which would be generic in nature. Arguably, this would make it easier and less confusing for senior citizens. In addition, with the uniformity in language, consumers could compare apples to apples and oranges to oranges, thereby taking any mystery out of the process.

DUPLICATION OF POLICIES

The proposal would prohibit the sale of duplicate policies. In addition, neither agents nor direct mail companies could sell policies to Medicaid beneficiaries. Agents, and presumably direct marketers as well, would be required to obtain a signed affidavit from the consumer. On the affidavit, a question would be asked of the client about whether he had any present coverage. If the answer is in the affirmative, no additional policy could be sold unless it was to replace the present one, presumably with additional benefits or one which would conform to new Medicare laws as amended by Congress. In an effort to regulate the sale of duplicate policies, the Stark proposal establishes a Federal data-match system at the Department of Health and Human Services (HHS) to monitor and facilitate the oversight of the anti-duplication provisions of this legislation.

UNIFORM CALCULATION OF LOSS RATIOS

The proposal envisions a revised NAIC Model which would provide a uniform methodology for determining loss ratios, calculated over a reasonable number of years. It is our understanding that this is intended to solve the controversy over whether projected loss ratios or actual loss ratios are the proper benchmark by which to judge a policy.

PREEXISTING CONDITION AND MEDICAL UNDERWRITING REFORMS

The proposal would codify existing standards with respect to preexisting conditions and waiting periods. Moreover, it establishes a six-month open enrollment period when individuals become eligible for Medicare, or in the case of the working aged, when they enroll in Medicare. Again, the intent we believe, is to improve access and promote full coverage for individuals when they become covered under Medicare. Consumers would have the advantage of obtaining more complete Medigap coverage without some of the obstacles which have heretofore been a problem.

LOSS RATIOS FOR DREAD DISEASE AND HOSPITAL INDEMNITY POLICIES

The proposal establishes minimum loss ratios of 55 percent for dread disease and 60 percent for hospital indemnity policies if such policies are sold to or renewed by Medicare beneficiaries. Such loss ratios would be calculated over a reasonable number of years. Although there has been some question about whether the loss ratio is an appropriate measure of the value of a policy, this proposal would essentially codify what is presently in the NAIC model, at least for indemnity policies. The current range in the NAIC model starts at 45 percent and goes as high as 60 percent, depending upon the type of policy (See the Guidelines For Filing Rates of Individual Health Insurance Forms, Section II).

ADMINISTRATION

Under the Stark plan, the NAIC would revise its Medigap standard within six months following the date of enactment. The Secretary of HHS would be required to issue regulations within twelve months after the date of enactment; such regulations would reflect the NAIC's revised standards, including uniform enforcement standards, providing the NAIC's revised standards carry out the enacted Medigap reform provisions.

States would have one year or the next legislative session to adopt the revised standards. In addition, states would continue to regulate Medigap policies provided the Secretary has certified that the revised Medigap standards have been adopted in their entirety and fully enforced by the states. If a state fails to adopt the revised standards, or enforce the standards, then policies sold in that state must be certified by the Secretary. The policy would have to be approved by either the State or the Secretary. Non-approved policies would be subject to a premium tax.

As I indicated at the outset, the details are still sketchy and we expect that a definitive package will be marked up in Mr. Stark's Subcommittee shortly.

It is our understanding that several members have endorsed S. 2640, proposed by Senator Daschle. While we support the goals of the legislation and many of its provisions, there are a few problems in the bill which must be addressed. First, we oppose the provision to place further restrictions on first-year agent commissions at 150% of renewals. This is objectionable for a number of reasons. The NAIC has already revised its model to restrict first-year commissions at 200% of renewals. Although we initially opposed the efforts by the NAIC to enact this provision, we have agreed to abide by their decision and NALU is not lobbying the state capitols to defeat it. Although we strongly disagree with the prospect of curbing abuses through caps on agent commissions, we would ask you to give the NAIC model an opportunity to work.

Before leaving the issue of agent commissions, let me make a few observations. Agents provide valuable personal assistance to the elderly, especially those in rural areas who might not have the same access to the choices in Medigap policies as those in urban areas. Agents spend countless hours answering complex questions about Medicare, explaining the advantages and disadvantages of certain policies and their benefits, and assisting senior citizens with claims. Squeezing agent-sold policies out of the market will only encourage more direct sales of products. While these may be fine for some, seniors who need the assistance of an agent will find small comfort in an 800 telephone number. With the increasing complexity of health insurance generally and Medicare rules, senior citizens need more guidance, not less.

Economically, reputable agents will be most adversely affected by limitations on the compensation they may receive. These same law-abiding agents will have to choose between spending less time with their clients or selling other insurance products to other consumers. To penalize those agents, and ultimately their clients, by tacking on additional arbitrary restrictions on all agent commissions would be a disservice to the industry and consumers.

Reductions in commissions will not remove the incentives for unwarranted sales or ill-advised replacement sales. Those who are violating the law will continue to do

so. It is the job of regulators to promote tough and effective enforcement of laws designed to weed out and prevent abuses.

The second problem is the extent of agent liability. Although it is our understanding that this is merely a drafting error, let us note it for the record. In terms of the affidavit which the agent would provide to the consumer, the agent is required to ask whether there is current coverage or if the individual is receiving Medicaid benefits. We have no problem in making such an inquiry. In fact, most agents presently inquire about their clients' insurance coverage. However, agents are only willing to obtain the signed affidavit provided that only a "good faith" effort is required. In other words, our reading of the bill makes no provision for elderly consumers who may be unsure of their other coverage yet tell the agent no other policies exist when in fact there are. Our concern is that strict liability might be imposed. Agents cannot be reasonably expected to investigate their clients, although they will happily record any and all information disclosed by such a client. As I indicated before, we have been assured that this is either a drafting error or a different interpretation of what was intended.

Finally, our third major objection is the increase in loss ratios for Medigap policies. Initially, there is the question as to whether loss ratios are an accurate indicia of good value. The recent study by Foster Higgins, "Loss Ratios on Medicare Supplement Policies—Interpretation and Analysis," June 19, 1990, suggests they are of limited consumer value. As the study notes, *Consumer Reports* in its June 1989 issue "endorsed the policies of several carriers with loss ratios on the order of 60-65% for mature business because of the benefits made available." In addition, the ratio must be sufficiently mature in order to be accurate. For example, it is not unreasonable to have a low loss ratio if there is little or no claims experience upon which to base it. A sixty-five year old male who purchases a policy may be healthy for several years and therefore the ratio of claims to premiums would necessarily be low or nil. Moreover, companies may by necessity move to cut agent commissions to achieve compliance with a higher loss ratio imposed by Congress. In our discussions with some of the companies, their representatives have argued that with a profit margin of 3% or less, they might have to either move out of the market or cut commissions to stay in this line of business. Either action would be would be bad public policy.

While we hope that you would favorably consider the Stark proposal, we will be happy to work with you and your staff in drafting a bill which is acceptable to the Senate Finance Committee.

Thank you again for the opportunity to testify. I will be pleased to answer any questions you may have.

PREPARED STATEMENT OF SENATOR JOHN HEINZ

Thank you Mr. Chairman for holding today's hearing, which, in the view of this Senator, represents the culmination of more than a year's effort to develop an improved regulatory framework for supplemental health insurance—one that protects the purchasers of these policies rather than the sellers.

Over the past year, in hearings before the Special Committee on Aging and this subcommittee, we have taken tally of the problems plaguing the market for supplemental health insurance. We heard about annual premium increases of up to 50 percent, about states without the enforcement stick to control questionable prices. We heard stories of beneficiaries being confused and coerced into purchasing multiple policies by overzealous agents and blatantly misleading advertisements. We learned that it is nearly impossible for consumers to make meaningful comparisons between policies on the basis of benefits and costs.

And, while we learned how insurers, agents and state insurance commissioners contribute to these problems, we would be remiss not to place part of the blame on the doormat of the Federal Government. After all, Congress and the Administration have created a Medicare program that is cumbersome, complicated, and inadequate in terms of covering the basic health care needs of our senior citizens. It is not surprising that into this morass of poor policy stepped the insurance industry with their Medigap plans.

Absent major Federal legislation to reform our health care system, our role today is not to quash the Medigap market, but to assure a better quality product. The Daschle/Heinz Medigap Fraud and Abuse Prevention Act would do just that.

Our bill, S. 2640, would simplify the purchase of a Medigap policy by limiting the number of benefit packages available and standardizing the format, terminology and benefits contained in each package. This would permit a true "apples-to-apples" policy comparison and encourage competition based on price and benefits. S. 2640

would also improve loss ratios, require prior approval for rate increases, mandate policies be guaranteed renewable, and prevent the sale of Medigap coverage to Medicaid recipients. Incentives for agents to "twist" or "churn" coverage would be minimized by reducing the allowable sales commission for new policies to no more than 150 percent of the commission for a renewal, and agents would be precluded from selling duplicate coverage to a beneficiary.

Most importantly, the Daschle/Heinz bill would make consumer education a priority through funds for state-sponsored health insurance counseling programs for Medicare beneficiaries—a concept developed by Senator Pryor and myself. Our hearings made it clear that older Americans have at best a hazy grasp of protections offered under Medicare—and thus an uninformed approach to purchasing additional coverage through Medigap. State counseling programs, such as Pennsylvania's, have proven invaluable to beneficiaries in an environment best characterized by the phrase "caveat emptor"—let the buyer beware.

Although insurers and agents do not support all provisions of S. 2640, they have expressed support of the bill's primary objectives and provisions. This hearing provides an excellent opportunity to focus on our areas of disagreement and learn how we might best meet the goals of the legislation without disrupting the stability of the Medigap market. I look forward to today's testimony and to working with consumer and industry representatives over the days and weeks to come to assure the passage of comprehensive reform legislation.

PREPARED STATEMENT OF LINDA JENCKES

Mr. Chairman and Members of the subcommittee, I am Linda Jenckes, Vice President for Federal Affairs of the Health Insurance Association of America. The HIAA is the principal trade association of the commercial health insurance industry. The 330 HIAA member companies underwrite over 85 percent of the private health insurance available from commercial companies in this country. Sixty HIAA member companies underwrite Medicare supplement policies.

I am here today in responds to your request for our comments on the Medicare supplement reform legislation before your committee. Those bills are: S. 2050 (Senator Kohl), S. 2189 (Senator Pryor), S. 2640 (Senator Daschle), S. 2641 (Senator Riegle), and S. 3020 (Senator Chafee). After some general comments on the regulation of Medicare supplement insurance, I will offer specific comments on some of the provisions of these bills. We hope they will be useful to the committee.

Medicare provides our senior citizens invaluable basic protection against health care expenses, yet three quarters of the program's beneficiaries also have private health insurance to protect themselves against expenses not covered by Medicare. A 1989 survey by the HIAA revealed that about a third of those seniors with private coverage in addition to Medicare have it provided by a former employer. Of those persons with private coverage not obtained through former employment, 45.1 percent purchased it through a group or association, 44.5 percent from an insurance company or agent, 6.9 percent by mail and 3.5 percent belong to a health maintenance organization.

Medicare is an extremely complicated benefit program—one whose details have been modified over the years by Congress. Because most Medicare supplement benefits dovetail with those provided under Medicare itself, they reflect that complexity.

Nevertheless, a great deal has already been done to help seniors understand both Medicare and Medicare supplement insurance. Attachment I to this statement lists the consumer protection measures presently in effect and currently being implemented by all state insurance regulators. We believe that as the Congress decides what additional Federal legislation is needed to protect purchasers of Medicare supplement insurance, it will want to take into account the safeguards already in place or currently being implemented by the states.

We can well understand that in the wake of the repeal of the Medicare Catastrophic Health Insurance Act, the Congress is especially interested in Medicare supplement insurance and is considering legislation aimed at correcting marketing abuses and assuring that seniors receive fair value for their insurance dollars.

LEGISLATIVE PROPOSALS

Proposals currently before the Committee would employ a variety of approaches to deal with problems in the Medicare supplement marketplace. We appreciate the concerns of the sponsors of these proposals and wish to work with you to craft solutions to those problems.

After studying all of the bills pending before committees of the Congress, the Association has developed a set of legislative recommendations—many of which are very much like various provisions of those bills. We believe that our recommendations will effectively deal with problems in the Medicare supplement market. These HIAA supported reforms, to be implemented within the current statutory framework, would improve the value of Medigap coverage and alleviate problems in the marketplace. They include:

- simplification of Medigap policies,
- guaranteed renewability of coverage,
- prohibiting the sale of Medigap policies to persons also enrolled in Medicaid,
- assuring that states have approved policies sold to their residents and the premiums charged for them,
- prohibiting the sale of duplicative Medigap policies,
- counseling for seniors on their health insurance needs, and
- limiting delays in coverage for preexisting conditions.

There are provisions of various bills that we cannot support because they would reduce the availability coverage. Of particular concern to the HIAA are proposals which would have the Federal government:

- increase the minimum loss ratio requirements for individual and group Medigap coverages,
- expand the Federal aegis to cover types of health insurance not sold primarily to seniors,
- regulate agents commissions, and
- limit medical underwriting.

These points will be addressed in somewhat greater detail in the following comments on the bills now before the Committee on Finance.

Counseling Medicare Beneficiaries: We would like to state our strong support for immediate Federal legislation to promote health insurance counseling and assistance to seniors. The Kohl, Riegle, Daschle, and Chafee bills all have worthwhile consumer counseling and assistance provisions. We believe that seniors would benefit most from a broadly focused counseling effort covering Medicare, Medicare supplement insurance, long-term care insurance, Medicaid and other forms of health coverage as provided for in Senator Pryor's proposal. Unbiased personal assistance has been shown to be a great help to Medicare beneficiaries seeking appropriate health coverage. Counseling programs already in existence have earned consumer support and their value has been recognized by a recent resolution of the NAIC encouraging all states to develop them.

Similarly, the establishment of toll-free hotlines called for by the Kohl, Riegle, Daschle, and Chafee bills to assist seniors with health insurance questions or problems would be a worthwhile and cost-effective initiative.

Increased Civil Penalties: The Kohl, Riegle and Daschle bills would impose much higher Federal civil penalties for violations of prohibited practices. We do not oppose such increases.

Agents and companies who knowingly commit abuses in marketing health insurance to Medicare beneficiaries should be exposed and disciplined.

Sale of Duplicative Coverages: The NAIC consumer protection amendments now being put into effect by the states deal effectively with the problem of seniors being sold more than one Medicare supplement policy. They prohibit the sale of a policy to a person who already owns one unless that person commits to dropping the first policy. We support similar Federal legislation specifically prohibiting the sale of duplicative Medicare supplements. We believe such a law will greatly reduce Congressional concerns about problems in the Medigap market place.

Agent Commissions: We believe that Federal legislation dictating how agents' commissions are structured would be an inappropriate intrusion into the business relationship between insurers and their agents. It is a matter best left to the states.

Approval of Premium Rates: The Kohl and Daschle bills would require all states specifically to approve any premium increases for Medicare supplement insurance. We support this requirement. Virtually all states presently have such a requirement for individual policies, but many do not require approval of group premium rates.

We cannot agree, however, with the Daschle bill's requirement that there be public hearings whenever the increase requested exceeds a certain amount. Such a requirement would be extremely burdensome and expensive both for multi-state insurers and for state insurance departments. In the end, hearings would only add to the cost of the insurance.

Simplification of Medicare Supplement Policies: One often-heard criticism is that while current law requires that Medicare supplements provide certain minimum benefits, it does not limit the additional benefits a policy can provide. This results in consumers being faced with too much variation among policies to make sound price comparisons. The Daschle and Riegle bills would address this problem by limiting the choices among policies to 10 standardized alternatives.

The HIAA has surveyed our major Medicare supplement underwriters to determine how much diversity there is in the nonmandated benefits offered to seniors. We found that eight benefits are by far the most common. They are:

- payment of greater than the Medicare allowable charge under Part B;
- payment for additional skilled nursing facility days during a Medicare certified skilled nursing facility admission;
- private Duty Nursing;
- prescription Drug Coverage;
- foreign Medical Care;
- hospital services not covered by Medicare (e.g., private room);
- immunizations;
- ambulance charges not covered by Medicare.

Only one-tenth of one percent of covered persons in the survey had nonmandated benefits other than these.

We are supportive of the concept of standardization, but do not believe it is either advisable or necessary to limit consumers to choosing among a few prescribed alternative packages, as contemplated by the Riegle and Daschle bills. If the goal is to simplify informed decision making by consumers, we believe it can be achieved in a way which provides consumers a greater range of choices while allowing insurers greater latitude to design competitive benefit packages.

Under the alternative system we have in mind, the Congress would require the NAIC to develop a list of standardized optional benefits and uniform language and formats to be utilized in Medicare supplement policies and outlines of coverage. Insurers would be permitted to select whichever of these individual standardized benefits they wished to offer in addition to the minimum benefit package currently required by the NAIC model regulation, but would also have to offer prospective purchasers a policy containing only the minimum required benefits.

The outline of coverage, which must be given prospective purchasers, would contain one column showing the benefits in the policy which are required by law and the total premium for those benefits. Another column would list the optional standardized benefits included in the policy and the total additional premium attributable to them. The outline would make it easy for consumers to determine the benefit differences between policies and the cost of those differences.

As we understand Senator Chafee's bill, its provisions on standardization are quite similar to what we would prefer. We would also like to state our support for opening the Medicare supplement market to managed care alternatives, as Senator Chafee's bill provides. The HIAA views managed care as a cornerstone for improving this country's health care financing and delivery systems. We, therefore, support the Medicare Select proposal as a modest step in the right direction.

We cannot, however, support that part of the proposal that would take program safeguard funds from Medicare intermediaries and carriers and use them to pay for the medical review activities of Medicare Select insurers. Subtracting from the proven and highly cost-effective efforts of carriers and intermediaries to fund as yet unproven Medicare Select insurers would be an unwise investment.

Hospital Indemnity or Dread Disease Policies: We do not agree that Federal action is needed either to regulate the loss ratios or limit the sale of hospital indemnity policies to Medicare beneficiaries. Hospital indemnity policies are not Medicare supplements. Unlike Medigap policies, these policies are unrelated to Medicare and they are marketed population-wide, not just to Medicare beneficiaries. Their loss ratios, benefits, outlines of coverage, and marketing are controlled by states under a separate NAIC model regulation.

Most seniors who own indemnity policies purchased them before becoming eligible for Medicare. Indemnity policies do not duplicate benefits provided by Medicare or Medicare supplement policies. Instead, they pay a stated cash benefit upon hospitalization. Another type of indemnity policy, sometimes called a "dread disease policy," pays various cash benefits based upon the type of disease being insured, i.e., cancer. While indemnity policies are no substitute for a Medicare supplement policy, for a person who has a Medicare supplement, they may provide useful supplemental income in case of serious illness.

One of our member companies surveyed its indemnity policy owners and found that:

- 75 percent used the indemnity payment received to cover expenses related to their illness not covered by other insurance;
- 50 percent used it to pay for post-hospital expenses such as home health care, ambulance service or prescription drugs not covered by Medicare;
- 23 percent used it to pay for extra costs in the hospital such as having a private room or a t.v.;
- 17 percent used it for transportation and parking costs for family members visiting the hospital; and
- 13 percent used the payment to replace lost earnings.

Protection for these expenses, while certainly not as essential as the coverages provided by Medicare supplement policies, may still be useful to have and should not be denied the elderly. Effective consumer education, addressing all types of health insurance available to seniors, as proposed in Senator Pryor's bill, is the best way to counteract seniors purchasing too many of these policies and to persuade current owners of multiple policies to drop excessive coverage.

Minimum Loss Ratios: The current Federal loss ratio standard for Medicare supplement insurance is 75 percent for group policies and 60 percent for individual policies. Under the NAIC model, states may set higher standards if they find that their demographic, geographic, and other characteristics make a higher requirement appropriate

The General Accounting Office has reported that a number of insurers are not meeting the minimum standards. However, the NAIC has noted that 95 percent of the premiums paid for Medicare supplement policies in force longer than three years are being paid to companies that are meeting the standard. The position of the HIAA is that insurers *should* be meeting the loss-ratio standards as defined by the states and that, as provided by the NAIC model regulation, regulators should require premium reductions where appropriate to assure that insurers do meet the current standard. Raising the minimum loss ratios is unrelated to the problem of insurers failing to meet the standard. Vigorous state enforcement of the standard is the solution to that problem. We believe that the recently strengthened NAIC loss ratio standards and reporting requirements will enhance enforcement and dramatically increase the number of insurers meeting the requirements.

We do not agree, however, that the current 60 and 75 percent standards should be raised. It is simply incorrect to assume that a high loss ratio is indicative of a policy being a "good value" to the consumer. As was pointed out during a recent House Energy and Commerce Committee hearing, a Medigap policy with a high loss ratio can have a higher premium than identical coverage from another insurer with a lower loss ratio. It is not a policy's loss ratio, but rather its price, how well its benefits suit the needs of the purchaser, and the dependability of the insurer offering the coverage that determine whether one policy is a better value than another.

Loss ratios directly reflect how actively and widely an insurer markets its coverages—the higher the degree of marketing activity, the lower the insurers loss ratio. A significant increase of the loss ratio standards for individual Medicare supplement policies will largely eliminate the use of agents in marketing this type of insurance. Before taking that step, the Congress should consider that it is agents who effectively reach individuals who are not reached by other marketing methods. Companies that do not use agents will incur lower loss ratios if they broaden their marketing strategies to reach the seniors now located by agents.

We have become very concerned about some of the ideas that have been expressed concerning loss ratios. A loss ratio is not a measurement of profit. It is a standard of reasonableness used by state regulators to review how much an insurer is paying in claims as compared to its costs of marketing and administering the product. Because the subject is so very complicated, we commissioned an independent consulting firm to write a paper explaining the significance of loss ratios and how they may vary due to operational differences between insurers. We have attached that paper to this statement and urge that it be studied by anyone interested in the loss ratio issue.

As stated previously, we also do not support the Federal government subjecting policies that are not Medicare supplements, such as hospital indemnity policies, to the same loss ratio standards as Medicare supplements. That is a matter that should be left to the expertise and experience of the states and the NAIC, which is studying the issue.

Health Insurance Sales to Medicaid Beneficiaries

Under the Riegle and Daschle bills, insurers would be prohibited from selling Medicare supplement policies to Medicare beneficiaries who are also on Medicaid. We think that such a prohibition might be worthwhile, but would like to point out that at least one state prohibits insurers from asking applicants if they are on Medicaid.

The Daschle bill also provides that when a Medicare supplement policyholder becomes eligible for Medicaid, the insurer must suspend coverage indefinitely, while the policyholder retains the right to reinstate coverage if he/she becomes ineligible for Medicaid at some later date. New York, Oregon, Washington and Minnesota ask whether Medicaid enrollees have private coverage and will pay the premium for them if doing so would reduce Medicaid's liability for their health care expenses. Several other states are considering adopting this cost-containment strategy. While we understand the intent of this provision, we note that its adoption would have the effect of increasing state Medicaid costs.

Having offered these observations, I would like to emphasize that the HIAA does not condone the sale of unneeded health insurance to people on Medicaid and will certainly cooperate with whatever workable measures the Congress decides to enact on this question.

We are pleased to have had the opportunity to appear before you today. We know that you recognize the value of Medicare supplement insurance in helping the elderly meet the substantial health care expenses that Medicare does not cover. We share your interest in seeing that supplemental policies continue to offer fairly priced, ethically marketed protection, and that our policyholders are satisfied with their coverage.

If you have questions, I will be glad to respond now or, where it might be necessary, submit information for the hearing record.

ATTACHMENT I.—STATE REGULATION OF MEDICARE SUPPLEMENT INSURANCE

Under current law, whenever a person eligible for Medicare applies to purchase any type of health insurance they must be given a government- written "Guide to Health Insurance for People with Medicare." It contains a good basic discussion of Medicare, Medicare supplements and other types of private health insurance, and gives sound advice on shopping for coverage. Also, at the time application for a Medicare supplement policy is made, the applicant must be given an outline of coverage in a format prescribed by the government that shows 1) what Medicare pays and does not pay, and 2) which of the supplemental benefits provided by the policy are required under the minimum standards for such policies and which of those benefits are additional to the minimum requirements.

This information is provided to all applicants before a policy is issued to them and each applicant has a 30 day "free look" period following issuance within which to cancel the coverage at no cost to themselves.

New Consumer Protection Provisions: As required by the Medicare Catastrophic Benefit Repeal Act of 1989, the states are now improving their regulation of Medicare supplements by adopting certain new requirements. These new rules were promulgated by the National Association of Insurance Commissioners (NAIC) last December. Under these important new consumer protection provisions:

- Individuals purchasing Medicare supplement insurance policies cannot be cancelled for any reason except for failure to pay the premiums or a material misrepresentation.
- People obtaining coverage under group Medicare supplement insurance policies are no longer subject to loss of coverage if their membership in that group ceases or the group policy itself terminates. They will be offered continuation of coverage through an individual policy.
- The sale of duplicative Medicare supplement policies is banned.
- Insurance companies and agents, when soliciting applications for Medicare supplement insurance policies, are required to obtain additional information concerning applicants' past and present health insurance coverage. This information will verify that individuals do not own more than one Medicare supplement policy.
- In order to assure that sales of duplicative Medicare supplement policies do not occur, insurance companies are also required, annually, to review their records for persons who have more than one Medicare supplement policy and report their findings to the states.
- When seniors purchase a new Medicare supplement policy to replace one they already own, the new NAIC requirements will:

—Prohibit the new insurer from imposing any new preexisting condition limitations or waiting periods for benefits being replaced; and

—Limit the front-end loading of agents' compensation in order to lessen their incentive to replace adequate existing policies.

- If they have not already done so, insurers are required to establish written marketing procedures to assure regulators that both existing and new consumer protection requirements are complied with.
- Such marketing practices as twisting, cold load advertising, and high pressure tactics are prohibited as part of the sale of Medicare supplement insurance policies.

These new consumer protection provisions are in addition to *existing* state regulations which:

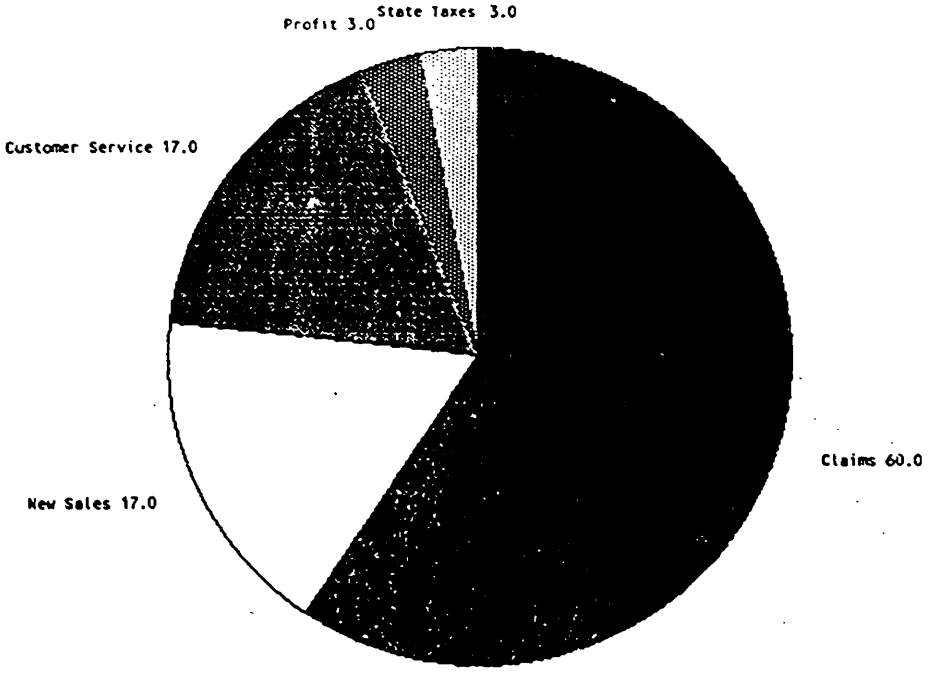
- prescribe the minimum benefits that a Medicare supplement must provide,
- require that policies automatically adjust to changes in Medicare deductibles and copayments,
- specify the information that must be provided by an insurer or agent when a policy is sold or updated,
- prohibit many types of policy limitations or exclusions, and
- require insurers to meet loss-ratio standards involving the ratio of claim payments to premiums.

In addition to its broad authority to regulate insurance, virtually every state has in effect the "Unfair Method of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance" statute.

Finally, insurance departments have other sanction authority such as their agent licensing laws which also enable the state to issue fines, revoke licenses and publicize the results of disciplinary actions.

Enclosures.

A 60% Loss Ratio Illustrated



$1.00 of Premium

LOSS RATIOS ON MEDICARE SUPPLEMENT POLICIES - INTERPRETATION AND ANALYSIS

INTRODUCTION

Medicare Supplement regulatory attention and concern have focused on loss ratios since the first NAIC Model Regulation was adopted in late 1979. While loss ratios have been an important regulatory tool, they have been subject to considerable misunderstanding. This paper has been written to provide background information -- quantitative and qualitative -- concerning loss ratios. The paper considers basic conceptual points, such as the relationship of loss ratio and policy value. It also contains detailed technical analysis concerning the progression of loss ratios over time, and the impact of that progression on minimum standard compliance. Our intent is to eliminate misunderstandings and improve the ability of governmental bodies to develop and enforce appropriate minimum standards.

SUMMARY

Loss ratios for health insurance policies represent the ratio of claims to premiums. This paper includes background information concerning loss ratios, and considers their application to regulation of individual medicare supplement policies. The major points developed are as follows:

- Management Tool: In health insurance, loss ratios are a tool used by financial managers to monitor emerging experience, and adjust premium rates when necessary to meet objectives. Care should be taken in using loss ratios for other purposes to ensure the application is reasonable and appropriate. In our view, loss ratios do not represent a measure of policy value, or a return on investment, and should not be used as such.

- Regulatory Applications: Minimum loss ratio standards should allow for the existence of different types of operations providing different types of coverage using different types of distribution systems. If two conditions are present, minimum standards should not act to exclude any one type of operation, even if that type has significantly lower loss ratios. Those conditions are:

  - The cost of the products provided by that type of operation are acceptable from a public policy perspective, and

  - Differences in the products offered by that type of operation create legitimate issues of consumer choice.

- Medicare Supplement Market: In the medicare supplement market there are, in fact, several different types of operations using different types of distribution systems. Differences in operations of commercial carriers, including marketing methods, operating costs, and products result in lower target loss ratios for their products. Minimum loss ratios for these types of operations should be set based on an independent assessment, as described in the preceding paragraph. To do otherwise would be to risk excluding viable classes of operations and carriers from the market.

- Consumer Value: Consumers consider a number of factors in assessing the value of an insurance policy:

  - Price,
  - Benefits available,
  - Carrier reputation, especially concerning service and solvency, and
  - Terms of coverage, including preexisting condition clauses and other health status requirements.

Loss ratios do not enter into this assessment, since the consumers generally do not know what the loss ratios are, and price is more important than loss ratio. A higher loss ratio does not imply a lower premium rate, as illustrated in this paper.

Consumer Reports, in its June 1989 issue, endorsed the policies of several carriers with loss ratios on the order of 60-65% for mature business because of the benefits made available.

- Loss Ratio Compliance: NAIC data for 1988 shows commercial carriers largely in compliance with minimum loss ratio requirements for mature business under the current NAIC Model Regulation. Average loss ratios for mature business (policies issued prior to 1986) were about 66%, well over the 60% minimum used in most states, as well as the 65% used in some.

  Loss ratios for all medicare supplement business in 1988 (new and mature combined) were generally consistent with loss ratios for other types of individual coverage during 1987/1988 -- slightly over 60%.

  Caution should be exercised in drawing conclusions from one year's data, since the year may not be representative. However, the data demonstrates a degree of compliance far greater than suggested by prior studies, when separate data on mature business was not available.

SECTION 1

LOSS RATIOS - DEFINITION AND USE

Summary

The loss ratio for an insurance product is defined as the ratio of claims to premiums. In health insurance, loss ratios are used as a tool by financial managers to:

- Determine whether emerging claims experience bears the desired relationship to premium income.
- Adjust premium rates to the appropriate level when it does not.

Analysis of this type is performed using a target loss ratio, which represents the ratio of claims to premiums desired by management. The target loss ratio is set by:

- Estimating the expense ratio (the ratio of expenses, taxes, and profit charges to the premium rate), and
- Subtracting the expense ratio from 1.00.

For example, if expenses, taxes, and profit charge will total 38% of premium, then the target loss ratio will be 62%.

Loss ratios are often used for purposes other than those for which they were originally intended. When this is done, care needs to be taken to ensure the application is reasonable. For example, we do not believe loss ratios are an appropriate tool for measuring the value of a policy to its purchaser.

Insurance and Financial Management

A risk is an event of uncertain financial impact which may occur at some future date. People buy insurance to protect themselves from risks by pooling their economic resources. Under an insurance or risk pool arrangement, each participant contributes funds -- premiums -- which are used to reimburse the members of the pool who have suffered covered losses -- claims.

To be financially sound, the premiums must exceed the cost of operations. Claims typically represent the largest expense, but the costs of forming and maintaining the insurance pool can also be significant. The types of nonclaim expenses which may be incurred are:

- Direct marketing expenses (e.g. agent's commissions, direct mail printing & postage)

- Marketing support (e.g. product development, marketing management)
- Underwriting (e.g. classification and control)
- Membership Administration (e.g. billing, change of address)
- Claims Administration (e.g. payment of claims, preparation of claims reports)
- Taxes -- federal, state, local
- Regulatory Compliance

Investment income generated on positive net cash balances, if any, would reduce net expenses.

Premiums are generally set equal to the total of:

- Estimated claims, plus
- Estimated expenses and taxes (net of investment income), plus
- A risk or profit charge.

The sum of the last two items, divided by the premium, is the expense ratio defined above.

Nonclaim expenses are often fairly predictable, although there are exceptions. For example, compliance expenses for medicare supplement policies incurred because of the implementation and repeal of the catastrophic program would have been difficult to predict.

On the other hand, claims for health insurance are difficult to predict with precision. Therefore, proper management of health insurance calls for:

- Monitoring the level of emerging claims in relation to the allowance in the premium rate, and
- Adjusting premiums to an appropriate level as needed.

Loss ratios -- the ratio of claims to premiums -- are used by insurance managers to help perform this function.

Types of Loss Ratios

There are several different types of loss ratios:

- Target or desired loss ratios: The loss ratio standard established by management when the premium rates are set, developed by subtracting the expense ratio from 1.00. The target loss ratio may be the same for all years of coverage, or it may vary by policy year, depending on the type of company and its pricing methodology.

- Historical or experience loss ratios: The actual ratio of claims to premiums for some period in the past. Historical loss ratios may be developed based on the actual claims paid during the period (paid loss ratio) or the claims which the insurer incurred a legal obligation to pay (incurred loss ratio).

- Anticipated or projected loss ratio: The loss ratio expected for some future period. This would be the same as the target loss ratio if no experience data were available. Otherwise, it would be based on the historical loss ratio, projected to reflect changes in claims due to inflation, etc., and may reflect changes in premiums as well.

In preparing to market a new line of business, a company will establish target loss ratios. Once sales have begun, historical loss ratios will be calculated using emerging experience data. Periodically, projected loss ratios will be developed from the historical data. Typically, the projected loss ratios will be developed assuming premium rates are unchanged. These projected loss ratios are compared to the current target loss ratios, which may differ from the original targets, to determine the required change in premiums.

SECTION 2

LOSS RATIOS - REGULATORY APPLICATIONS

Summary

Loss ratios have been adopted by regulators as a means of defining whether premium rates for a policy are reasonable in relation to the benefits provided. Rates for policies with loss ratios below a predetermined minimum standard are deemed to be unreasonable.

For some types of coverage, including medicare supplement, there are several different types of carriers providing coverage. Regulators need to consider how the operations conducted by these carriers differ, and how minimum standards should allow for the associated differences in:

- Operating expenses.
- Premium rating practices.

Otherwise, some types of operations may be inadvertently excluded from the market because of inability to comply.

Consistency of standards by type of carrier, operation and coverage is also important. Loss ratio standards for individual medicare supplement policies have been stricter than those for individual health insurance coverage in many jurisdictions. However, in recent years commercial carrier loss ratios for medicare supplement and other forms of individual health insurance have been about the same.

Differences in Carriers and Operations

When carriers, or the operations they conduct, differ with respect to marketing strategy, enabling legislation, or other characteristics, it is likely that operating costs will differ as well. As a result, differences in target loss ratios should be expected.

Suppose, for example, that there were two types of carriers providing a given line of coverage, and that the first, Type A, had significantly lower costs and higher target loss ratios than Type B. In setting minimum loss ratios, regulators need to consider points such as:

- Are their significant differences in their operations?
- Do operational differences result in differences in costs which are reasonable and legitimate?

- Considered independently, are the costs of the operations of a Type B carrier acceptable?
- Are there differences in the target markets, terms of coverage, and benefits and services offered by the two types of carriers?

Suppose there are differences in operations, and the associated differences in costs are legitimate. In addition, suppose the Type B costs are acceptable, and elimination of Type B carriers would restrict consumer choice or access to coverage. In our view, it would be difficult to rationalize setting minimum loss ratios at a level which would exclude Type B carriers, or the types of operations they conduct, from the market.

The next two sections provide information designed to assist in performing the analysis described above. Section 3 includes a discussion of the carriers in the medicare supplement market, and differences in the types of operations they conduct. Section 4 covers issues related to consumer choice.

One important difference in carriers or operations which often arises concerns premium rate setting policies. Minimum loss ratio standards should be designed to allow for legitimate differences in premium rate setting practices. These types of issues are described in section 5.

Consistency of Standards

The NAIC Model Regulation for medicare supplement policies calls for a 60% or 65% minimum loss ratio. Other forms of individual health insurance coverage are typically required to have a 55% minimum loss ratio. While the standards for other coverages are more liberal, actual loss ratios experienced by commercial carriers for medicare supplement and other coverages have been about the same in recent years -- a little over 60%.

For example, the A. M. Best Company Aggregates & Averages reports show that, during 1987 and 1988, commercial carrier experience on guaranteed renewable, collectively renewable, and noncancellable policies was as follows:

Year	Premium Income	Loss Ratio
1987	$8.9 billion	60.8%
1988	$9.7 billion	63.7%
Total	$18.6 billion	62.3%

This total loss ratio is very consistent with the 61.9% loss ratio for all commercial carrier individual medicare supplement policies in 1988, as reported in the 1988 NAIC loss ratio data.

SECTION 3

THE MEDICARE SUPPLEMENT MARKET

Summary

There are several different types of organizations providing medicare supplement coverage under different operational approaches. Differences in the type of organization and operation affect the marketing strategies employed, which, in turn, can affect the market segments served. As a result, their costs of operation are very different, as are their historical loss ratios.

These differences make it difficult to assess the reasonableness of the loss ratios of one type of operation based on comparison to another. We believe that operations conducted by commercial carriers in selling individual medicare supplement policies are often sufficiently different from other operations to warrant independent consideration with respect to minimum loss ratios, as described in the prior section.

Types of Carriers

The three major types of organizations providing medicare supplement coverage are:

- Commercial insurance carriers
- Associations
- Blue Cross/Blue Shield Plans

Often times, these different types of carriers differ with respect to the types of operations they conduct.

Commercial carriers may provide coverage through employers on a group basis, as well as to individuals through agents or by direct mail. Associations tend to solicit applications from their members through various types of member communications.

It is difficult to generalize about the Blue Cross/Blue Shield system, because its membership is so diverse. Most Blues plans provide coverage to both employer groups and to individuals. In marketing to individuals, some plans will use agents, just like the commercials. More commonly, especially in the Northeast, Blues plans will make coverage available through a combination of group conversions and direct applications. Under the group conversion approach, coverage is offered to employees aged 65+ who are retiring from Blue Cross covered groups. With direct applications, coverage is made available to anyone who applies directly to the plan.

This paper is primarily concerned with individual coverage. To help illustrate the differences between carriers, the discussion focuses on three distinct types of carriers and operations:

- Commercials using agents
- Associations using direct mail
- Blues plans using group conversions and direct applications

Marketing Strategies

The three different types of business operations differ primarily with respect to their marketing strategies and objectives. These differences, in turn, result in differences in costs for marketing and other functions. The primary differences relate to the breadth of the target market, and the aggressiveness with which it is pursued.

- Commercial Carriers: For commercial carriers, the target market is very broad. That is, any person over age 65 in a state where the carrier is licensed and does business could, potentially, obtain coverage from the carrier. Marketing activity and costs for this type of operation will increase in tandem. That is, the higher the agents' commissions, the higher the activity and associated cost of coverage for the individuals sought out.

- Associations: Associations, on the other hand, are much more focused. Coverage is usually restricted to the association's members. This does not mean that the target market will be small. Far from it. An association may have membership in the millions. However, in focusing on its membership, such an association would be able to conduct an active marketing campaign at lower cost than commercial carriers, for several reasons. For example, some organizations would have continual access to lists of members about to turn age 65 -- who are prime candidates for medicare supplement coverage -- which could be used to generate high response, cost effective direct mail campaigns. The tax status of the organization may allow for additional competitive advantages in the cost of operations.

- Blue Cross/ Blue Shield: A Blues plan conducting operations along the lines described above would be conducting two types of marketing campaigns at once. Group conversions represent a very focused, active, low cost type of marketing effort. Coverage is made

available only to former members of the plan's insured groups, and only at one point in time -- either upon turning 65, or at retirement.

Alternatively, the market covered by direct applications is very broad, similar to the market for a commercial carrier. As noted above, some plans will approach the market similar to a commercial carrier. Others, however, often approach this broader market far less aggressively. Marketing efforts may rely largely on occasional newspaper ads and word of mouth. In some plans, coverage cannot be purchased on a year round basis. Rather, application can only be made during special "open enrollment" periods which last one to two months. This more passive marketing approach is, at times, a reflection of the regulatory environment. Blues plans forced to provide coverage at subsidized rates -- common practice in some parts of the country -- could suffer financially if too much medicare supplement coverage is written.

Comparisons and Choices

Due to differences in operations, the appropriateness of one type of carrier's loss ratios cannot be assessed by comparing them to another. Medicare's loss ratio, imputed to be on the order of 98%, has been compared to commercial carriers' as a means of demonstrating the latter's lack of efficiency. Appendix 1 shows why this comparison is neither informative nor relevant.

Historically, Blue Cross/ Blue Shield plans have had higher loss ratios than commercial insurance carriers selling individual medicare supplement policies. For example, the NAIC 1988 experience reports show that, in 1988, commercial carriers with at least $250,000 in premium had an average loss ratio of 66.1% for mature business (business written prior to 1986). Blue Cross/Blue Shield plans had an average loss ratio of 93.4% for mature business.

In our view this comparison is largely irrelevant from both regulatory and consumer perspectives. The operations conducted by the two types of carriers are often different, and the Blue Cross loss ratios are artificially high due to subsidies, implicit and explicit, in some jurisdictions. As a result, the comparison does not suggest one type of carrier or operation is superior to another.

While similar data is not available for association groups, similar comments would apply if it were. Therefore, in our view, minimum loss ratios for commercial carriers or any other group should not be set based on comparisons to other carrier types. Rather, they should be developed based on analysis of the types of operations they conduct.

SECTION 4

CONSUMER VALUE

Summary

Assessment of policy value is a personal, subjective exercise. In evaluating a policy, a consumer needs to consider whether it covers the right services at an affordable price. Other important concerns are the carrier's financial strength, solvency, and commitment to service. Perceived value varies from person to person. It is unlikely that any one carrier has a policy which is right for all people in all situations.

Many people need or prefer to have an advisor such as an insurance agent assist with this type of evaluation. There are people who would likely never purchase needed coverage if not approached by an agent.

Within reasonable bounds, policy value cannot be assessed based on loss ratios. In developing its list of recommended policies, Consumer Reports did not use loss ratios as a basis for comparison. Its highest rated policy was sold by a company -- Banker's Life and Casualty -- which has experienced loss ratios as low as 60% for mature business.

Assessment of Value

In assessing policy value, some of the primary concerns are:

- Covered Services: The NAIC Model Regulation specifies certain minimum benefit levels for medicare supplement policies. However, consumers are faced with a wide range of optional benefits. These include:

  - Prescription Drug.

  - Excess Part B Charges.

  - Part B Deductible.

  The first two are often considered to be very valuable options. In his paper, "Outpatient prescription drug spending by the Medicare population", Dan Waldo estimated that the average person over age 65 will use over 18 prescriptions per year in 1991. At a cost of over $20 per prescription, the average total bill will exceed $400. For many users, costs will run into the $1,000s.

While this coverage is valuable, it is often hard to obtain. Insurers are concerned about anti-selection -- many people can assess their need for prescription drugs very accurately. In addition, insurers are worried about high trends on drug coverage, since drug prices are largely under the control of the manufacturers.

In the Wisconsin Individual Medicare Supplement Insurance Policy Study for 1990, for example, it is offered only by two carriers -- Blue Cross and State Farm. If the person is in poor health, coverage may only be available from State Farm, because Blue Cross requires a health statement. In 1989, AARP plans which provided drug benefits covered only 50% of costs up to a $500 annual maximum. This would cover most people adequately. However, it would leave people with large prescription bills -- about 10% of the population -- with large out-of-pocket expenses.

Coverage of Part B charges in excess of Medicare approved charge limits, while expensive, is also a valuable benefit. While some states, such as Massachusetts, restrict a physician's ability to make such charges, most do not. Many hospital-based physicians will not accept assignment, resulting in a significant liability for Medicare beneficiaries who are hospitalized. Consumer Reports noted that many Blues plans do not cover this type of expense.

Alternatively, coverage of budgetable items, such as the Part B deductible, may not be considered to be a valuable item, since the amount involved is budgetable ($75 per year). However, many insurers do not give the consumer a choice in this area, and include it as a mandatory benefit (e.g. 9 of the carriers in the Wisconsin study).

Price: Price is also an important element in assessing value. However, price will not necessarily vary with historical loss ratios, for a variety of reasons. (A high historical loss ratio may mean that the carrier is in need of a rate increase.)

A carrier may have both a lower historical loss ratio and lower premium rates than another carrier for similar coverage. For example, the 1988 NAIC loss ratio study showed American Family Mutual with a 58% loss ratio, while Blue Cross of Wisconsin had a 65% loss ratio. However, in the 1989 Wisconsin rate study, American Family Mutual's rates were lower than Blue Cross' by a minimum of 11%, and by as much as 25% at some ages.

Aggregate premium rate comparisons aside, premium rating practices often call for variations in rates by:

- Geographic Location
- Age
- Sex

These types of variations can give one carrier or operation an advantage with some groups of people, and another advantages with others. They introduce differences in price which may offset differences in loss ratios.

- Availability: Most carriers place some types of restrictions on who can purchase coverage. Generally, the purpose of these restrictions is to help ensure that new enrollees are in reasonably good health, although there may be other reasons. Regardless of the reason, the point is that coverage is not available to everyone who wants it when they want it.

  Associations will restrict coverage to their own members, although this may be only a minor restriction where it's easy and inexpensive to join. Commercial carriers and some Blues plans screen applicants using health questionnaires, rejecting applicants in extremely poor health, while other Blues plans use open enrollment periods to achieve the same end. Coverage under group conversions is usually only made available during a brief period following termination of employment.

- Solvency: Insurance is of no value if the carrier can't pay the claims. Some carriers may have lower loss ratios because they have properly assessed the cost and risks associated with this and other types of business, and have not been prohibited by regulators from setting premiums at a proper level. The added protection afforded to policyholders can be of considerable value.

At the present time, insureds have considerable flexibility in selecting the coverage they want based on these and other considerations.

Services Of Agents

Service is an important element of any product delivery system, especially insurance. For commercial carriers, service is often provided through their agents. Agents perform such services as:

- Educating customers concerning their needs for coverage.
- Helping customers select a carrier and a package of benefits.
- Helping customers interpret policies and file claims.

Properly performed, these types of services can and should be considered a type of benefit associated with the policy. Coverage has no value if it is not purchased, or purchased too late. To the extent that agents reach people who would not act in a timely way to purchase insurance, they are performing a legitimate service, and deserve to be compensated. The cost of these services are reflected in the loss ratios of policies sold by agents, but the associated reduction in loss ratio does not automatically decrease policy value.

Impact on Minimum Loss Ratio Standards

The policies offered by commercial carriers will be perceived as having higher value than those offered by other types of carriers by some consumers, and as having lesser value by others. Reputable observers, including Consumer Reports, have concluded that these commercial carrier policies may, at times, have higher value than policies offered by other types of carriers. Regulators should carefully examine the potential impact of changes in minimum loss ratios on consumer choice to ensure that the public benefits from the change.

SECTION 5

PREMIUM RATING AND LOSS RATIO COMPLIANCE

Summary

Commercial carriers often develop premium rates which provide for loss ratios which increase over time. This approach works to the advantage of policyholders who keep their coverage enforce for several years, since it can reduce long-term premium rate requirements.

Minimum loss ratio standards need to be properly structured and applied for carriers using this type of premium rating approach to comply. The current NAIC Model Regulation is a reasonable type of standard in this regard, in that it applies its loss ratio standards on a policy lifetime basis. The NAIC Model also requires policies to meet the loss ratio standard by the third year. This latter requirement can conflict with loss ratio progressions under some premium rating methodologies.

The prior standard was less clear in terms of its application to policies of different durations. Some regulators and observers applied loss ratio standards on a year-to-year basis, while others applied them on a lifetime basis. In our opinion, such differences in interpretation distorted the compliance record of commercial carriers.

Commercial Carrier Rating

Commercial carriers often develop premium rates which allow for loss ratios which increase by policy duration. They do this primarily because they have a substantial investment in new business. That is, the commissions paid to agents, or the cost of a direct mail solicitation campaign, represent an investment. This investment must be recovered over the life of the policy. Lower loss ratios at the early durations allow more of this investment to be recovered in the early policy years, thereby reducing future charges to long-term policyholders. This is demonstrated in Table 1.

In this table, policyholder premiums for a hypothetical portfolio are developed under two alternative rating strategies -- Constant Premium Rate and Constant Loss Ratio. Under the constant premium rate approach, rates are the same in all policy years. Loss ratios increase over time because per capita claims increase due to aging, inflation, and other reasons. Under the constant loss ratio approach, premium rates increase proportionately to claims.

In this example, the carrier provides medicare supplement coverage to 100 people in 1990. The number of people covered

reduces 20% in each of the next two years -- a fairly standard cancellation rate for this type of business. For simplicity's sake, results are shown only for the first three years of coverage, but this does not affect the legitimacy of the example.

Under each approach, the total premium collected over the three year period is the same -- $132,720. This results in a 60% loss ratio over the three year span. While the total premium collected over the three years is the same, policyholders who retained their coverage paid an average premium rate of $543.93 in the third year under the constant premium rate approach. This is 10.1% less than the $605 rate paid under the constant loss ratio approach.

The example shows that variations in loss ratio by duration can help to reduce premium rates over the longer term, which is desirable for the people who keep their coverage in force.

Compliance -- Current NAIC Model Regulation

The NAIC Model Regulation calls for the minimum individual loss ratio standard to be applied over the entire period for which rates are computed. In applying this standard, the regulation includes separate guidelines for policies in their first 3 years, and policies in durations 4 and later. It applies as follows:

- For policies in force less than 3 years, the expected loss ratio in the third year must meet the minimum standard.

- For policies which have been in force 3 or more years, both the actual incurred loss ratio for the most recent year and the expected incurred loss ratio over the period for which rates are calculated must exceed the minimum standard to be deemed reasonable.

These guidelines were first included in the model regulation in late 1987.

Guidelines of this type allow commercial carriers needed flexibility in designing premium rate scales. Historical data suggests that commercial carriers can and will comply with this type of standard.

The 1988 NAIC study on medicare supplement experience contains data on commercial carriers with total annual premiums of over $2 billion for individual medicare supplement policies. In the study, loss ratios for calendar year 1988 were shown separately for policies:

- Issued through 1985, which were three years old by the end of the study.

- Issued after 1985, which were in their first three years during the study.

The study showed that, for policies issued through 1985:

- Commercial carriers had an average actual loss ratio of 66.1%, which is substantially higher than the standard 60% minimum, and also exceeds the 65% minimum used in some states.
- Carriers with average loss ratios in excess of the standard 60% minimum accounted for 87% of total premium.
- Average total annual premium per carrier for carriers in compliance was about $7.9 million, almost 3.5 times the $2.3 million average for carriers not in compliance.

Certainly caution is necessary in interpreting results from a study covering one year, especially since the NAIC has indicated that the numbers are subject to change. However, the study does not support the notion that most commercial carriers fail to comply with minimum standards.

In this study, carriers with mature business which were not in compliance with the 60% standard tended to have smaller portfolios than those which are. Some of these smaller carriers may have been in the process of "learning" the business, and will comply in the future. Others may never learn, and pose a long-term regulatory problem. However, the total volume of business written by these carriers is relatively small.

Compliance -- Prior NAIC Model Regulation

Prior to 1988, the NAIC Model Regulation did not include guidelines concerning application of the standard to new and mature business. Consequently, interpretation and application of the standard varied. State rate filings indicate that some insurance departments applied the standard on a one year basis, whereas others applied it on a policy lifetime basis. That is, some insurance departments required the anticipated loss ratios for the coming year to be at least 60% (or 65% where appropriate), whereas others required the combined loss ratios -- historical and anticipated -- over the life of the policy to be at least 60% (or 65%).

The distinction is important, because it is very possible for a carrier to comply with the lifetime standard, while failing the one year standard. This is demonstrated by the examples in Appendix 2.

Differences in opinion concerning how to apply the guidelines, combined with limitations on available data, distorted the compliance picture for commercial carriers. Prior to 1988, the

major analyses performed by GAO, including its report of October 1986, were based on historical data for new and mature business combined. This data could only be used to measure compliance on the year-to-year basis referenced above. As a result, many more commercial carriers appeared to be below the 60% minimum than would have been the case if the current guidelines were to apply.

Table 1

Rating Strategies

Constant Premium Rate Strategy

Year	Number of Subscribers	Annual Premium Rate	Total Premium Income	Total Claims	Loss Ratios
1990	100	$543.93	$54,393	$30,000	55.2%
1991	80	543.93	43,515	26,400	60.7
1992	64	543.93	34,812	23,232	66.7
		Totals	$132,720	$ 79,632	60.0%

Constant Loss Ratio Strategy

Year	Number of Subscribers	Annual Premium Rate	Total Premium Income	Total Claims	Loss Ratios
1990	100	$500.00	$50,000	$30,000	60.0%
1991	80	550.00	44,000	26,400	60.0
1992	64	605.00	38,720	23,232	60.0
		Totals	$132,720	$ 79,632	60.0%

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APPENDIX 1

Loss ratios under the Medicare program are often compared to those for commercial insurance carriers to show that Medicare is more efficient. We believe this comparison is inappropriate, as shown below.

Medicare's Loss Ratio

Based on the 1988 Trustees' reports, Medicare expenditures (in millions) for 1987 were:

	Part A	Part B	Total
Benefit Payments:	$50.0	$29.9	$79.9
Expenses:	$ .8	$ .9	$ 1.7
Total:	$50.8	$30.8	$81.6

If the total expenditures are used as a proxy for premium income, then the loss ratio on a paid basis for 1987 would be 97.8% (79.9/81.6).

Some critics of commercial insurance carriers, who often have loss ratios on the order of 55-70% on a one year basis, have used this type of statistic to infer that Medicare operates far more efficiently than insurers. This comparison is inappropriate for the following reasons:

- Differences in Charge Base: On a per capita basis, Medicare benefits are far higher than benefit costs under medicare supplement policies. Since the benefit costs are higher, Medicare costs can be spread over a larger base. The resulting economies of scale distort the loss ratio comparison.

- Marketing Expenses: Medicare has a largely captive market. Most retirees turning age 65 are automatically enrolled in Part A when they apply for Social Security. Part B premiums are such a bargain that about 90% of the eligible population enrolls. As a result, Medicare costs include almost no component for marketing. For commercial carriers, this is usually the largest single component of expense.

- Taxes: Medicare is not subject to state premium tax, federal income tax, or other taxes and licenses.

- Risk/Profit Charges: The approach used to develop the loss ratio ignored the potential need for any risk margin or profit charge. Under typical commercial carrier operations, a risk or profit charge is needed to maintain the carrier's surplus position and provide a return to shareholders.

claims. If sales, premium tax and profit loadings are 20.0%, 2.5% and 3.0% respectively, then administrative expenses will be 8.2% of total premium. That is:

$$\frac{.1238}{1.1238} \times [1-(.200 + .025 + .03)] = 8.2\%$$

Therefore, adjusting for the charge base calls for an increase of 6.0% (8.2 - 2.2) in the loading for administrative expenses.

- Marketing Costs: In drafting this paper, we interviewed several major commercial carriers concerning their commission scales and other sales related expenses. It is very difficult to compare sales expenses between companies. Differences in contractual relations with agents and other sales management result in differences in the portion of total costs covered by commissions versus internal marketing costs. Based on our discussions we believe 20% is a reasonable estimate of the average total annual cost of commissions and other sales expenses.

- Taxes and Profit Charges: Taxes and profit charges are based on loadings observed in commercial carrier rate filings. Profit changes are net of investment income.

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- Expenses from Other Sources: The expenses charged to the trust funds do not include all the costs which are properly chargeable to the program. Other costs which should be considered include:

  - General Management costs attributable to executive branch functions performed by Office of Management and Budget, Office of Personnel Management, etc.

  - General Management costs associated with activities of the U.S. Congress.

Medicare's loss ratio cannot be compared to a commercial carrier's until it is adjusted to the level at which it would be if it conducted operations on a similar basis. In our opinion, adjusting for the first 4 factors would reduce the Medicare loss ratio to 66% if it were a typical commercial carrier selling business through agents. The adjustments are as follows:

• Reduction in Charge Base:	6.0%
• Marketing Costs:	-20.0%
• Premium Taxes:	-2.5%
• Profit Margin:	-3.0%
Total Adjustment:	-31.5%

Medicare Loss Ratio - pre Adj.	97.8%
Medicare Loss Ratio - post Adj.	66.3%

Details concerning each of these adjustments are outlined below.

Therefore, even without adjusting for the fact that the Trustees' report does not include all program expenses, we can reconcile Medicare expenditures with a 66.3% loss ratio for commercial carriers. Based on this analysis, Medicare does not appear to be far more "efficient" than commercial carriers.

Development of Adjustments

The adjustments were developed as follows:

- Charge Base Adjustment: Attachment 1 compares expected per capita costs during 1989 for the Medicare program with the costs for a typical medicare supplement policy. Medicare costs are 5.5 times typical medicare supplement costs. Both sets of expected costs were developed using our cost analysis system. The level of expected costs for medicare supplement, adjusted for prevailing loss ratio levels, is consistent with premium rate levels published by state insurance departments.

  Under Medicare, expenses are 2.2% of total costs, or 2.25% of claims. Decreasing the claims base by a factor of 5.5 increases the relative level of expenses to 12.38% of

APPENDIX 1

ATTACHMENT 1

Medicare and Medicare Supplement

Per Capita Claim Costs

Calendar Year 1989

Medicare

Part A:	$1704
Part B:	1113
Total:	$2817

Typical Medicare Supplement Policy

Part A

Deductible:	$151
Coin./Life. Res.:	37
365 Non Ren. Days:	19
Total:	$207

Part B

Deductible:	$ 58
Coinsurance:	251
Total:	$309
Grand Total:	$516

Medicare/Medicare Supplement = $2817 / $516

= 5.5

APPENDIX 2

Commercial carriers often design premium rate scales in a manner which results in loss ratios which will increase over time. This is done in part to keep long-term costs low.

The way this is done, the loss ratio for a given year may appear very low when compared to:

- the loss ratio for mature business (business more than 3 years old)
- the average loss ratio over the life of the policy.

Studies based on one year's loss ratios may, therefore, distort the compliance picture when compliance is defined using the former types of measures. The following examples show why this happens.

Loss Ratios - One Year's Issues

Attachment 1 illustrates the year-by-year progression of loss ratios for a hypothetical portfolio of medicare supplement policies issued by a typical commercial carrier. Specifications for this hypothetical portfolio are included as Appendix 3. Specifications are based on:

- The Foster Higgins Retiree Health Care Cost Analysis System, a standardized pricing system based on Medicare statistics supplemented by other published data.
- A review of selected commercial insurance carrier rate filings.

We believe these specifications are reasonable and realistic. However, they are not likely to be representative of the experience of any one carrier.

The attachment shows the year-by-year experience -- premiums, claims, and loss ratios -- over the first 20 years after issue in 1990 for 100 insureds. The annual loss ratio climbs from a low of 50.7% in the first year, to 62.6% in the third year, to 65.6% in the fourth and subsequent years. Over the first 20 years, the average loss ratio is 61.2%. Discounted at 8%, the loss ratio based on the present value of premium and claims is 60%. Thus, the policy could satisfy either a lifetime standard, or a 60% third year historical standard.

Loss Ratios - Multiple Issue Years

The example in Attachment 1 is oversimplified, in that it only considers 1 year's issues. In actual practice, a carrier would be issuing policies each year. Attachment 2 illustrates a scenario where the carrier issues 100 policies in 1990 and each

APPENDIX 2

ATTACHMENT 1

Annual Loss Ratios

100 Issues in 1990

YEAR	CLAIMS	PREMIUM	LOSS RATIO
1990	38,165	75,326	50.7%
1991	34,970	61,754	56.6%
1992	31,883	50,941	62.6%
1993	27,727	42,287	65.6%
1994	23,053	35,158	65.6%
1995	19,248	29,356	65.6%
1996	16,069	24,507	65.6%
1997	13,420	20,467	65.6%
1998	11,102	16,932	65.6%
1999	9,094	13,869	65.6%
2000	7,363	11,229	65.6%
2001	5,881	8,970	65.6%
2002	4,649	7,090	65.6%
2003	3,635	5,543	65.6%
2004	2,809	4,285	65.6%
2005	2,143	3,268	65.6%
2006	1,609	2,455	65.6%
2007	1,195	1,823	65.6%
2008	877	1,338	65.6%
2009	636	971	65.6%
TOTALS	$255,529	$417,568	61.2%
PRESENT VALUES	$183,159	$305,226	60.0%

subsequent year. As the attachment shows, year-by-year loss ratios will increase more slowly as a result of issuing new business because policies in the early durations with lower loss ratios are included. Despite this slower increase in year-by-year loss ratios, however, the carrier is still in compliance with the 60% standard on both a lifetime basis and a third year basis.

Attachment 2 shows that issuing new business can depress annual loss ratios. It stands to reason that new business growth will further depress annual loss ratios. Attachment 3 illustrates the impact of two alternative growth scenarios:

- Scenario A: No Growth (100 Issues per Year)
- Scenario B: 5% Compound Growth (100 Issues in 1990, 105 in 1991, increasing to 155 in 1999)

In this attachment, we have limited the projections to 10 years. Compound growth rates of 5% cannot be sustained over the long term, and we do not mean to imply that they can.

Growth in new business further depresses the year-to-year loss ratios. As the attachment shows, after 10 years, a 5% growth rate in new business will reduce the loss ratio to the level of the 60% target. This occurs even though the carrier is in compliance with a lifetime standard and third year historical standard. This shows that year-to-year loss ratios cannot be relied on to draw conclusions about compliance even when the block of business is relatively mature.

APPENDIX 2

ATTACHMENT 2

Annual Loss Ratios

100 Issues Each Year

	All Policies			Policies in Durations 3+		
YEAR	CLAIMS	PREMIUM	LOSS RATIO	CLAIMS	PREMIUM	LOSS RATIO
1990	38,165	75,326	50.7%	-	-	-
1991	73,135	137,079	53.4%	-	-	-
1992	105,017	188,020	55.9%	-	-	-
1993	132,744	230,307	57.6%	27,727	42,287	65.6%
1994	155,797	265,465	58.7%	50,780	77,445	65.6%
1995	175,045	294,821	59.4%	70,028	106,801	65.6%
1996	191,114	319,328	59.8%	86,097	131,308	65.6%
1997	204,534	339,795	60.2%	99,517	151,775	65.6%
1998	215,636	356,727	60.4%	110,619	168,707	65.6%
1999	224,730	370,596	60.6%	119,713	182,576	65.6%
2000	232,093	381,825	60.8%	127,075	193,805	65.6%
2001	237,974	390,795	60.9%	132,957	202,775	65.6%
2002	242,623	397,885	61.0%	137,606	209,865	65.6%
2003	246,257	403,429	61.0%	141,240	215,409	65.6%
2004	249,067	407,713	61.1%	144,050	219,693	65.6%
2005	251,210	410,981	61.1%	146,193	222,962	65.6%
2006	252,819	413,436	61.2%	147,802	225,416	65.6%
2007	254,015	415,259	61.2%	148,997	227,239	65.6%
2008	254,892	416,597	61.2%	149,875	228,577	65.6%
2009	255,529	417,568	61.2%	150,511	229,548	65.6%
TOTALS	$3,992,394	$6,632,954	60.2%	$1,990,785	$3,036,190	65.6%

Foster Higgins

APPENDIX 2

ATTACHMENT 3

Annual Loss Ratios

100 Issues Each Year

SCENARIO A: NO GROWTH

	All Policies			Policies in Durations 3+		
YEAR	CLAIMS	PREMIUM	LOSS RATIO	CLAIMS	PREMIUM	LOSS RATIO
1990	38,165	75,326	50.7%	-	-	-
1991	73,135	137,079	53.4%	-	-	-
1992	105,017	188,020	55.9%	-	-	-
1993	132,744	230,307	57.6%	27,727	42,287	65.6%
1994	155,797	265,465	58.7%	50,780	77,445	65.6%
1995	175,045	294,821	59.4%	70,028	106,801	65.6%
1996	191,114	319,328	59.8%	86,097	131,308	65.6%
1997	204,534	339,795	60.2%	99,517	151,775	65.6%
1998	215,636	356,727	60.4%	110,619	168,707	65.6%
1999	224,730	370,596	60.6%	119,713	182,576	65.6%
TOTALS	$1,515,916	$2,577,464	58.8%	$564,479	$860,899	65.6%

SCENARIO B: 5% GROWTH

	All Policies			Policies in Durations 3+		
YEAR	CLAIMS	PREMIUM	LOSS RATIO	CLAIMS	PREMIUM	LOSS RATIO
1990	38,165	75,326	50.7%	-	-	-
1991	75,043	140,846	53.3%	-	-	-
1992	110,678	198,829	55.7%	-	-	-
1993	143,939	251,057	57.3%	27,727	42,287	65.6%
1994	174,188	298,768	58.3%	52,166	79,560	65.6%
1995	202,146	343,062	58.9%	74,023	112,894	65.6%
1996	228,322	384,722	59.3%	93,792	143,045	65.6%
1997	253,158	424,425	59.6%	111,902	170,664	65.6%
1998	276,918	462,578	59.9%	128,599	196,129	65.6%
1999	299,857	499,577	60.0%	144,123	219,805	65.6%
TOTALS	$1,802,413	$3,079,191	58.5%	$632,332	$964,384	65.6%

APPENDIX 3

Specifications

Hypothetical Medicare Supplement Portfolio

Distribution of Issues by Age

Age	Percentage
65-69	45%
70-74	25
75-79	15
80-84	15

Claims Costs and Premium Rates for Selected Ages in 1990

	Annual Claim Cost by Year of Coverage				Annual Premium Rate
Age	Year 1	Year 2	Year 3	Year 4	All Years
65	$ 297.50	---	---	---	$ 589.75
70	382.50	427.50	450.50	490.00	758.75
75	467.50	522.50	530.00	605.00	926.75
80+	510.00	570.00	601.00	660.00	1,011.00

Cancellation Rates at Selected Ages and Durations

	Duration									
Age	1	2	3	4	5	6	7	8	9	10
67	.175	.170	.165	.160	.150	.145	.140	.150	.160	.170
72	.200	.195	.190	.185	.180	.185	.190	.200	.210	.220
77	.225	.215	.205	.210	.220	.230	.240	.250	.260	.270
82	.250	.250	.250	.260	.270	.280	.290	.300	.310	.320

Interest Discount - Present Value Calculations

8%

PREPARED STATEMENT OF WAYNE R. LINDLEY

Mr. Chairman and Distinguished Members of the Subcommittee: We are pleased to be invited here today to discuss the merits and benefits of establishing a Federal grant program for state health insurance information, counseling, and assistance programs.[1] Chris Arnold, the Director of the California Department of Aging, has asked me to speak on this issue on behalf of the Department's Health Insurance Counseling and Advocacy Program (HICAP). Terri Kennedy, Program Manager for Inland Counties Health Systems Agency HICAP, has assisted me with today's testimony. We will first review the need for counseling programs. Then we will discuss the cost effectiveness of this approach and the flexibility of state counseling programs. Finally, we will summarize our points in the conclusion.

Imagine for a moment you are 76 years old and newly widowed. Your children are in another state. You have recently been released from the hospital and a nursing home, and are receiving some home health care. You are also receiving several bills from different providers. It looks like you owe these providers well over $10,000. These bills keep coming every month. Some say "DO NOT PAY, THIS IS NOT A BILL, INSURANCE HAS BEEN BILLED." Others are notices from collection agencies:" IF WE DO NOT RECEIVE PAYMENT BY THIS DATE WE WILL BE FORCED TO SEEK LEGAL REMEDY . . . ." You have always paid your way and on time. But how do you know what you really owe? Should you just pay them all so you can sleep at night, if you even have the resources to do so? Who can explain this to you? How can you possibly get well with all this pressure?

The stress of circumstances such as the preceding example is not uncommon. Once an individual pays a medical bill, it may be very difficult to obtain a refund later. This scenario is an everyday occurrence, somewhere in the United States. In California last year, the Health Insurance Counseling and Advocacy Program (HICAP) counseled over 50,000 people. With over 500 volunteer Counselors, and about 60 local Full-Time Equivalent professional staff in support, we have been fortunate to launch one of the most comprehensive assistance programs in the nation in service to over 4 million constituents (see attachment B). Unusual in tight financial times, both Governor Deukmejian and the California Legislature have supported the concept of beneficiary counseling with real resources. However, while other states would like to start similar programs, the resources generally are not available. We hope our testimony here today will provide a little more insight into the value we see in making available Federal grant funds to start or support counseling programs throughout the United States and its territories. What California's HICAP has shown is that, with sufficient support, volunteer based programs can be an important factor in reducing the burden of health care costs on our elderly citizens.

THE NEED FOR COUNSELING AND EDUCATION

The methods for financing acute and long-term care have become more complex since Medicare's enactment in the mid 1960s. The average person can get lost in the plethora of conflicting interests, rules, and carefully worded private insurance policy contracts. While employed, a person may have good coverage and may think such conditions will last forever. Upon retirement, however, a person can be shocked to find coverage by both Medicare and private insurance is not what it was assumed to be. The irony of health insurance is that after years of paying premiums, it is only *after* a claim is filed that many find themselves perplexed about a denial of payment. Why should this occur? It occurs because the average person does not understand the complexities of health insurance and relies instead on sales literature or presentations. What is stated in advertising, however, is not a contract. Education and counseling can help. There are *three hints* I would like to make about the need for more public access to education and counseling.

First, the problems of interpreting what health insurance will do for you is not only an age related problem. Many younger people do not adequately understand their coverage either. People who happen to have good coverage while employed (incidentally, a condition we are seeing deteriorating as corporations seek benefit cost reduction), often do not question their coverage, so long as the costs seem reasonable. Unions and corporate risk managers are more involved than the average worker. It is not until an individual is faced with obtaining an individual policy that contract language is a concern. Unlike buying a car, an individual cannot "kick the tires" of an insurance policy. Many younger persons are just as susceptible as older

[1] For the purposes of this testimony, the generic term "counseling program" applies to all forms of such programs currently existing and generally as described in S. 2189.

individuals to accept the word of an insurance agent that a particular policy will come through when needed. Insurers will pay claims based on their own interpretation of contract terms and phrases, that had a different meaning to the consumer when the policy was initially advertised and sold All consumers could benefit from better education on what to expect from health insurance.

> In a sales presentation, an agent told a woman that her new Medigap policy would cover her while living abroad. The policy, however, did not cover her while she was out of the country. Through HICAP's intervention the HICAP Counselor arranged to have the agent refund the premium for the period of time she was out of the country ($495). She had not understood the actual contract provisions, but accepted instead what was advertised.

Second, while all age groups have difficulty understanding health insurance, the elderly are *particularly* vulnerable to false or misleading insurance sales practices for two important reasons: (1) Medicare is generally misunderstood as being complete in its coverage of illness and, especially, long-term care needs, and (2) fear. Fear is the "great motivator." Advertising health insurance relies upon the motivation of fear (look at a few samples of long-term care insurance advertising to see this point). For the elderly especially, the cost of health care or long-term chronic disability care is known to deplete assets which are intended to last an individual's full life expectancy. Fear of long-term illness or custodial care in nursing homes is more of a reality with retired elderly than it is with younger generations. "Impoverishment," "ward of the state," "burden on children" are the kind of phrases one hears from senior (or near senior) consumers for wanting to purchase as much insurance as possible. If not knowledgeable about the facts, the elderly are thus more likely to be sold excess insurance. The Special Committee on Aging has estimated the elderly purchase over $3 billion in unneeded health insurance each year in the United States. Counseling and education of the elderly population would go a long way toward preparing consumers to protect their interests.

> A distraught 72 year old woman presented a letter to the local HICAP Counselor from a collection agency demanding payment of $1,947 stemming from her husband's earlier open heart surgery. Under duress, she almost paid the bill, but because she had received assistance from HICAP before, she called. The letter contained no information to identify the provider of service, the date of service, or the total billing. The HICAP Counselor called the collection agency and in an ensuing investigation, the agency found errors in the billing. It had been an assigned claim for which no bill had ever been presented for payment. The HICAP saved her $1,947 on the first error and an additional $1,542 on a second error discovered in the process. Aside from the savings, this woman obtained peace of mind.

Third, laws and regulations, and enforcement of the laws and regulation, are two very important components of consumer protection in health insurance. By adding education and counseling to regulation and enforcement, it forms triad approach that complements each element. A low-cost counseling program in each state is an economical and cost beneficial way to strengthen consumer protection as an enhancement to existing regulation and enforcement. We have found that regulation has not always been enough, that public education and personal counseling can make a difference. The problem with more law and regulation is that for every hole plugged, there seems to be a surplus of clever ways to spring new leaks. This is a never ending effort. If we see counseling programs as an equally important partner, we go a long way toward assisting the consumer. In addition, counseling programs are in the unique position to discover and document problems that need to be corrected through regulation and enforcement.

HICAP Counselors in a rural mid-state county helped two couples cancel Medicare supplement insurance policies sold to them by the same insurance agent. It appeared the agent may have used unethical sales tactics in selling the policies. The HICAP Counselors were able to have the clients' previous insurance reinstated with no new waiting period for pre-existing conditions. The total reimbursement recovered for these clients was $3,939. In addition, the Department of Insurance was notified and an investigation started as a result of HICAP's intervention.

STATE COUNSELING PROGRAMS—A COST EFFICIENT ALTERNATIVE

According to a May 1990 Consumers Union survey, state counseling programs are cost efficient ways to directly help people. Wisconsin, for example, claims nine dol-

lars saved for every program dollar expended. We know from California's experience that more savings can be generated than the program costs, even considering the relatively greater resources California contributes to the program. These resources have established a comprehensive network of over 500 volunteer Counselors backed up by professional and legal staff. Consider the fact that in Fiscal Year (July 1 to June 30) 1988-89, California's HICAP reported savings of $4,689,231 to the clients and the state. That is almost a two dollar savings for every dollar spent in the program ($1.75 per dollar). Since late 1987, the HICAP has reported $10.7 million in savings.[2] In many instances, personal client savings can amount to several thousand dollars, with an average savings around $900 per client.[3]

State counseling programs also save time and expense for Federal programs. In California, the close working relationship between the Health Care Financing Administration (HCFA) District Office and HICAP has relieved the Federal office of many constituent problems. California's Peer Review Organization (PRO), California Medical Review, Inc. (CMRI), has stated that HICAP is a major contributor to getting information out to service providers and the public, making their job of education a little easier. Local Social Security offices refer clients to the HICAP routinely. In the two counties of Riverside and San Bernardino for example, the Social Security Administration (SSA) has made as many as 150 referrals a week to the local HICAP agency.

In addition to these direct savings, there is also "cost avoidance" which is considerably more difficult to measure, but nevertheless important. The Federal and state governments save money every time an individual can postpone spending down their resources and becoming eligible for Medicaid. Education and counseling can very often develop options for the client aimed at maximizing their independence and minimizing the need to spend their assets. Good pre-retirement planning also helps to avoid the necessity for the state or Federal governments to intervene prematurely.

THE FLEXIBILITY OF STATE COUNSELING PROGRAMS

Seventy-two year old Mrs. X was in a cafeteria of a major U.S. Air Force base in California when she collapsed. Medics rushed to the scene and CPR was applied. She was immediately taken to the base hospital for emergency surgery to repair a ruptured abdominal aneurysm. She subsequently spent 37 days in intensive care and an additional 14 days on a ward. She is now recovering in a nursing home. For her stay at the Air Force hospital, Mrs. X received a bill for $24,700. She was told by the hospital's billing department that she was the sole responsible party and although non-Medicare approved hospitals can, under certain circumstance, be reimbursed directly by the Medicare program, this fact was unknown by the military hospital. Consequently, Mrs. X's account was turned over to collections with an interest of $150 added to her bill monthly. She wrote or called every resource that she could think of, to no avail. Medicare would pay if the hospital would bill the Medicare program directly. Instead, she was threatened repeatedly for non-payment. Before HICAP was contacted, she finally agreed to pay $700 a month, with a 7 percent interest rate, out of her income of $965 per month and savings of $35,000.

It is difficult to comprehend how a seriously ill, 72 year old woman with complete medical coverage through a government insurance program, and supplement insurance, could end up privately paying with interest and penalties, literally stripping her of most of her remaining assets. Needless to say, when HICAP intervened on Mrs. X's behalf, she was finally heard. We do not claim that every person assisted by our program has a case as obvious as Mrs. X, however, *our point is that no law or regulation in and of itself would have helped Mrs. X. A counseling program and the personal attention to her case from a consumer vantage point did.*

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[2] Includes data only between FY 1987-88 and FY 1989-90. Data on savings before 1987 was not documented, otherwise this amount would have been greater.

[3] Savings are identified and calculated on the actual dollars returned to the client or state because of refunds, reductions or deletions of already billed amounts, and payment to the client by a third party (such as another insurance policy or an HMO), or the monetary equivalent saved by preventing or postponing what would otherwise be an out-of-pocket expense to the client without HICAP's intervention. These are the total dollars saved in a maximum 12 month period, despite the fact that savings can be generated for many years, as in the case of eliminating excess insurance. Annual Report to the Legislature, Health Insurance Counseling and Advocacy Program for FY 1988-89, Issued February 1990.

Consumers Union reports that there are currently 12 states that have independently developed counseling programs. There are at least a dozen more states interested in starting programs immediately, provided the resources can be developed. The existing programs range from more narrowly defined functions for specific consumer complaints within departments of insurance to much broader programs, such as California's HICAP, that offer education, counseling, and legal assistance on a full range of topics related to health insurance and health plans. Programs can be housed within departments of insurance or in departments of aging. For example, Washington state's Senior Health Insurance Benefits Advisors (SHIBA) program is about 12 years old and proven to be very successful by linking the training expertise of the department of insurance to local volunteer counselors. Wisconsin's Elderly Benefits Assistance Program moved from pilot status to statewide status in 1984, and, under the Bureau on Aging, uses Area Agencies on Aging and professional staff to administer the services.

Each existing state program has in common the desire to assist senior consumers face-to-face with the problems of health insurance. In a recent meeting of existing state programs and interested states, four goals were established for all such programs: (1) Educate the public and beneficiaries, (2) provide one-on-one counseling for seniors with problems, (3) advocate for the consumer's rights, and (4) support the enforcement of law, regulation and ethical practice. With low budgets for the most part (with the exception of California, many operate under $200,000 and others temporarily "redirect" existing personnel or resources from other commitments) the counseling programs are successful at reaching and educating thousands of seniors each year. With sufficient resources, existing programs can expand services greatly and states now contemplating programs can begin.

State counseling programs are highly flexible in conforming to the specific needs of the service population in each state. From the experience to date, there are two critical keys to the success of state counseling programs: (1) they are sponsored by *state regulatory or consumer organizations* independent of conflict of interest, and (2) they rely on volunteers to expand services beyond a core professional staff.

These programs can be at the center of networks such as the state regulatory system and the aging services network to form an efficient information grid unmatched by any private concern. Departments of insurance can work closely with departments of aging, and vice versa. This provides access to all the essential problem solving entities. Referral of program clients to other services in the aging network is an important asset of these programs, as is the state counseling program an important referral point from Federal, state, and local interests. State sponsored counseling programs are able to keep up with latest trends and changes in the system and are becoming more skilled at sharing information with fellow state programs.

State counseling programs can provide an element of trust that is missing from other forms of "counseling" (or marketing) offered within the industry. Our experience with industry counseling programs has reinforced our concern about conflict of interest. For example, in 1988, Aetna came to California and other states to organize a "counseling program" in a joint venture with the Area Agencies of Aging. However, the use of Aetna's name and logo on consumer materials developed under the program was fraught with conflict of interest problems. Because of California's existing state program and general resistance, Aetna subsequently dropped the idea in California. In another example, the California Association of Life Underwriters (CALU) established the Senior Citizens Health Insurance Counseling (SCHIC) as a public service program. Once again, because licensed agents were able to sell policies to clients counseled, the conflict of interest issue was raised.

State counseling programs work with Federal agencies and quasi private "watchdog agencies." In California, HCFA, California Medical Review, Inc. (PRO), the Department of Insurance, and the Department of Corporations work together with HICAP. This network forms a series of checks and balances heretofore missing from the consumers' vantage.

State counseling programs now have the flexibility to meet many different demands surrounding the acute and long-term care issues of interest to most seniors, and this flexibility should not be restricted in Federal statute. For example, meeting the demand for benefits counseling of the pre-retirement population may be equally important to post retirement counseling, since many problems can be avoided if education is provided early enough. Also, states should be encouraged to counsel on aging issues, related public and private plans such as Medicare, HMOs, and PPOs. In the future, there may be a need to turn this expertise to the fast changing world of ever-more-creative long-term care financing concepts. In short, state counseling

programs can keep up with the changing times and can be close to people, consumer oriented, and connected in a way that cannot be replicated by any other alternative.

CONCLUSION

The alternatives are: (1) continue the status quo (2) charge an existing Federal agency to provide counseling in addition to its existing functions, or (3) provide the means to assist states in developing volunteer supported counseling programs. As we have mentioned in the body of this testimony, we believe experience has shown us that state counseling programs offer cost efficient services . . . , especially when using trained volunteer Counselors.

The status quo offers no answers for the tens of thousands of elderly consumers faced with serious decisions and problems involving health insurance. Into the this vacuum will come dozens of insurance industry counseling programs and hundreds more local counseling services offered by "financial planners" and "insurance specialists" to add significantly to the existing confusion. There will be no stable and reliable place to go for help.

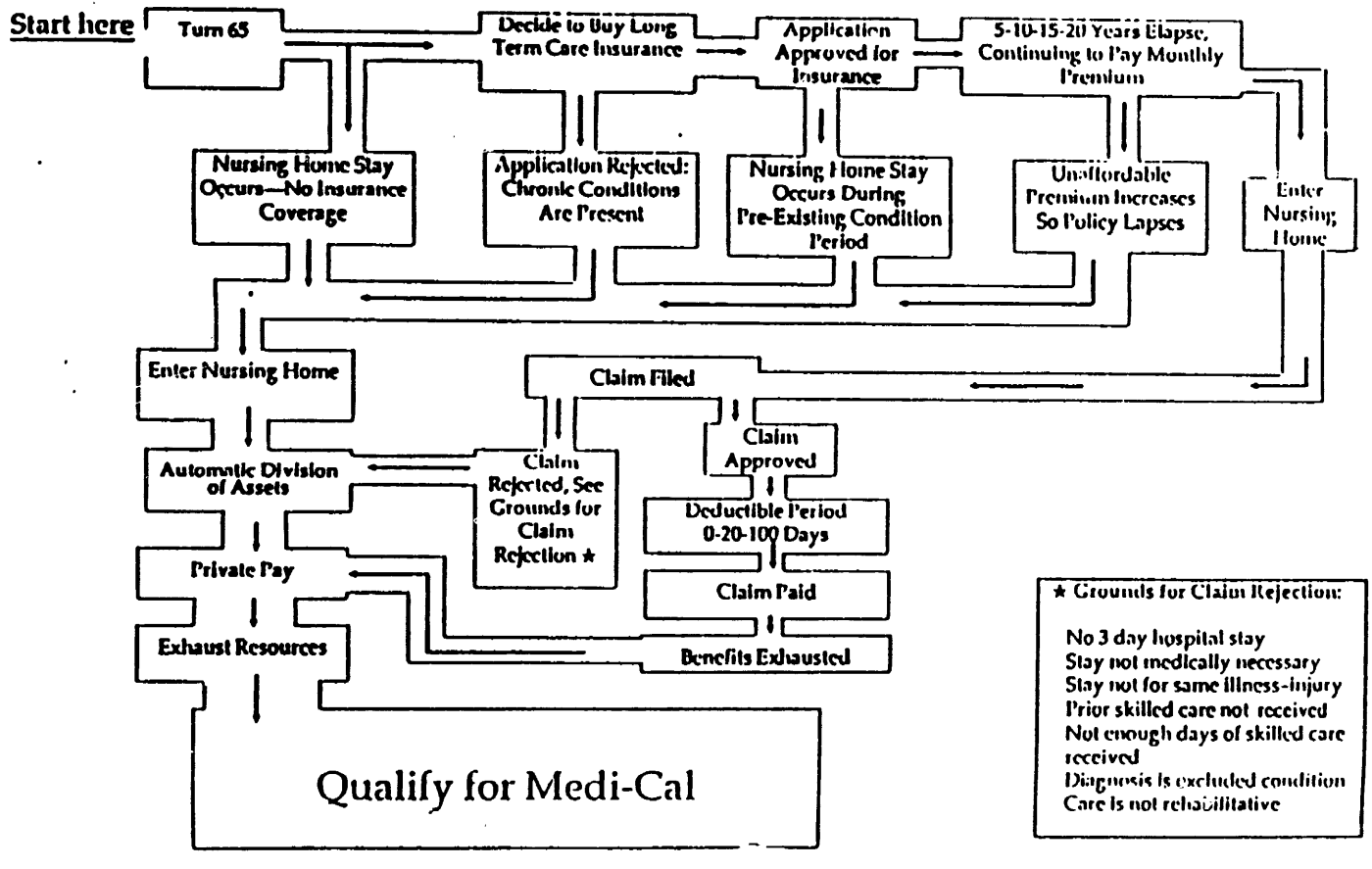
Charging an existing Federal agency, such as the Social Security Administration, to add counseling to their already extended work load would more likely be wishful thinking more than a substantive answer. It is unlikely that the Social Security Administration, or any other Federal organization, can afford to expand their mission in this regard without added expense and internal biases. These agencies have not traditionally operated large volunteer based services distributed on the local level.

The advantages of state administered counseling programs are: (1) they can tap the resource networks of the regulatory system, aging services and, consumer advocacy, (2) by using trained volunteers supported and supervised by professionals, they are cost efficient and far reaching, (3) they provide an objective source of information without conflict of interest, (4) they are trusted (especially if locally trained, registered, and supervised peer volunteer Counselors are used and, (5) they provide consistency by forming a nationwide network of consumer information and assistance tailored to the unique characteristics of each state.

We recommend in principle that counseling programs be developed in all states and territories of the United States. We further recommend that any Federal statutes: (1) allow states flexibility in designing programs, (2) encourage a broad range of services offered in counseling programs, (3) encourage departments of insurance, commerce, or other similar state entities to work with departments of aging, and vice versa, (4) establish a clearinghouse function that will serve the needs of programs for keeping up to date with private insurance products and Federal insurance programs, laws, and regulations.

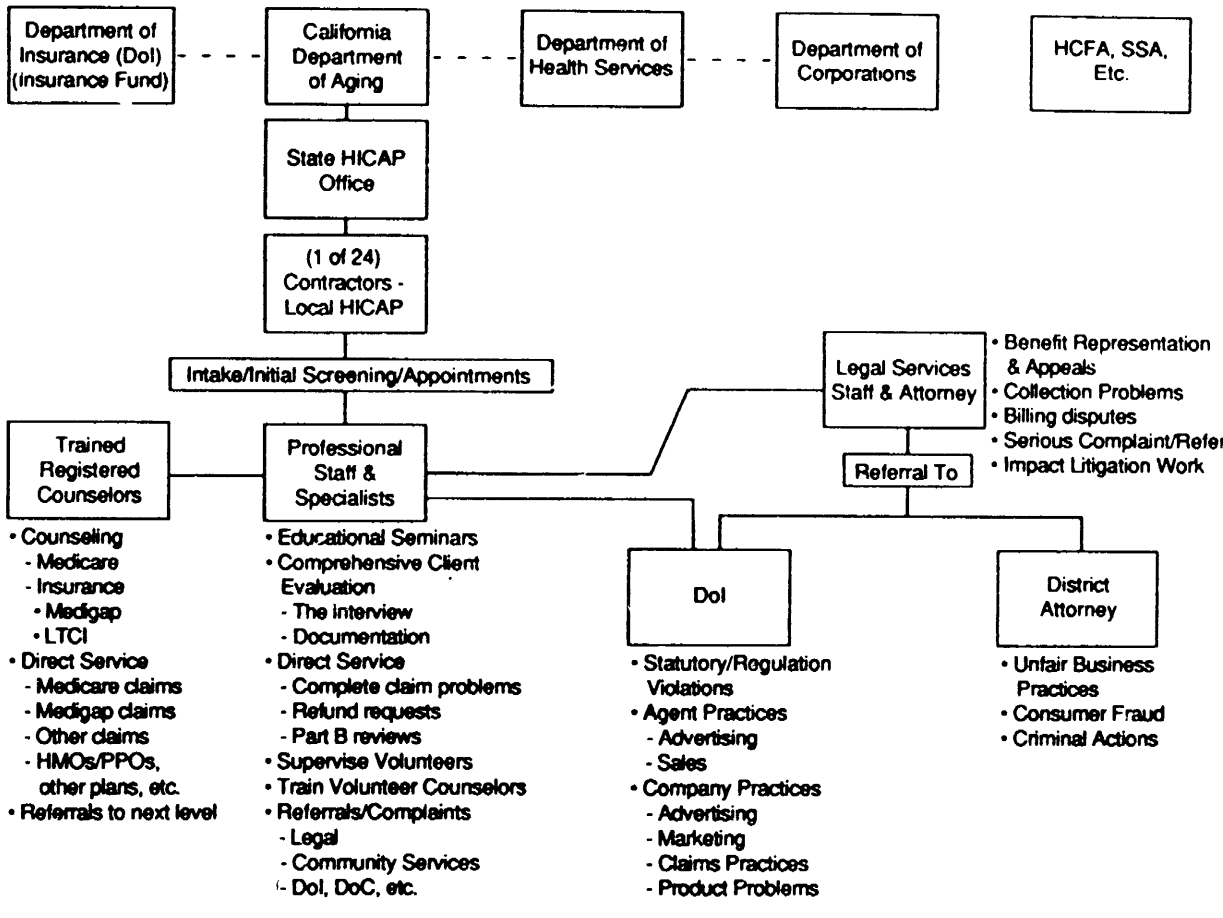
Attachments.

The Long Term Care Insurance Maze



Attachment B

HICAP ORGANIZATIONAL FLOW CHART



California Department of Aging

Annual Report to the Legislature
on the
Health Insurance Counseling
and Advocacy Program

I. BACKGROUND

A. INTRODUCTION

1. Legislative Authority

This report is submitted by the California Department of Aging to the California Legislature pursuant to Welfare and Institutions Code, Section 9756 (Chapter 1464, Statutes of 1984, AB 2419).

The 1984 legislation establishing the Health Insurance Counseling and Advocacy Program (HICAP), under the auspice of the California Department of Aging, requires the Department to contract for the provision of community education, counseling, and legal representation to as many Medicare beneficiaries as possible. These services provide assistance to people with Medicare and health insurance problems. The legislation also requires the Department to report to the Legislature each January, detailing the expenditure of funds appropriated for the purposes of this legislation and the savings realized by the State and Medicare beneficiaries through the Program.

2. Purpose of this Report

The purpose of this report is to provide information on the performance of the HICAP and its 24 projects located throughout the State. This information not only serves the purpose of meeting the requirements of State law, but it also serves as the Program's Annual Report to the public.

Since FY 1985-86, HICAP's emphasis has been to develop and support a network of local projects capable of providing a full range of Medicare and health insurance counseling services. These local projects are responsible for carrying out the legislative mandates of the Program for Medicare beneficiaries.

3. Scope

This report reviews the performance activities of the HICAP over the 12-month period from July 1, 1988 through June 30, 1989 (FY 1988-89).

As a public communications document, this report provides: 1) performance statistics on the assistance provided (see Section II.A.); and, 2) information on cost savings for the HICAP clients and for the State (see Section C).

4. Limitations

For the purposes of this report, a "client contact" is one person served per episode, who may or may not have been served more than once by a project in any particular fiscal year. Although an effort is made to reduce the number of "duplicative" counts, the Management Information System does not uniquely identify and track each person served. Therefore, some duplication is assumed even though it may be a small proportion. Attention should be paid to any qualifying remarks and footnotes.

Data reported herein may not reflect the trends of the Program currently as there is a delay of from 6 to 12 months in the reporting cycle.

B. DESCRIPTION OF THE HICAP PROJECTS

1. List of Local HICAP Projects

Throughout this report, references will be made to the HICAP projects, particularly in tables and charts. Each of the HICAP projects has a service delivery jurisdiction of one or more counties (none less than a single county). Therefore, we have developed identity (ID) references for each project that tells the reader the county where the project headquarter office is located and a reference to the number of counties in their particular service jurisdiction. For example, the Legal Assistance to the Elderly, Inc., is referenced as San Francisco (1). This tells the reader the service is headquartered in San Francisco and is made up of only one county. Sacramento (9) would represent the Legal Center for the Elderly and Disabled, headquartered in Sacramento County and having a service jurisdiction of nine counties.

The 24 current projects are listed below in alphabetic order by headquarter county. (See Appendix A for a Service Jurisdiction Map showing the locations and service areas of each of the projects.) Of the total number of projects, 13 projects are nonprofit social service agencies and 11 are government or nonprofit Area Agencies on Aging.

ID REFERENCE	PROJECT	JURISDICTION	ANNUAL AWARD
Alameda (1)	Legal Assistance for Seniors, Inc.	Alameda	$ 103,976
Butte (5)	Area Agency on Aging, PSA 3	Butte, Colusa, Glenn, Plumas, Tehama	47,672
Calaveras (5)	California Human Development Corporation	Alpine, Amador, Calaveras, Mariposa, Tuolumne	42,172
Contra Costa (1)	Contra Costa County Office on Aging	Contra Costa	62,682
Fresno (2)	Fresno-Madera Area Agency on Aging	Fresno, Madera	56,185
Humboldt (2)	Humboldt Senior Resource Center	Del Norte, Humboldt	42,172
Kern (1)	Kern County Office on Aging	Kern	42,172
Kings (2)	Kings/Tulare Area Agency on Aging	Kings, Tulare	42,172
Los Angeles (1)	Medicare Advocacy Project, Inc.	Los Angeles	409,733
Merced (1)	Merced County Area Agency on Aging Programs	Merced	42,172

(Continued)

ID REFERENCE	PROJECT	JURISDICTION	ANNUAL AWARD
Monterey (1)	Monterey County Area Agency on Aging	Monterey	$ 42,172
Orange (1)	Visiting Nurse Association Foundation	Orange	158,559
Riverside (4)	Inland Counties Health Systems Agency	Inyo, Mono, Riverside, San Bernardino	182,174
Sacramento (9)	Legal Center for the Elderly and Disabled	El Dorado, Nevada, Placer, Sacramento, San Joaquin,Sierra, Sutter, Yolo, Yuba	162,563
San Diego (2)	Progressive Social Services System Technology (PRO-TECH)	San Diego, Imperial	198,577
San Francisco (1)	Legal Assistance to the Elderly	San Francisco	102,172
San Mateo (1)	Little House	San Mateo	62,099
Santa Barbara (2)	Central Coast Commission for Senior Citizens	San Luis Obispo, Santa Barbara	53,638
Santa Clara (1)	Council on Aging of Santa Clara County	Santa Clara	95,466
Santa Cruz (2)	Seniors Council of Santa Cruz and San Benito Counties	San Benito, Santa Cruz	42,172
Shasta (5)	PSA 2 Area Agency on Aging	Lassen, Modoc, Shasta, Siskiyou, Trinity	42,172
Sonoma (6)	North Bay Health Resources Center	Lake, Marin, Mendocino, Napa, Solano, Sonoma	126,025
Stanislaus (1)	Salvation Army Modesto Corps	Stanislaus	42,172
Ventura (1)	Grey Law	Ventura	46,931

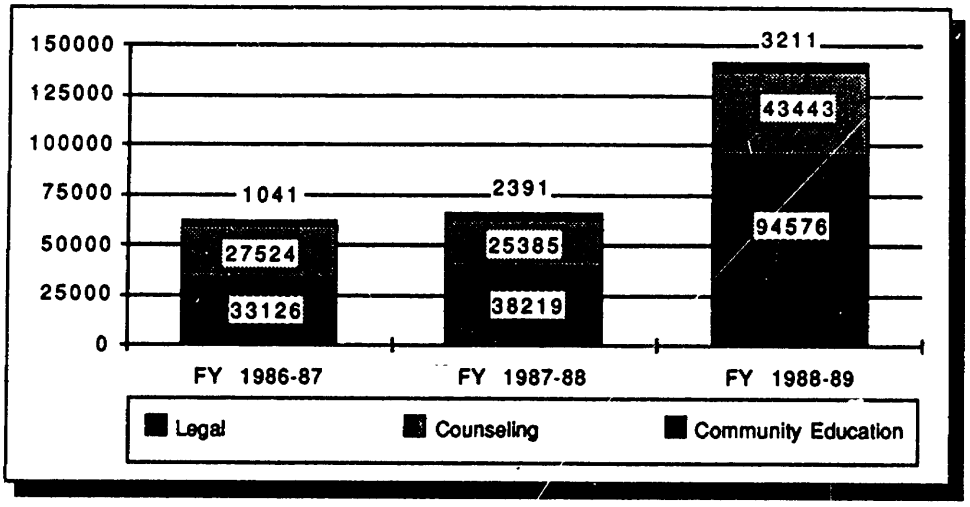
II. PROGRAM PERFORMANCE

A. STATEWIDE SUMMARY

Chart 1 compares three years of HICAP's performance, FY 1986-87, FY 1987-88, and FY 1988-89.[2] Table 1 shows the statewide HICAP performance for FY 1988-89 by Quarter.

As indicated in Chart 1, the HICAP has shown a remarkable increase in services in FY 1988-89. This is due in part to the expansion of the Program and to the maturing nature of the newer projects. From FY 1987-88, community education activities increased by 147 percent (discounting electronic media), counseling services increased by 71 percent, and legal services increased by 34 percent.

Chart 1
HICAP PERFORMANCE COMPARISON
AMONG FY 1986-87, 1987-88, AND FY 1988-89
BY SERVICE



[2] In FY 1986-87, there were only ten HICAP projects. By the end of FY 1987-88, 22 HICAP projects were established. By the end of FY 1988-89, all 24 HICAP projects were in operation.

Table 1
HICAP STATEWIDE SERVICES
FY 1988-89
BY SERVICE, BY QUARTER/YEAR END

	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	FY TOTAL
Community Education (Media)	37,630	17,080	18,354	83,420	156,484
Community Education (Presentations)	14,138	22,034	31,937	26,467	94,576
No. of Presentations	336	413	596	516	1,861
Avg. No. of Clients/Presentation	42	53	54	51	51
Counseling	9,446	9,630	11,600	12,767	43,443
Legal	832	703	783	893	3,211
Avg. Number of Volunteers	382	451	497	567	474
Total Volunteer Hours	11,020	12,720	14,574	15,688	54,002
Avg. Hours per Volunteer per mo.	9.6	9.4	9.8	9.2	9.5

By specific service, the HICAP's performance is described as follows:

1. Community Education

As shown in Table 1, persons contacted and provided educational information in community forums reached 94,576 in FY 1988-89. This is an average of over 7,880 persons per month. A total of 1,861 community presentations were made, averaging 155 presentations per month, up about 150 percent over last year's average of 62 presentations per month. The monthly average number of persons attending public forums or workshops was 51, about the same as last year. These workshops were presented in community centers, senior centers, libraries, and other donated meeting rooms throughout local communities.

The use of electronic media brought a new dimension to HICAP in FY 1988-89. In addition to the direct approach at community forums, HICAP projects experimented with a variety of mass media approaches, including hour-long programs on cable, local television programs, radio talk shows, and detailed educational articles in newspapers with high target population readership. This is the first year the HICAP recorded this type of media use. The estimated number of persons contacted through mass media techniques was 156,484.[3]

2. Counseling

As indicated in Table 1, the HICAP projects (supported by approximately 500 volunteers) had 43,443 client counseling contacts in FY 1988-89, up 71 percent over last year's 25,385 client counseling contacts. In FY 1988-89, the average counseling client contacts per month was 3,620. This is an average of 92 counseling sessions per volunteer, per year.

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3 Estimated audiences for mass media are determined by circulation or audience estimates of the media being used. The methodologies are often the same as those used to calculate market size for advertising purposes.

3. Legal Representation

During FY 1988-89, 3,211 legal services client contacts were established as indicated in Table 1. This is an average of 268 legal service contacts per month.

4. Volunteers

At the end of FY 1988-89, there were 558 volunteers in the Program. The average number of active volunteers was 474. Over the year, these volunteers contributed 54,002 hours which represent an average of 9.5 hours per month per volunteer.

B. PROJECT PERFORMANCE

Table 2 provides FY 1988-89 performance information by project. Discretion should be used in the interpretation and use of this information because of regional variables. Conclusions on project performance should not be determined strictly on this information alone.

Table 2
HICAP PROJECT PERFORMANCE
FY 1988-89
BY PROJECT, BY SERVICE

	Alameda	Butte	Calaveras	Contra Costa	Fresno	Humboldt
Community Ed. (Media)	0	1,200	0	0	7,000	0
Community Ed. (Pres.)	6,777	2,295	955	4,563	1,566	892
Counseling	1,781	1,700	1,648	1,420	308	612
Legal Services	41	18	0	35	20	7
Avg. Active Vol./Mo.	29	20	6	28	3	3
Total Hours/Year	4,250	3,553	521	2,908	544	928
Avg. Monthly Hrs/Vol.	12.1	14.8	7.7	8.7	13.6	25.8

	Kern	Kings	Los Angeles	Merced	Monterey	Orange
Community Ed. (Media)	0	0	86,010	0	0	0
Community Ed. (Pres.)	1,785	1,203	9,253	458	2,021	7,356
Counseling	730	374	3,134	706	1,565	5,460
Legal Services	7	0	1,408	11	556	77
Avg. Active Vol./Mo.	11	8	45	5	8	48
Total Hours/Year	744	311	1,957	204	819	5,078
Avg. Monthly Hrs/Vol.	5.6	3.3	3.6	3.2	8.7	8.9

	Riverside	Sacramento	San Diego	San Francisco	San Mateo	Santa Barbara
Community Ed. (Media)	2,274	0	60,000	0	0	0
Community Ed. (Pres.)	8,428	7,887	3,175	4,342	4,645	2,456
Counseling	2,084	4,522	1,792	1,036	1,064	1,061
Legal Services	0	351	215	103	15	0
Avg. Active Vol./Mo.	21	30	32	15	12	11
Total Hours/Year	2,810	2,550	4,090	818	1,999	1,143
Avg. Monthly Hrs/Vol.	11.0	7.2	10.7	4.6	14.0	8.4

	Santa Clara	Santa Cruz	Shasta	Sonoma	Stanislaus	Ventura	Total All Agencies
Community Ed. (Media)	0	0	0	0	0	0	156,484
Community Ed. (Pres.)	6,983	1,346	928	11,767	1,108	2,387	94,576
Counseling	3,136	1,760	368	5,708	740	534	43,443
Legal Services	165	80	22	67	2	11	3,211
Avg. Active Vol./Mo.	30	14	14	63	7	11	474
Total Hours/Year	4,237	888	832	10,971	1,168	683	54,002
Avg. Monthly Hrs/Vol.	11.9	5.3	5.0	14.4	13.3	5.0	9.5

1. Alameda (1) - Legal Assistance for Seniors, Inc.

   a. Background

      The HICAP project of Alameda County is Legal Assistance for Seniors, Inc., (LAS) and is based in Oakland. LAS provides legal representation and advice, and community legal education to Alameda County senior citizens. These services are provided at the Oakland office and at service sites throughout the County.

   b. Historical Development

      LAS began in 1976 as a program within Bay Area Community Services, Inc., and has operated as an independent legal entity since July 1986. Health insurance and access to health care have always been priorities for LAS and for many years LAS has provided legal advice, representation and education regarding Medicare, Medi-Cal and private health insurance. Several years ago, LAS dropped its services regarding private health insurance due to lack of resources, but picked up services again as a HICAP contractor in the spring of 1988. LAS became a HICAP agency because of the opportunity to strengthen existing health-related advocacy services.

   c. Services

      FY 1988-89 was the first full year that LAS provided HICAP services. These services were: community education (6,777 client contacts), counseling (1,781 client contacts), and legal services (41 client contacts).

      Community education efforts were 175 percent of planned activity level (estimated at 3,880 client contacts). The average attendance at 1 of their 116 presentations was 58, ranging from a high of 144 to a low of 17.

      Counseling services averaged 148 contacts per month, for a total of 1,781 which was less than the planned activity level of 2,340 by 24 percent. LAS had 15 counseling sites in June 1989.

      Legal services were 73 percent below their planned activity level of 150 for the fiscal year.

   d. Volunteers

      For FY 1988-89, the average number of volunteers per month was 29. These volunteers contributed 4,250 hours to HICAP last year. The average number of hours per volunteer per month was 12 hours.

2. Butte (5) - Area Agency on Aging, PSA 3

   a. Background

      The Area Agency on Aging in Planning and Service Area 3 (PSA 3) is a division of the University Foundation of California State University, Chico, and is one of the 33 Area Agencies in the State. Located in Chico and serving Butte, Colusa, Glenn, Plumas, and Tehama Counties, PSA 3 plans, coordinates and advocates for the development of a comprehensive service delivery system. PSA 3 contracts to provide nutrition, transportation, ombudsman, legal, homemaker, and Alzheimer's Day Care services to persons over 60 years of age. Additionally, PSA 3 staff provides

information, referral and case management services, the Multipurpose Senior Services Program, and operates as a Regional Resource Center for brain-impaired adults.

b. Historical Development

The Area Agency was founded in 1980 incorporating the Senior Information and Referral Center (SIRC), which had served ten Northern California counties for five years. The Area Agency originally provided services through the Older Americans Act funds exclusively, but has grown to provide services with Medi-Cal, California Department of Mental Health and Older Californians Act monies. PSA 3 originally identified the need for health insurance counseling services through its information, referral and case management services. When PSA 3 information and assistance staff visited the homes of elderly clients they were frequently greeted by the "shoebox" of unpaid bills or tales of unethical sales practices. The HICAP meets this need, functioning as an integral part of the service delivery network.

c. Services

For FY 1988-89, the total services rendered were distributed among community education presentations (2,295 client contacts), counseling (1,700 client contacts), and legal services (18 client contacts). In addition to community education presentations, estimated community education contacts using media were 1,200.

Community education was provided using both presentations and media. The community presentation contacts showed a 51 percent increase over last fiscal year's activity. In community education, they achieved 81 percent of their planned activity level of 2,830.

Counseling services increased 16 percent over FY 1987-88. PSA 3 averaged 142 contacts per month, for a total of 1,700 which was 9 percent more than the planned activity level of 1,558. The number of counseling sites increased from two in June 1988 to three in June 1989.

Legal services increased from 1 in FY 1987-88 to 18 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 20. This is an 18 percent increase over 17 in FY 1987-88. These volunteers contributed 3,553 hours to HICAP, an increase of 3 percent over last fiscal year. The average number of hours per volunteer per month was 14.8 hours.

3. Calaveras (5) - California Human Development Corporation

a. Background

The California Human Development Corporation (CHDC) operates the HICAP in the five Mother Lode Counties of Calaveras, Alpine, Amador, Tuolumne, and Mariposa. In addition to HICAP, the parent agency, located in Santa Rosa, provides job training and employment for people without marketable skills, criminal justice and community services, energy conservation, food production, disabled services/training, child development programs and elder services, and manages over 150 grants.

b. Historical Development

CHDC was started in 1967 as the North Bay Human Development Corporation and obtained federal funding to implement the life-stabilizing training/employment services for eligible low-income Latinos. An original grant was secured in the amount of $125,000 to implement these services throughout the Northern California Counties of Contra Costa, Lake, Napa, Mendocino, Solano, and Sonoma. Since then, the organization has grown considerably, currently implementing $16 million worth of human service contracts in the states of California, Hawaii, Oregon, and Washington. CHDC is one of the original funded projects providing HICAP services. The grant provided services to residents of Calaveras County only and has since expanded in October 1987 to include the counties of Alpine, Mariposa, Tuolumne, and Amador. The HICAP is part of a broad spectrum of services offered to seniors, including information and referral, telephone reassurance, home weatherization, congregate and home-delivered meals, and an independent living assistance program.

c. Services

The total services rendered were distributed among community education (955 contacts), counseling (1,648 contacts), but no legal services (0 contacts).

Community education efforts showed a 260 percent increase over last fiscal year's activity. The average attendance at 1 of their 21 presentations was 45, ranging from a high of 85 to a low of 27. They achieved 159 percent of their planned activity level of 600.

Counseling services increased 241 percent over FY 1987-88. The CHDC averaged 137 contacts per month, for a total of 1,648 which was 27 percent less than the planned activity level of 2,244, although higher than last year's performance. The number of counseling sites stayed the same at seven in both June 1988 and June 1989.

No legal services were provided by CHDC in FY 1987-88 and FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was six. This is an increase from two in FY 1987-88. These volunteers contributed 521 hours to HICAP, an increase of 324 percent over last fiscal year. The average number of hours per volunteer per month was 7.7 hours.

4. Contra Costa (1) - Contra Costa County Office on Aging

a. Background

In Contra Costa County, the Volunteer Services Division of the County Office on Aging administers the local HICAP project. The Office on Aging is a separate administrative unit within the County Social Service Department. Under the provisions of Title III of the Older Americans Act, the Office on Aging plans, coordinates, and administers the Area Plan for programs on aging for persons age 60+ in the County. Over the years, the Office on Aging has become involved in a variety of activities beyond those required for Area Agencies on Aging. The Office on Aging provides direct services to persons age 60+ in the areas of information and referral and case management for frail elderly, as well as administers the Senior

Community Services Employment Program (SCSEP) and the Retired Senior Volunteer Program (RSVP) for the County. The Contra Costa Office on Aging's HICAP project cooperates with other Bay Area HICAP organizations because of the mutual needs within the greater metropolitan area.

b. Historical Development

The County Board of Supervisors established the Office on Aging in 1975 to carry out the functions of the Area Agency on Aging for the County. The need for health insurance counseling in Contra Costa County later became apparent because the senior information and referral system, which is an in-house operation of the Office on Aging, tracks "gaps in service." The Senior Information Coordinator organized a health insurance counseling program and, therefore, Contra Costa's program pre-dates the 1986 establishment of HICAP in the County. The senior information service continues to provide many referrals to the HICAP and vice versa.

c. Services

The total services rendered were distributed among community education (4,563 contacts), counseling (1,420 contacts) and legal services (35 contacts).

Community education efforts showed a 58 percent increase over last fiscal year's activity. The average attendance at 1 of their 118 presentations was 39, ranging from a high of 73 to a low of 19. They achieved 130 percent of their planned activity level of 3,500.

Counseling services increased 12 percent over FY 1987-88. The Contra Costa County Office on Aging averaged 118 contacts per month, for a total of 1,420 which was 5 percent less than the planned activity level of 1,500. The number of counseling sites increased from 19 in June 1988 to 23 in June 1989.

Legal services decreased from 37 in FY 1987-88 to 35 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 28. This is an increase from 24 in FY 1987-88. These volunteers contributed 2,908 hours to HICAP, an increase of 55 percent over last fiscal year. The average number of hours per volunteer per month was 8.7 hours.

5. Fresno (2) - Fresno-Madera Area Agency on Aging

a. Background

The Fresno-Madera Area Agency on Aging (FMAAA) was established through a Joint Power Agreement in 1980 by the City of Fresno and Fresno and Madera Counties. A Board of Directors, Advisory Council, and FMAAA staff work together to fulfill goals, objectives, and activities mandated by the Federal Older Americans Act and the California State Older Californians Act.

b. Historical Development

Fresno-Madera Area Agency on Aging joined HICAP in September of 1988 and provided HICAP services for the last six months of the fiscal year. The initial

organization of the HICAP was brought about by forming a steering committee composed of representatives from the Fresno County Economic Opportunity Commission, Fresno-Merced Counties Legal Services, Law Offices of Anthony L. Terry, San Joaquin Valley Health Consortium, Madera Senior Services, American Association of Retired Persons, Retired County Employees Organization, the Neighborhood Watch Association, Older Americans Organizations and potential HICAP volunteers. Members of the steering committee are now the nucleus of a HICAP Advisory Committee.

c. Services

Services were distributed among community education presentations (1,566 contacts), counseling (308 contacts), and legal services (20 contacts). In addition to community education presentations, estimated community education contacts using media were 7,000.

Community education was provided using both presentations and media. The presentation efforts were 70 percent of their planned activity level of 2,250. The average attendance at 1 of their 35 presentations was 44, ranging from a high of 56 to a low of 26.

Counseling services averaged 26 contacts per month, for a total of 308 which was less than the planned activity level of 980 by 69 percent. Fresno-Madera had 15 counseling sites in June 1989.

Legal services were 87 percent below their planned activity level of 149 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month for the three months they had volunteers was 13. These volunteers contributed 544 hours to HICAP. The average number of hours per volunteer per month for three months was 13.6 hours. This differs from the data shown in Table 2 because all the data shown in Table 2 is based on a full 12-month year.

6. Humboldt (2) - Humboldt Senior Citizens Council

a. Background

The mission of the Humboldt Senior Citizens Council (HSCC) is promoting independence and self-sufficiency among the senior citizens and impaired adults of Humboldt County. To achieve this, HSCC offers an integrated array of advocacy, health, nutrition, and social services designed to enhance the dignity and protect the rights of individuals in both home and out-of-home settings. Serving the elders of Humboldt and Del Norte Counties, senior services are centered in the Humboldt Senior Resource Center and the Del Norte Senior Center with outreach services throughout both Counties.

b. Historical Development

The HSCC is a community-based nonprofit corporation formed in 1974 to serve rural Humboldt County. Initially dedicated to serving senior citizens, the HSCC voted in February 1985 to expand its target population to include impaired adults

over age 18. The HSCC has implemented many successful programs in the past 14 years, including a full range of long-term care and Older Americans Act, Title III programs. These include Multipurpose Senior Services Program (MSSP), Linkages, Respite, Adult Day Health Care (ADHC), and Alzheimer's Programs, as well as Nutrition and Senior Information and Referral services. In addition, Humboldt County is part of the "SEED" effort and HSCC has been a major contributor to this project. HSCC's HICAP started services in April 1988.

c. Services

FY 1988-89 was the first full year that Humboldt Senior Resource Center provided HICAP services. These services were distributed among community education (892 contacts), counseling (612 contacts), and legal services (7 contacts).

Community education efforts were 66 percent of their planned activity level of 1,360. The average attendance at 1 of their 25 presentations was 36, ranging from a high of 71 to a low of 10.

Counseling services averaged 51 contacts per month, for a total of 612 which was more than the planned activity level of 485 by 26 percent. Humboldt had four counseling sites in June 1989.

Legal services were 93 percent below their planned activity level of 97 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was three. These volunteers contributed 928 hours to HICAP. The average number of hours per volunteer per month was 26 hours.

7. Kern County (1) - Kern County Office on Aging

a. Background

The HICAP in Kern County is a component of the Kern County Office on Aging, Information and Referral Service. The primary purposes of the Office on Aging include planning, monitoring, and assessing programs serving persons age 60 and over in Kern County. The Office on Aging provides staff support to the Kern County Commission on Aging which advises the Kern County Board of Supervisors and the Office on Aging about issues and concerns of Kern County senior citizens. The Office on Aging also works toward the development of a comprehensive and coordinated service delivery system for older people of Kern County. Finally, the Office is responsible for the operation of the Information and Referral (I&R) Program.

b Historical Development

The Kern County Office on Aging was designated as the Area Agency on Aging for Planning and Service Area 33 on October 1, 1980. The transfer of contract administrative responsibility to the Office on Aging from the California Department of Aging was completed July 1981. The Office on Aging began administering the I&R Program on July 1, 1984. Prior to that date, the I&R Program had been administered by Bakersfield College through a contract with the Office on Aging.

Along with providing I&R services, the I&R Program has expanded to include case management and now HICAP services. The HICAP is a result of priorities established for the I&R Program by the Kern County Commission on Aging. The development of the HICAP was ranked second behind the development of case management. These priorities were then presented to the Kern County Board of Supervisors in meeting all the statewide HICAP requirements for an effective Program.

c. Services

FY 1988-89 was the first full year that Kern County Office on Aging provided HICAP services. These services were distributed among community education (1,785 contacts), counseling (730 contacts), and legal services (7 contacts).

Community education efforts were 139 percent of their planned activity level of 1,282. The average attendance at 1 of their 46 presentations was 39, ranging from a high of 70 to a low of 27.

Counseling services averaged 61 contacts per month, for a total of 730 which was less than the planned activity level of 1,044 by 30 percent. Kern County had four counseling sites in June 1989.

Legal services were 81 percent below their planned activity level of 36 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 11. These volunteers contributed 744 hours to HICAP. The average number of hours per volunteer per month was 5.6 hours.

8. Kings (2) - Kings/Tulare Area Agency on Aging

a. Background

The Kings/Tulare Area Agency on Aging (K/T AAA) has considerable experience in planning, designing, implementing, delivering, monitoring, and evaluating services to seniors. The K/T AAA has developed a program of education and professional development in which the need for intensive long-term care services in Kings and Tulare counties was promoted. The K/T AAA prepared two grants: Adult Day Health Care (ADHC) and Multipurpose Senior Services Program (MSSP). A series of changes were initiated which transformed the K/T AAA into an intensive information, counseling, and referral program. The K/T AAA is working to provide coordination among such programs as Adult Protective Services, In-Home Supportive Services, Public Guardian, and Veterans Affairs, currently provided by the Department of Public Social Services.

b. Historical Development

The K/T AAA has operated as a special governmental district under a Joint Powers agreement between the counties of Kings and Tulare since 1980. For the last five years, the K/T AAA has operated all programs for aging services in these counties. A first step to improve long-term care services in the rural counties was taken three years ago with the establishment of the Tulare County Multi-Agency Task Force,

which brought together a cohesive group of "public" health and social service agencies to establish a more uniform system of services.

c. Services

FY 1988-89 was the first full year that K/T AAA provided HICAP services. These services were distributed among community education (1,203 contacts), counseling (574 contacts), but no legal services (0 contacts).

Community education efforts were 32 percent of their planned activity level of 3,717. The average attendance at 1 of their 31 presentations was 39, ranging from a high of 65 to a low of 14.

Counseling services averaged 48 contacts per month, for a total of 574 which was less than the planned activity level of 1,810 by 69 percent. K/T AAA had five counseling sites in June 1989.

Legal services were not provided although they had a planned activity level of 19 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was eight. These volunteers contributed 311 hours to HICAP. The average number of hours per volunteer per month was 3.3 hours.

9. Los Angeles (1) - Medicare Advocacy Project, Inc.

a. Background

The Medicare Advocacy Project, Inc. (MAP), specializes in Medicare, Private Medicare Supplemental Health Insurance, Long-Term Care Insurance, Health Maintenance Organizations (HMOs), and related issues. MAP is fully qualified to address these areas of vital concern to seniors and other Medicare beneficiaries. Thousands of Los Angeles County beneficiaries receive individualized assistance and advocacy from professionals and specially trained volunteers. Thousands more are helped through the community outreach component via the media, workshops, and presentations.

b. Historical Development

MAP was founded in 1984 in response to the pressing need for accurate information regarding Medicare/Medigap insurance and related issues of concern to seniors. MAP began as a three-person storefront and has grown over the years to meet the ever increasing need for information and advocacy of the 800,000 plus Medicare beneficiaries in Los Angeles County. In 1986, MAP was awarded the HICAP grant for Los Angeles County. This grant allowed MAP to substantially expand its capacity to provide service.

c. Services

The total services rendered were distributed among community education (9,253 contacts), counseling (3,134 contacts), and legal services (1,408 contacts). In addition to community education presentations, estimated community education contacts using mass media was 86,010.

Community education was provided using both presentations and media. The community presentation contacts showed a 128 percent increase over last fiscal year's activity. This was 40 percent below the planned level of 15,405 contacts.

Counseling services decreased 2 percent over FY 1987-88. MAP averaged 262 contacts per month, for a total of 3,134 which was less than the planned activity level by 8 percent. The number of counseling sites remained at 40 in both June 1988 and June 1989.

Legal services decreased 12 percent, from 1,597 in FY 1987-88 to 1,408 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 45. This is an 18 percent increase over FY 1987-88. These volunteers contributed 1,957 hours to HICAP which is an increase of 11 percent over last fiscal year. The average number of hours per volunteer per month was 3.6 hours.

10. Merced (1) - Merced County Area Agency on Aging

a. Background

In addition to the responsibility for planning, programming, implementing, monitoring, auditing, evaluating, and reporting for Merced County senior citizen programs, the Merced County Area Agency on Aging (AAA) works in cooperation with its Advisory Council and local service providers to avoid overlap and duplication of services and to advocate for senior citizen programs for which there is a demonstrated need. The Area Agency administers a variety of supportive and nutrition services and has taken special effort to establish local long-term care services within the rural service area. The Merced HICAP is an integral part of the Merced County Senior Service Program and takes advantage of the support of the local Area Agency service delivery system. A regular schedule is maintained to provide HICAP services at six Senior Services Programs and nine Nutrition sites within the rural service area.

b. Historical Development

The Merced County AAA has existed as a separate County Department since 1979. County Ordinance #964, adopted by the Board of Supervisors on November 27, 1979, established the purpose of the AAA "to plan, coordinate, administer, monitor, and subcontract services and resources relative to the aged programs in Merced County; to further assist in improving the lives of older persons; and to stimulate the commitment of additional funds by public and private agencies to support programs needed by older persons." In an effort to enhance its current array of supportive services provided to senior citizens, the Merced County AAA applied for and received funding to provide HICAP services on March 1, 1988.

c. Services

FY 1988-89 was the first full year that Merced County AAA provided HICAP services. These services were distributed among community education (458 contacts), counseling (706 contacts), and legal services (11 contacts).

Community education efforts were 46 percent of their planned activity level of 1,000. The average attendance at 1 of their 16 presentations was 29, ranging from a high of 90 to a low of 5.

Counseling services averaged 59 contacts per month, for a total of 706 which was more than the planned activity level of 250 by 182 percent. Merced had five counseling sites in June 1989.

Legal services were 87 percent below their planned activity level of 83 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was five. These volunteers contributed 204 hours to HICAP. The average number of hours per volunteer per month was 3.2 hours.

11. Monterey (1) - Monterey County Area Agency on Aging

a. Background

The Monterey County Area Agency on Aging (AAA) is a division of the Department of Social Services and has administrative control over funding from the Older Americans Act, Title XX Adult Services, Linkages, and funds for senior programs from the County.

b. Historical Development

The AAA has provided a coordinated system of services to seniors since its inception in 1980. Two agencies were contracted to provide HICAP services: the Alliance on Aging and Legal Services for Seniors (LSS). Established in 1970, the Alliance on Aging is a nonprofit agency with the purpose of providing services to enable older persons to live with independence and dignity. It has grown to provide food services, senior employment services, and senior supportive services. LSS is a nonprofit organization which provides free legal services to the elderly in Monterey County. Founded in 1985, LSS is dedicated to providing quality legal assistance to the elderly. LSS has considerable experience in Medicare and health insurance counseling.

c. Services

FY 1988-89 was the first full year that the Alliance on Aging and LSS provided HICAP services. These services were distributed among community education (2,021 contacts), counseling (1,565 contacts), and legal services (556 contacts).

Community education efforts were 149 percent of their planned activity level of 1,360. The average attendance at 1 of their 56 presentations was 36, ranging from a high of 67 to a low of 6.

Counseling services averaged 130 contacts per month, for a total of 1,565 which was 195 percent of the planned activity level of 802. Monterey had four counseling sites in June 1989.

Legal services were 363 percent above their planned activity level of 120 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was eight. These volunteers contributed 819 hours to HICAP. The average number of hours per volunteer per month was 8.7 hours.

12. Orange County (1) - Visiting Nurse Association Foundation

a. Background

Professional care, volunteer commitment and community service are the underlying principles of the Visiting Nurse Association (VNA) Foundation of Orange County. Through the years, VNA has identified community need for health care and has satisfied that need with appropriate services. The Orange County HICAP operates within the VNA organization. While some client referrals come from VNA social workers and nurses, the majority come from public forums and the Area Agency on Aging. The VNA is willing to look to the future and expand services while networking with many agencies in Orange County to provide a full spectrum of services, including the HICAP.

b. Historical Development

The VNA is a community based, nonprofit organization which has been providing home health services to residents of Orange County since 1947. Their 41-year history has been filled with growth, and they now provide a full spectrum of medical, rehabilitative, and supportive services (HICAP falling into this latter category). The VNA established the VNA Foundation in 1985 to raise money to provide services for those without the ability to pay. It is under the VNA Foundation that HICAP is housed. In November of 1986, the agency which initially established the HICAP in Orange County dissolved. Consequently, VNA accepted the local responsibility for providing HICAP services.

c. Services

For FY 1988-89, the total services rendered were distributed among community education (7,356 contacts), counseling (5,460 contacts), and legal services (77 contacts).

Community education efforts showed a 108 percent increase over last fiscal year's activity. The average attendance at 1 of their 119 presentations was 62, ranging from a high of 98 to a low of 36. They achieved 108 percent of their planned activity level of 6,800.

Counseling services increased 23 percent over FY 1987-88. VNA averaged 455 contacts per month, for a total of 5,460 which exceeded the planned activity level by 44 percent. The number of counseling sites increased from 38 in June 1988 to 54 in June 1989.

Legal services increased 1,000 percent, from 7 in FY 1987-88 to 77 in FY 1988-89. This large increase is attributed to establishing a formal referral and tracking system.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 48. This is a 27 percent increase over FY 1987-88. These volunteers contributed 5,078 hours to HICAP which is an increase of 64 percent over last fiscal year. The average number of hours per volunteer per month was 8.9 hours.

13. Riverside (4) - Inland Counties Health Systems Agency

a. Background

The Inland Counties Health Systems Agency (ICHSA) serves Inyo, Mono, Riverside, and San Bernardino Counties. The project, which began in March 1988, is a diversified nonprofit regional health planning and home care organization. In addition to HICAP, the agency operates two State-funded projects, a hypertension control project and an early intervention project for handicapped and high-risk infants, and a home repair services program for older persons that is 1 of 11 projects nationwide funded by the Robert Wood Johnson Foundation. The agency also provides private duty home health care and operates Riverside County's In-Home Supportive Services program. Finally, the agency provides marketing research and consulting services.

b. Historical Development

ICHSA has been in existence since 1969. During the period 1976 through 1987, ICHSA was the federal and State designated health planning agency for the four-county area (Health Service Area 12). Congress terminated funding for heath planning in 1986, and ICHSA became an affiliate organization of the Visiting Nurse Association of the Inland Counties on May 1, 1987. ICHSA is involved in a broad range of health and related activities and has a long history of interest and involvement in older people's health care. The agency has considerable experience in volunteer participation and serving a large and diverse four-county service area. The HICAP project is viewed by the agency as a natural response to its historical and current interest and experience in the field of health care for older persons.

c. Services

FY 1988-89 was the first full year that ICHSA provided HICAP services. These services were distributed among community education presentations (8,428 contacts), counseling (2,084 contacts), but no legal services (0 contacts).

Community education was provided using both presentations and mass media. The average attendance at 1 of their 170 presentations was 50, ranging from a high of 87 to a low of 21. In addition to community education presentations, estimated community education contacts using mass media was 2,274.

Counseling services averaged 174 contacts per month, for a total of 2,084 which was less than the planned activity level of 2,234 by seven percent. ICHSA had 20 counseling sites in June 1989.

Legal services were not provided although they had a planned activity level of 16 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 21. These volunteers contributed 2,810 hours to HICAP. The average number of hours per volunteer per month was 11 hours.

14. Sacramento (9) - Legal Center for the Elderly and Disabled

a. Background

The Legal Center for the Elderly and Disabled (LCED) has been providing legal services to low-income seniors and disabled persons in Sacramento County for the past 15 years. A wide range of legal assistance is offered by the staff of attorneys and paralegals. With the addition of the HICAP contract, the LCED now provides a broader and more comprehensive number of services. While the LCED services are limited to residents of Sacramento County, the HICAP component is responsible for the nine-county area of Sacramento, San Joaquin, Yolo, Yuba, Sutter, Placer, Nevada, El Dorado, and Sierra. Only HICAP-related legal services are provided for clients in other than Sacramento County. The HICAP unit, as a member of the LCED family, is able to offer a comprehensive service since legal resources are readily available when needed.

b. Historical development

The Sacramento HICAP began in September of 1985. Sites were established in libraries, senior centers, schools, nutrition sites, and other public facilities. Former teachers, government workers, nurses, doctors, attorneys, and other professionals volunteered to take training and become Counselors. These volunteers have proven to be of the highest caliber and are dedicated to helping people. The "Organizational Advocate of the Year" was awarded to Sacramento's HICAP by the California Commission on Aging in 1988. In addition, LCED has received commendations from county and city officials.

c. Services

The total services rendered were distributed among community education (7,887 contacts), counseling (4,522 contacts), and legal services (351 contacts).

Community education efforts showed a 5 percent increase over last fiscal year's activity. The average attendance at 1 of their 103 presentations was 77, ranging from a high of 158 to a low of 20. They achieved 75 percent of their planned activity level of 10,500.

Counseling services increased 4 percent over FY 1987-88. The Legal Center for the Elderly and Disabled averaged 377 contacts per month, for a total of 4,522 which was 10 percent less than the planned activity level of 5,000. The number of counseling sites decreased from 21 in June 1988 to 16 in June 1989.

Legal services increased 44 percent, from 243 contacts in FY 1987-88 to 351 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 30. This is a decrease from 34 in FY 1987-88. These volunteers contributed 2,550 hours to HICAP, an increase of 25 percent over last fiscal year. The average number of hours per volunteer per month was 7.2 hours.

15. San Diego (2) - Progressive Social Services System Technology (PRO-TECH)

a. Background

PRO-TECH, the San Diego HICAP, works closely with other social service programs in the County and provides client referrals and interagency presentations. The greatest problem in the provision of services in San Diego/Imperial Counties is the large geographical service area and the many small and relatively distant communities which must be served. However, the aging network and social service delivery system are fairly well-developed and are used to access clients.

b. Historical Development

PRO-TECH is a nonprofit charitable corporation organized in 1978. It has been providing general legal services to the elderly in San Diego County for the past ten years. These services included representation and counseling on Medicare and Medi-Cal issues. PRO-TECH was funded for the HICAP in early 1988 and has included HICAP functions in its community outreach network.

c. Services

FY 1988-89 was the first full year that PRO-TECH provided HICAP services. These services were distributed among community education presentations (3,175 contacts), counseling (1,792 contacts), and legal services (215 contacts).

Community education was provided using both presentations and mass media. The presentation efforts were 31 percent of their planned activity level of 10,200. The average attendance at 1 of their 81 presentations was 39, ranging from a high of 80 to a low of 10. In addition to community education presentations, estimated community education contacts using media was 60,000.

Counseling services averaged 149 contacts per month, for a total of 1,792 which was less than the planned activity level of 3,130 by 43 percent. PRO-TECH had 26 counseling sites in June 1989.

Legal services were 20 percent below their planned activity level of 270 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 32. These volunteers contributed 4,090 hours to HICAP. The average number of hours per volunteer per month was 10.7 hours.

16. San Francisco (1) - Legal Assistance to the Elderly

a. Background

Legal Assistance to the Elderly (LAE) is a non-sectarian, nonprofit organization which has a goal to protect, defend, and advocate for the legal rights, benefits, and services of elders by providing legal counsel, representation, and community education free to residents of San Francisco who are 60 and older. Clients are seen at intake sites throughout this culturally diverse city. The frail client is visited at home, in the hospital, or other settings. Clients are provided information, advice, counsel, and representation for problems associated with Social Security or Supplemental Security Income, Medicare and Medi-Cal, private health insurance, nursing homes, housing, private pensions, powers of attorney, and physical and financial abuse.

b. Historical Development

Originally founded by the American Jewish Congress in 1975, LAE was incorporated as an independent nonprofit agency in 1979, governed by a 22-member Board of Directors and guided by a 10-member Senior Advisory Committee. LAE's involvement with HICAP came as a result of realizing that many clients were having difficulty negotiating the maze of Medicare and supplemental health insurance. These concerns were instrumental in working with others in the field of aging to implement the HICAP. Because of LAE's access to the elderly community and commitment to health issues, it was obvious that many of LAE's resources would enhance the HICAP. The San Francisco HICAP has worked to develop an ongoing relationship with all HICAP projects throughout the State to facilitate communication with other agencies which have similar resources.

c. Services

The total services rendered were distributed among community education (4,342 contacts), counseling (1,036 contacts), and legal services (103 contacts).

Community education efforts showed an 87 percent increase over last fiscal year's activity. The average attendance at 1 of their 92 presentations was 47, ranging from a high of 212 to a low of 23. They achieved 96 percent of their planned activity level of 4,500.

Counseling services increased 75 percent over FY 1987-88. LAE averaged 86 contacts per month, for a total of 1,036, which was less than the planned activity level of 1,800 by 42 percent. The number of counseling sites increased from 12 in June 1988 to 15 in June 1989.

Legal services decreased 45 percent, from 186 in FY 1987-88 to 103 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 15. This is an increase over 8 volunteers in FY 1987-88. These volunteers contributed 818 hours to HICAP, an increase of 71 percent over last fiscal year. The average number of hours per volunteer per month was 4.6 hours.

17. San Mateo (1) - Peninsula Volunteers/Little House

a. Background

Peninsula Volunteers, Inc., is a private nonprofit organization dedicated to promoting the general community welfare of the senior population. The focus within its parent organization, Little House, is twofold: 1) to make an immediate contribution to the older person by providing companionship and the stimulus of a multi-level program of educational, cultural, recreational, and community activities; and 2) to provide the opportunity for needed research in gerontology. Peninsula Volunteers/Little House has now developed a Well Elder Center at which rehabilitative and consultative services are provided by the medical staffs of Stanford and Sequoia Hospitals and other health care providers in the County.

b. Historical Development

Incorporated in 1947, the Peninsula Volunteers/Little House is a charitable organization. In 1949, the Corporation developed the first suburban senior center in the country which has become the model for coordinated and comprehensive services to the elderly. In addition, Peninsula Volunteers/Little House developed Rosener House, an adult social day center, and two independent living facilities: Crane Place and Partridge Place. Because Peninsula Volunteers/Little House is recognized as the major multi-purpose senior center in San Mateo County, the County Area Agency on Aging agreed in 1988 that Little House would be the agency best suited to implement the HICAP. In developing the Program, Peninsula Volunteers/Little House has had exceptional cooperation from both the San Francisco County and Santa Clara County HICAP agencies.

c. Services

FY 1988-89 was the first full year that Little House provided HICAP services. These services were distributed among community education (4,645 contacts), counseling (1,064 contacts), and legal services (15 contacts).

Community education efforts were 232 percent of their planned activity level of 2,000. The average attendance at 1 of their 88 presentations was 53, ranging from a high of 81 to a low of 18.

Counseling services averaged 89 contacts per month, for a total of 1,064 which was less than the planned activity level of 1,200 by 11 percent. Little House had 14 counseling sites in June 1989.

Legal services were 50 percent below their planned activity level of 30 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 12. These volunteers contributed 1,999 hours to HICAP. The average number of hours per volunteer per month was 14 hours.

18. Santa Barbara (2) - Central Coast Commission for Senior Citizens

a. Background

The Central Coast Commission for Senior Citizens (CCCSC) is a California nonprofit public benefit corporation serving senior citizens in Santa Barbara and San Luis Obispo Counties. The CCCSC is the designated Area Agency on Aging for San Luis Obispo and Santa Barbara Counties. The Commission currently operates several other senior citizen programs: Retired Senior Volunteer Program (RSVP), Senior Nutrition Program of San Luis Obispo County, Caring Callers, Senior Community Service Employment Program (SCSEP), and PIC Older Worker Program (Fifty Five Plus). The Commission is governed by a Board of Directors, 75 percent of whom are 60 years of age or older. All members are residents of San Luis Obispo or Santa Barbara Counties, with 5 of the 14 directors appointed by the respective County Board of Supervisors, and the Santa Maria, Santa Barbara, and San Luis Obispo City Councils.

b. Historical Development

First chartered in March 1975, the CCCSC was designated the Area Agency on Aging soon after. Throughout the past 13 years, the CCCSC has maintained and expanded its community commitments with a focus on development of in-home supportive services and long-term care programs. In 1985, the Area Agency on Aging conducted an Elder Needs Assessment Survey which indicated 25 percent of those surveyed experienced difficulty in completing health insurance claim forms. Also, in FY 1985-86, the Area Agency on Aging secured funding from the Department of Aging to initiate a Medicare and insurance billing service in the Santa Maria area. The Area Agency on Aging granted the monies to the Marian Medical Center (MMC) which continues to operate the program. The program has proven very successful and is now fully funded by MMC. This program provided services only to the northern Santa Barbara area on a limited basis. Because the need for health insurance counseling services was evident throughout Santa Barbara and San Luis Obispo Counties, the CCCSC applied for and received the HICAP grant in 1988.

c. Services

FY 1988-89 was the first year that the CCCSC provided HICAP services. These services were distributed among community education (2,456 contacts), counseling (1,061 contacts), but no legal services (0 contacts).

Community education efforts were 108 percent of their planned activity level of 2,282. The average attendance at 1 of their 55 presentations was 45, ranging from a high of 60 to a low of 31.

Counseling services averaged 88 contacts per month, for a total of 1,061 which was less than the planned activity level by 6 percent. CCCSC had established 11 counseling sites by June 1989.

Legal services were not provided this fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 11. These volunteers contributed 1,143 hours to HICAP. The average number of hours per volunteer per month was 8.4 hours.

19. Santa Clara (1) - Council on Aging of Santa Clara County

a. Background

The Council on Aging of Santa Clara County, Inc. (COA), is a private nonprofit Area Agency on Aging which operates the HICAP to bring consistency and continuity to existing service providers, and to expand the Program to all parts of the County.

Santa Clara County has the privilege of being the home of Stanford University, where a model health insurance counseling program was started over ten years ago under the leadership of Leona McGann of Palo Alto. In fact, the COA provided funding for the first volunteer training manual developed for use in the County at that time. The addition of HICAP services has greatly enhanced the Area Agency's advocacy efforts in the areas of health planning and health insurance, and has brought an entirely new group of elderly into the Area Agency's service network. The COA, as one of the first group of ten HICAP grantees in California, continues to play an active role in the coordination and sharing of resources among all HICAPs.

b. Historical Development

The COA has been operating since 1975. In the capacity of an Area Agency on Aging, the COA has actively planned, coordinated, advocated, developed programs, and distributed Older Americans Act funding to create and maintain a comprehensive system of services for older persons in Santa Clara County. For the past ten years, the COA has also provided senior employment services through the Older Americans Act Title V program. In the last five years, the COA has evolved into one of the largest providers of direct services in the County by developing and providing gap-filling services in the absence of other provider organizations. Currently, in addition to its Area Agency on Aging functions and responsibilities, the COA also directly provides senior services in the areas of employment, long-term care, case management, Multipurpose Senior Services Program (MSSP), emergency home response, and friendly telephone reassurance, as well as the HICAP.

c. Services

For FY 1988-89, the total services rendered were distributed among community education (6,983 contacts), counseling (3,136 contacts), and legal services (165 contacts).

Community education efforts showed a 156 percent increase over last fiscal year's activity. The average attendance at 1 of their 108 presentations was 65, ranging from a high of 78 to a low of 10. They achieved 171 percent of their planned activity level of 4,089.

Counseling services increased 13 percent over FY 1987-88. COA averaged 261 contacts per month, for a total of 3,136 which was 17 percent more than the

planned activity level of 2,674. The number of counseling sites increased from 15 in June 1988 to 25 in June 1989.

Legal services decreased 15 percent, from 194 in FY 1987-88 to 165 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 30. This is an increase over 24 in FY 1987-88. These volunteers contributed 4,237 hours to HICAP, an increase of 35 percent over last fiscal year. The average number of hours per volunteer per month was 11.9 hours.

20. Santa Cruz (2) - Seniors Council of Santa Cruz and San Benito Counties/Area Agency on Aging

a. Background

The Area Agency on Aging (AAA) is located in Aptos and it operates the local HICAP project. HICAP services for FY 1988-89 were performed under contract with two agencies: 1) Senior Network Service, Inc., an information and referral agency, and 2) the Senior Legal Services, Inc. Both agencies have provided health insurance counseling for many years. The AAA's approach to the delivery of HICAP service involves a three-part arrangement under the leadership of the Seniors Council of Santa Cruz and San Benito Counties, Inc. The operation of the HICAP in Santa Cruz and San Benito Counties is overseen by an official Advisory Council which answers to the Seniors Council Area Agency on Aging Board of Directors. Interagency committees convened by the AAA in both counties are also conducive to regular communication and exchange of information among providers of a wide diversity of services to elders.

b. Historical Development

The Santa Cruz HICAP was established by the AAA in March 1988. The Senior Network Services agency is a multi-purpose agency providing Santa Cruz County residents with senior supportive services. The Senior Citizen Legal Services was the prototype for legal services to the elderly nationwide, and is well established in both counties. Together, these agencies developed an integrated system of service in the two-county area. Volunteer counseling sites, legal assistance sites, and community education locations are selected from existing senior service sites (such as senior centers) to more effectively reach the service population.

c. Services

For FY 1988-89, the total services rendered were distributed among community education (1,346 contacts), counseling (1,760 contacts), and legal services (80 contacts).

Community education efforts showed a 5 percent decrease over last fiscal year's activity. The average attendance at 1 of their 22 presentations was 61, ranging from a high of 165 to a low of 22. They achieved 179 percent of their planned activity level of 750.

Counseling services increased 16 percent over FY 1987-88. The Seniors Council of Santa Cruz and San Benito Counties averaged 147 contacts per month, for a total of 1,760 which was 76 percent more than the planned activity level of 1,000. The number of counseling sites decreased from 12 in June 1988 to 10 in June 1989.

Legal services decreased 17 percent, from 96 in FY 1987-88 to 80 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 14. This is a decrease from 17 in FY 1987-88. These volunteers contributed 888 hours to HICAP, an increase of 4 percent over last fiscal year. The average number of hours per volunteer per month was 5.3 hours.

21. Shasta (5) - PSA 2 Area Agency on Aging

a. Background

The PSA 2 Area Agency on Aging is located in Yreka and oversees the HICAP in the counties of Lassen, Modoc, Shasta, Siskiyou, and Trinity. PSA 2 has contracted with the Senior Legal Center of Northern California to operate the HICAP in their five-county jurisdiction.

b. Historical Development

Incorporated in 1981, the Senior Legal Center of Northern California is a nonprofit multi-program corporation whose principle purpose is to provide assistance to the senior population in the PSA 2 area. The Senior Legal Center was selected to sponsor the Long-Term Care Ombudsman Program in 1982, and the HICAP in 1988.

c. Services

The PSA 2 Area Agency on Aging joined HICAP in September of 1988 and provided HICAP services for the last nine months of the fiscal year. These services were distributed among community education (928 contacts), counseling (368 contacts), and legal services (22 contacts).

Community education efforts were 59 percent of their planned activity level of 1,577. The average attendance at 1 of their 28 presentations was 33, ranging from a high of 60 to a low of 19.

Counseling services averaged 31 contacts per month, for a total of 368 which was less than the planned activity level of 675 by 45 percent. PSA 2 had seven counseling sites in June 1989.

Legal services were twice their planned activity level of 11 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of volunteers per month for the eight months they had volunteers was 21. This differs from the data shown in Table 2 because all the data shown in Table 2 is based on a full 12-month year. These volunteers contributed 832 hours to HICAP. The average number of hours per volunteer per

month (for eight months) was five hours. (Note: Volunteers fluctuated from a high of 57 to a low of 11.)

22. Sonoma (6) -North Bay Health Resources Center

a. Background

North Bay Health Resources Center (NBHRC) is based in Petaluma and has functioned for many years as a former Health Planning Organization. Prior to providing HICAP services, they provided health insurance counseling in the counties of Napa, Sonoma, and Solano. The NBHRC HICAP project coordinates with other existing resources to provide an integrated and comprehensive service program. NBHRC supports a philosophy that: 1) primary prevention of problems is more effective than crisis intervention; 2) people should know their rights and obtain what they are entitled to from Medicare; 3) people should understand their options and rights under supplemental health insurance policies and receive what they are entitled to; and 4) all Medicare eligible people in the service area, including minorities, low-income, and isolated rural residents, should have access to necessary information and assistance.

Currently, the program is reaching approximately 10 percent of the 65+ population through public information and education efforts and through the program's decentralized counseling and advocacy system. The service delivery approach employed by the NBHRC is integrated with the greater social service delivery system in this large six-county service area. HICAP staff work closely with the Area Agencies on Aging, Information and Referral networks, senior service providers, Social Security offices, and other organizations to accomplish its goals.

b. Historical Development

The NBHRC HICAP has served five counties (Mendocino, Lake, Sonoma, Napa, and Solano) since 1985, and was extended to a sixth county (Marin) during the FY 1987-88 funding period. The program functions in a large geographic service area which includes urban, suburban, and rural communities with considerable diversity in their values and attitudes.

c. Service Performance

For FY 1988-89, the total services rendered were distributed among community education (11,767 contacts), counseling (5,708 contacts), and legal services (67 contacts).

Community education efforts showed a 41 percent increase over last fiscal year's activity. The average attendance at 1 of their 246 presentations was 48, ranging from a high of 104 to a low of 31. They achieved 102 percent of their planned activity level of 11,578.

Counseling services increased 19 percent over FY 1987-88. North Bay averaged 476 contacts per month, for a total of 5,708 which was 14 percent less than the planned activity level of 6,604. The number of counseling sites increased from 43 in June 1988 to 50 in June 1989.

Legal services increased from 27 in FY 1987-88 to 67 in FY 1988-89.

d. Volunteers

For FY 1988-89, the average number of volunteers per month was 63. This is a 34 percent increase over 47 in FY 1987-88. These volunteers contributed 10,971 hours to HICAP, an increase of 23 percent over last fiscal year. The average number of hours per volunteer per month was 14.4 hours.

23. Stanislaus (1) - Modesto Salvation Army

a. Background

The Modesto Salvation Army is committed to helping aging persons cope with their special problems and successfully adjust to changing lifestyles. The Salvation Army supports a variety of services to seniors of Stanislaus County, including nutritional services, information and referral, and poverty assistance programs.

b. Historical Development

The Salvation Army was established in Modesto in 1890. It has continued the work of its founder, William Booth, by offering nutrition, housing, and information and referral, among other services to those in greatest need in the greater Modesto area. Although senior citizens have always been recipients of services at the Salvation Army, it was felt in 1980 that a special effort was needed to serve some of the unmet needs of the many seniors of the area. The Salvation Army began a county-wide Information and Referral service in November 1980 which has continued for the last seven and one-half years. The Salvation Army had, in fact, been providing insurance counseling to seniors since 1983, but had to limit program expansion for lack of funding. Becoming a HICAP agency in 1988 was a major achievement in the effort to expand and provide Stanislaus County more professional counseling services.

c. Services

FY 1988-89 was the first full year that the Modesto Salvation Army provided HICAP services. These services were distributed among community education (1,108 contacts), counseling (740 contacts), and legal services (2 contacts).

Community education efforts were 74 percent of their planned activity level of 1,500. The average attendance at 1 of their 22 presentations was 50, ranging from a high of 152 to a low of 14.

Counseling services averaged 62 contacts per month, for a total of 740 which was more than the planned activity level of 614 by 21 percent. The Modesto Salvation Army had four counseling sites in June 1989.

Legal services were 90 percent below their planned activity level of 20 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of The Salvation Army's volunteers per month was seven. These volunteers contributed 1,168 hours to HICAP. The average number of hours per volunteer per month was 13.3 hours.

24. Ventura (1) - Grey Law

a. Background

Grey Law of Ventura County, Inc., is a nonprofit corporation dedicated to providing free legal services to the senior citizen population of Ventura County. Grey Law has representatives available on a regular basis at 13 senior centers throughout the County. Grey Law also has speakers who will cover any subject related to senior issues. These speakers have spoken at numerous senior centers and to other organizations throughout the County.

b. Historical Development

Grey Law opened its doors January 1979 and started a Comprehensive Employment Training Act (C.E.T.A.) project with the goal of providing legal assistance to senior citizens and the disabled of Ventura County. Eventually, Grey Law evolved into a senior citizen legal aid project. In the years the program has been operational, Grey Law's work has allowed many seniors to remain active participants in the economic and social life of the community by providing them access to and representation in the legal system. Since Grey Law already had an existing network that served the senior population of Ventura County and they were dealing in HICAP issues on a limited basis, they quickly incorporated HICAP into its existing network and expanded services.

c. Services

FY 1988-89 was the first full year that Grey Law provided HICAP services. These services were distributed among community education (2,387 contacts), counseling (534 contacts), and legal services (11 contacts).

Community education efforts were 99 percent of their planned activity level of 2,400. The average attendance at 1 of their 34 presentations was 70, ranging from a high of 113 to a low of 22.

Counseling services averaged 45 contacts per month, for a total of 534 which was less than the planned activity level of 1,500 by 64 percent. Grey Law had seven counseling sites in June 1989.

Legal services were 93 percent below their planned activity level of 156 for the fiscal year.

d. Volunteers

For FY 1988-89, the average number of Grey Law's volunteers per month was 11. These volunteers contributed 683 hours to HICAP. The average number of hours per volunteer per month was five hours.

C. COST SAVINGS TO CLIENTS AND TO STATE

As a consequence of the Supplemental Report of the Budget Act of 1987, the HICAP began documenting cost savings in July of 1987. Cost savings, whether for the client or for the State, are difficult to predict ahead of time. In many cases, legal services are used to settle complicated benefit disputes and may take several months to settle. When these cases are settled they often represent a great deal of money. In FY 1988-89, total savings were reported to be $4,689,231. This represents savings for the client and savings for the State. State savings are reported as a subset of all savings.

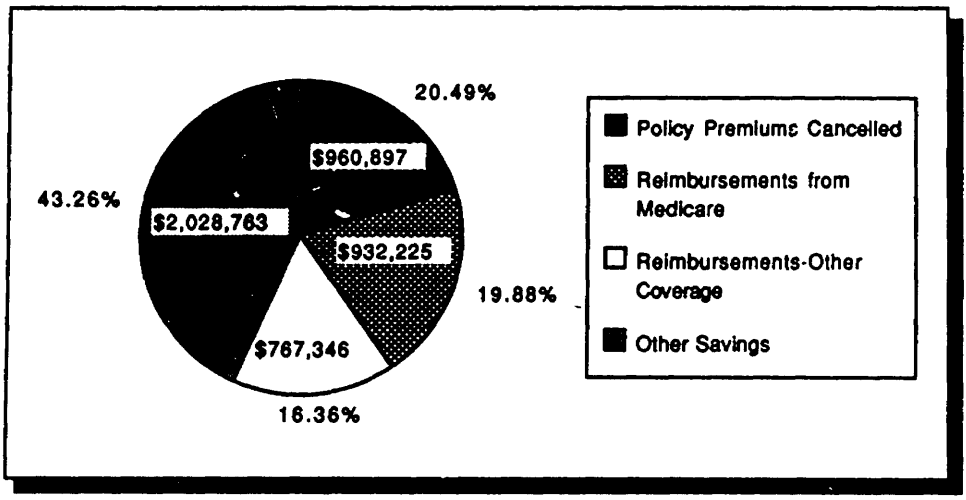
These data show that HICAP had a 176 percent return, in terms of the cost/benefit ratio of the Program. This is almost a two dollar savings for every dollar expended in the Program. While the savings do not contribute to the costs of the Program, this reflects a significant favorable impact of the Program. The trend in cost savings is both an increasing overall savings rate and an increasing per capita savings to the clientele.

1. Client and State Cost Savings

Chart 2 shows cost savings reported for FY 1988-89. There are four categories of savings reported by the contractors. First, the category "Policy Premiums Cancelled" represents the dollars saved by reducing the amount of insurance purchased. This would include the cancellation of unnecessary policies when a client is over-insured, such as having excess or inadequate Medicare supplement or long-term care policies, specific illness policies, or excess accident or indemnity policies, and for Medi-Cal beneficiaries who were sold policies for health care already covered by Medi-Cal.

The second category, "Reimbursements from Medicare," represents claims adjustments, including money reimbursed for claims errors that were corrected or for appeals to Medicare that were won. The third category, "Reimbursements-Other Coverage," is a catch-all category for situations concerning entities other than Medicare or insurers, such as savings to the client from overpaid provider reimbursements. "Other Savings" is a catch-all for unusual situations such as dated checks from insurers unknowingly held by the client that were finally processed. These types of situations do not easily fit into the major cost savings categories but do represent a service to the client.

CHART 2
HICAP STATEWIDE SUMMARY
FY 1988-89
TOTAL CLIENT AND STATE COST SAVINGS BY TYPE



In FY 1988-89, HICAP saved 5,134 clients an average of $913.37 each.[3] Policies cancelled because they were duplicative or unnecessary resulted in savings to clients in the amount of $960,897, or 20.49 percent of all savings. Reimbursement for unnecessary out-of-pocket expenses from faulty Medicare claims resulted in $932,225 worth of savings to Medicare beneficiaries, or 19.88 percent of all reported savings. Savings from insurance claim adjustments or service provider claims were $767,346, or 16.36 percent. "Other savings" of $2,028,763 amount to 43.26 percent of the total savings.

2. State Savings

Chart 3 shows cost savings to the State reported for FY 1988-89. In Chart 3 there are two categories of savings to the State reported by HICAP contractors. The first category, "Reimbursements from Medicare," includes dollars saved the State by resubmitting or appealing Medicare claims for Medi-Cal recipients. The second category "Reimbursements-Other Savings," represent dollars saved the State from sources other than Medicare, contributing to the health care expenses of Medi-Cal recipients.

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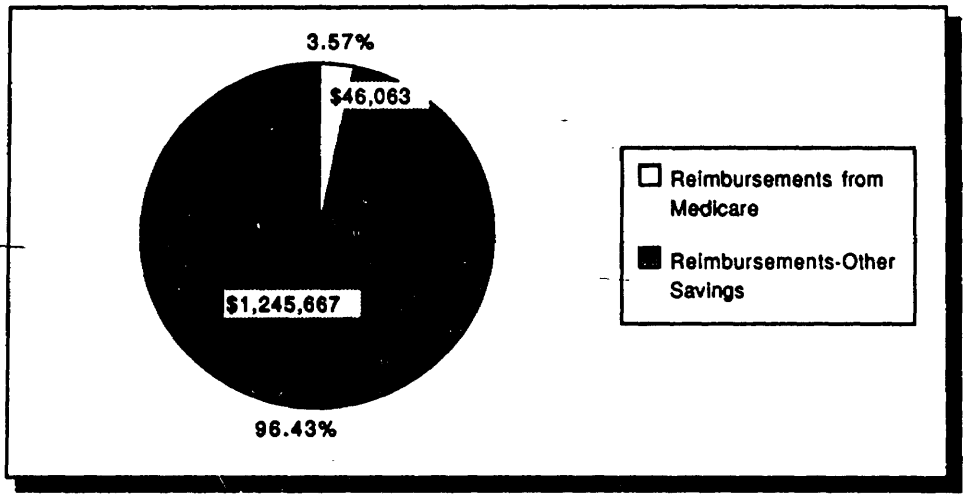
3 This average includes savings identified based on the actual dollars returned to the client because of refunds, reductions, or deletions of already billed amounts and payment by a third party, or the monetary equivalent saved by preventing or postponing what would otherwise be an out-of-pocket expense, and dollars saved for any State agency, such as Medi-Cal, because Medicare paid for expenses that would otherwise have been paid for by the State. In the latter case, the State receives the benefits, not the client.

The reported reimbursement to the State, as a result of Medicare coverage supplanting Medi-Cal coverage (also known as "cost shifting"), amounted to $46,063 or 3.57 percent of total State savings and about 1 percent of total savings reported.

CHART 3
HICAP STATEWIDE SUMMARY
FY 1988-89
STATE COST SAVINGS BY TYPE



In addition to these direct savings, there is also "cost avoidance" which is much more difficult to measure, but nevertheless important. In effect, the State saves money every time a client is capable of postponing spending their own funds to the point of becoming eligible for Medi-Cal. The educational and counseling aspects of the Program are aimed at maximizing the clients' planned benefits and minimizing the need to spend down their savings. Good pre-retirement planning helps to avoid the necessity for the State to intervene at an earlier stage.

The appropriate use of private insurance, Medicare, and medical plans reduces the dependency on the State. Many clients are not initially Medi-Cal recipients, but rather Medicare beneficiaries who have to make hard choices concerning their health coverage. With the right counseling, these clients can improve their chances for staying independent longer. This is both good for the client and for the State, as it reduces State Medi-Cal costs.

D. CASE EXAMPLES (ANECDOTES)[4]

Local HICAP Counselors work with seniors who face a variety of problems in paying for and obtaining health care, whether as a result of Medicare policies or the limitations to health insurance. The best way to show this variety is to provide examples of actual cases. The following are anecdotes describing actual cases, although names or other identifiers have been changed to protect the confidentiality of the clients.

- A Spanish speaking couple in Southern California were referred to HICAP after having been pressured into joining a Health Maintenance Organization (HMO) by an aggressive marketing representative. The representative told the clients they could cancel the membership by phone. The couple signed the enrollment form, primarily to disengage from the representative, believing they could call the next day and cancel. The following day they called to cancel their membership in the HMO.

  The couple continued to use their non-HMO providers. When Medicare started to deny claims, they realized the HMO had not cancelled their membership. They tried three more times to disenroll, but only after the intervention of a city councilman did the HMO finally disenroll the couple. By that time the couple was liable for $26,000 worth of unpaid claims. The HICAP intervention used a bilingual Counselor who assisted the couple in their appeal. The appeal was successful and the HMO ended up paying the $26,000 in out-of-plan claims.

- HICAP Counselors in a mid-State county helped two couples cancel Medicare supplement insurance policies sold to them by the same insurance agent. It appeared the agent may have used unethical sales tactics in selling the policies. The HICAP Counselors were also able to have the clients reinstated with their previous insurer, with no new waiting period for pre-existing conditions. The total reimbursement recovered for these clients was $3,939. In addition, the Department of Insurance began investigating the sales practices of the agent involved as a result of HICAP's intervention.

- An 83-year-old client bought a Medicare supplement policy for which she paid a full year's premium of $990. The policy was issued by the agent to her the same day she completed the application and paid the premium. Within the 30-day "free look" period, the client decided she did not want the policy and returned it to the company with written notice that she wanted to cancel.

  Subsequently, the company issued her a refund check, but only in the amount of $90. Several attempts to contact the selling agent were unsuccessful. A HICAP Counselor assisted the client by writing to the insurance company and to the Department of Insurance. The full refund check in the amount of $900 was issued to the client and delivered by Federal Express mail within six days of the letter sent to the Department of Insurance.

- In a sales presentation, an agent told a woman that her new Medigap policy would cover her while living abroad. The policy, however, did not cover her while she was out of the Country. Through HICAP's intervention, the HICAP Counselor

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[4] These stories are compiled to exemplify the type of problems faced by and resolved by HICAP projects. Each year, new anecdotes are provided to reflect work conducted in the reporting period; however, some anecdotes are not from the reporting year simply because they are good examples of the kind of work done by the HICAP.

arranged to have the agent refund the premium for the period of time she would be out of the Country ($495). After consulting with the HICAP Counselor, the client also decided to drop a "Medibill" service (a private service that takes care of billings for a fee) at an annual savings of $195. The Counselor was able to provide the necessary forms and instructions to allow the client to handle her own bills and claims.

- An older worker is a member of a Health Maintenance Organization (HMO). The HMO is the primary payer and should only bill Medicare as secondary payer. However, this HMO and its doctors billed Medicare as the first payer. Medicare paid the client who, in turn, paid his doctors and the HMO. When Medicare caught the errors, it requested a refund from the HMO. The HMO did not respond, so Medicare billed the client. The client explained the situation to Medicare, but Medicare insisted the client was liable for the overpayment which was in excess of $3,000. The client, out of desperation, contacted the HICAP when Medicare threatened to garnish his Social Security checks. The HICAP Counselor sent letters to the HMO which finally responded. The HMO had the doctors refund the $3,000 to Medicare. Medicare then dismissed the charges to the client.

- A distraught 72-year-old woman presented a letter to the local HICAP Counselor from a collection agency demanding payment of $1,947 for services received by her husband for his open heart surgery in 1986. The local HICAP project had been assisting the client and her husband with their medical billing and reimbursement off and on since 1985. The Counselor knew that the client did not have a bill for this amount and all other bills had been attended to and resolved for her husband's surgery. The letter contained no information to identify the provider of service (doctor), the date of service, nor the total of the bill. The client attempted to get this information from the collection agency and was confronted with a rude demand for payment. The local HICAP Counselor called the agency and spoke with an account representative who could not identify the provider and demanded an additional amount of money ($1,542), citing an error in the original letter which did not reflect the total amount due. Later on this "error" turned out to be an additional mistake by the collection agency because the charge had already been paid by Medicare and the client's supplemental insurance company.

  In a discussion with the account representative's supervisor, it was discovered that the HICAP client had been billed in error. The agency had not researched the client's account and did not know it had been an assigned claim for which no bill had ever been presented to the client for payment. The collection agency was provided sufficient information to correct the billing error which had occurred in 1986 when the client's doctor first billed Medicare. They agreed to cease all efforts to collect payment from the HICAP client and immediately sent a letter of apology to the client for any anxiety the firm had created. The local HICAP project saved the client $1,947 which would have been paid if HICAP had not intervened and an additional $1,542 which would have been paid if the second error had not been discovered.

- During March 1988, a lady with emphysema came into the HICAP project with a stack of Explanation of Medicare Benefits (EOMB) forms. On a few forms, Medicare had approved payment for oxygen and durable equipment; however, on others, both had been denied. The total amount denied was $1,177. The local HICAP Counselor assisted her with a request for reconsideration, which was denied. A request for a review was also denied. The HICAP participant was then assisted in the preparation and submission of a request for a Fair Hearing. The Hearing Officer sent the

participant a letter approving the entire amount. The letter was signed and returned to the Hearing Officer. Early in May 1988, the participant received $949.60 (80%) from Medicare, and the HICAP Counselor assisted the client with the submission of a supplemental insurance claim. By the end of May, the client had received $227.40 from her insurance company. She was reimbursed a total of $1,177.

- A HICAP client's husband had died of cancer. In addition to grieving her loss, the client had to contend with bills from 33 different providers. The local Counselor assisted the client by organizing and processing claims and payments during a period of several months. The Counselor also contacted the doctors to ask if they would accept assignment for their services. Many of the doctors agreed to accept assignment which saved the client between $4,000 and $5,000.

- A Spanish-speaking HICAP client visited the local HICAP project because he had numerous Medicare claims which were denied payment. Medicare had denied the claims because he had a group insurance policy. A HICAP Counselor determined that Medicare was wrong since the client had been retired for several years and his retirement plan did not include health insurance. The client had completed 2-3 questionnaires from Medicare stating that he was not employed, but the information was not entered correctly in Medicare's computer. By the time he visited the HICAP project, there was a considerable amount of money owed to the client. The HICAP Counselor called Medicare, the client's files were reexamined, and delayed payments were sent to the physicians. Medicare discovered an incorrect code was entered which indicated that another insurance claim was involved. Because of the language barrier, the Counselor wrote a letter for the client, which the client signed, outlining the problems. The letter also confirmed the previous telephone conversations and the proposed outcome by Medicare. Consequently, the client was extremely grateful that the Counselor had been able to accomplish in just two phone calls what he had been trying to achieve for many months.

E. CONCLUSION

The HICAP met its performance objectives for Fiscal Year 1988-89. The Program exceeded last year's overall performance. Reflecting the performance of all 24 projects, a comparison of the FY 1987-88 performance data with FY 1988-89 shows a 147 percent increase in the number of community education clients contacted, a 71 percent increase in the number of counseling client contacts, and a 34 percent increase in the number of legal client contacts.

The HICAP projects reported $4,689,231 in savings to 5,134 clients during FY 1988-89 for an average savings of $913.37 per person.[5] This savings represents a 176 percent return in terms of cost savings compared to the expense of the Program. Within the total, $1,291,960 was reported saved for the State's Medi-Cal program. Although client savings were significant, the real benefits are derived from cost avoidance by preventing or postponing the need for people to rely on the State's Medi-Cal program.

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5 This average includes savings identified based on the actual dollars returned to the client because of refunds, reductions, or deletions of already billed amounts and payment by a third party, or the monetary equivalent saved by preventing or postponing what would otherwise be an out-of-pocket expense, and dollars saved for any State agency, such as Medi-Cal, because Medicare paid for expenses that would otherwise have been paid for by the State. In the latter case, the State receives the benefits, not the client.

The Health Insurance Counseling and Advocacy Program is a volunteer supported program that provides assistance with Medicare and health insurance. The HICAP is one among only a few programs in the nation committed solely to offering this unbiased assistance in Medicare and health insurance issues to the elderly population. The Program provides a needed service to California's older population, and the Department looks forward to continuing this progress in subsequent years.

APPENDIX A

HICAP SERVICE JURISDICTIONS
(24)

APPENDIX B

ADMINISTRATIVE CONTACTS LISTING

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM
(Revised February 1990)

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Eddy Laine, Director Kathy Gibbs KERN COUNTY OFFICE ON AGING 2717 O Street (Mail Address: 1415 Truxtun Ave.) Bakersfield, CA 93301-5215	Kern	(805) 861-2218

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ADMINISTRATIVE CONTACTS LISTING

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM
(Revised February 1990)

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ADMINISTRATIVE CONTACTS LISTING

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(Revised February 1990)

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ADMINISTRATIVE CONTACTS LISTING

HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM
(Revised February 1990)

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APPENDIX B

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(Revised February 1990)

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APPENDIX B

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Prepared Statement of Earl R. Pomeroy

I. INTRODUCTION

Mr. Chairman and members of the Committee, I am Earl R. Pomeroy and I am the President of the National Association of Insurance Commissioners (NAIC) and Commissioner of Insurance in the State of North Dakota. The NAIC thanks you for this opportunity to discuss the important topic of Medicare supplement insurance and the bills that have been introduced by Members of this Committee.

The NAIC is a nonprofit organization whose members are the insurance officials of each state, the District of Columbia, Guam, American Samoa, Puerto Rico and the Virgin Islands.

The NAIC shares the concerns voiced by Members of this Committee and others about the problems associated with the Medicare supplement insurance marketplace, which include failure to meet minimum loss ratios, duplication of coverage, confused policyholders, and abusive marketing and sales practices.

To address these concerns, the NAIC added enhanced consumer protection provisions to its Medicare Supplement Insurance Minimum Standards Model Act and Regulation ("NAIC minimum standards") in September 1988 and again in December 1989. In addition, an NAIC task force currently is considering further enhancements, such as benefit standardization and increased loss ratio requirements. We welcome your interest in these important issues and pledge to work with you and other interested members of Congress as we move forward with our work.

II. NAIC MODEL MINIMUM STANDARDS

In 1980, Congress passed the Baucus amendment to the Social Security Act, which set forth a voluntary certification for Medicare supplement state regulatory programs. The Baucus amendment established the NAIC Model Act and Regulation as the minimum standards for certifying these state programs. If a state fails to enact the minimum standards, insurers can submit their policies directly to the Secretary of the Department of Health and Human Services ("HHS") for certification.

The NAIC has been called upon twice in the past three years to amend these minimum standards: once when the Catastrophic Coverage Act was enacted and again when it was repealed. In each instance, the NAIC went beyond making the necessary changes to the minimum benefit standards and promulgated amendments to strengthen regulatory standards relating to loss ratios, premium and benefit disclosure, and sales and marketing practices.

In December 1987, the NAIC added significant requirements to its Model Regulation regarding monitoring of loss ratios, filing requirements for out-of-state groups and filing requirements for Medicare supplement advertisements.

The 1989 Revisions

In December 1989, the NAIC added a number of important "Consumer Protection Amendments" to the NAIC minimum standards. They are discussed in the order in which they appear in the Model Regulation.

1. Require Guaranteed Renewability

The amendments require all individual policies and certificates to guarantee renewability of coverage. Thus, individual policies must be guaranteed renewable, although a commissioner may authorize a cancellation or nonrenewal.

The amendments require group policies to guarantee continuation or conversion of coverage. If a group policy is terminated and the policy is not replaced, the insurer must offer the certificate holders an individual policy. The individual has the choice of continuing the same benefits in the old policy or the minimum benefit standards policy recommended by the NAIC. If *membership* in a group is terminated, the amendments require the insurer to offer conversion or continuation.

2. Limit Agent Commission Structure

The amendments provide a three-prong approach to agent commissions. First, a limit on the differential between the first and second year commissions is imposed. Commissions or other compensation in the first year may be no more than 200 percent of the commissions or other compensation paid in the second year.

Second, the commission paid in the subsequent (renewal) years must be the same as that provided in the second year. The subsequent years' commissions must continue for a reasonable number of renewal years also. This means that an insurer may not load all of the commission into the first and second years.

Third, agents may not receive first year commissions on a replacement policy, unless the replacement policy contains benefits which are clearly and substantially

greater than the benefits under the replaced policy. Insurers must establish a method of determining which replacement sales qualify for the first year commissions.

3. Require Additional Information and a New Arrangement for the Outline of Coverage

The amendments require the benefits in the Outline of Coverage to be arranged in two major categories: the minimum benefit standards and the "add-ons." The total premium for the policy must be placed in a certain location on the Outline. The new arrangement is designed to help consumers compare the cost and coverages available to them.

4. Require Additional Responsibilities of Agents and Companies During Application Process

The amendments create new responsibilities for agents and companies. Questions concerning an applicant's existing coverage are required, as well as questions about the applicant's coverage by Medicare. These questions are intended to furnish information about whether the sale of a Medicare supplement policy is appropriate, given the individual's circumstances.

In addition to the questions mentioned above, agents must list all health policies sold to the applicant in the last five years, indicating those still in force. Agents also must now sign the Notice of Replacement which is to be delivered to the applicant informing the applicant that a replacement sale is involved.

5. Require Companies to Establish Standards for Marketing and Audit Procedures

The amendments require companies to establish standards for marketing and to establish auditable procedures for verifying compliance. In addition, twisting, high pressure tactics, and deceptive cold lead advertising are specifically prohibited.

6. Prohibit Sale of More than One Policy Except Under Certain Circumstances; Determine Appropriateness of Recommended Purchase

The amendments require agents to make reasonable efforts to determine the appropriateness of a recommended purchase or replacement. They also prohibits the sale of more than one Medicare supplement policy, unless, when combined with the individual's health coverage already in place, the additional policy insures no more than 100 percent of the individual's actual medical expenses covered under the combined policies. In virtually all instances, selling a duplicative Medicare supplement insurance policy is prohibited.

7. Require Reporting of Multiple Policies

The amendments require companies to provide a list of all individuals who have in force more than one Medicare supplement policy. This list must be provided to the State Insurance Department and must show the policy and certificate number and date of issuance, grouped by individual policyholder.

8. Prohibit Preexisting Condition Exclusions in Replacement Policies

The amendments prohibit any replacement policy, including replacements made by another company, from containing any new preexisting conditions, waiting periods, elimination periods and probationary periods.

III. LEGISLATIVE PROPOSALS

The NAIC would like to congratulate the sponsors of the Medicare supplement legislative proposals before you. These proposals address such important and sometimes contentious issues as simplification of policies, standards for loss ratios and agent commissions, duplication of coverage, and counseling programs for older consumers. We would like to offer comments on several of the issues raised in the proposals:

Certification

NAIC believes that the Baucus voluntary certification program has been largely effective and should remain in effect. After the changes in the Baucus program required by passage of the Medicare Catastrophic Coverage Act of 1988, 49 states met the certification requirements within the deadline established in the Act. Further, the states, through the NAIC, have added significant consumer protections and enforcement provisions to the Medicare supplement standards, including increased reporting of actual loss ratio experience to state regulators. The NAIC feels confident

that loss ratio and other consumer protection standards can be effectively monitored by state insurance departments within the existing Baucus framework.

Several of the proposals before you would modify the Baucus structure to increase Federal involvement and oversight. For example, one of the bills would require Federal certification of policies if state programs do not meet applicable standards (Federal certification of policies is voluntary under Baucus). Another proposal would impose Federal rulemaking and oversight of state insurance department activities. States would be required to report annually to the Secretary of HHS on loss ratio compliance and other matters deemed relevant by the Secretary.

The NAIC has serious concerns about proposals to increase the Federal role in regulation of this market, especially proposals which would create Federal agency oversight and state reporting requirements regarding state regulatory activities and enforcement efforts. State insurance officials, whether elected or appointed by elected officials, are responsible to the citizens of their state. Oversight by a Federal agency diminishes this role and dilutes local accountability. The goal of the Baucus amendments was to encourage states to adopt uniform minimum standards through participation in a voluntary certification program. This goal has been met: virtually every state has enacted standards which meet or exceed the Baucus minimum standards. We are concerned, however, that enactment of more intrusive Federal agency oversight may have just the opposite effect of discouraging state interest and participation in the Baucus certification program.

We understand the Federal interest in establishing strong and uniform standards for Medicare supplement insurance. Unlike other insurance products, Medicare supplement insurance is closely interconnected with the federally provided health benefits of the Medicare program. However, we believe that any Federal role should be limited to certifying that minimum standards are in place. Ultimately, state officials must do the hard work of developing and enforcing regulatory standards to ensure that consumers are adequately protected. State insurance departments can bring far greater resources to this job—in terms of numbers of staff, expertise, and local presence—than any Federal agency. Most important, state officials are far closer and more responsive than Federal agencies to individual consumers. We believe that the Baucus framework should continue to rely on state law and state accountability to ensure adequate enforcement. Efforts by individual states and the NAIC in the last several years demonstrate their commitment to strong consumer protection and represent a significant improvement in regulation of this marketplace.

Standardization

The NAIC supports efforts to provide simpler and clearer choices to consumers in this confusing market. This Spring, the NAIC formed a working group of state regulators to develop a model approach to standardization of benefits, policy language and format for Medicare supplement policies. The working group currently is considering several standardization options, including the approaches already implemented in the states of Massachusetts, Minnesota and Wisconsin. An advisory committee, composed of consumer and industry representatives, is furnishing assistance to the working group to develop methods to survey consumer preferences regarding the various approaches to achieve standardization and the appropriate policy benefits to be included. We are pleased that several of the proposals before you would rely on the NAIC to design a model approach for standardization of Medicare supplement policies.

There is language in some of the proposals before you, however, which may unduly limit the NAIC's flexibility in designing a standardization approach. For example, two bills would limit the total number of benefit combinations to ten. Such a provision would essentially prohibit approaches (such as those adopted in Wisconsin or Minnesota) which call for offering a core benefit package plus optional additional benefits. We believe that this result was not intended, and we have been working with your staff to fashion language which addresses this problem.

Consumer Counseling

The NAIC supports the concept contained in several of the proposals before you of establishing a voluntary grant program for insurance counseling programs for older consumers. A number of states, including California, Idaho, Illinois, Kansas, Maryland, Mississippi, Montana, Massachusetts, Michigan, New Jersey, North Carolina, Oregon, Tennessee, Texas, Washington, and Wisconsin have implemented formal seniors counseling programs. Many other states conduct consumer counseling and education activities on a more informal basis. We believe that the availability of funds through a grant program would encourage more states to develop counseling programs and education activities.

The NAIC would like to offer its assistance in serving as a clearinghouse of information and training services for such a program. The NAIC already provides training and support services for state insurance departments in a wide range of areas. In addition, the NAIC has developed a number of consumer publications for use by states, including the *Health Insurance Shoppers Guide, the Health Insurance Shoppers Guide for Senior Citizens, the Guide to Health Insurance for People With Medicare, and the Shoppers Guide for Long-Term Care Insurance.* A shoppers guide for insurance products related to continuing care retirement communities is currently being developed. We would ask that legislation enacting a grant program for insurance counseling for seniors permit the grant agency to contract with the NAIC as clearinghouse for information, training and related services.

Other Consumer Protection Issues

The NAIC supports efforts to clarify and tighten the Baucus standards against duplication of coverage. In 1989 the NAIC amended it model standards to prohibit selling duplicative Medicare supplement coverage in virtually all instances, to require agents to make reasonable efforts to determine the appropriateness of a recommended purchase, to require questions about existing coverage (including Medicaid) on applications for Medicare supplement insurance, and to require insurers to establish auditable standards to demonstrate compliance with these and other consumer protection standards. We believe that the changes proposed in S. 2640 and S. 2641 on nonduplication are consistent with NAIC changes and we support their adoption.

In terms of loss ratios for Medicare supplement insurance and limited benefit plans, the NAIC is still in the process of considering whether changes to existing NAIC model standards are appropriate. This week in Kansas City, an NAIC Task Force directed NAIC staff to undertake a study of existing limited benefit plans, including specific disease and hospital indemnity contracts. We anticipate a preliminary report will be completed by the end of the year.

Finally, the NAIC cannot support requirements for prior approval and public hearings for increases in rates. These are significant intrusions into the mechanics of the state regulatory process that may entail shifting limited department resources from other important tasks. We are not aware of any evidence that demonstrates that prior approval produces either lower rates or increased loss ratio compliance. The NAIC believes that the manner of enforcing loss ratio and other standards should be left to the states.

IV. CONCLUSION

As President of the NAIC, I am proud of the consumer protection amendments and other improvements we have made in our model standards for Medicare supplement insurance. The NAIC is committed to continuing to work with the states to improve enforcement of these standards. The increased loss ratio reporting requirements recently adopted already are improving state compliance efforts. Other efforts to improve state enforcement efforts, including a loss ratio technical manual, are underway.

The NAIC would again like to thank you for inviting us to testify on these important issues. We look forward to working with you and members of your staff as you continue deliberation of the proposals before you.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good afternoon. Chairman Rockefeller, I would like to commend you for holding this very important hearing and for your commitment to solving the problems in the Medigap market. We have been plagued with fraud and abuse in this industry since the inception of Medicare, and I am pleased we are focusing much needed attention on this issue. I look forward to hearing the testimony of all of our witnesses today, and would like to extend a special welcome to Wayne Lindley and Terri Kennedy of California's Health Insurance Counseling and Advocacy Program.

I am pleased to join my colleagues today in urging legislation that will make important improvements to the Medigap market. In particular, I would like to take this opportunity to applaud the ongoing efforts and commitment of Senators Baucus, Daschle, Durenberger, Heinz, Riegle, and Rockefeller. All have played leadership roles on this issue and I am glad to be working with them on this greatly needed reform.

The legislation being discussed today represents a bipartisan, cooperative effort to craft a reasonable, effective approach to remedying the ills of the Medigap market. S. 2189, the Health Insurance Counseling and Assistance Act, S. 2640, the Medigap

Fraud and Abuse Prevention Act and S. 2641, the Medigap Simplification Act of 1990 address crucial areas for reform: simplification, counseling programs, duplication, loss ratios, agent commission structures, and premium increases. I strongly support each of these bills. By focusing on the key issues for reform, these bills will bring effective, comprehensive reform to this market.

We are all deeply concerned about the understandable confusion many older persons have about their health insurance needs and coverage, as well as their vulnerability to high pressure, and sometimes unscrupulous, sales practices. At a March 1990 Aging Committee hearing, we heard about how some of the most vulnerable of our society—the elderly—are victimized by insurance marketing abuses.

During the hearing, Charlene Blackburn, an 80 year old resident of Santa Cruz, California, told us she was sold over 13 Medigap policies in the course of less than four years. We also received testimony from an incarcerated insurance agent in Florida who, due to extraordinarily high commission structures, made more than $245,000 in one year.

At this same hearing, we also heard about the use of slick, misleading come-ons that are used to scare or trick vulnerable consumers into buying something of questionable value that they don't need and can't afford. The use of these misleading come-ons has no bounds. For example, we have seen the establishment of questionable senior citizens' organizations whose main purpose is to develop mailing lists to target insurance leads.

Just this week, Mrs. Lillian Chapman, a 77 year old resident of Little Rock sent to me a mailing she and her husband received from the so-called "Association of Retired Americans"—you may have heard me speak of this organization before. Evidently, this organization is directly related to an insurance company that sells Medigap, even though nothing on the mailing states such a relationship.

Mrs. Chapman told my staff that she thought this mailing was from the government, and called to ask if this form is something she needed to fill out. Heralding the "Congressional Repeal of Medicare Catastrophic Act," the bulletin offers a "Free Medicare Supplement Comparison." It says: "Purpose: if you are Medicare-age, you probably have been affected by the cancellation of this law. There is a good chance you will need to revise your present benefit plan - and that you may qualify for substantial savings by doing so."

It is mailings like this that make very clear the need for Medigap reform, in particular for counseling programs and for simplification of policies. A counseling and assistance program would provide people like Mrs. Chapman with the opportunity to seek objective advice about the adequacy of their current coverage. Counseling programs, coupled with simplification and the other elements of the proposed Medigap market reform, can protect our seniors from being vulnerable to these deceptive practices.

Also, as Chairman of the Aging Committee, I am hearing from many constituents about similar problems with private long term care insurance policies. I can assure you that I, along with my colleagues on the Finance Committee, will be looking into the problems in that market as well.

In spite of over a decade of state and Federal regulatory efforts, we continue to face severe problems surrounding the affordability and marketing of Medigap insurance policies. I am pleased to join you, Chairman Rockefeller, in this important effort to address the many critical issues related to the Medigap supplemental insurance market. I believe that the testimony from our witnesses today will help us to craft creative and responsive approaches to these problems.

PREPARED STATEMENT OF GAIL SHEARER

Mr. Chairman and members of the subcommittee, Consumers Union [1] appreciates the opportunity to testify before you on the issue of private health insurance to sup-

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[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide information, education and counsel about consumer goods and services and the management of family income. Consumers Union's income is derived solely from the sale of Consumer Reports, its other publications and films. Expenses of occasional public service efforts may be met, in part, by nonrestrictive, noncommercial contributions, grants and fees. In addition to reports on consumers Union's own product testing, Consumer Reports, with approximately 4 million paid circulation, regularly carries articles on health, product safety, marketplace economics, and legislative, judicial, and regulatory actions which affect consumer welfare. consumers Union's publications carry no advertising and receive no commercial support.

plement Medicare ("Medigap" insurance). We commend the leadership that the members of this subcommittee bring to this issue. The legislative proposals introduced by subcommittee members address many of the problems faced by consumers who are confused and concerned about their medigap coverage.

In my written statement, I plan to evaluate legislation sponsored by Senators Kohl, Pryor, Riegle, Daschle, and Chafee. Before commenting on each bill, I will describe the key elements that Consumers Union believes should be in a medigap reform bill. Consumers Unions believes that Senator Daschle's proposal (which has been cosponsored by many members of this Subcommittee), incorporates the best provisions and assembles a comprehensive reform package that should serve as the basis for your deliberations. The essential elements are:

SIMPLIFICATION OF THE MARKET. Simplification of the market (through policy standardization) should be the centerpiece of regulatory reform. Simplification could be achieved through one of two frameworks: a standard core benefit plus optional rider approach or a prepackaged standard benefit package approach, with policy benefits ranging from "low" to "high" in the alternative packages.

We recognize that simplification necessarily involves some limitation on consumer choice. Consumers Union believes that senior citizens want a **meaningful** choice in this marketplace, instead of the baffling array of choices that exists today. It does not make sense to force senior citizens to study the merits of hundreds of alternative policy types. The variation that exists in the marketplace today seems to benefit insurance companies, who use the variation as a marketing tool, but not senior citizens.

The Department of Insurance of the State of Illinois recently conducted a survey of its volunteer counselors in its Senior Health Insurance Program (SHIP). 90 percent of the respondents (200 counselors) favored standardization of the medigap market. The Department's summary of results described some comments of those who favor standardization: "First and foremost, they want simplification. They believe that Medicare supplement insurance in its current state is complicated and confusing for most seniors."

COUNSELING PROGRAMS. In light of the confusion in this marketplace, the history of marketing abuses, and the fear senior citizens have about health care costs, senior citizens need a source of objective advice about health insurance. In May, Consumers Union released the results of a survey of health insurance counseling programs that have been established in 12 states to provide such objective advice. The survey found that with relatively low budgets, these programs are extremely successful at reaching and educating thousands of senior citizens. congress should encourage all the states to establish their own counseling programs, by establishing a grant program and an information clearinghouse.

DUPLICATION. The 1980 Baucus Amendments allowed the sale of more than one medigap policy, as long as the policies do not coordinate benefits. This definition of "duplication" led to the redesign of medigap policies; the market evolved from one in which benefits were coordinated to one in which benefits were not coordinated, to comply with the letter, if not the spirit, of the law. Congress should close this loophole and impose penalties for the sale of all duplicative medigap policies.

LOSS RATIOS. The General Accounting Office continues to find that many medigap policies fail to meet the 60 percent loss ratio requirement for individual policies and 75 percent loss ratio requirement for group policies. Congress should require that companies provide refunds to policyholders in the event the policy fails to meet the loss ratio standard, and should establish compliance with loss ratio standards as a condition of approval for rate increases.

In addition to improving enforcement of loss ratio standards, congress should increase loss ratios. Since 1980, when the Baucus Amendment was enacted, health care inflation has consistently been higher than the overall consumer price index. It makes sense for the loss ratio standard to increase from 60 percent to 70 percent, since it is the overall consumer price index, not the health inflation index, that is relevant for marketing costs, administrative costs and profits. It is appropriate, therefore, for these costs to be required to represent a smaller percentage of the health insurance premium dollar.

SALES COMMISSIONS. Agents typically earn a hefty commission for first-year premiums, and much less for policy renewals. Front-loaded commission structures have been the driving force behind the common practice of agents "twisting" a consumer from one medigap policy to another. congress should curb this practice by limiting first-year commissions to no more than 150% of the second year commission, or even by requiring a level premium structure.

In sum, the essential features of comprehensive medigap reform are: simplifying the market through standardization of benefits, encouraging state counseling pro-

grams, prohibiting the sale of duplicative medigap policies, improving enforcement of loss ratio standards, increasing loss ratios, and discouraging twisting by leveling sales commissions. The next part of my testimony will evaluate the key bills that have been introduced in the Senate with regard to these features.

S. 2050, MEDIGAP FRAUD AND ABUSE PREVENTION ACT OF 1990—(SENATOR KOHL)

While S. 2050 contains some desirable features increasing loss ratio standards on individual medigap policies, requiring states have a process for approving or disapproving medigap premium increases, and a GAO study on state enforcement of medigap standards), some of its provisions do not go far enough to improve the performance of this market. For example, while it would change language in the present law regarding duplication from prohibiting the sale of duplicative policies from "policy substantially duplicates" to "policy duplicates," it fails to close the loophole in the Section 1882 language that allows duplicative coverage if the policies do not coordinate benefits.

S. 2050 would establish a grant program for the establishment of toll-free telephone hotlines to provide individuals with information about medigap insurance. Each state receiving a grant would be required to develop a Medicare supplement insurance brochure. While toll-free hotlines have the potential to provide useful information to consumers, Consumers Union prefers the approach of S. 2189, which would help states establish programs that would provide one-on-one (in person) counseling. (See below.)

S. 2189, HEALTH INSURANCE COUNSELING, AND ASSISTANCE ACT OF 1990—(SENATOR PRYOR ET AL.)

S. 2189 would establish a grant program to provide health insurance information, counseling, and assistance to Medicare-eligible individuals and establish a national resource center for health insurance information. Consumers Union strongly supports S. 2189 since we believe that counseling programs have the potential to dramatically improve the performance of the medigap market. The impressive track record of existing counseling programs lends strong support for this view. As you know, we believe that counseling alone is not enough, and we are very pleased that the counseling proposal of S. 2189 has been incorporated into S. 2640, the Medigap Fraud and Abuse Prevention Act of 1990. (See below.)

S. 2641, MEDIGAP SIMPLIFICATION ACT OF 1990—(SENATOR RIEGLE ET AL.)

The key feature of S. 2641 is the requirement that the National Association of Insurance Commissioners (or the Secretary of HHS) simplify the medigap insurance benefits structure. The legislation would require either a core benefit package with separately priced optional riders or a limited number of separate benefit packages. Consumers Union strongly supports this provision, since we believe that simplification of this market should be the centerpiece for medigap reform.

In anticipation of the enactment of Congressional legislation, the National Association of Insurance Commissioners (NAIC) has established a working group to develop a model simplification regulation. We are participating actively in the NAIC's deliberations on how to best simplify the market. Getting down to the details is proving to be a challenging and controversial task. S. 2641 appropriately instructs the NAIC (or the Secretary) to balance the objectives of (1) simplifying the market to facilitate comparisons among policies, (2) avoiding adverse selection, (3) providing consumer choice, and (4) promoting market stability. While many companies would like to retain the flexibility to "bundle" riders however they want,[2] we believe that such flexibility severely compromises the simplicity goal and would preclude "apples-to-apples" comparisons, a principle we believe to be central to true simplification of this market. We do not believe that simplification will have occurred if there continue to be hundreds of different medigap policies on the market. In your

[2] For example, Blue Cross/Blue Shield has circulated a proposal that would standardize policy language and format, require a separately priced core package, and allow insurers to bundle the optional riders in any way that they want. While this improves on the present system, it does not go far enough. It would allow standard price comparisons for less than half of the typical policy's premium. Since few companies would bundle the identical benefit packages, it would continue to be virtually impossible to compare the cost of comparable benefits that are beyond the core package. Most companies argue that few consumers want to buy the core minimum. Therefore, most consumers would be left with a complicated marketplace and the inability to make apples-to-apples comparisons for the full range of policy benefits.

deliberations on this provision, we believe it is imperative that you preserve the principle of the need for apples-to-apples comparisons.

Other provisions of S. 2641 include waivers for innovative benefits, requiring NAIC educational efforts, a GAO study on the effectiveness of the simplification program, a prohibition on the sale of policies that duplicate Medicaid benefits, a study (by the Administrator of the Health Care Financing Administration) of the use of medigap policies by individuals entitled to Medicaid, and a toll-free consumer hot-line grant program to provide information on medigap policies, Medicaid, and Medicare. We support S. 2641 and are pleased that key provisions in it have been incorporated into S. 2640. Like counseling, simplification alone does not solve the problems in this market, but it is a powerful tool that should be a central part of the comprehensive reform bill.

S. 2640, MEDIGAP FRAUD AND ABUSE PREVENTION ACT OF 1990—(SENATOR DASCHLE ET AL.)

S. 2640 is a comprehensive bill that dramatically changes the way Medicare supplement insurance would be regulated. Key provisions of the bill are:

—Benefit simplification: the bill requires the National Association of Insurance commissioners (NAIC) or the Department of Health and Human Services (DHHS) to simplify the medigap market through uniform language and format and through the development of either a core group of basic benefits plus separately priced optional riders or through standard benefit packages;
—State approval for all policies sold in the state;
—Consumer education: the bill requires the Secretary of HHS to establish a program of grants to States to assist in establishing counseling programs to help senior citizens compare medigap policies.
—Prohibition of the sale of duplicative policies and the sale of a policy to Medicaid recipients;
—Loss ratios: The bill would require premium refunds to consumers in the event that the loss ratio failed to comply with the standard. In addition, the bill would increase loss ratio standards to 80 percent for group policies and 70 percent for individual policies.
—Flattening of agent commissions, limiting first-year commissions to no more than 150 percent of subsequent year commissions.[3]

Other valuable provisions in the bill include: requiring the provision of information sheets clearly disclosing premiums for optional benefits and loss ratios; requiring that policies be guaranteed renewable; allowing states to permit the issuance of policies with innovative benefits (including cost control measures); requiring hospital indemnity and dread disease policies to meet loss ratio standards of 80 percent for group policies and 70 percent for individual policies;[4] requiring statements about loss ratios to be submitted by certified actuaries; requiring public notice and public hearings in the event of significant price increases; requiring regular audits of compliance with loss ratio standards by the GAO; and prohibiting imposition of pre-existing condition clauses on replacement policies.

Consumers Union strongly supports S. 2640. It would dramatically change the private health insurance market to the benefit of senior citizens. It would lead to a less complicated market, improved value for premium dollars, increased price competition, reduced waste on the purchase of excessive policies, and curbed agent abuses. In addition, it would provide senior citizens with a source of objective advice about their health insurance needs. S. 2640 provides all of these benefits with a minimal price tag.

S. 3020 MEDIGAP AMENDMENTS OF 1990—(SENATOR CHAFEE)

S. 3020, the Medigap Amendments of 1990, introduced on September 11, takes an entirely different approach than does S. 2640. While it has several individual provisions that are a step in the right direction, the absence of provisions to simplify the market, to establish one-on-one counseling programs, to restrict the sale of duplicative policies, to level commission structure, and to increase loss ratios make S. 3020

[3] We support level commissions (as done in Minnesota and Washington), but accept the 150 percent proposal as a significant improvement on the present commission structure.

[4] We would prefer that hospital indemnity and dread disease policies be banned outright, but support the proposed loss ratio standard as a reasonable compromise that would dramatically increase the value for premium dollars spent on this type of coverage.

less desirable than S. 2640 as the basis for consideration of true medigap reform legislation. I will briefly review the key features of the proposal:

Monitoring of State Medigap Programs: This section would require each state seeking approval from the Department of Health and Human Services to file annual reports on its program, including information on loss ratios. This increases the opportunity that DHHS has to review the performance of the (few) states that may participate in the Federal certification process.

Assistance for State Medigap Programs: This provision would allow the Secretary of DHHS to make technical assistance available to the states, and would authorize $20,000,000 for grants to the states to strengthen enforcement efforts. It is not clear what medigap expertise HCFA has to share at this point with the states, in light of the minimal role that HCFA has played to date in this market. It is certainly possible, however, that in playing in increased role in monitoring the medigap market, HCFA would develop expertise that could be helpful to the states. Consumers Union supports increased state enforcement efforts. It is not clear to us, however, that it is appropriate for the Federal Government (and Federal taxes) to fund state enforcement efforts. Alternative uses for any available funds, such as establishing counseling programs, may have a higher priority.

Education: S. 3020 would require DHHS (in consultation with the NAIC) to prepare annual reports for each State comparing Medicare supplemental policies with respect to benefits, loss ratios, consumer satisfaction, and other matters "as may be useful to potential purchasers." It is not clear who the intended audience for these reports would be. If it is the state insurance commissioner, then it is not clear why information should be flowing from the Federal Government to state insurance departments. If the intended audience is individual consumers, then the focus should probably be a cost comparison guide, which is most effective only when the market has been simplified through policy simplification.

The bill would establish a Medicare and Medigap information telephone. While a national hotline may be helpful for providing very basic information on Medicare, it would be less helpful in providing accurate information on medigap policies that are available in various states. More localized telephone hotlines, as well as one-on-one consumer counseling, are likely to be more effective means of educating consumers about this complicated market.

Federal Certification and Loss Ratio Adjustments. The bill would collect a fee of $20,000 for certification and a fee (of no more than $10,000) for renewal. In order to renew the certification, the insurer would be required to provide rebates or premium reductions to offset any previous failure to meet loss ratio standards.

This fee would probably have the effect of encouraging companies to work to make state regulation comply with requirements so that companies can avoid the Federal certification and fee. We strongly support the linking of recertification to premium rebates. In the event that insurers go the route of Federal certification, this provision would help to enforce the loss ratio standards.

Required Disclaimer for Unapproved Policies. This provision would allow companies to market policies in states without an approved regulatory program and without Federal certification. It would require disclosure of this fact. Consumers Union strongly opposes this provision. We believe that two regulatory options are more than adequate: either the state enacts the approved model regulation, or the policy gets certified by HCFA. In light of the long history of abuses in this marketplace, a "caveat emptor" approach is inappropriate. You can count on the need for many future Congressional hearings with a long line of elderly victims of agent abuses if this provision is adopted.

Revision of the NAIC Model standards and minimum benefits requirements. This section requires the Secretary of DHHS to determine (91 days after the bill's enactment) whether the NAIC has revised its model act and regulation with regard to: format and uniform definition of terms (for policies and related documents) the calculation, reporting, and review of loss ratios; including an alternative low-cost minimum benefit policy; and additional regulations of loss ratios for specified disease and hospital indemnity policies. In the absence of NAIC action, the Secretary would promulgate Federal model standards for each requirement not addressed by the NAIC.

While uniform definition of terms is an essential ingredient of true simplification of this market, it does not assure that consumers will be able to compare medigap policies effectively.

We support NAIC and DHHS review of procedures for calculating, reporting and reviewing loss ratios. While the NAIC has recently taken steps in this direction, it is appropriate for legislation to explicitly require this review.

Including an alternative minimum benefit policy can be a positive step. We support requiring insurers to offer the equivalent of a "Baucus minimum" policy,[5] excluding first dollar Part A and Part B deductibles, for example. It is not clear how bare-bones a policy is envisioned in the proposed bill, and we are concerned by the language indicating the minimum benefit policy should be "significantly less expensive than the standard minimum benefit policy." We believe that going below a "Baucus minimum," *e.g.,* to a $400 Part B deductible, may be inappropriate. If consumers can afford to be exposed to $1000 (combined Part A and Part B deductible in a truly catastrophic policy) in first-dollar out-of-pocket costs, they can probably afford and prefer to buy a more comprehensive (Baucus minimum) policy that would cost about $35 to $45 per month. If people can not afford to be exposed to $1000 in first-dollar out-of-pocket costs, they are probably not well served by a catastrophic medigap policy, even if they can save about $10 to $13 per month on premiums.[6]

We support improved loss ratio regulation for specified disease and dread disease policies. While our first choice is to ban these low-value policies outright, a second best alternative is to require that they meet loss ratios required of Medicare supplement insurance policies.

It is not clear how effective a Federal model regulation will be, in the event that the NAIC fails to act on any of these issues. The bill does not contain any action-forcing mechanism to ensure that states adopt the Federal model.

Medicare Select. The national goal of controlling health care costs makes it appropriate to allow for the use of innovative cost control techniques. We support the "Medicare select" concept, which would allow for the marketing of Medicare supplement policies that use preferred provider organizations. We are concerned, however, that consumers receive information that they need to make a truly informed choice about whether this type of policy meets their needs. This concept works best in a market that has been simplified through policy standardization. With simplification and consumer counseling, consumers will be in the best position to make an educated choice about this option.

In sum, S. 3020 has some strong points and some weak points. We support increasing DHHS review of loss ratios and state enforcement, uniform format and definition of terms, a minimum benefit policy (equivalent to the Baucus minimum standard), loss ratio requirements for dread disease and hospital indemnity policies, and allowing the marketing of medigap policies that use a preferred provider network to achieve cost savings. We oppose allowing the sale (with a disclaimer) of unapproved policies and the absence of an action-forcing mechanism to assure uniform tough regulation either at the state or Federal level. Other serious omissions from the bill are simplification of the market (through standardization that allows apples-to-apples comparisons), incentives for states to establish one-on-one counseling, closing the loophole that allows for the sale of duplicative policies, and leveling of agent commissions.

In conclusion, Consumers Union strongly supports S. 2189, the Health Insurance Counseling and Assistance Act of 1990, S. 2641, the Medigap Simplification Act of 1990, and S. 2640, the Medigap Fraud and Abuse Prevention Act of 1990. The keys to ending abuses in this market are simplification, one-on-one counseling, ending duplication, enforcing and increasing loss ratios, and leveling agent commissions. We look forward to working with you to assure that medigap reform is a reality this year. Thank you for providing Consumers Union with the opportunity to present our views.

PREPARED STATEMENT OF ERIC SHULMAN

Mr. Chairman, members of the Committee, my name is Eric Shulman. I am the Legislative Director for the National Council of Senior Citizens (NCSC). NCSC represents over five million older Americans nationwide through our 5,000 affiliated clubs. The National Council was founded in 1961 to advocate for Medicare, whose 25th birthday we celebrated earlier this year. After achieving the passage of Medicare, the Council turned to other advocacy issues, including National Health Care, Social Security issues, housing and employment programs for the low-income elder-

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[5] Included, for example, in the "basic" policy would be coverage for deductibles for extended hospital stays and the 20 percent Part B coinsurance. Coverage for the first-day hospital deductible and $75 Part B deductible would not be included.

[6] Estimates for the cost of a basic policy range from $400 (Minnesota) to $560 (NAIC) HCFA estimates that premiums would decrease by 28% if the minimum benefit policy included a substantial Part B deductible.

ly. NCSC also works closely with other organizations to ensure that the policy needs of other age groups are not ignored.

I appreciate the opportunity to testify before you today. I am particularly pleased to be here because the National Council of Senior Citizens feels that the current debate taking place in Congress is somewhat misdirected. While other Congressional hearings and witnesses have focused mainly on consumer protections, such as preventing the sale of duplicative policies and eliminating the unscrupulous behavior of some insurance agents, most seniors are more concerned with how much their policy costs; how much their rates have gone up in the last two years; and what, if anything, Congress can do about it.

AFFORDABILITY

Approximately 20 million seniors spend over $15 billion a year on private insurance policies designed to cover the gaps created by inadequate Medicare coverage. These older Americans, many of whom subsist on fixed incomes, are afraid that an illness will send them into destitution and are, therefore, prey to insurance companies and agents who feel they can charge consumers whatever they can get away with.

At the National Council's recently held 20th Constitutional Convention in Chicago, our membership expressed their concern regarding the high cost of supplemental insurance. The one thing we were told over and over again is that all the reforms in the world will not matter if the insurance is not affordable.

At this Convention our members unanimously adopted a resolution calling for reforms that address their concerns about pricing.[1]

Medigap prices continue to rise. The United States General Accounting Office (GAO) reports that of twenty insurers who responded to their queries about price increases, one said they would not raise rates this year, while the others will increase their premiums from five percent to over 51 percent. According to a House Aging Committee report dated November 2, 1989, increases in Medigap premiums ranged from 10 percent in Massachusetts to 133 percent in Arizona. Amazingly, this was before the repeal of the Catastrophic Health Insurance Act, which was supposed to limit premium increases.

To demonstrate how Medigap price increases affect the average senior, I would like to read to you a letter written by one of our members—Mr. C. H. Capp of Mechanicsburg, Pennsylvania. We have edited the letter to remove the name of the insurance company, but let me assure you, it is not one of the smaller ones.

> "I . . . have an insurance policy which is at present $47.90 per month to pay. I just received a notice from the [insurance company] stating July 1 my insurance premium will be $62.00 per month, a difference of $14.10 per month which most people of our fixed income cannot afford to pay.
>
> "We have trouble meeting our budget and although this policy covers my spouse. it is out of reason. It is nearly $5.00 per month more than the COLA we received last January 1.
>
> "My wife had a stroke and lost sight in her right eye 100 percent and the left one is about 60 percent. I had a broken right knee joint for 26 years and had it replaced in September 1986, and the surgeon said your left knee exray [sic] shows it to be worn out too. In January 1987, I had it replaced and the joint came out in cinder form.. Now we spend over $100.00 per month for prescriptions and have taxes to pay on our home of about $600.00 and have to pay the prices on everything we purchase. Our surgeon sent my bill to Medicare and they cut his price way down and paid 80 percent of what they figured was enough, which left me with 20 percent of that amount and the difference between the actual cost and what they thought fair."

Mr. Chairman, this is just one of the many letters we have received on this subject. I am sure that your office has also gotten many letters of this nature. There is one thing I would like to add, however. In addition to Mr. Capp's having to spend $62.00 a month of his Medigap policy, he also has to spend $28.60 a month for himself and another $28.60 for his wife in order to maintain Part B coverage. Mr. Capp's total *monthly* insurance premiums are $118.20.

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[1] See Appendix A.

LOSS RATIOS

Loss ratios are set too low and, under current law, are voluntary targets. Again, according to the GAO, the private insurance industry is failing to meet even these very minimal standards of 60 percent. Excluding the Prudential Insurance Company, other commercial policies had an average loss ratio of 59 percent. This means that insurance companies are only returning an average of 59 cents to beneficiaries for every dollar they take in. And, yet, some people would argue that loss ratios should stay the same.

The National Council, and the senior community, feels very strongly that loss ratios need to be increased and made mandatory. Access to supplemental insurance will not be harmed and the overall value of the policies would be increased, making them a better buy. While some Medigap insurers get away with returning less than 60 cents for every dollar they take in, reputable firms currently have loss ratios which exceed the targets in all proposed legislation before the Senate. Also, the loss ratios for health insurance for those under age 65 averages out to be approximately 80 percent. The loss ratio for Medicare is 97 to 98 percent. A case of the government being *much* more efficient than private industry.

OTHER PROBLEMS

Current Medigap laws are inadequate and poorly enforced. As mentioned above, loss ratios are set too low. Premium increases consistently out pace the rate of medical inflation, even when Congress expands Medicare benefits. Agents use whatever means necessary to sell new policies. Seniors, afraid of facing their future penniless, often buy more than one policy.

Consumers are also confused. Due to the legal mumbo-jumbo policies are written in, most seniors do not really know what they are covered for. This leads them into purchasing duplicative policies with duplicative coverage. These seniors are simply throwing their money away because there is no point in paying for the same coverage twice.

An even greater abuse occurs when agents are selling policies to Medicaid beneficiaries. Over three million poor seniors receive benefits through the Medicaid program. Since Medicaid covers out-of-pocket costs for seniors living below the poverty line, there is no need for these people to spend their few meager dollars on Medigap insurance.

There are also problems with how insurance agents sell their policies. All too frequently, abuses of the system are left unpunished and are actually, from the agent's point of view, financially rewarded. Larger commissions are offered for first year policies, so agents are encouraged to find new purchasers or to find someone who can be pressured into getting rid of their old policy and buying a new one. Even when someone is convicted of such a crime, the fines and punishments are surprisingly low.

These problems are exacerbated by the fact that the law allows for little or no consumer participation when it comes to establishing premium rates. Texas, along with other states, requires public hearings when automobile companies wish to increase rates. We allow consumer representation when it comes to pricing utilities, why not for Medigap insurance?

ACCOUNTABILITY

Only 16 states require that the State Insurance Commissioner formally approve a premium increase for group policies before they take effect. Only 32 states require prior approval for individual policies. This says nothing about involving the public. Many rate increases, even if approved beforehand, take place without consumer representation. While a public hearing does not guarantee lower rates, it does provide an opportunity for advocates to turn up the heat on insurers and to make insurance commissioners more accountable. A case in point is Rhode Island.

Last year, Rhode Island Group Health Association received an $18 a month increase with no public hearing; Blue Cross/Blue Shield received only a six percent increase (after asking for 22 percent) with a public hearing. This does not mean that Blue Cross is suffering in Rhode Island. It does mean that they could not justify an increase larger than six percent to the State Insurance Commissioner with consumers looking on.

The National Council of Senior Citizens feels very strongly that a Federal prior-approval requirement be a part of the final package enacted by Congress.

LEGISLATIVE SOLUTIONS

There are currently half a dozen legislative proposals before the United States Senate which try to correct some of the problems associated with the supplemental insurance industry.

Senator Kohl has introduced S. 2050, the Medigap Fraud and Abuse Prevention Act of 1990. Senator Kohl's bill increases the civil penalties for violating Section 1882 of the Social Security Act; tightens up the duplication prohibition; increases loss ratios and requires the states to provide stricter enforcement; requires states to establish a process for approving all rate increases; and, funds Medigap toll-free hotlines to provide assistance to those who purchase this insurance.

There is a large loophole in current law which states that an agent cannot knowingly sell a duplicative policy. If an agent does not ask if a consumer has a Medigap policy, then he has not violated the law. This bill will eliminate it. NCSC supports other provisions of the bill, as well. Our only concern is the Senator's approach regarding rate increases. Mr. Kohl does require that states approve all rate increases. However, he does not require public involvement. Without it, NCSC cannot endorse this bill.

S. 2189, the Health Insurance Counseling and Assistance Act of 1990, has been introduced by Senators Pryor, Heinz, Baucus, Daschle, Kohl, Glenn, Cohen, Riegle, Rockefeller, Burdick, Graham, Wilson, Bradley, Kassenbaum, Danforth and Durenberger. This bill provides Federal funding so the states can establish counseling programs for supplemental insurance purchasers. Counseling is important in giving consumers access to information which may be otherwise unavailable. We urge this Committee to include it in any measure passed.

The Medicare Supplemental Policy Consumer Warning Act, S. 2293, was introduced by Senator Wilson. This bill requires a warning label to be placed on all policies stating that Medigap policies contain coverage gaps and that advice should be sought for information about such policies. Warning labels are well and good, but as we have seen with other such labels, consumers tend to ignore them, and sellers try to put them in hard-to-see places.

Senators Riegle, Pryor, Daschle and Rockefeller introduced S. 2641, the Medigap Simplification Act of 1990. This bill requires that the National Association of Insurance Commissioners (NAIC) set standards that all policies must adhere to. NCSC applauds this approach. By eliminating confusing language and by developing a core benefits package, consumers will be able to tell exactly what they are buying and how much it is going to cost them. This solution makes it easy for insurers and consumers alike to sell and compare policies, while still providing room for innovation in developing new packages in response to changing consumer demand. Our only objection to S. 2641 is that it does not go far enough. Only a comprehensive approach will add more value to current policies and prevent uncalled for price increases.

Senator Chafee introduced S. 2931, the Medicare Managed Care Act of 1990. This bill would permit Medigap insurers to use managed care approaches to meet the NAIC model standards. While NCSC approves of managed care procedures to keep costs down, the Medicare experiments with managed care demonstrates that seniors are not yet ready to accept managed care on a large scale.

S. 2640

Senators Daschle, Heinz, Riegle, Pryor, Durenberger and Rockefeller introduced S. 2640, also called the Medigap Fraud and Abuse Prevention Act of 1990. Mr. Chairman, the National Council has endorsed this bill and urges you and your colleagues to mark it up as quickly as possible.

The Daschle bill addresses both of our major concerns regarding a public hearing process and increased loss ratios. While NCSC feels that a public hearing should be held on all rate increases, we understand the need for some type of triggering device so that state insurance commissions are not overwhelmed. We support the provisions requiring higher loss ratios and feel that the approach of requiring rebates for policies that do not meet minimum loss ratios to be innovative and necessary. We also believe that only through a public hearing process will consumers again feel as if they have some control over a process which all too often seems to roll right over them.

NCSC also supports the other provisions in S. 2640. The three million poor seniors on Medicaid should not be sold policies. We applaud the efforts Congress is making to eliminate the lucrative market from agents who are looking to make a fast buck.

Finally, NCSC supports the provisions that toughen penalties for agents who use deceptive tactics to sell policies and insurance companies who sell substandard policies.

The National Council firmly believes that only a comprehensive approach, such as that provided by S. 2640, will alleviate some of the pressures on the Medigap system. NCSC wholeheartedly supports this bill and urges its adoption.[2]

NATIONAL HEALTH CARE

Unfortunately, Mr. Chairman, even with all of these protections, NCSC realizes that it will not be possible to put a total halt on large premium increases. While a public hearing will make the insurance companies more accountable, the State-Insurance Commissioner more responsive, and give access to millions of consumers who had none before, it will not put a halt to medical inflation and to the physicians' tendency to over-value procedures. Until Congress finally enacts a comprehensive national health care system utilizing strict cost-containment measures, including movement towards a single-payer system, medical inflation will continue to grow unabated and all insurance premiums will rise with it.

Again, thank you for your consideration. I will be happy to answer any questions you may have.

APPENDIX A

MEDIGAP

WHEREAS over 20 million seniors purchase private health insurance policies; and

WHEREAS older Americans spend $16 billion a year on Medigap policies; and

WHEREAS, in 1989, premium increases averaged between 40 and 60 percent; and

WHEREAS Medigap premiums for comprehensive policies can run as high as $1,200 per year; and

WHEREAS insurance companies only have to return 60 cents for every dollar they take in as premiums; and

WHEREAS the General Accounting Office finds that 55 percent of Medigap policies fail to meet even this minimum standard; and

WHEREAS only 16 states require insurance companies to receive the prior approval of their insurance commission before raising rates; and

WHEREAS between 17 and 34 percent of Medigap consumers hold duplicative policies; and

WHEREAS first-year commissions to agents can be as high as five times renewal commissions; and

WHEREAS state governments, which regulate the insurance industry, have no control over policies which originate in other states.

THEREFORE BE IT RESOLVED, That the membership of the National Council of Senior Citizens commits itself to support H.R. 4840 and S. 2640, introduced by Congressman Ron Wyden (D-Ore.) and Senator Tom Daschle (D-S.D.)—the only legislation before the Congress which grants a public-hearing process allowing consumers access to the system and make the insurance companies and state insurance commissioners more accountable to the public; and

BE IT FURTHER RESOLVED, That NCSC supports the increased, mandatory loss ratios included in these bills so that insurance companies have to return more money in benefits than they do under current law; and

BE IT FURTHER RESOLVED, That the National Council supports the other provisions of H.R. 4840 and S. 2640 to eliminate the sales of duplicative policies, to standardize the marketplace eliminating confusion over what a policy will and will not do, to prevent the sales of Medigap policies to Medicaid recipients, to guarantee the renewability of Medigap policies, to increase the penalties for agents who use scare tactics to sell policies, and to authorize consumer counseling projects throughout the states.

APPENDIX B

NATIONAL COUNCIL OF SENIOR CITIZENS,
Washington, DC, May 16, 1990.

Hon. THOMAS A. DASCHLE,

[2] See Appendix B.

U.S. Senate,
317 Hart Senate Office Building,
Washington, DC.

Dear Senator Daschle: Thank you very much for introducing the Medigap Fraud and Abuse Prevention Act. The National Council of Senior Citizens, representing over five million older Americans, applauds your efforts on behalf of seniors across the country.

Approximately 20 million seniors spend over $15 billion a year on private insurance policies designed to cover the gaps created by inadequate Medicare coverage. These older Americans, who subsist on fixed incomes, are afraid that an illness will send them into destitution and are therefore prey to insurance companies who feel they can charge consumers whatever they can get away with.

The current Medigap laws are inadequately and badly enforced. Loss ratios (the rate the insurance company has to return to beneficiaries compared with premium dollars brought in) are absurdly low. With most health insurance policies maintaining loss ratios of about 80 percent, Medigap insurers are supposed to reach a target of only 60 percent. According to the U.S. Government Accounting Office (GAO), less than 50 percent are able to do even that.

Another problem with current Medigap law is that there is no method for consumer participation. Only sixteen states require their insurance commission to hold a public hearing. While a hearing process does not guarantee lower rates, it does provide an opportunity for advocates to turn up the heat on insurers. A case in point is Rhode Island. Last year, Rhode Island Group Health Association received an $18 a month increase with no public hearing; Blue Cross/Blue Shield received only a six percent increase (after asking for 22 percent) with a public hearing.

Your bill addresses both of these problems. It requires states to approve all rate increases before they take effect, allowing a public hearing for any company which raises its premiums more than twice the medical economic index. The bill also raises loss ratios, while providing greater sanctions for those who fail to meet the minimum standards. While the National Council feels that a public hearing should be held on all rate increases, we understand the need for some type of triggering device so that State Insurance Commissions are not required to hold hearings on every rate increase. We are especially pleased by the requirement that companies that do not meet the minimum loss ratios would have to return the excess to the consumer in the form of rebates.

NCSC is also pleased to support your efforts to simplify Medigap policies, provide guaranteed renewability, prevent sales to those who are Medicaid-eligible, preclude the sales of duplicative policies, strengthen sanctions on agents who use hard-sell tactics, and provide consumer counseling. These are all important steps to help prevent seniors from paying more for their policies than they should be.

However, even with all these protections, this will not put a total halt to large premium increases. Until a comprehensive national health care system is put into place utilizing strict cost-containment measures, medical inflation will continue to grow unabated. And insurance premiums of all types will rise with it.

Again, thank you for introducing such an important and comprehensive package. We are proud and happy to support your efforts and we are looking forward to working with you to ensure that seniors will no longer have to face outrageous premium increases.

Sincerely,

LAWRENCE T. SMEDLEY, *Executive Director.*

PREPARED STATEMENT OF GAIL R. WILENSKY

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss Medicare supplemental insurance, or Medigap, and the Department's principles for reform, should congress decide to advance further legislation in this area.

I share your concern that the elderly and those who purchase Medicare supplemental insurance should be able to secure the best value for their money. We believe that the best way to protect consumers is to give them more and better information and ensure a broad range of choice. And, we believe that States should retain the responsibility for Medigap regulation.

I would also like to point out that while it is important for beneficiaries to be able to have protection against high out-of-pocket costs, Medigap insurance can have the effect of nullifying the coinsurance and deductible structure that congress built into the Medicare program. Studies have shown that coinsurance and deductibles provide incentives for individuals to be prudent in their use of health care.

In the non-elderly population, the RAND health insurance experiment indicated that coinsurance and deductible payments reduce costs with no discernible impact on the health outcomes measured in the study. A 1987 study by the congressional Budget Office estimated the impact of cost-sharing on utilization among the Medicare population. In particular, the CBO study found that, after adjusting for differences in health status and other relevant factors, Medicare enrollees having Medigap coverage use 24 percent more inpatient hospital and physician services than enrollees having no supplementary coverage. CBO did not draw any conclusions about health outcomes as a result of differences in utilization. Importantly, this corresponds to an increase in Medicare outlays of approximately $17 billion a year for the 71 percent of seniors with conventional Medigap.

Thus, in considering any legislation to reform Medicare supplemental insurance it is important to remember the critical role that such insurance plays in the Medicare program.

BACKGROUND

Designed to supplement Medicare coverage, Medigap insurance is sold to Medicare beneficiaries by private insurance companies. In 1980, in response to fraud and abuse found in the sale and marketing of Medigap policies, Congress enacted the Baucus Amendments. The Baucus legislation established minimum Federal standards for Medigap policies by adopting model standards developed by the National Association of Insurance commissioners (NAIC).

States choosing to participate in this program submit their regulations or statute to the Supplemental Health Insurance Panel for review. The Panel, made up of the Secretary and four State insurance commissioners, determines if the State's Medigap program meets the NAIC model standards. States are then responsible for ensuring that the Medigap policies marketed within their borders satisfy these criteria for minimum benefits and consumer protection. Any State that chooses not to participate in the Baucus program is free to implement its own Medigap regulation.

In States that do not obtain Panel approval, Congress provided the option for insurers to submit their Medigap policies directly to the Secretary for certification that it meets minimum standards. In the past, this option has been used infrequently, as most States have received Panel approval, and no policy has ever been certified under this provision.

The current Medigap program operates on a fully voluntary basis. There is no requirement that States submit their Medigap regulatory program for review, and there is no requirement for plans in non-Panel approved States to come to the Secretary for certification. Furthermore, neither the Panel nor HCFA monitors State Medigap programs once they are approved.

In general, as Congress has mandated changes to the NAIC model standards, States wanting to continue to approve Medigap policies under the Baucus framework have been required to incorporate the revisions into their Medigap program. States then have to submit their revised regulatory program for Panel approval.

CATASTROPHIC AND ITS REPEAL

Prior to the Medicare catastrophic coverage Act of 1988, all but four States were participating in the Baucus program. The catastrophic legislation significantly expanded Medicare benefits. Federal minimum standards, as defined by the NAIC and incorporated into the Medigap regulations, were subsequently revised to conform Medigap coverage to the expanded Medicare benefits. Following these revisions to the model standards, all but one of the State Medigap programs were approved by the Panel.

The repeal of catastrophic coverage once again required a change in Medigap standards to supplement the reduction in Medicare benefits. The repeal legislation also incorporated new consumer protection provisions into the Baucus structure, adding standards for agent commissions and marketing procedures. States have until December 13, 1990 to adopt these newest revisions to the Medigap standards and submit them for Panel approval.

On September 12, the Panel met to consider 15 State regulatory programs submitted for approval. To date, the Panel has granted full approval to eight States and conditional approval, meaning the proposed regulations were in compliance but not

in effect, to eight States. The Panel will continue to consider any further programs submitted prior to the December deadline.

CURRENT LEGISLATIVE PROPOSALS

Although many States are taking positive action to comply with the latest requirements, others appear to be taking a "wait and see" approach. They realize that Congress is currently considering a number of legislative proposals which would once again require amendments to their Medigap program.

There are more than a dozen bills pending in Congress to amend the Medigap program. These proposals represent a wide variety of initiatives. Some proposals would make minimal changes to the existing law, while others represent sweeping reforms in regulatory practice. Should any new legislation be enacted this year, it would be the third consecutive year that the statute has been amended. These revisions in Medigap regulations over the past two years have been disruptive to the Medigap industry, confusing to beneficiaries, and burdensome to States, which have had to continually update their regulations to keep up with the legislative changes.

While I applaud your concern for protecting Medicare beneficiaries in this area, I urge you to consider the effect any changes would have both on the Medigap industry and on the effectiveness of State regulation of Medigap policies.

If Congress chooses to enact legislation this year, that legislation should be comprehensive enough to address Medigap concerns for the foreseeable future. States may then be able to concentrate more fully on enforcing their Medigap consumer protection standards rather than implementing annual changes. The response States may give to continuing mandatory changes may be to drop out of the voluntary program. We need to reverse this incentive and encourage continued State participation in the voluntary Medigap program.

MEDICARE SELECT

I feel strongly that our Medicare SELECT proposal should be included in any Medigap reform legislation. Medicare SELECT gives older Americans access to another option in health care, one that has been available to consumers in the private sector for several years, the preferred provider organization. Medicare SELECT would allow these managed care networks to link with supplemental insurance to provide "wrap around" Medicare coverage. Because it is an important step to providing beneficiaries with the full range of health care options available in mainstream medicine, this proposal should be passed even if Congress decides not to enact more fundamental changes in Medigap.

The current Medigap law is not flexible enough to allow marketing of a managed care Medigap plan. Giving the statute this flexibility would benefit Medicare beneficiaries as well as the Medicare program.

BASIC PRINCIPLES FOR REFORM

As Congress considers options for Medigap legislation, there are three important principles that we believe should be incorporated into any reform. These tenets uphold the basic premises upon which the Baucus standards were established. Let me briefly outline our principles.

1. Maintain State Responsibility—We believe States should continue to bear the responsibility for regulation of Medigap. The regulation of health insurance has traditionally been the role of State rather than Federal government. The McCarran Ferguson Act of 1945 firmly established that Federal involvement in insurance regulation should be limited so long as States assumed this responsibility. We want to protect the traditional State role in insurance regulation.

I am concerned about proposals under consideration that could lead to direct Federal involvement in insurance regulation. Under one proposal, in States that do not voluntarily participate in the Baucus program, insurers would be required to submit their Medigap policies for certification by the Federal government. We are troubled that this would be a significant step toward the Federal government taking over Medigap regulation. It would be unfortunate if McCarran Ferguson were undermined inadvertently through Medigap reform. Beyond these concerns, Federal involvement could impose substantial administrative burdens and costs during a time of fiscal constraint.

A better approach would be to develop incentives to promote State participation in the Baucus structure. This would allow us to work directly with the States, instead of with individual insurers, to protect Medigap consumers.

For instance, incentives could be constructed so that insurers would be more likely to urge State participation in Medigap regulation. Insurers in non-participat-

ing States that do not obtain certification by the Secretary might then be required to print a statement on their policies indicating that the policy was not certified as meeting minimum requirements.

2. Ensure Choice—We think that as consumers of Medigap insurance, Medicare beneficiaries should be able to choose from a range of policies that best fits their needs. Some bills pending before your committee would limit the number and types of policies available to consumers. With adequate and appropriate information, Medicare beneficiaries should be able to make an informed decision regarding their Medigap insurance.

Policy standardization would unnecessarily hurt consumers by limiting their choice of insurance protection. creating a rigid insurance market by restricting the type and number of Medigap policies that may be offered would deprive beneficiaries of the ability they currently have to select a benefit package that fits their individual needs.

Standardization of benefits would also inhibit innovative approaches to Medigap insurance and the addition of new services to existing benefit packages. The ability to adapt to the changing needs of the health care environment is a necessity of any regulatory program. Medigap requirements should be flexible enough to respond to ongoing changes and innovation in the insurance industry.

There are other, more reasonable means for ensuring that beneficiaries are able to make informed decisions about the Medigap policies they purchase. This could be achieved by:

- Establishing set definitions of terminology used to describe Medigap benefits in order to reduce consumer confusion.
- Requiring every Medigap insurer to offer a policy limited to just the minimum benefit package, in addition to any other policies they currently offer.
- Requiring policies that offer more benefits than the minimum package to detail how much of the cost of a policy is due to the minimum benefit package, and how much is due to the additional benefits.

Though we would prefer no standardization, if the NAIC is asked to develop a model for standardized benefits, we believe it should be on a voluntary basis. No Federal law should require standardization.

3. Permit a Minimum Benefit Package—We believe that Medigap insurance should be widely available to Medicare beneficiaries. Medicare supplemental insurance protects beneficiaries from burdensome health care costs through a package of benefits designed to fill gaps in the Medicare program. However, some beneficiaries are unable to find basic Medigap insurance and cannot afford the enriched insurance coverage now available.

Any revision in Medigap regulation should provide seniors with the option of buying catastrophic-only coverage. At present, such coverage is precluded. We believe that seniors should have this choice. Moreover, in view of the fact that first-dollar Medigap increases utilization and costs, this change is particularly important for the Medicare program.

CONCLUSION

Each of these three principles is consistent with a basic philosophy I bring to HCFA—that beneficiaries should have a broad range of choice in receiving their health care and that they should have the information necessary to make informed decisions. Medicare beneficiaries should not be precluded from having the same options available to other consumers of health care. We must keep Medicare moving on the same track as mainstream medicine and health insurance, not away from it. Our Medicare SELECT proposal helps to accomplish this goal.

The Administration shares your commitment to the individuals served by the Medicare program. As Medigap legislative proposals are debated, I urge you to consider our concerns and priorities.

I would be pleased to answer any questions you may have.

COMMUNICATIONS

STATEMENT OF THE NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Chairman Rockefeller, the National Committee to Preserve Social Security and Medicare strongly supports Medigap reform. We urge you to pass legislation this year to tighten loss ratios, to require strict review of rate increases before they go into effect, to prevent duplicative coverage and discourage unnecessary switching of policies, to standardize and simplify policy language and to provide insurance counseling for beneficiaries.

Members of the National Committee have made their position clear. Almost 200,000 postcards have been sent to Congress from members urging support of the Daschle-Wyden Medigap Fraud and Abuse Prevention Act to clamp down on the Medigap abuses. This overwhelming response to our July Legislative Alert confirms that many seniors are impatient with unchecked premium increases and questionable sales practices leading to costly and unnecessary coverage.

We are also pleased to stand with the Pepper Commission in calling for new Federal standards for Medigap policies. The Baucus Amendment, passed ten long years ago, was only a beginning step in that it asked for voluntary compliance and left oversight responsibilities to states. It is time to revisit and to strengthen the Baucus Amendment. The important efforts by the National Association of Insurance Commissioners to encourage states to comply with basic standards cannot alone solve the abuses in the Medigap market.

Loss Ratios. This year's dramatic premium increases in many states, brought to light the unevenness with which state insurance commissioners scrutinize insurance companies' request for higher premiums. Consumers have no way of knowing whether premium increases are justified. It is time to set Federal standards on procedures for strict review of requests for premium increases, standards on how loss ratios should be calculated and how much they should be. No state should allow insurance rates to go up without prior approval. According to the Select Committee on Aging survey, two-thirds of the surveyed states do not require changes in rates for group Medigap insurance to be approved before going into effect. Over a third of the states do not require group policies to file their rates and rate changes with the state. And several states, including Alabama and the District of Columbia, do not require that rate changes—whether individual or group—be filed at all. Even in states that require a review before rate increases go into effect, the process varies widely. Some states conduct paper reviews, while a few have public hearings. A stop must be put to unchecked premium increases by requiring state-level reviews by independent actuaries. No increase should be accepted unless insurance companies assure seniors an average of at least 70 cents in benefits for every dollar paid in premiums.

Duplication. Duplication of coverages occurs for many reasons, but frequently it is based on concern of not having sufficient coverage in case of serious illness. We cannot legislate away these concern, but we can pass legislation which reduces the possibility of duplication. For example, by standardizing terms and limiting policy options, seniors would be less confused about coverage. In addition to terms that mean one thing in one policy and something else in another policy, there are at least three areas which often leave seniors confused.

First and foremost is the coverage of nursing home stays. This area continues to be of great concern because policies may call for skilled nursing home coverage and often it is not made clear what exactly "skilled care" means. Nor may it be pointed out that it is a very limited benefit tied directly to Medicare coverage. The second area of confusion is related to non-assigned charges. Seniors turning 65 and not yet familiar with Medicare and the concept of assignment and non-assignment may be

quite surprised to realize that most Medigap policies do not cover balance billing by providers. Third, seniors do not always realize that Medigap rarely covers services *not* approved by Medicare. If Medicare denies a claim for any reason, the beneficiary is out of luck because Medigap will not cover the service either. It is easy to think of Medigap as an addition to Medicare, but faulty, because Medigap usually does not cover what Medicare does not approve. Rather, Medigap should be thought of as a policy that "wraps around" Medicare-covered services. Not being aware of these facts can lead seniors to buy multiple policies in pursuit of full protection.

Case Example. Perhaps one of the most onerous situations occurs when seniors are left without coverage because they cancelled their old policy not realizing the new policy had a waiting period for preexisting conditions. One 82-year old National Committee member from St. Louis, Missouri, signed a check for $2,200 on January 23, 1990, during a visit by an insurance agent, believing he was buying better insurance than his current Blue Cross Blue Shield coverage. Not being told that there would be a waiting period, he proceeded to cancel his Blue Cross policy. Only after filing numerous claims with the new company did he discover that in effect he was without insurance coverage. He proceeded to call the insurance broker who told him that the agent who had sold him the policy was not longer with the company, but a new broker would come to the house and straighten out the problem. The new broker proceeded to sell Mr. W. yet another policy for which Mr. W. wrote out a check in the amount of $1,300. His daughters stepped in and are now trying to hold the agent to his promise of a 30-day "free look" period. They have reapplied to Blue Cross—which, not unexpectedly, now requires a new waiting period. Mr. W. remains uncovered.

Counseling. Mr. Chairman, this is not an isolated case. It illustrates the clear need for Medigap reform legislation—legislation which includes a strong counseling program. Seniors must have places to turn to get sound advice. We are particularly pleased that the Medigap Fraud and Abuse Prevention Act includes Federal grants matched with state dollars to establish insurance counseling for seniors. Until we develop more streamlined Medicare and Medigap insurance systems, we have a responsibility to fund insurance counseling programs to assist seniors through the mad of these systems. Some states have excellent programs that can be used as models. Hopefully, this provision will encourage states to build on the services they already have or create new services. The availability of counseling will allow seniors to sit down one-on-one and get clear answers to perplexing questions.

Consumer organizations have an important responsibility to educate their members about these programs. In an effort to help our members find their way through the Medigap maze, we have developed an easy-to-use Medigap policy comparison chart which we provide our members free of charge. But more one-on-one education is needed than what senior organizations can accomplish.

The National Committee urges the committee to support Medigap legislation and pledges to do its part to see that Congress acts on this far-reaching legislation during this legislative session. It is essential so that we may speed up the time when seniors can feel assured they are getting the insurance coverage they need—no more and no less.

STATEMENT OF SENIOR HEALTH INSURANCE PROGRAM, STATE OF ILLINOIS, DEPARTMENT OF INSURANCE

My name is Bernadette Nolan, Program Director, SHIP (Senior Health Insurance Program) of the Illinois Department of Insurance. The Department established SHIP in the fall of 1988. Two staff of the Illinois Department of Insurance train volunteers in the areas of health insurance coverage and benefits which affect senior citizens, particularly Medicare, Medicare supplement and long term care insurance. This training is comprehensive and usually takes three days. The volunteers then receive continuing education to keep them informed of the changes in the health insurance areas that affect the elderly population.

SHIP operates in conjunction with community based organizations that are involved in senior citizens services.

At this time SHIP has trained 645 volunteers and services 69 of the 102 Illinois counties. During the first six months of 1990 SHIP volunteers have counseled over 2,000 seniors, one on one, in their own communities and have contributed 4,000 hours of volunteer time.

Thank you for the opportunity to submit this testimony for the September 14 Hearing on Medigap insurance.

More than thirty million persons in the United States are eligible for Medicare. The complexities of Medicare, particularly in light of the changes that continually occur in the program, make health insurance confusing for many people. Many senior citizens feel the need for qualified unbiased assistance in making decisions about the kind of benefits and amount of insurance coverage they should have.

How much insurance do I need?
What does and doesn't Medicare cover?
What should I look for in a policy for Long Term Care?
Should I ever have more than one Medicare Supplement policy?

These are the types of questions that volunteer counselors are trained to answer and provide to the senior population.

Senior citizens in the United States purchase billions of dollars more health insurance than they need, primarily out of ignorance and fear of being a burden on their families. Health insurance counseling programs can be (and are) important aids in combating the problems seniors face in preparing for their health insurance needs.

There are currently twelve states that provide health insurance counseling services and most of these programs are able to operate on a relatively small budget. They are by and large volunteer programs with professional staff to ensure quality training and service.

These counseling programs are very effective and have saved senior citizens millions of dollars annually.

We believe that state counseling programs, by using volunteer support, are a cost effective means of providing additional consumer protection to our elderly population.

We would like to state our strong support for prompt action on Federal legislation to promote, establish and expand state health insurance counseling programs.

Several Bills have been introduced on this issue which incorporate worthwhile consumer and assistance provisions. We believe that the elderly population would benefit most from the broadly focused counseling effort covering Medicare, Medicare supplement, long term care insurance, Medicaid and other health insurance coverage as provided in S. 2189.

Attachment.

[State of Illinois, Department of Insurance]

SENIOR HEALTH INSURANCE PROGRAM (SHIP)

Senior citizens often have questions about health insurance programs but all too frequently have nowhere to go for answers. Now they will, thanks to a new program sponsored by the Illinois Department of Insurance. The Department's "Senior Health Insurance Program," or "SHIP," will recruit, train and organize senior volunteers to serve as teachers, advocates and insurance resource persons for other Illinois seniors. These volunteers will be given 25 hours of training in the basics of insurance, including a survey of the medical insurance field, with a focus on Medicare, Medicare supplement policies, long term care insurance and consumer protection.

After completion of training, the "SHIP" volunteers will become advisors to other senior citizens in their communities. They will be ready to answer basic health insurance questions and refer people to the proper government or social agencies to find solutions to their insurance problems.

These advisors will be organized geographically into "units." The Department will provide personnel to train these volunteers on an on-going basis and will keep in close touch with the units. In addition to monthly training classes, each unit will be provided with counseling material, instruction booklets and handouts to supplement classroom instruction.,

Under the continuing guidance of the Department, trained advisors will work in conjunction with local senior citizen groups. Local senior organizations will provide office facilities and will help coordinate local activities and refer inquiries from the public to "SHIP" volunteers.

FOR FURTHER INFORMATION

If you would like to learn more about the Senior Health Insurance Program, call or write to us at this address:

Senior Health Insurance Program
Illinois Department of Insurance
State of Illinois Center

100 West Randolph
Suite 15-100
Chicago, Illinois 60601
(312) 917-2427

[State of Illinois, Department of Insurance]

SHIP

TEN COMMANDMENTS

1. Never make a person's decision for them.

In particular, don't tell a person to buy or not to buy supplemental health insurance, or join or not to join any particular HMO. Our purpose is to give the person as much information as possible so that he or she can make an informed decision. Respect the individual; give the person the knowledge and power to make their own decisions.

Many of your clients may ask you, "Well, what would you do?" Answer this question by exploring the various options available to your client. Review the pros and cons of each option and resist the temptation to say, "If I were you, I would

2. Treat the client like a friend you want to help.

One purpose of peer counseling is to remove communication barriers that can arise in a professional client relationship. Strive to treat all clients with courtesy, respect, and empathy. Not only is such an attitude helpful and appropriate, but it will also improve communication.

3. Make sure you understand the question the person is asking before you provide an answer.

In particular, make sure the person is asking about Medicare, supplemental health insurance or HMO's. It will not always be immediately apparent. Listen carefully for clues; people don't usually articulate their problem the way a textbook would. And make sure you answer the question being asked. This is an area in which a Counselor will get better with practice.

4. Learn as much as you can about Medicare and Medigap insurance coverage as well as HMO's . . . and keep on learning.

Your initial and follow-up training with SHIP, as well as the meetings and conversations with SHIP (Department of Insurance) staff, will convey a great deal of information to you. The more you know, the better you will be able to serve people.

5. When in doubt, check it out!

If you are not certain about the accuracy of information you want to give, check it out first. You are not expected to know everything. You have SHIP staff and written materials to use as resources. However, telling or implying that something is fact, when it may not be so, can be very dangerous. If you do not know the answer to a question, be sure to tell your client that you will look into it and that you will call them later with the answer.

6. Don't tell someone that their problem will be resolved by a court or another agency or by the Illinois Department of Insurance.

Never tell anyone that their claim will be resolved to their satisfaction, since this is not always possible.

7. Be alert to time limits.

If a client indicates that they are in any way unhappy with a Medicare decision and are interested in challenging it, be sure to alert them to the time limits that are noted on their Explanation of Medicare Benefits (EOMB) statement. Failing to be attentive to these limits could result in a person's loss of appeal rights.

8. Before a client leaves you, make sure both of you know what, if any, further contact will be necessary.

Confirm whether the person is to bring something to you or call you with information. Confirm what, if anything, you've agreed to do for the person. Unless the client has to call or return with further information, your contact will usually be completed at the time of your counseling session.

9. No job is finished until the paperwork is done.

Complete the counseling report at the time of the counseling session and other paperwork in a timely manner. The information you are required to take is impor-

tant for the assessment of the individual's problem, and also in analyzing the problems of the senior population as a whole. In addition, the records confirm your understanding of what a client was told.

10. All client information is confidential.

Everything a client tells you is in confidence. As an Advisor, you are expected to respect this confidentiality. Never discuss or share information regarding a client's case with friends or relatives. Client cases may only be discussed with SHIP, Illinois Department of Insurance staff.

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