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FOR FURTHER INFORMATION CONTACT: Julie Walton, (410) 966–4622.

SUPPLEMENTARY INFORMATION:

I. Background

The Medicare program covers approximately 38 million beneficiaries who are age 65 or over, are disabled, or have permanent kidney failure. The program consists of two separate but complementary insurance programs, a hospital insurance program (Part A) and a supplementary medical insurance program (Part B). Although Part A is called hospital insurance, covered benefits also include medical services furnished in skilled nursing facilities or by home health agencies and hospices.

Part B covers a wide range of medical services and supplies such as those furnished by physicians or others in connection with physicians' services, outpatient hospital services, outpatient physical and occupational therapy services, and home health services. Part B also covers other items including certain drugs and biologicals that cannot be self-administered, diagnostic x-ray and laboratory tests, purchase or rental of durable medical equipment, ambulance services, prosthetic devices, and certain medical supplies.

While the Medicare program provides extensive hospital insurance benefits and supplementary medical insurance, it was not designed to cover the total cost of providing medical care for its beneficiaries. In particular:

- Benefits under both Parts A and B are reduced by certain deductible and coinsurance amounts, for which the beneficiary is responsible.
- When beneficiaries receive covered services from physicians who do not accept assignment of their Medicare claims, the beneficiaries may also be required to pay amounts in excess of the Medicare approved amount (''excess charges''), up to a limit established under the Social Security Act (the Act).
- There are a number of items generally not covered under either of Medicare's two insurance programs, such as most outpatient prescription drugs, custodial nursing home care, dental care, and eyeglasses.

Beneficiaries are liable for all of the costs listed above and may choose to purchase additional private insurance to help pay these costs.

A. Supplements to Medicare

Because Medicare does not cover the total cost of providing medical care, approximately 75 percent of Medicare beneficiaries purchase, or have available through their own or a spouse's employment or former employment, some type of private health insurance coverage to help pay for medical expenses, services, and supplies that Medicare either does not cover or does not pay in full. This coverage includes Medicare supplemental (''Medigap'') insurance; employer group health plans based on active employment or retiree coverage; hospital indemnity insurance; nursing home or long-term care insurance; and specified disease insurance. (Throughout this notice, the terms ''Medicare supplemental policy'' and ''Medigap policy'' will be used interchangeably.)

An alternative to Medigap is enrollment in a managed care plan that has a risk or cost contract with HCFA under section 1876 of the Act or a Health Care Prepayment Plan (HCPP) agreement under section 1833 of the Act. Beneficiaries who enroll in these plans are generally covered for out-of-pocket costs associated with Medicare benefits and often receive additional benefits such as prescription drugs coverage and preventive health care services at little or no cost.

In addition to the approximately 75 percent of Medicare beneficiaries with private insurance coverage, nearly 12 percent of Medicare beneficiaries are eligible for at least some Medicaid benefits. For most of these beneficiaries, Medicaid covers their Medicare coinsurance and deductible liabilities and may also provide additional benefits that Medicare does not cover, such as long term care.

B. Federal and State Regulation of Insurance

After Medicare was enacted in 1965, a number of States enacted laws and regulations governing insurance sold to supplement Medicare. However, the scope and enforcement of these laws varied considerably. Although Federal law recognizes the States as the primary regulators of insurance, in 1980 the Congress addressed certain abuses associated with the sale of health insurance to elderly Medicare beneficiaries. On June 9, 1980, Congress enacted section 507(a) of the Social Security Disability Amendments of 1980 (Public Law 96–265) (the ''Baucus Amendment''), adding section 1882 to the Act.

In adding section 1882 to the Act, Congress recognized the progress already made by the National Association of Insurance Commissioners (NAIC) and some States in the area of Medigap regulation and chose not to alter the traditional role of the States in regulating insurance.

Created in 1871, the NAIC is the organization of the chief insurance regulatory officials from all 50 States, the District of Columbia and the four territories. It provides a forum for the development of uniform public policy where uniformity is deemed appropriate by its members. The NAIC's primary instruments of public policy are model laws, regulations, and guidelines. States are free to adopt the NAIC models in their entirety, modify them, or not adopt them at all. Federal statutory requirements, however, require all States to adopt at least the minimum standards reflected in the NAIC's ''Model Regulation to Implement the Requirements of the NAIC Medicare Supplement Minimum Standards Model Act''.

The Baucus Amendment established a voluntary program under which the Federal government would certify that Medigap policies met minimum standards established by section 1882 of the Act, although policies could still be sold even if they were not certified. It also provided that if State regulatory programs met or exceeded minimum standards, including standards established by the NAIC, Medigap policies issued in those States would be deemed to meet the Federal certification requirements, and separate Federal certification would not be available in those States. However, after hearing reports of continuing abuses in the marketplace, as part of extensive Medigap reforms contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508) enacted on November 5, 1990, the Congress made the certification program mandatory for both States and issuers. The Congress continued to base the Federal standards on the NAIC model regulation for Medicare supplement policies and continued to leave enforcement to the States. The model regulation was amended on July 30, 1991, to reflect the requirements of the new statutory