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**MEDIGAP INSURANCE:
Proposals for Regulatory
Changes And 1988 Loss Ratio Data**

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Before the
Subcommittee on Commerce, Consumer
Protection, and Competitiveness
and the Subcommittee on Health and
the Environment
Committee on Energy and Commerce
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SUMMARY

Medicare supplemental (Medigap) insurance is private insurance designed to cover Medicare's deductibles and coinsurance. This insurance has been available almost from the beginning of Medicare.

In response to marketing abuses, the Congress added section 1882 to the Social Security Act in 1980. This section, commonly referred to as the Baucus amendment, established federal minimum benefit standards for Medigap insurance and established federal criteria for state insurance regulatory programs. The Baucus amendment retains the traditional role of the states as primary regulators of insurance if the states adopt requirements at least as stringent as those contained in a model adopted by the National Association of Insurance Commissioners (NAIC).

Congress is concerned that the consumers of Medigap insurance are protected. Reports of abuses in the marketing of Medigap insurance have continued.

H. R. 4840 would expand consumer protections for the elderly who purchase Medigap insurance. These include reducing the combinations of benefits that insurers may offer, raising the loss ratio standards, and encouraging states to implement counseling programs to aid consumers in making choices on what coverage to buy. H. R. 4840 also contains provisions suspending policy premiums and benefits during times that a policyholder is also eligible for Medicaid, strengthening the prohibition on selling policies that duplicate coverage that the purchaser already has, requiring state approval of rates, and guaranteeing renewability and conversion privileges for policyholders.

GAO believes that the enactment of the protections contained in H. R. 4840 would go a long way toward improving consumer protections for purchasers of Medigap insurance and will also improve the economic value of this insurance.

The 1988 loss ratios of 34 percent of the commercial companies with over $250,000 in earned premiums from individual policies in force for 3 years or more were below the minimum standard of 60 percent. For Blue Cross/Blue Shield plan individual policies, about 98 percent met or exceeded the minimum standard. For group plans, about 66 percent of commercial companies and 24 percent of Blue Cross and/or Blue Shield plans had loss ratios that were below the minimum standard of 75 percent. H. R. 4840 would raise the minimum loss ratio requirement from 60 percent and 75 percent for individual and group policies to 70 percent and 80 percent, respectively.

Mr. Chairmen and Members of the Subcommittee:

We are pleased to be here today to discuss your concerns with the marketing and performance of Medicare supplemental (Medigap) insurance, concerns that are addressed in H. R. 4840, the proposed "Medigap Fraud and Abuse Prevention Act of 1990." Enactment of H. R. 4840 will go a long way toward improving consumer protections for purchasers of this insurance and will also improve the economic value of this insurance. This legislation includes many features that we suggested the Congress consider. My testimony today will focus on the main points of the proposed bill, and we have an additional item for your consideration.

THE MEDICARE PROGRAM AND MEDIGAP INSURANCE

Medicare provides coverage for a broad range of health services for most people 65 years of age or older and some disabled persons. The program has two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health care. Part B, supplementary medical insurance, covers many types of noninstitutional services, such as physicians, clinical laboratory, X-ray, and physical therapy services. Both parts require beneficiaries to share in the cost of their care through deductibles and coinsurance.

Almost from Medicare's beginning in 1966, private insurance companies have offered Medigap policies to cover some of the out-of-pocket costs incurred by Medicare beneficiaries. Policies may also provide benefits for services not covered by Medicare. Because of abuses identified in marketing Medigap policies, the Congress in 1980 added section 1882 to the Medicare law. This section, commonly known as the Baucus amendment, sets forth requirements that must be met before a policy can be marketed as Medigap insurance. The Baucus amendment incorporated model Medigap regulations adopted by the National Association of Insurance Commissioners (NAIC) as federal standards. The Baucus amendment retained the traditional role of the states as the regulators of insurance, as long as they have regulatory standards at least as stringent as the federal requirements.

The NAIC's most recent revision to its model regulations, adopted in early December 1989, included several new consumer protection provisions. In the Medicare Catastrophic Coverage Repeal Act of 1989, these new standards were incorporated into the Baucus amendment as the criteria for approval of state regulatory programs and are now before the states for their consideration and adoption. Some of the consumer safeguards of H. R. 4840 are similar to those in the NAIC's consumer protection amendments. Because states are expected to adopt the NAIC's consumer protection amendments to obtain federal approval of their regulatory programs, I will point out the major similarities and differences between the provisions of H. R. 4840 and the NAIC's consumer protection amendments.

ECONOMIC VALUE OF POLICIES AS MEASURED BY LOSS RATIOS

The Congress has been concerned about the portion of Medigap premiums returned to policyholders in the form of benefits, or the policies' loss ratios. A loss ratio is computed by dividing total incurred claims[1] by total earned premiums for the same period. The result of this computation is usually expressed as a percentage.

The Baucus amendment set loss ratio targets for Medigap policies. Those targets were established as expected loss ratios for Medigap policies -- at least 75 percent for group policies and at least 60 percent for individual policies.

H. R. 4840 would increase these targets to 80 percent for group policies and 70 percent for policies sold to individuals. In earlier testimony, we suggested that the Congress consider raising the loss ratio targets.

Generally, we have reported that pre-1988 loss ratios of most commercial policies were below the minimum standards. In contrast, the pre-1988 loss ratios of Blue Cross and Blue Shield plans were generally above the standards. For example, in our 1986 report, we said that the 1984 average loss ratio for individual policies sold by 92 commercial firms was 60 percent; for policies sold by 13 Blue Cross and Blue Shield plans, the average was 81 percent.

Some caution is needed in the interpretation and use of loss ratio data because a number of factors may affect the computations. For example, early policy experience may result in a relatively low loss ratio because policies do not cover costs related to pre-existing conditions during the policy's waiting period. Also, new policyholders may be relatively healthy and

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[1]Incurred claims include actual payments for claims plus reserves for claims incurred but not yet received or processed by the insurer.

file few claims, so a policy with substantial amounts of new business may experience a relatively low loss ratio. Thus, a policy's loss ratio should be viewed over the time that represents "mature" experience.

For years prior to 1988, the NAIC form used by insurers to report Medigap loss ratio data included the reporting year's experience for all policies in force and a cumulative report of the 3 most current years' experience. Beginning with reports covering 1988 and later, the NAIC provides a two-tiered set of criteria for determining if loss ratios comply with loss ratio standards:

-- For policies that have been in force 3 years or more, the most recent year's loss ratio must equal or exceed the 60 or 75 percent standard (whichever is applicable).

-- For policies that have been in force less than 3 years, the policies must have a third-year expected loss ratio equal to or greater than the 60 or 75 percent standard.

Because of the changes in loss ratio reporting requirements, pre-1988 loss ratios cannot be directly compared with more current loss ratio information.[2]

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[2]In addition, the NAIC has revised the formula for determining the incurred claims portion of the loss ratio. Prior to 1988, incurred claims included actual payments for claims plus reserves for claims incurred but not yet reported to or processed by the company plus a life-time reserve for future claims. For loss ratios covering 1988 and later years, incurred claims no longer include the life-time reserves in the computation.

We have obtained 1988 loss ratio data (the latest available) for Medigap insurance from NAIC[3] and the Blue Cross and Blue Shield Association. The data are reported in aggregate for all policies sold by a company. These aggregate data measure a company's overall performance because they average experience across all policies. This means that a company whose aggregate loss ratio is below the standards has one or more policies which fail to meet the minimum standards but may have other policies that meet or exceed the standards. Conversely, a company can have an aggregate loss ratio above the standards but have some policies that fall below them.

The aggregate loss ratios by companies for policies in force 3 years or more with more than $250,000 in earned premiums are summarized in appendices I and II. Many company loss ratios are still not meeting the minimum standards. In 1988, the loss ratios for companies with policies in force 3 years or more were based on total earned premiums of approximately $3.7 billion. For policies sold to individuals:

-- By commercial insurers, 34 percent of the company loss ratios were below the 60 percent minimum standard. The average loss ratio for companies exceeding the standard was 68.5 percent while the average for companies below the standard was 50 percent. About 88 percent of total earned

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[3]The NAIC labeled its data "preliminary results only," and these data are subject to change.

premiums was with companies whose average loss ratio exceeded the minimum standard.

-- Among the Blue Cross and Blue Shield plans, 98 percent met or exceeded the target loss ratio percentage. The average loss ratio for these plans was 93.4 percent; the loss ratio of the single plan that fell below the standard was 53.9 percent. Over 99 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

For group coverage:

-- About 66 percent of the commercial company loss ratios were below the 75 percent minimum standard. The average loss ratio for companies that were at or above the target was 101.5 percent, and the average for those below the target was 62.6 percent. About 93 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

-- Among the Blue Cross and Blue Shield plans, 24 percent had loss ratios that fell below the minimum target. The average loss ratio for plans that met or exceeded the target was 91.4 percent, and the average for those below the target was 71.5 percent. About 88 percent of total earned premiums was with plans whose average loss ratio exceeded the minimum standard.

Earned premiums for policies in force less than 3 years totaled approximately $3.5 billion for 1988. Details on the loss ratios of these policies are in appendices III and IV.

If H. R. 4840 were to become law, the loss ratio targets would be raised to 70 percent for policies sold to individuals and 80 percent for group policies.[4] In appendices V and VI, we have grouped the policies as if the higher loss ratio targets had been in effect in 1988. For companies whose policies had been in force for 3 years or more:

-- 37 percent of commercial company loss ratios on policies sold to individuals would meet the 70 percent target, and these policies would account for about 21 percent of total earned premiums.

-- 92 percent of the Blue Cross and Blue Shield plans would meet the higher target for their individual business, and these policies would account for about 96 percent of total earned premiums.

-- 28 percent of commercial company loss ratios on group policies would meet the 80 percent target, and these policies would account for about 89 percent of total earned premiums.

-- 68 percent of the Blue Cross and Blue Shield plans would meet the higher target for group business, and these

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[4]The bill would also apply these loss ratio requirements to hospital indemnity and specified disease policies.

policies would account for about 81 percent of total earned premiums.

Raising the loss ratio requirements would increase the economic value of Medigap policies, and we support an increase in those requirements.

The Baucus amendment requires that policies be expected to meet the loss ratios stated in the provision. In effect, as long as the insurer estimates that a policy will meet the standard, it has complied with the requirement whether or not its actual loss ratio ever meets the minimum standard. The NAIC model regulation requires that policies in effect for 3 years or more actually meet the loss ratio standard. H. R. 4840 also requires insurers to meet the loss ratio standards and specifies that if they do not, refunds must be made to policyholders. These provisions would put teeth in the loss ratio requirements, and we support their enactment.

PROPOSED CONSUMER PROTECTION PROVISIONS

Over the years, the Congress has been concerned about reports of continuing abuses in the sale of Medigap insurance to the elderly. We issued a report in 1986[5] and testified earlier this year[6] on some the problems that have been identified in the marketing of Medigap insurance and described proposals to curb

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[5]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

[6]See "MEDIGAP INSURANCE: Premiums and Regulatory Changes After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data", Statement of Ms. Janet Shikles before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-90-16).

some of those abuses. H. R. 4840 addresses many of those concerns.

Suspending policies for Medicaid beneficiaries

A provision of H. R. 4840 would suspend the premiums and benefits of a Medigap policy for any period of time that a policyholder is eligible for benefits under Medicaid. A Medicare beneficiary who is also eligible for Medicaid does not need a Medigap policy because Medicaid will cover the beneficiary's deductibles and coinsurance. This proposal could be an important safeguard for Medicare beneficiaries who become eligible for Medicaid because they would not have to continue to pay premiums on their Medigap policies while receiving Medicaid benefits. These persons would be entitled to reactivate their Medigap policy within 90 days of no longer being eligible for Medicaid. We support this provision of the bill.

Duplication of coverage

One problem in the sale of Medigap insurance that has been identified over the years is that some Medicare beneficiaries purchase multiple policies that duplicate coverage. Since the Baucus amendment was enacted, it has been illegal for an agent to knowingly sell duplicative Medigap policies to an individual, but many state regulators have told us that it is difficult to prove that an agent knowingly violated the law. H. R. 4840 would add a requirement that sellers obtain a written statement listing the other health policies that prospective clients have in force and stating whether the individual purchasing the insurance is qualified for Medicaid. The bill would require this statement to be on a form that (1) tells the applicant that a Medicare beneficiary does not need more than one Medigap policy, (2) tells the applicant that he or she may be eligible for Medicaid and that, if so, the Medigap policy will be suspended during the time the individual is covered by Medicaid, and (3) gives the name, address, and telephone numbers of the state Medicaid office and counseling program, if the state has a counseling program.

H. R. 4840 has a strict definition of duplicative coverage, prohibiting the sale of more than one Medigap policy to a Medicare beneficiary. The bill also extends this prohibition on duplication to other policies sold to Medicare beneficiaries, such as hospital indemnity, specified disease, and policies primarily covering long-term care expenses. If an applicant already has a policy but indicates that he or she intends to cancel that policy when the new one becomes effective, the seller may take the individual's application without violating the prohibition on selling duplicate policies.

The NAIC's consumer protection amendments also require agents to attempt to find out what coverage a prospective client has before selling someone a Medigap policy. The NAIC's provisions, which apply only to Medigap policies, require agents, when they determine that an applicant is replacing an in-force Medigap policy, to give the applicant a form, advising the applicant that he or she should review all existing coverage before deciding to terminate existing coverage. The NAIC consumer protection amendments would allow the sale of more than one Medigap policy if the combined coverage under the Medigap policy and other health coverage already in force would cover no more than 100% of the policyholder's actual medical expenses.

The provisions of H. R. 4840 would provide greater protection of consumers' interests than the NAIC standards, and we support those stronger requirements.

Replacement of coverage

Another problem with Medigap marketing has been frequent replacement of policies. Unnecessary replacement of policies could harm consumers' interests because policies often have waiting periods for pre-existing conditions. Insurance agents had an incentive to sell replacement policies because the sale commission structure gave much higher remuneration for the first year a policy was in effect than for renewal years. The provisions in H. R. 4840 should decrease the incentives to sell new policies by placing restrictions on the way commissions are paid and prohibiting waiting periods when replacement policies are sold. The bill would limit the first-year commission and other compensation[7] that may be paid to an agent selling a Medigap policy to 150 percent of the commission and other compensation for servicing or selling the policy in a second or subsequent year. Also, the commission or compensation for selling a replacement policy cannot exceed the compensation that would apply to the

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[7]Compensation includes bonuses, gifts, prizes, awards, finders fees, and other similar forms of remuneration.

renewal of an existing policy. These commission requirements will prevent companies from loading agent compensation into the first years a policy is in effect, thus decreasing the incentive to sell replacement policies. Finally, when issuing a replacement Medigap policy that had been in effect for 6 months or longer, insurers must waive waiting periods applicable to pre-existing conditions or other similar restrictions to the extent such time was spent under the policy being replaced.

The NAIC consumer protection amendments contain similar provisions, except that under NAIC's rules first-year commissions will be limited to 200 percent of the commission for the second and subsequent years. Limiting first-year commissions to 150 percent of subsequent year commissions would lessen the incentive for agents to unnecessarily replace policies. We support the stricter limit in H. R. 4840 and the other proposals regarding replacement of coverage.

Policy simplification

H. R. 4840 requires the NAIC, within 9 months of enactment of the legislation, to promulgate simplification standards for Medigap policies. If the NAIC does not act within the time allowed, the Secretary of Health and Human Services shall promulgate such standards. These simplification standards must limit the combinations of benefits that may be offered in Medigap policies and prescribe uniform language and format for describing benefits in policies. The simplification standards must include a core group of benefits, standard to all policies, which include only the minimum benefits required under the NAIC's model regulation. If a company offers a policy that covers more than the core group of benefits, it must also offer a policy that covers only the core group. Also, companies that offer policies with benefits in addition to the core group will be limited to the approved benefit combinations. For each policy that includes benefits in addition to the core group, the premium for the additional benefits must be separately stated.

Under the current Baucus amendment, Medigap policies must meet minimum benefit levels, but companies can offer any combination of benefits in addition to the minimums. This makes it difficult for consumers to comparison shop for the best price, because policies offered by two different companies may have different benefit structures as well as different premiums. We suggested that Congress consider a requirement for standardized or simplified policies in earlier testimony because we believe this change would make it easier for consumers to comparison shop among companies on the basis of price and service, knowing that the products are comparable. Simplifying policy options is not a new idea. Massachusetts, Minnesota, and Wisconsin require Medigap insurance issued in those states to offer standard combinations of benefits.

H. R. 4840 should not limit consumer choice to any great extent because it allows up to 10 different combinations of benefit packages in the initial simplification standards. Also, the proposed law allows the Secretary to waive the standards to enable testing of new benefit combinations. The proposed law would allow for the addition of up to three additional combinations of benefits based on the results of such tests.

We support the intent of H. R. 4840 to simplify the policies and improve the consumers' ability to comparison shop for coverage.

Consumer counseling

H. R. 4840 would establish a grant program that would assist states to establish counseling programs to aid individuals in comparing and choosing Medigap policies. This grant program would require matching funds from the states.

In connection with on-going work on Medigap insurance, we recently visited 12 states to obtain information about their insurance regulatory program. Four of those states had some type of consumer counseling service, relying on insurance department or office of aging employees, or volunteers, to help the elderly assess their Medigap needs and the options available.

In our earlier report on Medigap insurance, we identified many of the complexities involved in purchasing a Medigap policy. Counseling programs would help the elderly understand the options available.

Rate approval

H. R. 4840 requires state approval of rate increases, including public notice and a public hearing before approving increases that exceed twice the rate of increase in the medical component of the consumer price index since the effective date of the last rate. The proposal permits states to operate an approval process whereby proposed rates may be deemed approved if they are not disapproved within 90 days of the company's filing.

According to the NAIC, 14 states[8] require that rate changes be approved before they go into effect. In another 29 states, rates must be filed with the state for a specified period of time before they go into effect; rates may be put into effect in these states if they are not disapproved by the state within the specified waiting time. In the remaining 11 states, rates may become effective when they are filed with the state, or insurers are not required to file rates with the state.

Enactment of this premium approval requirement would provide some assurance that states review company justifications for rate increases, but this may also require at least some states to hire additional personnel or to shift personnel from rate reviews of other lines of insurance to Medigap rate reviews. We are not aware of research showing that rate approval will help control premium increases or assure that loss ratio requirements are met. However, the process in H. R. 4840 would provide more opportunity for public involvement in the rate approval process.

Renewability and conversion standards

H. R. 4840 would require that Medigap policies be guaranteed renewable, and the bill contains conversion privileges in case a group policy is replaced or if a policyholder leaves the group. Similar provisions are part of NAIC's consumer protection

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[8]The term states includes the 50 states, the District of Columbia, and the territories, a total of 54 jurisdictions.

amendments. These could be important safeguards for consumers, and we support this provision of the bill.

CONGRESS MAY WANT STATES TO REVIEW MEDIGAP ADVERTISING MATERIALS

In addition to the proposals contained in H. R. 4840, we have an additional suggestion for the Subcommittees to consider. As in the case of rate reviews, states have varying advertising review authority.[9] The NAIC says that most states are file and use jurisdictions. Of the 12 states we visited, 1 was a prior approval state and 11 were file and use states. Under current federal law, insurers are required to follow state law regarding submission of their advertising materials for state review.

H. R. 4840 would require that information describing policy benefits be in uniform language and in a format approved by the state to facilitate comparison shopping. Also, the bill establishes penalties for anyone who mails advertising or soliciting material into a state where a Medigap policy has not been approved for sale. While these provisions would improve protections available, the Congress may wish to require all states to subject advertising material to some level of review before it may be used. Requiring prior review of advertising material would make advertising review consistent across the states and would help

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[9]There are three basic types of review authority. Under prior approval authority, insurers are required to submit their advertising for review and may use it after receiving approval from the state. Under file and use authority, insurers must submit their advertising and may use it if it is not disapproved within a stated period of time. Under use and file authority, insurers may begin using their advertising at the same time they submit it for state approval.

assure that the elderly are not exposed to deceptive or misleading Medigap advertising materials.

Mr. Chairman, this concludes my prepared remarks. I will be happy to answer any questions you have.

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR 3 YEARS OR MORE

For policies sold to individuals,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%	4	$ 7,666	31.8
40 - 49%	12	40,786	46.5
50 - 59%	28	52,179	55.4
Sub-total	44	$100,631	50.0
60 - 69%	38	$520,946	64.3
70 - 79%	22	76,570	74.8
80 - 89%	16	61,326	83.2
90 - 99%	9	29,332	91.9
100% or more	2	1,617	116.7
Sub-total	87	$689,791	68.5

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%			
40 - 49%			
50 - 59%	1	$527	53.9
Sub-total	1	$527	53.9
60 - 69%	3	$ 68,904	65.7
70 - 79%	7	111,726	75.9
80 - 89%	15	510,690	84.3
90 - 99%	13	754,340	95.2
100% or more	12	$ 441,326	109.8
Sub-total	50	$1,886,986	93.4

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS
FOR POLICIES THAT HAVE BEEN IN FORCE FOR 3 YEARS OR MORE

For policies sold to groups,
with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	4	$ 6,725	38.0
45 - 54%	3	1,317	48.4
55 - 64%	5	5,773	58.5
65 - 74%	7	34,778	68.5
Sub-total	19	$48,593	62.6
75 - 84%	3	$ 25,769	78.2
85 - 94%	3	4,474	92.4
95 - 104%	1	568,199	102.4
105% or more	3	1,493	161.3
Sub-total	10	$599,935	101.5

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%			
45 - 54%	2	$ 2,496	47.8
55 - 64%	2	1,534	58.1
65 - 74%	4	43,598	73.3
Sub-total	8	$47,628	71.5
75 - 84%	5	$ 30,939	79.3
85 - 94%	11	134,125	91.3
95 - 104%	4	173,024	96.3
105% or more	6	22,688	112.8
Sub-total	26	$360,776	91.4

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS

For policies sold to individuals, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%	17	$ 50,387	32.6
40 - 49%	23	88,986	44.1
50 - 59%	43	476,239	54.8
Sub-total	83	$615,612	51.4
60 - 69%	33	$447,597	62.4
70 - 79%	12	160,302	71.4
80 - 89%	5	13,573	85.9
90 - 99%	3	20,082	93.4
100% or more	2	8,000	114.7
Sub-total	55	$649,554	66.7

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 40%			
40 - 49%			
50 - 59%			
Sub-total			
60 - 69%	7	$ 89,699	68.5
70 - 79%	6	127,254	73.9
80 - 89%	10	479,385	85.6
90 - 99%	10	452,326	94.0
100% or more	3	$ 66,606	108.1
Sub-total	36	$1,215,270	87.5

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS FOR POLICIES THAT HAVE BEEN IN FORCE FOR LESS THAN 3 YEARS

For policies sold to groups, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	1	$ 3,246	34.0
45 - 54%	4	21,213	48.0
55 - 64%	4	11,309	59.3
65 - 74%	6	11,956	72.2
Sub-total	15	$47,724	55.8
75 - 84%	1	$ 521	77.7
85 - 94%	1	60,265	92.8
95 - 104%	3	553,092	100.6
105% or more	1	1,828	117.6
Sub-total	6	$615,706	99.9

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 45%	1	$ 561	42.8
45 - 54%			
55 - 64%			
65 - 74%	2	12,406	68.4
Sub-total	3	$12,967	67.3
75 - 84%	6	$ 87,947	81.9
85 - 94%	5	217,078	93.0
95 - 104%	1	24,136	95.9
105% or more	4	34,394	115.2
Sub-total	16	$363,555	92.6

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS IF THE HIGHER TARGETS OF H. R. 4840 HAD BEEN IN FORCE, FOR POLICIES IN FORCE FOR 3 YEARS OR MORE

For policies sold to individuals, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 70%	83	622,870	62.0
70% or more	48	167,552	81.3

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 70%	4	69,431	65.6
70% or more	47	1,818,082	94.5

For policies sold to groups, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 80%	21	68,924	67.0
80% or more	8	579,604	102.3

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 80%	11	76,133	74.3
80% or more	23	332,271	95.3

DISTRIBUTION OF 1988 MEDIGAP LOSS RATIOS IF THE HIGHER TARGETS OF H. R. 4840 HAD BEEN IN FORCE, FOR POLICIES IN FORCE LESS THAN 3 YEARS

For policies sold to individuals, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 70%	117	1,135,379	56.9
70% or more	21	129,787	79.9

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 70%	8	114,736	68.7
70% or more	28	1,100,534	89.4

For policies sold to groups, with more than $250,000 in earned premiums

Commercial plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 80%	16	48,245	56.0
80% or more	5	615,185	99.9

Blue Cross/Blue Shield plans

Loss ratios	Number of companies	Earned premiums (000)	Average loss ratio (%)
Under 80%	4	15,857	69.0
80% or more	15	360,665	92.7