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MEDIGAP INSURANCE:
Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums

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Before the
U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Commerce,
Consumer Protection, and Competitiveness

SUMMARY

Almost from the beginning of Medicare in 1966, private insurance companies have offered Medigap policies designed to pay some or all of beneficiaries' deductibles and coinsurance.

In 1988, the Congress passed the Medicare Catastrophic Coverage Act, one of the most significant expansions of the program. The changes contained in that act will significantly reduce the liability of beneficiaries who require a substantial amount of health care services.

Changes to Medicare coverage resulting from the Catastrophic Act are being phased in over the 1989-93 period. As of January 1, 1989, all inpatient hospital coinsurance was eliminated, and the maximum coinsurance for skilled nursing facility care was greatly reduced. Maximum beneficiary liability for part A services was capped at $764 for 1989, whereas under prior law this amount would have exceeded $25,000 and could have been even higher if the beneficiary needed more than the maximum days of care formerly covered by Medicare. These changes to Medicare virtually eliminated Medigap policy exposure to claims for part A services. However, because very few beneficiaries have covered lengths of stay long enough to invoke the former coinsurance requirements, the Department of Health and Human Services estimated that the value of the additional part A coverage will average $65 in 1989.

In 1990, the Catastrophic Act establishes a cap on beneficiary liability for part B services at $1,370 per year. This will further reduce Medigap policy exposure to claims.

In 1986, GAO reported that the loss ratios (the percentage of premiums returned to policyholders as benefits) of most individual policies it obtained data on were below federal targets of 60 percent. The loss ratios of policies offered by most of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Company were above the target, and these were the policies most commonly purchased.

GAO updated the loss ratio data on 92 commercial policies and six Blue Cross/Blue Shield policies, which together accounted for about 79 percent of the 1984 earned premiums included in its 1986 review. The loss ratios of the commercial policies generally increased slightly over the 1984-85 period. Most of these policies had loss ratios below 60 percent in 1987. The six Blue Cross/Blue Shield policies had an average loss ratio of 87 percent in 1984, and their loss ratio had increased to 104 percent in 1987.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the work we have done for the Congress on Medicare supplement, or Medigap, insurance policies and how they may be affected by the Medicare Catastrophic Coverage Act of 1988. You asked that we specifically cover how Medicare benefits change under the Catastrophic Act, how these changes will affect Medigap policies, and what percentage of Medigap premiums has been returned as benefits (that is, loss ratios) over the years.

In summary, the Catastrophic Coverage Act added significant new benefits to Medicare for beneficiaries who require a substantial amount of health care in a given year. Starting in 1990, these new benefits will substantially decrease the maximum amount a Medigap policy faces in claims. For 92 policies sold by commercial insurance companies for which we have data covering the 1984-87 period, loss ratios have remained at a relatively low level, with most having ratios less than 60 percent in both 1984 and 1987.

MEDICARE AND MEDIGAP

Medicare, authorized by title XVIII of the Social Security Act, 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. 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 by reference the model Medigap regulations adopted in June 1979 by the National Association of Insurance Commissions (NAIC). The model

-- required Medigap policies to cover Medicare's inpatient hospital and part B coinsurance and prohibited the policies from limiting their liability below certain floors;
-- standardized many terms used in policies;
-- mandated that policy termination and cancellation clauses be prominently displayed;

-- limited the period during which payment can be denied for preexisting conditions; and

-- required that purchasers have a "free look" period during which they can cancel the policy and receive a full refund of any premiums paid.

In addition to setting the NAIC model regulations as federal Medigap standards, the Baucus amendment established loss ratio targets for policies. Medigap policies had to be expected to pay out at least 60 percent of premiums as benefits for individual policies and 75 percent for group policies. The amendment also established federal criminal penalties for engaging in abusive marketing practices for Medigap policies.

The Baucus amendment retained the traditional role of the states as the regulators of insurance, as long as they have regulatory processes at least as stringent as the federal requirements. The amendment also established the Supplemental Health Insurance Panel, which reviews state regulatory programs and certifies those that meet the federal Medigap requirements.

Insurance companies can seek federal approval of policies directly from the Department of Health and Human Services. This approval enables the policies to be marketed as Medigap insurance in those states that have not been certified.

Our 1986 report on Medigap insurance concluded that the Baucus amendment had accomplished its primary goal of increasing and standardizing state regulation of Medigap policies[1]. At that time, 46 states and the District of Columbia had been certified as meeting federal requirements. This, in turn, had increased the protection afforded the elderly against substandard and overpriced policies.

HOW THE CATASTROPHIC COVERAGE ACT CHANGED MEDICARE

The Medicare Catastrophic Coverage Act (P.L. 100-360), which became law in July 1988, provided the most significant expansion of Medicare benefits since the program's beginning. Beneficiary out-of-pocket costs for covered services will be capped and additional services will be covered when the law is fully implemented.

The provisions of the Catastrophic Act related to part A of Medicare generally became effective on January 1, 1989. The principal changes to part A were:

-- The maximum beneficiary liability for covered inpatient hospital services in a year will be one inpatient hospital deductible, which is $560 in 1989. All inpatient coinsurance requirements were repealed, as was the limit on

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

days of care during a benefit period. While only a small percentage of beneficiaries have very long hospital stays, this change gives them a substantial benefit. For example, under the old law, a beneficiary hospitalized for 150 days (the maximum possible coverage period), would have been liable for the $560 deductible and $21,000 in coinsurance. Under the Catastrophic Act, the beneficiary's liability is limited to $560. In addition, previously beneficiaries could be responsible for more than one deductible in a year if they had multiple hospitalizations.

-- The number of days of care covered for skilled nursing facility care increased from 100 to 150 and the method of computing coinsurance changed. Under prior law, the first 20 days of care were without cost to the beneficiary, while during the next 80 days the beneficiary was liable for one-eighth of the hospital deductible each day, which would have been $70 per day in 1989. Now, beneficiaries are responsible for coinsurance for each of the first 8 days. The amount is equal to 20 percent of the national average cost of a day in a skilled nursing facility, $25.50 in 1989. Again, relatively few beneficiaries have long stays in skilled nursing facilities that qualify for Medicare payment, but those that do will benefit substantially under the Catastrophic Act. For example, a beneficiary with a 100-day covered stay would have been liable for $5,600 in coinsurance under prior law but is now liable for $204.

-- The hospice care benefit was extended from a maximum of 210 days to an indefinite period. Also, the requirement that home health services must be "intermittent" in nature was further defined, with the effect that more intensive home care is now covered.

The Department of Health and Human Services estimated that the actuarial value of these changes to part A is $65 per beneficiary in 1989.

Most of the changes to part B take effect on January 1, 1990, and will be fully in place by 1993. Major changes are:

-- Beneficiary liability for the part B deductible and coinsurance will be limited to $1,370 in 1990, whereas there was no limit under prior law. The limit will be changed each year so that 7 percent of beneficiaries will exceed the limit during the year.

-- New benefits for respite care and for periodic mammography screening will become effective in January 1990. Respite care benefits relieve the person who normally assists a Medicare beneficiary with essential daily personal care.

-- Beginning on January 1, 1991, Medicare will for the first time help beneficiaries pay for insulin and outpatient prescription drugs that can be self-administered[2]. After

[2]On January 1, 1990, coverage of intravenous drugs that can be safely administered in the home will be covered under the drug benefit.

meeting a deductible, set at $600 for 1991 and $652 for 1992, Medicare will pay a portion of beneficiaries' drug costs. Medicare will pay half the cost in 1991, 60 percent in 1992, and 80 percent in 1993. The deductible for 1993 and following years is to be set so that 16.8 percent of beneficiaries will exceed the deductible and qualify for benefits.

The act required Medigap insurers to notify policyholders no later than January 31, 1989, of the changes in Medicare coverage and how these changes will affect Medigap policies' benefits and premiums. In addition, HHS was required to send beneficiaries an annual notice clearly and simply explaining Medicare benefits, limits on payments including deductible and coinsurance amounts, and the limited nature of long-term care benefits under Medicare and the long-term care benefits generally available under Medicaid.

HOW THE CATASTROPHIC COVERAGE ACT AFFECTS MEDIGAP POLICIES

Before the Catastrophic Coverage Act, Medigap policies were required to cover part A inpatient hospital coinsurance, but now all such coinsurance has been eliminated. Also, the coinsurance for skilled nursing facility care, which Medigap policies are not required to cover but a number of policies do, was limited to a relatively low amount, $204 in 1989. In addition, Medigap policies

had to cover 90 percent of the costs of hospital care for up to 365 days after a beneficiary had exhausted the maximum Medicare benefit of 150 days in a spell of illness. The need for this coverage was also eliminated because Medicare now covers 365 days of care per year. Thus, in 1989 there is no required coverage for Medigap policies related to part A services. Although not required to, many Medigap policies cover the inpatient hospital deductible. For these policies, the maximum exposure for 1989 is $560, and for such policies that also cover skilled nursing facility coinsurance, that amount is $764.

As far as part B benefits are concerned, Medigap policies were required to cover the 20-percent coinsurance for which beneficiaries were liable and were not permitted to restrict the policy's coverage to less than $5,000. In 1990, Medicare will limit beneficiaries' liability for part B coinsurance to $1,295; this will become a Medigap policy's maximum exposure for part B. Many Medigap policies cover the $75 part B deductible, and doing so increases exposure to $1,370.[3]

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[3]Medicare counts beneficiary liability for catastrophic coverage purposes as the difference between the Medicare-allowed amount for a service and the Medicare payment. If a provider charges more than the allowed amount and does not accept assignment, the beneficiary is also liable for the amount by which the provider's charge exceeds the Medicare allowance. In our 1986 report, we identified only a few Medigap policies that helped pay this additional beneficiary liability.

In our 1986 report we also discussed the kinds of services Medigap policies covered that Medicare did not. Very few policies provided any such coverage.

In summary, the Catastrophic Coverage Act substantially reduced the maximum exposure to benefit payments of Medigap policies. In 1990, Medigap policies will be required to cover a maximum of $1,295, whereas without the act policies would have been required to cover an amount in the neighborhood of $50,000.

LOSS RATIOS OF MEDIGAP POLICIES

In our 1986 report, we discussed the loss ratios of 398 Medigap policies, which together accounted for about $2 billion of an estimated nationwide total of about $5 billion in 1984 premiums for such policies.

A loss ratio represents the percentage of premiums collected that are paid in benefits; thus, it is sometimes considered a measure of the policy's economic value. The actual loss ratios of most policies we obtained data on were below the Baucus amendment targets of at least 60 percent for individual policies and 75 percent for group policies. The loss ratios of the policies offered by most of the nine Blue Cross/Blue Shield plans reviewed and by the Prudential Life Insurance Company--the policies most commonly purchased--were above the targets. The Blue Cross/Blue

Shield individual policies we reviewed had 1984 premiums of $776.6 million and a weighted average loss ratio of 81 percent; the commercial individual policies included in our analysis had nationwide 1984 premiums of $1.3 billion, and Prudential--with a 1984 loss ratio of about 78 percent--had almost 25 percent of that business.

For the individual policies of all commercial insurers studied, the weighted average loss ratio was about 60 percent for 1984. In other words, $770 million in benefits were returned for the $1.3 billion in premiums paid. Thus, for every $1 in premiums, 60 cents was returned as claims payments or used to increase reserves, and 40 cents represented administrative and marketing costs and profits. The same figures for the Blue Cross/Blue Shield plans studied are 81 cents in benefits and 19 cents in costs and profits.

In preparation for hearings in 1987,[4] we obtained 1985 data (the latest available at that time) to update the loss ratio data for some of the policies covered by our report. We obtained data on 56 of the 395 individual commercial policies and 6 of the Blue Cross/Blue Shield policies. These policies represented over 53

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[4] Statement by Mr. Michael Zimmerman before the Subcommittee on Health, House Committee on Ways and Means (GAO/T-HRD-87-3, Mar. 10, 1987); and "Medigap Insurance: Update on Regulation Under the Baucus Amendment," Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-87-18, July 22, 1987).

percent of the 1984 earned premiums for all of the policies included in our review. The 1985 loss ratios were basically the same as those for 1984, generally changing by only a few percentage points. Overall, the 56 commercial policies, with total 1985 earned premiums of $1.1 billion, had a weighted average loss ratio of about 65 percent, the same as in 1984. The 6 Blue Cross/Blue Shield policies, with total 1985 earned premiums of $453 million, had a weighted average loss ratio of about 89 percent versus a 87-percent ratio in 1984.

In preparing for this hearing, we obtained 1987 loss ratio information, the latest available, on 92 commercial and 6 Blue Cross/Blue Shield plans.[5] The 1987 loss ratios for the commercial policies were generally slightly higher than 1984 ratios. However, Prudential's share of total premiums has increased significantly and its relatively high loss ratio of 83 percent in 1987 resulted in the weighted average loss ratio for the commercial policies increasing to 74 percent in that year. The other policies averaged about 59 percent. Total premiums for the commercial policies were over $1.7 billion.

The six Blue Cross/Blue Shield policies had larger increases in their loss ratios during the 1984-87 period, except for the plan that had a loss ratio of 110 percent in 1984. The weighted

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[5]The Blue Cross/Blue Shield plans are the same ones we updated earlier. For commercial policies, we updated information on 49 of 56 policies included in the earlier update. Information on the other 7 policies was not available.

average loss ratios for the six plans was 104 percent in 1987 and total premiums were about $475 million.

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