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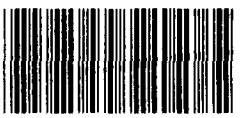

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MEDIGAP: INSURANCE
Effects of the Catastrophic Coverage Act of 1988 on Future Benefits

Statement of
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Before the
Committee on Finance
United States Senate

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 of 1988, one of the most significant expansions of the program since its beginning. 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 hospital care formerly covered by Medicare. These changes to Medicare virtually eliminated Medigap policy exposure to claims for part A services, because they are required only to cover coinsurance for inpatient hospital services, which no longer exists. 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 the actuarial value of the additional part A coverage will average $65 per Medicare enrollee 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.

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

We recently updated the loss ratio data on 92 commercial policies, 75 Blue Cross/Blue Shield individual plans, and 47 Blue Cross/Blue Shield group plans, which together account for about $4.9 billion in earned premiums in 1987. Overall, the commercial policies had an average loss ratio in 1987 of about 74 percent. This loss ratio was significantly influenced by the experience of Prudential, which had a loss ratio of 83 percent. Without Prudential, the average commercial policy loss ratio was about 59 percent. The 75 Blue Cross/Blue Shield individual plans had an average loss ratio of 93 percent, and the 47 group plans of those same Blue Cross/Blue Shield organizations had a loss ratio of 96 percent in 1987.

Mr. Chairman and Members of the Committee:

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 any given year. Starting in 1990, these new benefits will substantially decrease the potential liability of beneficiaries and their Medigap policies. About half of the commercial policies and about 10 percent of the Blue Cross/Blue Shield plans for which we have the most recent data had loss ratios below the federal target amounts.

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 a section, commonly known as the Baucus amendment, to the Medicare law. This section set 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 levels;
-- 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 payments made.

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 schemes at least as stringent as the federal requirements. The amendment also established the Supplemental Health Insurance Panel, which reviews state regulatory programs and approves those that meet the federal Medigap requirements. In those states whose programs have not been approved by the Panel, insurance companies can seek federal certification of Medigap policies directly from the Department of Health and Human Services.

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 approved as meeting federal requirements. This, in turn, had increased the protection afforded the elderly against substandard and overpriced policies.

Under the NAIC standards, Medigap policies were not intended to provide full catastrophic insurance coverage for acute or long-term care. The policies did not limit a policyholders' out-of-

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

pocket expenses. For example, under the standards in effect before January 1, 1989, Medigap policies were required to cover 90 percent of covered charges for hospital stays longer than 150 days (the maximum period of Medicare coverage) up to a lifetime total of 365 days of inpatient care. Also, Medigap policies were allowed to limit benefits under the policy to $5,000 for part B type services. In addition to the above limits on benefits paid, Medigap insurers can choose not to insure certain individuals, while Medicare's new catastrophic coverage, discussed below, applies to all Medicare beneficiaries.

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, which covers inpatient hospital services, 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, set at $560 in 1989. All inpatient coinsurance requirements were repealed, as was the limit on 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. An additional benefit is the limit of one hospital deductible per year; 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 coinsurance equal to 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 of care, and the coinsurance 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 coverage requirement for home health services when patients need extensive care was specified, with the effect that more intensive home care is now covered.

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

Most of the changes to part B, covering physician and related services, will 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 adjusted each year to an estimated amount so that 7 percent of beneficiaries will meet it.

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

-- 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 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 meet it.

In summary, these changes, when fully implemented in 1993, will significantly expand Medicare benefits well beyond those previously available through both the program and most Medigap policies. The new provisions include unlimited hospitalization for approved care, subject only to a single annual deductible. The skilled nursing and home health benefits were both expanded. Beginning in 1990, Medicare will also cap a beneficiary's out-of-pocket share of approved charges for services covered by part B. New benefits for respite care, mammography screening, insulin, and outpatient prescription drugs further improve the protection offered by the program.

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 the need for such coinsurance coverage has been eliminated. Also, the coinsurance for skilled nursing facility care was limited to a

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

relatively low amount, $204 in 1989. Under the former standards, Medigap policies were not required to cover this coinsurance, but a number of policies did. 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, the maximum exposure is $764.

As far as part B benefits are concerned, under the former standards, Medigap policies were required to cover the 20-percent coinsurance, and insurers were not permitted to restrict the policy's coverage to less than $5,000. By way of comparison, in 1990, a Medicare beneficiaries' liability for part B coinsurance will be capped at $1,295, which must be covered by a Medigap policy. For those Medigap policies that also cover the part B deductible, their exposure in 1990 will be $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 only the out-of-pocket limit for part B services; 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 discussed in our 1986 report 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 an average loss ratio of 60 percent, and Prudential--with a 1984 loss ratio of about 78 percent--had almost 25 percent of that business.

In preparing for hearings earlier this year[4] and for additional work we are doing concerning Medigap insurance, we obtained 1987 loss ratio information, the latest available, on 92 commercial policies, 75 Blue Cross/Blue Shield individual plans, and 47 Blue Cross/Blue Shield group plans, which had a total of about $4.9 billion in premiums in 1987. The 1987 loss ratios for the commercial policies averaged 74 percent. Prudential's share of total premiums has increased significantly since 1984, and although many policy loss ratios increased between 1984 and 1987, Prudential's relatively high loss ratio of 83 percent in 1987 helped raise the overall average loss ratio for the commercial policies. Without Prudential, the other commercial policies' loss ratios averaged about 59 percent. Total premiums for the commercial policies were over $1.7 billion. The 75 individual Blue Cross/Blue Shield plans had total 1987 earned premiums of $2.6 billion and an average loss ratio of 93 percent. Those same Blue Cross/Blue Shield plans reported loss ratio data for 47 group plans. For these plans, earned premiums totaled $600 million and loss ratios averaged 96 percent.

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[4]"Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums", Statement of Mr. Michael Zimmerman before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce (GAO/T-HRD-89-13, Apr. 6, 1989).

For the 92 commercial policies, a loss ratio of 74 percent means that for each $1 of premium, 74 cents was returned as claims payments or used to increase reserves, and 26 cents represented administrative and marketing costs and profits. For the Blue Cross/Blue Shield plans, the comparable figures are 93 cents in benefits and 7 cents in costs and profits for individual plans and 96 cents in benefits and 4 cents in costs and profits for group plans. In 1987, for each $1 Medicare spent, about 98 cents was for health care services and about 2 cents for program operational expenses.

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