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Loss Ratios On Medigap Insurance

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Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the report that we prepared for the Subcommittee last year on the federal standards designed to protect the elderly from substandard and overpriced Medigap policies. That report focused on how well these objectives were being met, in view of what was envisioned when the standards were enacted in 1980.[1] You expressed particular interest in the Medigap policies' loss ratios--that is, the percentage of premiums returned to policyholders as benefits.

Baucus Amendment Meeting Its Objectives

In June 1980, the Congress established requirements that insurance policies must meet in order to be marketed as Medigap policies. The Congress acted because of revelations that some policies were providing very low benefits in relation to their premiums and because of abuses that had occurred in the marketing and selling of policies. The provision, commonly known as the Baucus Amendment for its principal sponsor in the Senate, established minimum standards for loss ratios, set requirements for minimum coverage of benefits, and provided criminal penalties for abusive sales practices. The Baucus Amendment was designed to encourage state regulation of Medigap policies. It included a federal policy certification program to

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

enable marketing of Medigap insurance in states that did not regulate Medigap insurance in accordance with the federal standards.

To evaluate whether policies being marketed as Medigap insurance met the standards of the Baucus Amendment, we visited nine states and the District of Columbia that had laws and/or regulations at least as stringent as the federal standards and two states that did not. We reviewed 142 policies for compliance with the federal standards and obtained loss ratio data for 394 individual and 4 group policies sold by 92 commercial firms and 13 Blue Cross/Blue Shield plans. Premiums collected nationwide on the 394 individual policies totaled over $2.1 billion in 1984. The total estimated Medigap market in that year was about $5 billion.

Overall, we found that the Baucus Amendment was meeting its objectives. It had encouraged state adoption of Medigap insurance regulatory programs at least as stringent as the federal standards, and only four states had not done so as of September 1986. This has resulted in more uniform regulation of Medigap insurance and increased protection for the elderly against substandard and overpriced policies.

Abuses still occur in the sale of Medigap policies. But many states have attempted to prevent abuse through such actions as monitoring sales and advertising practices and revoking or suspending insurance agent licenses and issuing cease and desist orders to insurers.

As mentioned above, the Baucus Amendment established standards for anticipated loss ratios; that is, the expected loss ratio had to be at least 60 percent for individual policies and 75 percent for group policies. The law does not require that actual loss ratios meet these requirements but only that the actuarially determined expected loss ratios do so.

The actual loss ratios of most policies we obtained data on were below the Baucus Amendment targets. However, the loss ratios of the policies of most of the Blue Cross/Blue Shield plans and the Prudential Life Insurance Company were generally above the targets. These were the policies most commonly purchased. The Blue Cross/Blue Shield individual policies we reviewed had 1984 premiums of $776.6 million and a weighted average loss ratio of 81.1 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 77.9 percent) had almost 25 percent of that business.

For the individual policies of 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 to 19 cents in costs and profits.

We recently obtained 1985 data (the latest available) to update our loss ratio data for some of the policies included in our review. We obtained data on 38 of the 394 commercial policies and 6 of the Blue Cross/Blue Shield policies. These policies represented over half (51 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 1 or 2 percent. Overall, the 38 commercial policies (total 1985 earned premiums of $1 billion) had a weighted average loss ratio of 65.8 percent versus a 1984 ratio of 65.4 percent. The six Blue Cross/Blue Shield policies (total 1985 earned premiums of $453 million) had a weighted average loss ratio of 88.6 percent versus a 1984 ratio of 86.5 percent.

Once again Prudential, the largest commercial Medigap insurer, had a relatively high loss ratio of 79.3 percent in 1985 (77.9 percent in 1984), while 63 percent (22 of 35) of the other policies had loss ratios below 60 percent. The Blue Cross/Blue Shield plans had loss ratios ranging from 80.8 percent to 122.0 percent in 1985.

Loss ratios need to be used carefully. State insurance regulatory officials told us that loss ratios are a useful tool in analyzing insurance policy performance, but caution that they are only a step in any analysis. Loss ratios must be interpreted with care because of the factors that may affect the

computations. Early policy experience may result in a relatively low loss ratio because of waiting periods for certain conditions when the policy will not cover services. Also, new policyholders may be relatively healthy and file few claims, so a policy experiencing substantial amounts of new business may experience a relatively low loss ratio. Thus, loss ratios should be viewed over the time that represents "mature" experience. State officials could not give us a clear definition of mature experience, giving periods of 3, 4, or 5 years. Among the states we visited, Pennsylvania asks insurers to report annually their loss ratio data for the last 4 years, whereas Maryland requests data covering 5 years. A new reporting format recommended by the National Association of Insurance Commissioners requests data on 3 years' experience.

We obtained 3 years' loss ratio experience for 55 commercial policies during our review last year. The combined 1984 earned premiums for those policies was $500 million, and the weighted average 3-year loss ratio was 60.5 percent. We also obtained 3 years' loss ratio experience for 11 Blue Cross and Blue Shield policies. The combined 1984 earned premiums for those policies was $572 million, and the weighted average 3-year loss ratio was 88 percent.

Medigap Is Not Catastrophic Insurance

As pointed out in our report, Medigap policies are not catastrophic insurance for acute or long-term care. They do not

place a limit on policyholder out-of-pocket expenses and, in fact, can limit benefits for part B type services to $5,000 per year, after which benefits for these services cease.

Medigap policies could be changed to become catastrophic acute care insurance. Insurers then could either (1) increase their premiums to cover the anticipated increase in benefit payouts or (2) choose to absorb all or part of the increase, thereby increasing their loss ratios. We do not know what, if any, proportion of the extra costs insurers would decide to absorb because this depends on their willingness to earn lower profits on this line of business. On the other hand, if there is a Medicare-administered catastrophic plan, the payouts on insurance for beneficiary out-of-pocket costs below the catastrophic threshold--that is, what Medigap insurance would become--would be lower than under current Medigap policies. Insurers could decrease premiums to reflect all or part of the decrease or use the lower payout to increase profits.

In addition, administrative costs for a Medicare-administered catastrophic program should be minimal, and benefit payouts should represent virtually all of such a program's costs. Regardless of differences in cost to beneficiaries, there should be several advantages for beneficiaries to a Medicare-administered catastrophic insurance plan over one administered by the private sector. First, Medicare would make such insurance universally available to Medicare beneficiaries. Commercial insurers, on the other hand, generally can pick who they insure and can choose not to insure individuals. Second, beneficiaries would only need to

submit one claim. If administered by the private sector, presumably two claims would need to be submitted--one to Medicare and, after that claim was paid, another to the private insurer.

Finally, if a catastrophic acute-care insurance program for Medicare beneficiaries is established, there will probably continue to be a demand for Medigap-type policies. We believe that at least some portion of beneficiaries will still seek insurance against the out-of-pocket expenses they incur before the catastrophic limit is reached.

This concludes my remarks. I will be happy to answer any questions you may have.