United States General Accounting Office

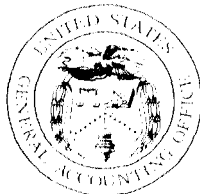
GAO

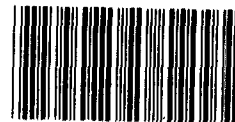
Report to Congressional Requesters

March 1991

# MEDIGAP INSURANCE

# Better Consumer Protection Should Result From 1990 Changes to Baucus Amendment



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**United States**
**General Accounting Office**
**Washington, D.C. 20548**

**Human Resources Division**

B-242783

March 5, 1991

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

This report, prepared at your request, discusses industry and state compliance with federal standards controlling Medicare supplemental insurance policies during the period covering the Medicare Catastrophic Coverage Act's passage and repeal.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 7 days from the date of this letter. At that time, we will send copies to interested parties and make copies available to others upon request.

If you have any questions on this report, please call me on (202) 275-5451. Other major contributors are listed in appendix VI.

Janet L. Shikles
Director, Health Financing
and Policy Issues

## Purpose

The enactment in 1988 and repeal in 1989 of the Medicare Catastrophic Coverage Act (MCCA) resulted in substantial short-term changes in Medicare coverage. These changes also required significant modifications to the regulatory program for Medicare supplemental insurance, known as Medigap. After MCCA became law, two congressional requesters asked GAO to review actions taken by the insurance industry to modify Medigap policies and to review federal and state government actions to adapt Medigap regulation in response to the act. When MCCA was repealed, the requesters asked that GAO continue its work on state efforts to regulate Medigap insurance and to educate consumers about these kinds of policies. Specific questions included:

- What have been the results of state activities to identify and prevent abusive sales practices?
- How do states monitor Medigap advertising to prevent deceptive materials from being used?
- How effective have state efforts been to educate the elderly about Medigap policies?
- What percentage of premium dollars are returned as benefits to Medigap policyholders (the policy's loss ratio)?

## Background

Medicare is a federal health insurance program that helps its beneficiaries pay for health services. The program does not cover every type of health service, and beneficiaries are responsible for deductibles and coinsurance. Many Medicare beneficiaries purchase Medigap insurance to help pay program deductibles and coinsurance. Some of these policies also pay for some services not covered by Medicare.

In 1980, in response to reports of abuses in the marketing and sale of Medigap insurance to the elderly, the Congress amended the Social Security Act to establish federal standards for Medigap policies. This amendment, commonly known as the Baucus amendment, retained the traditional role of states in regulating Medigap insurance, provided that state laws and regulations are at least as stringent as the federal standards. Those standards include certain requirements contained in the Baucus amendment and the model law and regulation adopted by the National Association of Insurance Commissioners (NAIC).

In the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), the Congress revised the Medigap insurance requirements. Under OBRA 1990, NAIC, or the Secretary of Health and Human Services if NAIC does not act in a timely manner, must develop simplification standards for policies

that will facilitate comparison shopping. The Congress also tightened provisions to prevent the sale of duplicate policies. In states that fail to adopt laws and regulations at least as stringent as the NAIC model, insurers are required to submit their Medigap policies to the Secretary for approval. Other provisions of OBRA 1990 increase the loss-ratio standard applicable to policies sold to individuals, require the Secretary to monitor loss ratios, and require insurers to pay a refund or issue credit against future premiums if a policy loss ratio does not meet the federal standards.

## Results in Brief

Medigap sales abuses have continued although officials in many of the 12 states GAO visited said that abuses have declined since the implementation of the Baucus amendment. When the revised standards required by OBRA 1990 and consumer protection provisions of NAIC's 1989 model regulation are fully implemented, they should help curb abusive sales tactics.

State regulatory reviews of Medigap advertising materials vary considerably. In the 12 states GAO visited, insurers must submit advertising materials to the state for review, and the insurer may use the material unless the state disapproves it within a specified period, typically 30 days.

State consumer education efforts related to Medigap also vary. Some states have outreach programs (including group sessions and individual counseling) to inform the elderly about Medigap insurance, while others depend mainly on distribution of written materials. Although little quantitative data on the effectiveness of education efforts were available, state officials believe their programs are worthwhile.

The 1988 loss ratios of about 38 percent of the companies were below the minimum standards; however, about 88 percent of premium dollars were with companies with loss ratios that met the standards.

## GAO's Analysis

### Sales Abuses and Consumer Protection

None of the states GAO visited maintained sufficient data to assess the extent of abuses in the sale of Medigap policies to the elderly, but available data show that problems continue to exist.

The consumer protection amendments included in NAIC's 1989 revision to its model regulation can help eliminate several sales abuses that have been associated with Medigap insurance. An NAIC representative told GAO that in a majority of states, insurers can use advertising materials before they are approved by state regulators. State officials said that they do find problems with insurance company advertising material from time to time, and that they have penalized companies and issued cease-and-desist orders because of deceptive advertising material that has reached the public.

## Consumer Education Efforts Vary

Educating the elderly about Medigap insurance is a key element in protecting these consumers against fraudulent sales practices. Several states sponsor educational efforts to help the elderly become better-informed consumers. These state programs vary from providing literature and speakers on request to more active efforts, including the state's own shoppers' guides, state-sponsored volunteer counseling services, and toll-free telephone assistance. The federal government also mails information to the elderly explaining Medicare benefits, assists NAIC in preparing a guide to health insurance, and maintains a toll-free telephone service. Under OBRA 1990, the federal government will be required to operate a health insurance advisory service and may also make grants available to the states to assist them in operating consumer counseling programs.

## Medigap Loss Ratios

In 1988, 38 percent of insurance company loss ratios were below the minimum standards established by the Baucus amendment—60 percent for individual policies and 75 percent for group policies. In OBRA 1990, the Congress increased the loss-ratio standard for policies sold to individuals from 60 to 65 percent for policies sold or issued after November 1991. The standard for policies sold to groups remains at 75 percent.

# Recommendations

This report contains no recommendations.

# Agency Comments

GAO did not obtain written comments on a draft of this report, although the views of responsible federal, state, and NAIC officials have been incorporated where appropriate.

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### Abbreviations

| | |
|---|---|
| GAO | General Accounting Office |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |
| MCCA | Medicare Catastrophic Coverage Act of 1988 |
| NAIC | National Association of Insurance Commissioners |
| OBRA 1990 | Omnibus Budget Reconciliation Act of 1990 |

# Introduction

Medicare helps its beneficiaries pay for health services. The program requires beneficiaries to pay deductibles and coinsurance and does not cover every kind of health care cost. Many beneficiaries purchase private Medicare supplemental insurance—commonly called Medigap insurance—to pay for some of their remaining costs. In 1988 policyholders paid about $7 billion in premiums for Medigap insurance.

In July 1988, the Medicare Catastrophic Coverage Act (MCCA), Public Law 100-360, was enacted. The changes in MCCA significantly reduced the cost-sharing liability of beneficiaries who required substantial health care services. After much public controversy, in November 1989 the Congress repealed MCCA and restored most Medicare benefits to what they were before the act's passage. When MCCA reduced beneficiary cost-sharing liability, it also reduced coverage requirements for Medigap policies. Repeal of MCCA restored Medigap coverage requirements to essentially what they were before the act was passed.

Before MCCA's repeal, the Chairman of the House Committee on Energy and Commerce; the Chairman of the Subcommittee on Health, House Committee on Ways and Means; and 23 other Members of the House asked us to review actions taken by the insurance industry, the states, and the federal government to comply with changes to federal standards regulating Medigap policies brought about by the act. After repeal of MCCA, some of the questions raised in those requests became moot, but the requesters remained concerned that purchasers of Medigap insurance be adequately protected from sales abuses and receive an adequate return of benefit payments in relation to their premiums. This report summarizes the current status of the Medigap industry's compliance with and states' actions related to federal minimum standards.

## The Medicare Program

Medicare is a federal health insurance program authorized by title XVIII of the Social Security Act. It pays much of the health care costs of eligible individuals—almost all people 65 years of age or older and some disabled persons. Benefits are provided under two parts. Part A, or hospital insurance, pays for inpatient hospital, skilled nursing facility, home health, and hospice services. It is financed primarily by a Social Security payroll tax paid by employees, employers, and the self-employed.

Part B, supplementary medical insurance, is a voluntary program covering physician services and a broad range of other ambulatory services, such as laboratory and X-ray services and medical equipment used in

the home. All persons 65 years of age or older and disabled persons eligible for part A are eligible for part B. Persons choosing part B coverage pay 25 percent of its cost through monthly premiums, and the government funds the other 75 percent through general federal revenues.

## The Baucus Amendment

Insurance regulation has historically been a state responsibility. However, during the 1970s the Congress became aware of many marketing and advertising abuses in the sale of Medigap insurance, and in 1980, it enacted Public Law 96-265, which added section 1882 to the Social Security Act. This provision, referred to as the Baucus amendment,[1] established federal minimum standards for marketing and selling Medigap policies. The amendment essentially adopted as federal requirements those contained in a model regulation approved by the National Association of Insurance Commissioners (NAIC).[2] At that time, the minimum standards (1) required Medigap policies to cover Medicare's coinsurance within certain limits; (2) provided prospective policyholders a "free look" period, during which they may return the policy for cancellation and receive a full refund of any premium paid; (3) standardized many of the terms used in policies; (4) limited the period for which coverage may be denied for preexisting conditions; and (5) required that cancellation and termination clauses be prominently displayed. MCCA and the act repealing it modified and added to these standards (see pp. 10-11).

The Baucus amendment also established loss-ratio targets for Medigap policies. A loss ratio is the intended minimum percentage of insurance premiums returned to policyholders in the form of benefits. The Baucus amendment's loss-ratio targets for Medigap policies are 60 percent for individual policies and 75 percent for group policies. In the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), Public Law 101-508, the Congress raised the minimum for individual policies to 65 percent, effective in November 1991.

Enforcement of the Baucus amendment minimum standards rests primarily with the state insurance commissioners. The Baucus amendment

[1] Named after Senator Max Baucus, the amendment's chief sponsor in the Senate.

[2] NAIC consists of the heads of the insurance departments of the 50 states, the District of Columbia, and four U.S. territories. Its basic function is to encourage uniformity and cooperation among the states and territories in regulating the insurance industry. Among its many activities, NAIC promulgates model insurance laws and regulations for state consideration and enactment.

established the Supplemental Health Insurance Panel[3] to review state insurance regulatory programs and approve those that meet the amendment's minimum standards. OBRA 1990 deleted reference to the panel and assigned responsibility for approving state programs to the Secretary, Department of Health and Human Services (HHS). In states that do not maintain Medigap insurance regulatory procedures that receive the Secretary's approval, insurers must submit their policies to the Secretary for approval.

The Baucus amendment also established federal penalties, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain HHS's certification of a policy, (2) posing as a federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage an individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

## The Medicare Catastrophic Coverage Act and Its Repeal

On July 1, 1988, the President signed MCCA. Because MCCA made sweeping changes to the Medicare program, it also required that the Medigap regulatory standards be revised, either by NAIC or by HHS if NAIC failed to do so within 90 days of enactment. NAIC approved new standards on September 20, 1988. All states but Massachusetts adopted the MCCA-required standards within a year, the time limit permitted by that law for states to retain federal approval of their regulatory programs.

The basic purpose of the revised model regulation was to assure that Medigap policies not duplicate the new MCCA Medicare benefits. MCCA also contained several other required modifications to Medigap standards. For example, the act required insurers to provide a uniform 30-day free-look period when a Medigap policy is purchased.[4] MCCA also required states to collect information on actual loss ratios as a condition for approval of state regulatory programs.

The Medicare Catastrophic Coverage Repeal Act of 1989, Public Law 101-234, became law on December 13, 1989. This act repealed MCCA and

[3]This panel consisted of the Secretary of Health and Human Services and four state insurance commissioners or superintendents of insurance appointed by the Secretary.

[4]Prior requirements were for a 10-day free-look period for policies sold through agents and a 30-day period for policies sold through the mail.

restored most Medicare benefits to what they were before MCCA's passage. The requirements that policies have a uniform 30-day free-look period and states collect actual loss-ratio data were not repealed.

Responding to MCCA's repeal, NAIC revised its model Medigap law and regulation again. This revision, adopted in early December 1989, changed the minimum standards to reflect MCCA's repeal. The new minimum benefit standards for Medigap policies (which states must adopt for approval of their Medigap regulatory program under federal law) differ in some aspects from those required before MCCA was enacted. For example:

- Current NAIC standards require Medigap policies to cover either all or none of the part A deductible ($592 per benefit period in 1990). The NAIC standard in effect before MCCA allowed a policy to cover just a portion of that deductible.
- NAIC's current standards require Medigap policies to cover all coinsurance for services covered by part B of Medicare, after the policyholder has paid the part B deductible of $75 per year. This coinsurance is 20 percent of the Medicare-approved charge for services. Before MCCA, the NAIC standards required Medigap policies to pay part B coinsurance after the policyholder paid $200 (the $75 annual part B deductible plus $125 in part B coinsurance), and Medigap policies could limit coverage to $5,000 in benefits in any calendar year.

In addition to addressing the changes required by the repeal of MCCA, NAIC added certain consumer protection amendments to its model regulation in the December 1989 revision. These amendments are discussed in chapter 2.

As of December 1990, the Secretary had given final approval to the laws and regulations of Delaware, Idaho, Maine, Montana, New Mexico, Rhode Island, Wyoming, and the Virgin Islands. He also gave conditional approval, pending final implementation within the state, of the laws and regulations of Illinois, Mississippi, North Carolina, Oregon, Pennsylvania, South Carolina, Utah, and Puerto Rico. The Medigap regulatory programs of American Samoa, Guam, Massachusetts, New York, and Oklahoma are not expected to be approved. Action is pending for the other states and territories.

## Additional Changes to Federal Standards Contained in OBRA 1990

In October 1990, the Congress passed OBRA 1990, which included provisions further modifying the Baucus amendment. The act increased the loss-ratio standard for individual policies to 65 percent, required rebates to policyholders when any policy fails to meet the applicable loss-ratio standard, directed that policies be simplified and standardized, limited the number of optional benefit packages offered, increased protection against the sale of duplicate policies, provided seed money for state Medigap consumer education programs, and made other changes to protect such consumers.

We had suggested many of these changes in testimony in March and June 1990. Further details about these changes are presented throughout this report.

## Objectives, Scope, and Methodology

We initiated our work based on two similar requests to review actions taken by the insurance industry, the states, and the federal government to comply with changes to federal standards regulating Medigap insurance policies required by MCCA. The first request was in December 1988 from the Chairman, Subcommittee on Health, House Committee on Ways and Means; the second was in February 1989 from the Chairman, House Committee on Energy and Commerce. In addition, in August 1989, 23 Members of the House asked us for similar information. The Chairman, Subcommittee on Health, also asked us to monitor Medigap insurance premiums and loss ratios for 1988[5] through 1994. After MCCA's repeal, the requesters asked that we continue our assessment of state regulation of Medigap insurance. Specifically, the requesters wanted answers to the following questions:

- What have been the results of state activities to identify and prevent abusive sales practices?
- How do states monitor Medigap advertising to prevent deceptive materials from being used?
- How effective have state efforts been to educate the elderly about Medigap policies?
- How do states review for approval Medigap premium changes?
- What percentages of premium dollars are returned as benefits to Medigap policyholders?

We did our work at Health Care Financing Administration (HCFA) headquarters, and in Arizona, California, Florida, Illinois, Maryland, New

[5]Premium changes for 1988 and 1989 are discussed in appendix I.

Jersey, New York, North Dakota, Pennsylvania, Texas, Washington, and the District of Columbia.[6] We selected these states to include ones in which Medicare beneficiaries comprise a relatively large percentage of the state's population and states with a significant portion of the nation's Medicare population. We also selected states that had active programs regarding particular aspects of Medigap insurance, such as monitoring loss ratios or providing consumer education.

From the state insurance departments we collected information regarding laws, regulations, and procedures governing the sale of Medigap insurance, including premium and advertising approval and the monitoring of loss ratios. We reviewed each state's rate-filing procedures to determine how it approves premium adjustments and how it uses loss ratios in this process. We also obtained a description of the state's educational efforts to assist its elderly from falling victim to abusive Medigap sales practices. In addition, we discussed regulatory enforcement actions with state officials and collected data on complaints and prosecutions of cases of abusive or illegal practices concerning the marketing and sale of insurance policies.

We visited or collected information from five major commercial insurers and three Blue Cross and Blue Shield Plans that sell Medigap insurance. These companies were selected on the basis of their large volume of Medigap earned premiums during 1987 (the latest year for which we had reasonably complete data when we made our selections). At these companies, we discussed their compliance with the changes required by MCCA, premium adjustments, loss-ratio reporting, and advertising. We also asked company officials for their opinions on NAIC's proposed consumer protection amendments to Medigap laws and regulations.[7]

We obtained 1988 loss-ratio data from the Blue Cross and Blue Shield Association for its member plans. We obtained these data for commercial insurers from NAIC.

[6]For convenience, the District of Columbia is referred to as a state in this report.

[7]Several of these proposed amendments were later incorporated into NAIC's model regulation and are discussed in chapter 2.

In addition, we contacted 29 of the larger commercial Medigap insurers and asked them to estimate the effect repeal of MCCA would have on 1990 premiums.[8]

At HCFA headquarters, we reviewed files on the operation of the Supplemental Health Insurance Panel in approving state regulatory programs and HCFA's actions to verify that state regulatory programs meet the Baucus amendment standards and changes required by MCCA.

Our work was performed from March 1989 to June 1990 in accordance with generally accepted government auditing standards. The requesters' offices asked that we not obtain written comments on this report; however, the views of federal, state, and NAIC officials have been incorporated where appropriate.

[8]See Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 6, 1989) and Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act, Statement of Ms. Janet Shikles before the Senate Special Committee on Aging (GAO/T-HRD-90-9, Jan. 8, 1990).

# Abuses in the Sale of Medigap Insurance and Regulatory Responses

Purchasing a Medigap insurance policy can be a complex and confusing experience. Medicare's cost-sharing system of coinsurance and deductibles can confuse program beneficiaries and may produce a real or perceived need to purchase supplemental insurance. Making informed decisions in the Medigap market can be difficult, and many elderly persons may be susceptible to deceptive sales practices.

If enforced, state insurance laws and regulations on sale practices and advertising provide a framework for consumer protection. Some states have responded to identified abuses with fines, cease-and-desist orders, license suspensions, and license revocations. Nevertheless, abuses continue.

NAIC's consumer protection amendments are designed to enhance efforts, as reflected in the Baucus amendment, to eliminate Medigap sales abuses. While their effectiveness will depend on state actions to adopt and enforce these consumer protections, the revised standards should help curb abusive Medigap sales tactics.

## Extent of Abusive and Fraudulent Sales Practices Is Not Known

Over the years, numerous cases of Medigap sales abuse have been reported. Examples include (1) selling multiple policies that duplicate coverage to an individual, (2) unnecessarily replacing policies, which created gaps in coverage, (3) using sales tactics that frighten or place undue pressure on people, and (4) using deceptive advertising to develop "leads" for sales.

Officials in the states we visited said that they have not identified widespread abuse in the sale of Medigap policies. Data that could be used to assess the extent of abuse are not available, and data that are available are not consistent across states.

The following sections present the information we were able to obtain related to Medigap sale abuses.

### Disciplinary and Enforcement Actions

Arizona, California, Illinois, New Jersey, Texas, and Washington[1] each provided some information on disciplinary and enforcement actions between 1985 and 1988 concerning abusive Medigap sales practices. State disciplinary actions during this time are summarized in table 2.1.

[1]The other state recording systems could not distinguish actions taken for improper sales practices regarding Medigap insurance from actions taken regarding other types of insurance.

**Table 2.1: Summary of State Disciplinary Actions Regarding Medigap Sales Abuses**

| Type of disciplinary action | Number of cases |
|---|---|
| License revocations | 73 |
| License suspensions, restitutions, and warning letters | 13 |
| Fines | 43 |
| Cease-and-desist orders | 12 |
| **Total** | **141** |

In addition, California and Illinois insurance department officials told us their states initiated a total of five criminal prosecutions for Medigap abuses between 1985 and 1988.

## State Complaint Data Collection Systems Are Not Uniform

All of the states we visited had formal insurance complaint-handling systems that included procedures for recording complaints, investigating the facts, and attempting to resolve the problems. Insurance department records showed that Medigap-related complaints generally involved delays in paying claims or disputes about the amount of payments, poor service, premiums, marketing, coverage, or agents. Of the 12 states we visited, 10 recorded Medigap complaints[2] received in 1988, and 9 categorized the nature of the complaints. Each state defined their complaint categories differently, making comparisons and summaries difficult. For example, in 1988, New York used 64 categories to describe complaints, while California used 13. Also, of the 10 states that could provide complaint data in 1988, 4 provided data for 1985-88, 1 for 1986-88, and 2 for 1987-88.

The 10 state insurance departments recorded 4,412 complaints in 1988. Florida recorded the most complaints that year, 1,693, but the state did not categorize them. Texas recorded the next highest number of complaints—1,429. Of the complaints in Texas, 47 were agent-related,[3] 45 were advertising-related,[4] and the other 1,337 complaints concerned delays in claim payment or disputed payment amounts, premiums and ratings, and poor service. California recorded 119 Medigap complaints in 1988; 96 were agent-related, 18 were advertising-related, and 5 involved improper agent licensing.

[2]In the other two states, insurance department personnel could not tell from their complaint summary files what type of insurance product was involved.

[3]Included allegations of premium diversion; misrepresentation; false comparisons to induce a policyholder to lapse, surrender, borrow on, convert, or replace an insurance policy; frequent policy replacement; failure to place coverage; forgery; and others.

[4]Included improper advertising, misleading advertising, marketing/sales complaints, and others.

## Federal Medicare Hotline

HCFA offers a toll-free Medicare hotline[5] that allows beneficiaries to ask questions or voice complaints about the Medicare program or Medigap insurance. The hotline number[6] appears in several HCFA publications available to Medicare recipients, including the Guide to Health Insurance for People with Medicare. This guide, published jointly by NAIC and HCFA, describes abusive and fraudulent sales tactics and encourages beneficiaries to report incidents to the federal hotline, state insurance department, or state office on aging. Since the hotline's inception in July 1988, HCFA has received about 300,000 calls per year, about 130 of which were related to Medigap.

## State Regulation and Monitoring of Insurance Advertising

Federal law requires all Medigap insurers to provide a copy of any advertising, whether written or broadcast through radio or television, to the state's insurance commissioner in accordance with each state's requirements. State insurance commissioners have varying levels of authority to regulate advertising, and state review processes vary. State regulatory authority over advertising generally fits one of three models:

- Prior approval. In these states, insurers must submit proposed advertising material for approval before use.
- File and use. In these states, including all 12 of the states we visited, insurers must submit advertising for review and may use the material unless the state disapproves it within a specified period of time. An NAIC representative told us that most states have file-and-use authority concerning advertising.
- Use and file. In these states, insurers may begin using advertising upon filing it with the state, but may have to stop using it later if the state identifies problems.

When reviewing advertising, state officials told us they look for false or exaggerated claims, such as "will pay 100 percent" or "you pay nothing." State insurance department officials told us that minor problems with advertising do occur, but, for the most part, insurers are willing to change their advertisements to comply with state requirements. New Jersey and Washington officials told us that they have penalized companies and issued cease-and-desist orders because of deceptive advertising material that reached the public.

[5]The Medicare Catastrophic Coverage Repeal Act of 1989 did not repeal the requirement for the hotline.

[6]1-800-638-6833 (1-800-492-6603 in Maryland).

When a company does not comply with state advertising requirements, states may fine the offender or issue a cease-and-desist order to force compliance. For example, New Jersey officials told us of two cases in 1987 in which the insurance department fined insurance companies for advertising rule violations regarding Medigap insurance.

## Lead Cards Can Deceive Consumers

One method that has been used to obtain names of potential purchasers of insurance is "cold-lead" advertising. Over the years, cold-lead advertising abuses have troubled the Medigap industry. The NAIC consumer protection amendments to its Medigap model regulation prohibit cold-lead advertising, which the regulation defines as:

> "Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company."

The intent of cold-lead advertising is to generate a list of prospects who may be interested in a certain product or service from those who respond to a lead-card solicitation. Lead cards may be distributed through direct mail or may be included as inserts with other mail (such as bills) or inserted in magazines or newspapers.

Typically, lead cards are distributed by companies that specialize in that business. These companies compile lists from the respondents to their lead cards and offer the lists for sale. In 1989, Consumer's Union reported that insurance agents pay nearly $20 each for names and addresses supplied by lead-card companies.

Lead cards that disclose information about a potential insurance agent call or visit are permitted, but cards that do not disclose such information or are otherwise misleading are prohibited under many state laws and regulations. Figure 2.1 is an example of a lead card that Florida officials determined to be deceptive.

**Figure 2.1: Example of a Lead Card**

NO POSTAGE NECESSARY IF MAILED IN UNITED STATES

BUSINESS REPLY CARD
First Class Permit #14048 Washington, D.C.

POSTAGE WILL BE PAID BY ADDRESSEE

NATIONAL ASSOCIATION OF RETIRED PERSONS
1050 CONNECTICUT AVE., N.W.
SUITE 800
WASHINGTON, D.C. 20036-9990

PLEASE FILL OUT COMPLETELY

Name ____________ Phone ____________
Street ____________ City ____________
County ____________ State ____________ Zip ____________
Ages: Husband ____________ Wife ____________

☐ YES, I would like further information on NARP Benefits and this Special Plan.

MAIL POSTAGE PAID CARD TODAY!

NARP 88

Florida officials said the card was misleading and deceptive in two respects. First, it gives the false impression that the recipient's reply will result in the National Association of Retired Persons providing information concerning a group-sponsored Medigap insurance plan, although the association did not offer such a plan. Second, it does not alert the recipient that the card will be used by an insurance company and its agent to solicit individual Medigap applications on behalf of the

company.[7] On October 31, 1986, the Florida Department of Insurance ordered the offending insurance company to stop using this card.

The states we visited had varying views of lead-card companies and have taken different actions toward controlling them. California, Florida, Texas, and Washington had taken actions to regulate lead-card companies. For example:

- California prohibits advertisements designed to produce leads that have misleading names, addresses, and logos, or that fail to state that the advertisement is not connected with or endorsed by the U.S. government or the Medicare program. California insurance department officials told us that, since 1986, they have had numerous discussions with lead-card companies concerning their compliance with California advertising regulations, and that the state had issued one cease-and-desist order.
- Florida holds insurance companies responsible for advertising, including lead-generating devices. Florida officials told us that the state had issued cease-and-desist orders in two cases, one in 1986 and the other in 1988, involving the use of deceptive lead cards.
- A Washington state official told us that because the insurance department has authority over insurance companies and their agents and not lead-card companies, the department must try to establish a link between a lead-card company and an insurance company or agent in order to enforce its advertising rules. This insurance department added that insurance companies and their agents are reluctant to admit to using lead cards, and the lead-card companies almost always refuse to disclose the names of their clients. A Washington official said the state has stopped about a dozen lead-card companies that formerly operated in the state.
- Texas officials told us they became interested in investigating the actions of lead-card companies because they learned of the work done in California and Washington and because many lead-card companies are headquartered in the Dallas-Fort Worth area. Until recently, Texas insurance regulators said they did not have authority to enforce state insurance advertising laws against lead-card companies. In July 1989, the Texas legislature passed legislation to combat deceptive lead-card companies. In August 1989, using this new authority, the state attorney general initiated a prosecution of two lead-card companies to enforce the state's rules. These cases were in litigation as of December 1990.

[7]In addition, the state said that the use of a Washington, D.C., return address may give the impression that it is from a federal agency or somehow related to Medicare.

Officials in the other states we visited did not believe that lead cards were a serious problem in their states.

## NAIC Consumer Protection Amendments

In December 1989, NAIC adopted several new consumer protection amendments while revising its Medigap model regulation. NAIC designed its amendments to help combat problematic sales tactics for this insurance. These revised standards continue efforts in the Baucus amendment to reduce abuses in the sale of Medigap policies.

A persistent problem in the sale of Medigap insurance is that some Medicare beneficiaries purchase multiple policies that duplicate coverage. Revised consumer protection provisions in the NAIC model should alleviate this problem. Under the NAIC model, application forms must include questions asking whether the applicant has another Medigap policy in force and, if so, whether the policy being applied for is intended to replace any medical or health insurance already in force. Agents must also list on the application any health insurance policies they have sold to the applicant. The sale of more than one Medigap policy to an individual is prohibited, unless the combined policies' coverage does not exceed 100 percent of the individual's actual medical expenses. In addition, if the sale involves replacement of a Medigap policy, an insurer or its agent must provide the applicant with a notice, before the replacement policy goes into effect, that the coverage applied for replaces health insurance in force. This notice will give purchasers an additional opportunity to review their coverage and cancel the replacement policy without penalty if they decide not to replace the policy in force.

In adopting OBRA 1990, the Congress tightened this provision further, effective for policies issued or sold beginning in November 1991. Those new provisions will require agents to obtain a written statement from applicants for Medigap insurance stating what other health insurance they have and whether they are eligible for benefits under Medicaid. This information must be obtained on a form that informs the applicant that Medicare beneficiaries do not need more than one Medigap policy and that Medicaid beneficiaries usually do not need a Medigap policy. Further, each Medigap policy must provide that benefits and premiums can be suspended for up to 2 years if the policyholder so requests upon becoming eligible for Medicaid.

Another problem with Medigap sale practices has been the unnecessary replacement of policies, which results in new waiting periods during

which policyholders are not covered for preexisting conditions. Insurance agents had an incentive to sell replacement policies because they generally received a much higher commission for new policies than for renewals. New provisions in the NAIC model should decrease the incentives to sell new policies because they place restrictions on the way commissions are paid and prohibit waiting periods when replacement policies are sold. The compensation provision limits the first-year commission and other compensation[8] that may be paid to an agent selling a Medigap policy and also requires companies to spread the total compensation over a reasonable number of years. These requirements will decrease the incentive for agents to unnecessarily sell replacement coverage by preventing companies from loading agent compensation into the first years a policy is in effect. Also, when issuing a replacement Medigap policy, insurers must waive waiting periods applicable to preexisting conditions or other similar restrictions to the extent such time was spent under the original policy.

In addition, the consumer protection amendments require that all insurers adopt fair-marketing standards that prohibit high-pressure sales tactics and deceptive cold-lead cards.

States must adopt the new NAIC model, including the consumer protection amendments, if they wish to meet requirements for state regulatory program approval under the Baucus amendment. Although there has been some controversy surrounding the consumer protection amendments, largely because some insurers perceive the amendments to be overly restrictive, NAIC expects nearly all states to adopt them. As mentioned in chapter 1, the Secretary of HHS is reviewing state laws and regulations for compliance with this requirement.

[8]Includes bonuses, gifts, prizes, awards, finders' fees, and similar forms of remuneration.

# Educating Elderly Consumers About Medigap Insurance

Educating the elderly about Medigap insurance can help make them less susceptible to fraudulent marketing practices and other sales abuses. HCFA has several consumer education efforts underway. The states also offer various programs that make Medigap insurance educational material available to the elderly. State officials believe these education approaches are effective, but they also believe the programs are not reaching everyone.

HCFA's educational efforts focus primarily on disseminating literature, including The Medicare Handbook, special informational mailings to Medicare beneficiaries, and a consumers' guide (developed jointly by HCFA and NAIC). Educational efforts vary from state to state. State programs include disseminating literature, making public service announcements, holding seminars, and training volunteer counselors.

Some states have more active educational programs for consumers than others. Examples of these programs include

- training volunteers to counsel consumers on how to compare supplemental insurance options; understand policy terminology, conditions, and limitations; and assess their need for Medigap insurance;
- publishing shoppers' guides that outline Medigap policies' benefits and prices; and
- providing toll-free hotline services for answering consumer questions.

## Federal Educational Efforts

The federal government makes Medicare and Medigap information available to the public through various HCFA publications. For example, HCFA in conjunction with NAIC, developed and periodically updates the Guide to Health Insurance for People with Medicare. This guide summarizes services covered by Medicare and those that are the beneficiary's responsibility. It warns the elderly: "Don't Buy More Policies Than You Need. Duplicate coverage is costly and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages." The guide provides information designed to help the elderly determine whether they need a Medigap policy, and what they should look for in a policy. HCFA distributes the guide to senior citizen groups, Social Security district offices, and local offices on aging. The NAIC model regulation requires all insurers soliciting Medigap insurance to provide a copy of this guide to consumers at the time of sale, either when an agent takes the application for insurance sold through direct sale, or not later than when the policy is delivered if the insurance is sold through the mail.

HCFA also publishes The Medicare Handbook, which provides information on Medicare, appeal rights, and claims procedures. This handbook is mailed annually to all Medicare beneficiaries.

In December 1989, after MCCA was repealed, HCFA prepared for the media a repeal information kit explaining the resulting changes. In January 1990, HCFA mailed all Medicare beneficiaries a notice containing similar information on the repeal.

## State Educational Efforts

All states we visited had programs to educate the elderly about Medigap insurance. The educational programs varied depending on the funding and resources provided the insurance department, but the state programs generally included disseminating literature, making public service announcements, holding seminars, or training volunteer counselors.

For example, Arizona insurance department personnel have counseled elderly persons over the telephone, provided seminars, and publicized information about Medigap insurance in a newspaper directed toward Arizona's senior citizens.

Texas gives seminars for the elderly, uses radio and television public service announcements, supplies HCFA's Guide to Medicare to about 700 libraries throughout the state, provides speakers on request, and makes available an informational video on Medicare and Medigap insurance. Texas also operates toll-free telephone lines the elderly can use to ask questions or voice complaints.

In the District of Columbia, the insurance department provides the NAIC/HCFA guide and other guides upon request. The office on aging does not directly provide educational services or materials, but it refers incoming calls and letters to the appropriate agency for resolution.

Florida disseminates literature, operates a toll-free consumer hotline, and conducts seminars followed by "help sessions," in which insurance department representatives meet with consumers to answer questions.

All state insurance departments we visited, except the District of Columbia's, have recently conducted presentations or seminars on insurance sold to the elderly.[1] Like other educational efforts, the programs vary widely among the states. For example, Texas and Pennsylvania conduct seminars in response to requests, whereas California has a 15-person speakers' bureau and sponsors presentations on the department's initiative. North Dakota has hired a consultant to solicit and conduct seminars.

## Volunteer Counseling Programs

Washington, California, New Jersey, and Illinois employ many of the educational techniques discussed above and have additional programs, including volunteers to counsel and advise the elderly about insurance. Most volunteer programs are carried out jointly by the state insurance department and other state agencies. These counseling programs provide the elderly with knowledgeable, independent sources of information about Medicare and Medigap insurance. Counselors help consumers compare insurance options; understand policy terminology, conditions, and limitations; and assess their need for Medigap insurance.[2]

Another educational service provided by some states is Medigap shoppers' guides. Of the 12 states we visited, 8—Arizona, California, Florida, Maryland, New Jersey, New York, Texas, and Washington—publish shoppers' guides. The guides varied in the level of detail provided. Some contain rates and summaries of policy coverages for all approved Medigap policies sold in the state, while others give examples of representative premiums. Many guides explain Medicare and other types of health insurance, suggest factors to consider when deciding whether to buy Medigap insurance, suggest alternative sources for bridging Medicare's gaps, and include tips on how to shop for health insurance. In conjunction with its guide, New Jersey produces a chart comparing the premiums and benefits of all individual Medigap policies marketed in the state. The Maryland guide contains examples of premiums and benefits for Medigap and long-term care policies available in the state. Much of the information in these guides is not otherwise generally available to the elderly.

[1]The District's consumer education division has not received any requests for presentations on Medigap insurance in the last 2 years, but an insurance department official said the division would provide a speaker if so requested.

[2]In the Washington state program—called Senior Health Insurance Benefits Advisors—volunteers provide information to the elderly at the community level. California has a similar program called the Health Insurance Consumer Advocacy Program. In New Jersey and Illinois, similar volunteer counseling programs are called the Senior Health Insurance Program.

## Toll-Free Telephone Services for Consumer Information and Complaints

Several states and HCFA operate toll-free telephone services for persons seeking information or wishing to register complaints about their Medigap insurance. The HCFA/NAIC Guide to Health Insurance for People with Medicare describes prohibited sales practices for Medigap insurance and encourages people who believe they have been victimized to report the incident to the appropriate authority. The guide also encourages people to call HCFA, their state insurance department, or their state office on aging if they have questions about Medicare or their Medigap insurance coverage.

In addition to HCFA's toll-free telephone number, the 1990 version of the HCFA/NAIC guide also contains the toll-free number of 6 state insurance departments and 12 state offices on aging.

## Effectiveness of State Education Efforts Is Difficult to Measure

The effectiveness of educational programs is difficult to measure, and none of the state insurance departments we visited quantitatively measured the effectiveness of their programs. Officials in several states cited various approaches that they thought were effective, but they also noted that many elderly persons are not being reached.

Several state insurance department officials said they believe that counseling the elderly one-on-one is the most effective way to educate them. Also, because Medicare and Medigap insurance are complicated, state insurance department officials told us that it is important to give the consumer easily understandable written materials that they can refer to after the counseling session.

California and Washington insurance department officials told us that after some seminars and counseling sessions, they receive more inquiries and complaints about insurance. These officials believed that the increases were an indication that their education efforts are successful.

Despite the efforts of some state insurance departments to disseminate information on Medigap insurance, officials in those states believe that many of the elderly still are not reached. Washington state insurance department officials believe they are just "scratching the surface" regarding the number of the elderly who receive Medigap consumer information. New Jersey insurance department officials told us that their volunteers have counseled about 15,000 out of an estimated 994,000 elderly persons in the state. An Illinois official estimated that volunteers held about 220 counseling sessions during 1988 and had almost doubled that rate of seminars through the first 7 months of 1989.

OBRA 1990 required the Secretary of HHS to establish a beneficiary assistance program to assist Medicare beneficiaries in obtaining information on Medicare, Medicaid, and other health insurance programs. The Secretary was also authorized to make grants for state-operated health insurance information, counseling, and assistance services for Medicare-eligible individuals.

# State Regulation of Medigap Premiums

State insurance commissioners have varying authority to regulate Medigap premiums. In the states we visited, the degree to which state insurance department officials review premium adjustments and the resources devoted to that review also varied. Rate reviewers used a variety of techniques to assess rate filings, including loss-ratio data,[1] actuarial memoranda that explain the rationale for the rate adjustment request, and individual rate reviewer judgment and experience.

## State Review of Medigap Rate Requests Varies

Most states require insurers selling Medigap insurance to file premium adjustments with the state insurance commissioner. State rate review authority falls into three categories:

- Prior approval. Under this authority, insurers must submit rate requests for approval before implementing them. An NAIC representative told us that 14 states require prior approval by the state insurance department before Medigap rate revisions can be implemented. In some states, rates may be deemed approved if they are not denied within a specified number of days.
- File and use. Under this authority, insurers may implement rate changes (1) as soon as they are filed or (2) if the rate is not disapproved within a specified period of time, typically 30 days. Twenty-nine states (including the District of Columbia) are file-and-use jurisdictions.
- Use and file. This authority allows insurers to use new rates as long as the rate change is filed within a specified amount of time. The insurer may continue to use the new rates unless the state insurance department disapproves them. In two states the insurance commissioner has use-and-file authority over rate requests.

Six states have filing requirements that do not fit into the above categories. For example, according to an NAIC summary, Alabama requires only an informational filing. Utah requires prior approval for filings related to individual policies but has no filing requirement for group policies. Alaska, Missouri, Montana, and South Carolina have no rate-filing requirement.

The number and type of personnel devoted to rate reviews also vary from state to state.[2] In Florida, for example, one actuary within the

[1] A policy loss ratio is the percentage of premiums returned to policyholders in the form of benefits. Loss ratios are discussed in more detail in chapter 5.

[2] According to the 1990 yearbook of the American Society of Actuaries, 20 state insurance departments have actuaries on staff.

department of insurance was responsible for reviewing all Medigap rate requests for policies sold in the state. Florida's department of insurance reviewed 107 Medigap submissions from January 1 through June 30, 1989.

North Dakota did not have an actuary to review rate requests at the time of our visit. Rate requests were reviewed by a market conduct examiner and a forms and rate analyst. At the time of our visit, North Dakota planned to hire an actuary to assist with Medigap rate-filing review.

The degree of rate-filing review and the tools used to review filings also vary from state to state. In Washington, for example, the state insurance department requires insurers to submit their rates for approval before adjusting them. Insurers must submit data showing the policy's projected loss ratio over a period of future years and must submit supporting documentation of the policy's claims experience. Insurance department personnel make their own estimates of the policy's future loss ratio. If the department's independent estimates demonstrate that the insurer will not meet the loss-ratio target, the rate filing is disapproved. California, on the other hand, relies more on reviewer judgment. A California insurance department attorney told us that he performs an initial screening on all rate filings and, from his years of experience with rate-filing review, decides which filings need further review. The attorney told us that he will forward those rate requests that he determines need closer review to an insurance department actuary for detailed review.

States require insurers to submit an annual Medicare Supplement Experience Exhibit to the state insurance department. This exhibit summarizes the companies' earned premiums and incurred claims for both statewide and nationwide Medigap business. Reviewers use these loss-ratio data to assess the historical percentage of earned premiums paid as benefits for each company submitting a Medigap rate filing. Insurers also submit actuarial memoranda to support their rate filings. These documents explain a company's rationale and assumptions justifying the requested premium adjustment and include a projection of the policy's future loss ratio. Actuarial memoranda must be signed by an actuary, who certifies that the information in them is complete and accurate. Finally, rate-filing reviewers rely on the knowledge they developed from past reviews to assist them in determining which filings require more intense scrutiny.

Insurance department personnel in several states told us that the rate review process involves some give and take between the insurance department and the insurance companies over rate requests; however, these discussions were not always documented. The personnel added that if the state questions a rate request, a company will sometimes withdraw the request and resubmit a lower one. From the data available, we summarized state regulatory actions on 370 rate requests in seven states. In those 370 cases, documentation in the state's files indicated that the state approved requested increases in 236 cases (63.8 percent), approved a requested decrease in 7 cases (1.9 percent), approved a requested increase after some negotiation in 91 cases (24.6 percent), and disapproved a requested increase in 36 cases (9.7 percent).

# Monitoring and Enforcement of Medigap Loss-Ratio Standards

Despite the expectations established in the Baucus amendment and the NAIC model regulation, many company loss ratios do not comply with the minimum standards. NAIC revised its loss-ratio reporting form for 1988 and later, which should help states monitor and enforce the loss-ratio standards. Additional requirements included in OBRA 1990, effective for policies sold or issued after November 1991, will require companies to issue refunds or credits against future premiums to bring their loss ratios into compliance with the federal requirements.

## Explanation of Loss Ratios

An insurance policy loss ratio, usually expressed as a percentage, is the portion of premiums returned to policyholders in the form of benefits. While the loss-ratio definition appears simple, several variables make up the computation.

Benefits are the policy's incurred claims, which include claims paid during the period for which the loss ratio is computed plus a reserve for claims incurred but not yet reported or paid. Before 1988, incurred claims included an estimate for active life reserves for future claims.[1] Beginning with loss-ratio reports for 1988, NAIC instructed companies to delete the active life reserves from the computation so that the loss ratio for 1988 and later years more nearly reflects current experience.

Earned premiums include premiums collected in the period for which the loss ratio is computed minus an allowance for premiums received for time not in the loss-ratio period.[2] Earned premiums also are adjusted for premiums due but unpaid in the current period.

Some caution is needed in interpreting and using loss ratios because of several factors that 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 preexisting conditions during the policy's waiting period. Also, new policyholders may be fairly healthy and file few claims, so a policy with 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. Although

[1] An actuary from one state told us that the intended effect of including active life reserves in the computation was to inflate the loss ratio in the early years of a policy and to suppress it in later years, giving a more stable ratio from year to year.

[2] For example, if a policyholder paid an annual premium on April 1, only 9 months of that premium would be earned premium in that year's loss-ratio computation.

there are different opinions on what constitutes a mature policy, NAIC believes that a mature Medigap policy is one that is 3 or more years old.

Another factor affecting the interpretation of loss ratios is the "credibility" of the earned premium experience. The credibility of a loss ratio increases as the amount of earned premiums increases. Actuaries from two state insurance departments we visited are preparing for NAIC a manual to assist state regulators in reviewing Medicare supplement loss-ratio exhibits. The draft manual states that a loss ratio is credible if it is based on statewide earned premiums greater than $150,000. One of the authors of the manual told us that, on a national basis, he would consider earned premiums greater than $250,000 to be credible experience.

## Minimum Loss-Ratio Standards

The Baucus amendment set federal targets for loss ratios for Medigap policies. The amendment required as a condition of approval that Medigap policies be expected to have loss ratios of at least 75 percent for group policies and at least 60 percent for individual policies. If an insurer demonstrates that a policy can reasonably be expected to meet the standard, it has complied with the requirement whether or not its actual loss ratio ever meets the standard. MCCA revised the amendment to require states to collect data on actual Medigap loss ratios.

In December 1987, NAIC amended its model regulation to require that policies in effect for 3 years or more actually meet loss-ratio standards. Also, the revised regulations eliminated the preferential treatment that had been applied to direct mail groups, such as policies sold through the American Association of Retired Persons. Those policies used to be treated as individual policies, subject to the 60-percent standard, but are now subject to the 75-percent standard for group policies.

The Baucus amendment and the NAIC model require states to adopt a loss-ratio standard of at least 60 percent for individual policies, and most states have set their standard at that level. Twelve states (Connecticut, Delaware, Maine, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Rhode Island, Washington, and Wyoming) have opted for a higher, 65-percent minimum standard for individual Medigap policies.

## Many 1988 Loss Ratios Do Not Comply With Minimum Standards

We obtained 1988 loss-ratio data (the latest available) for Medigap insurance from NAIC and the Blue Cross and Blue Shield Association. The data are reported in aggregate for all policies sold by a company and are presented in appendixes II-V. 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 that 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 offer some policies that fall below them.

As we have reported in our earlier report[3] and testimonies,[4] many company loss ratios have not met the minimum standards. For 1988, earned premiums totaled about $3.7 billion for all policies in force 3 years or more with nationwide earned premiums of over $250,000. For policies sold to individuals (see app. II):

- By commercial insurers, 34 percent of the loss ratios were below the 60-percent minimum standard. The average loss ratios for companies exceeding the standard was 68.5 percent, while the average for companies below the standard was 50 percent. About 87 percent of total earned premiums were with companies whose average loss ratio exceeded the minimum standard.
- By 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 were with plans whose average loss ratio exceeded the minimum standard.

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

[4]See Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits, Statement of Mr. Michael Zimmerman before the Senate Committee on Finance (GAO/T-HRD-89-22, June 1, 1989); 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); 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, March 13, 1990); and Medigap Insurance: Proposals for Regulatory Changes and 1988 Loss Ratio Data, Statement of Ms. Janet Shikles before the Subcommittee on Commerce, Consumer Protection, and Competitiveness and the Subcommittee on Health and the Environment, House Committee on Energy and Commerce (GAO/T-HRD-90-35, June 7, 1990).

For group coverage (see app. III):

- By commercial insurers, about 66 percent of the 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 were with plans whose average loss ratio exceeded the minimum standard.
- By 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 94.1 percent, and the average for those below the target was 71.5 percent. About 88 percent of total earned premiums were with plans whose average loss ratio exceeded the minimum standard.

Earned premiums totaled about $3.5 billion in 1988 for all policies in force less than 3 years with nationwide earned premiums of over $250,000. For policies sold to individuals (see app. IV):

- By commercial insurers, 60 percent of the company loss ratios were below the 60-percent minimum standard.
- Among the Blue Cross and Blue Shield plans, all met or exceeded the standard.

For group coverage, about 71 percent of the commercial companies and 16 percent of the Blue Cross and Blue Shield plans did not meet the 75-percent target. Additional details are in appendix V.

OBRA 1990 made several changes to the loss-ratio standards. The minimum loss-ratio requirement for policies sold to individuals was increased to 65 percent. In addition, the act requires insurers to issue refunds or premium credits for any policy whose loss ratio does not comply with the minimum standard so that a new loss ratio computed on the premium collected less any refund or credit meets the standard. This refund or credit would be required after a policy has been in force for 2 years. These changes are effective for policies sold or issued after November 1991.

## Loss Ratios as a Regulatory Tool

Under the Baucus amendment, states are responsible for (1) monitoring whether Medigap policies meet the loss-ratio standards and (2) taking action as allowed under state law (such as seeking reductions in premiums or denying requests for rate increases) when they do not. State regulatory personnel told us that they use loss ratios to assist them in reviewing rate filings.[5] The majority of insurers and state regulators we talked to said that loss ratios, while not ideal, are the best regulatory tool available.

In the past, states did little to assure that the loss-ratio standards were actually met. This was because the standards were expressed as targets, and the manner in which loss-ratio data were reported by insurers did not facilitate monitoring.

Under NAIC's current loss-ratio standards, ratios for policies that have been in force for 3 years must meet the standards, and the way in which ratios are reported will make such determinations easier than in the past. NAIC adopted its tougher standards in 1987, and those standards were adopted by the states[6] after MCCA was enacted. Thus, the states should be better able to enforce the standards than was the case previously.

As noted above, after November 1991, OBRA 1990 will require insurers to make proportional refunds or issue credits if their loss ratios do not meet the standards after policies have been in force for 2 years. OBRA 1990 also involves HHS in monitoring loss ratios, requiring the Secretary to report (1) what policies do not meet the standards and (2) what actions, including refunds or credits or denial of premium increases, were taken to bring the ratios into compliance.

[5]As discussed in chapter 4, loss ratios are one of the tools used to evaluate the appropriateness of rates. Other tools include actuarial memoranda and reviewer experience.

[6]Massachusetts did not adopt the NAIC model. An official in that state's insurance department told us that the Massachusetts regulation regarding loss ratios requires Medigap policies issued to persons aged 65 and over to have an anticipated loss ratio of 65 percent.

# Medigap Premium Changes, 1988-89

The Chairman, Subcommittee on Health, House Committee on Ways and Means, asked us to monitor Medigap insurance premiums and loss ratios for the years 1988-94.

## Premium Changes After MCCA Passage Are Mixed

When MCCA was enacted, many people thought that Medigap premiums would decrease because the expansion of Medicare benefits that were to be phased in under MCCA would leave fewer costs for Medigap policies to cover. We summarized 506 Medigap rate changes from commercial and Blue Cross/Blue Shield plans, representing rates in 25 states. This summary compares the rate for a policy before MCCA became effective with the rate under the first year of MCCA's expanded benefits. Those rate comparisons are summarized in table I.1.

**Table I.1: Comparison of Medigap Policy Premiums in 25 States Before and After the Effective Date of MCCA**

| Premiums before MCCA compared with premiums after MCCA | Policies reviewed Number | Policies reviewed Percent | Average percentage change |
|---|---|---|---|
| Increased | 228 | 45.1 | + 18 |
| Decreased | 114 | 22.5 | − 10 |
| No change | 164 | 32.4 | |
| **Total** | **506** | **100.0** | |

The insurers gave one or more of the following justifications for raising premiums: the increase in the part A hospital deductible (30.4 percent), poor underwriting or utilization experience in prior years (27.3 percent), inflation (26.5 percent), additional part B benefits or other new benefits (10.6 percent), and other reasons (5.2 percent). Insurers gave one or more of the following reasons for decreasing premiums: elimination of duplicate coverage (57.8 percent), elimination of certain coinsurance (16.8 percent), elimination of coverage of deductibles (13.9 percent), prior years' experience not meeting minimum loss-ratio standards (8.7 percent), and other reasons (2.8 percent). In some cases, insurers cited one or more of the above reasons for increasing premiums that were partially or wholly offset by one or more of the reasons for decreasing premiums. The changes summarized in table I.1 show the net effect of those increases and decreases.

## Premium Changes Resulting From MCCA and Its Repeal

Shortly before the Congress repealed MCCA, we compiled information on the possible effects repeal would have on Medigap premiums.[1] During October and November 1989, we contacted 29 commercial insurers with over $10 million in earned premiums on Medigap policies during 1987 (the latest year for which we had reasonably complete data) and asked those insurers to estimate (1) their 1990 Medigap insurance monthly premium for their largest selling policy, assuming MCCA was not repealed, and (2) the effect repeal would have on their 1990 premiums.

Twenty companies provided data covering over 2.5 million Medigap insurance subscribers. These insurers reported that repeal of MCCA would result in an average increase of 15.4 percent in monthly premiums. The reported increases ranged from 6.3 to 41.3 percent. The insurers reported that repeal would cost the 2.5 million policyholders covered by our survey over $250 million in 1990.

After the Congress repealed MCCA in November 1989, we again contacted the same 29 insurers. Twenty insurers responded and told us at that time that repeal of MCCA would result in an average increase of 19.5 percent in monthly premiums. The reported increases ranged from 5.0 to 51.6 percent for 19 companies, and one company did not expect its 1990 premium to change. The average increase was $11.44 per month and would cost the 2.6 million policyholders covered by these policies over $230 million in 1990. The insurers attributed about half of the average premium increase to increased benefits and administrative costs necessitated by repeal of MCCA and about half to other factors, such as inflation, increased use of medical services, and prior years' claims experience.

[1]See Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 6, 1989) and Medigap Insurance: Expected 1990 Premiums After Repeal of the Medicare Catastrophic Coverage Act, Statement of Ms. Janet Shikles before the Senate Special Committee on Aging (GAO/T-HRD-90-9, Jan. 8, 1990).

# Distribution of 1988 Medigap Loss Ratios for Policies in Force for 3 Years or More—Policies Sold to Individuals

Dollars in thousands

| Loss ratios | Number of companies | Earned premiums | Average loss ratio (%) |
|---|---|---|---|
| **Commercial plans:** | | | |
| Under 40% | 4 | $7,666 | 31.8 |
| 40 - 49% | 12 | 40,786 | 46.5 |
| 50 - 59% | 28 | 52,179 | 55.4 |
| **Subtotal** | **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 |
| **Subtotal** | **87** | **689,791** | **68.5** |
| **Total** | **131** | **$790,422** | **66.1** |
| **Blue Cross/Blue Shield plans:** | | | |
| Under 40% | • | • | • |
| 40 - 49% | • | • | • |
| 50 - 59% | 1 | $527 | 53.9 |
| **Subtotal** | **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 |
| **Subtotal** | **50** | **1,886,986** | **93.4** |
| **Total** | **51** | **$1,887,513** | **93.4** |

Note: For policies with more than $250,000 in earned premiums.

# Distribution of 1988 Medigap Loss Ratios for Policies in Force for 3 Years or More—Policies Sold to Groups

Dollars in thousands

| Loss ratios | Number of companies | Earned premiums | Average loss ratio (%) |
|---|---|---|---|
| **Commercial plans:** | | | |
| 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 |
| **Subtotal** | **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 |
| **Subtotal** | **10** | **599,935** | **101.5** |
| **Total** | **29** | **$648,528** | **98.5** |
| **Blue Cross/Blue Shield plans:** | | | |
| Under 45% | • | • | • |
| 45 - 54% | 2 | $2,496 | 47.8 |
| 55 - 64% | 2 | 1,534 | 58.1 |
| 65 - 74% | 4 | 43,598 | 73.3 |
| **Subtotal** | **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 |
| **Subtotal** | **26** | **360,776** | **94.1** |
| **Total** | **34** | **$408,404** | **91.4** |

Note: For policies with more than $250,000 in earned premiums.

# Distribution of 1988 Medigap Loss Ratios for Policies in Force for Less Than 3 Years—Policies Sold to Individuals

Dollars in thousands

| Loss ratios | Number of companies | Earned premiums | Average loss ratio (%) |
|---|---|---|---|
| **Commercial plans:** | | | |
| Under 40% | 17 | $50,387 | 32.6 |
| 40 - 49% | 23 | 88,986 | 44.1 |
| 50 - 59% | 43 | 476,239 | 54.8 |
| **Subtotal** | **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 |
| **Subtotal** | **55** | **649,554** | **66.7** |
| **Total** | **138** | **$1,265,166** | **59.3** |
| **Blue Cross/Blue Shield plans:** | | | |
| Under 40% | • | • | • |
| 40 - 49% | • | • | • |
| 50 - 59% | • | • | • |
| **Subtotal** | | | |
| 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 |
| **Subtotal** | **36** | **1,215,270** | **87.5** |
| **Total** | **36** | **$1,215,270** | **87.5** |

Note: For policies with more than $250,000 in earned premiums.

# Distribution of 1988 Medigap Loss Ratios for Policies in Effect for Less Than 3 Years—Policies Sold to Groups

Dollars in thousands

| Loss ratios | Number of companies | Earned premiums | Average loss ratio (%) |
|---|---|---|---|
| **Commercial plans:** | | | |
| 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 |
| **Subtotal** | **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 |
| **Subtotal** | **6** | **615,706** | **99.9** |
| **Total** | **21** | **$663,430** | **96.7** |
| **Blue Cross/Blue Shield plans:** | | | |
| Under 45% | 1 | $561 | 42.8 |
| 45 - 54% | • | • | • |
| 55 - 64% | • | • | • |
| 65 - 74% | 2 | 12,406 | 68.4 |
| **Subtotal** | **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 |
| **Subtotal** | **16** | **363,555** | **92.6** |
| **Total** | **19** | **$376,522** | **91.7** |

Note: For policies with more than $250,000 in earned premiums.

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