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MEDICARE SUPPLEMENT UPDATE

Track: Health

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Summary: High claims trend, burdensome regulation, fixed plan design, limited underwriting ability, and disenrollment to and then reenrollment from capitated plans have contributed to slim or negative margins in the Medicare supplement market.

Panelists explore these and other issues facing carriers offering these products, including potential federal legislation, National Association of Insurance Commissioners (NAIC) pursuits, and the American Academy of Actuaries (AAA) task force.

MR. MICHAEL ABROE: David Shea is going to present information on the Academy report on Medicare supplement trends. David is Director and Actuary for Trigon Blue Cross/Blue Shield. He is a Fellow of the Society of the Actuaries and a member of the American Academy of Actuaries. He specializes in health insurance and was a member of the Academy Medicare Supplement Task Force that studied the trends.

David Kerr is Senior Manager in the actuarial services practice of KPMG. He specializes in health insurance and has 18 years of experience in pricing, plan design, financial analysis, valuations, strategic planning and management. He has extensive experience in a variety of healthcare plans, working intensively in the senior insurance market for 17 years, and has also served in leadership roles on various assignments in senior and commercial managed healthcare markets. Dave is an Associate of the Society of Actuaries, a member of the Academy, and has a bachelor's degree in actuarial science from Lebanon Valley College. He is going to present information on market and loss ratio trends.

Steve Calfo is going to present the federal Medicare program update. Steve works at HCFA in Baltimore. He works on budget estimates, Medicare + Choice rates, premium promulgation and proposed prescription drug benefit cost estimates. He also works on other proposed coverage changes including modernization of Medicare benefits. Steve just recently became an FSA.

Bill Weller is Assistant Vice President and Chief Actuary for the Health Insurance Association of America (HIAA). He has been with HIAA for over 10 years dealing with Medicare supplement issues at the NAIC. He serves on the Academy's Board of Directors. He was also a member of the Academy committee that developed the Medicare supplement trend study. Bill is a Fellow of the Society and he will present the federal and NAIC update.

MR. DAVID SHEA: Who has, either as an employee or consultant, worked for a carrier that sells Medicare supplement policies? How many of you actually own a Medicare supplement policy? Many of you sell the policies but you don't own them. Sometimes it's difficult to understand things that you don't actually possess.

I'd like to review a recent work product of the Academy. It was a report to the NAIC on Medicare supplement trends. It was produced as a result of a request from the NAIC asking the Academy to examine factors that affect the cost of Medicare supplement policies. Specifically, the request took the form of five questions. They wanted to know if there are specific benefit components of Medicare supplement insurance plans that are contributing to the recent, significant rate increases, and if so, what are they? What additional costs are attributable to the guaranteed issue of Medicare supplement policies? Do age distributions differ based on rating methodology? What is the relationship between Part B co-insurance paid by Medicare supplement insurance, and the amount paid by Medicare? And has there been a change in the percentage of Medicare supplement business that's been issued based on disability eligibility? If so, what is the impact of this change on Medicare supplement claims experience?

To attempt to answer that question, and obviously, generate a few more, data from 11 companies, including six Blues plans, were compiled covering the period 1996–98. The data represented over 2 million insureds and almost $2 billion dollars

in incurred claims. There were three states that were excluded due to their grandfathered status when standardization occurred in 1992.

As you can imagine, with data coming from many diverse carriers in data warehouses and systems, the data collection and aggregation process was not for the faint-hearted. I can attest to that personally. So in order to answer the questions posed by the NAIC, numerous areas of study were targeted, including claim trends just about any way you could slice them including plan, state, region, nationwide, disabled mandate, and state rating requirements. For example, if the state required issue age rating or banned attained age rating, we looked at it. We also took a look at outpatient hospital claims, disability issues, rating methods, Plan C versus Plan F (based on evidence, anecdotal and otherwise, the cost didn't exactly follow expectations), prescription drug costs, Medicare + Choice, and guaranteed issue. We also wanted to take a look at the impact of fraudulent claims and the aging of the Medicare supplement block.

Based on the nationwide data (all of the carriers in the study), we looked at the trends for Plans A, C, F and all the plans combined. That's how the analysis took shape. Plans A, C, and F were largely credible on their own. The other plans were a lot smaller so we grouped those together. We compared them to expected trends for the period. The actual trends were double those expected and expected trends were provided by the Health Care Financing Administration's (HCFA) office of the actuary.

We found an 'all plans combined' trend of 11.2% and that's over the two-year period Part B was the culprit in driving up the trends at 11.9%. The trend for parts A and B was 11.2%. That was the total trend for the period and everything of relative to that.

For the four geographical regions as defined in the study, I explain how the 11.2% splits up . The Northeast was the highest at 13.9% and the West was the lowest at 9.4%. The West was about 10% of the total exposure base so there was a little credibility issue there, but not terrible. The South was at 9.7% and the Midwest was at 10.7%

Now as you can imagine, the data request that went out didn't exactly match the data that came in. We asked for a lot of data. Particularly, a lot of carriers had difficulty counting claimants. We wanted to try and get an idea of the number of non-claimants. We got their membership and asked them to tell us how many claimants were in the database, and more often than not, you had more claimants than you had members. There was one carrier that could take a look at their Plan F claim trends and separate out the hospital outpatient portion from the total. According to their data, it was definitely the area of the large increase. Although it just represents one carrier, the results are compelling. Steve Calfo is going to be

discussing what some of the driving forces behind these high outpatient hospital trends are.

Some of you may know for hospital outpatient services, Medicare pays 80% of their allowable charge. The beneficiary is liable for 20% of the billed charges, which obviously is considerably different and rises at a different rate than Medicare's allowable. What has happened over the years is that the beneficiary's effective co-insurance is approximately 50% of Medicare's allowable. Medicare took care of this recently and introduced an outpatient prospective payment system. That is going to save the day. It was introduced in August 2000. Overall, nationwide costs on a per-visit basis for hospital outpatient services are expected to be considerably lower than they have been in the past. Steve is going to touch on some of the methodology used to develop that as well.

We're going to take a little divergence from the Academy study. Chart 1 is a graph of our company's experience. What you're looking at here is Trigon's med supp business, both pre- and post-standardized. This is our hospital outpatient cost per visit. That was the best way we could measure this with the data available. A visit was defined as same patient, same facility, same day. That's not exactly how the payment system was set up, but it was certainly close enough. And as you can see, the green and the yellow lines are monthly claims cost per visit for 1998 and 1999 and that red line is 2000. I'm not going to tell you, but you can pretty much see the months that the outpatient prospective payment system came into play. We have seen drops in our outpatient costs per visit, of anywhere from 11 to 17%. And those drops are continuing through 2001. The HCFA did a good job.

We also wanted to take a look at this to try and compare HCFA's estimates. They came up with estimates, which are part of the Academy study by state, urban versus rural. Nationwide they expected about a 12% decrease in this component, and for our state, they expected about the same. So this pretty much came in line with expectations. In fact, it was a little better.

We compared the annual claim costs of Plan C to Plan F. The categories we looked at included 64-69, 70-74, 75-79, 80-84, and over 85. In about every category we looked at, Plan C was about 8-12% higher than Plan F. We have seen similar experience at our company, and obviously others have seen it as well. There was only one company in the study that didn't exhibit this same phenomenon. We, in the work group, discussed this apparent anomaly. One theory was that insureds purchasing Plan F use a higher proportion of doctors accepting assignment and these doctors have a higher utilization practice. It's more or less the rural versus urban issue.

Another theory is those doctors not accepting assignments are more likely to be located in rural areas where health care access is more limited, which thereby limits

utilization. The bottom line is these claim costs looked weird. We tried to come up with reasons, but that was it.

The comparisons of drug costs in the three drug plans showed that H and I combined, with Plan J shown separately because of the different annual maxes, should come as no surprise. The drug benefit component had a higher trend than the non-drug benefit component. Fascinating.

But as actuaries, we're supposed to substitute facts for impression. The ratio of annual claims costs for disabled-eligible beneficiaries to that of age-eligible beneficiaries should again, be no surprise. The disableds cost significantly more, obviously, as they become a larger proportion of a Medicare supplement pool. The percentage of people who are disabled-eligible increased 33% in our study period from 1996 to 1998. The disabled includes those with end stage renal disease (ESRD). This is still a small percent of the total but nonetheless, the number went up by a third.

What conclusions can be reached from this data? We went out on a limb here. First of all, obviously hospital outpatient costs had a major impact on claims cost trends during the 1996-98 period of study. A significant portion of the Medicare supplement trend had been attributed to the increase in co-insurance claims on outpatient hospital services.

Individuals eligible for Medicare because of disability had significantly higher claims cost trends, and claims costs than those individuals eligible by reason of age. For all plans studied, the rate was about 78%. Disableds were about 78% higher in their annual claims cost than the age-eligible folks. The trend for prescription drug benefits is higher than the trends for non-prescription drug benefits with Plans H, I and J. The claims cost trends for H through J are suppressed because of the annual limits on the benefits. Nonetheless the drug trends were high.

The average age of the Medicare supplement enrollee at the time the policy is issued has increased about a year from 1996 to 1998 when all issue ages are combined. This is somewhat consistent with studies concluding that Medicare managed care plans attract younger individuals who may in turn choose not to purchase Medicare supplement policies.

There are certainly things we cannot conclude from the study and it was determined that the average age in duration of community- and entry age-rated policies was greater than that of attained age-rated policies. However, the work group concluded that there was really no definitive answer that could be given regarding a particular rating methodology consistently affecting claims levels or trends. Those nasty data limitations prevented the work group from reaching a conclusion on the impact of state rating mandates on trends.

Also, it was a little bit too early to evaluate the impact of the Balanced Budget Act of 1997. However, in future studies we can take this into account.

The NAIC has given the Academy approval to update their study, possibly through the year 2000 and updated every couple of years. Depending upon when it gets started, it could be 2001 or 2002.

MR. DAVID KERR: I have a couple of objectives I want to achieve regarding market and loss ratio trends. First, I would like to give you a little bit of perspective on what the market looks like today in terms of the composition of the market between the commercial companies, the Blues plans, and other carriers out there including the AARP group. I would also like to look at historical trends on premiums and also on covered lives. When I looked at this I found some interesting trends.

I'm going to turn my attention to the primary focus of the study, which is the analysis of loss ratio trends. As you all know, loss ratios are a key driver of overall profitability of Medicare supplement business. We want to take a look at some of the trends from a historical perspective and hopefully that will provide some insights into where this market is going. We will look at that by market segment and policy duration. Then, I'd like to look at some of the key loss ratio drivers—particularly rate increases and claims trends, or claim cost increases. Lastly, I'd like to draw a few conclusions and try to make some sense about what all of this means. Before I get into the numbers though, I'd like to talk a little bit about the data sources that were used in this analysis. First of all, the primary source is the Medicare Supplement Experience Exhibits. As you all know, these are prepared and filed annually, containing quite a bit of information about Medicare supplement loss ratios. Each year, these exhibits are compiled and analyzed by the NAIC and published in an annual report. You may have all seen those reports and what I'm going to do is basically extract data from the NAIC reports at a very high level. The information includes both pre-standardized and standardized plans. Medicare Select plans are included although they are a much smaller segment of the total market.

The analysis that I'm going to present covers the time period 1990-98, so you get to see quite a historical perspective on what the loss ratio trends look like as well as some of the premium trends. We would have liked to have included 1999 experience as well, however, there have been some delays at the NAIC in making this report available. That report will be published very soon.

Let’s take a look first at the market composition. The total market today consists of approximately $14 billion dollars in premium earned. That is a 1998 figure. My understanding is that it is a little bit higher than that for 1999. It’s comprised primarily of two-thirds individual business and one-third of the business is group. BCBS had $5.18 billion (38%). The commercial business was at $5 billion (36%). UHC/AARP has $3.2 billion (23%). The remaining $0.37 billion was in the other category (3%). I would like to make a comment about the group numbers. In past

years, the AARP business had been reported all as group business. In 1998, which was the first year that United had reported the AARP business in the NAIC reports, we saw that there was quite a bit of business reported as both individual and group. I'm not here to dispute how that had been reported, but just so you know, I've included all of the AARP business in with the group business so that we can compare consistent trends from 1997 to 1998.
The individual market is comprised primarily of about $10 billion in premiums, split evenly between Blue Cross plans ($4.54 billion) and commercial plans ($4.35 billion), with the majority of the remaining market ($0.35 billion) being the AARP business.

The individual market, as I mentioned, makes up two-thirds of the total market. It's approximately $9.24 billion in premium. It represents the business of approximately 300 carriers. The premium is equally divided between commercial and Blue Cross plans.

As one might expect, this doesn't really surprise anybody. The group market makes up about $4.51 billion and it's mostly the AARP business. The group market does comprise about 90 companies and about 70% of that is the AARP business.

Now I would like to share with you some of the premium trends. Since 1990, the market has grown from $10 billion up to almost $14 billion in 1998. This represents a total growth of 38%. It averaged about four percent per year. Most of that growth occurred in the first half of the decade where the total growth there was 26.4%. In the last half, it was 8.8% growth.

Similar trends exist in the individual market. In this segment of the market there was a total of 29% premium growth, from $7.15 billion in 1990 up to $9.24 billion premium in 1998. Again most of that growth occurred in the first half of the decade.

The group market experienced the most growth on a percentage basis, 58%, from $2.85 billion in 1990, to $4.51 billion in 1998. The growth was split fairly evenly between the first half and second half of the decade.

I'd like to turn your attention to trends in covered lives. This information was first captured by the NAIC's reports in 1994, so that's as far back as I've gone. It was interesting to see that the total market trend in covered lives has decreased approximately six percent per year on average. This included 14.2 million lives in 1994, down to about 11 million lives in 1998.

One of the possible reasons for that is during the mid 1990s there was a rise in the enrollment in Medicare HMO managed care plans. That could have been contributing to some of the trends. The trends in the individual market are very similar, again, as the total market. For the individual market, covered lives declined from 9.6 million

in 1990, to 7.6 million lives in 1998. That is, again, about an average of six percent decline per year. There was a similar trend in the group market where the lives have decreased approximately one million over that five year time period.

I'd like to talk a little bit about loss ratios and we'll look first by market segment. When I looked at the market segment, I had a couple of observations. First of all, the industry loss ratios appear to be above the minimum required levels over the lifetime of the business. As you know, 65% is the minimum required loss ratio for individual and 75% for group. Those loss ratios have definitely been met and exceeded.

Another observation is that within the two primary market segments, individual and group, the loss ratios have tended to move together until recently, where the loss ratios have converged at about 80%. As one might expect, historically the group loss ratios have been higher than individual. There are some reasons for that.
For the individual market, rather than look at all 300 companies, I took a sample of the top 20 companies with the largest amount of premium. That represented about 55% of the market share of the total individual market and it included seven commercial carriers and 13 Blues plans. What I saw was that the loss ratios for this sample of 20 companies have pretty much mirrored the total market. For the commercial companies, loss ratios have been increasing from 1994 to 1998. The loss ratios reached a low point of about 62% in 1993 and have grown to about 73% in 1998. There are reasons for that trend, which I will discuss.

The Blue Cross plans, as expected, have a significantly higher loss ratio than the commercial companies. The loss ratios have been fairly flat since the mid 1990s. The highest level was 91.5% in 1995. This clearly demonstrates that the loss ratio requirement, in total, is definitely being met.

For loss ratios in the group market, I also split between commercial companies versus the Blues. I also broke out the AARP business. There are some interesting trends there. Again, we look at the top 20 companies, but in this case, the 20 companies at the top represented over 95% of the total group market. One interesting trend there to see is that on the commercial side in recent years, the loss ratios appear to have gone up and on the group side they have come down, particularly with respect to the AARP business.

I'd like to share with you some of the loss ratios by policy duration. As you all know, the NAIC and the Medicare Supplement experience exhibits track two categories of loss ratios. They include policies issued in the last three years and policies issued more than three years ago. For ease of discussion, I'm going to refer to the business issued in the last three years as new business and the other part of the business as the older business.

The interesting observation here was that, historically in the total market, the older business has had significantly higher loss ratios, as one might expect. But recently, the loss ratios have converged together at about 80% in 1998. In 1998, we noticed from the NAIC reports that when United reported their AARP business, they reported it all as business that was issued in the last three years. However, we all know that the business itself is much older than that, but technically speaking, United has had that business less than three years. Their reported number is included in the 77.7% loss ratio for the AARP business. What I did not attempt to do was make a projection or a guess of how that business would be split out between older and newer business. It turns out that in 1997 for the AARP business, the loss ratios for the older and newer business were very close to one another—about two percentage points apart. I believe in 1997 it was about 85% total. For the older business it was about 86%, and for the newer business it was about 84%.

For policies issued in the last three years, the loss ratios by policy duration in the individual market have grown dramatically in the second half of the decade. Today, the loss ratios for the total market are pretty much the same regardless of the duration of the business. There was quite a bit of growth in new business loss ratios taking place in the latter half of the 1990s.

In the group market we saw just the opposite occur, where loss ratios have been declining since the mid 1990s. In the group market, the loss ratios on business issued more than three years ago have declined from 97% to 86% in 1997.

Historically, the group loss ratios have been higher than individual in most years, although in 1993, the loss ratios were about the same. But in recent years, the group and individual loss ratios have moved closer together.

Basically, there has been a growth trend in loss ratios in the individual market and a decline in the group market. I probably should have mentioned this earlier. What this represents, for example, is that business in 1998 was issued in 1995 and prior, business in 1996 was issued in 1993 and prior, and so on.

Historically, the group loss ratios have been significantly higher than the individual business, although those loss ratios are as well moving closer together in the recent years at the end of the 1990s. That's primarily due to a decline in the loss ratio in the AARP business.

I'd like to talk a little bit about some of the things that are driving the loss ratios. The two key components are rate increases and claim cost increases. Before I do that, I would just like to run through a couple of the definitions. This is fairly fundamental, but I thought I'd run through it anyway.

The rate increase represents the change in the average premium from year to year. The claim cost increase represents the change in the average claim cost from year to year per insured. I'm defining the average premium as being the earned premium divided by the average number of insureds for the year. Similarly, the claims cost is defined as the incurred claims divided by the average number of insureds.

The average number of insureds is defined as the average number of covered lives. You'll see that in the NAIC reports, covered lives are measured at the end of the calendar year and first became available at the end of 1994. So for example, if you want to look at 1995 exposure or any other calendar year's exposure, you take the lives at the end of the prior two years and average them together. That may or may not be perfect, but for purposes of this analysis, that's how we're measuring exposure.

What does this mean? The average premium and claim costs available from the NAIC reports first became available in calendar year 1995. That means that the first year that we can actually look at the increases in these two components is calendar year 1996. What we're going to look at is the time period 1996-98, which coincidentally, coincides with the Academy's report that David presented earlier.

Rate increases averaged about nine percent per year in total. The low point was in 1997 (5.3%). The high point was 13.5% in 1996. The group rate increases have been higher than the individual rate increases each year. Interestingly, the rate increases have moved together across each of the market segments—individual, group and in total.

Claim cost increases averaged about 6.5% per year in total. The individual claim costs (4.6-10.3%) have been slightly higher than the group claim costs (4.1-7.4%). However, they have moved together and they ended up being about the same in 1998 (about 4.5%). For those of you who have caught this already, I mentioned that the 6.5% average claim cost would be on a comparable basis to the 11.2% that David presented earlier from the Academy study. There are some reasons for the difference, which we can get into if there is time

In total, the rate increases at 29.3% exceeded the claim cost increases at 20.6% by about nine percentage points. That's really the driving force behind why we're seeing a decline in the loss ratios in the last half of the 1990s.

On the individual side, the rate (23.7%) and claims costs (22.1%) were about the same. What's really driving this is on the group side. The rate increases were almost 42% for the three-year period versus only 18% for claim cost increases.

There are some general conclusions we were able to draw from this analysis. First, there's been a steady premium growth in this market each year. The premium now stands at about $14 billion a year and the growth has been about four percent per

year on average. Obviously, that's due to general rate increases to cover claim trend and so forth, but possibly, also due to the issue age versus attained age rating scales in the marketplace. Attained age rating coupled with an aging population will also push up premiums and that's probably a contributing factor to the increase in premium overall.

Second, we've seen a steady decline in covered lives since 1994 at about six percent per year. That's possibly due to increases in enrollment in managed care plans during that time period.

Third, overall the total market loss ratios have declined steadily. This is primarily due to declines in the group business loss ratios where rate increases significantly outpaced the claim cost increases. For example, for the decade, the highest loss ratio in any year was in 1995 at 85%. It was about 80% at the end of 1998.

Last, we've seen an increase in loss ratios on new business in the individual market. We're not really sure why that is, but certainly we believe that the competitive pressures that exist with the standardized plans have contributed to this trend as the market matures.

I'm not sure what all this means in terms of where the business is going, but hopefully this has provided you with some insight into where things have been and give you some ideas on where things might be going.

MR. STEPHEN CALFO: What I'd like to do is discuss a piece of federal legislation that was passed in December 2000. Specifically, it's the Medicare/Medicaid and SCHIP Benefit Improvement and Protection Act (BIPA) of 2000. My presentation is going to be from the Medicare perspective and will discuss some of the major provisions in BIPA. BIPA affects both Part A hospital insurance and Part B supplemental medical insurance. I'll be discussing the provisions that have a significant financial impact on Medicare. Following that, I will discuss some of the authority and the framework for the Outpatient Prospective Payment System (PPS). Specifically, I'm going to talk about some of the components of the system, which are quite complicated. I'm going to try to simplify some of the details. I'd like to pay particular attention on the impact of these provisions on Medigap claims.

Basically, BIPA was passed into law December 21, 2000. It affects beneficiaries with the amounts they pay—the deductibles and co-insurance amounts. It affects the providers' payment increases.

First, I'd like to discuss the provisions related to Part A hospital insurance. Most of the provisions of BIPA affect the increase in the payment update factors to hospitals. As an example, for inpatient hospitals, the payment increase factor from 2000 to 2001 prior to BIPA was set at the market basket minus one. Market basket is just an inflation factor similar to the CPI. It reflects a basket of services

related to labor in a hospital. Prior to BIPA, the increase factor was set at market basket minus one and BIPA increased it to the market basket. So, in 2001, we will see an increase of an additional percent in payments to providers.

Some of the other provisions are the Medicare + Choice plans. They'll be receiving an extra percent as well. The minimum increase from 2000 to 2001 was updated from two percent to three percent. Most of the provisions increase payments to providers.

What is the impact on Medigap claims of BIPA? Basically, the hospital insurance deductible and the increase in the hospital insurance deductible is legislated. The increase is based on the PPS update factor. There was a BIPA provision which changed the PPS update factor from market basket minus one to the market basket percentage increase. That's the current estimate of the calendar year 2002 deductible. The current estimate of the calendar year 2002 hospital insurance deductible increased from $792 prior to BIPA to $812. You'll see an extra percent increase in the deductible. The co-insurance amounts are based on a percentage of the deductible amount so you'll see a percentage increase there as well.

The provisions related to Part B supplemental medical insurance incorporate payments for new technologies. It either improves existing coverage or offers new preventive benefits.

Some of the significant provisions will be discussed. One provision that I'll be talking about a little bit later is a limiting of the maximum beneficiary co-insurance that a beneficiary pays for outpatient services. An example of some preventive or new services would be annual screening of glaucoma for high-risk individuals. Some improvements to existing coverage are bi-annual pap smears and pelvic exams, and also an improvement to the coverage of immunosuppressive drugs. Immunosuppressive drugs are given to transplant patients. Largely, these enrollees are Employment Retirement Savings Deductions (ESRD) beneficiaries who have kidney transplants.

Some other provisions include the following: BIPA provides changes to the increase in some of the other services including durable medical equipment and prosthetics and orthotics. There are Medicare + Choice provisions and they affect the floor or minimum payment. The floor was $475, and the increase was to $525 for counties which have greater than 250,000 in Medicare enrollment.

I'd like to switch gears a little bit and talk about the hospital outpatient history. Prior to the Balanced Budget Act there were two problems. One was that the providers were receiving greater than 100% of their costs and the beneficiary co-insurance amounts were roughly 50% of these costs. The beneficiary co-insurance amounts were based on 20% of allowable charges, and since charges were greater than the cost, the coinsurance percentages were increasing over time. These beneficiary co-

insurance amounts ranged anywhere from 20% to 90% of cost. These two problems were addressed by the Balanced Budget Act of 1997 which eliminated the formula-driven overpayment to providers. Also, the BBA established the outpatient perspective payment system.

In 1999 the Balanced Budget Refinement Act was passed which gave some refinements to the outpatient PPS. The hospital outpatient PPS was originally supposed to be implemented on January 1, 1999, but there were several delays and it finally was implemented on August 1, 2000. Basically, the system set up a payment fee schedule. These payment amounts are called Ambulatory Patient Classification (APC) groups. These APCs are a numerical coding system that is similar to the diagnostic related groups (DRGs) for inpatient. They are based on similar use of resources or clinical comparability. Group codes are mapped into these APCs. Initially there were 451 but they increased in 2000 to include some of the new technologies and other devices as well as certain drugs. The APCs covered a bundle of services including, but not limited to, operating room costs, recovery room costs, anesthesia and some drugs. There were some constraints placed on the grouping of these APCs including the median cost of the most expensive service in a group, which couldn't be more than twice that of the least expensive service.

The APC payment rates were basically equal to a relative weight times a conversion factor. Sixty percent of the rate is geographically adjusted. For multiple surgical procedures, the highest APC was paid at the full amount and then each subsequent service was paid at 50%.

Another component of the APC system includes the national unadjusted co-insurance amounts and this prescribed the new beneficiary co-insurance amounts. The national unadjusted coinsurance amounts are developed from national median charges billed in 1996. The key word here is the median charges.
On average, the median charges were 12% less than the mean charges, which means that on average, the amounts that the beneficiaries were paying and co-insurance was going to be decreasing on average by about 12%.

I would like to make a couple of other points about the growth of the national unadjusted co-insurance amounts (NUCA). They're developed from 1996 median charges. They were multiplied by 0.2 and inflated to 1999. If the NUCA is greater than 20% of the APC, then the dollar level amount of that is frozen. Sixty percent of this NUCA is geographically adjusted.

The only thing I want to say here about the beneficiary co-insurance amount is that it's limited to the inpatient deductible.

One of the most significant provisions relating to the outpatient PPS of BIPA is the maximum coinsurance rate that a beneficiary could pay is on a downward sale. Starting April 1, 2001, the maximum co-insurance percentage was set at 57%. In

2002 it will come down to 55%. In 2006, it will come down to 40%. This has significant impacts on Medigap claim costs.

I'd like to give two examples of the way that the PPS is going to work. The first one is under pre-PPS. Let's consider a service where charges were $2000 and costs were $1000. Beneficiary co-insurance amounts were based on 20% of charges, which basically is the $400 and Medicare pays the difference. So Medicare pays $600.

On implementation of the PPS, the cost becomes the APC rate. What happens is for an average service, the beneficiary co-insurance amounts are 12% less than pre-PPS. The beneficiary co-insurance, which is based on the NUCA, is now $350. Medicare picks up the difference. Medicare pays $650. There's a significant transfer of payment liability from the beneficiary to Medicare.

Then on January 1, 2001, the APC is updated by the market basket. I just assumed it was 3%. The APC increased to $1030. Now the point to make here is that the dollar level of the beneficiary co-insurance, because that $350 is greater than 20% of the APC, remains constant. So it's set at $350. Medicare picks up the difference. The thing that is important is that from January 1, 2001 on, for all these services whose co-insurance percentage is greater than 20%, we won't see any trend.

On January 1, 2002, you'll see the APC is updated again. The beneficiary co-insurance amount, since it's greater than 20% of the APC, remains constant. Another point I want to make is that the average effective co-insurance rate is falling from 45% in 2000 at implementation of the PPS, to 43% in 2002. It keeps falling to about 33% in 2006.

I'd like to give an example of how the caps come into play. The maximum beneficiary co-insurance amounts were 57% in 2001. For example, I assumed charges of $4000, costs were $1000 and beneficiary co-insurance amount was set at 20% of charges, so it's $800. Medicare pays the difference. So on implementation of the PPS on August 1, 2000, the beneficiary co-insurance based on the national unadjusted co-insurance amounts now is $704. That is 12% than what it was prior to the PPS and Medicare pays the difference. On January 1, 2001, the APC was updated. The beneficiary co-insurance percentage is greater than 20%, so it remains constant at $704. Once again Medicare picks up the difference.

On April 1, 2001, the maximum co-insurance percentage that the beneficiary paid was capped at 57%. So 57% of the APC is equal to $587. There was an average decrease of about 4% across all services, once the cap was implemented. The beneficiary co-insurance, because of this cap, goes down from $704 to $587. Medicare has the increased liability of $443.

Then on January 1, 2002, the maximum beneficiary co-insurance amount was decreased to 55% and that's $583 for this example. Those are two examples of how the system is going to work, the second of which shows the impact of caps.

What does this all mean for Medigap claim costs? As Dave pointed out, on August 1, 2000, he should have realized a 12% decrease in aggregate per service cost sharing. I think the range for Dave's company was from 11 to 17 and that's going to fluctuate by company and geographic area.

On April 1, 2001, when your data tabs come in, you should realize that because of the 57% cap, there is a reduction of four percent of per service co-insurance amount. On January 1, 2002, you should realize about a two percent drop in average beneficiary co-insurance amounts.

In these simulations I want to point out that there are some caveats that include the fact that these simulations were done based on 1996 bills and the frequencies were static or held constant. There is nothing done about new technologies or new procedures that have come into play since 1996.

MR. BILL WELLER: Medicare supplement uses ten standardized plans. They are defined by the NAIC and basically the NAIC can't change them without Congressional action that gives them authority to make changes except for adding innovative benefits. So we start looking for potential reasons why Congress would provide for some changes. There are two. One is a total reform of Medicare, which has been suggested in several Congresses. It's unlikely to occur in 2001 and probably not in 2002. The second one is the potential for some Congressional action relating to prescription drugs for seniors and I'll be spending a little bit more time on that.

The NAIC is in the process of what I would call getting ready for the possibility of changing the plans. I arrived at HIAA in October 1990, which was right after Omnibus Budget Reconciliation Act (OBRA) 90 passed. The NAIC was given nine months to create the ten standardized plans, develop their new model law and model regulation and get them adopted. They had only two meetings within those nine months which were already prescheduled.

Now they recognize that they really need to be well underway before Congress passes anything. They are looking at the current plans (A through J) and they've noted that in many situations, the differences frequently relate to what they consider minor benefits. That might be one of the areas that they will look at. They clearly are also looking at how to deal with prescription drugs. Three plans (H, I and J) already have drugs. They recognize that those are much more expensive than the other seven plans. Even for the non-drug benefits there is higher utilization.

The NAIC would like more options for people to purchase drugs but they recognize that there is an anti-selection potential. I suspect that their idea of how much that anti-selection would cost versus the company's estimation of what that anti-selection would cost are probably not in the same ballpark. I think that's basically the status of the NAIC. They are meeting, they are looking at this, but they recognize their constraints.

From a federal point of view, where is Congress going to go? As I said, Medicare reform is not likely, so what's going to happen with prescription drugs? I think there's going to be a lot of talk but there are three Cs that I think work against any prescription drug benefit. These are the calendar, collaboration, and compatibility with the budget.

Looking at the calendar for 2001, we have taxes which have already gone through for President Bush. His next items are education and energy. Clearly, energy is becoming a really important point with California. Education was an election issue. These are the three agenda points that he would want to get passed in 2001.

In 2002, we have the election coming and that gets into the next point which is collaboration. At this point, there is little or none. As you will note, the Senate has now changed leadership. It has 49 Republicans and 50 Democrats, and one Independent, which gives the Democrats control of the committees. When it was 50/50 and the Republicans had control, the budget that included the tax bills structure passed with 48 Republicans and five Democrats in favor, and 45 Democrats and two Republicans voting against it. Recognize that because tax changes were in the budget, it only needed a simple majority when it went to the Senate floor that they clearly were going to have. If it hadn't been in the budget they would have required 60 plus votes and they would not have gotten those.

In the House, the numbers probably change a little bit but generally the Republicans have a 10 vote spread. They control the rules, which like the Democrats when they controlled the House, really drive what can happen.

There are other health issues that are going to have to be dealt with too. The Patients Bill of Rights is clearly one that's hot in Congress. Whether it's hot in the country anymore or not is a question. As far as the uninsured, particularly as we're seeing increases in the number of people laid off, the effects of higher unemployment are going to, I think, raise this issue from a public point of view.

Ultimately, I think collaboration is going to come down to whether or not President Bush and Senate Majority Leader Daschle (D-SD) want there to be some collaboration. Historically, neither of them has been prone to compromise. Each has been pushing his own agenda.

Finally, there's the compatibility with the budget. Prescription drugs are an extremely costly benefit to add to Medicare. The Republicans successfully used up very large portions of the projected budget margins with their $1.3 trillion tax cut. That included $0.3 trillion for prescription drugs over 10 years, but interestingly, none of that was in the fiscal year 2002 budget, which means that before they do anything, there will be some more Congressional Budget Office (CBO) numbers which are likely to include reductions in revenues because of the slowing economy as well as further increases in drug costs. When they get around to prescription drugs there's going to be less margin and more cost.

There's one other area that Medicare supplement carriers need to be watching—not what Congress can do, but what the Courts can do. A recent court ruling that I think is headed for the Supreme Court—the County of Erie, Pennsylvania v. Erie County Retirees Association, et al.—effectively makes it very difficult for employers to offer what they used to consider as comparable coverage to retirees—under 65 and not eligible for Medicare yet, and retirees over 65. If there's no relief for employers it's very likely that they will use that as their basis for saying, "We have no further retiree coverage." This would put all of those people into the Medicare supplement market. That's another area that we can look forward to further growth in this market.

MS. VALERIE LENDT: (World Insurance Company) I repeatedly ask the claims department at my company whether paying the outpatient outright is something that should flow through automatically or if it is something we should watch for. How do you feel we should handle this?

MR. SHEA: My guess is the PPS should be flowing through automatically but your operations department should be prepared for it. They need to know what to expect. They don't always interpret payments the way an actuary would interpret them. In fact, when outpatient PPS came in for us in August, I was getting e-mails from our operations area. They would say they're seeing costs go up. I would ask, "Compared to what?" Obviously they weren't normalizing it for the number of insureds, but they were calling a claim something different. I had all this information from HCFA that pretty much said we should see costs in our state go down. Now obviously, it's going to vary from carrier to carrier, but I felt that we were pretty big in our state. We got to have a 50% market share. We will probably exceed what they expect. I was a little hesitant to go out on a limb and make some calls about decreasing claims costs in that segment of the business. So I waited a couple of months and then started looking at the claims the way I explained and the costs were going down.

I think they should be flowing through. I'm not so sure the operations folks need to do anything terribly different. It's more or less like the inpatient deductible going up every year. They really don't need to do anything different, it just happens.

MS. LINDA COLLINS: (USAA Life Insurance Company) Mr. Shea, you said you included 2 million lives in your study. Do you know how many disabled lives were included?

MR. SHEA: It was a very, very small percentage of the total—it was less than one percent. In fact, I think in 1996, it was tenths of a percent and it went up to a little bit more than one percent of the total.

MS. COLLINS: I was interested in the fact that there were a small number of disableds.

MR. SHEA: It wasn't many. But we had them so we compared them.

MR. ABROE: There were 17 states through the end of 1998 that passed enabling legislation for disableds to be enrolled. At the beginning of the period it was a much smaller number of states.

FROM THE FLOOR: Mr. Kerr, you mentioned that you would talk a little about the difference between your 6.5% number and the 11% in the Academy study.

MR. KERR: David Shea probably knows more about that than I do. We were talking a little bit about that earlier. Obviously, the number I presented, 6.5%, comes as a result of what is in the NAIC reports, which represents the entire industry, so it includes 11 million lives. Primarily, the main reasons for the difference is that the Academy studies just cover standardized plans. The studies don't cover the pre-standardized plans whereas the NAIC reports cover everything.

MR. SHEA: David and I talked about this earlier when we were getting together via phone to talk about our presentations. I said, "You know, that's a question that's going to come up." It's the differences in those numbers. So we talked about it a bit and while he was talking, I kind of jotted down just a few of the differences that could generate the difference in the numbers. As David had said, the Academy study is a subset of the total. It was 11 insurance companies and it was only standardized business. There was no pre-standardized business at all. Also in that 11.2% and again, we're talking about trends, that 11.2% number did not include the drug plans. That 11.2% was Plans A through G. So again, we're talking total versus subset. Also, this probably doesn't make a great deal of difference, but those NAIC numbers are never adjusted year after year for run out. It's whatever you have at the end of the year for incurred claims. That's what you report. The Academy study had at least a year's worth of run out if not more. Again, the effect on trend could make a difference. Also in the Academy study, we took great pains to relate the claims and the insureds. There was a timing match where the NAIC report, to get the number of insureds, you took an average from year to year. So, mix that all up and I can tell you, the Academy study data was scrubbed real well.

The NAIC study is at the mercy of how the companies fill out those reports. Those are the reasons why the numbers could be different.

FROM THE FLOOR: Did the NAIC study include new entrants whereas the Academy did not?

MR. SHEA: The Academy study did not exclude new entrants and neither did the NAIC.

MR. KERR: I can at least answer on the utilization side. So far we haven't seen an uptick in hospital outpatient visits per thousand. We've seen them go up just like they've gone up every other year. We haven't seen accelerating trend. I seem to remember talking with another person at HCFA a while back, and were some adjustments made in the outpatient co-insurance to keep the hospitals whole? In other words, the Medicare payment was ramped up a little bit because the hospitals figured out real quick that this is going to be a decreasing revenue for them.

MR. CALFO: The total amount that the hospital was to receive at the implementation of outpatient PPS would be the same as it was before the implementation. I think what this is eluding to is that those are additional payments to providers for cost that are allotted for in the prospective payment system. So what happens is, the provider can apply for more money as long as the total payments are less than 2.5% of the total outpatient program costs. So the total hospital revenue is neutral, but it's actually going to pull down the APC and it's also going to pull down some of the beneficiary payments. So then the question becomes, how are the providers going to gain in the system? We're assuming that there's going to be an increase of about 3.5% in utilization.

MR JOHN RAGAN: (Highmark Blue Cross/Blue Shield) First of all, just a note that the Blue Cross/Blue Shield loss ratios from Mr. Kerr are higher. I'm not sure if your data has the subsidy issue that we subsidize those products with some of the group premium. If that revenue does or does not include subsidy, that would be an issue in explaining the loss ratio comparisons. I have a comment related to the same loss ratio analysis that talks about new business for the individual loss ratios that were shown to be on the increase. Are there going to be any studies showing this type of analysis for existing Medicare risk business versus not having Medicare risk business? That's played a part in some of our loss ratios comparisons, where we have some other newer, younger retirees going into the Medicare risk and not really taking Medicare supplemental products. I don't know how that would affect some of the loss ratios comparisons, but I think it might be something worth looking into. Medicare risk plans might be on the downside right now, so some of these people might be going back into the Medicare supplement-type products.

MR. CALFO: I think that in regard to the group loss ratios, it's whatever is reflected in the NAIC report, which I believe accounts for the subsidy you're talking about.

MR. RAGAN: I'm not sure what would be the case.

MR. CALFO: It's basically whatever you report on your Medicare supplement experience exhibit. Whatever you put in that report is what has come through here. It's just summarized in a much higher level. I think your comment on the comparison of loss ratios on new business with or without presence of Medicare risk is a good comment. It could very well be one of the reasons why loss ratios have been going up. It would be interesting to continue to look at this as time goes by to see which direction those loss ratios turn. But I think it was a good comment and I agree with you.

MR. WELLER: It seems to me that the timeframe of the increase in the loss ratios was very consistent with the true implementation of the open enrollment that came about as part of OBRA '90. Companies were issuing policies subject to the open enrollment, starting in 1993-94. The states had to adopt new rules before you were actually required to do open enrollment. What we would have expected is that the initial period (first three years) would move close to the ultimate level because you are eliminating, to a significant extent, the potential for underwriting. From here on out, I would not expect to see much difference in the loss ratios unless we end up with so many options for guarantee issue, that we see the reverse. Then your loss ratios in the early years would be higher because of anti-selection.

Chart 1

Trigon Medicare Supplement Hospital O/P Cost per Visit