THE PRICING OF MEDI GAP CONTRACTS

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REVIEWED BY Robert F. Bartik

I feel the approach used and described in the paper to be very useful. The author covered the specific subject of using primarily external data to produce a composite claim cost for a mixture of coverages for an older age population very well.

I will make a few comments regarding individual items directly related to the paper and then continue to pursue the general subject of rating a Medicare supplement type plan, extending into a few areas not covered by this paper. As we approached this problem ourselves a few years ago, we also tackled many of the items referred to in the paper. At that time some of the external data referred to was not available, but I would feel a strong inclination at this time to pursue an adoption of much of the procedure presented here.

However, as we advanced further in our research on the subject, we were soon led to the conclusion that for the type of contract we finally decided upon, that the subsequent considerations proved to be of such a significant character, in regard to determination of final rate level, that further sophistication at that time in regard to this aspect of the detail would not have great impact on that final determination.

The extreme costs of medical care for the aged strongly influenced

employers when they tried to include retirees or even active employees over 65 into group health plans. Therefore, what could have been a natural relief mechanism for the problem did not hold and increased the bind the aged were caught in, producing even greater pressure for the passage of Medicare.

The tables showing the impact of the Medicare Program on the population are horrendous in themselves, but an even more comprehensive study (showing more horrendous results) may be found in "Ten Years of Medicare: Impact on the Covered Population" (SSB July 1976, pp 3-21). Table 20 (page 18) of that source puts Table 1 of this paper in better perspective in that it gives not only percentage, but per capita dollars, and in that the record of the insurance industry is set out by itself.

The third of the major elements of cost should take into account the "Reserve Days" under Medicare. It may be that this is accounted for elsewhere, but I was not able to discover it.

The Part B coinsurance in the plan depends on actual Medicare allowances. There has been a definite trend toward Medicare allowing a lesser and lesser percentage of actual charges by a process of charge screens, the adjustment of which have not even come close in recent years to matching the increase in level of

actual charges of the medical industry. Accordingly, our trend on this portion of the coverage is not based on the factors in the intermediary letters (Appendix D) but on either the CPI or on the SSB tabulations of Part B charges.

The author has introduced a significant variety of curve fitting of the data for purposes of projection and has selected the process of averaging these results for the final answer. I suspect that if one were to attempt a more sophisticated analysis of these procedures over time, significant refinements would become apparent, such as a weighting of the curves under various circumstances and the total elimination of some, with even the possible emergence of a best single curve, producing better results than any composite.

Once the basic data has been determined, the process of using it to produce the estimated parameters entering into the subsequent steps is very well displayed, explained and easy to follow. The subsequent steps of modifying and tieing together the estimated parameters to produce the separate pieces of the total claim costs is also handled very well and easy to follow. The final summary of the separate pieces into a consistent whole total is a neatly laid out summary, totally contained within the single Exhibit 15. Actually there are many different policies on the market offering

some degree of supplementation of medicare benefits and even those that tend to offer in effect full supplementation, there are differences. There are also some differences between the typical contract offered by the "Blues" as opposed to those offered by other comapnies. A very significant difference between policies is referred to later in this review. Therefore, I would like to have had included a more detailed outline of the policy coverages and provisions referred to in the paper.

One additional major factor involved in the final rate structure is the decision regarding rate relativities by age. Although the claim costs for the senior citizen classifications is significantly higher than under 65, there are significant differences by age within the classification itself, easily ranging up to two and one half to three times the cost in the higher age brackets (depending upon where one decides to establish an "all over age" bracket) vs. the 65 to 69 bracket. Therefore, a rate derived for the composite of the classification derived from the population date of the classification will reflect the age distribution of that population, but can conceivably attract a much different distribution of insureds by age, very likely including most of the older individuals but a significantly lesser proportion of those from 65 to 69.

Another major factor in the rating of this block of business involves a high proportion of business being marketed with level rates even when separate classifications by age are used. Therefore, significant attention must be paid to the persistency expectations and although one can take from a claim standpoint at least a conservative approach, and assume only normal mortality, it is highly likely that a significant portion of insureds do not continue with the policy selected for their entire remaining life span, and as a result, such a conservative approach, although

commendable from a safety standpoint, will undoubtedly produce a totally non-competitive rate in the marketplace and produce zero business from which to be even able to determine its adequacy. Interestingly, although interest assumptions could also prove a significant factor, the net effect tends to be significantly reduced because of the dramatic drop off in persistency, if for no reason than mortality, thereby lessening the major effect of the increasing claim cost by age and its effect upon the investment income.

One significant aspect of this type of policy marketed to senior citizens who are already at the age where they have or soon will have significant continuing medical problems, is the fact that it is usually written with minimal or no underwriting, that is, in effect a mass marketing type operation. An attempt is made to offset the effects of this through the use of preexisting condition clauses with time limitations, ranging from a few months to two years. The variation of expected results from this clause can vary dramatically. The primary effects of the clause are to set up a screening device which will deter the poorest risks from selecting this particular policy and (especially in this particular marketplace) from transferring from an existing policy to a new one.

In addition, there is a direct claim cost savings from the non payment

of expenses during the preexisting period. However, there is a significant limitation upon this since the preexisting clause does not totally and indefinitely exclude continuing conditions. That is, once the time interval has passed, medical expenses from that point on for an already existing disability become payable. Therefore, there is a significant question regarding the degree of effectiveness of the provision and the competitive situation has produced a relatively short time interval common on this particular form, normally three to five months. Since little data is available regarding the value of such clauses even of longer duration and on younger populations, for the circumstances of short duration and older populations it is virtually non-existent. The expected claim costs can easily be double that of an underwritten or even population block with zero preexisting, which will hopefully range down to equality of expected claim cost at some point near two years.

The significant question is, what is such a value for say, five months preexisting. It is my feeling that this is still a rather significant and elusive figure, but in any event, the primary need is for the proper factor to use in determining the premium to charge for this coverage. In any event, we are in the process of accumulating experience data under this form which will answer many of these questions directly at least as a composite of the structure

we are using. At that time a procedure such as this will be essential to keep pace with the changing conditions, both of the economy and the legislation, as well as its implementation.