NAIC

National Association of Insurance Commissioners

NAIC Medicare Supplement Insurance Issue Paper

Medicare Supplement Insurance Issue Paper

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by
the Accident and Health Working Group
of
the Life and Health Actuarial Task Force

November 30, 2000
Adopted by the Health and Managed Care (B) Committee

NAIC

National Association
Of Insurance Commissioners

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I. Scope

A. Medicare History

One of the most significant pieces of legislation pertaining to health care coverage was enacted in 1965 with the passage of the Medicare legislation. Medicare was designed to provide extensive coverage against the costs of medical care for most persons aged 65 and over in the United States. Subsequent to 1965, the benefits provided by Medicare have been frequently reviewed and often revised, such as:

1) Benefit deductibles and copays have been updated annually or frequently.

2) In 1973, eligibility was extended to end-stage renal disease cases and disabled individuals meeting certain criteria.

3) In 1988, the Medicare Catastrophic Act which expanded hospital and medical benefits was passed. It was repealed in 1989.

4) In 1997, the Balanced Budget Act expanded managed care coverage.

Recent discussions have also included extending eligibility to the near-elderly, Medicare reforms in general, and coverage of prescription drugs.

B. Medicare Supplement Insurance

Carriers have developed policies to cover health care costs not covered by Medicare. These policies are often called Medicare supplement or "Medigap" policies. Medicare supplement policies do not include arrangements where an entity has agreed to provide services in lieu of Medicare, such as under a health maintenance organization (HMO) risk arrangement. Various regulations have developed covering Medicare supplement policies, including:

1) Prior loss ratio minimum requirements

2) In 1992:
    a) Standardized benefits;
    b) Open enrollment;
    c) Refund formula; and
    d) Medicare Select

3) 1997 Balanced Budget Act:
    a) Changes in Medicare reimbursement;
    b) New rules for Medicare+Choice; and
    c) Expanded guarantee issue for Medigap

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C. Purpose of Paper

An article in the September 1998 issue of *Consumer Reports*[1] states that the Medicare HMOs and traditional Medicare supplement insurance market is "in turmoil" and that premiums are rising "beyond the reach of many beneficiaries." The article goes on to report that since 1994:

1) Medicare supplement insurance premiums have increased 35 percent on average
2) "Premiums for Plan C, the most popular of the 10 standardized Medicare supplement plans, are up 41 percent"
3) Plan A premiums increased 44 percent
4) Plan F premiums increased 23 percent

State regulators are aware of Medicare supplement rate increases and have increasing concerns about their impact on the consumer and the market. As a result of those concerns, the Medicare Supplement Working Group of the Senior Issues (B) Task Force sent a memorandum on March 3, 1998 expressing their concerns and requesting assistance from the Accident and Health Working Group of the Life and Health Actuarial Task Force. This paper is the Accident and Health Working Group's response to that request.

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II. Current Environment

A. State Survey

A survey of states conducted by the Accident & Health Working Group in 1998 on Medicare supplement rate changes in the prior 12 months found that these changes ranged from a reduction of 20% to an increase of 50%. Forty-two states responded, of which only two states indicated that none of the requested information was available. A copy of the survey is provided in Appendix 1 and the state-by-state responses are provided in Appendix 2. Appendix 3 is a summary of the responses.

Also, in recent years there has been a substantial difference between the trend in Medicare expenditures-per-person reported by the Health Care Financing Administration (HCFA) and the trend in claims costs experience by Medicare supplement insurers. In its paper (Appendix 4), the American Academy of Actuaries (AAA) Medicare Supplement Insurance Work Group found this ratio was 2 to 1. Over the period 1996 through 1998, overall Medicare supplement trend for standard plans was an average annual 11.2%, while the average annual trend for all Medicare beneficiaries for the period was 5.7%.

Table A
Nationwide Trend
All Plans Combined

Year	Academy Study	Estimated Trend *	Excess (Academy-Estimated)
97/96	13.1%	7.1%	6.0%
98/97	9.4%	4.3%	5.1%
98/96	11.2%	5.7%	5.5%

* Estimated trend for Medicare deductibles, copayments and co-insurance provided by HCFA's Office of the Actuary

Source: Table III—A-2 on page 11 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

B. Sources of Trend Differential

With the substantial input of both data and analysis by the Academy Work Group, the Accident and Health Working Group has identified five possible factors which may contribute to the difference in trend noted above.

1) Outpatient costs

2) Aging and anti-selection among Medicare supplement policyholders

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3) Increased proportion of disabled-eligible policyholders

4) Rating methodology

5) Special considerations for plans with prescription drug coverage

Each of these is considered in more detail in the following sections.

1) Outpatient Hospital Claims

The AAA Study concluded that a significant portion of Medicare supplement trend, and a major reason for the observed differential between Medicare and Medigap claim cost trends, is attributable to the increase in coinsurance claim costs on outpatient hospital services. In order to see why this is so, it is necessary to understand Medicare's provider reimbursement methodology during the period studied (1996-1998).

For most outpatient services, Medicare did not cover the annual Part B deductible nor 20% of the hospital's **billed charges**. It is important to note that no limits were placed on the absolute level or amount of annual increase of hospital billed charges, so Medigap claims were subject to full medical inflation on the liability. The final hospital payment from Medicare was determined retrospectively for a cost-reporting period based on the least of:

(a) The hospital's reasonable costs;

(b) The hospital's customary charges; or

(c) A blended amount (weighted average) of reasonable costs or customary charges and a fee schedule.

The AAA study concluded that because hospital billed charges were generally much higher than Medicare's hospital payment basis (i.e., reasonable costs, customary charges or the blended amount) the aggregate beneficiary cost sharing currently accounts for nearly 50% of the total payment to the hospital. Further, because hospital billed charges have increased faster than Medicare's hospital payment basis, the percent of hospital outpatient reimbursement paid by Medigap plans has increased significantly from the 1992 level of 41% of the total payment to the hospital.

(a) <u>Hospital Outpatient Medicare Supplement Study</u>

One carrier was able to isolate its Plan F's hospital outpatient claim cost trend for the study period, which is shown below.

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Table B
Hospital Outpatient Claim Cost Trend
Plan F Only
(Reported by a Single Carrier)

Incurred Year	Total Claim Cost Trend	Hospital Outpatient Claim Cost Trend	Trend Claim Cost Trend if Hospital Outpatient Trend had Equaled Other Part B Coinsurance Claim Cost Trend	Hospital Outpatient Claims as a % of Total Claims
1995	6.9%	19.8%	4.6%	22.9%
1996	6.1%	19.2%	2.3%	25.7%
1997	8.8%	18.4%	5.4%	28.0%
1998	9.0%	15.3%	6.7%	29.6%
Average	7.7%	18.2%	4.8%	

Source: Table on page 29 (Section V.B) of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

From 1995 to 1998, the increase in outpatient claim costs caused overall trend to be 2.9% higher per year than it would have been if the outpatient trend had equaled the average of the other components. Assuming that these results are representative of the experience of all Medigap carriers during this period, adding 2.9% to an annual trend rate over an 8-year period (the number of years since standardization) would cause an additional 25% increase in claim costs.

(b) <u>Medicare's New Prospective Payment Methodology for Outpatient Services</u>

Inpatient care is covered under Medicare Part A and is paid for using a prospective payment system (PPS) when a hospital is compensated a predetermined rate per discharge based on payment categories called diagnosis related groups (DRGs). Effective August 1, 2000, most hospital outpatient services covered under Medicare Part B are reimbursed under a prospective payment system (PPS) where payment rates are established for ambulatory payment classification (APC) groups. Some hospital outpatient services are excluded from the PPS and will continue to be paid on a prospective basis under existing fee schedules.

Under the new PPS, beneficiary coinsurance will be limited to the greater of a geographically adjusted fixed dollar amount (copayment) per APC group or 20% of the APC fee schedule or payment rate. Each year the APC fee schedules will be updated, but the copayment amount will remain fixed except for slight variations in the geographical adjustment. As a result, the beneficiary copayment

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will gradually decline as a percentage of the total hospital reimbursement until it reaches the 20% level, which may take up to 40 years according to the Medicare Payment Advisory Commission.

Upon implementation of the outpatient PPS, the beneficiary liability for most services will have a one-time decrease on a nationwide aggregate basis for all Medicare beneficiaries although some states or regions within states will experience significant increases. Additionally, for several years following implementation, coinsurance price trend should be virtually eliminated, but some trend in the volume and intensity of services can be expected. Overall trend within the Medicare program for aggregate beneficiary cost sharing should be lower than recent experience under the cost-based system. However, at this time, it is impossible to project a definitive impact on coinsurance levels for Medicare supplement outpatient trends by state or regions within states.

2) Aging and Anti-Selection among Medicare Supplement Policyholders

In its paper, the Academy Work Group found that the block of policyholders of standard Medicare supplement plans is aging. It found this to be the case for both current year issues and for renewals. In each case, over the three-year period 1996-98 the average age increased by approximately one year.

Over the same period, the number of lives covered by Medicare supplement policies have decreased even as the number of Medicare eligibles has increased. Taken together, these findings indicate that population of Medicare supplement policyholders is aging faster than the overall Medicare population.

This aging of the Medicare population affects filed premium schedule increases for policies differently depending upon the rating methodology used in the policy – issue-age, attained-age, or community rated (see Appendix 5 for Explanation of Rating Methodologies). For example, closed blocks of business sold on a community-rated basis would be impacted the most. The reason for this is that a community rate is the average rate for a block of insureds covered by that policy. When the average age for the block of insureds increases, it means that there is a greater percentage of insureds at the older ages than previously. This means that the average rate for the block also needs to increase in order to reflect the higher percentage of older insureds and their associated higher costs. This increase in the rate attributable to the aging of the block would be in addition to any trend increases attributable to medical costs, utilization, cost-shifting, etc. Attained-age rated should be impacted the least, because attained-age premium rates automatically increase as the individual ages. However, attained-age rated policies do not require filing additional rate increases for aging of a block of insureds because premiums automatically increase as the age of an individual increases. Rate increases filed for attained-age rated policies would reflect only trend in medical costs, utilization, cost-shifting, etc.

There are two potential reasons for this aging. One is the rise of Medicare HMOs, and the other is the guaranteed issue requirements contained in the Balanced Budget Act of 1997.

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(a) Medicare-Risk HMOs

During the 1990s, enrollment in Medicare-Risk HMOs surged. Several studies have found that enrollees in these HMOs were healthier than Medicare enrollees in general. The implication is that Medicare supplement plans attracted a less healthy group among the first time eligible population. Perhaps more importantly, by attracting a larger portion of those newly eligible for Medicare, the Medicare-Risk HMOs reduced the number of new Medicare supplement policyholders, contributing to the overall aging of this block. In the Academy Work Group paper, it is estimated that the impact of Medicare HMOs is an addition of 0.5% to 0.9% to overall Medicare supplement trend.

(b) Guaranteed Issue Provisions

The Academy Work Group found that it is too early to quantify effects of the 1997 Balanced Budget Act requirements for the guaranteed issue of certain Medicare supplement plans to individuals who lose Medicare+Choice coverage. But it noted that the requirement has the potential to increase Medicare supplement trend by providing opportunities for anti-selection. The level of anti-selection will be affected by individuals' health status, by whether Medicare+Choice alternatives exist, and the ease to move in and out of plans (e.g., in Massachusetts, there are virtually no limits, so very easy to move around often).

Prior to July 1, 1998, guaranteed issue coverage was only universally available during the first six months of Medicare eligibility. The new regulations require guarantee issue coverage of certain Medicare supplement insurance policies to specified eligible individuals. The guaranteed issue coverage requirement applies when an individual has been continuously covered, terminates enrollment, and subsequently applies for a Medicare supplement insurance policy. The application for coverage must be made within 63 days of termination. In addition, individuals must submit evidence of termination or disenrollment along with the application.

3) Rating Methodology

When states are categorized according to mandated rating methodology, the data show apparent lower claim cost trends in states that mandate issue-age rating (see Tables C and D). But, the Academy Work Group was not able to conclude a relationship actually existed for various reasons. First, there is insufficient geographic diversity among the states that require community rating (heavily northeastern states) or entry-age rating (both states are in the south). In addition, many states with rating requirements also have other mandates that may impact trends. Consequently, the data presented below may show effects other than that related solely to state rating restrictions. Section VII of the AAA's report attempts to analyze the impact of rating methodology in states not mandating any rating requirements.

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Table C
Claims Trend By State Rating Requirements
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	Exposed Lives Thousands	Difference From All States	Percentage Difference
All	97/96	13.1%	3,921.1		
	98/97	9.4%	4,647.5		
	98/96	11.2%			
Community	97/96	14.6%	483.0	1.5%	11.5%
	98/97	9.9%	628.3	0.5%	5.5%
	98/96	12.2%		1.0%	8.9%
Entry Age	97/96	8.3%	315.9	-4.8%	-36.3%
	98/97	7.0%	411.9	-2.4%	-25.7%
	98/96	7.7%		-3.6%	-31.8%
No Mandate	97/96	13.4%	3,122.1	0.3%	2.0%
	98/97	9.6%	3,607.4	0.2%	1.9%
	98/96	11.5%		0.2%	2.0%

Source: Table III-D-1 page 19 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

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Table D
Claims Trend By State Rating Requirements
All Insurers Surveyed Combined
All Benefits

	Trend Period	Standardized Plan A	C	F	BDEG	ABCDEFG
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
	98/96	17.6%	10.9%	9.0%	12.8%	11.2%
Community	97/96	9.8%	12.3%	12.9%	17.3%	14.6%
	98/97	12.5%	12.6%	6.3%	10.8%	9.9%
	98/96	11.1%	12.4%	9.5%	14.0%	12.2%
Entry Age	97/96	15.6%	9.5%	4.7%	9.9%	8.3%
	98/97	3.8%	8.5%	6.8%	5.9%	7.0%
	98/96	9.5%	9.0%	5.8%	7.9%	7.7%
No Mandate						
	97/96	23.8%	12.0%	10.8%	15.8%	13.4%
	98/97	13.4%	9.6%	7.8%	10.6%	9.6%
	98/96	18.5%	10.8%	9.3%	13.1%	11.5%

Source: Table III-D-2 page 20 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

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Table E
Average Age Trends By Issue By Rating Method By Incurral Year

All Plans Combined, All Ages

Average Age – Current Year Issues

	Incurral Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	69.4	70.2	70.4	0.8	0.2	1.0
Entry Age (EA)	71.1	71.7	71.2	0.6	-0.5	0.1
Community Rate (CR)	72.4	73.2	73.4	0.8	0.2	1.0

Average Age – Renewal

	Incurral Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.4	70.8	71.2	0.4	0.4	0.8
Entry Age (EA)	72.8	73.5	74.0	0.7	0.5	1.2
Community Rate (CR)	74.5	74.8	75.3	0.3	0.5	0.8

Source: Table XII-2 page 48 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

4) Disability Issues

Disabled-eligible Medicare beneficiaries as used in this issue paper and the American Academy of Actuaries' Report include those eligible for Medicare by reason of disability and those eligible for Medicare due to end stage renal disease (ESRD), (except in Massachusetts where those with ESRD are not required to be issued coverage).

Approximately 12% of Medicare enrollees are disabled. In contrast, the proportion of Medicare supplement policyholders which are disabled is below 1% nationally. Therefore, at present mandated offer of coverage to the disabled is not a significant contributor to Medicare supplement trend, or to the differential between Medicare and Medicare supplement trend. But as the Academy study notes, given the high claims costs for the disabled, it remains a potential contributor. Also, it should be noted that the proportion of disableds may vary from company to company, and plan to plan. Therefore, for a particular company this can already be a significant factor.

Nineteen states have implemented laws requiring open enrollment of Medicare supplement insurance to disabled-eligible Medicare beneficiaries. The plans which must be offered and the duration of the guarantee issue period vary by state. While 19 states have requirements, only 11 were included in the select data used to develop the tables in this section of this report. (Please refer to the Academy Report for specific information about the states included.) Note that some insurers offer coverage to under age 65

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Medicare beneficiaries in excess of the minimum requirements. Some insurers may also underwrite this coverage or charge higher rates. Many of these disabled individuals were underwritten so the relative claim costs for disabled and non disabled individuals are understated for the purpose of assessing the impact of open enrollment of disabled individuals.

Table F compares annual claim costs for disabled and age-eligible populations. The data is developed from Attachment G in the AAA Report (Appendix 4). The disabled population was derived by assuming that everyone with an attained age of less than 64 qualified for Medicare by reason of disability. The age eligible population was derived by assuming that everyone with an attained age equal to or greater than 64 qualified for Medicare by reason of age.

Table F
Benefit Relativities By Plan
Under Age 65 Versus Age 65 and Older
Disabled Eligible and Age Eligible
Annual Claims Cost

	(1) Disabled Eligible	(2) Age Eligible	(3) Ratio (3)=(1)/(2)	(4) Disabled Exposure
Plan A	$ 2,311	$ 604	3.83	2,185
Plan C	2,494	1,006	2.48	3,125
Plan F	1,201	892	1.35	8,907
Plan BDEG	1,530	987	1.55	715
All Plans	1,650	929	1.78	14,933
Plans C+F	1,537	939	1.64	12,032

Source: Table VI-1 on page 32 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

Disabled-eligible beneficiaries have significantly higher Medicare supplement claim costs than age-eligible beneficiaries. Increases in the percentage of a Medicare supplement block that is disabled-eligible will lead to increased overall trend. It may also be possible that the claim cost trend for the disabled eligible is different from the claim cost trend for the age eligible. In states limiting rates, age-eligible individuals are subsidizing disabled-eligible individuals.

The percentage of disabled individuals included in the survey increased 33% from 1996 to 1998 (from 0.77% to 1.03% of exposure). Although the percentage is small, the data includes many states not mandating coverage for disabled individuals. Of the 16 states for which select data was contributed, only five mandate coverage of disabled individuals. Thus, the 33% percentage point increase is indicative of the potential growth rate for covering disabled individuals.

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When trend in states where open enrollment to the disabled eligible is mandated was compared to trend in states where there is no such mandate, differences in trend were found. But the Academy Work Group found that these differences could not be attributed solely to the presence or absence of the mandate.

Table G presents annual claim trend for states mandating coverage for under age 65 disabled individuals.

Table G
Claims Trend for States Mandating Under Age 65 Disabled Individuals
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	NAIC Exposed Lives Thousands	Difference From All States	Percentage Difference
All	97/96	13.1%	3,921.1		
	98/97	9.4%	4,647.5		
	98/96	11.2%			
Covering Disabled	97/96	15.4%	1,689.1	2.3%	17.6%
	98/97	9.8%	1,665.1	0.4%	4.0%
	98/96	12.6%		1.3%	11.8%
Not Covering Disabled	97/96	11.4%	2,232.0	-1.7%	-13.2%
	98/97	9.2%	2,982.4	-0.2%	-2.3%
	98/96	10.3%		-1.0%	-8.5%

Source: Table III-C-1 on page 17 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

Please note that, for the 98/96 period, the annual claim trend for covering disableds is 2.3% higher than the trend for not covering disabled individuals. The results may have more to do with geography (trend was lower in the south and Texas was the only southern state mandating coverage for disabled individuals) than any marginal impact from disabled individuals. The trend may reflect geographic differences. Some states (including Connecticut, Oklahoma, and Texas) require only designated plans be made available to disabled individuals, but the data includes experience for all plans.

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5) Prescription Drug Trend

The data in this section present annual claim trend for standardized plan options H, I and J. **Note that these trends are not directly comparable to the other sections of the study due to the different companies contributing data to this section.** Plans H and I include benefits for prescription drugs of 50% coinsurance up to $1,250 annual maximum benefit after a $250 deductible. Plan J provides the same benefit but with a $3,000 annual maximum. The Massachusetts mandated drug product, which does not have a maximum drug benefit, was also studied.

Table H
Claims Trend Comparison
All Insurers Surveyed Combined
NAIC Market Exposure Used to Weight By State
Company Exposure Used To Weight By Plan Within State

	All Benefits	Rx Only Benefits	Non-Rx Benefits
Trend Period : 1996 to 1997			
Plan HI	10.0%	15.3%	8.6%
Plan J	5.9%	12.2%	3.4%
Plan H-J	9.3%	14.8%	7.6%
Mass	19.3%	26.2%	14.9%
Trend Period : 1997 to 1998			
Plan HI	12.9%	14.4%	12.5%
Plan J	9.7%	16.1%	7.1%
Plan H-J	11.3%	15.2%	9.9%
Mass	13.7%	24.0%	6.3%
Trend Period : 1996 to 1998			
Plan HI	11.4%	14.9%	10.5%
Plan J	7.8%	14.2%	5.2%
Plan H-J	10.3%	15.0%	8.7%
Mass	16.5%	25.1%	10.5%

Source: Tables IX-1 through IX-4 on pages 39-42 of the Report to the National Association of Insurance Commissioners by the American Academy of Actuaries Medicare Supplement Insurance Work Group, June 8, 2000

The average annual trend for the drug benefits under plans H-J was 15%. This is thought to be consistent with the generally increasing drug expenditures of the 65+ population, where relatively high increases in drug costs and utilization have been observed. Drug benefit trends under Medicare supplement insurance plans would tend to be higher due to leveraging of the deductible (some insureds have claims over $250 where none existed

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before), but lower due to the maximum limits being reached (insureds collecting the maximum benefit can not increase any more). Increases for non-drug benefits under plans H-J averaged 8.7% per year. This is lower than the trend for (non-drug) benefits under plans A-G, even after adjusting for the different companies involved. Additional data would be needed to determine possible causes for this difference.

In Massachusetts, the 25% annual trend on unlimited drug benefits combines with a 10.5% trend on non-drug benefits to produce an overall average trend of 16.5%. Given the available data, the AAA Work Group was unable to determine the portions of this trend related to the mandate for unlimited drug coverage as compared to other state coverage mandates such as rules that allow individuals to easily move between plans.

C. Other Actuarial Considerations

There are two issues concerning benchmark loss ratios that should be addressed. (A history of loss ratio standards is provided in Appendix 6.) The first issue is whether benchmark loss ratios should differ for issue-age, attained-age, and community-rated products. The second issue is whether, for issue-age policies, the time period to reach the 65% or 75% loss ratio minimums should be longer than three years.

Loss Ratios

If attained-age and community-rated premium rates include only the costs for the risk of the next policy year and if no underwriting is involved, expenses are often evenly distributed across all policy durations. This means that anticipated loss ratios used in developing premium rates for non-underwritten attained-age and community-rated premium rates would be level regardless of duration. However, for community-rated or attained-age rated policies that are underwritten, the anticipated loss ratios may increase somewhat with policy duration to reflect the effect of underwriting.

For issue-age policies, individuals pay more than is attributable to the exposed risk in the early years in order to prefund anticipated premium deficiencies in the later years. Loss ratios are defined to be claims divided by premiums and loss ratio calculations do not reflect active life reserves. This prefunding included in issue-age premiums causes loss ratios for issue-age products to be graduated -- lower in the early years when premiums are more than sufficient for claims and expenses, and higher in the later years when premiums are not sufficient for the claims at older ages and expenses. The initial duration where premiums alone are insufficient to cover claims differs by issue age. Based on recent Medicare data by age, the point where premiums alone are insufficient lies in a range from 8 to 11 years for issue age 65, 5 to 8 years for issue age 75, and 2 to 5 years for issue age 85. The low and high end of the ranges reflect differing underlying actuarial assumptions and different reserving methods.

This means that, based on common issue-age pricing methodology, a 65% loss ratio in any one year would not be expected until the 8th to 11th year for issue age 65, the 5th to 8th year for issue age 75, and the 2nd to 5th year for issue age 85.

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Benchmark Loss Ratio

When benchmark loss ratios were originally developed, Medicare supplement policies were primarily issued on an issue-age basis. Currently, however, Medicare supplement insurance is frequently issued on an attained-age basis. The existing benchmark loss ratios permit a 3-year grading to the 65% or 75% loss ratio minimums. This means that attained-age business which may be priced with level loss ratios is being compared to graduated loss ratio minimums.

There has been some discussion that the 3-year requirement to meet the 65% or 75% loss ratio minimums may have contributed toward the shift in new business from issue-age to attained-age. The reason being that three years is not enough time to build the active life reserves necessary for issue-age policies. An 8 to 11-year period would be more typical for issue age 65 business.

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III. Conclusions

A. Benchmark Loss Ratios for the Refund Calculation

The Accident and Health Working Group recommends that the NAIC develop revised benchmark loss ratios. These revisions would reflect the following:

1. Have four separate benchmark loss ratio requirements.

Currently, there are two separate benchmark loss ratio categories – one for individual and the other for group. The Accident and Health Working Group is recommending that there also be two separate subcategories within group and individual. One of the subcategories would be applicable to issue-age products. The other subcategory would be applicable to non-issue age products (i.e., attained-age and community-rated products).

2. Extend the time period for issue-age policies to meet the loss ratio minimums of 65% or 75% to 7 years.

The current 3-year time period appears to have originated to provide enforceable requirements and does not allow for the extensive time period typically needed to build active life reserves required by an actuarially sound issue-age rating methodology. As explained in the Current Environment section, for issue-age policies, the time needed to accumulate adequate active life reserves varies by issue age, and can be as long as 11 years. The Accident and Health Working Group is recommending a time period of 7 years before the minimum loss ratios of 65% or 75% should be required. This 7-year period represents a weighted average of issue ages, and assumes that 50% of policies are issued at age 65.

Depending on the actuarial assumptions used, and the type of reserving methodology used, the 65%/75% loss ratio may be attained earlier than 7 years. The 7-year period allows companies discretion in the actuarial assumptions used to price Medicare supplement policies, and in the methodology used in building contract reserves. In doing so, and combined with the following recommendation, the minimum loss ratio requirements and the corresponding refund calculations will assume a more neutral role in the decisions companies make regarding pricing methodologies.

A longer period for achieving a 65%/75% loss ratio necessitates the adjustment of the Annual Refund Calculation format. New benchmark loss ratios will need to be calculated, both during and beyond the recommended 7-year development period.

3. Leave the 3-year time period for non-issue age policies unchanged, but recalculate the benchmark loss ratios.

The Accident and Health Working Group recommends that the non-issue age subcategory loss ratio minimums be recalculated to still achieve a 65% loss ratio for individual business and a

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75% loss ratio for group business by the third duration. Higher first and second duration benchmark loss ratios would reflect the lack of pre-funding in non-issue age rating methods.

B. Actions Needed

The actions required to implement the above recommendations are:

1. Develop revised benchmark loss ratios, for both issue-age and non-issue age products.

2. Determine whether the Social Security Act would need to be revised because it references the 1991 NAIC Medicare Supplement Model Regulation (see Appendices 7 – 10 for specific language).

3. Revise the benchmark loss ratios in the NAIC Medicare Supplement Insurance Model Regulation.

4. Revise subsection 14C in the NAIC Medicare Supplement Insurance Model Regulation so that policies in-force less than 3 years shall meet the loss ratio minimums over the entire period for which rates are computed.

The Accident and Health Working Group stands ready to answer any questions the Medicare Supplement Working Group may have with regard to the above recommendations, and to assist with the implementation of these recommendations as needed.

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[1] Health Care Special Report, Medicare: New choices, new worries," *Consumer Reports*, September 1998, 27-38.

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Appendix 1

Medicare Supplement Rate Increases Survey

The Accident and Health Working Group of the Life and Health Actuarial (Technical) Task Force has been requested by the Medicare Supplement Working Group of the Senior Issues Task Force to study the rates of Medicare supplement insurance and the effect of rate changes. In response to that request, the Accident and Health Working Group is developing an issue paper that analyzes the various issues associated with rate increases for Medicare supplement insurance policies. As part of that issue paper, you are being requested to complete the following survey.

1. Number of Medicare Supplement Carriers in your state: _____
   a. Number actively marketing: ______
   b. Number who offer Plan J: ______

2. Range of rate increases over the past 12 months:
   Minimum: ________________ Maximum: _______________ Most common: ____________

3. Level of annualized cost trend assumed in rate increase requests:____________________
   Minimum: ________________ Maximum: _______________ Most common: ____________

4. Anything distinctive about the rate increases:
   (For example:
   Plans covering prescription drugs are receiving higher increases than other plans.
   The levels of the rate increases are higher than prior years.)
   ____
   ____
   ____
   ____

5. What are the most common justifications?
   ____
   ____
   ____
   ____
   ____

6. Do carriers combine plans for determining an overall increase or is the rate increase determined independently for each plan?
   Yes _____ No _____ Is this required by your state? Yes _____ No _____
   Comments:
   ____
   ____
   ____
   ____

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7. If rate increases are determined independently for the various plans, are the rate relationships among the plans reasonable?

Yes _____ No _____

Comments:

____

____

____

____

8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?

Yes _____ No _____ Is this required by your state? Yes _____ No _____

Comments:

____

____

____

____

9. Do carriers combine disabled business with over age 65 business to determine rate increases?

Yes _____ No _____ Is this required by your state? Yes _____ No _____

Comments:

____

____

____

____

10. a. Is issue age rating permitted? Yes _____ No _____
b. Is attained-age rating permitted? Yes _____ No _____
c. Is community rating **required**? Yes _____ No _____

Name ________________________________

Phone ____________________

Please e-mail, fax, or telephone your responses to Diana Wright **by August 25** at the following numbers:
e-mail: Dwright@naic.org **fax:** (816) 889-4446 **phone:** (816) 889-4490.

Any and all information is appreciated. Thank you for your attention and participation.

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Appendix 2

STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Alabama	**Alaska**	**Arizona**
1. Number of carriers in state	Unknown		
a. Number actively marketing	Unknown	20 had premium in 97	86
b. Number offering Plan J	Unknown	1 had premium in 97	Not Available
2. Range of rate increases over past 12 months			
Minimum	8%	0%	+5%
Maximum	35%	22%	+25%
Most common	15%	5-10%	+10%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	9%	5%	4%
Maximum	14%	16%	12%
Most common	10%	6-8%	8%
4. Anything distinctive about rate increases	Plan C appears to be subject to the highest increase	(1)	Nothing commonly distinctive
5. What are the most common justifications	(2)	Increases in utilization and benefit cost increases	(3)
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	No	No	Yes[4]
Is this required?	No	No	No
Comments	Determined by plan		
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	(5)	Yes
Comments			
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	No
Comments			In some instances where both pre-standardized and standardized business are closed blocks they are combined for rating.
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No	Some rate separately but most combine	No
Is this required?	No	No	No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Arkansas	California	Colorado	Connecticut
1. Number of carriers in state	54	Information not available	104	34
a. Number actively marketing	54		50	18
b. Number offering Plan J	8		9	4
2. Range of rate increases over past 12 months				
Minimum	5%		4%	0%
Maximum	21%		33%	35%
Most common	12%		13%	15%
3. Level of annualized cost trend assumed in rate increase requests				
Minimum			4%	10%
Maximum			20.1%	15%
Most common	Medical Price Index		10%	12%
4. Anything distinctive about rate increases				The levels of increases are slightly lower than in prior years. Prescription drug prices are receiving much larger increases.
5. What are the most common justifications	Inflation and increase in utilization		Losses	(6)
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes		Yes	No
Is this required?	Yes			No
Comments	In some cases.		Sometimes to make more credible.	(7)
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes		Yes	Yes
Comments			If credible experience is provided.	The department attempts to keep the benefit relativities in line with what makes sense.
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No		No	No
Is this required?	No			No
Comments				(8)
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No		No	Yes
Is this required?	No			Yes
Comments				(9)
10.a. Is issue age rating permitted?	No		Yes	No
b. Is attained-age rating permitted?	No		Yes	No
c. Is community rating required?	Yes, consolidated premium		No	Yes

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Delaware	**Florida**	**Georgia**[10]
1. Number of carriers in state	27	124	85
a. Number actively marketing	27	46	38
b. Number offering Plan J	8	9	5
2. Range of rate increases over past 12 months			
Minimum	Not available	0%	0%
Maximum	Not available	16.3%	30%
Most common	Not available	10.76%	10%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	Not available	~4%	4
Maximum	Not available	>20%	14
Most common	Not available	7.5-8%	9
4. Anything distinctive about rate increases	Frequently determined on a nationwide basis.	Frequently requests are higher than justified by a plain reading of the rules.	Plans H, I and J (containing drug benefits) tend to be associated with higher increase requests.
5. What are the most common justifications	Increasing costs of medical care.	Experience is worse than expected.	Increase in claims incidence
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	No	Yes	No
Is this required?	No	Yes	No
Comments	Carriers do not combine plans for determining an overall increase.	Some variability of increase can be considered as long as the relationships between plans are not distorted.	
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes		Yes
Comments			Each request for increase is supported by claims experience and trend data
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	Yes
Is this required?	No	No	Yes
Comments		Some combinations may be required in the future.	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No	Yes	No
Is this required?	No	Yes	No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	No	No
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Idaho	**Illinois**	**Indiana**
1. Number of carriers in state	63	120	113
a. Number actively marketing	55 (estimate)	83	38
b. Number offering Plan J	45 (estimate)	13	6
2. Range of rate increases over past 12 months			
Minimum	2%	1.9%	0%
Maximum	25%	26%	30%
Most common	10%	10-15%	10-15%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	5%	7%	7.5%
Maximum	25%	19%	12%
Most common	10%	10%	10%
4. Anything distinctive about rate increases	No		Higher increases on drug benefit plans
5. What are the most common justifications	Loss ratios	Medical cost inflation; utilization increase	Loss ratios, persistency, trend
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes	Yes	Independently
Is this required?	No	No	No
Comments		This is permitted only in cases where the plans' experience is not credible	State has a strong bias for treating plans independently.
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes		Sometimes
Comments		NA	
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	No
Comments		This is allowed in rare instances.	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No	Yes	Some companies do, to enhance credibility
Is this required?	No	No	No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	No	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Iowa	**Kansas**	**Kentucky**[11]
1. Number of carriers in state	51	71	80
a. Number actively marketing	45		
b. Number offering Plan J	11	9 (approximately)	16
2. Range of rate increases over past 12 months	(12)		
Minimum	0% (pre-standardized)	0%	
Maximum	50% (pre-standardized)	26%	
Most common	9.93% (pre-standardized)	10-15%	
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	3%		
Maximum	12%		
Most common	8%	5%-12%	
4. Anything distinctive about rate increases	Nothing unusual at this time	Increases for each plan vary based on experience rather than plan benefits	
5. What are the most common justifications	Benefit changes, Part A, Part B deductible and coinsurance costs (due to inflation and increased utilization), and of course, loss ratios	Experience	
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	No, not always	No	
Is this required?	No	No	
Comments	(13)		
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Perhaps not	Yes	
Comments	(14)		
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	
Is this required?	No		
Comments	(15)		
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Sometimes	Yes	
Is this required?	No		No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No[16]

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Maine	**Maryland**	**Massachusetts**[17]
1. Number of carriers in state	54 (approximately, including prestandardized)	45	2
a. Number actively marketing	12	45	2
b. Number offering Plan J	3	15	0
2. Range of rate increases over past 12 months		Information not available	
Minimum	0% (prestandardized) 0% (standardized)		0%
Maximum	30% (prestandardized) 25% (standardized)		25%
Most common	10% (prestandardized) 10% (standardized)		25%
3. Level of annualized cost trend assumed in rate increase requests			Varies by benefit component and carrier
Minimum	7.2%	0	0%
Maximum	12.7%	25	40%
Most common	10%	10	20%
4. Anything distinctive about rate increases	(18)	Information not available	(19)
5. What are the most common justifications	Experience, claim trend, changes to Medicare	Change in Medicare benefits; change in trend; high loss ratio	People with drug coverage are sicker and have more hospitalizations. Healthier people enroll in HMOs.
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?		Yes	Yes
Is this required?	No	No	No
Comments	Carriers vary	Companies are permitted to do this if the experience for each plan is not credible.	
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments			
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	Yes	No
Is this required?	No	No	No
Comments	(20)	(21)	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes	Yes	Yes
Is this required?	Yes	No	Yes and No
Comments	Community rating		(22)
10.a. Is issue age rating permitted?	No	Yes	No
b. Is attained-age rating permitted?	No	Yes	No
c. Is community rating required?	Yes	No	Yes

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NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Michigan	Minnesota	Mississippi
1. Number of carriers in state	130 (approximately	66	100
a. Number actively marketing	70 (approximately)	28	50
b. Number offering Plan J	13	28	30
2. Range of rate increases over past 12 months			
Minimum	5%	-20%	0%
Maximum	25%	48%	25%
Most common	10%-15%	15 or 20%	10%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum		7%	0%
Maximum		25%	10%
Most common		15%	8%
4. Anything distinctive about rate increases	Plans A and C must be offered as guaranteed issue. We see increases in Plan C the most.	(23)	The levels of the rate increases are higher than prior years
5. What are the most common justifications	24	(25)	Experience
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Sometimes	No	Yes
Is this required?	No	No	Yes
Comments	Various companies present the data in various ways. Most companies show each plan independently.	(26)	
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments		Some antiselection may be reflected.	
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	No
Comments	Generally	Due to the refund formula, we cannot require this combination.	Carriers are not permitted to combine pre-standardized business with standardized.
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes	Yes	No
Is this required?	No	Yes	No
Comments	(27)	(28)	Carriers are required to rate disabled and over age 65 separately.
10.a. Is issue age rating permitted?	Yes	No	Yes
b. Is attained-age rating permitted?	Yes	No	Yes
c. Is community rating required?	No	Yes	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Montana	**Nebraska**	**Nevada**
1. Number of carriers in state	65 (approximately)	75	79
a. Number actively marketing	60	74	32
b. Number offering Plan J	17	19	9
2. Range of rate increases over past 12 months			
Minimum	0%	0%	5% requested
Maximum	50%	40%	45% requested
Most common	10%	10-15%	15% requested
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	8%	7%	7%
Maximum	12%	12%	14%
Most common	10%	10%	0%7.5%
4. Anything distinctive about rate increases	(29)	Plans including prescription drugs are higher.	Additional benefits
5. What are the most common justifications	(30)	Higher than expected losses.	Loss ratio history
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes	No	Yes
Is this required?	No	No	No
Comments	(31)	Carriers are not permitted to combine plans for determining an overall increase.	In some instances, they will combine plans but ask for different increases by plan. In those cases, we require individual, by plan, loss ratio histories.
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments	(32)		
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	No
Comments	We require that the experience be provided separately, since the two types of business have different loss ratio requirements.	Carriers are not permitted to combine pre-standardized business with standardized.	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes	No	Yes
Is this required?	No	No	No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	New Hampshire	**New Mexico**	**New York**
1. Number of carriers in state	50 (approximately)		27
a. Number actively marketing	13	79	17
b. Number offering Plan J	3	21	1
2. Range of rate increases over past 12 months			
Minimum	0%	0%	0%
Maximum	40%	30%	20%
Most common	10-15%	10%	10%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	8%	6%	10%
Maximum	18%	18%	20%
Most common	12%	9%	15%
4. Anything distinctive about rate increases	(33)	(34)	
5. What are the most common justifications	Actual experience must be worse than expected and forming the basis for revised expectations for future emerging experience	Experience, and trend	Higher medical costs; higher utilization rates; need to reduce loss ratios to adjust for limitations on premium increases in previous years.
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes and No (some do and some don't)	No	
Is this required?		No	
Comments	(35)	36	(37)
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments	To the extent 'reasonable' is 'defined' in the NAIC compliance guide.	Isolated incidents of cases where rate relativity was more than 5% off was primarily due to experience	We check the proposed rates for a reasonable rate relationship between plans if rate increases are determined independently.
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	
Comments	Wouldn't such a requirement advantage new entrants over existing writers?	Usually all pre-standardized plans experience is combined	(38)
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes	Yes	Yes
Is this required?	Yes	Yes	Yes
Comments	This is now required, effective 1/1/98.		
10.a. Is issue age rating permitted?	Yes	Yes	No
b. Is attained-age rating permitted?	Yes	Yes	No
c. Is community rating required?	No	No	Yes

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	North Dakota	Ohio	Oklahoma
1. Number of carriers in state	59	94	NA
a. Number actively marketing	50 (estimate)	50 (approximate)	
b. Number offering Plan J	14	23	
2. Range of rate increases over past 12 months			
Minimum	0%	0%	0%
Maximum	20%	40%	25%
Most common	12%	12.72%	9%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum			0%
Maximum			35%
Most common	12%		15%
4. Anything distinctive about rate increases	The increases for '96-'98 have been in the 12-15% area while the years '93-'95 were generally flat.	(39)	We are holding companies to lower rate increases due to overall impact of increases on seniors/disabled on Med supp.
5. What are the most common justifications	Rapid increase in outpatient utilization and costs. Rapid increase in prescription drug costs.	Poor experience	Trend, loss ratios much higher than anticipated.
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?		Both	Yes
Is this required?		No	No
Comments	Prestandard – all pooled Standardized – usual position is to require one increase for all plans but allow % to differ by plan	Depending on credibility of the block.	Some carriers combine, others do not.
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?		Yes	Yes, generally
Comments	The relationship of premiums by plan gets changed if allow different % increases by plan.	If credible.	
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No, generally
Is this required?		No	No
Comments			
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No	Yes	Yes
Is this required?		No	No
Comments			
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Oregon	Pennsylvania	Rhode Island[40]
1. Number of carriers in state	57	55	14
a. Number actively marketing	50	46	3
b. Number offering Plan J	9	6	1
2. Range of rate increases over past 12 months			
Minimum	0%	3.4%	
Maximum	15%	50%	
Most common	8%	15-16%	11%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	2%		
Maximum	10%		
Most common	5%		8.55%
4. Anything distinctive about rate increases	Prescription drug plans are higher due to higher loss ratios – other plans about the same.	Plans with prescription drugs typically receive higher increases (the 50% increase was for Plan H) than the plans without prescription drugs.	Very little drug coverage outside Medicare HMOs
5. What are the most common justifications	Experience, inflation, utilization and changing benefits.	(41)	Increase and SNF copay. Increase and SNF Part B copay utilization and mix.
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Sometimes	Yes	No (carriers do not combine plans for determining an overall increase)
Is this required?	No		No
Comments		(42)	
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments		(43)	
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	Yes
Is this required?	No		No
Comments			Relates to Plan C 90% of market.
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes	Yes	Yes
Is this required?	Yes	Yes	No
Comments		44	Less than 65 block not credible.
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	South Dakota	Tennessee	Texas
1. Number of carriers in state	41	62	132
a. Number actively marketing	NA	62	76
b. Number offering Plan J	8	13	10
2. Range of rate increases over past 12 months			
Minimum	3%	0%	2%
Maximum	35%	30%	40%
Most common	8-12%	15%	15-25%
3. Level of annualized cost trend assumed in rate increase requests			
Minimum	4%	0%	2%
Maximum	12%	12%	15%
Most common	8%	6%	8-10%
4. Anything distinctive about rate increases	Not available	No	
5. What are the most common justifications	Increased costs	Adverse experience; change in deductible	Past poor experience; worse then expected claim experience; medical cost trend
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes	Yes and No (both ways)	
Is this required?	No		
Comments	Combine only to get credible experience		(45)
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	No	Yes	Yes
Comments	Rate relationships are not always reasonable		
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	No
Comments			
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	No	No	
Is this required?	No	No	No
Comments		Carriers are required to rate disabled and over age 65 separately.	Some carriers combined the disabled business with over age 65 business, but they are not required to do so.
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	No	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Utah	Vermont	Virginia
1. Number of carriers in state	Unknown	21	66
a. Number actively marketing	Unknown	21	Unknown
b. Number offering Plan J	Unknown	3	19 (approved; the number marketing this Plan is unknown)
2. Range of rate increases over past 12 months	Not tracked	Approved increases	(46)
Minimum		0	
Maximum		25%	
Most common		4-15%	
3. Level of annualized cost trend assumed in rate increase requests	Not tracked	Not tracked	
Minimum			7.5% (estimate, information not tabulated)
Maximum			15% (estimate, information not tabulated)
Most common			
4. Anything distinctive about rate increases		No	(47)
5. What are the most common justifications	Poor experience	Increasing cost of services; no control over package coverage	Trend and the developing experience
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?			
Is this required?			No
Comments	A carrier may pool experience	(48)	(49)
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Unknown	Yes	
Comments		Accompanying documentation must be provided justifying reasonableness	(50)
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	
Is this required?	No	No	
Comments	Not to our knowledge	Pre-standardized plans cannot be combined with standardized plans	(51)
9. Do carriers combine disabled business with over age 65 business to determine rate increases?		Yes	Yes
Is this required?			No
Comments	Not known		
10.a. Is issue age rating permitted?	Yes	Yes	Yes
b. Is attained-age rating permitted?	Yes	Yes	Yes
c. Is community rating required?	No	Yes (state is in the first of a three year community rating phase in)	No

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STATE RESPONSES
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998
As of 5/24/99

	Washington	Wisconsin	Wyoming
1. Number of carriers in state	Unknown	65	60 (estimate)
a. Number actively marketing	34 (estimate)	43 (approximately)	40
b. Number offering Plan J	13 (estimate)	2 base & 6 riders	10
2. Range of rate increases over past 12 months			Don't routinely track
Minimum	-10%	-10%	
Maximum	29%	30%	
Most common	10-20%	8-10%	
3. Level of annualized cost trend assumed in rate increase requests			Don't routinely track
Minimum	3%	N/A	
Maximum	20%	N/A	
Most common	7-11%	8-14%	
4. Anything distinctive about rate increases	Plans covering prescription drugs are receiving higher increases than other plans	Nothing – similar to last year	Don't routinely track
5. What are the most common justifications	Bad experience	Loss ratio; medical inflation	Claims experience; cost trends
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?		Yes	
Is this required?		Yes	No
Comments	(52)	(53)	Carriers can determine independently
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes	Yes	Yes
Comments	Most of the time	Rider rates are reviewed for reasonableness	Actuarial Memorandum accompanies a rate increase request
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	No	No	No
Is this required?	No	No	
Comments	(54)	(55)	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?		Yes	
Is this required?	No	Yes	No
Comments	Some carriers combine disabled business with over age 65 business to determine rate increases. It is not required by our state.	1994 require carriers to offer disabled	Haven't any knowledge. Medigap for disabled is not mandated
10.a. Is issue age rating permitted?	Yes (for enrollment prior to 1/1/96)	Yes	Yes
b. Is attained-age rating permitted?	No	Yes	Yes
c. Is community rating required?	Yes (for enrollment after 1/1/96)	No	No

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[1] We have begun to discourage having a product approved that is not marketed. We do not allow any increase above trend in these cases. Two companies provided trends for drug coverage of 18% and 32%. Rate increases have generally been higher for H, I and J. Rate increase actually appear lower than prior years except for H, I and J.
[2] 1. Federal increases in co-pays and deductibles and the leveraging thereof. 2. Increased utilization. 3. Increased cost of services and procedures.
[3] Benefit increases resulting from Medicate benefit reductions, i.e., increased deductibles, coinsurance, etc. Also, poor loss experience.
[4] Pre-standardized plans are generally combined for rating, while standardized plans are generally rated separately by plan.
[5] Companies that do not have any inforce and are not really marketing the product in the state are only allowed trend and therefore the rates for those plans may not be in proper relationship.
[6] For prestandardized it's the fact that it is a closed block, as well as higher utilization. For standardized, it's higher utilization of services and increased cost at providing those services.
[7] The department requires that each plan satisfy loss ratio requirements, but the department does review credibility of the experience and analyze benefit relativities.
[8] Only recently has one carrier requested to combine pre-standardized business with standardized business. We continue to review this and will allow it when it makes sense.
[9] Prior to a 1998 law, only Plan A was a required offering to the disabled, but as of this new law if a carrier offers Plan B and/or Plan C they must offer these to the disabled. As a result Plan A and Plan B/C are required to combine disabled and non-disabled business together.
[10] Supporting documents sent with survey.
[11] We will have the rating information by next year.
[12] Standardized:

	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Average:	10.77%	9.98%	9.93%	7.84%	6.11%	7.68%	5.59%	9.02%	10.62%	8.71%
Min:	-7.60%	0.00%	-7.60%	0.00%	0.00%	-7.60%	-5.00%	0.00%	0.00%	0.00%
Max:	30.00%	30.00%	35.00%	20.00%	20.00%	30.00%	25.00%	25.00%	30.00%	22.00%

[13] In general, rate increases are determined based upon the experience generated for each plan. For carriers with small market share and premium volume, credibility becomes an issue when individual plan experience is analyzed; in this case, combined plan experience is the basis for the rate increase.
[14] This is an area that I'm sure is a problem in most states. Since it is common to base the rates upon the experience generated for each plan, there is bound to be some rate differentials due to factors other than benefit adjustment factors.
[15] There does not seem to be a trend in this direction. I have only reviewed two or three filings that combined the two blocks for rating purposes.
[16] Not aware of anyone who has filed a community rated plan.
[17] State is a waivered state and this is somewhat unique as far as rate review and contract forms. For example, each rate filing for an increase over 10% requires a full hearing with two statutory intervenors and any other interested party.
[18] Drug plans tend to receive higher percent increase and assumed to have 18% claim trend; didn't see many increases in standardized plans for several years until experience became more credible; some state experience still not very credible so those filings rely on national experience.
[19] Plans covering prescription drugs are receiving higher increases than other plans. Major shift to HMOs from indemnity coverage. HCFA decision to allow HMOs to eliminate or reduce drug coverage required by state law will lead to further dislocation in the indemnity market.
[20] Those with pre-standardized plans can switch to a standardized plan at any time. Notice of this right is required on each policy anniversary and at the time of any rate increase. Those switching can choose any standardized plan offered by the carrier unless it has greater drug benefits than their existing plan.
[21] Considerations would include the effect pre-standardized business would have on standardized business and how pre-standardized business compares with standardized business.
[22] For the two carriers remaining, community rating requires no discrimination against disabled. Prior to 1995, there was no such restrictions.
[23] Plans covering prescription drugs are receiving higher increases than other plans. The levels of the rate increases are higher than prior years. Pre-standardized forms are getting higher increases.
[24] Quite often companies will state that increasing medical costs justify the increases. Actually though, we look at the loss ratio for justification.
[25] Poor recent claim experience. Aging and anti-selection or closed community-rated block.
[26] When a small block has bad experience we usually request that the carrier combine it with other blocks.

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[27] Many companies will combine the under 65 experience with age 65 experience. Some companies have separate rates for under 65 disabled. Some do not make the differentiation and just use the age 65 rates.
[28] Our community rating law requires the same rates for the same benefits.
[29] No, except that (not surprisingly) prestandardized business has higher rate increases than standardized. But on average, those increases aren't really that much higher.
[30] Insurers justify the increase by saying (and showing) it's needed to keep the lifetime loss ratio close to the minimum required loss ratio. They also cite medical trend and changes in Medicare as reasons for at least part of the increase.
[31] Often initial rate filings base the request on combined experience. We ask them for experience by plan (for standardized business) and in our review give higher consideration to experience by plan than to overall experience. Most carriers determine the increase separately for each plan. (For pre-standardized business, we're more likely to base our decision on all plans combined, and don't ask for experience by plan. Insurers are more likely to submit the experience on a combined basis.)
[32] "Reasonable" depends on both differences in benefits and differences in experience. We try to ensure that rates are reasonable in relation to benefits, and take that into consideration in reviewing rate filings. But if experience is really poor on a lower-benefit plan, we can't justify refusing to grant a rate increase even if it puts that plan's rates out of line with that of higher-benefit plans.
[33] Plans with drug benefits are getting higher increases in general than other plans. The greater the amount of 'community' rating inherit in the product, the greater the increase. Age community rated plans, like the "AARP" plan with which we are all familiar, seem to be implementing the largest increases. Plans with a limited number of attained age categories, i.e. 65-69, 70-74 and 75+, would be next. Plans which vary rates by attained age through 99 generally seem to be realizing the least. Issue age plans are mixed.
[34] Plan A, and plans covering prescription drugs are receiving rate increases due to higher trend and due to higher utilization.
[35] We look at credibility. Where requests for rate relief, or revised cost assumptions, are based on non-credible experience, the request will be denied.
[36] Rate increases are being determined based upon the national experience for each plan separately.
[37] Insurers are allowed to use their discretion as long as credible experience exists for each plan for which they propose an independent rate increase. (Benefits must be reasonable in relationship to premiums.)
[38] The loss ratio experience of the pre-standardized and standardized Medicare supplement blocks of business are considered separately for premium revision purposes.
[39] H,I, J are the highest increase in prescriptions. Rate increases for 93 are 9% avg; 94 are 13% avg; 95 are 8% avg; 96 are 7.36% avg; 97 are 11.63% avg.
[40] Answers represent Plan C 90% of the market, though less than 90% of the carriers.
[41] Insurers are showing the minimum loss ratio has already been exceeded. For some less mature blocks, companies will request an increase when the durational loss ratios exceed those anticipated in the original filing. In a few cases, lapse rates have been lower than expected, so the company is experiencing higher cumulative loss ratios.
[42] Since refund calculations are based on each plan rate increases are based on each plans data. For non-profit plans that maintain loss ratios of over 85%, we do look at some of the data on a combined basis.
[43] We monitor the insurers rate increases for this, especially for plans with limited experience. For plans with credible data, there is less emphasis on the relativities among plans, and more concern with the individual plan meeting the loss ratio requirements because of the refund calculation required.
[44] Since open enrollment must be offered to persons eligible for Medicare because of disability during the 6 months after the person enrolls in Medicare Part B at a rate no greater than the age 65 open enrollment rate, the data for all insureds must be combined.
[45] Pre-standardized: carriers are required to combine plans for an overall increase. Standardized: rate increase determined independently; however, if because of credibility problem, carriers could combine the similar benefit plans for rate increase filing purpose.
[46] Companies have filed for rate decreases as well as increases. The range of percentages is not available nor is information available that indicates the most common rate increase requested.
[47] Nothing of which we are aware. However, we do agree that Plans covering prescription drugs are receiving higher increases than other plans.
[48] If the block is closed and the stats used are not creditable, then plans may be combined, but generally, each plan must be computed independently.
[49] Rate reasonableness is generally reviewed based on the experience of each Plan separately. The experience of the separate Plans is allowed to be combined only if such experience is determined to be not significantly credible.
[50] Not always, although this can be a consideration. However, the primary concern is whether the experience of the specific Plan justifies the proposed rate.

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[51] Companies are required to file the experience for these two groupings separately. They may not combine the experience of the pre-standardized business with the experience of the standardized business to determine rate increases.
[52] As required by our state regulations, all pre-standardized plans need to be combined for rate adjustment purpose. The standardized plan rate increase can be determined independently for each plan.
[53] This is a waiver state. The NAIC standardized plans are not required. State request base plan with six rider options. Somewhat combination because riders are not rated separately.
[54] Our state only requires carriers to combine all pre-standardized plans but not with standardized plans. Most carriers have one rate increase request for all pre-standardized plans. For standardized plans, the carriers are allowed to project the rates by plan and by type.
[55] All pre-standardized policies of carrier are combined as group or individual for rating for standardized, if a rider is discontinued that was previously offered, the experience for the discontinued experience must be included for rating purposes.

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*SUMMARY OF RESPONSES (*As of 5/24/99)
NAIC MEDICARE SUPPLEMENT RATE INCREASES SURVEY, AUGUST 1998

	Summary*
1. Number of carriers in state	
a. Number actively marketing	
b. Number offering Plan J	
2. Range of rate increases over past 12 months	
Minimum	-20%
Maximum	50%
Most common	
3. Level of annualized cost trend assumed in rate increase requests	
Minimum	0%
Maximum	40%
Most common	
4. Anything distinctive about rate increases	
5. What are the most common justifications	
6. Do carriers combine plans for determining an overall increase or is rate increase determined independently for each plan?	Yes – 15 No – 11 Sometimes – 6 No answer -- 10
Is this required?	Yes – 4 No – 27 No answer – 11
Comments	
7. If rate increases are determined independently for the various plans, are the rate relationships among the plan reasonable?	Yes – 31 No – 1 Other – 4 No answer – 6
Comments	
8. Do carriers combine pre-standardized business with standardized business to determine rate increases to prevent price-spirals associated with closed blocks?	Yes – 3 No – 36 Other – 1 No answer – 2
Is this required?	Yes – 1 No – 33 No answer – 8
Comments	
9. Do carriers combine disabled business with over age 65 business to determine rate increases?	Yes – 22 No – 12 Other – 3 No answer – 5
Is this required?	Yes – 10 No – 26 Other – 1 No answer – 5
Comments	
10.a. Is issue age rating permitted?	Yes – 36** No – 6
b. Is attained-age rating permitted?	Yes – 32 No – 10
c. Is community rating required?	Yes – 8* No – 34

*Responses have been received for 43 states. One of the 43 states indicated that the requested information was not available. This state was excluded from the tally in each of the questions.

**One state indicated that issue-age rating was permitted for enrollment prior to 1/1/96; community rating is required for enrollment after 1/1/96.

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AMERICAN ACADEMY OF ACTUARIES
MEDICARE SUPPLEMENT INSURANCE WORK GROUP

REPORT TO THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

June 8, 2000

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

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Attachments

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I. Executive Summary

The American Academy of Actuaries (Academy) was asked by the Accident and Health Working Group (Life and Health Actuarial Task Force) of the National Association of Insurance Commissioners to examine factors that may be affecting the cost of Medicare Supplement insurance policies. The Academy formed a Medicare Supplement Insurance Work Group that collected and analyzed data from 11 insurance carriers providing Medicare Supplement coverage.

This final report examines the relationships between various factors and Medicare supplement insurance claim cost trend. Issues discussed in this report include:

- Annual claim cost trend nationwide, by geographic area, plan and state (Sections III and IV)
- Hospital outpatient costs (Section V)
- Coverage for beneficiaries under age 65 (Section VI)
- Rating methods mandated by states (Section VII)
- Prescription drug coverage (Section IX)
- Guaranteed issue and Medicare+Choice plans (Section X)
- Fraudulent claims (Section XI)
- Increasing average age of insured individuals (Section XII)

Claim cost trends from 1996 through 1998 were reviewed by plan, state and some benefit types (e.g. Medicare Part A and B, hospital outpatient, prescription drug coverage, etc.) for the standardized Medicare supplement insurance plans of several large insurers who participated in the study. The aggregate nationwide annual claim trend from 1996 through 1998 was 11.2% for all plans A through G combined. This was twice the 5.6% expected trend over the same time period (1996-1998). This report discusses and seeks to quantify, where possible, the underlying causes of this trend differential.

The analyses presented in the report reveal that several of the above factors affected claim cost trend significantly.

- Hospital outpatient costs had a major impact on claim cost trend between 1996 and 1998. A significant portion of the Medicare Supplement trend has been attributed to the increase in coinsurance claim costs on outpatient hospital services. Medicare Supplement insurance policies reimburse beneficiaries for their liability for hospital outpatient charges.

- Individuals eligible for Medicare because of disability have significantly higher Medicare Supplement claim costs than those individuals eligible because of age (for all plans the rate is 78% higher).

- The trend for prescription drug benefit costs are higher than the trend for non-prescription drug benefits within Plans H, I and J. Claim trend for such costs in Plans H, I and J are suppressed because of annual limits on benefits. A study of prescription drug costs in one nonstandard plan with liberal benefits in a single state exhibited higher cost trends than Plans H, I and J.

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- Fraud affects the cost of Medicare Supplement claims; however, the Work Group was unable to quantify the impact. Recent efforts to crack down on fraudulent claims could have an effect on Medicare and Medicare Supplement insurance claim trend. The Health Care Financing Administration's (HCFA) recoveries of fraudulent claim payments are not shared with Medicare Supplement insurers.

- The average age of Medicare Supplement insurance enrollees at the time the policy is issued has increased one year from 1996 to 1998 when all issue ages are combined. This is consistent with studies concluding Medicare managed care plans attract younger, healthier individuals who may in turn choose to not purchase Medicare Supplement coverage.

However, for several analyses presented in the report definitive answers as to the impact on claim trend or claim cost levels could not be concluded:

- The average age and average duration of community and entry-age rated policies was greater than that of attained age policies. However, the overall conclusion of the Work Group is that no definitive answer could be given whether a particular rating methodology consistently affects claim levels or trends.

- Data limitations prevented the Work Group from reaching conclusions on the effect of state rating mandates on trends.

- While it may be too early to evaluate the quantitative effects of the 1997 Balanced Budget Act requirements for the guaranteed issue of certain Medicare Supplement plans to individuals who lose Medicare+Choice health plan coverage, this requirement may provide opportunities for anti-selection. The level of anti-selection will be affected by individuals' health status, by whether Medicare+Choice alternatives exist, and the ease to move in and out of plans (e.g., in Massachusetts, there are virtually no limits on individuals moving in and out of plans).

- Significant volatility of claim trend is exhibited at the state level. No attempt was made to identify local (state) factors causing the volatility.

Care should be taken not to draw conclusions from examination of a particular factor in isolation. No attempt was made to isolate the effects of individual factors. Other effects are always present that may be partially or wholly responsible for claim cost trend that appear to be associated with a particular factor.

Trends reflect claims experience for the insurers who participated in the study. For certain analyses, states where all of the major participating insurers were not in the market were not included in the study. Target markets varied considerably among participating insurers. Participating insurers have differing procedures with regard to which plans they underwrite; whether they sell to beneficiaries under age 65 in states where this coverage is not mandated; and whether they apply different rates to plans for beneficiaries under 65 in states where it is permitted.

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Participating insurers apply pre-existing condition exclusions of varying lengths, or may waive the exclusion, depending on the circumstances and the particular insurer. The analyses combine statistics from group and individual insurance. To obtain the information used in the studies, it was necessary to combine data that the various insurers keep in widely varying formats.

For all of these reasons, this study should not be viewed as an attempt to rigorously quantify the effects on Medicare supplement claim cost trend of the factors it examines. Nevertheless, the analyses do provide a great deal of information that is useful in explaining the causes of recent Medicare supplement insurance rate trends.

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II. Introduction

A. NAIC Charge

At the Spring 1999 National NAIC Meeting, the American Academy of Actuaries was asked to analyze Medicare Supplement insurance claim trend. This request was subsequently delineated by the NAIC's Accident and Health Working Group as covering the following issues:

- Are there specific benefit components of Medicare Supplement insurance plans that are contributing to recent significant rate increases? If yes, what benefit components are they?
- What additional costs are attributable to the guarantee issue of Medicare Supplement insurance policies?
- Do age distributions differ based on rating methodology: (issue-age, attained-age, or community rating)?
- What is the relationship between Part B coinsurance paid by Medicare Supplement insurance and the amount paid by Medicare for Part B benefits?
- Has there been a change in the percentage of Medicare Supplement insurance business that has been issued based on disability eligibility? If yes, what has been the impact of this change on Medicare Supplement insurance claim experience?

B. Academy Work Group

The American Academy of Actuaries formed the Medicare Supplement Insurance Work Group (Work Group) to respond to the NAIC request. This report is the final work product of the Work Group. Attachment A lists members of the Work Group. The Academy wishes to thank the members of the Work Group for the significant time and effort provided on this project, especially those who volunteered for the Data and Analysis Subcommittees. In addition, the Academy appreciates the assistance provided by Janet Falco with Milliman and Robertson in drafting this report.

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C. Contributing Companies

Attachment B lists the insurance companies that contributed data to the study. Not all of the company data collected by the Work Group was used in this study. The Academy would also like to express its appreciation to those insurers for their efforts in providing claim data.

D. Data Contributed

Data was contributed in several formats:

Select - detailed information by age, plan, state, type of benefit, etc. Attachment C provides an overview of the select data elements. The actual data elements reported by type of benefit (Benefit Indicator) varied from company to company based on the degree of detail maintained in their claims records.

The following is an outline of the scope of the **Select** data contributed:

- Data for each standardized plan A, C and F, and combined data for plans B, D, E and G.
- Plans H, I and J were excluded.
- Medicare Select plans were not studied.
- Data was gathered in a limited number of states (California, Connecticut, Florida, Georgia, Illinois, Iowa, Indiana, Kansas, Mississippi, New Hampshire, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota and Texas).
- Not all companies contributed data for all select states.
- Data covers claims experience for calendar years 1996, 1997 and 1998 and issue years 1992 through 1998.

The volume of select data contributed for the study is shown in Table II-1.

Table II-1
Select Contributed Data

	Covered Lives	Incurred Claims ($ millions)
1996	598,485	515.0
1997	573,012	545.1
1998	579,379	557.5

* Based on claims paid through May/June 1999.

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Control - summary information by plan and state. Attachment D provides an overview of the control data elements

The following is an outline of the scope of the **Control** data contributed:

- Data for each standardized plans A, C, F, and combined data for plans B, D, E, and G.
- Plans H, I and J were excluded.
- Medicare Select plans were not studied.
- Data for policies issued in "grandfathered states" (Massachusetts, Minnesota, and Wisconsin) was not included. However, some companies contributed data by the state of residence of the enrollee so a small amount of "move-in" business from those states was included.
- Data covers claims experience for calendar years 1996, 1997 and 1998 and issue years 1992 through 1998.

The volume of data contributed for the study is shown in Table II-2.

Table II-2
Contributed Data

	Covered Lives	Incurred Claims* ($ millions)
1996	2,138,057	1,677.2
1997	2,169,678	1,871.5
1998	2,093,301	1,926.4

* Based on claims paid through May/June 1999.

Plans Providing Prescription Drug Benefits – summary information by plan and state

The following is an outline of the scope of the data contributed.

- Data for each standardized plan H, I and J by state for all states excluding Massachusetts, Minnesota and Wisconsin.
- Data for the Massachusetts mandated prescription drug plan.
- Data covers claims experience for calendar years 1996, 1997 and 1998, with all issue years combined.

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- Claims experience split between prescription drug benefits and all other benefits.

The volume of data contributed for the Prescription Drug study is shown in Table II-3.

Table II-3
Contributed Data

	Covered Lives	Incurred Claims* ($ millions)
1996	212,597	274.2
1997	219,271	317.7
1998	219,090	352.0

* Based on claims paid through May/June 1999.

NAIC Exposure Base

The NAIC Medicare Supplement database was used for several studies to combine experience by state into nationwide and other state summary formats.

E. Data Audits

Data was not audited. However, the Data Subcommittee reviewed the data for reasonableness. In addition, as the various data summaries and analyses were determined, data anomalies were discussed with each contributing company. In several situations, companies were asked to resubmit data. As a result, data for several companies was not compatible with the data requirements of the study and was not used.

F. Sources of Increasing Claim Costs

The Accident and Health Working Group in its May 24, 1999, report titled *Medicare Supplement Insurance Issue Paper* identified many areas that could be the cause of increasing claim costs. The American Academy of Actuaries Medicare Supplement Work Group has identified some additional areas.

Some of these issues may overlap, but they are all listed below:

(1.) Outpatient costs
(2.) Fraud
(3.) Cost shifting
(4.) Balance billing
(5.) Anti-selection
(6.) Risk adjustments
(7.) Duration from issue
(8.) Aging of the senior population
(9.) Attained age vs. issue-age pricing
(10.) Prescription drug costs (Plans H, I and J)
(11.) Ventilator dependent hospitalizations

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(12.) Medicare risk contract enrollment
(13.) Covering disabled individuals
(14.) Increased average age of newly insured individuals
(15.) Selection wear-off
(16.) High trend for skilled nursing facility utilization
(17.) Increasing percentage of open enrollments

There are some countervailing areas of decreasing claim costs that could also impact on overall trends. An example is based on anecdotal information for a Blue Cross and Blue Shield health plan. This example is local to the geography of the Blue Cross and Blue Shield plan and should not be automatically extended to all states.

A Medicare Health Maintenance Organization (HMO) with prescription drug coverage insured a disproportionate share of bad risks. Decreased enrollment and a negative trend (e.g. annual claim costs declined) resulted for the Blues Plan as individuals switched coverage to the HMO. When the Medicare HMO exited the market another Medicare HMO with prescription drug benefits entered the market and, predictably, the bad risks went to the new HMO. If this HMO exits the market, the bad risks have nowhere to go but back into the Medicare Supplement market, thus reversing claim trend.

A note of caution is appropriate here. Although Medicare HMOs may have attracted relative poorer risks in certain geographic areas, available nationwide studies have indicated a better than average risk profile for Medicare HMO enrollees. The *1996 Annual Report of the Physician Payment Review Commission* reported on studies of Medicare enrollees and those leaving the health maintenance organization, and concluded that better than average risks enroll in such plans and worse than average risks leave the plan.

Applying the results of the above study to nationwide Medicare HMO enrollment patterns to estimate the impact of enrollments into HMOs implies a 0.5% to 0.9% adverse average **annual** addition to Medicare and Medicare Supplement claim trend for the period 1996 through 1998. The impact on a specific carrier is not likely to be this average.

G. Measuring Claim Trend

Claim trend is measured as the change in annual claims cost per covered life. State claim trend for a contributing insurer is measured as the change in annual claim cost per covered life in a particular state. Composite claim trend for all insurers combined or for state combinations, were then determined by aggregating claim trend using exposed lives.

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The analyses of claim trend presented herein do not attempt to differentiate between the above listed potential causes of increasing or decreasing claims. Care should, therefore, be used when reviewing the claim trend data for several reasons:

- The influence of claim trend factors can vary by state, even by geographic area within a state.
- The influence of claim trend factors can vary by insurer.
- Since not all insurers contributed, combining the data of contributing insurers can only approximate claim trend for the entire market.
- The study is looking at changes for only three years (1996-1998), which may mask averages or longer term trends.
- In some cases, average trends over the two-year period for a combination of plans or subgroups may be higher or lower than the individual plans or subgroups involved. This can occur when the mix of business changes and shifts the weights toward higher or lower trend plans or subgroups.
- When considering trends for disabled-eligible beneficiaries, note that state requirements vary greatly and some companies may offer more than the minimum state requirements. Trends can vary by insurer depending on underwriting, pre-existing conditions exclusions, rating methods, marketing methods and group vs. individual markets.
- To avoid distortions from non-credible experience, the Work Group reviewed the data eliminating small exposures. It was determined that little additional credibility was gained from using a number higher than 1000 while a substantial number of cells would be eliminated. Using a smaller number would have created excessive volatility – in fact even at 1000 lives there appears to be substantial volatility for Plan A.

H. Final Report

This is intended to be the final report that is presented to the Accident and Health Working Group at the NAIC Summer National Meeting in June 2000.

The Academy Work Group had intended to study some issues not contained in this final report, such as long duration hospital claim and claim trend by component within Part A and/or Part B. Unfortunately, data to perform such studies or analyses was not available.

As this report essentially completes the charge to the Academy Work Group, we do not expect to do further analyses. As always, the members of the Academy Work Group stand ready to answer any questions that may arise.

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III. Claim Trend

A. Nationwide Trend

Table III-A-1 and Table III-A-2 present aggregated nationwide annual claim trend by Medicare Supplement Insurance standardized plan and calendar year. The nationwide annual claim trend was constructed as follows:

- Annual claim trend for 97/96 and 98/97 was determined by plan and contributing company.

- A min/max of ± 33% was applied to eliminate results that did not seem to make sense. As an example, a 33% trend was used for one company with a reported 27,678% claim trend (the trend reported was for Plan A when claims costs went from $0.18 to $50.00 in a state).

- To further increase statistical credibility, a minimum 1,000 exposure base was applied. That is, unless exposed lives exceeded 1,000 for a company, state and plan combination, the cell was not used in accumulating the state's annual claim trend for all companies and all plans combined.

- State claim trend for all plans and companies were determined by weighted average of all cells meeting the above tests using submitted exposure count.

- Nationwide annual claim trend was then determined using NAIC market weights and state annual claim trend. The NAIC market weights were developed from the NAIC Medicare Supplement database by calendar year (1997 for 97/96 trend and 1998 for 98/97 trend). The Academy Work Group decided to use the NAIC weighting and not weighting by contributed data as this approach is more reflective of the market and not of the contributing companies.

- HCFA trends are reflective of Medicare experience related to deductibles, copayments and co-insurance for all beneficiaries in the Medicare fee-for-service program.

- The expected trends are based on internal research by Milliman & Robertson, Inc. (M&R) which relies on HCFA data. The internal research develops cost and claim trend weighted by Medicare Supplement Insurance Plan.

- All tables presented in this section III are based on the methodology described above.

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Table III-A-1
Nationwide Trend Comparisons
Medicare Supplement Plans

	Medicare Supplement Plan				
	Year	**A**	**C**	**F**	**BDEG**
Academy Study	97/96	22.4%	11.8%	10.5%	15.6%
	98/97	13.0%	10.0%	7.5%	10.1%
	98/96	17.6%	10.9%	9.0%	12.8%
Expected Trend [1]	97/96	8.7%	6.8%	6.6%	8.4%
	98/97	5.7%	4.5%	4.4%	3.3%
	98/96	7.2%	5.6%	5.5%	5.8%
Excess (Academy - Expected)	97/96	13.7%	5.0%	3.9%	7.2%
	98/97	7.3%	5.5%	3.1%	6.8%
	98/96	10.4%	5.3%	3.5%	7.0%

[1] Expected based on internal research by Milliman & Robertson, which relied on HCFA data.

Table III –A-2
Nationwide Trend
All Plans Combined

Year	Academy Study	Expected [1]	HCFA [2]	Excess (Academy-Expected
97/96	13.1%	7.1%	7.1%	6.0%
98/97	9.4%	4.2%	4.3%	5.2%
98/96	11.2%	5.6%	5.7%	5.6%

[1] Expected based on internal research by Milliman & Robertson, which relied on HCFA data

[2] Estimated trend for Medicare deductibles, copayments and co-insurance provided by HCFA's Office of the Actuary.

Please note the following observations relative to Table III-A-1 and Table III-A-2.

- The aggregate nationwide annual claim trend from 1996 through 1998 was 11.2% for all plans A through G combined. This was twice the 5.6% expected trend over the same time period (1996-1998).

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- The excess trend is greater than that shown in the previous Academy draft report. This is due to 1) using NAIC weights and 2) using the minimum 1,000 exposure test. The Academy Work Group believes the above two criteria result in a more accurate estimate of nationwide annual trend.

- Plan A clearly has the highest trend and is likely influenced by 1) the relatively small exposure base, and 2) the majority of Plan A benefits are Part B. (Please refer to Table III-A-2.) Another possible influence is the increasing proportion of the underage 65 disabled or those with end stage renal disease in Plan A. The higher claim costs associated with these insureds (see Table VI-1) may impact Plan A more than other plans. Policyholder anti-selection could also be affecting trend.

- Plan C continued to exhibit higher trends than Plan F as more doctors accepted assignment, and these doctors may have had higher utilization practices. Please refer to a later section of this report comparing Plan C and Plan F experience.

  Table III-A-3 shows nationwide exposure from the NAIC database and for contributed company experience. Please note if a plan, state, company cell did not exceed 1,000 lives, this cell was left out of the calculations.

Table III-A-3
Nationwide Exposure

Year	Standardized Plan				
	A	**C**	**F**	**BDEG**	**ABCDEFG**
			NAIC Exposure		
1997	335,545	1,176,281	1,539,128	898,013	3,948,967
1998	674,463	1,167,425	1,942,332	865,418	4,649,638
			NAIC Exposure as a % of All Plans Combined		
1997	8.5%	29.8%	39.0%	22.7%	100.0%
1998	14.5%	25.1%	41.8%	18.6%	100.0%
			Contributed Company Exposure		
1997	94,488	762,756	908,156	283,026	2,048,426
1998	81,283	666,489	911,708	303,348	1,962,828
			Contributed Company Exposure as a % of All Plans Combined		
1997	4.6%	37.2%	44.3%	13.8%	100.0%
1998	4.1%	34.0%	46.4%	15.5%	100.0%

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Please note contributed data is concentrated in Plans C and F relative to NAIC market data. This reinforces the thoughts of the Academy Work Group that the analyses performed for this report are more statistically credible for plans C and F as compared to Plans A or BDEG.

Table III-A-4 presents annual claim trend by Medicare Parts A and/or B.

Table III-A-4
Annual Claim Trend by Medicare Parts A and/or B and Calendar Year
All Insurers Surveyed Combined

	Plan				
	A	**C**	**F**	**BDEG**	**ABCDEFG**
			Parts A and B Combined		
97/96	22.4%	11.8%	10.5%	15.6%	13.1%
98/97	13.0%	10.0%	7.5%	10.1%	9.4%
98/96	17.6%	10.9%	9.0%	12.8%	11.2%
			Part A		
97/96	-21.4%	9.6%	10.1%	15.4%	8.5%
98/97	14.6%	8.8%	2.1%	4.0%	6.0%
98/96	-5.1%	9.2%	6.0%	9.5%	7.2%
			Part B		
97/96	23.4%	12.6%	10.5%	14.8%	13.2%
98/97	11.6%	10.4%	9.6%	12.8%	10.7%
98/96	17.3%	11.5%	10.0%	13.8%	11.9%

Please note the following observations relative to Table III-A-4:

- Most Part A benefits are proportional to the Part A Initial Deductible, which would imply approximately 1.9% annual trend absent all other influences. Clearly annual trends for Part A are significantly in excess of 1.9%.

- The fluctuation in the Medicare Part A trend for Plan A is expected due to benefits and exposure volume. Only Plan A does not cover the Part A deductibles. Plan A covers extended hospitalization benefits which are generally low frequency, high dollar claims.

- For both Parts A and B, the average 98/96 annual claim trend for Plan C exceeds that for Plan F.

B. Trends by Geographic Region

Table III-B-1 presents an aggregate trend analysis by calendar year and state geographic regions. All Medicare Supplement Plans and insurers were combined. Attachment E provides a listing of the various state groupings.

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For purposes of this analysis, the trend rates presented represent a weighted average of company trends by their exposure by Plan. In addition, some data was not used due to nondisclosure of state specific information on some records.

Table III-B-1
Claim Trend By Geographic State Grouping and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	NAIC Exposed Lives Thousands	Difference From All States	Percentage Difference
All	97/96	13.1%	3,921.1		
	98/97	9.4%	4,647.5		
	98/96	11.2%			
Northeast	97/96	16.9%	1,259.4	3.8%	28.8%
	98/97	11.1%	1,160.4	1.7%	17.7%
	98/96	13.9%		2.7%	24.0%
Midwest	97/96	12.9%	1,066.8	-0.1%	-1.1%
	98/97	8.6%	1,354.0	-0.8%	-8.8%
	98/96	10.7%		-0.5%	-4.4%
South	97/96	9.8%	1,226.7	-3.3%	-25.3%
	98/97	9.6%	1,601.0	0.2%	2.5%
	98/96	9.7%		-1.5%	-13.5%
West	97/96	11.7%	368.2	-1.4%	-10.3%
	98/97	7.1%	532.1	-2.3%	-24.1%
	98/96	9.4%		-1.8%	-16.2%

Observations from reviewing Table III-B-1.

- The Northeast states show the highest trend, as the excess averaged 2.7% annually (a 24% difference) above the all states value.
- The South and West states show a low trend averaging 1.5% or 1.8% expected below that for all states surveyed.
- However, please note the West states have the lowest exposure base.

Tables III-B-2, III-B-3 and III-B-4 present annual claim trend by geographic state grouping, plan and calendar year for all benefits, Part A benefits only and Part B benefits only.

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Table III-B-2
Claim Trend By Geographic State Grouping, Plan and Calendar Year
All Insurers Surveyed Combined
Parts A and B Combined

	Trend	Standardized Plan				
	Period	**A**	**C**	**F**	**BDEG**	**ABCDEFG**
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
	98/96	17.6%	10.9%	9.0%	12.8%	11.2%
Northeast	97/96	25.2%	12.0%	12.4%	19.0%	16.9%
	98/97	11.9%	12.3%	9.3%	9.2%	11.1%
	98/96	18.3%	12.2%	10.9%	14.0%	13.9%
Midwest	97/96	16.6%	12.1%	12.7%	14.2%	12.9%
	98/97	14.4%	9.8%	7.1%	8.6%	8.6%
	98/96	15.5%	10.9%	9.8%	11.4%	10.7%
South	97/96	18.4%	10.8%	7.9%	10.9%	9.8%
	98/97	17.6%	9.2%	8.0%	11.9%	9.6%
	98/96	18.0%	10.0%	8.0%	11.4%	9.7%
West	97/96	14.8%	14.1%	10.8%	11.3%	11.7%
	98/97	12.2%	7.4%	6.6%	7.8%	7.1%
	98/96	13.5%	10.7%	8.7%	9.5%	9.4%

Table III-B-3
Claim Trend By Geographic State Grouping, Plan and Calendar Year
All Insurers Surveyed Combined
Part A Benefits Only

	Trend	Standardized Plan				
	Period	**A**	**C**	**F**	**BDEG**	**ABCDEFG**
All	97/96	-21.4%	9.6%	10.1%	15.4%	8.5%
	98/97	14.6%	8.8%	2.1%	4.0%	6.0%
	98/96	-5.1%	9.2%	6.0%	9.5%	7.2%
Northeast	97/96	-27.8%	9.9%	9.9%	18.8%	6.7%
	98/97	15.1%	13.1%	5.8%	1.5%	10.4%
	98/96	-8.8%	11.5%	7.8%	9.8%	8.5%
Midwest	97/96	-16.8%	10.2%	14.6%	18.5%	12.6%
	98/97	24.1%	8.7%	1.6%	0.5%	5.2%
	98/96	1.6%	9.4%	7.9%	9.2%	8.9%
South	97/96	0.6%	8.4%	4.3%	8.2%	6.1%
	98/97	-4.4%	6.8%	3.0%	8.0%	4.9%
	98/96	-2.0%	7.6%	3.6%	8.1%	5.5%
West	97/96	-28.0%	16.2%	12.0%	8.7%	12.0%
	98/97	-2.4%	5.8%	-0.5%	2.0%	1.5%
	98/96	-16.1%	10.9%	5.5%	5.3%	6.6%

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Table III-B-4
Claim Trend By Geographic State Grouping, Plan and Calendar Year
All Insurers Surveyed Combined
Part B Benefits Only

	Trend Period	Standardized Plan A	C	F	BDEG	ABCDEFG
All	97/96	23.4%	12.6%	10.5%	14.8%	13.2%
	98/97	11.6%	10.4%	9.6%	12.8%	10.7%
	98/96	17.3%	11.5%	10.0%	13.8%	11.9%
Northeast	97/96	26.4%	12.6%	10.9%	16.9%	16.5%
	98/97	11.8%	11.8%	9.8%	14.0%	12.1%
	98/96	18.9%	12.2%	10.4%	15.5%	14.2%
Midwest	97/96	17.4%	12.7%	12.1%	12.7%	12.6%
	98/97	8.1%	10.2%	9.1%	11.9%	9.6%
	98/96	12.7%	11.4%	10.6%	12.3%	11.1%
South	97/96	18.3%	11.6%	8.9%	12.1%	10.8%
	98/97	17.8%	10.4%	10.1%	12.9%	11.1%
	98/96	18.0%	11.0%	9.5%	12.5%	10.9%
West	97/96	16.8%	13.3%	9.8%	15.1%	11.2%
	98/97	11.8%	8.0%	9.4%	9.6%	9.1%
	98/96	14.3%	10.6%	9.6%	12.3%	10.1%

Please note the following when reviewing the above three tables:

- The 98/96 average trend for Plan C consistently exceeds that for Plan F by geographic area and for both Part A benefits and Part B benefits.

C. Trends by States Mandating Disabled Coverage

Table III-C-1 presents annual claim trend for states mandating coverage for under age 65 disabled individuals.

Nineteen states have implemented laws requiring issues of Medicare Supplement insurance to disabled – eligible Medicare beneficiaries. Of the 19 states, some implemented requirements during 1998 and 1999 and were not included as states mandating coverage of Medicare eligible disableds. Please refer to Attachment E for a list of states included.

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Table III-C-1
Claim Trend for States Mandating Under Age 65 Disabled Individuals
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	NAIC Exposed Lives Thousands	Difference From All States	Percentage Difference
All	97/96	13.1%	3,921.1		
	98/97	9.4%	4,647.5		
	98/96	11.2%			
Covering Disabled	97/96	15.4%	1,689.1	2.3%	17.6%
	98/97	9.8%	1,665.1	0.4%	4.0%
	98/96	12.6%		1.3%	11.8%
Not Covering Disabled	97/96	11.4%	2,232.0	-1.7%	-13.2%
	98/97	9.2%	2,982.4	-0.2%	-2.3%
	98/96	10.3%		-1.0%	-8.5%

Please note that, for the 98/96 period, the annual claim trend for covering disableds is 2.3% higher than the trend for not covering disabled individuals. The results may have more to do with geography (trend was lower in the south and Texas was the only southern state mandating coverage for disabled individuals) than any marginal impact from disabled individuals The trend may reflect geographic differences. Some states (including Connecticut, Oklahoma, and Texas) require only designated plans be made available to disabled individuals, but the data includes experience for all plans.

Section VI of this report discusses disability issues in more detail. Note that the above table reflects trends. Refer to Table VI-1 for claim costs and exposure by plan. Tables III-C-2, III-C-3 and III-C-4 provide annual claim trend by plan and for all benefits, Part A only and Part B only.

Table III-C-2
Claim Trend for States Mandating Under Age 65 Disabled Individuals
All Insurers Surveyed Combined
All Benefits – Parts A and B Combined

	Trend	Standardized Plan				
	Period	A	C	F	BDEG	ABCDEFG
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
	98/96	17.6%	10.9%	9.0%	12.8%	11.2%
Covering Disabled	97/96	25.0%	11.9%	11.5%	17.7%	15.4%
	98/97	12.5%	11.1%	5.9%	9.6%	9.8%
	98/96	18.6%	11.5%	8.6%	13.6%	12.6%
Not Covering Disabled	97/96	16.5%	11.8%	10.3%	12.8%	11.4%
	98/97	14.2%	9.3%	8.0%	10.4%	9.2%
	98/96	15.3%	10.6%	9.1%	11.6%	10.3%

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Table III-C-3
Claim Trend
All Insurers Surveyed Combined
Part A Benefits

	Trend Period	Standardized Plan				
		A	**C**	**F**	**BDEG**	**ABCDEFG**
All	97/96	-21.4%	9.6%	10.1%	15.4%	8.5%
	9897	14.6%	8.8%	2.1%	4.0%	6.0%
	98/96	-5.1%	9.2%	6.0%	9.5%	7.2%
Covering Disabled	97/96	-24.3%	10.3%	12.1%	16.8%	7.8%
	98/97	13.9%	11.8%	-0.2%	3.7%	7.5%
	98/96	-7.1%	11.0%	5.8%	10.1%	7.7%
Not Covering Disabled	97/96	-14.4%	9.8%	9.5%	13.4%	9.2%
	98/97	16.0%	7.2%	2.8%	4.2%	5.1%
	98/96	-0.4%	8.5%	6.1%	8.7%	7.1%

Table III-C-4
Claim Trend
All Insurers Surveyed Combined
Part B Benefits

	Trend Period	Standardized Plan				
		A	**C**	**F**	**BDEG**	**ABCDEFG**
All	97/96	23.4%	12.6%	10.5%	14.8%	13.2%
	98/97	11.6%	10.4%	9.6%	12.8%	10.7%
	98/96	17.3%	11.5%	10.0%	13.8%	11.9%
Covering Disabled	97/96	26.0%	12.3%	10.3%	16.2%	15.0%
	98/97	12.4%	10.8%	8.0%	13.4%	11.0%
	98/96	19.0%	11.5%	9.1%	14.8%	13.0%
Not Covering Disabled	97/96	17.3%	12.5%	10.6%	12.8%	11.7%
	98/97	9.9%	10.2%	10.0%	12.4%	10.5%
	98/96	13.6%	11.3%	10.3%	12.6%	11.1%

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D. Trends by State Rating Requirement

This subsection presents claim trend by mandated state rating requirement – community rating (six states studied), entry age rating (two states studied), and no rating mandate (balance of states studied). Please refer to Attachment E for the state groupings.

There is insufficient geographic diversity among the states that require community rating (heavily northeastern states) or entry age rating (both states are in the south). In addition, many states with rating requirements also have other mandates that may impact trends. Consequently the data presented below may show effects other than that related solely to state rating restrictions. Section VII of this report attempts to analyze the impact of rating methodology in states not mandating any rating requirements.

Table III-D-1
Claim Trend By State Rating Requirements
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	Exposed Lives Thousands	Difference From All States	Percentage Difference
All	97/96	13.1%	3,921.1		
	98/97	9.4%	4,647.5		
	98/96	11.2%			
Community	97/96	14.6%	483.0	1.5%	11.5%
	98/97	9.9%	628.3	0.5%	5.5%
	98/96	12.2%		1.0%	8.9%
Entry Age	97/96	8.3%	315.9	-4.8%	-36.3%
	98/97	7.0%	411.9	-2.4%	-25.7%
	98/96	7.7%		-3.6%	-31.8%
No Mandate	97/96	13.4%	3,122.1	0.3%	2.0%
	98/97	9.6%	3,607.4	0.2%	1.9%
	98/96	11.5%		0.2%	2.0%

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Table III-D-2
Claim Trend By State Rating Requirements
All Insurers Surveyed Combined
All Benefits

	Trend Period	Standardized Plan				
		A	C	F	BDEG	ABCDEFG
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
	98/96	17.6%	10.9%	9.0%	12.8%	11.2%
Community	97/96	9.8%	12.3%	12.9%	17.3%	14.6%
	98/97	12.5%	12.6%	6.3%	10.8%	9.9%
	98/96	11.1%	12.4%	9.5%	14.0%	12.2%
Entry Age	97/96	15.6%	9.5%	4.7%	9.9%	8.3%
	98/97	3.8%	8.5%	6.8%	5.9%	7.0%
	98/96	9.5%	9.0%	5.8%	7.9%	7.7%
No Mandate	97/96	23.8%	12.0%	10.8%	15.8%	13.4%
	98/97	13.4%	9.6%	7.8%	10.6%	9.6%
	98/96	18.5%	10.8%	9.3%	13.1%	11.5%

Table III-D-3
Claim Trend By State Rating Requirements
All Insurers Surveyed Combined
Part A Benefits

	Trend Period	Standardized Plan				
		A	C	F	BDEG	ABCDEFG
All	97/96	-21.4%	9.6%	10.1%	15.4%	8.5%
	98/97	14.6%	8.8%	2.1%	4.0%	6.0%
	98/96	-5.1%	9.2%	6.0%	9.5%	7.2%
Community	97/96	-8.9%	9.5%	10.1%	18.7%	13.0%
	98/97	-1.1%	16.0%	-0.3%	3.6%	5.8%
	98/96	-5.1%	12.7%	4.8%	10.9%	9.4%
Entry Age	97/96	-24.1%	2.5%	-3.0%	9.9%	0.4%
	98/97	-3.6%	7.3%	2.7%	1.0%	3.5%
	98/96	-14.4%	4.8%	-0.2%	5.4%	1.9%
No Mandate	97/96	-21.9%	10.9%	11.2%	14.9%	8.8%
	98/97	15.8%	7.6%	2.3%	4.7%	6.3%
	98/96	-4.9%	9.2%	6.7%	9.7%	7.5%

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Table III-D-4
Claim Trend By State Rating Requirements
All Insurers Surveyed Combined
Part B Benefits

	Trend Period	Standardized Plan				
		A	C	F	BDEG	ABCDEFG
All	97/96	23.4%	12.6%	10.5%	14.9%	13.2%
	98/97	11.6%	10.4%	9.6%	12.8%	10.7%
	98/96	17.3%	11.5%	10.0%	13.8%	11.9%
Community	97/96	12.5%	12.6%	11.8%	11.9%	12.0%
	98/97	13.2%	11.2%	8.6%	15.8%	12.1%
	98/96	12.8%	11.9%	10.2%	13.8%	12.1%
Entry Age	97/96	18.5%	11.7%	7.2%	10.0%	10.1%
	98/97	4.2%	9.1%	8.0%	7.3%	8.0%
	98/96	11.1%	10.4%	7.6%	8.6%	9.0%
No Mandate	97/96	24.4%	12.4%	10.7%	16.4%	13.6%
	98/97	11.8%	10.5%	9.8%	12.6%	10.7%
	98/96	18.0%	11.5%	10.2%	14.5%	12.2%

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IV. <u>Volatility by State</u>

Table IV-1 presents claim trend by state, plan and calendar year for all contributing companies combined. Annual claim trend was computed using the same methodology as described in Section III of this report.

Please note the following while reviewing Table IV-1:

- Significant fluctuation of trend rates exists from state to state.

- A minimum 1,000 exposure criteria was applied at the state, plan company level. The min/max ± 33% annual claim trend limit also applies at the state, plan, company level. As can be seen from the detailed data, this primarily affects Plan A trend.

- At one time, the Academy Work Group discussed correlation analyses of state trends versus 1) HMO market penetration, 2) population, or 3) other criteria. However, the Academy Work Group decided not to pursue these analyses due to lack of data.

- Please note a number of states did not meet minimum exposure criteria for Plan A, but did meet minimum exposure criteria for other plans. In these states, blanks are shown.

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Table IV-1
Claim Trend by State and Calendar Year
All Insurers Surveyed Combined
Parts A & B – Yearly Trend

State	Incurred Year	Standardized Plan A	C	F	BDEG	ABCDEFG
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
All	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
All	98/96	17.6%	10.9%	9.0%	12.8%	11.2%
AK	97/96					
AK	98/97	Does Not Meet Minimum Exposure Criteria				
AK	98/96					
AL	97/96		7.1%	8.4%	6.5%	7.4%
AL	98/97		10.3%	8.0%	16.3%	11.1%
AL	98/96		8.7%	8.2%	11.3%	9.2%
AR	97/96		19.6%	8.9%	29.2%	16.7%
AR	98/97		16.3%	6.6%	19.1%	12.9%
AR	98/96		18.0%	7.7%	24.0%	14.8%
AZ	97/96	26.0%	15.5%	8.2%	11.4%	12.2%
AZ	98/97	15.3%	7.5%	4.4%	5.9%	6.3%
AZ	98/96	20.6%	11.4%	6.2%	8.6%	9.2%
CA	97/96	5.7%	4.8%	5.8%	15.5%	6.8%
CA	98/97	9.4%	7.0%	4.9%	7.3%	6.6%
CA	98/96	7.5%	5.9%	5.3%	11.3%	6.7%
CO	97/96		7.4%	7.4%	-11.9%	5.2%
CO	98/97		3.1%	12.4%	-3.0%	8.2%
CO	98/96		5.2%	9.9%	-7.5%	6.7%
CT	97/96	1.8%	10.0%	24.3%	20.1%	17.0%
CT	98/97	3.2%	9.7%	9.7%	9.3%	9.4%
CT	98/96	2.5%	9.9%	16.7%	14.6%	13.1%
DC	97/96					
DC	98/97	Does Not Meet Minimum Exposure Criteria				
DC	98/96					
DE	97/96					
DE	98/97	Does Not Meet Minimum Exposure Criteria				
DE	98/96					
FL	97/96	10.8%	7.9%	3.9%	8.8%	7.2%
FL	98/97	1.0%	7.4%	6.5%	4.9%	5.8%
FL	98/96	5.8%	7.6%	5.2%	6.8%	6.5%

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Table IV-1
Claim Trend by State and Calendar Year
All Insurers Surveyed Combined
Parts A & B – Yearly Trend

State	Incurred Year	Standardized Plan A	C	F	BDEG	ABCDEFG
GA	97/96	32.5%	12.5%	6.5%	14.2%	11.9%
GA	98/97	9.8%	11.0%	7.5%	9.2%	9.3%
GA	98/96	20.6%	11.7%	7.0%	11.7%	10.6%
HI	97/96					
HI	98/97	Does Not Meet Minimum Exposure Criteria				
HI	98/96					
IA	97/96		10.1%	9.4%	4.4%	9.1%
IA	98/97		2.3%	4.4%	12.0%	4.8%
IA	98/96		6.1%	6.9%	8.1%	6.9%
ID	97/96		31.7%	9.5%	0.0%	15.8%
ID	98/97		6.7%	8.1%	0.0%	7.7%
ID	98/96		18.5%	8.8%	0.0%	11.7%
IL	97/96	32.3%	12.3%	10.1%	16.7%	13.3%
IL	98/97	11.7%	7.8%	7.3%	8.2%	7.9%
IL	98/96	21.6%	10.0%	8.7%	12.4%	10.6%
IN	97/96	7.2%	14.3%	15.6%	11.1%	14.5%
IN	98/97	19.0%	11.9%	7.1%	6.8%	8.8%
IN	98/96	12.9%	13.1%	11.3%	8.9%	11.6%
KS	97/96	8.1%	10.2%	10.2%	19.6%	10.3%
KS	98/97	-12.5%	1.4%	3.9%	2.1%	3.1%
KS	98/96	-2.7%	5.7%	7.0%	10.5%	6.6%
KY	97/96	28.8%	16.3%	10.7%	-0.4%	12.9%
KY	98/97	19.0%	13.2%	12.3%	9.8%	12.5%
KY	98/96	23.8%	14.7%	11.5%	4.6%	12.7%
LA	97/96	30.5%	11.0%	5.3%	15.0%	9.6%
LA	98/97	0.0%	10.4%	15.1%	29.8%	15.1%
LA	98/96	14.3%	10.7%	10.1%	22.2%	12.3%
MA	97/96					
MA	98/97	Not Studied				
MA	98/96					
MD	97/96	10.7%	10.7%	17.1%	7.7%	12.7%
MD	98/97	24.5%	1.0%	0.3%	19.5%	5.3%
MD	98/96	17.4%	5.7%	8.4%	13.4%	8.9%

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Table IV-1
Claim Trend by State and Calendar Year
All Insurers Surveyed Combined
Parts A & B – Yearly Trend

State	Incurred Year	Standardized Plan				
		A	C	F	BDEG	ABCDEFG
ME	97/96		8.8%	12.1%	11.9%	10.7%
ME	98/97		19.4%	4.0%	11.3%	11.0%
ME	98/96		13.9%	8.0%	11.6%	10.9%
MI	97/96	13.6%	9.1%	11.3%	7.2%	9.7%
MI	98/97	15.5%	18.5%	12.6%	7.1%	13.0%
MI	98/96	14.6%	13.7%	11.9%	7.2%	11.3%
MN	97/96					
MN	98/97			Not Studied		
MN	98/96					
MO	97/96	19.5%	14.1%	13.0%	16.8%	14.2%
MO	98/97	14.5%	12.7%	8.5%	15.5%	11.2%
MO	98/96	16.9%	13.4%	10.7%	16.1%	12.7%
MS	97/96	7.9%	11.5%	6.8%	11.6%	8.4%
MS	98/97	24.7%	1.4%	4.1%	12.8%	6.2%
MS	98/96	16.0%	6.3%	5.4%	12.2%	7.3%
MT	97/96		12.7%	11.7%	0.0%	12.0%
MT	98/97		7.9%	9.3%	0.0%	8.9%
MT	98/96		10.3%	10.5%	0.0%	10.4%
NC	97/96	21.7%	14.9%	5.9%	10.7%	10.6%
NC	98/97	27.3%	9.8%	13.3%	12.4%	12.8%
NC	98/96	24.5%	12.3%	9.5%	11.5%	11.7%
ND	97/96		0.0%	17.9%	0.0%	17.9%
ND	98/97		0.0%	12.7%	0.0%	12.7%
ND	98/96		0.0%	15.3%	0.0%	15.3%
NE	97/96		12.1%	12.6%	0.0%	12.5%
NE	98/97		7.6%	10.6%	0.0%	10.1%
NE	98/96		9.8%	11.6%	0.0%	11.3%
NH	97/96		15.9%	10.1%	21.6%	14.7%
NH	98/97		15.4%	17.4%	5.0%	14.6%
NH	98/96		15.6%	13.7%	13.0%	14.6%
NJ	97/96	20.2%	15.9%	6.3%	17.2%	12.9%
NJ	98/97	12.5%	11.5%	9.5%	8.1%	10.4%
NJ	98/96	16.3%	13.7%	7.9%	12.6%	11.6%

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Table IV-1
Claim Trend by State and Calendar Year
All Insurers Surveyed Combined
Parts A & B – Yearly Trend

State	Incurred Year	Standardized Plan				
		A	C	F	BDEG	ABCDEFG
NM	97/96		10.5%	5.6%	3.5%	7.1%
NM	98/97		20.3%	13.3%	16.2%	16.4%
NM	98/96		15.3%	9.4%	9.7%	11.7%
NV	97/96		26.0%	16.2%	0.0%	20.2%
NV	98/97		-2.0%	9.0%	0.2%	4.0%
NV	98/96		11.1%	12.6%	0.1%	11.8%
NY	97/96	10.3%	12.7%	9.0%	16.0%	11.5%
NY	98/97	13.3%	9.8%	9.4%	9.4%	9.9%
NY	98/96	11.8%	11.2%	9.2%	12.6%	10.7%
OH	97/96	11.0%	11.6%	11.5%	12.6%	11.7%
OH	98/97	17.3%	9.0%	6.4%	8.3%	8.7%
OH	98/96	14.1%	10.3%	8.9%	10.4%	10.2%
OK	97/96	33.0%	12.6%	11.3%	14.5%	13.6%
OK	98/97	33.0%	9.6%	7.9%	8.0%	9.9%
OK	98/96	33.0%	11.1%	9.6%	11.2%	11.7%
OR	97/96		14.3%	14.6%	29.9%	16.8%
OR	98/97		5.8%	3.4%	13.0%	6.2%
OR	98/96		10.0%	8.9%	21.2%	11.3%
PA	97/96	27.3%	12.3%	11.2%	20.9%	15.0%
PA	98/97	11.6%	11.0%	3.9%	8.3%	10.2%
PA	98/96	19.2%	11.6%	7.5%	14.4%	12.6%
PR	97/96		11.4%	0.0%	0.0%	11.4%
PR	98/97		15.6%	21.5%	0.0%	18.5%
PR	98/96		13.5%	10.2%	0.0%	14.9%
RI	97/96		14.7%	19.2%	0.0%	14.8%
RI	98/97		3.7%	0.0%	0.0%	3.7%
RI	98/96		9.1%	9.2%	0.0%	9.1%
SC	97/96	12.9%	6.2%	3.3%	10.3%	6.1%
SC	98/97	33.0%	13.2%	11.9%	16.1%	14.2%
SC	98/96	22.6%	9.6%	7.5%	13.2%	10.1%
SD	97/96		33.0%	33.0%	0.0%	33.0%
SD	98/97		12.4%	4.5%	0.0%	5.1%
SD	98/96		22.3%	17.9%	0.0%	18.2%

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Table IV-1
Claim Trend by State and Calendar Year
All Insurers Surveyed Combined
Parts A & B – Yearly Trend

State	Incurred Year	Standardized Plan A	C	F	BDEG	ABCDEFG
TN	97/96	7.9%	13.1%	8.1%	7.9%	10.2%
TN	98/97	13.6%	11.5%	6.1%	10.7%	9.3%
TN	98/96	10.7%	12.3%	7.1%	9.3%	9.7%
TX	97/96	21.9%	8.2%	9.0%	3.0%	8.8%
TX	98/97	33.0%	11.4%	6.3%	12.5%	10.3%
TX	98/96	27.4%	9.8%	7.7%	7.7%	9.5%
UT	97/96		11.8%	4.6%	0.0%	7.4%
UT	98/97		11.0%	6.5%	0.0%	8.3%
UT	98/96		11.4%	5.6%	0.0%	7.8%
VA	97/96	17.9%	11.7%	20.1%	18.7%	17.0%
VA	98/97	7.0%	6.4%	3.5%	10.6%	6.2%
VA	98/96	12.4%	9.0%	11.5%	14.5%	11.5%
VI	97/96					
VI	98/97	Does Not Meet Minimum Exposure Criteria				
VI	98/96					
VT	97/96		4.5%	0.0%	24.4%	8.5%
VT	98/97		17.5%	0.0%	11.7%	15.6%
VT	98/96		10.8%	0.0%	17.8%	12.0%
WA	97/96	13.4%	18.9%	21.1%	7.2%	18.0%
WA	98/97	16.2%	6.1%	-4.5%	17.4%	4.5%
WA	98/96	14.8%	12.3%	7.5%	12.2%	11.0%
WI	97/96					
WI	98/97	Not Studied				
WI	98/96					
WV	97/96	0.8%	7.1%	7.3%	6.3%	6.7%
WV	98/97	15.9%	11.3%	7.2%	22.0%	11.4%
WV	98/96	8.1%	9.2%	7.3%	13.9%	9.0%
WY	97/96		19.6%	8.1%	0.0%	11.8%
WY	98/97		9.0%	13.0%	0.0%	11.7%
WY	98/96		14.2%	10.5%	0.0%	11.7%
All	97/96	22.4%	11.8%	10.5%	15.6%	13.1%
All	98/97	13.0%	10.0%	7.5%	10.1%	9.4%
All	98/96	17.6%	10.9%	9.0%	12.8%	11.2%

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V. Outpatient Hospital Claims

This section discusses annual claim trend implications of Outpatient Hospital Supplemental benefits. The discussion is segmented into three subsections:

A. Background – This subsection presents a historical detailed summary of Medicare's reimbursement methodology.

B. Hospital Outpatient Medicare Supplement Study – This subsection presents the Academy's findings from this study and initial observations.

C. Medicare's New Prospective Payment Methodology for Outpatient Services – This subsection discusses the mechanics and the potential impact of the new payment methodology for outpatient services.

A. Background

A significant portion of Medicare supplement trend has been attributable to the increase in coinsurance claim costs on outpatient hospital services. An understanding of Medicare's provider reimbursement methodology during the period studied (1996-1998) provides additional insight into the forces propelling this trend. A small percentage of the outpatient services have been paid based on a Medicare fee schedule, and the beneficiary liability has been limited to the $100 deductible plus a coinsurance equal to 20% of the fee schedule. Increases in the fee schedules were limited by Medicare program rules, which could help contain trend.

For most outpatient services, the Medicare beneficiary was liable for the annual Part B deductible plus 20% of the hospital's **billed charges**. It is important to note that no limits were placed on the absolute level or amount of annual increase of hospital billed charges, so beneficiaries were subject to full medical inflation on their coinsurance liability. The final hospital payment from Medicare was determined retrospectively for a cost-reporting period based on the least of:

(a) the hospital's reasonable costs minus beneficiary cost sharing,

(b) the hospital's customary charges minus beneficiary cost sharing or

(c) a blended amount (weighted average) equal to 42% of the lower of reasonable costs or customary charges minus the beneficiary cost sharing plus 58% of 80% of a fee schedule minus the beneficiary deductible (changed October 1, 1997, to 58% of a fee schedule minus the beneficiary cost sharing, which corrected the formula-driven overpayments whereby a hospital could increase their total reimbursement by increasing billed charges).

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Because hospital billed charges were generally much higher than Medicare's hospital payment basis (i.e., reasonable costs, customary charges or the blended amount) the aggregate beneficiary cost sharing currently accounts for nearly 50% of the total payment to the hospital. Further, because hospital billed charges have increased faster than Medicare's hospital payment basis, the percent of hospital outpatient reimbursement paid by the beneficiary has increased significantly from the 1992 level of 41%.

B. Hospital Outpatient Medicare Supplement Study

One carrier was able to isolate their Plan F's hospital outpatient claim cost trend for the study period, which is shown below.

Incurred Year	Total Claim Cost Trend	Hospital Outpatient Claim Cost Trend	Total Claim Cost Trend if Hospital Outpatient Trend had Equaled Other Part B Coinsurance Claim Cost Trend	Hospital Outpatient Claims as a % of Total Claims
1995	6.9%	19.8%	4.6%	22.9%
1996	6.1%	19.2%	2.3%	25.7%
1997	8.8%	18.4%	5.4%	28.0%
1998	9.0%	15.3%	6.7%	29.6%
Average	7.7%	18.2%	4.8%	

From 1995 to 1998, the increase in outpatient claim costs caused overall trend to be 2.9% higher per year than it would have been if the outpatient trend had equaled the average of the other components. Adding 2.9% to an annual trend rate over an 8-year period (the number of years since standardization) would cause a 25% additional increase in claim costs.

C. Medicare's New Prospective Payment Methodology for Outpatient Services

Inpatient care is covered under Medicare Part A and is paid for using a prospective payment system (PPS). A hospital is compensated a predetermined rate per discharge based on payment categories called diagnosis related groups (DRGs). With a PPS, a hospital cannot boost Medicare's reimbursement simply by increasing, intensifying, or unbundling their services. Effective July 1, 2000, all hospital outpatient services covered under Medicare Part B are to be reimbursed under a similar PPS methodology where predetermined payment levels are set for ambulatory payment classification (APC) groups.

When PPS is first implemented, the immediate impact will be a reduction in the aggregate coinsurance costs nationwide but results will vary significantly by state including both sizable increases and decreases. Following the initial transition, future hospital outpatient trend is expected to moderate. Beneficiary coinsurance will be limited to the greater of a geographically adjusted fixed dollar amount per APC group or 20% of the APC fee schedule or payment rate. Each year the APC fee schedules will be updated, but the coinsurance

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dollar amount will remain fixed except for slight variations in the geographical adjustment. As a result, the beneficiary coinsurance will gradually decline as a percentage of the total hospital reimbursement until it reaches the 20% level, which may take up to 40 years according to the Medicare Payment Advisory Commission. A detailed explanation of the Work Group's understanding of how the PPS will operate is described in the following two paragraphs.

The PPS will apply to all outpatient hospital services except for those exempt under the Maryland all-payer system and critical access facilities paid under a cost basis, which combined account for less than 5% of Medicare outpatient expenditures. Each APC will represent services that are similar clinically and in terms of resources required. The national payment rates (fee schedules) are a product of the APC's relative weight, which reflects the comparative resources required, and a conversion factor. The initial conversion factor for 1999 was established at a level that would produce aggregate payments to hospitals equivalent to those made under the cost-based system. The conversion factor will be increased at the Medicare hospital inpatient market basket minus 1 percent for years 2000 through 2002 and the full market basket thereafter. A national payment rate will be geographically adjusted to localized levels (metropolitan statistical areas) using a weighted average equal to 40% of the national rate and 60% of the local rate. The local rate is determined by multiplying the national rate by the local inpatient hospital wage index.

The 1997 Balanced Budget Act required that a national unadjusted coinsurance (NUC) level be established as a fixed-dollar amount for each APC based on 20 percent of the national median charges for services in the group furnished during 1996, and updated to 1999 using HCFA's estimated change of growth. The NUCs will be frozen at the 1999 levels and adjusted geographically using the wage index adjustment. Beneficiary coinsurance per APC charge will be determined as the greater of the geographically adjusted NUC or 20 percent of the geographically adjusted payment rate, but cannot exceed the inpatient hospital deductible. Except for minor year-to-year fluctuations in the wage index adjustment, the beneficiary coinsurance for specific services will remain unchanged until the localized NUC is less than 20 percent of the localized payment rate. Initially, the coinsurance for the majority of services will exceed 20 percent of the localized payment rate.

The initial one-time nationwide aggregate reduction in the coinsurance cost will be due primarily to BBA 97 language that requires the national unadjusted coinsurance levels to be based upon 20% of the 1996 median charges for an APC, instead of the cost-neutral mean charges. HCFA estimates that, in aggregate, the geographically adjusted coinsurance paid in 1996 would have been 12% lower for services subject to the PPS due to the use of median charges that are lower than the mean charges for the majority of APCs. The proportional impact in 1999 should be comparable to that in 1996 because the coinsurance amounts were increased from 1996 to 1999 using estimated trends in hospital outpatient charges. The estimated impact is expected to vary significantly by state and for urban and rural regions within a state as shown in Attachment F. It is important to note that these estimates are applicable to all Medicare beneficiaries, not just those with Medicare supplement insurance. While they may be indicative of future Medicare supplement claim costs, other influences have not been considered.

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There are two other factors that will add to the aggregate reduction in beneficiary coinsurance estimated by HCFA. First, the national unadjusted coinsurance amounts were frozen as of 1999 and do not reflect trend to July 1, 2000, the anticipated PPS implementation date. Second, the coinsurance for each APC is limited to the Part A inpatient deductible, reducing the coinsurance liability for some procedures.

Although no significant price inflation is expected during the first several years of the program, HCFA's Office of the Actuary expects increases in hospital outpatient service volume and intensity. The annual trend in per-capita utilization is projected to start at 1%, increase to 3% within two years and remain at 3% for the next four years. Case-mix trend of 2.5% per-annum is anticipated for the next six years. These figures are gross estimates and reflect projections of national trends. Local results will vary.

In summary, upon implementation of the outpatient PPS, the beneficiary liability for most services will have a one-time decrease on a nationwide aggregate basis for all Medicare beneficiaries although some states or regions within states will experience significant increases. Additionally, for several years following implementation, coinsurance price trend should be virtually eliminated, but some trend in the volume and intensity of services can be expected. Overall trend within the Medicare program for aggregate beneficiary cost sharing should be lower than recent experience under the cost-based system. However, at this time, it is impossible to project a definitive impact on coinsurance levels for Medicare supplement outpatient trends by state or regions within states.

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VI. Disability Issues

Nineteen states have implemented laws requiring open enrollment of Medicare Supplement insurance to disabled-eligible Medicare beneficiaries. The plans which must be offered and the duration of the guarantee issue period vary by state. While nineteen states have requirements, only eleven were included in the select data used to develop the tables in this section of this report. Please refer to Attachment E for specific information about the states included. Note that some insurers offer coverage to under age 65 Medicare beneficiaries in excess of the minimum requirements. Some insurers may also underwrite this coverage or charge higher rates. Many of these disabled individuals were underwritten so the relative claim costs for disable and nondisabled individual s is understated for the purpose of assessing the impact of open enrollment of disabled individuals.

Disabled-eligible Medicare beneficiaries as used in this report include those eligible for Medicare by reason of disability and those eligible for Medicare due to end stage renal disease (except in Massachusetts where those with ESRD are not required to be issued coverage).

Table VI-1 compares annual claim costs for disabled and age-eligible populations. The data is developed from Attachment G. The disabled population was derived by assuming that everyone with an attained age of less than 64 qualified for Medicare by reason of disability (e.g. ESRD). The age eligible population was derived by assuming that everyone with an attained age equal to or greater than 64 qualified for Medicare by reason of age.

Table VI-1
Benefit Relativities By Plan
Disabled Eligible and Age Eligible
Annual Claim Cost

	Disabled Eligible	Age Eligible	Ratio	Disabled Exposure
Plan A	$ 2,311	$ 604	3.83	2,185
Plan C	2,494	1,006	2.48	3,125
Plan F	1,201	892	1.35	8,907
Plan BDEG	1,530	987	1.55	715
All Plans	1,650	929	1.78	14,933
Plans C+F	1,537	939	1.64	12,032

Disabled-eligible beneficiaries have significantly higher Medicare Supplement claim costs than age-eligible beneficiaries. Increases in the percentage of a Medicare Supplement block that is disabled-eligible will lead to increased overall trend. It may also be possible that the claim cost trend for the disabled-eligible is different from the claim cost trend for the age-eligible. In states limiting rates, age eligible individuals are subsidizing disabled eligible individuals.

The percentage of disabled individuals included in the survey increased 33% from 1996 to 1998 (from 0.77% to 1.03% of exposure). Although the percentage is small, the data includes many states not mandating coverage for disabled individuals. Of the 16 states for which select data was contributed, only five mandate coverage of disabled individuals. Thus, the 33% percentage point increase is indicative of the potential growth rate for covering disabled individuals.

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Table VI-2 shows annual claim cost relativities for individuals under 64 by calendar duration from issue. The data is developed from Attachment G. The Work Group assumed that once the individual's attained age was 64 years or greater, they would be eligible for Medicare and for Medicare Supplement coverage regardless of whether or not they were disabled.

Table VI-2
Claim Cost Relativities by Calendar Duration From Issue

	1	2	3	4	5+	All	2+
Plan A	138%	124%	89%	78%	69%	108%	100%
Plan C	111%	110%	98%	95%	69%	102%	100%
Plan F	124%	108%	100%	92%	83%	105%	100%
Plan BDEG	122%	89%	102%	112%	139%	106%	100%
All Plans	122%	113%	97%	89%	77%	104%	100%
Plans C+F	118%	111%	99%	91%	76%	104%	100%

Please note the anti-selection by duration from issue. While not specifically studied, this may also be the result of higher claim costs by those with ESRD in the early durations. The portion of insured individuals with ERSD compared to those with other disabilities is expected to decrease over time. This trend would be expected to decrease composite claim costs over time even if the overall costs for each subgroup increases.

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VII. Rating Methods

This section compares claim cost trend by rating method. Based on the contributed data, the Work Group was unable to reach a definitive answer to whether the use or state mandate of a particular rating methodology consistently affects claims levels or claim trend. Not considering the varying levels of data submitted by type and by state, there are many other dynamics which may either mask or offset the impact from the rating methodology.

Table VII-1
Claim Cost Relativities By Rating Method
Nationwide Ratio as a Percentage of Attained Age [1]

	Plan					
	A	**C**	**F**	**BDEG**	**All**	**C&F**
				Unadjusted Claims		
Attained Age	100%	100%	100%	100%	100%	100%
Entry Age	65%	103%	134%	71%	104%	121%
Community Rated	124%	103%	137%	114%	122%	123%
				Adjusted Claims		
Attained Age	100%	100%	100%	100%	100%	100%
Entry Age	67%	100%	124%	70%	100%	114%
Community Rated	129%	100%	127%	111%	117%	116%

[1] Reflects 1997 and 1998 NAIC Weights and estimated age factors for states with no credible select data.

Table VII-1 presents the claim cost relativities determined as the ratio of entry age rated and community rated claim cost to attained age rated claim costs. This table shows these ratios on both an unadjusted and an age-adjusted basis. A total of 28 states were included in this analysis. Only states with no rating mandate were included. In addition, a minimum 1,000 exposed lives criteria was applied on a plan/state basis to deem a cell as credible.

For those states with select data contributed, age weighted morbidity factors were developed by state, plan, rating method and calendar year using claim cost relativity factors provided by M&R. The average for all states with select data was used in states where no underlying age distributions were available.

Age factors were then applied to the state/plan/calendar year average unadjusted claim costs to develop age adjusted claim costs.

The claim costs by state, plan and incurred year were normalized to the attained age claim costs by dividing each respective claim cost by the respective attained age claim cost. These normalized ratios were subsequently weighted by 1997 and 1998 NAIC weights to develop average nationwide ratios by plan and rating method.

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It is difficult to separate all the impacts from the overall results based on rating methodology. For example, based on the overall contributing companies, the 1996-1998 study period per member per year claim cost for attained age policies is 85% of community rated policies and 72% of entry age rated policies. It would be dangerous to extract any benefit to the policyholder based on this information without adjusting the information for age, sex, underwriting, laws, etc. Listed below are observations made from the data provided from the contributing companies.

Table VII-2
Various Data Observations

Rating Type	Exposure	Annual Claim Cost Per Insured	Average Age	Average Duration
Attained Age	743,915	$ 770	70.49	3.07
Community	392,080	902	74.45	3.79
Entry Age	614,881	1,073	73.05	3.72

Looking at plans C & F combined (since they have the most significant exposure) adjusted for age differences show an approximate 15% difference in per member per year costs between the entry age/community rated and the attained age policies. From Table VII-2, it is noted that the average duration is approximately 20% longer for the entry age and community rated plans. This may explain approximately one-third of the difference (since the community rate and entry age policies are approximately at the same duration). The remaining differences could be attributable to the underwriting process, legal situation, competition, market dynamics, etc. Overall, it appears the experience of the three rating methods may be comparable given enough information and adjustments.

Community rates charged by a company can be lower than the attained age rate offered at relatively young ages, even though this doesn't appear to be a reasonable outcome. Part of the reason for this is the target loss ratio at which the various carriers manage the business. This may also explain why the average age differences may be smaller than what one would expect.

In the states where the attained age rates are lower than community rates for 65 year olds, then later become higher, a market dynamic exists where there in a financial incentive for changing insurance carriers. This results in the attained-age carrier "losing" some older, more costly insureds, and the community rated carrier picking them up. While the trend for the two carriers combined would not be affected, the attained-age carrier's trend is dampened while the community rated carrier's is increased - not because of increases in how their group uses benefits, but because the make-up of the groups changes. Over several years, the impact can be significant.

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The following Table VII-3 shows the states included in the rating study. Only states not mandating rating requirements were included.

Table VII-3
States Included in Rating Study

AL	KS	MT	PA
AZ	KY	NC	SC
CA	LA	NE	TN
CO	MD	NH	TX
IA	MI	NJ	VA
IL	MO	OH	WV
IN	MS	OK	

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VIII. Plan C Compared to Plan F

Throughout this report, Plan C and F results are compared.

- Plan C annual claim trend and level of claim costs appear greater than Plan F.
- Plan C relativities by rating method appear non-existent whereas Plan F relativities (35% not adjusting for age and 25% after adjusting for age) appear to be due to 1) durations, 2) underwriting practice, and 3) market dynamics.

In this section, cost relativities by attained age, all rating methods, and states combined will be discussed.

Table VIII-1 compares annual claim costs for Plans C and F. The data is from Attachment G, which shows claim costs by Plan, attained age group, and calendar duration from issue. Please note this attachment is based on submitted select data, all contributing companies combined, all rating methods, and underwriting styles combined.

Based on discussions with contributing companies, attained age 64 data is for age-eligible persons and was included with 65-69 persons to form the 64-69 age grouping. Individuals under attained age 64 were assumed to be disabled.

Table VIII-1

Attained Age	Plan C	Plan F	C to F Ratio
Under 64	$2,494	$1,201	208%
64-69	859	765	112
70-74	1,029	936	110
75-79	1,174	1,059	111
80-84	1,249	1,161	108
85+	1,293	1,172	110

Please note the high ratio of Plan C to F for ages less than 64 and the constant ratios for all higher attained age groups. Several contributing companies have experienced consistent results. One national contributing company has not.

Please note the data has not been adjusted for geographic differences and lists data for only 16 states. It is not clear if a true nationwide study would produce the same relationships by attained age.

Attachment G also indicates differing selection/underwriting patterns between Plans C and F. Please see Table VIII-2 below. This may indicate some insured anti-selection exhibited by Plan C purchasers or a different mix of open enrollment and underwritten business.

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Table VIII-2
All Attained Ages 64+

Calendar Duration From Issue	Plan C	Plan F
1	83%	79%
2	95	89
3	98	93
4	100	105
5+	104	110
All	99	98
2+	100	100

The Academy Work Group has discussed this apparent anomaly. One theory mentioned is that insureds purchasing Plan C use a higher proportion of doctors accepting assignments and these doctors have higher utilization practice patterns (rural versus urban issues). Another theory is that those doctors not accepting assignments are more likely to be located in rural areas where access to medical facilities is more limited which limits utilization of all medical services. Finally, Plan C, in general, has had higher increases than Plan F, in general, which may have caused a deterioration of experience.

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IX. Impact of Drug Coverage and Prescription Drug Costs

The tables in this section present annual claim trend for standardized plan options H, I and J. **Note that these trends are not directly comparable to the other sections of the study due to the different companies contributing data to this section.** Plans H and I include benefits for prescription drugs of 50% coinsurance up to $1,250 annual maximum benefit after a $250 deductible. Plan J provides the same benefit but with a $3,000 annual maximum. The Massachusetts mandated drug product, which does not have a maximum drug benefit, was also studied.

Results are shown for all states and by geographic state grouping. The NAIC market weights were used to group states using the same methodology as described in Section III of this report. However, no minimum exposure level test nor cap on annual trend was used.

The first three tables present annual claim trend for 1) all benefits, 2) Rx only benefits, and 3) non-Rx only benefits. The fourth table compares claim trend for Plans A-G to those for H-J and Massachusetts.

Table IX-1
Claim Trend by State Grouping and Calendar Year
All Insurers Surveyed Combined
NAIC Market Exposure Used to Weight By State
Company Exposure Used To Weight By Plan Within State

All Benefits

	Trend	Plan			
	Period	HI	J	HIJ	MASS
All	97/96	10.0%	5.9%	9.3%	19.3%
	98/97	12.9%	9.7%	11.3%	13.7%
	98/96	11.4%	7.8%	10.3%	16.5%
Northeast	97/96	9.2%	11.1%	9.2%	19.3%
	98/97	9.8%	11.3%	10.2%	13.7%
	98/96	9.5%	11.2%	9.7%	16.5%
Midwest	97/96	15.9%	6.7%	11.6%	0.0%
	98/97	15.0%	12.4%	13.6%	0.0%
	98/96	15.4%	9.5%	12.6%	0.0%
South	97/96	15.2%	7.8%	11.4%	0.0%
	98/97	12.5%	8.1%	10.0%	0.0%
	98/96	13.9%	7.9%	10.7%	0.0%
West	97/96	8.7%	2.1%	4.2%	0.0%
	98/97	15.9%	9.2%	11.6%	0.0%
	98/96	12.3%	5.6%	7.9%	0.0%

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Table IX-2
Claim Trend by State Grouping and Calendar Year
All Insurers Surveyed Combined
NAIC Market Exposure Used to Weight By State
Company Exposure Used To Weight By Plan Within State

Rx Benefits Only

	Trend Period	Plan HI	J	HIJ	MASS
All	97/96	15.3%	12.2%	14.8%	26.2%
	98/97	14.4%	16.1%	15.2%	24.0%
	98/96	14.9%	14.2%	15.0%	25.1%
Northeast	97/96	15.4%	19.3%	15.4%	26.2%
	98/97	12.4%	17.5%	13.7%	24.0%
	98/96	13.9%	18.4%	14.5%	25.1%
Midwest	97/96	16.7%	17.5%	17.1%	0.0%
	98/97	16.4%	16.7%	16.6%	0.0%
	98/96	16.5%	17.1%	16.8%	0.0%
South	97/96	11.9%	14.3%	13.1%	0.0%
	98/97	15.5%	14.7%	15.1%	0.0%
	98/96	13.7%	14.5%	14.1%	0.0%
West	97/96	24.2%	6.3%	12.0%	0.0%
	98/97	15.8%	16.9%	16.5%	0.0%
	98/96	20.0%	11.5%	14.3%	0.0%

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Table IX-3
Claim Trend by State Grouping and Calendar Year
All Insurers Surveyed Combined
NAIC Market Exposure Used to Weight By State
Company Exposure Used To Weight By Plan Within State

Non-Rx Benefits Only

	Trend	Plan			
	Period	HI	J	HIJ	MASS
Nationwide	97/96	8.6%	3.4%	7.6%	14.9%
	98/97	12.5%	7.1%	9.9%	6.3%
	98/96	10.5%	5.2%	8.7%	10.5%
Northeast	97/96	7.4%	8.3%	7.4%	14.9%
	98/97	8.9%	9.0%	9.0%	6.3%
	98/96	8.2%	8.6%	8.2%	10.5%
Midwest	97/96	16.3%	2.4%	9.8%	0.0%
	98/97	14.8%	10.4%	12.4%	0.0%
	98/96	15.5%	6.3%	11.1%	0.0%
South	97/96	17.6%	5.0%	11.2%	0.0%
	98/97	12.3%	5.2%	8.3%	0.0%
	98/96	14.9%	5.2%	9.7%	0.0%
West	97/96	3.0%	0.5%	1.3%	0.0%
	98/97	16.0%	6.6%	9.9%	0.0%
	98/96	9.3%	3.5%	5.5%	0.0%

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Table IX-4
Claim Trend Comparison
All Insurers Surveyed Combined
NAIC Market Exposure Used to Weight By State
Company Exposure Used To Weight By Plan Within State

	All Benefits	Rx Only Benefits	Non-Rx Benefits
Plan A	17.6%		
Plan C	10.9%		
Plan F	9.0%		
Plan BDEG	12.8%		
Plan A-G	11.2%		
Plan HI	11.4%	14.9%	10.5%
Plan J	7.8%	14.2%	5.2%
Plan H-J	10.3%	15.0%	8.7%
Mass	16.5%	25.1%	10.5%

The data reveals that the average annual trend from 1996 to 1998 for standardized drug plans H, I and J combined was 10.3%. This compares to the trend for plans A-G of 11.2% shown in Section III. Note that these trends are not directly comparable due to the different companies contributing data to each of these studies. The majority of experience used to analyze the prescription drug standardized plan trends came from one company. Analysis using just that company's data shows an annual trend for plans A-G that is lower than that for plans H-J. This is more in line with what would be expected given the higher trends noted below on the prescription drug benefits under plans H-J.

The average annual trend for the drug benefits under plans H-J was 15.0%. This is thought to be consistent with the generally increasing drug expenditures of the 65+ population, where relatively high increases in drug costs and utilization have been observed. Drug benefit trends under Medicare Supplement insurance plans would tend to be higher due to leveraging of the deductible (some insureds have claims over $250 where none existed before), but lower due to the maximum limits being reached (insureds collecting the maximum benefit can't increase any more). Non-drug benefits under plans H-J averaged 8.7% per year. This is lower than the trend for (non-drug) benefits under plans A-G, even after adjusting for the different companies involved. Additional data would be needed to determine possible causes for this difference.

By region, trends vary from nationwide depending on the plan, the year and type of benefit.

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The trend for drug benefits was lower for plan J than for plans H and I combined from 1996 to 1997 (11.9% vs. 15.3%), but higher from 1997 to 1998 (16.1% vs. 14.4%). Over the three-year period, plan J was slightly lower than H/I (14.0% vs. 14.9%). These results varied by region, with the West showing the most pronounced differences in average trend.

The trend for non-drug benefits varied even more by plan. The average annual trend for plan J was 5.2% compared to 10.5% for plans H/I. Except in the northeast region where these trends were pretty even, the pattern of higher trend for plans H/I was consistent across other regions and years.

In Massachusetts, the 25% annual trend on unlimited drug benefits combines with a 10.5% trend on non-drug benefits to produce an overall average trend of 16.5%. Given the available data, the Work Group was unable to determine the portions of this trend related to the mandate for unlimited drug coverage as compared to other state coverage mandates such as rules that allow individuals to easily move between plans.

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X. Guaranteed Issue Medicare Supplement Coverage and Medicare+Choice Plans

While it may be too early to evaluate the quantitative effects of the 1997 Balanced Budget Act requirements for the guaranteed issue of certain Medicare Supplement plans to individuals who lose Medicare+Choice coverage, this requirement may provide opportunities for anti-selection. The level of anti-selection will be affected by individuals' health status, by whether Medicare+Choice alternatives exist, and the ease to move in and out of plans (e.g., in Massachusetts, there are virtually no limits, so very easy to move around often).

Prior to July 1, 1998, guaranteed issue coverage was only available during the first six months of Medicare eligibility. The new regulations require guarantee issue coverage of certain Medicare Supplement insurance policies to specified eligible individuals. The guaranteed issue coverage requirement applies when an individual has been continuously covered, terminates enrollment, and subsequently applies for a Medicare Supplement insurance policy. The application for coverage must be made within 63 days of termination. In addition, individuals must submit evidence of termination or disenrollment along with the application.

The guaranteed issue coverage is extended to the following persons:

1. An individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.

2. A person enrolled with a M+C organization who leaves the plan other than during an annual election period because: (a) the termination of the health plan's certification as a M+C organization, (b) the individual moves outside of the health entity's service area, or (c) the individual leaves the health plan due to cause.

3. An individual enrolled with a risk or cost contract health maintenance organization, a similar organization operating under a demonstration project authority, a health care prepayment plan, or a Medicare Select policy, and enrollment ceases for the reasons noted above. This coverage is not required for Medicare Select policies if there is a provision in state law or regulation that provides for continuation of coverage or conversion to another Medicare Supplement policy.

4. An individual is covered by a Medicare Supplement insurance policy and enrollment ceases because: (a) the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable state law for the continuation of such coverage, (b) the issuer substantially violates a material provision of the policy, or (c) the issuer materially misrepresented the policy's provisions.

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5. An individual who was enrolled under a Medicare Supplement insurance policy, subsequently terminates such enrollment and enrolls with a M+C organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare select policy, and terminates such enrollment during any period within the first 12 months during which the individual is permitted to terminate enrollment, but only if the individual was never previously enrolled with such an entity.

6. An individual who upon first becoming eligible for Medicare at age 65, enrolls in a M+C plan, and disenrolls from such plan within 12 months.

   The guaranteed issue coverage is generally for plans A, B, C or F. For persons described in paragraph (5) above, it refers to the same policy in which the person was previously enrolled, if available from the same insurer. For persons described in paragraph (6), guaranteed issue coverage is available for any Medicare Supplement insurance policy. There is a requirement for notification of the rights outlined in these provisions for individuals who lose coverage or cease enrollment.

   As a result of these changes, Medicare Supplement insurance carriers can expect a certain amount of anti-selection from these individuals who can obtain coverage on a guaranteed issue basis. The level of anti-selection will be related to a number of factors, including other available M+C coverage in the area and the health status of the individuals.

   HCFA has issued regulations implementing the contracting standards for the Medicare+Choice program outlined in the Balanced Budget Act of 1997. These regulations expand the choice of private health plan options available to Medicare beneficiaries. One of the major changes that affected the Medicare Supplement market is the requirement of guaranteed issue coverage of Medicare Supplement insurance plans in certain situations, related to coverage under the M+C program.

   If there are a number of other M+C options available in the area for individuals, it is expected that a good portion of these individuals will choose coverage under another M+C program. Those individuals who choose Medicare Supplement insurance coverage instead will include those who were dissatisfied with their prior M+C coverage. For example, those who were unhappy with the level of benefits provided under their M+C program (i.e., they had less than desired coverage or coverage limitations), or with the M+C program restrictions (choice of providers, for example) would likely choose Medicare Supplement insurance coverage.

   Another factor, which would increase the expected level of anti-selection generated by individuals, is their health status. Because of some of the limitations present in M+C programs, individuals with less than average health have an incentive to enroll in Medicare Supplement insurance plans, as this coverage is guaranteed issue, with no provider restrictions, and few limitations on the level of benefits available. For less healthy individuals, the additional coverage provided by Medicare Supplement insurance plans more than offsets the deterrent of higher Medicare Supplement insurance premiums. Those individuals who have better than average health would be expected to enroll in M+C

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programs, as they would be less concerned about benefit restrictions or limitations, and the lower (or zero) premiums for these plans would have more appeal.

Anti-selection may be limited somewhat due to the same carrier restriction in point 5), i.e., the guaranteed issue is only for the same plan from the same insurer, and the limit of one disenrollment per enrollee (and in the first 12 months) in point 6).

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XI. Impact of Fraudulent Claims

We know that fraud affects the cost of Medicare Supplement claims, however, we do not know how much fraudulent claims are currently impacting premium rate levels and the trend from year to year. According to the Government Accounting Office and the Office of the Inspector General of the Department of Health and Human Services, costs for fraud are believed to be 3-10% of health care expenditures. In 1996, this cost would have been anywhere from 6-20 billion dollars for Medicare. As a result, HCFA started a campaign in 1995 against fraud called Operation Restore Trust (ORT). This program is a demonstration project in five states: Texas, New York, Florida, California, and Illinois. More than 40% of all Medicare and Medicaid beneficiaries reside in these states. Four industries in particular are under observation: home health agencies, nursing homes, durable medical equipment suppliers and hospice care centers.

There are many procedures that HCFA has implemented including: encouraging citizens to report fraudulent activities, increased review of medical claims, and emphasizing high volume claims such as eye exams, chest X-rays, echocardiography, and colonoscopy tests. There have also been a number of recent legal judgements and settlements resulting from the efforts to crackdown on fraud activity. Currently, these settlements are being paid to the government and are not being shared with the Medicare beneficiaries or Medicare Supplement insurers. Nor are they providing sufficient information to Medicare Supplement insurers to allow them to preserve a separate cause of action. Thus, the fraudulent claims that have been paid in the past are not being offset with the settlement against these claims. The result is that Medicare trends will not increase as quickly as Medicare Supplement trends.

The overall crackdown on fraud could have an impact on Medicare trends to the extent that it deters future fraud. However, the impact is unknown since it is dependent upon the split between Part A and Part B and the volume of certain claims such as home health care to crackdown on fraud activity. While Medicare has stepped up its activity, this does not always translate into savings for Medicare supplement policyholders. Some Medicare administrators have been known to pass electronic claims along to Medicare supplement insurers indicating approval by Medicare even though they have withheld payment for Medicare's share pending investigation results. Medicare supplement insurers can protect their policyholders by specifying the exclusion of these claims in their crossover contracts with Medicare administrators, where the administrators allow it.

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XII. Aging Block

The tables in this section of the report present average age by contributing company rating method. Select attained age data was used to determine average age. First, exposure data was summarized into age groupings. The age groupings and assumed age for each grouping is shown in the following table. This produces a consistent but slightly different average age than shown in a previous section (Section VII).

Table XII-1
Attained Age Grouping and
Assumed Age for Each Grouping

Age Grouping	Assumed Average Age
<65	60
65-69	67
70-74	72
75-79	77
80-84	82
85+	90

Table XII-2 shows the average age for all covered persons and Table XII-3 shows the average age for all persons age 65+.

Table XII-2
Average Age By Rating Method
All Plans Combined, All Ages

Average Age – Current Year Issues

	Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	69.4	70.2	70.4	0.8	0.2	1.0
Entry Age (EA)	71.1	71.7	71.2	0.6	-0.5	0.1
Community Rate (CR)	72.4	73.2	73.4	0.8	0.2	1.0

Average Age – Renewal

	Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.4	70.8	71.2	0.4	0.4	0.8
Entry Age (EA)	72.8	73.5	74.0	0.7	0.5	1.2
Community Rate (CR)	74.5	74.8	75.3	0.3	0.5	0.8

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Table XII-2 (Continued)
Average Age By Rating Method
All Plans Combined, All Ages

	Average Age – All Issues					
	Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.2	70.7	71.1	0.5	0.4	0.9
Entry Age (EA)	72.6	73.4	73.9	0.8	0.5	1.3
Community Rate (CR)	74.3	74.7	75.2	0.4	0.5	0.9

	Rating Method Age Differences (All Insurers)		
	Year		
	1996	**1997**	**1998**
EA – AA	2.4	2.7	2.8
CR – AA	4.1	4.0	4.1

Table XII-3
Average Age By Rating Method
All Plans Combined, Ages 65+

	Average Age - Current Year Issues					
	Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.9	71.4	71.6	0.6	0.2	0.7
Entry Age (EA)	72.6	72.6	73.2	0.0	0.6	0.6
Community Rate (CR)	72.8	73.8	73.5	1.0	-0.2	0.8

	Average Age – Renewal					
	Year			Change In Average Age		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.8	71.1	71.5	0.3	0.4	0.7
Entry Age (EA)	72.8	73.6	74.1	0.4	0.4	1.3
Community Rate (CR)	74.6	75.0	75.4	0.8	0.5	0.8

	Average Age – All Issues			Change In Average Age		
	Year			Year		
	1996	**1997**	**1998**	**97/96**	**98/97**	**Total**
Attained Age (AA)	70.9	71.2	71.5	0.3	0.3	0.6
Entry Age (EA)	72.8	73.5	74.0	0.7	0.5	1.2
Community Rate (CR)	74.5	74.9	75.3	0.5	0.4	0.9

	Rating Method Age Differences (All Issues)		
	Year		
	1996	**1997**	**1998**
EA – AA	2.0	2.3	2.5
CR – AA	3.6	3.7	3.8

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The following are some observations:

- Over the 1996-1998 period, the average age for community rated business over the entire time period from 1996-1998 is 1.4 years older than that for entry age rated business which in turn is 2.6 years older than that for attained age rated business. If only 65+ ages are looked at, the average age difference is slightly less.

- The average issue age is constant for entry age rated business over the 1996-1998 period. For community and attained age rated business, the average issue age increased 1 year from 1996 to 1998. During the 1996-1998 study period, Medicare managed care plan enrollment grew substantially. Further, several studies have concluded that Medicare managed care plans attract younger and healthier individuals.

- The average age for current year issues for all rating methods is in excess of 70 years of age which suggests that a substantial number of policies were issued outside of the usual open enrollment period (i.e. when individuals are first eligible for Medicare coverage by reason of age).

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Attachment A
Members of the Academy Medicare Supplement Work Group

NAME	COMPANY
Mike Abroe, Chairperson	Milliman and Robertson, Inc.
David Bahn	Blue Cross and Blue Shield of Florida
Mark Billingsley	Pyramid Life Insurance Company
John Bryson	Blue Cross and Blue Shield of Connecticut
Gina Calise	Blue Cross and Blue Shield of Rhode Island
William Cashion	Capital Blue Cross
Susan Clark	Blue Cross Blue Shield of Kansas
Rich Coyle	Health Care Financing Administration
Randy Edwards	Blue Cross and Blue Shield of Kansas
Doug Feekin	Mutual/United of Omaha Insurance Co
Patrick Fleming	Bankers Life and Casualty Co
William Gilmore	Blue Cross and Blue Shield of Mississippi
Dave Hutchins	Blue Cross and Blue Shield of Kansas
Nancy King	Physicians Mutual Insurance Co.
Gail Lawrence	American Republic Insurance Company
Tom Lindquist	United HealthCare Insurance Company
Doug Littleton	United HealthCare Insurance Company
Diana Long	Blue Cross and Blue Shield of Florida
Amber Lubeck	Mutual/United of Omaha Insurance Co.
Dan Martin	Blue Cross and Blue Shield of Arkansas
Robert McCarthy	Milliman and Robertson, Inc.
Mike Murray	Blue Cross and Blue Shield of Delaware
Dotti Outland	United HealthCare Insurance Company
Carol Pawlak	Blue Cross and Blue Shield of Rhode Island
Mike Recorvits	Blue Cross and Blue Shield of Rhode Island
Don Roll	Anthem Blue Cross and Blue Shield
David Shea	Trigon Blue Cross Blue Shield
Donald Sheak	United HealthCare Insurance Company
Jamie Trimble	Milliman and Robertson, Inc.
John Troy	Blue Cross Blue Shield Association
Dave Tuomala	Wellmark, Inc.
Chris Walker	Physicians Mutual Insurance Company
David Walker	United HealthCare Insurance Company
Bill Weller	Health Insurance Association of America
Tom Wilder	American Academy of Actuaries
Byron Wingo	Blue Cross/ and Blue Shield of Mississippi
Diana Wright	National Association of Insurance Commissioners

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Attachment B

Companies Submitting Data

The following is a listing of companies that agreed to contribute. Some companies were only able to contribute control data. Two companies were not able to contribute data in the format specified.

Bankers Life and Casualty

Blue Cross and Blue Shield of Arkansas

Blue Cross and Blue Shield of Connecticut

Blue Cross and Blue Shield of Florida

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Mississippi

Blue Cross and Blue Shield of Rhode Island

United/Mutual of Omaha

Physicians Mutual

United Health Care

Wellmark

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Attachment C
Select Record Layout

Field	Columns	Data Element	Description	All Data Right Justified/Data Keys
1	1-2	State of Residence	State of Residence Use standard 2 character abbreviation	
2	3-4	Plan	Standardized States – Standardized Plans Standardized States – Select Plans	A, B, ... AA, BB, ...
3	6-9	Benefit Indicator	Standardized Products Part A A Deductible A Co-pays Lifetime Reserve SNF Additional to 365 Days Home Health Care All Other Part A Part B Ded Part B All Other	Use Following Data keys: ADED ACOP ALTR ASNF A365 AHHC AOTH PTBD PTBO
4	11-13	Electronic Claims Received	Yes or no for the benefit	YES, NO
5	15-18	Attained Age	age last birthday	III
6	20	Sex	Male, Female, or Unisex	M, F, U
7	22-25	Issue Year	1992 through 1998	1992, 1993, ...
8	27-30	Incurred Year	1993 through 1998*	1992, 1993, ...
9	32-43	Exposure Count	Number of insured years exposed to risk	xxxxxxxxx.dd
10	45-56	Incurred Claims	Based on claims paid through June 1999**	xxxxxxxxx.dd
11	58-69	Remaining Liability	Dollars and cents	xxxxxxxxx.dd
12	71-74	Premium Type	Community, Entry Age or Attained Age	COMM, ENTA or ATTA
13	76-79	Underwriting Style		GUAR or MUND
14	81-92	Exposure with no claims	Two decimal places	xxxxxxxxx.dd

* Preferred, some carriers are submitting 1994 or 1996 through 1998.
** Some companies are basing incurred claims on payments through May, 1999.

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Attachment D

Control Record Layout

Field	Columns	Data Element	Description	**All Data Right Justified/Data Keys**
1	1-2	State	State of Residence – Use standard 2 character abbreviation	
2	4-5	Plan	Standardized States - Standardized Plans Standardized States - Select Plans	A, B, ... AA, BB, ...
3	7-10	Benefit Indicator	Part A Part B	PTAA PTBB
4	12-14	Electronic Claims Received	Yes or no for the benefit	YES or NO
5	16-19	Issue Year	1992 through 1998	1992, 1993, ...
6	21-24	Incurred Year	1993 through 1998*	1992, 1993, ...
7	26-37	Exposure Count	Number of insured years exposed to risk	xxxxxxxxx.dd
8	39-50	Incurred Claims	Based on Claims Paid through June 1999**	xxxxxxxxx.dd
9	52-63	Remaining Liability		xxxxxxxxx.dd
10	65-68	Premium Type	Community, Entry Age or Attained Age	COMM, ENTA or ATTA
11	70-73	Underwriting Style	Guaranteed Issue or Medically Underwritten	GUAR or MUND

* Preferred, some carriers are submitting 1994 or 1996 through 1998.
** Some companies are basing incurred claims on payments through May, 1999.

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Attachment E
Part 1
Geographic Grouping of States

Northeast	Midwest	South	West
Maine	Ohio	Delaware	Montana
New Hampshire	Indiana	Maryland	Idaho
Vermont	Illinois	District of Columbia	Wyoming
Massachusetts	Michigan	Virginia	Colorado
Rhode Island	Wisconsin	West Virginia	New Mexico
Connecticut	Minnesota	North Carolina	Arizona
New York	Iowa	South Carolina	Utah
New Jersey	Missouri	Georgia	Nevada
Pennsylvania	North Dakota	Florida	Washington
	South Dakota	Kentucky	Oregon
	Nebraska	Tennessee	California
	Kansas	Alabama	Alaska
		Mississippi	Hawaii
		Arkansas	
		Louisiana	
		Oklahoma	
		Texas	

Includes all 50 states plus District of Columbia. Wisconsin, Massachusetts and Minnesota are excluded from the survey. Puerto Rico and Virgin Islands are not included in the following geographic groupings.

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Attachment E
Part 2
Grouping By States Mandating /not Mandating Coverage (3) of Under 65 Medicare Eligible Individuals

Implemented Mandate 1997 and Prior	Implemented Mandate 1998 and Subsequent (1) (2)	Not Mandating
Connecticut	Louisiana	Rest of States
Kansas	Maryland	(Includes VI,PR,
Maine	Massachusetts	District of Columbia)
New Hampshire	Minnesota	
New Jersey	Missouri	
New York	North Carolina	
Oklahoma	South Dakota	
Oregon	Wisconsin	
Pennsylvania		
Texas		
Washington		

The above state groupings were used in developing summaries in Section III of the report. For Section VI, of the 16 states for which select data was contributed (see Section II-D), the 5 states mandating coverage of under 65 Medicare eligible individuals are Connecticut, Kansas, New Hampshire, Pennsylvania and Texas. The remaining 11 states are classified as "Not Mandating."

Please note the following:
1 – Some states implemented requirements during 1998 or 1999 and were not included as disabled states for the purposes of this study. These include Louisiana, Maryland, Missouri, North Carolina and South Dakota.
2 – Massachusetts, Minnesota and Wisconsin are listed, but are not part of the survey.
3 – The classification is based on state requirements and not company practices.

Part 3
Grouping By State Rating Requirement

Community Rated	Entry Age	No Mandate
Arkansas	Florida	All remaining states
Connecticut	Georgia	
Idaho		
Maine		
Massachusetts		
Minnesota		
New York		
Washington		

Please note the following:

1 - Massachusetts, Minnesota and Wisconsin are listed, but are not part of the survey.
2 - The classification is based on state requirements and not company practices.
3 - Georgia and Idaho prohibit attained age rating practices.

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Attachment F

Health Care Financing Administration
Under OPD PPS Compared to Current Law Using
1996 Claim Data By State and Urban/Rural Area
Does Not Include Co-pay Ceiling or
Changes in Costs and Charges from 1996 to 2000
Reflects Service Mix Provided in 1996

State	Urban/Rural Area	Percent Change
ALL STATES		-12.2
ALABAMA	RURAL	-27.7
ALABAMA	URBAN	-29.9
ALASKA	RURAL	3.7
ALASKA	URBAN	13.7
ARIZONA	RURAL	-12.5
ARIZONA	URBAN	-24.2
ARKANSAS	RURAL	-16.2
ARKANSAS	URBAN	-8.4
CALIFORNIA	RURAL	-19.6
CALIFORNIA	URBAN	-25.5
COLORADO	RURAL	-0.6
COLORADO	URBAN	-8.9
CONNECTICUT	RURAL	-8.4
CONNECTICUT	URBAN	6.7
DELAWARE	RURAL	-17.5
DELAWARE	URBAN	11.9
DISTRICT OF COLUMBIA	URBAN	-15.6
FLORIDA	RURAL	-26.4
FLORIDA	URBAN	-29.9
GEORGIA	RURAL	-14.2
GEORGIA	URBAN	-8.6
HAWAII	RURAL	-12.9
HAWAII	URBAN	-17.2

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Health Care Financing Administration
Under OPD PPS Compared to Current Law Using
1996 Claim Data By State and Urban/Rural Area
Does Not Include Co-pay Ceiling or
Changes in Costs and Charges from 1996 to 2000
Reflects Service Mix Provided in 1996

State	Urban/Rural Area	Percent Change
IDAHO	RURAL	18.2
IDAHO	URBAN	25.5
ILLINOIS	RURAL	-10.3
ILLINOIS	URBAN	-20.1
INDIANA	RURAL	-11.1
INDIANA	URBAN	-1.7
IOWA	RURAL	-3.5
IOWA	URBAN	3.5
KANSAS	RURAL	-8.5
KANSAS	URBAN	-20.1
KENTUCKY	RURAL	-17.4
KENTUCKY	URBAN	-12.6
LOUISIANA	RURAL	-26.4
LOUISIANA	URBAN	-23.2
MAINE	RURAL	-12.6
MAINE	URBAN	2.3
MASSACHUSETTS	RURAL	-16.9
MASSACHUSETTS	URBAN	-6.0
MICHIGAN	RURAL	-1.5
MICHIGAN	URBAN	-11.7
MINNESOTA	RURAL	-1.5
MINNESOTA	URBAN	8.5
MISSISSIPPI	RURAL	-14.6
MISSISSIPPI	URBAN	-13.9
MISSOURI	RURAL	-12.6
MISSOURI	URBAN	-20.8

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Attachment F

Health Care Financing Administration
Under OPD PPS Compared to Current Law Using
1996 Claim Data By State and Urban/Rural Area
Does Not Include Co-pay Ceiling or
Changes in Costs and Charges from 1996 to 2000
Reflects Service Mix Provided in 1996

State	Urban/Rural Area	Percent Change
MONTANA	RURAL	-1.1
MONTANA	URBAN	17.0
NEBRASKA	RURAL	2.4
NEBRASKA	URBAN	-2.5
NEVADA	RURAL	-18.4
NEVADA	URBAN	-23.3
NEW HAMPSHIRE	RURAL	5.3
NEW HAMPSHIRE	URBAN	4.7
NEW JERSEY	URBAN	-1.9
NEW MEXICO	RURAL	-10.0
NEW MEXICO	URBAN	-5.0
NEW YORK	RURAL	7.5
NEW YORK	URBAN	10.2
NORTH CAROLINA	RURAL	-10.2
NORTH CAROLINA	URBAN	2.3
NORTH DAKOTA	RURAL	-10.9
NORTH DAKOTA	URBAN	-6.7
OHIO	RURAL	-5.5
OHIO	URBAN	-0.9
OKLAHOMA	RURAL	-10.2
OKLAHOMA	URBAN	-12.3
OREGON	RURAL	16.4
OREGON	URBAN	25.9
PENNSYLVANIA	RURAL	-6.9
PENNSYLVANIA	URBAN	-22.6

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Attachment F

Health Care Financing Administration
Under OPD PPS Compared to Current Law Using
1996 Claim Data By State and Urban/Rural Area
Does Not Include Co-pay Ceiling or
Changes in Costs and Charges from 1996 to 2000
Reflects Service Mix Provided in 1996

State	Urban/Rural Area	Percent Change
PUERTO RICO	RURAL	38.3
PUERTO RICO	URBAN	19.3
RHODE ISLAND	URBAN	1.3
SOUTH CAROLINA	RURAL	-13.3
SOUTH CAROLINA	URBAN	-14.4
SOUTH DAKOTA	RURAL	5.2
SOUTH DAKOTA	URBAN	15.7
TENNESSEE	RURAL	-11.2
TENNESSEE	URBAN	-11.0
TEXAS	RURAL	-18.7
TEXAS	URBAN	-23.7
UTAH	RURAL	20.2
UTAH	URBAN	14.9
VERMONT	RURAL	-4.2
VERMONT	URBAN	47.2
VIRGIN ISLANDS		11.7
VIRGINIA	RURAL	-9.3
VIRGINIA	URBAN	-12.4
WASHINGTON	RURAL	11.8
WASHINGTON	URBAN	10.3
WEST VIRGINIA	RURAL	-6.8
WEST VIRGINIA	URBAN	5.2
WISCONSIN	RURAL	0.0
WISCONSIN	URBAN	-1.2

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Attachment F

Health Care Financing Administration
Under OPD PPS Compared to Current Law Using
1996 Claim Data By State and Urban/Rural Area
Does Not Include Co-pay Ceiling or
Changes in Costs and Charges from 1996 to 2000
Reflects Service Mix Provided in 1996

State	Urban/Rural Area	Percent Change
WYOMING	RURAL	4.4
WYOMING	URBAN	-5.9
GUAM		-10.3

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Plan	Calendar Duration						
	1	2	3	4	5+	all	2+
Age grouping - Under Age 64							
Annual Claims Cost ($)							
Plan A	2,957.44	2,651.80	1,897.21	1,674.92	1,477.78	2,311.40	2,142.98
Plan C	2,715.00	2,689.52	2,399.04	2,317.06	1,691.99	2,493.57	2,440.69
Plan F	1,420.36	1,242.03	1,144.99	1,051.09	946.35	1,200.76	1,145.15
Plan BDEG	1,759.20	1,284.27	1,478.38	1,613.34	2,004.44	1,529.58	1,444.47
All Plans	1,925.72	1,777.67	1,528.64	1,403.72	1,216.46	1,649.60	1,578.80
Plans C+F	1,745.04	1,646.38	1,466.82	1,351.44	1,131.64	1,536.53	1,484.51
Annual Claim Cost Ratio to Duration 2+							
Plan A	138%	124%	89%	78%	69%	108%	100%
Plan C	111%	110%	98%	95%	69%	102%	100%
Plan F	124%	108%	100%	92%	83%	105%	100%
Plan BDEG	122%	89%	102%	112%	139%	106%	100%
All Plans	122%	113%	97%	89%	77%	104%	100%
Plans C+F	118%	111%	99%	91%	76%	104%	100%
Incurred Claims ($)							
Plan A	1,336,499	2,020,568	924,339	460,720	309,269	5,051,394	3,714,896
Plan C	1,635,676	3,060,556	1,715,222	919,155	461,784	7,792,393	6,156,717
Plan F	2,556,423	3,646,164	2,371,274	1,340,494	781,109	10,695,464	8,139,041
Plan BDEG	340,252	341,615	215,562	98,688	97,870	1,093,988	753,735
All Plans	5,868,850	9,068,903	5,226,398	2,819,056	1,650,032	24,633,239	18,764,389
Plans C+F	4,192,099	6,706,720	4,086,496	2,259,648	1,242,892	18,487,857	14,295,757
Exposure (Lives)							
Plan A	452	762	487	275	209	2,185	1,734
Plan C	602	1,138	715	397	273	3,125	2,523
Plan F	1,800	2,936	2,071	1,275	825	8,907	7,107
Plan BDEG	193	266	146	61	49	715	522
All Plans	3,048	5,102	3,419	2,008	1,356	14,933	11,885
Plans C+F	2,402	4,074	2,786	1,672	1,098	12,032	9,630

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Ages 64 Through 69

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	468.17	555.61	578.27	553.98	522.56	543.16	553.00
Plan C	743.52	831.92	861.51	877.65	894.37	859.07	868.69
Plan F	673.78	725.82	752.04	822.89	826.60	765.46	776.03
Plan BDEG	634.69	943.88	821.08	927.06	831.37	837.63	870.01
All Plans	670.95	774.37	789.44	849.49	837.04	796.60	810.80
Plans C+F	696.09	759.05	794.59	849.20	854.61	801.71	812.56
Annual Claim Cost Ratio to Duration 2+							
Plan A	85%	100%	105%	100%	94%	98%	100%
Plan C	86%	96%	99%	101%	103%	99%	100%
Plan F	87%	94%	97%	106%	107%	99%	100%
Plan BDEG	73%	108%	94%	107%	96%	96%	100%
All Plans	83%	96%	97%	105%	103%	98%	100%
Plans C+F	86%	93%	98%	105%	105%	99%	100%
Incurred Claims ($)							
Plan A	2,005,535	5,097,609	5,249,050	3,260,547	4,447,293	20,060,035	18,054,500
Plan C	14,998,875	41,165,290	56,116,374	51,767,282	61,268,993	225,316,815	210,317,940
Plan F	28,899,940	78,769,823	77,038,146	52,474,211	80,369,430	317,551,551	288,651,610
Plan BDEG	12,541,862	24,655,483	27,362,313	21,210,601	34,531,663	120,301,921	107,760,060
All Plans	58,446,212	149,688,205	165,765,884	128,712,641	180,617,379	683,230,322	624,784,110
Plans C+F	43,898,815	119,935,113	133,154,521	104,241,493	141,638,424	542,868,366	498,969,550
Exposure (Lives)							
Plan A	4,284	9,175	9,077	5,886	8,511	36,932	32,648
Plan C	20,173	49,482	65,137	58,984	68,505	262,281	242,109
Plan F	42,892	108,525	102,439	63,768	97,228	414,853	371,960
Plan BDEG	19,761	26,121	33,325	22,879	41,536	143,622	123,861
All Plans	87,110	193,303	209,978	151,517	215,780	857,688	770,579
Plans C+F	63,065	158,007	167,576	122,752	165,734	677,134	614,069

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Plan	**Calendar Duration**						
	1	2	3	4	5+	all	2+
				Ages 70 Through 74			
				Annual Claims Cost ($)			
Plan A	521.44	676.59	776.70	753.21	630.39	672.32	692.57
Plan C	843.70	1,006.98	1,047.03	1,035.66	1,064.71	1,028.93	1,044.03
Plan F	725.54	870.96	918.55	981.21	1,001.47	935.60	957.56
Plan BDEG	831.16	941.73	957.37	1,067.29	1,041.45	995.76	1,016.83
All Plans	765.56	914.69	966.09	1,002.09	1,009.44	962.52	982.67
Plans C+F	770.88	928.33	980.62	1,007.89	1,027.39	976.55	995.95
				Annual Claim Cost Ratio to Duration 2+			
Plan A	75%	98%	112%	109%	91%	97%	100%
Plan C	81%	96%	100%	99%	102%	99%	100%
Plan F	76%	91%	96%	102%	105%	98%	100%
Plan BDEG	82%	93%	94%	105%	102%	98%	100%
All Plans	78%	93%	98%	102%	103%	98%	100%
Plans C+F	77%	93%	98%	101%	103%	98%	100%
				Incurred Claims ($)			
Plan A	1,414,851	2,785,753	3,045,339	3,026,976	5,148,833	15,421,751	14,006,901
Plan C	8,613,481	21,631,543	28,484,935	30,975,766	49,667,051	139,372,776	130,759,295
Plan F	11,897,368	25,651,941	26,736,223	30,541,660	67,263,192	162,090,385	150,193,016
Plan BDEG	6,600,834	9,949,558	8,310,591	10,569,122	34,259,218	69,689,323	63,088,490
All Plans	28,526,534	60,018,795	66,577,088	75,113,524	156,338,294	386,574,235	358,047,701
Plans C+F	20,510,849	47,283,484	55,221,158	61,517,426	116,930,243	301,463,160	280,952,311
				Exposure (Lives)			
Plan A	2,713	4,117	3,921	4,019	8,168	22,938	20,225
Plan C	10,209	21,482	27,206	29,909	46,648	135,454	125,245
Plan F	16,398	29,453	29,107	31,126	67,164	173,248	156,850
Plan BDEG	7,942	10,565	8,681	9,903	32,896	69,986	62,044
All Plans	37,262	65,617	68,914	74,957	154,876	401,626	364,364
Plans C+F	26,607	50,934	56,313	61,036	113,813	308,702	282,095

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Plan	Calendar Duration						
	1	2	3	4	5+	all	2+
				Ages 75 Through 79			
				Annual Claims Cost ($)			
Plan A	465.42	642.96	707.45	729.38	723.80	667.94	702.54
Plan C	943.37	1,133.94	1,201.75	1,202.42	1,221.01	1,173.79	1,195.78
Plan F	822.38	1,002.48	1,039.40	1,071.53	1,164.43	1,059.37	1,088.07
Plan BDEG	968.76	1,115.75	1,166.45	1,212.59	1,283.37	1,172.60	1,212.43
All Plans	858.50	1,040.17	1,098.93	1,122.07	1,177.30	1,092.40	1,121.61
Plans C+F	871.07	1,060.91	1,119.94	1,136.67	1,188.62	1,111.44	1,137.70
				Annual Claim Cost Ratio to Duration 2+			
Plan A	66%	92%	101%	104%	103%	95%	100%
Plan C	79%	95%	100%	101%	102%	98%	100%
Plan F	76%	92%	96%	98%	107%	97%	100%
Plan BDEG	80%	92%	96%	100%	106%	97%	100%
All Plans	77%	93%	98%	100%	105%	97%	100%
Plans C+F	77%	93%	98%	100%	104%	98%	100%
				Incurred Claims ($)			
Plan A	1,023,584	1,933,578	1,961,831	1,923,411	3,225,865	10,068,270	9,044,686
Plan C	7,048,184	16,755,567	21,368,965	22,404,525	33,095,807	100,673,049	93,624,864
Plan F	9,122,358	18,514,813	18,773,926	20,149,009	42,249,324	108,809,430	99,687,072
Plan BDEG	5,544,955	7,458,131	5,745,882	6,550,113	15,769,254	41,068,335	35,523,380
All Plans	22,739,082	44,662,090	47,850,604	51,027,059	94,340,249	260,619,084	237,880,003
Plans C+F	16,170,543	35,270,380	40,142,891	42,553,534	75,345,131	209,482,479	193,311,936
				Exposure (Lives)			
Plan A	2,199	3,007	2,773	2,637	4,457	15,074	12,874
Plan C	7,471	14,776	17,782	18,633	27,105	85,767	78,296
Plan F	11,093	18,469	18,062	18,804	36,283	102,711	91,619
Plan BDEG	5,724	6,684	4,926	5,402	12,287	35,023	29,299
All Plans	26,487	42,937	43,543	45,476	80,133	238,575	212,088
Plans C+F	18,564	33,245	35,844	37,437	63,389	188,479	169,915

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Plan	**Calendar Duration**						
	1	2	3	4	5+	all	2+
				Ages 80 Through 84			
				Annual Claims Cost ($)			
Plan A	443.89	627.36	667.62	680.02	664.96	629.11	659.68
Plan C	1,027.54	1,192.56	1,249.70	1,266.11	1,318.87	1,249.00	1,268.75
Plan F	832.22	1,084.46	1,138.72	1,205.90	1,257.92	1,161.24	1,194.88
Plan BDEG	1,068.65	1,315.61	1,299.15	1,477.36	1,520.20	1,376.44	1,434.47
All Plans	901.91	1,118.24	1,163.64	1,226.26	1,283.57	1,185.09	1,217.13
Plans C+F	914.54	1,134.45	1,194.41	1,234.57	1,283.35	1,200.92	1,228.50
				Annual Claim Cost Ratio to Duration 2+			
Plan A	67%	95%	101%	103%	101%	95%	100%
Plan C	81%	94%	98%	100%	104%	98%	100%
Plan F	70%	91%	95%	101%	105%	97%	100%
Plan BDEG	74%	92%	91%	103%	106%	96%	100%
All Plans	74%	92%	96%	101%	105%	97%	100%
Plans C+F	74%	92%	97%	100%	104%	98%	100%
				Incurred Claims ($)			
Plan A	612,194	1,242,398	1,269,279	1,142,991	1,857,442	6,124,304	5,512,110
Plan C	4,110,861	9,624,834	12,282,429	13,161,302	21,833,740	61,013,165	56,902,304
Plan F	4,570,011	10,175,286	11,110,703	13,788,619	29,097,095	68,741,715	64,171,704
Plan BDEG	3,279,630	4,593,987	3,263,710	4,334,135	11,156,866	26,628,328	23,348,698
All Plans	12,572,695	25,636,505	27,926,122	32,427,047	63,945,142	162,507,511	149,934,816
Plans C+F	8,680,872	19,800,120	23,393,132	26,949,921	50,930,834	129,754,880	121,074,008
				Exposure (Lives)			
Plan A	1,379	1,980	1,901	1,681	2,793	9,735	8,356
Plan C	4,001	8,071	9,828	10,395	16,555	48,850	44,849
Plan F	5,491	9,383	9,757	11,434	23,131	59,197	53,705
Plan BDEG	3,069	3,492	2,512	2,934	7,339	19,346	16,277
All Plans	13,940	22,926	23,999	26,444	49,818	137,127	123,187
Plans C+F	9,492	17,454	19,585	21,829	39,686	108,046	98,554

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Ages 85 and Older

Plan	**Calendar Duration** 1	2	3	4	5+	all	2+
	Annual Claims Cost ($)						
Plan A	380.09	536.02	562.50	491.90	579.55	522.54	548.03
Plan C	1,082.20	1,335.33	1,308.73	1,288.07	1,315.65	1,292.83	1,311.24
Plan F	779.41	1,035.56	1,155.12	1,246.41	1,280.78	1,171.60	1,211.15
Plan BDEG	1,187.66	1,356.77	1,450.11	1,557.78	1,543.42	1,454.98	1,497.34
All Plans	904.43	1,152.66	1,203.69	1,248.98	1,292.61	1,209.08	1,242.56
Plans C+F	901.78	1,171.42	1,228.91	1,265.47	1,294.90	1,224.45	1,255.09
	Annual Claim Cost Ratio to Duration 2+						
Plan A	69%	98%	103%	90%	106%	95%	100%
Plan C	83%	102%	100%	98%	100%	99%	100%
Plan F	64%	86%	95%	103%	106%	97%	100%
Plan BDEG	79%	91%	97%	104%	103%	97%	100%
All Plans	73%	93%	97%	101%	104%	97%	100%
Plans C+F	72%	93%	98%	101%	103%	98%	100%
	Incurred Claims ($)						
Plan A	393,091	609,448	653,754	633,695	1,271,363	3,561,352	3,168,261
Plan C	2,789,996	6,811,810	8,056,074	8,775,416	15,022,111	41,455,407	38,665,410
Plan F	2,962,575	6,373,576	7,690,839	10,076,489	21,500,138	48,603,616	45,641,042
Plan BDEG	2,344,556	3,257,457	2,484,030	3,681,213	9,230,001	20,997,257	18,652,701
All Plans	8,490,218	17,052,291	18,884,697	23,166,813	47,023,612	114,617,631	106,127,413
Plans C+F	5,752,571	13,185,386	15,746,913	18,851,905	36,522,249	90,059,023	84,306,452
	Exposure (Lives)						
Plan A	1,034	1,137	1,162	1,288	2,194	6,815	5,781
Plan C	2,578	5,101	6,156	6,813	11,418	32,066	29,488
Plan F	3,801	6,155	6,658	8,084	16,787	41,485	37,684
Plan BDEG	1,974	2,401	1,713	2,363	5,980	14,431	12,457
All Plans	9,387	14,794	15,689	18,549	36,379	94,797	85,410
Plans C+F	6,379	11,256	12,814	14,897	28,205	73,551	67,172

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Plan	Calendar Duration						
	1	2	3	4	5+	all	2+
All Ages							
Annual Claims Cost ($)							
Plan A	473.78	484.20	469.99	936.02	524.85	502.92	506.88
Plan C	825.88	865.33	786.97	748.95	805.17	804.61	802.92
Plan F	696.15	716.47	691.07	789.93	717.29	710.28	712.64
Plan BDEG	707.03	1,211.38	645.48	561.61	825.60	789.42	804.02
All Plans	710.96	784.41	699.16	727.55	753.01	740.68	744.90
Plans C+F	723.66	750.40	725.62	759.90	751.07	742.70	745.27
Annual Claim Cost Ratio to Duration 2+							
Plan A	93%	96%	93%	185%	104%	99%	100%
Plan C	103%	108%	98%	93%	100%	100%	100%
Plan F	98%	101%	97%	111%	101%	100%	100%
Plan BDEG	88%	151%	80%	70%	103%	98%	100%
All Plans	95%	105%	94%	98%	101%	99%	100%
Plans C+F	97%	101%	97%	102%	101%	100%	100%
Incurred Claims ($)							
Plan A	6,785,753	13,689,355	13,103,592	10,448,339	16,260,066	60,287,106	53,501,353
Plan C	39,197,073	99,049,599	128,024,000	128,003,446	181,349,485	575,623,604	536,426,531
Plan F	60,008,676	143,131,603	143,721,112	128,370,482	241,260,287	716,492,161	656,483,485
Plan BDEG	30,652,089	50,256,232	47,382,089	46,443,872	105,044,871	279,779,153	249,127,064
All Plans	136,643,591	306,126,789	332,230,793	313,266,139	543,914,709	1,632,182,023	1,495,538,432
Plans C+F	120,017,352	286,263,207	287,442,223	256,740,964	482,520,575	1,432,984,322	1,312,966,969
Exposure (Lives)							
Plan A	12,062	20,179	19,322	15,786	26,331	93,679	81,618
Plan C	45,034	100,050	126,823	125,131	170,505	567,543	522,509
Plan F	81,475	174,920	168,095	134,492	241,419	800,401	718,926
Plan BDEG	38,663	49,530	51,302	43,542	100,087	283,124	244,461
All Plans	177,234	344,678	365,542	318,951	538,342	1,744,747	1,567,513
Plans C+F	162,950	349,839	336,190	268,985	482,838	1,600,802	1,437,852

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Attachment G

Attained Age Claims Analysis
1996 through 1998 Experience
1996/1997 Trended to 1998

Ages 64 and Older

	Annual Claim Cost						
Plan A	469.37	600.97	646.64	643.92	610.62	603.71	623.23
Plan C	845.37	970.45	1,001.59	1,018.84	1,062.60	1,006.05	1,019.78
Plan F	721.08	811.04	851.38	953.56	999.52	891.73	910.83
Plan BDEG	787.95	1,013.21	922.00	1,065.88	1,049.07	986.82	1,018.18
All Plans	750.78	874.79	903.02	979.51	1,009.83	929.32	949.31
Plans C+F	765.58	869.24	916.22	985.13	1,025.66	939.31	956.82

	Annual Claim Cost Ratio to Duration 2+						
Plan A	75%	96%	104%	103%	98%	97%	100%
Plan C	83%	95%	98%	100%	104%	99%	100%
Plan F	79%	89%	93%	105%	110%	98%	100%
Plan BDEG	77%	100%	91%	105%	103%	97%	100%
All Plans	79%	92%	95%	103%	106%	98%	100%
Plans C+F	80%	91%	96%	103%	107%	98%	100%

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Explanation of Rating Methodologies

Basically, there are three types of rating methodology -- attained-age, issue-age, and community-rated. Under an attained-age rating structure, individuals pay rates that are relevant to the risk at their particular age and do not reflect any prefunding of risk for older ages. Rates may vary by single ages or age-bands. For attained-age pricing, annual rate increases are a combination of trend increases and cost increases attributable to being one year older. Rates on an issue-age basis may also have rate changes, but those rate changes are not attributable to the aging of that individual. Rate changes would be due to increases in trend, such as increases in medical procedures. In developing the premiums for issue-age policies, the increases attributable to age have been leveled over the premium paying period. This means that an individual will pay more than necessary to cover the risk in the early years and less than necessary to cover the risk in the later years. Active life reserves are established to cover claims in the future to the extent that future premiums are insufficient. Community-rated premiums are determined such that an individual pays the anticipated average rate for all policyholders for the upcoming year.

Consider the example, where in year T, the following three individuals have Medicare supplement policies:

Person A	is currently age 70 and purchased a Medicare supplement policy 5 years ago at age 65
Person B	is currently age 70 and is now purchasing a Medicare supplement policy
Person C	is currently age 65 and is now purchasing a Medicare supplement policy

The relationship between the rates of the above individuals in year T under the three basic pricing structures is shown below:

Attained-Age
- Persons A and B are charged the same rate.
- Person C is charged the rate that Person A was charged 5 years ago adjusted for trend.

Issue-age
- Persons A and C are charged the same rate.
- Person B is charged a higher rate.

Community-rated
- All three pay the same rate.
- The rate is approximately equal to the average of attained-age rates for two 70-year olds and one 65-year old.
  - ∗ The 70-year olds would pay a little less than a 70-year old attained-age premium.
  - ∗ The 65-year old would pay a little more than a 65-year old attained-age premium.

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History of Loss Ratio Minimums

The earliest mention of requiring loss ratios to meet specific loss ratio minimums after 3 years is in Subsection 9C of the July, 1988 NAIC Medicare Supplement Insurance Model Regulation. According to the report of the Medicare Supplement Subgroup to the Executive Committee on December 11, 1987, the loss ratio standards were "improved to provide enforceable requirements under which Medicare supplement policies would produce loss ratios at least equal to the model loss ratio benchmarks after three years as well as over the lifetime of the policy." The relevant language from the 1988 version of the Medicare Supplement Insurance Model Regulation is provided in Appendix 7.

The federal government then enacted the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). Two sections of that legislation are relevant to loss ratios. The first is OBRA-90's paragraph (a)(2)(A) that requires a State's regulatory program to contain NAIC standards or Federal standards. The second is OBRA–90 section (r). Specifically, paragraph (r)(2)(A) exempts a policy from the refund requirement in the first 2 years, and allows for a report containing recommendations on adjustments to the 65% or 75% loss ratio minimums in order to apply paragraph (1)(B) to the first 2 years in which policies are effective. These sections from OBRA-90 are provided in Appendix 8.

The NAIC revised the Medicare Supplement Insurance Model Regulation in July 1991. The second paragraph of subsection 9C was deleted in its entirety. This was the section containing the third year loss ratio requirement. New language was added to the first paragraph of subsection 9C requiring that "the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed." Additionally, new language stated that an expected 3-year loss ratio shall be greater than or equal to the loss ratio minimums for policies in force less than three years. These sections with revision markings are provided in Appendix 9.

The federal government then passed H.R. 5252 which made technical corrections to OBRA-90. Paragraph (a)(2)(A) was revised to specifically reference the 1991 NAIC Model Regulations and the 1991 Federal Regulations instead of undated NAIC standards. Revisions were also made to paragraph (r)(2)(A). All references to two years were removed. The refund requirement was now applicable after 12 months following issue. Additionally, the sentence referring to appropriate loss ratio adjustments no longer limited the adjustments to the first 2 years. These sections with revision markings are provided in Appendix 10.

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NAIC Medicare Supplement Insurance Model Regulation
July 1988

Section 9. Loss Ratio Standards
:
:
C. Every entity providing Medicare supplement policies in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

For the purposes of this sections, policy forms shall be deemed to comply with the loss ratio standards if: i) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (ii) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force

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Omnibus Budget Reconciliation Act of 1990 (OBRA-90)

Certification of Medicare Supplemental Health Insurance Policies
(a) Submission of Policy by Insurer
:
:
(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(c) of this section, unless –

(A) the State's regulatory program under subsection (b)(1) of this section provides for the application and enforcement of the standards and requirements set forth in such subsection (including the NAIC standards or the Federal standards (as the case may be)) ….
:
:
(r) Loss Ratios and Minimum Refund of Premiums, and/or Return of Benefits and/or Credits to Policyholders; Loss Ratio Compliance Audits

(1) A medicare supplemental policy may not be issued or sold in any State unless –

(A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology including uniform reporting standards, developed by the National Association of Insurance Commissioners,) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies;

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (1) of the amount of premiums received necessary to assure that the ratio of aggregate benefits provide to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).
:
:
(2) (A) Paragraph (1)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy with respect to the first 2 years in which it is in effect. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be appropriate in order to apply paragraph (1)(B) to the first 2 years in which policies are effective.

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NAIC Medicare Supplement Insurance Model Regulation

(July, 1988 Version Modified to Reflect July 1991 Revisions)

Section 13. Loss Ratio Standards and Refund or Credit of Premium
:
:
C. An issuer of Medicare supplement policies and certificates issued before or after the effective date of [insert citation to state's regulation] in this State shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

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OBRA-90 with H.R. 5252 Corrections

(H.R. 5252 made technical corrections to OBRA-90 and was passed in 1994)

Certification of Medicare Supplemental Health Insurance Policies
(a) Submission of Policy by Insurer
:
:

(2) No medicare supplemental policy may be issued in a State on or after the date specified in subsection (p)(1)(c) of this section, unless –

(A) the State's regulatory program under subsection (b)(1) of this section provides for the application and enforcement of the standards and requirements set forth in such subsection (including the 1991 NAIC Model Regulations or 1991 Federal Regulation (as the case may be)) ….

:
:

(r) Loss Ratios and Minimum Refund of Premiums, and/or Return of Benefits and/or Credits to Policyholders; Loss Ratio Compliance Audits

(1) A medicare supplemental policy may not be issued or sold in any State unless –

(A) the policy can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such periods and in accordance with a uniform methodology including uniform reporting standards, developed by the National Association of Insurance Commissioners,) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of the aggregate amount of premiums collected in the case of group policies and at least 65 percent in the case of individual policies;

(B) the issuer of the policy provides for the issuance of a proportional refund, or a credit against future premiums of a proportional amount, based on the premium paid and in accordance with paragraph (1) of the amount of premiums received necessary to assure that the ratio of aggregate benefits provide to the aggregate premiums collected (net of such refunds or credits) complies with the expectation required under subparagraph (A).

:
:

(2) (A) Paragraph (1)(B) shall be applied with respect to each type of policy by policy number. Paragraph (1)(B) shall not apply to a policy until 12 months following issue. The Comptroller General, in consultation with the National Association of Insurance Commissioners, shall submit to Congress a report containing recommendations on adjustments in the percentages under paragraph (1)(A) that may be. In the case of a policy issued before the date specified in subsection (p)(1)(C), paragraph (1)(B) shall not apply until 1 year after the date specified in section 171(m)(4) of the Social Security Act Amendments of 1994.

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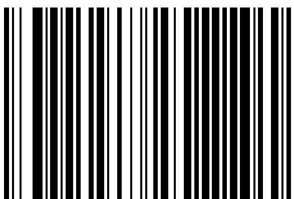

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