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INDIVIDUAL MEDICARE SUPPLEMENT PRODUCTS

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- o Is there a future?
- o Block strategies
- o Benefits
- o Regulations
- o Underwriting

MR. CLIFFORD K. POWELL: The tone of the material on this topic is "can anybody stay in it with all of these problems we're having?" I think most of us know the problems so I thought what I would try to do would be to bring a spectrum of speakers who can give you some thinking that will support a reason to stay in the business. Then you can analyze that and see if that fits your particular situation.

The first speaker is John Habig. John was until recently with Blue Cross/Blue Shield of Indiana. He does a lot of Medicare supplement business. He has now moved to Farm Bureau, but is still speaking somewhat from the perspective of Blue Cross.

MR. JOHN C. HABIG: As a student of the Society, I have to quote a study note in which I am currently heavily involved. The study note, "Financial Security Programs in the U.S," is written by Mr. Vincent Donnelly. "The future of Medicare Supplement policies was clouded when Congress adopted a major expansion of Medicare effective beginning in 1989." To reinforce Mr. Powell's comments, I think it is safe to say that the bias of the panel is that we believe that there is a future. At least in my case, I have no where to go but up. Since I have moved to Farm Bureau Insurance, currently we have a block of about 600 lives on Medicare supplement. What Blue Cross loses, hopefully I'll gain.

Blue Cross/Blue Shield of Indiana has been in the Medicare business and the Medicare supplement business since 1965. They were the Part A and Part B intermediary since the beginning in Indiana. They have also had an individual Medicare supplement policy for Hoosiers through all of this period, based on obscure records. They are obscure to me now because I can't look at them; but also because they are shrouded in the midst of history. It appears that Medicare supplement, that is to say individual Medicare supplement, made contributions to surplus through the 1960s and 1970s.

In the late 1970s and the early 1980s, there was a growth of the underlying benefit by Medicare, and at the same time Blue Cross/Blue Shield decided to expand the Medicare supplement benefits. There were two big expansions of benefits in this period. Part B coverage was expanded beyond the Medicare allowed amount to what I'll call plan U&C, the usual and customary of the Blue Cross/Blue Shield plan. It so happens that in Indiana, usual and customary is significantly higher than the Medicare allowed amount. So this was a significant benefit expansion. Also, in 1982, the plan offered a prescription drug card to the Medicare supplement enrollees with a very small copay of $5. The combination of plan U&C and the prescription drug card resulted in huge financial losses to the plan. In July 1983, the entire Medicare supplement block was cancelled and reissued. The losses were around the order of tens of millions of dollars. You can imagine that this was a substantial watershed for the plan as far as Medicare supplement was concerned.

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The new products that were offered in 1983 featured the Medicare allowed amount as the highest level of benefits. Prescription drugs were offered now as a major medical rider with a $200 deductible and 20% copay, no out-of-pocket maximum. Since 1983, the portfolio has been categorized by a fairly wide spectrum of products; that is to say from the high end of covering all Medicare deductibles, copays and the prescription drug major medical rider down to a bogus minimum benefit plan. There were also plans at intermediate ranges. In 1984, the portfolio was age rated to address entry market concerns.

In 1985, there was an actual price reduction. It turned out that coming out of the block cancellation in 1983 was some conservatism in the rating and we were starting to enjoy significant financial gains. It was felt that these should be passed back to the customer. In 1986, so-called managed care products were introduced with both a PPO and an HMO option. I'll talk about these a little bit later under block strategies. In 1987 and 1988, there were rate holds on the traditional products with the hope that the managed care products would come on-line and take over the financial risks of the block.

To give you some idea of how all this affected membership, in 1979 the enrollment was 270,000 lives in Indiana alone. I don't know what the market share was in 1979, but I suspect it was on the order of 60%. The balance was not covered or perhaps commercial insurance companies were becoming active in the late 1970s. After the 1983 cancellation, it was down to 240,000 lives. The cancellation obviously affected our business, but commercial insurance companies were becoming more and more active. By the end of 1988, the block was down to 150,000 lives. This was all in spite of the growth of the aged population. So essentially Blue Cross took it on the chin in terms of membership; however they did stem their financial losses by the block cancellation. To summarize, these are really war stories now because I was there at the time. Nothing was particularly effective in stopping the membership drop. I would attribute most of the loss to the arrival of aggressive competitors on the scene, not the least of which are my esteemed colleagues. But more importantly was the arrival of the AARP group underwritten by Prudential. AARP is second only to Blue Cross of Indiana as a carrier of Medicare supplement policies. I am not saying that Blue Cross/Blue Shield did not do a lot of silly things in the Medicare supplement market place during this era. But I would submit that it wouldn't have made any difference had not commercial carriers come along and done things better in terms of marketing and perhaps even in terms of benefit offerings.

Moving on to block strategies, Blue Cross/Blue Shield of Indiana was in what I would call a managed care frenzy in 1986. They were introducing a statewide hospital PPO and their HMO was expanding aggressively in the metropolitan Indianapolis area and was also moving into the rural areas of the state. A physician PPO was conceived for the Medicare supplement market which had two product offerings, one of which paid 170% of Medicare allowed to the doctors. The other, the low-end product, offered 140%. The plan experienced difficulties with specialists and most especially anesthesiologists in signing up for this. Basically, some counties were able to get sufficient penetration of the panel to actively start marketing. But the product did not meet marketing expectations. An HMO product was also introduced for Medicare eligibles who opted into HMOs for their Medicare benefits. Blue Cross/Blue Shield has a captive HMO.

Unfortunately at $20 a month the product was way too cheap. The Health Care Finance Administration's (HCFAs) review process for allowing a certain number of days per thousand was not sufficient. Based on experience the rate was doubled a year later and finally the product was cancelled, trying to really stem not only the Medicare supplement losses but also HMO losses in general. The traditional fee-for-service products lost ground to the managed care products in the 1986-1987 era. Now they are all migrating back as Blue Cross HMO left the market and the PPO products have not met expectations.

On the benefit side, the cadillac high-end products are always the most marketable. Currently 75% of the traditional market has the most expensive and richest benefit products. Basically all Medicare deductibles and copays are covered. Products offer U&C coverage beyond Medicare, as a percentage of Medicare allowed, not as a separate plan U&C. Specifically 170% of Medicare allowed is the high-end traditional product. This has been found to be more effective as a cost control rather than some other type of U&C. The major medical rider currently is about 90% prescription drug content.

Another feature of Blue Cross/Blue Shield of Indiana products has been concurrent processing. What that means is that the plan bought Medicare-paid claims directly from Medicare. Since the plan was also the intermediary that was a fairly straightforward process. Essentially Part A claims that had both a Medicare and a Medicare supplement liability were almost not touched by human hands. The value of this benefit was not widely recognized either by the plan itself or as a marketing tool. There was very little question as to its efficacy. Estimates have been made that the benefit of having concurrent processing was worth perhaps 20-30% of the Part B supplement coverage. The 1989 portfolio completely unbundles the Medicare supplement offering. Concurrent processing is offered as a convenience package. Prescription drugs and vision, dental and physical exam benefits are offered as options. From a regulatory standpoint, I personally feel that Medicare supplement is a relatively low-risk venture because the benefit is tied to a big social insurance program. Medicare will typically telegraph its potential changes to the public. The companies and the carriers can react to that in a fairly timely way. To the extent that the Medicare supplement carrier limits his liability to Medicare copays, I believe that it is fairly easy to prospectively rate the claim content of your benefit.

Blue Cross/Blue Shield does very little in the way of underwriting for Medicare supplement. We were able to get a question on the application that asked "Are you in the hospital currently, or are you in a nursing home?" If the answer to that question was "yes" then we asked the prospective insured to come back when they were out of the hospital or the nursing home. There were also no current preexisting condition exclusions.

As to the future, Blue Cross/Blue Shield believes that there definitely is one. Under their current decentralization program, Medicare supplement has been established as a separate distribution and marketing company with responsibility also including a long-term care product. In order to expand its markets beyond Indiana, they are looking at marketing products through a life insurance subsidiary which Blue Cross holds. There is also renewed interest in hospital PPO products -- more as a marketing tool than a managed care product. The initiative here is to work with an already established panel and price the product based on whatever fee schedule is in that panel, rather than try to impose a fee schedule on a provider community.

One need I would see in the Medicare supplement market as a whole, and it is not because of my actuarial experience but because I have parents who are on Medicare, is the need to figure out a way to show an explanation of benefits that takes the patient from the Medicare payment through the copays, through Medicare supplement, through the out-of-pocket amount so that the individual patient doesn't have to deal with three or four sets of paperwork from three or four carriers and providers. Fortunately, we impose all of this paperwork on retired people who have time to keep track of it.

At Farm Bureau Insurance, we have 600 lives covered on Medicare supplement. The loss ratios are extremely good, mostly due to strong underwriting. One of my early suggestions as an actuary was to allow the individual major medical product to be sold up to age 64 and use that as a vehicle to get more people on Medicare supplement. As a former Blue Cross/Blue Shield actuary, I look to them as a fertile source of Medicare supplement enrollees because they won't miss a few thousand and hopefully they will be my members in years to come.

MR. POWELL: As most of you know, Golden Rule is one of the largest writers of Medicare supplement in the country. These poor people at Golden Rule are actually willing to let other companies sell their products through their sponsored marketing program. If that is not faith in the future of this business, then I don't know what is. I think our next speaker can give us some idea of why they have this kind of faith and why they are able to realize the results that they are quite happy with on Medicare supplement.

MR. RANDAL E. SUTTLES: Let me modify a little bit about what Mr. Powell said. I don't think we are one of the largest writers of Medicare supplement in the country. We write a lot of it, but we have never been a real big player in it. I'll cover that soon. We are the largest writer of individual major medical. That ties in with why we believe there is going to be a pretty strong future in Medicare supplement. The reason we think there is a lot of potential there is because, having become as big as we are, we have the marketing distribution. We are looked to as a health insurance company. So the brokers writing our health insurance coverages also look to us for Medicare supplement. Now, the future in that market as we see it has changed not just because of

the Medicare Catastrophic Act; the benefits have changed and those things are going to continue. There will be changes in the future.

One of the things that has changed the marketplace is the Medicare supplement regulation that was passed by the NAIC last fall. We had a lot to do with the design of some sections of that. What they wanted to do in terms of the minimum loss ratios goes back to bogus amendments and things like that. They wanted to specify that for an individual Medicare supplement product the loss ratio had to be a certain number. They wrote in 60/65 as they couldn't decide which they wanted. Whatever it was, they wanted to start from the first day that the policy was in force. Well, on an individual product, unlike the Blues for instance, we underwrite the policies. If we are at 60% in the first year then that policy is going to be 120% in the third year. We shouldn't be selling that. We had some influence in getting that design changed in the regulation so that those loss ratios do not have to be met until after the second year. It's not a lifetime ratio after the second year. It's in the third year that you have to be at 60 or better. Then over the lifetime you have still got to meet the 60. That is important in terms of where we see the future in this market and why we have not been the biggest player in the country.

In the past, to meet the loss ratio standard, the commissions that have historically been paid on many policies are not going to be able to be paid. It has just been too high. We have never been able to pay those high commissions. Our commissions generally run half of what brokers could get elsewhere. We tell the story that we were told by a broker. Whose Medicare supplement policy was he writing? Well, for his customer he was writing from company "x," but for his mother he wrote ours. The commission was lower, the benefits were higher. It's what we have always felt is a very good product. But in terms of the future the market is going to change the new loss ratio standards. The new benefits that have to be paid have changed that market. We still see one. We have been active in it all along and have sold a good deal of it at less than the highest commissions.

Let me tell you about what the product is. I mentioned that it is medically underwritten. It is age-rated at issue. We used to have one premium structure for all ages at issue. Two years ago we changed that as we looked at what the loss ratio results were. We concluded that it just didn't make any sense to continue to take the higher ages at the same premiums, as in the ages of 65-69 for instance. So it is now age-rated at issue. Another thing we have found, and one of the reasons why it has been successful for us is that we looked at our data and have found that we can write the product very successfully at ages 64-69 or 70. When we get much above 70, the people are not going to pass our underwriting. We have recognized that and we've told the broker force that so we get a lot less antagonism from the field force. They write an application on somebody who is 74 years old and turn it in and we reject it. So we have learned where that market is and it's in the younger age band. So age rating at issue certainly helps us sell the product in that band and not in the higher ones. We still see that as the future market.

The coverages that we offer include two policies: a plain vanilla policy which covers the hospital and the Medicare copays, and the cadillac plan. We have always paid over Medicare allowable; we didn't make this change because of the Medicare Catastrophic Act. We've paid the excess doctor's charges up to usual and customary. We have always provided a drug benefit. I don't believe the new changes in Medicare are going to change that market. We also provide a foreign travel benefit. A lot of seniors travel. If they get sick in a foreign country, then Medicare is not going to pay anything. We provide a per-trip benefit for that.

As I mentioned, we are pretty tight underwriters. We have a pretty good book of business. So going in, we expect to have reasonable loss ratios and to be able to turn a profit. We also find that, in comparison with our major medical products, the loss ratios are much more stable. It has a lot to do with the benefits that are paid. There are limits in terms of the Medicare copays. The level of rate changes that we have to deal with on Medicare supplement has not been nearly as drastic as seen on individual products nor on group products. In fact, as was mentioned, Blue Cross reduced premium. We held our premiums and didn't increase them for two years. Finally, last year we did change the premiums and increased them, matching up the new product with the new coverages. But, by and large, it has been a very stable book of business, the loss ratios have been very stable, premium history has been very stable, and the persistency is very good.

One of the things that is in the new Medicare Catastrophic Act when they do begin to pay drug benefits, is a specific percentage limitation. Roughly 16% of the Medicare moneys can be used to

pay drug benefits. When that finally happens, we are likely to see that where the seniors have been told that Medicare is going to start picking up prescription drugs, it's not going to happen, at least not to the levels that everybody expects. Because they did put in this limit, I think they recognized the cost of the drugs and that this benefit might get out of line. There is going to be a need for that coverage for the public from a private source, and we provide that coverage. So to the extent that Medicare doesn't pay it, and they have satisfied a small deductible, then we will pick up the prescription drugs.

A couple of problems are the state level not the federal level. We have some states that have not approved new policies that have been filed to be sold to match up with the new Medicare coverages. There is just regulatory delay in a few states. I was at the NAIC meeting last December, and these new rules were to go into effect January 1. We were just weeks away and by and large most of the companies had not filed new products nor had they amended their old products. I won't say unanimously, but hardly any regulator that you would talk to knew how they were going to deal with this. All that they knew was that they were going to be inundated with policy filings. That kind of regulatory confusion is not going to do the market any good. That just means there are lots of senior citizens who might like to buy policies, but who can't buy them. So in terms of the future, I see the biggest problem coming from the regulatory side, not from the question "Is there going to be a market"? and "Are there benefits that the public would like to buy?" I think there are, we're certainly committed to it. In our history, we have shown that there is a large demand for it. Our product has sold very well. We just put it on the shelf and the demand pulls it through. We suspect that will continue. We continue to be a player in that market.

MR. POWELL: How would you like to work for a company that runs hospitals that are so spectacularly popular that they can give you a very large discount on your Part A deductible? This discount may be 100%. Do you think that might influence your pricing or your interest in staying in this market? We have somebody who can tell you a little more about that, the chief actuary at Humana, David Wille.

MR. DAVID WILLE: I am going to talk to you about applying the PPO concept to the individual Medicare supplement business. I am sure most of you are familiar with the advantages of a PPO. There are advantages on both sides. From the customer's standpoint, he gets a lower premium rate, possibly better coverage and a better plan of insurance. On the medical care provider's side, they get more business in the door, more volume, and they are willing to grant these provider discounts in order to get more business. Both parties gain, both come out ahead. It is because of this economic advantage on both ends that the PPO concept has made a lot of sense for group health insurance for employer-employee groups. I think it will make more sense for individual Medicare supplement in the future. But what I'm going to get into is the way Humana has applied this kind of concept to the Medicare supplement business.

I have broken this into three components: the hospital part, the physician charges, and finally prescription drugs with the common theme of the PPO arrangement. For the hospital end, as Mr. Powell has mentioned, Humana is not just an insurance company. We are an insurance subsidiary of a hospital company. That makes a big difference for the products that we sell. We are in this business primarily for one purpose, and that is to help out the Humana hospital division, to bring patients into the Humana hospitals. That is the whole reason that we sell this. We structured the plan entirely along those directions. For the Medicare Part A deductible, we cover that only if you stay in a Humana hospital. But we go a step further than that. It is not just that benefit restriction, there is actually more. If you have a physician's bill for in-hospital services and that physician takes care of you in a Humana hospital, we will pay for it. However if that same physician treats you at some other hospital other than Humana, we don't pick up the physician's bill. So we have these benefit restrictions on both sides. Both Part A and Part B direct the use of Humana hospitals. In order to sell it this way, we sell it only in limited service areas in major metropolitan areas where there are Humana hospitals. We have a defined geographic area. If you live outside of that area we won't sell the policy because we feel that you are not a good prospect to use our hospital network. It is a very limited marketing prospect. We could not sell a national account because we are just not set up in that way. So by structuring it in this way, what makes the whole thing work is the level of provider discounts that we get. The Humana group health division has substantial discounts when paying for hospital services to the Humana hospital division. It is this level of discount that makes the whole product work and keeps the prices competitive.

The physician part has been a lot harder for us because we have really not gotten it onto a PPO-type arrangement yet; or at least in most markets we are not there yet. We just pay the 20% of Medicare allowable that Medicare does not pay. We realize that is not a very good benefit. There are a lot of doctors who will balance-bill for the excess over what we pay and what Medicare pays. We haven't really solved that yet. For our marketing purposes we try to encourage the use of doctors who accept Medicare assignment. We try to have a list of such doctors available to send people to advise them. But that is not really enough. There are just not enough doctors around who are willing to accept that. So in order to go on to the next step, we are trying to move toward a more limited physician panel-type arrangement, which we have only done so far on a small scale in a couple of markets. What we are trying to do is enroll physicians who are willing to accept our level of reimbursement and agree not to balance-bill the patient for anything. From the customer's standpoint, it is a much better product. You know that if you use the panel as you are supposed to there is no out-of-pocket cost at all. The problem we have had in developing that is bringing in enough physician enrollment to make it work. Our starting point is that we pay only 20% of Medicare allowable now and we don't want to pay much more than that to get the doctors in the panel. It is hard to enroll them with that kind of level of reimbursement. The type of arrangement that seems to work better for covering the physician's cost is the Medicare risk plan (the Medicare HMO plan). I know that is kind of getting off the subject of what we are going to cover, but I think it is important to recognize the competition that exists for Medicare supplement.

The Medicare risk-type plan is very strong and very important competition to Medicare supplement. With Medicare risk the Federal government pays us a fixed amount per enrolled person. In return for this fixed capitation we cover everything through the HMO network. We take care of all doctor's charges, all hospital charges, everything that is done through our HMO. From the customer's standpoint, it makes a lot of sense. In some of our markets we are able to do this where there is no premium from the individual, 100% coverage, and no worry about deductibles or coinsurance. We cover whatever you need as long as it is through our network, through our HMO. The whole thing that makes it work though is that the payment from HCFA is high enough to cover our actual cost of delivering this service. Whether this works depends to a large extent on geographic area, and whether this HCFA payment of the Adjusted Average Per Capita Cost (AAPCC) is high enough to make the thing work. Now folks in Indiana found that it didn't work for them, but it has worked better for us in Florida where we receive a higher level of payment from HCFA. It may be that a lot of the Medicare supplement business is moving toward Medicare risk because of its higher level of benefits.

The third part is prescription drugs. We do have a drug card where you take your card to a participating pharmacy, pay your copayment up front, (no claim forms, nothing to file) and the plan pays 100%. So far we're the same as a lot of other companies. What we have done beyond that though is go another step where we do not try to contract with every pharmacy in town. We negotiate with a very small select group of pharmacies. By doing it that way, we are able to negotiate discounts from the drug stores. They give us a discount both on the dispensing fee and on the wholesale price that they charge back to us as part of the price of the drugs. We get a much better level of discount out of that than we would have, had we tried to contract with every pharmacy in the city. Again, it is the application of the PPO concept to this kind of business.

We have had some bad experience on the prescription drug part of the coverage. We have brought on a lot of this bad experience ourselves. It is our own fault with our marketing. Our underwriting standards are very liberal. If you are covered by Medicare Part B and if you are not in the hospital on the day you apply, you can have the plan. There are no medical questions, no health questionnaire, no questions of any kind; we just take them all. Plus, you can buy any one of our plans, one of which has prescription drugs. As you can expect with all of this individual self-selection, the people who buy the prescription drug coverage are the people who are going to use it. We see this all of the time. Very high users of the drug benefits are the people who buy this card. The thing that goes beyond that though is the interesting correlation between high prescription drug card use and high use of other medical services. We have tried to measure this and see how much these correlate. It has been interesting that the hospital days per thousand are 60% higher among our drug card policies than among other policyholders. So if you have high use on one side it seems to go along with high use on the other side. We also look for physician claims to see if there is a correlation there. It is a little harder to measure physician claims because we have a mixture of plans. Our high plan, our comprehensive plan, covers prescription drugs, plus we pay for the $75 Medicare Part B deductible. The lower plan, the preferred plan, doesn't cover drugs and we don't cover this $75 deductible. Anyway, we measured just the physician claims in a

recent period of time. The comprehensive plan was $242 in annual claim cost per member. The preferred plan was $123. There is a big gap in the annual claim cost. Part of that can be accounted for by the deductible. One covers the deductible and one doesn't. There is a $119 difference in the claim cost between these two. Take out the $75 deductible and there is still a $44 difference in claim costs between these two that is not accounted for just by the deductible. This $44 accounts for 36% of the preferred plan physician services. So again it shows that the people who buy the prescription drug card are also the higher users of the physician services.

Finally, I would like to talk just a little about marketing. In this line of business, as in other parts of the insurance business, it's marketing that really drives what block of business you have and whether the whole plan will work. We market, as I have said before, only in specific service areas. Our membership has gone up from 42,000 in February 1988 to just over 100,000 now. So the marketing people must be doing something right. What they do is concentrate on the positive. From a positive standpoint, we have several marketing advantages. First, we have liberal underwriting; we'll take you without the health questions. Second, we have no preexisting condition exclusion. Third, rates are below major competitors. But the reason that happens is again the PPO concept with discounts from providers allows us to have a rate below competitors. There are some negative elements from a marketing standpoint. First, we cover the preferred providers only, so if someone wants to use a hospital other than a Humana hospital, this plan just won't work for him. There is no advantage to the customer and we are not going to get that person enrolled in our plan. Second, we have no individual policy of any kind available for people under age 65, so we can't sell the package plan to a person over age 65 with a husband or wife under age 65.

We market this through our own sales force, our own full-time agents. There are about 1,000 agents in 27 offices around the parts of the country where there are Humana hospitals. A lot of their work is to follow up leads developed from our telemarketing department. We have telemarketing people on the phone using a list of phone numbers of those over age 65. They get on the phone and talk to them. The telemarketing person tries to set up an appointment for our agent to come and talk to a prospect. All our agent gets out of it is a referral. It may be a good prospect and it may not, but at least it gives the agent someone to talk to. A lot of the work is done after the agent gets in the door. Telemarketing goes only so far on this. Our successful agents have found that they don't have to rely on telemarketing to a great extent, once they get into the business and once they learn it and develop a customer base. They get a large amount of business just through referrals. They will ask you about your friends. Do your friends want it? Does someone at work that you know want it? Who else can buy it? They work the referrals and they come out way ahead in the marketing on that side.

MR. POWELL: This is kind of a fundamental problem, when you think about it. Under this contract, under certain conditions you will cover copay and deductibles with no premium to the enrollee. How would you like to compete with that? You probably are in a few markets, South Florida, for instance.

MS. BARBARA A. KELLER: Mr. Wille, what happens if a subscriber moves out of the area served by the Humana hospital? Would you cancel the contract?

MR. WILLE: We have a limited period of time that the contract stays in force. I don't know exactly how many days, maybe 90 days. But after that we do cancel. You are no longer eligible after you move out of the service area.

MR. ANTHONY J. WITTMANN: Mr. Habig, when you went to the excess Part B benefit, did you offer that as an option, or did you have the 20% of Medicare allowable on one plan and then the excess Part B benefit on another plan?

MR. HABIG: Both of those options are available. You can buy the base benefits and then you can add on what they called in marketing, the prevention package. Essentially it was U&C beyond Medicare allowed as well as other things.

MR. WITTMANN: Did you see a lot of antiselection in terms of higher nonassigned rates when there was an option?

MR. HABIG: I was interested in some of the comments that were made on people with drug coverage having higher utilization rates. In our experience the combination of prescription drug and coverage beyond Medicare allowed resulted in a higher utilization to the extent that low-end products enjoyed a very favorable selection. The drug-covered products had fairly high loss ratios. Remembering that the block was 75% high end, the product was rated to meet the targets based on that 75% block. So the low-end products kind of got dragged along with the high-end products and they weren't necessarily rated very carefully, because there wasn't very much experience on them.

MR. WITTMANN: Mr. Wille, on the Part A deductible on your participating providers in your hospitals, do you waive that deductible, or do you pay it?

MR. WILLE: No, it's an insurance contract. We issue an insurance policy that says the insurance contract covers this. But it is really easy; there is no claims form to fill out if you are in a Humana hospital. The insurance company pays the Humana hospital division. It's just an insurance benefit.

MR. STEVEN KESSLER: Mr. Wille, do you sell to the under-65 Medicare-eligible disabled?

MR. WILLE: Yes, we do sell to the disabled. However, we don't pay any commissions on it yet and that is one thing we are discussing. Do we want to get into that business? Do we want to expand? We figure if we are going to expand to the under 65, maybe we should charge a higher rate. Maybe we will justify a higher rate there than we do for over 65.

MR. KESSLER: In discussion of the drug program, what is the pliability of mail-order drugs for the market segment?

MR. HABIG: Indiana experimented with mail-order drugs. I actually left before I had any credible experience in it. I suspect it was not very widely used because the market was not used to using that kind of a thing. Since Blue Cross/Blue Shield had the benefit for several years, it's going to be an education process for the market.

MR. BRIAN K. LEONHARDT: Mr. Suttles, are you anticipating having to refile your Medicare supplement contracts each year as the benefits are being phased in under the Catastrophic Act or have you been able to build in some provisions in the contract that will make it satisfactory for the next couple of years?

MR. SUTTLES: My compliance people could tell you for sure, but I believe we have structured it so that it will be able to fit in with the changes that we have said it will make. It will follow Medicare as the Act currently exists. I am sure there are states where we have not been successful in doing that. We have had some variations state by state.

MS. KELLER: We filed at least three new Medicare plans last October in different companies that comprise the HBJ Insurance Companies. We are still having a terrible time in getting them approved. I doubt our experience is unique. In several states they say that our benefits are not explicit enough. They want us to spell out exactly what we will pay, which of course will necessitate a different form each year. I was wondering if you would mind telling us what states you are still having difficulties with.

MR. SUTTLES: I just don't know.

MS. KELLER: The Marketing Department tell us we are having more trouble than everybody else.

MR. SUTTLES: They all say that, but I don't think that is true. When the regulation was redesigned last fall, there was an appendix that specified what the benefits were going to be. It was very clear and certainly emphasized to the regulators to use standard terminology, standard benefits, standard wording. We can't have these varied state by state. That has not happened.

We have found that several states have made so many regulations that the individual people reviewing the policies can't keep up with all of the regulations. This is what slows things down. It will take a reviewer a couple of days with each policy in order to figure out whether or not it is

O.K. In fairness to the states, they have been swamped with policies, company after company. I think our policies are no more standard than the states approving standards in the language. Each state has a variant and every company has a variant. They have been swamped, but it hasn't been very helpful to the marketplace. As the law continues to change, these kinds of problems are going to continue. I don't have an answer.

MR. LEONHARDT: I was interested, Mr. Suttles, in your comments about the duration of loss ratio requirements that were adopted by the NAIC. I know that Florida and Washington have enacted the NAIC of the model legislation or a portion of it, but do you know of any other states that have? One of the things that we have seen with that requirement is the removal of the change in active life reserves from the loss ratio calculation. Could you comment a little bit on some of the discussion that went in on in that decision?

MR. SUTTLES: Florida has been the leader among the states in the regulation. They drafted it, they wrote it. I commented earlier that the standard that they applied to the individual was 60/65. The 65 was in there because Florida wanted to go to 65. I am not aware of the active life reserve situation because we are not carrying those on our Medicare supplement in Florida. But I do know in the discussions, and in the model reporting format that was submitted and approved by the committee, it does include the changes in the reserves. So for Florida to have now taken it out, I am surprised. The model reporting format had paid claims, incurred claims, and active life reserves, all of the reserves in reporting your experience year by year. I don't have any answer for you.