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MEDICARE SUPPLEMENT INSURANCE BASICS

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- Current issues

MS. DAWN E. HELWIG: The primary issues we want to focus on are: (1) what some of the requirements are for Medicare supplement policies with regard to annual filings of rates, especially relating to the draft compliance manual; and (2) what some of the requirements are for rate-refund calculations -- technically, how you go through them, where they came from, and what they're going to mean for companies in the future.

My first group of tables give a very cursory overview of Medicare benefits. The only point that I would like to make in Table 1 is that the Part A deductible is what drives the Medicare benefits on days 61-90, 91-150 (the reserve days), and skilled nursing facility (SNF) days. The reserve days are half of the Part A deductible; days 61-90 are a quarter of it; and the SNF days are one-eighth of it. For next year, currently the Part A deductible is slated to be $696. That is not cast in concrete. It was supposed to have been signed into law by September 15, but it hasn't been signed yet. The Health Care Financing Administration believes that it's going to stay at the $696 level, but there are several layers of review that the deductible has to go through, and it has to be signed off at each of those layers. It has not made it through all those review procedures yet. There is a slight chance that it's still going to change.

TABLE 1
Benefits Covered by Medicare
Versus Benefits Paid by Beneficiary
(1993 Levels)

Service -- Part A	Medicare Pays	Beneficiary Pays
Hospital		
First 60 days	All but $676	$676
Days 61-90	All but $169/day	$169/Day
Days 91-150 (lifetime "reserve" days – available only once)	All but $338/Day	$338/Day
After lifetime reserve days	$0	All costs

Note: 1994 Part A deductible = $696

Tables 2, 3, and 4 show the SNF benefits, which we've already discussed, the blood benefits, and the Part B benefits, respectively. The Part B benefit has historically been based upon Medicare-approved or reasonable charges. Typically those payments have been about 70-80% of the actual billed charges. The remainder of the billed charge was either basically "eaten" or cost shifted by the physician, or was billed to the patient if the physician was not a participating physician. The excess charges have been capped in recent years. Table 5 shows some of the miscellaneous benefits. The only thing I would add to this is that as part of the Clinton proposal,

prescription drugs would be added to the Medicare benefits. The current proposal calls for a 25% cost sharing in the premium on the prescription drugs and a $250 deductible. The Clinton plan proposes that those benefits be phased in beginning in 1995.

TABLE 2
Benefits Covered by Medicare
Versus Benefits Paid by Beneficiary
(1993 Levels)

Service – Part A	Medicare Pays	Beneficiary Pays
Skilled Nursing Facility (SNF)		
First 20 days	All approved costs	$0
Days 21-100	All but $84.50/Day	$84.50/day
Days 101+	$0	All costs

TABLE 3
Benefits Covered by Medicare
Versus Benefits Paid by Beneficiary
(1993 Levels)

Service – Part A	Medicare Pays	Beneficiary Pays
Blood		
First 3 pints	$0	100%
Additional amounts	100%	$0

TABLE 4
Benefits Covered by Medicare
Versus Benefits Paid by Beneficiary
(1993 Levels)

Service – Part B	Medicare Pays	Beneficiary Pays
Medical Expenses		
First $100 of approved amounts	$0	$100 (Part B deductible)
Remainder of expenses	80% of approved charges	20% of approved charges, plus charges in excess of approved (subject to 115% cap)

Table 6 gives you an idea of why there has been an emphasis in recent years on keeping costs down and, in particular, why the resource-based relative value scale (RBRVS) was implemented. Medicare has typically tried to hold the increases in costs per enrollee down to only about 2-3% per year. If you look at the first column, you'll see that the actual trend that the Health Care Financing Administration (HCFA) has experienced in Part B costs per enrollee has normally been double digit. Most of this difference between the 2-3% cost increases and the total increase is utilization driven. I've compared these charges to what the consumer price index (CPI) has been. You

can see from the third column that the Medicare trends have been significantly in excess of the CPI going back for the last 10 or 15 years.

TABLE 5
Benefits Covered by Medicare
Versus Benefits Paid by Beneficiary
(1993 Levels)

Miscellaneous Services - Part B	Medicare Pays	Beneficiary Pays
Home Health Care:		
Medically necessary skilled services	100%	0%
Durable medical equipment (subject to Part B deductible of $100)	80% of approved charges	20% of approved charges, plus excesses
Clinical diagnostic lab tests	100%*	0%
Pneumococcal vaccine	100%*	0%
Screening pap smears	100% (once every 3 years)	0%
Screening mammographies	80% (once every 2 years)	20%

* Part B deductible does not apply.

In an effort to keep costs down and to address what have been perceived to be "ills" in the Medicare-supplement market, there have been a number of regulations in recent years that have affected this market. The Omnibus Budget Reconciliation Act (OBRA) bills of 1989-90 implemented physician payment reforms via RBRVS. They implemented some caps on Part B excess payments. They required standardization of policies, which was implemented through the National Association of Insurance Commissioners (NAIC's) recent model act. They changed loss-ratio mandates effective November 5, 1991, and they introduced Medicare select programs. There is a compliance manual out now, still in draft form; its purpose is to try to clarify some of the issues that were required in the NAIC model law. We'll get into the current status of the draft manual and its requirements later.

The purpose of RBRVS was to try to lower the double-digit inflationary costs that Medicare has seen. The jury is still out on whether it's been successful in doing that.

Excess charges have been brought down over the last few years. Physicians who did not participate in Medicare historically were able to bill the full excess to the patients. Starting in 1991, physicians were limited in what they could bill. Their excess charge could be no more than 25% or 40% in 1991 of the actual Medicare charge; 25% was used for most services, but they could go up to 40% for evaluation and management services. This Medicare-excess-charge cap was brought down to 120% in 1992, and for 1993 and later it's 115%. I imagine many of you have seen your trends greatly dropping as a result of these cap limitations.

FROM THE FLOOR: Will there be any change in the Part B deductible?

TABLE 6
Medicare Part B Expenses
History of Trends in Part B
Costs per Enrollee

	HCFA Total Reimbursement/ Enrolee Part B Trend	CPI-U Professional Medical Services U.S. City Average Annual Change	Ratio Part B/CPI-U
1978	14.8%	7.5%	1.97
1979	13.9	8.7	1.60
1980	18.5	11.1	1.67
1981	18.8	10.3	1.83
1982	14.2	8.5	1.67
1983	20.3	7.1	2.86
1984	13.9	7.2	1.93
1985	7.5	6.1	1.23
1986	14.6	6.4	2.28
1987	15.6	6.6	2.36
1988	12.5	6.8	1.84
1989	9.5	6.3	1.51
1990	10.4	6.7	1.55
1991	6.8	6.1	1.11
1992	5.4	5.7	0.95
1993	10.1*	5.1**	1.98
1994	13.7*	5.5**	2.49

*HCFA Estimates; 1994 estimate was before MEI freeze
** Estimated
Sources: Health Care Financing Administration, 1993 Trustees Report, and Bureau of Labor Statistics Published Data

MS. HELWIG: No, there is no scheduled change in the Part B deductible at this point. It's still set at $100.

Next I'll discuss some of the requirements of the NAIC model act for Medicare-supplement policies. The NAIC model has mandated that all Medicare-supplement policies provide certain, specified benefits. The basic benefits, which are provided in what they've called Plan A, are the hospital coinsurances, 365 days of hospital expenses beyond the reserve days, the first three pints of blood, and Part B coinsurance. These are the basic or core benefits that must be in all the plan packages.

In addition, there are several different benefits that are taken in various combinations to put together the other allowable plans. Those possible benefits are the Part A deductible, Part B deductible, skilled nursing facility coinsurance, Part B excesses (which could either be covered at 100% or 80%), foreign travel, at-home recovery, preventive care, and prescription drugs. For prescription drugs, two different benefits were defined, one being a basic benefit and the other an extended or more comprehensive one. In addition, I should mention that the model left it open for allowing a company to offer "innovative benefits." I'm not aware of any company that has tried to do that. Have any of you tried any innovative benefits?

FROM THE FLOOR: Yes. We have added region care.

MS. HELWIG: What was that?

FROM THE FLOOR: It's a preferred provider organization (PPO) type of in care benefit.

MS. HELWIG: It wasn't in a Medicare select policy. It was in a basic plan?

FROM THE FLOOR: We added it in Plan C and Plan F.

MS. HELWIG: And that was in Arkansas?

FROM THE FLOOR: Yes.

MS. HELWIG: Table 7 shows how these miscellaneous benefits are put together to create the ten plans. Everyone is required to sell Plan A. That's the minimum core benefit plan that is required in every state. The other plans that are most popular that I've seen have been Plans C and F. If a company is selling a prescription drug plan, it's usually Plan I. There have been a smattering of Plans D and G, but these haven't seemed to be very popular. A few companies are offering the full array of ten plans, or at least have them in their portfolio and say they're offering them, but the majority of companies seem to be concentrating on A, C, and F. The impression I've gotten recently, too, is that Plan F, which used to be the predominant one for many companies, is falling out of favor right now. More and more people are buying something like Plan C, as more and more doctors are accepting assignment.

TABLE 7
Medicare-Supplement Standardized Plans

Benefit	A	B	C	D	E	F	G	H	I	J
1. Basic	X	X	X	X	X	X	X	X	X	X
2. Part A Deductible		X	X	X	X	X	X	X	X	X
3. Part B Deductible			X			X				X
4. SNF Coinsurance			X	X	X	X	X	X	X	X
5. Part B Excess						X	X[a]		X	X
6. Foreign Travel			X	X	X	X	X	X	X	X
7. At-home Recovery				X			X		X	X
8. Preventive Care					X					X
9. Prescription Drugs								X[b]	X[b]	X[c]

[a] Only 80% of excesses covered
[b] Basic coverage
[c] Extended coverage

The NAIC model regulation has attempted to keep down the number of forms that a company can offer. The NAIC has decided that for each of the ten possible plan levels, you can have four different types of policies. You can have an individual policy, a group policy, an individual select, or a group select. If you are in both the

regular and the select market doing both individual and group, with all ten plans, you immediately have a possibility of 40 different forms that you could be filing. Thus, you're not as limited as the ten plans may imply. In addition, within each of the different types of levels, you could sell up to five different form numbers for each type. You could have five different individual nonselect forms for Plan E, for example.

If every state had a Medicare-select program in place, which they don't right now -- only 13 states do, you'd be potentially talking about five different form levels, for four different form types, for ten different plans, for a possibility of 200 different forms. This also implies 200 different annual filings that you'd have to submit to the states. And that doesn't account for the fact that each state may ask to see its own separate experience, so you may have to have separate exhibits by state, too.

The rate-refund calculations are done at the type level. For those, you'd have the four different types for the ten different plans in 50 different states. So you'd have 2,000 different rate-refund calculations that you'd have to do by each May 30.

You can have five different possible form levels within each type. The model law has outlined the different reasons for changing or having a different form number within a particular type. The first reason is that you might want to include an innovative benefit. You could have a Plan C sold on an individual basis, and you could sell two different forms, one where it's just the generic Plan C and another one where you've added an innovative benefit. You could also change your form number if you're going to be marketing on a direct-response basis versus agent-marketed. Note that you cannot have different form numbers for different policies that are just sold by different agency marketing groups. It used to be common that a company would develop a particular form that was going to be sold by a particular brokerage operation, giving different rates and different commission structures. That's no longer allowable. If you have an individual or group agent sold form, you're going to have to have one form number and one rate for the entire agency force. You can also have different form numbers if the policy is guaranteed issue versus if it's underwritten, and you can have a different form number if you're going to sell to disabled versus the aged, but these are the only allowable reasons for having different form numbers.

FROM THE FLOOR: Speaking of the limited number of forms: Does the limit apply to the number available for sale? If you have a discontinued form, is that counted against your limit?

MS. HELWIG: There are also certain rules regarding discontinuance of a policy form.

FROM THE FLOOR: You have a new form and you get inspired and you want to get a couple of innovative benefits approved. Do you have to use a total of three forms for that?

MS. HELWIG: Yes. The question is, if you have an innovative benefit product and you decide you don't want to do that benefit any more so you change to a new innovative benefit, have you used up two of your forms? I think the answer to that is, yes. That new innovative benefit is a new form that has to be given a new form

number. However, you will be limited under the discontinuance rules in how soon you can file that new form.

FROM THE FLOOR: And if you discontinue the sale of the first, you've still used up two altogether?

MS. HELWIG: The regulation isn't really specific on that. My impression is that you can't have more than five totally. It's not just a matter that there are five that are actively being marketed. You can't have more than five form numbers filed for a particular type. Again, that's something that the regulation does not get into in any more detail and the draft compliance manual does not expand on that.

Within any particular form, you can have several different rate parameters, and the draft compliance manual delineates what some of those are. You can vary your rates by age, by sex, by family status, by smoker versus nonsmoker, by underwriting status, by area, and by rating methodology (for example, attained-age versus issue-age versus community rated). One implication of this is that you cannot have both an issue-age form and an attained-age form marketed at the same time. They have to be the same form number. The draft compliance manual has gone on to state that you cannot sell both issue-age and attained-age rates at the same time. You can change the methodology. If you are an issue-age company, you can change to attained-age rates, but you can't offer both of them at the same time.

The model act has definite rules regarding what constitutes discontinuance of a policy form. If you want to stop selling a particular form, you have to notify the commissioner at least 30 days before you stop selling it. If you have a form that you have filed with the commissioner but you've never actively sold it, the commissioner will automatically deem it discontinued if you haven't sold anything on it for 12 months. The draft compliance manual does make a slight exception to this in the case of a conversion policy, where it's available but you haven't sold any because nobody has opted to take the conversion. As long as it's been available and you've offered it, they're not going to consider that a discontinuance.

If you do discontinue a particular policy form, you can't file another form of that type and plan for five years. That gets to the question that was asked about innovative benefits, too. If you decide you don't want one innovative benefit any more and you want to try another one, this is going to limit you in doing that. You're going to have to wait five years period before you can file another policy of that type, unless you discontinue it by simply having no sales for 12 months. The NAIC is trying to prevent companies from getting in and out of the market with different policy types. The NAIC wants you to pick what you're going to do and stick with it. The NAIC also said that it considers the sale or transfer of a block of business as a discontinuance. If you've been selling Plan C and you decide that you want to sell that block of business to another company, you can't get back in and sell another Plan C for five years.

FROM THE FLOOR: Do you have anything for me on assumption reinsurance of health insurance -- if we assume the whole block?

MS. HELWIG: The NAIC would consider that a discontinuance of a form if you did an assumption of the entire block of business.

FROM THE FLOOR: If you have problems getting a new filing through the insurance department but you can't sell your existing plan, what happens? Somewhere down the road, won't it be considered a discontinuance of the existing plan, so that you're out for five years?

MR. RICHARD H. HAUBOLDT: I have a good example of what you're asking. We've seen instances in which at rate-filing time, the proposed rate increase may be zero. In other words, in the annual filing, the rate increase is zero and the state doesn't agree. The question becomes, What does that mean? Are we out of business? From a practical matter, it meant that your rates reverted to what was in force, which was in fact the old rates, which means that nothing happens. As long as you are able to sell at that old level, you won't be forced out in that situation.

FROM THE FLOOR: I have another example. Let's say you had a problem with advertising. You couldn't use your advertising forms because they're not approved, did that render you out of the market?

MS. HELWIG: Did you have those advertising forms approved earlier and now they're no longer acceptable, or are you just going in for initial approval? If you're just going into the state for the first time trying to get a policy form approved, and trying to get your advertising approved, then presumably you haven't been selling that particular product type within that state, so there's no discontinuance. If you run into a situation in which you have been selling it in the state already, and the state takes a second look at it and discovers there's something wrong with it, then I think your question applies. Is that considered a discontinuance? Hopefully the state would be reasonable about that. Until the state actually goes in there and actively disapproves of what you're already selling, you can continue to do business there. If you've already been selling, and the state takes another look at it and says you can't sell it any more, then yes, I assume it's a discontinuance, unless its a simple matter of correcting something with the state.

FROM THE FLOOR: Another example is what's happened in Florida, where there's a new rating law and a company can't continue with existing issue-age rates.

MS. HELWIG: Florida is definitely an excellent example here, because it changed October 1 to requiring issue-age rates. There are a lot of companies that have been selling attained-age-rate products, have submitted new filings for issue-age rates, and by October 1, did not have their issue-age rates approved yet. Technically they are out of business in Florida until they can get them approved. If that goes on for a year and they don't get their rates approved, hopefully Florida would make some exception in that case, but it could say, you haven't sold this for a year, so you're out for five years now.

FROM THE FLOOR: Is there any minimum standard for how much business has to be sold to qualify as active business?

MS. HELWIG: No, there is not. Only where the compliance manual talks about the exception of the conversion policy. "Actively" is not defined anywhere.

Only one type of rating methodology is allowed. The draft compliance manual explains what is considered a change in rating methodology. Earlier we were talking about how you could sell only issue-age rates or attained-age rates, one or the other. You can't sell both of them at the same time, but you can change from one rating methodology to the other. The draft compliance manual defines a change in rating methodology as "a change in demographic rating classes, which is actuarially equivalent to the current rating practice under reasonable assumptions." Actuarial equivalent is not defined; reasonable assumptions are not defined. If you change from issue-age to attained-age rates and want to change your lapse assumption, are they equivalent rates? I don't know the answer, and that's not discussed in the compliance manual, but they do give examples of what they consider a change in rating methodology. You could change your age structure from community to issue age to attained-age. You could change your class structure. You could have unisex rates and switch to male, female. You could have a single rate structure and switch to smoker, non-smoker. All those things would be considered to be within the same form number and would just be changes of rating methodology. The compliance manual says that you cannot have more than one of these rating methodology structures offered at one time. You can't have, in one part of the state, one brokerage force selling a product that is age-banded and, in another part of the state, one that separates its rates by age. That's not allowable. There is one exception: an area-factor change is not considered a change in rating methodology. You can make revisions to your area factors as part of your annual rate review process.

FROM THE FLOOR: As I recall from wording of the draft, changes in area factors are not rating methodology changes. Let's say you don't rate by area in a state and then you want to area rate. Would that be considered a change?

MS. HELWIG: I think it's going to depend on the state. If a company has gone in with a particular area rate and then reduced that area factor so that it is ending up with a lower rate for that particular block of business, some companies have taken the position that they don't need to file that with the states. There are states that would disagree with that practice. Florida, for example, wants to know every single change in rate, even if you take a particular zip code and you move it from having an area factor of 1.3 down to 1.0; the state wants to approve it beforehand. Most states take the position that if you had one rate for the entire state and now you're going to switch to having four or five area tiers, they need to have that filed and approved.

FROM THE FLOOR: I understand that if you're going to change rates, you have to have them filed and approved, but would it be considered a change in methodology? We've been into standardization for a couple of years now. Let's say that beginning in 1994 you're going to produce area rating in the state. Do you apply those area factors to the in force? It would be a change of methodology as I understand it when the old is rated under one methodology and the new is rated under a separate methodology. For area rating, how would that apply?

MS. HELWIG: I have had situations in which I've changed the area factors and made them apply to existing business. When I've done that, I haven't considered it a change in rating methodology because I haven't proven that they're actuarially equivalent to the rates that were there before. In many cases, if I'm changing my area factors, I'm probably doing it because experience in the state is better or worse than originally expected, and I'm modifying the area factors to reflect that. I consider that more of an experience increase or an experience adjustment to the rates, rather than a change in the rating methodology. I file it in the memorandum that way, stating that the rates need a 10% experience increase and this has been affected by making a change in the area factors.

MR. HAUBOLDT: There are two things there. One, you have a change in the factors versus you have one rate for the entire state and you want to introduce area factors. The latter is similar to a situation in which I have a community rate, but now I want to do age and sex rating. That's one of those situations that they would consider a change-of-rating methodology. The same would be true if you went by detailed zip code and you now wanted to go to one rate for the entire state, or vice versa. That's my opinion, and states may differ on that.

MS. HELWIG: I think that's what the draft compliance manual is talking about when it states that a change in area factors does not constitute a change in rating methodology. What it's referring to is going in and fine-tuning area factors, or adjusting them, based on experience. It's not a total change from not area-rated to area-rated, and it doesn't address that issue. What happens there is going to be on a state-by-state basis.

MR. HAUBOLDT: One complication that you can get into is, for example, say you have ten areas now, and as you get the experience, you find out that one of those areas should have been subsidized further. Many of us would look at that and say this is a correction of one of our assumptions. We're not really changing the methodology as much as if we had one whole area and now we're going to have 10 or 15. However, there is the potential that it could be interpreted by the state as a change in methodology.

MS. HELWIG: If you do decide to change your rating methodology, the model regulation states that it's not considered a discontinuance if you do the following two things. First, you have to submit an actuarial memorandum that describes the differences between the two sets of rates. In my opinion, the language leaves it open for you to change some assumptions. For example, you could change your lapse rate slightly, as long as you describe that in your memorandum. That's an untested area right now. Second, the model regulation states that if you do make a change in rating methodology (for example, if you switch from issue-age rates to attained-age rates), all subsequent rate changes cannot cause the percentage differential between the discontinued and current rates to change. In other words, you need to take the same rate increases on both sets of rates going forward. If you have an issue-age policy and an attained-age policy, you cannot take a different rate increase on the issue-age policies versus the attained-age policies in the future.

FROM THE FLOOR: Can we change our operating expense assumption from 30%, for example, to 25%.

MS. HELWIG: The question is if you start out with an expense load or an expected expense level that was 30% of premium and that changes to be 25% of premium, so that your expected loss ratio could go up, do you need to file that as a change of rating methodology? I would say, no. The company could always make the corporate decision that it's going to increase its loss ratio from 65-70%.

FROM THE FLOOR: Can it decrease it too?

MS. HELWIG: You obviously can't go below 65%. Decreasing is a little different because it depends on what you certified to the state in your initial filing. If you originally certified that you had an expected loss ratio of 70%, you would have to go back to the state if you wanted to modify that downward to 65%.

FROM THE FLOOR: If you want to modify your expense loading, would that be considered an assumption change or a rate methodology change?

MS. HELWIG: I would consider that an assumption change. If a change in your assumption is going to cause you to go back to the insurance department and say, "We originally filed this at 70%, but our expenses have increased. We don't feel we can stay at 70% any more, and we need to request 65%." That doesn't fall into the category of a rating methodology change. If you had originally filed and said your loss ratio is expected to be at least as great as 65%, you don't run into that problem. However, some states, such as Florida, may want to know exactly what the expected loss ratio is. That is something that's not covered in the compliance manual.

MR. HAUBOLDT: We have found it difficult to justify a rate change due to change in expenses in various states. One of the things the compliance manual is trying to do is to make you come out up front and say what your lifetime loss ratio target is going to be. You can be off on your expenses just as you can be off on your costs, but from a practical viewpoint it's been very difficult to get a rate increase through because you missed the expenses. If it would cause you to go from a 70% target to 65%, I can see where the state may try to enforce your certification of 70% on these premiums, and, effectively, the state says that it might put you in a loss position if you can't get the expense side under control. From a practical standpoint, that's what I've seen when people had expense problems. I would consider it an assumption issue.

MS. HELWIG: I have one last comment regarding subsequent rate changes that do not cause the percentage differential to change. Florida used this clause as the rationale for why it would not allow a company to switch from issue-age rates to attained-age rates, or vice versa. The feeling was that if you have an issue-age-rate scale and then switch to an attained-age-rate scale, it is impossible to have the same percentage rate increases going forward on those two products. This is because the attained-age-rate scale person would be moving up the attained-age scale, and the rate increase would be a different percentage than on the issue-age policy. Florida is the only state that took that position, but that was the reason for not ever allowing a company to change from one to the other. Now Florida has mandated that everyone has to be on an issue-age basis.

MR. HAUBOLDT: I'm going to talk briefly about rate filings: new-product filings, annual filings, and rate-revision filings. While the compliance manual has been issued as a draft at this point, to give guidance to regulators, insurance companies will be looking at the manual to see what they need to comply with. I'd like to take an informal survey via a show of hands. Rank yourselves on a scale of one, two or three: one meaning that you're trying to comply with every aspect of the compliance manual, two, that you're complying with some; and three, as little as possible. Is anybody at level one, where you're trying to comply with every possible thing there? Only one. How about two, where you're complying with some aspects, but not all? Most everybody. How about three, those complying with as little as possible? Nobody at that level.

There's a lot of information in the manual about supplying state experience. It comes down to credibility; is it worthwhile to show the state experience? States vary greatly on what they're requiring now. We've seen some come back with a set of questions indicating that they are going through the compliance manual and asking for everything that is in there. Other states have not changed things too much as far as filing requirements. Many companies look at this as only a draft compliance manual, therefore it's just a guide and that's all it means at this point.

One of the things that has come up is what happens to your existing business. Technical corrections to the NAIC model were introduced before and were tacked onto the recent budget bill, but they didn't go through. If they ever go through, existing business will be subject to a rate-refund requirement, which means that everything that you had in force as of November 5, 1991, would be subject to a refund.

Right now, without the technical corrections, there are several things in the model regulation that still apply to existing business. Benefit standards for existing business are basically similar to the Plan B benefit. On older policies, there's probably not much problem with compliance on this. There are some rules about sickness causes that have to be reimbursed at the same level as accidents, that you'll automatically update your benefits for changes in Medicare deductibles and coinsurances, and that the only nonrenewal basis is going to be for failure of premium payments. These standards are not too much different from before. There are some broad based claim payment standards. You must accept the Medicare carrier statement to make your payments from; you must notify the physician or beneficiary of the outcome of the payments; and you must pay physicians directly. The annual rate filings are the biggest change. Initially when the standardized plans came out, many companies were asking if they actually have to file the rates for all business. The answer is, yes. In addition, reporting of multiple policies will be required. You need to report if you sold two policies to a customer. While there are questions on the applications about duplicate coverage, the way I interpret the NAIC model act is that you must report if you sold two policies to a particular person.

There will be basically three types of filings: your new product filing, the annual filing, and the rate-revision filing. The latter two could be combined. It's important to notice what the purpose of each filing is. For the new product, it's to demonstrate loss ratio compliance, and I emphasize demonstrate. More and more we see states wanting to see a demonstration of how you get to the target loss ratio as well as

certification. In addition, in the new product filing you are requesting approval of the rates.

You'll need the usual general policy benefit description. One of the things that has come up in here is that you must give the date the policy was approved by the home state. If you don't have it approved, it could hold up the filing. If your home state is slow in the approval process, that slows you down throughout the entire nation. In the initial filing, you'll have to justify if you're going to have a different form and also you must describe the method of conversion, if it's a group policy.

As with most new product filings, you have to describe your methodology assumptions. We have seen more emphasis on this. The compliance manual has a checklist of information, and many states are now accumulating averages. If you list your assumptions, you may find out that you have to go back and actually justify where they came from, be it experience or whatever.

Continued information required in the new product filings are your rate sheets and factors. On the factors, the states want everything. It used to be that area factors fell through the cracks. Maybe you had something out there initially, but companies would make changes. Now, they want to see everything. We've had requests recently for plans that use underwriting selection factors: What are they? Where did they come from? How did you get to them?

The average annual premium per policy is something that is required. The key item is going to be the loss-ratio projections and demonstrations. For a new product, you're going to have to show that you can meet the lifetime loss ratio. As Dawn said earlier, stating that the loss ratio is expected to be at least 65% may not make it in some of the states. They will come back and ask, What that loss ratio is exactly? How did you obtain it? We have had questions from states, asking us to go step by step, showing the process. The key there is demonstration, and you're also going to have to demonstrate that you made your third-year target. Even though you may have your ten-year-policy loss ratios listed in the filing, you may get questions back to actually show how you got those ratios.

FROM THE FLOOR: When you say the third year, you mean the third policy year?

MR. HAUBOLDT: The third policy year, yes. Finally, with a new product filing there is an actuarial certification required. They have given you two things you're supposed to certify. One, that you're in compliance with the laws and regulations of the state. You have to make sure that you understand what those may be and they could differ from state to state. Second, that the rates are reasonable in relationship to the benefits. This may cause a dilemma because the compliance manual explicitly states that there will be subsidies among different rating characteristics. Primarily, the guaranteed-issue people will be subsidized. You cannot charge more for those people than anyone else because of adverse selection. The states know there will be subsidies, but yet they want you to say the rates are reasonable in relation to benefits. There's no guidance there on how much of a subsidy can exist and still have a reasonable relationship. So far I have not seen any states come back with questions on that. You have to be careful that you're in compliance with your actuarial standards of practice as well as what is required in the law.

As I mentioned before, annual rate filings are required for all forms of business, existing as well as new business. Some of the same information is required for the annual filing as well as for the new filings. They want to see all the rates, rating schedules, and any supporting documentation that will indicate what you're using for rates. The purpose of the annual rate filing is twofold. One is to demonstrate loss-ratio compliance and the second is to get approval of the rates. Even if you're asking for no rate increase, you have to do a filing to get approval to continue to use those rates. It is an approval process, therefore you need to justify that your current rates are still valid even with no rate increase.

You need to demonstrate compliance with three separate loss-ratio measures. Because this assumes that you have some experience, the state would be looking at your accumulated past experience, plus the present value of future experience to see if you're on track with the lifetime loss ratio that you certified to in your initial new product filing. Also, you would look at the present value of the future loss ratios so that you don't recoup past losses in the future. Finally, you need to look at your third-policy-year loss ratio target to see that you meet 65% by that time. For plans that are only in their first or second duration, you may have to demonstrate that you still believe you will make your third-year target.

Rate increases may be part of the annual rate filing, or they can be separate; it's up to each company how best to present that. You need to keep in mind that the annual filing is done using a form. When you do your rate refund calculation, that's done on the plan-type level. You've got your business cut different ways. Thus, when you look at taking rate increases on a particular form, you need to keep in mind where you're going to be by plan, by state, etc., when you do rate refunds.

A final item is that there are no more automatic rate increases. This relates to the pre-standardized days in which companies often had a claim cost and associated premium for every $4 change in the Part A deductible coinsurance benefits. Many companies interpreted this to mean that they did not have to file that increase or get it approved. The increase was filed with the initial contract. If the Part A deductible went up *x* number of $4 units, they would just apply that automatically. You can't do that anymore. You must actually file for approval of your rates. Even if you had such a mechanism, you'd have to go through the steps and say you'd like to apply this; it would be similar to a rate-increase filing.

For all business, the annual rate filing is going to be at the form level versus plan and type levels. That presents a dilemma from a practical issue of how you're going to track things and get everything organized. Most of the time at the company level, you're trying to make it as efficient as possible and cut down the number of filings and experience reviews. Some grouping is allowed for rate-increase filings so that you could account for old blocks of business. One of the problems with the annual rate filings being by form and the refunds by plan and type is that you could very easily have a situation where rates go up and down. If you look at experience by form, but don't keep in mind where you're going to be under the refund issue, you may find out that you're going to have to give a refund on a form on which you just increased the rate. It's prudent to take a look at both levels and then take action from there.

The purpose of the annual rate filing is to show loss-ratio compliance and get approval of rates. You'll need to show general policy descriptions, benefit descriptions, rate sheets, and factors. Some other additional information, which in the past has not always been required, is the rate history for at least five years and in-force counts since inception by state and nationwide. These requirements were added by the compliance manual. Many companies believe that state-by-state experience is not going to be credible and may not have actually provided that this year-end. It seems that, other than a few states, Florida being the example, we have not noticed many states coming back asking for the state information if it wasn't included.

FROM THE FLOOR: If there are some policy forms that are so small that you can hardly draw any statistical conclusions from the data, how do you account for them?

MR. HAUBOLDT: The first thing that I would do is appeal to the credibility of it and justify your standard of credibility. Some people have gone to the rate refund calculation and used the credibility standards there.

FROM THE FLOOR: Couldn't you do some grouping of policy forms?

MR. HAUBOLDT: It may also make some sense to do some grouping at that point. You could recognize potential expected benefit differences, varying by group. The thing to keep in mind is that the refund is required at the plan-type level. You could go through the annual filing process and do some grouping, but sooner or later you're going to have to look at things at the plan-type level. If your business is small enough, you may not have a problem with refunds because of the credibility factors. However, you may find some states may not like grouping for the annual filings.

MS. HELWIG: It's going to come down to how closely the states follow the draft compliance manual, which states that you can do some grouping, but only on the older, nonstandardized forms. It does not allow any grouping on any of the standardized forms. I have found that many companies are not selling much of Plan A at all. So many of the filings I did this year on Plan A had totally noncredible experience. Even though there was very little experience there, I did a separate filing. Then I made the projection for future experience based on pricing assumptions and said in the memorandum that the experience is totally noncredible. Even though the compliance manual allows grouping on the older, nonstandardized forms, that's only for the rate-increase filing. It still says that the annual filing has to be separated by form. If you want to combine the two filings, you have to them separate by form. Again it's going to depend on whether the states are going to follow the draft compliance manual to the n-th degree, because if they do, it may imply no grouping.

FROM THE FLOOR: Does that mean that we have to have 10,000 life years exposed to decide if it's credible?

MS. HELWIG: The draft compliance manual leaves it up to the company to decide what your measure of credibility is going to be. I chose to use the credibility table from the refund calculation, but I chose "noncredible" to be something at the bottom of the table. It's going to be at the actuary's discretion, but you have to be able to justify to the state why you used the measure you did.

MR. HAUBOLDT: The advantage of using something out of the refund calculation is not necessarily that that's right, wrong, or whatever, but you're saying the compliance manual happens to already use some type of credibility measure. You may feel that it is not the right level to do at all, but the advantage of using something like that is that it's been accepted. I think you'd be able to offer a reason why you think credibility ought to be based on *x* life years.

The last thing is certification. For the annual filings, a few points are listed in addition to those for new rate certifications. One, you must certify that the assumptions are your best judgment for expected values, and they are consistent with the issuer's business plan. Two, you must certify that the lifetime, the future, and the third-policy-year loss ratios are above what the standard calls for. Three, you must certify whether or not you had any change in the rating methodology and that you maintained the proper relationships between policies that had different rating methodologies. The compliance manual says if you have two different rate methodologies, those two methods must always get the same percentage increase. Four, the filing has been prepared based on standards put out by the Actuarial Standards Board. Here's where we get into how much subsidy you have in rates for guaranteed-issue policies and whether that is reasonable in relationship to benefits.

There are some references in the compliance manual to the fact that the loss-ratio standards may need to be adjusted if you have any prefunding. With issue-age rates, obviously you would have that. The compliance manual comments that this perhaps might require a different scale of expected loss ratios to compare to, other than a flat 65% at every duration, but nothing has been determined at this point. In the past, for the later years your slope of claim costs would be rising with an issue-age premium that's level, and you would probably not have much difficulty in showing that your expected future loss ratio exceeded a flat 65% minimum standard. However, the 65% standard would need to be adjusted to reflect the expected future loss ratio at that later policy duration. The manual also requires that what you look at is incurred claims divided by premiums; you cannot look at anything adjusted for active life reserves. The same is true in the annual filing. Also, if you have trend in your claims, you must have trend in your premiums. Remember that the annual filing is not necessarily for rate increases.

There is some guidance given in the draft compliance manual for allowable slopes by age and rate relationships by plan. From the experience I've seen, the age slopes don't match what I think is most appropriate. They are intended to be guidelines, but we have had numerous questions come from states questioning the slope in our loss ratios. We've gone back and given them actual experience. One of the things I find most interesting is that the drug slope in the guidelines is completely flat. Also, we've had a lot of questions on the Part B costs, for which the guidelines tend to be flat and narrow. The manual has also shown examples of the claim cost slopes for various plans. So the most important thing is to be able to justify your slope, whether it be with experience or however you decide that those are the most reasonable assumptions. The manual does specify that for discounting your present values or accumulating your past experience, the minimum interest will be the valuation rate.

Rate revision filing requirements are going to be similar to the annual filing and the new product requirements. Here you must have approval by the home state, which could slow things down, and you must indicate whether the form is open or closed. The scope and reason for the rate increase must be in the filing.

More information on the rate increase methodology and assumptions must be given. Interestingly enough, even though the manual indicates that expense assumptions could be excluded, we have often seen requests at rate increase time for what the expenses are. Perhaps that gets back to the earlier question of what to do if your expenses aren't coming in as expected. Perhaps the states are trying to monitor that as well. If you had a change in rating methodology at rate revision time, you must demonstrate the equivalence, and you must show the annual premium before and after the rate increase.

You'll need year-end premiums, incurred claims by duration, annual premiums, and policies in force to get to historical claim costs. You're going to need to compile, track, and justify your experience by Part A versus Part B, or even further by the pieces within there, the A deductible, the B coinsurance, etc. You may also need to keep track of how much of the rate increase last year got in this year's experience, when it got in, how it affected your premiums, when your rate increase is expected to be filed, and will you get it in on January 1?

You'll need to make assumptions on lapse rates, underwriting selection factors, and trends. We've seen more questions recently asking for justification for these and the experience of the company. Any seasonality effects need to be accounted for, such as when you have experienced the Part B deductible claims. The claim cost per unit is much higher earlier in the calendar year than later. Last but not least, the effect of shock lapses must be accounted for in antiselection, and it may not only be because of rate increases. When you have a rate increase, people decide whether to persist or not persist. Those that have lower expected claim costs usually are those that will drop out. The same thing can happen upon normal lapse; the people who are lapsing may be the lower cost people. So you may be getting antiselection all the time, even without a rate increase. Once you've gotten a projection made, then you need to take a look at what you do for a rate refund.

MS. HELWIG: Is there anybody who is actively selling Medicare select or who came because they want to know more about Medicare select?

FROM THE FLOOR: I want to know more about it.

MS. HELWIG: Effective November 5, 1991, the loss-ratio standards for Medicare supplements changed to 75% for group, 65% for individual, and 65% for mass-marketed policies. However, the NAIC model drafting note suggested that for mass-marketed policies the loss ratio also be set at 75%. I don't think too many states have gone with that. Most mass marketers feel that the expenses of mass marketing are much more like those of individual policies, and they really belong with the 65% loss ratio. Prior to the most recent NAIC model with the rate refund calculations, it was "hit or miss" among the states whether or not they looked at the annual rate filings and how closely they monitored loss ratios. We had situations with states where they didn't allow any kind of rate increase until you were already at the 60%

lifetime loss ratio. If you've got any kind of prefunding in your premiums and you get to a 60% loss ratio without getting any rate increases, you're in big trouble, because your loss-ratio curve is going to continue to go up from there and you're going to be grossly deficient over the lifetime. There were other states that basically approved any filing that was put before them.

The rate-refund calculation was put into the last NAIC model in an attempt to bypass these variations that existed among the states and to get something in place that would objectively measure whether rates were deficient or redundant. As of now, these rate-refund calculations apply only to standardized policies, with one minor exception, which we'll talk about more. They do probably apply to nonstandardized policies that were issued after November 5, 1991. Until technical corrections passes, these refund calculations don't apply to any of the old, nonstandardized business sold before November 5, 1991.

Table 8 is a copy of the refund calculation form. The basic concept of this rate-refund calculation is very simple. All it's asking you to calculate is your inception-to-date loss ratio on the particular plan. You get to leave out the current year's issues, but otherwise you calculate an inception-to-date loss ratio. You also get to adjust that for credibility. If the experience for that plan is not totally credible, you can add something into the loss ratio to adjust it. Then you're going to take the credibility-adjusted loss ratio and compare it to a benchmark.

If your loss ratio is less than that benchmark, you have to give a refund. This entire worksheet is basically going through that calculation. In the first line, you're taking your current year's experience and subtracting out the current year's issues. Current year's issues are considered to be too new and too heavily based on reserves to be credible. In line two, you add in all the prior year's experience to get your grand total experience, claims incurred and premium earned. In line two, when you add in the past year's experience, it's not simply a matter of going and pulling what last year's form said. This is because the draft compliance manual asks you to restate the claims from prior year's experience, so that you're using an accident-year-of-incurral method for claim liabilities. You're not supposed to just use claims paid plus change in claim reserves throughout the year. You're supposed to actually replace the liability from last year with claims paid over the year plus the new estimate of liability.

You're then allowed to take your premiums and, in lines four and five, subtract out the refunds that you gave in the past so that you're left with the earned premiums less refunds. Line seven is where you enter the benchmark loss ratio. This is what you're going to be comparing to, and it's taken off a completely different worksheet. In line eight you calculate your experienced loss ratios since inception, and in line nine you look at your life years exposed from the table down at the bottom. You can see that if you have less than 500 life years exposed, this table is giving no credibility to the experience. If you have 500-999 life years, you basically get to add 15 points on to the loss ratio that you just calculated. If you were only at a 35% loss ratio, you'd get to restate it and say you were at 50%. In line ten, you bring in that tolerance margin from the credibility table. In line eleven, you are calculating your actual loss ratio adjusted by adding the tolerance margin in. Line twelve is your adjusted incurred claims. That's what the hypothetical incurred claims would have been if you had that full tolerance.

TABLE 8
Medicare Supplement Refund Calculation Form
For Calendar Year _____

TYPE: _____ SMSBP(p): _____
For the state of: _____
Company Name: _____
NAIC Group Code: _____ NAIC Co. Code: _____
Address: _____
Person Completing This Exhibit: _____
Title: _____ Telephone Number: _____

		Earned Premium	Incurred Claims	
1.	Current Year's Experience			
	a. Total (All policy years)			
	b. Current year's issues			
	c. Net (1a–b)			
2.	Past Year's Experience (All policy years)			
3.	Total Experience (1c + 2)			
4.	Refunds Last Year (excluding interest)			
5.	Previous Since Inception (excluding interest)			
6.	Refunds Since Inception (excluding interest)			
7.	Benchmark Ratio Since Inception (Ratio 1)			
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)			
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop			
10.	Tolerance Permitted (from credibility table)			
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)			If Line 11 > Line 7, a refund/credit is not required
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11			
13.	Refund (Line 3, Col. a – Line 6 – (Lines 12/7)) De Minimus Amount (.005 x Annualized Premium IF at 12/31)			The refund is only paid if it exceeds the DeMinimus Amount. The distribution methodology must be filed also.

Medicare Supplement Credibility Table	
Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000-9,999	5.0
2,500-4,999	7.5
1,000-2,499	10.0
500-999	15.0
If less than 500, no credibility.	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

It's your earned premium less refunds multiplied by the adjusted loss ratio. In line 13, you calculate the refund. Here you're first calculating what earned premium you would need to have to support the benchmark loss ratio. To do that, you take your adjusted claims incurred with the tolerance margin in there, divide it by the benchmark loss ratio, and then compare that to actual earned premiums. If those actual earned premiums were greater than the earned premiums that would have supported the benchmark ratio, you have to refund the difference.

Table 9 is the sheet that you have to go through to calculate the benchmark ratio. This sheet is a lot less complicated than it looks. The only column where you have any numbers to input on this sheet is column B, where you're inputting earned premiums. The earned premium that goes into column B is only the premium that is earned on policies issued in a particular year. If we were doing this form in May 1997, the experience year that we would put on the top would be calendar year 1996. Then "year one" is the current calendar year minus one, or 1995. What you'd actually put in column B for year one would be the earned premium in 1995 on policies issued in 1995. Year two would be earned premium in 1994 on policies issued in 1994, etc. It's only the premium earned in the year of issue. What the rest of this worksheet is doing is hypothetically calculating what the inception to date earned premium and incurred claims on those blocks of business would be, given some preestablished lapse assumptions and loss ratios. If in year one we had put in premiums earned in 1995 on policies issued in 1995, then the very first factor, 2.770, would indicate that you need to multiply those premiums by 2.770 to estimate cumulative premium earned on that block as of a year and a half later.

Likewise, the cumulative loss ratio would be 44.2%. You're going to end up adding all these down, i.e., all the years of issue, and at the bottom you'll have the benchmark loss ratio. They have split this sheet into two different sections. Columns C through F are identical to columns G through J. In columns C through F, you're concentrating on the first two policy years of experience, and columns G through J you are concentrating on the third and later years.

Underlying the calculation of the benchmark loss ratios and interest in the factors that are used to calculate cumulative premium or cumulative claims are certain basic assumptions, such as what lapsed rates were going to be, what selection was going to look like, and what loss ratios by duration were going to be. This slide basically outlines what those various assumptions were. It's helpful to know these because if your historical experience differs materially from these assumptions, it potentially could affect the timing of your refunds. First of all, they assume that the lifetime loss ratios are achieved over a 15-year period and that policies are uniformly issued throughout a calendar year. They've assumed a 10% trend in both premiums and claims. Their loss ratios by policy year were assumed to be 40% the first year, 55% the second year, 65% the third year, and then grading on up for individual forms. The group loss ratios were exactly 75/65 of these. You may note that this particular pattern of selection is quite a bit steeper than what most companies who are doing minimal underwriting would actually experience.

TABLE 9

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year _____

(Company Information)

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.157		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k)		(l)		(m)		(n)		

Benchmark ratio since inception: (l+n)/(k+m):

(a): Year 1 is the current calendar year - 1, year 2 is the current calendar year - 2, etc.

(Example: If the current year is 1991, then year 1 is 1990; year 2 is 1989, etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

That has an advantage for most companies in the sense that it's going to delay the refunds a little bit. You're going to be comparing your actual experience, which you may have anticipated to have a 55% first-year expected loss ratio, to a benchmark loss ratio, which was based on 40%. Thus, you're going to look good for a few years and it may delay refunds a little bit.

The lapse rates that have gone into the calculation of the loss ratios have been 30% in the first year, 25% in the second, 20% for three years, and then 17%. This is supposed to include both voluntary lapse and mortality. They may be a little low for a company that has traditionally sold through a brokerage market, but may be high for a Blues' plan or captive agency market.

If you take the given assumptions -- the loss ratios, the persistency assumptions, the claims, and premium increase assumptions -- and calculate the expected present value of future claims over present value of future premiums with a 0% interest rate, that you would get exactly the 65% lifetime loss ratio. Note that they use a 0% interest rate. If you use a higher discount rate, such as 3%, you are going to be getting a 63.8% lifetime loss ratio with these particular assumptions. If you use 5% interest, you're only getting a 62.9% lifetime. Thus, there's a little bit of margin here. If you use a 5% discount rate in developing your premiums, you're going to avoid having to do rate refunds, while only getting a 63% lifetime loss ratio.

Let's go through some of the practical issues on how the rate refund calculations are done. First of all, the calculations must be done for all forms of a given type combined. In other words, all your individual Plan A's are combined into one rate-refund calculation; all the group Plan A's are combined into one rate-refund calculation; etc. You don't do a separate rate-refund calculation for each of the individual forms that you have out there. The rate-refund calculations must be separated by state. This is where we get into the potential for 2,000 different rate refund calculations. It has to be completed by May 31 of each year. If you do need to give a rate refund, it has to include interest from December 31 to the date of the refund. The actual rate of interest will be set every year by the Secretary of the Department of Health and Human Services. It has to be at least equal to the average rate of interest for a 13-week Treasury note.

If you do have to give a refund, the refund must be completed by September 30 of each year. One of the implications of this is that it makes premium vouchers or premium credits nonworkable for a company that has a lot of annual business, because an annual-mode policy will potentially not have received that premium credit by September 30. The whole transaction is supposed to be completed by September 30. The incurred claims that go into the rate-refund calculation must exclude claim expenses and guaranteed renewable (GR) reserves, and the earned premiums must include the model loadings and policy fees. This is different from what we historically were allowed to do, where many times you could restate your premiums to be on an annual-mode basis. That's not allowable any more.

If technical corrections never pass, the rate-refund calculation would technically apply to all policies issued after November 5, 1991. This is the NAIC's interpretation. The NAIC has written to the Health Care Finance Administration (HCFA) for verification, but so far HCFA has not responded. The NAIC technically does not have the

authority to require a rate-refund calculation on those policies sold from November 5, 1991 until the date the states passed the model regulation, because it was the federal government that mandated the 65% loss ratio for policies sold in that interim. The states did not have the laws in place to do that. The NAIC feels that it doesn't have the jurisdiction to require states to do rate-refund calculations on policies sold in that interim, but HCFA may require it. If you did a rate-refund calculation for the policies issued after November 5, 1991, it should have been done by May 31, 1993, and you should have done the rate-refund calculation just on those policies that were issued from November 5, 1991 to the end of 1991. The refund calculations were supposed to be kept separate by form number.

If technical corrections ever passes, things are going to be different. Then all policies, whether they're standardized or prestandardized, that were in force as of the effective date the state passed the NAIC model will be combined together and put into one rate-refund calculation with an effective date that's equal to the effective date of the state regulation. This has some implications for the way companies are keeping track of their date. As things stand right now, without technical corrections, you need to be separately tracking the experience on prestandardized forms sold after November 5, 1991, and you need to know the experience by issue year and by calendar year on those forms. If technical corrections ever passes, you're going to have a different block of business that you need to be keeping track of separately, including any standardized forms that may have been sold in a particular state before the state passed the model regulation. Those standardized forms would have to be included with all the old, prestandardized business experience. In other words, if you decided to start selling standardized forms everywhere on January 1, 1992, but the states rolled in the effective dates of the model regulation, you would have to go back in every single state, figure out what date the state's regulation became effective, and then pull out the experience on any standardized policy sold before that date in that state. You have to be keeping track of the experience both ways, in case technical corrections is ever passed.

If technical corrections does pass and you need to do a refund calculation on all the old, prestandardized business, you're going to use the same benchmark loss ratios as you do for standardized, even though the old business may have been sold at a 60% lifetime loss-ratio requirement. The feeling of the drafters of the compliance manual was that you're going to be treating this older business as having been issued on the date the regulation was passed, and it should be in the later policy durations, therefore you should have no problem meeting those higher benchmark loss ratios.

According to the draft compliance manual, the policyholder needs to be placed into the state of issue, not residence. This could cause some real accounting problems for companies. Everyone participates in the refund, even those in their first year. Even though they weren't included in the experience, they still get a refund. Last, you cannot use your rate-refund calculation as part of your justification in your annual rate filing. Your annual rate filing has to use assumptions that are company specific.

The draft compliance manual gives you several different options for how a refund can be given. You can give it in equal amounts or equal percentages. You can vary the amount of the percent by issue year. You can vary the amount of the percent by form. This may give you some flexibility if you have a grouping of forms, one of

them with a high loss ratio and the rest low. If the low ones predominate and you need to give a rate refund, you may be able to submit a refund plan that doesn't give as much refund to the people on the high loss ratio form. However, the compliance manual does say that you have to give some refund to everybody, even those that have the high loss ratio form.

MR. HAUBOLDT: One thing to point out is about open enrollment issues, and what you can and cannot do. You cannot charge smoker or standard rates to a 65-year-old if nonsmoker and preferred rates are available. Florida is a notable exception to this. On guaranteed issue, you must charge the lowest rate in most states. In Florida, it's just the opposite. They want you to charge the highest rate to the guaranteed-issue people.