RECORD OF SOCIETY OF ACTUARIES
1993 VOL. 19 NO. 1B

MEDICARE SUPPLEMENT

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- Compliance with NAIC requirements
- Medicare-select products

MS. DAWN E. HELWIG: So much has happened with the Medicare supplement during the last couple of years. We're planning to talk about the requirements of the NAIC model regulation and model act and then talk about the draft compliance manual and additional requirements. For background, I'm going to first discuss just some of the changes that have taken place in the Medicare supplement regulations during the last couple of years. As you would expect, Medicare supplement policies cover a substantial portion of the beneficiary obligation. Medicare is broken up into Part A and Part B. Part A services cover hospital and skilled-nursing facility (SNF). Hospital benefits are broken down by length of stay. During the first 60 days of hospitalization, Medicare covers all but the Part A deductible. For 1993, that is $676. For days 61-90, it covers all but $169 per day. For days 91-150, which are known as the lifetime-reserve days, it covers all but $338 per day. After the lifetime-reserve days are exhausted, nothing is covered. Notice the relationship between these numbers. The benefit for the reserve days is one-half of the Part A deductible, and the benefit for days 61-90 is one-fourth of the Part A deductible.

The skilled-nursing-facility benefit is one-eighth of the Part A deductible after the first 20 days. So Medicare pays $84.50 per day. But this benefit is paid only for a skilled-nursing-facility stay that follows a hospital stay.

There also is a miscellaneous blood benefit. The beneficiary is responsible for the first three pints of blood.

On the Part B side, Medicare pays on the basis of what are referred to as the Medicare-approved amounts. They're also called the Medicare reasonable amounts. These charges are the ones that Medicare has determined to be reasonable. They used to be based on the physician's own fee schedule and the usual, customary or prevailing charges. That's in the process of being replaced by the resource-based relative value schedule (RBRVS). The amounts that Medicare has approved and finds reasonable are typically only about 70-80% of the actual billed charges.

Physicians who have chosen not to participate in Medicare, commonly called the nonpar physicians, can bill the excess charges, the amounts above the Medicare-approved, directly back to the beneficiary.

There's also a $100 deductible on the Part B side. The first $100 of Medicare-allowable charges are excluded. Medicare covers 80% of the remainder, with the beneficiary being left with the 20%, plus any excess-charge amounts above the Medicare allowable. The Omnibus Budget Reconciliation Act (OBRA) has introduced some caps, but we'll get into those in more detail later.

Some limited home-health-care benefits and some screening, pap smears and mammographies are being covered.

One of the main reasons that Washington finally decided that a few things needed to change with Medicare was that it was seeing rather large increases in the amounts that it was reimbursing on the Part B side per enrollee, shown in the second column on Table 1. In fact, going back to 1978, there are only two years where those amounts were not double-digit increases.

TABLE 1
Medicare Part B Expenses
History of Trends in Part B
Costs per Enrollee

	HCFA Total Reimbursement/ Enrollee Part B Trend	CPI-U Professional Medical Services U.S. City Average Annual Change	Ratio: Part B/CPU-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	11.1	6.1	1.82
1992	12.9*	5.7	2.26
1993	11.0*	6.5**	1.69

* HCFA Estimates
** Estimated
Sources: Health Care Financing Administration, 1992 Trustees Report, and Bureau of Labor Statistics Published Data.

This was despite the fact that the Health Care Finance Administration (HCFA) was limiting the amount by which it was increasing the reasonable charges to only about 2% a year. So the rest of the double-digit increases were coming from increases in utilization. The physicians were making up for low reimbursements by increasing frequencies. If you compare the change in total reimbursement per enrollee to the change in the medical-care component of the CPI, you'll see that it's been generally 1.5-2.5 times medical inflation. So the RBRVS was implemented to keep these costs down.

In 1989 and 1990, two different OBRAs were passed. The first is to reform the way that physicians are reimbursed for the work that they do, in an effort to keep down the rate of increase in the cost per enrollee. The change in the physician-payment practices was accomplished by introducing RBRVS, volume performance standards, and Part B caps.

For the rest of this session, we're going to talk about some of the other major changes. Starting in 1992, policies were required to conform to a standardized set of benefits. Loss ratios were mandated to be either 65% or 75%, along with requirements for rate refunds, if those loss ratios were not met. The Medicare Select program was introduced.

I'm going to briefly discuss RBRVS and physician-payment reform, and then we'll turn to the other topics.

Under RBRVS, physician fees are based on the product of three factors. The first is a work factor that measures the amount of work that a physician must do. It does not vary by physician. In other words, if a surgeon and a general practitioner perform the same operation or procedure, they should be paid the same amount. That was the theory behind having a common relative-value unit to reflect physician work.

There was recognition that the amount paid for a particular procedure should vary because malpractice costs vary, and practice overheads vary by specialty. So there are really three different relative-value units. They are all adjusted by a geographic factor. The geographic factor, however, only applies partially to the physician work component. Finally, the units are multiplied by a conversion factor to convert the relative-value units into actual hard dollars.

The RBRVS is in the process of being phased in right now. Beginning in 1992, anyone within 85-115% of the value determined by RBRVS went directly to the RBRVS value. Everyone else went to a weighted average of what they had before and the RBRVS. By 1996, it's supposed to be fully operational, and everyone will be paid according to the RBRVS schedule.

The last thing I want to touch on regarding the OBRA regulations is the limit on nonparticipating physicians' charges in excess of the Medicare allowable amount. Prior to the OBRA legislation, the sky was the limit. If you've ever looked at the amounts that nonpar physicians charged in relation to the Medicare allowable amount, you saw that many specialists, in particular, charged 200-300% of the Medicare allowable amount. Caps were phased in beginning in 1991. Anyone who provided evaluation and management services could bill up to 140% of the Medicare Allowable Amount. For other than evaluation and management services, they could only bill up to 125%. The cap has steadily decreased. From 1993, the maximum amount that a physician can bill is 115% of the Medicare allowable amount. With that, we'll get started on actually describing what the model act has required.

MS. DIANE R. SEAMAN: The first thing I'd like to mention is that the model act applies to virtually all Medicare supplement with a few exceptions, those being employer plans and labor-union plans.

The model act requires ten standard benefit plans. Those standard benefit plans have some basic building blocks. The first of those building blocks is common to all ten plans. Sometimes you'll hear them called basic benefits, sometimes they will be called core benefits. The core benefits consist of the hospital coinsurance, 365 days of hospital days beyond the lifetime reserve days, the first three pints of blood and the Part B coinsurance amounts.

The second building block is the Part A deductible and the third is the Part B deductible. Then we go on to the SNF coinsurance and the Part B excess charges, covered at 100% of the excess or 80% of the excess amount. There's also a foreign-travel building block, with an annual maximum. The at-home recovery benefit is a bit different from the current home-health-care benefits. The at-home recovery benefit is specifically for assistance with activities of daily living. There is no medical-necessity requirement.

Preventive care is another building-block benefit. This is one that has generated much concern. It's wide open. Some specific services are mentioned in the model act: annual physical, mammography and other types of screening: cholesterol, diabetes, etc. Then there's a catch-all category: any other preventive service determined appropriate by the physician. The benefit does have a $120 annual maximum, so that's a safeguard.

The last building block is prescription drug benefits. There are two plans; one is basic, and the other is extended. They both have a $250 deductible and 50% copayment. The difference is in the annual maximum benefit paid. The basic plan will pay up to $1,250 a year, and the extended will pay up to $3,000.

To arrive at the ten standardized plans, the NAIC took the nine or ten building blocks, scrambled them up, and created ten plans. The ten plans that we have to deal with include the basic core package, and all but one of the plans include the Part A deductible. The "A" plan is the only one that does not.

The plans are arranged from A to J, A obviously having the lowest benefit content, J having the highest. The intention was that the plans grouped in the middle would have approximately the same cost. From Table 2, you can see that they didn't just take a stair-step approach; they mixed things up in the middle.

TABLE 2
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(1)		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(2)	X(2)	X(3)

(1) Only 80% of excesses covered
(2) Basic coverage
(3) Extended coverage

I'd like to switch gears now and talk about Medicare Select, which originated from OBRA 1990. Medicare Select refers to Medigap policies that have some restriction

for payment or require that a certain provider be used. It works in either a PPO or an HMO context. The program was designed as a 3-year, 15-state pilot, with the states chosen by the HCFA. As you might suspect, several states have large concentrations of retirees, which makes sense. The states are Alabama, Arizona, California, Florida, Indiana, Kentucky, Missouri, Minnesota, Ohio, North Dakota, Texas, Washington, and Wisconsin. As of November 18, 1992, only 13 states were authorized. The designation of the two remaining states is pending.

FROM THE FLOOR: What other two states are pending?

MS. SEAMAN: I'm not aware. There were two slots open at the end of 1992, but there may be more than two under review now. There was actually one state, I believe it was Oregon, that had been appointed as a Medicare Select state and then withdrew.

With Medicare Select, the carrier is required to do some extra work. The Medicare Select program has to be approved by the commissioner. You need to first file a plan of operation. That plan of operation has to demonstrate that there's availability and accessibility of services, subject to what I'll call a restricted network. To use the term PPO would be a bit misleading, because an HMO might be involved. It must also include a definition of the service area, a description of a grievance procedure, a description of the quality-assurance program, and a complete list of network providers by specialty. That list must be updated and submitted to the commissioner quarterly.

For a Medicare Select plan, the in-network benefit is fairly simple. It must follow one of the ten standardized plans. For out-of-network benefits, there are the standard kinds of PPO and HMO restrictions. In other words, you cannot impose a penalty because there was an emergency or the service was not available or accessible on an in-network basis. The model is otherwise silent on what the out-of-network benefits must look like.

An HCFA representative made a presentation at a meeting I attended and indicated that when the guidelines were drafted, it was the intention that the out-of-network benefit design be unrestricted. In other words, zero benefits out-of-network would be permissible. There is at least one state, however, that I'm aware of, that does not share HCFA's philosophy. When a Medicare Select plan is filed in that state, the out-of-network benefits must meet certain minimums.

Another facet of Medicare Select is that there are several "must-offer" categories. At initial application, the applicant must have the opportunity to purchase a non-Select policy.

As an aside here, the use of the words *any* and *a* or *one,* in the Model Act is rather confusing. For example, one could interpret "any" to mean "each and every" or "any one of." The compliance manual clears some of this up. So, if you're reading the model act and wondering if you need to offer your whole portfolio to a Medicare Select applicant, look at the compliance manual first.

At the request of someone in a Medicare Select program, you must also offer non-Select coverage of comparable or lesser benefits, and you cannot require evidence of insurability if the policy's been in force for more than six months.

Recall that Medicare Select is a three-year pilot. What happens if at the end of three years it's not reauthorized, and you have many Medicare Select policyholders in force? Well, the model also covers that. At that point, you are required to offer a Medigap policy, without network restrictions, of comparable or lesser benefits, without evidence of insurability.

Another facet to Medicare Select is the additional administration it requires. There's a series of disclosures to the applicant. Some of the disclosures apply to nonSelect also. For example, the outline of coverage is the same for Select and nonSelect. Then there are the additional disclosures for Select plans, due to the use of restricted networks. These include listing the network providers, the out-of-network benefits, emergency and out-of-service-area coverage, the limitations on referrals, and a description of quality assurance and grievance procedures. You must inform policyholders of their rights to purchase other Medigap policies. The insurer must get a signed receipt from the applicant, acknowledging that the disclosure has been made. So as you see, there's a lot of additional paperwork associated with the Medicare Select programs.

MS. HELWIG: Next we're going to cover what I would guess is one of the main reasons most of you are here -- a fear of the rate-refund calculations.

As you know, the OBRA legislation changed the minimum loss ratios on Medicare supplement policies. Group policies were raised from 70% to 75%. Individual policies were raised from 60% to 65%. These used to vary somewhat by state. Many states were already at 65% and 75%, but the OBRA legislation made this official for all states.

The OBRA legislation left the minimum loss ratio for mass-marketed policies at 65%. The NAIC was not thrilled, so it added a drafting note to the model regulation. The drafting note said that the NAIC really thought it should be 75%, but it couldn't override OBRA. The drafting note encouraged states to consider a 75% loss ratio. As you can imagine, there was much protest from mass marketers. They felt that the expenses associated with mass-marketed policies are much more akin to those of individual policies, therefore the loss ratios ought to be 65%.

Note that the loss-ratio standards are effective for policies issued after November 5, 1991. This is before the time most companies started selling the standardized forms. The result is a strange little window between November 5, 1991 and January 1, 1992, the date on which some of the states started bringing in the standardized policies. So there's about a two-month window of sales where most companies were selling their old forms but were subject to the new loss-ratio requirements of 65% and 75%. It probably depends somewhat on the state in which you're domiciled. For example, during the regular year-end filings, Illinois started asking companies what they had done to their rates for policies issued after November 5, 1991 to guarantee that they would meet 65%.

This becomes an issue with the rate-refund calculations also. The model would indicate that the rate-refund calculations apply to standardized forms only, but the NAIC made it clear at its last meeting that it also intended the rate-refund calculations to apply to any policy issued after November 5, 1991. So if you issued nonstandardized forms for a couple of months and then switched to your standardized forms in 1992, you do need to file a rate-refund calculation on those few months' issues by May 31 of this year. We'll get more into that a little later.

Prior to the implementation of the OBRA legislation, the loss-ratio enforcement was very sporadic and varied greatly from state to state. Some states took a very strict stance and didn't allow any kind of rate increases until cumulative loss ratio had reached 60% or whatever the requirement was. Obviously, by that point in time, it's really too late. You're well in excess of 60%. On the other hand, some states approved almost any filing. As a result, the NAIC introduced the rate-refund calculation in an effort to provide more uniformity among the states' review of compliance with loss-ratio requirements.

I'm going to spend a fair amount of time actually going through the details of the rate-refund calculations. I'd like to concentrate on the mechanics first – what the refund calculation is trying to do and how it's done. And then we'll get into some of the theory behind it; where they came up with these strange-looking factors that appear on the worksheets.

Chart 1 is a copy of the rate-refund calculation form. The basic concept behind it is really very simple. Forget about the trees for a minute and take an overview of the forest. All they're really trying to do here is calculate your inception-to-date loss ratio on a given block of experience. They allow you to exclude any experience on policies just issued within the most recent calendar year. Then you compare the inception-to-date loss ratio to a benchmark loss ratio, calculated on yet another worksheet. They allow some leeway in your actual loss ratio, depending on the credibility of the experience. If your experience is not very credible, you can add up to 15 points to your actual-experience loss ratio. You compare this actual loss ratio, including credibility adjustment, to the benchmark.

If your adjusted, actual loss ratio is not as large as the benchmark, you must provide a refund. The amount of the refund is such that it would put you in the same financial position as if you had met the benchmark loss ratio.

First we'll go through the mechanics, then we'll work through a numerical example. On the first line is your current calendar year's experience, less the experience on the policies that were just issued in that calendar year. In other words, they're in their first calendar year after issue. You're required to list both the earned premium and the incurred claims on the worksheet. There are some parameters for the definitions of earned premium and incurred claims, which we'll cover later.

On the second line, you enter the grand total of all the prior years' earned premiums and incurred claims. You should be able to pick these up from the experience form that you prepared last year, with the exception that claims incurred should be updated to reflect claim liability run off. The draft compliance manual specifies that you use run offs, rather than claims paid plus change in claim liability.

CHART 1

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 Years 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 De Minimus 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 _____

The third line simply adds together the first two lines to get the cumulative inception-to-date experience, excluding the current year's issues. In lines 4, 5 and 6, you subtract any past refunds from premiums earned. In effect, you take credit for any prior refunds that you've had to provide. You do not, however, get to take credit for the interest paid on the refunds. You just subtract the refunds.

On the seventh line, you enter the benchmark loss ratio, calculated from another worksheet and posted to this worksheet. On the eighth line, you enter the loss ratio that you have developed, the actual inception-to-date incurred loss ratio.

The ninth line is used to determine your credibility. You look at the actual life years that you have exposed since inception on the policy. The credibility table is shown at the very bottom of the worksheet. You determine how many life years you had exposed since inception, find it on the table, and that is the amount or the percentage that you get to add into your actual, incurred loss ratio.

So, if you had less that 500 life years exposed, there's no credibility. Between 500 and 999, you get to add 15 points into your actual loss ratio. So if you've only experienced a loss ratio of 30%, you treat it as though you've experienced a 45% loss ratio for purposes of finishing this form. If you have more than 10,000 life years exposed, it's considered to be fully credible, and you're using the actual loss ratio for the rest of the form.

FROM THE FLOOR: Is this by state and by plan?

MS. HELWIG: Yes, this has to be filled out on a state-by-state basis. I'll get into that in more detail later.

FROM THE FLOOR: Is the tolerance factor also on the same basis?

MS. HELWIG: Yes, it's on a state-by-state basis.

FROM THE FLOOR: And plan by plan within that state?

MS. HELWIG: Correct.

FROM THE FLOOR: So if you do well in one state, but not in another state, what happens?

MS. HELWIG: Too bad. You make a refund in one state and get your lumps in the other. There's no sharing or cost-subsidization among states or plans in these calculations.

FROM THE FLOOR: Does this just apply to the standardized plans, or does it apply also to prior plans?

MS. HELWIG: At the moment, they include any plans that were issued after November 5, 1991. That's the magic date. But, this may change with technical corrections. But we'll discuss that in more detail later. So if you sold nonstandardized plans for a period of time before you introduced your new 1992 standardized

plans, those plans have to be put through this worksheet. And they have to be put through on a form-specific basis. So if you sold five or six different Medigap plans, you have to fill out a worksheet for each one of them, for each state in which it was sold.

FROM THE FLOOR: On line 1, current year's experience, would total experience be the same as net experience for November and December 1991 issues? Because current year's issues (1992) are zero?

MS. HELWIG: That's right, assuming you started selling your standardized plans on January 1, 1992, the date some states adopted the model regulation.

So if you only sold the nonstandardized plans from November 5, 1991 to December 31, 1991, then you have 1991 cumulative experience, but you have no issues in 1992 on most blocks of business. So in filling this out for 1992, you'd have something on line 1(a). Line 1(b) would be zero; you wouldn't subtract anything, because there were no 1992 issues. So line 1(c) would equal line 1(a). The grand total, line (3), would represent all 1991 and 1992 experience on those policies issued November 5, 1991 through December 31, 1991.

FROM THE FLOOR: So for the ones issued in 1992 with the standardized form, do you need to fill these out, showing zeros? Or, do you need to fill them out at all?

MS. HELWIG: I don't think you need to fill them out, but that's still an open question. I don't think the states are expecting them this year. For the standardized policies that you first start issuing in 1992, they're not really expecting to get these forms until May 31, 1994.

FROM THE FLOOR: But they are expecting them for the November and December 1991 issues?

MS. HELWIG: They are expecting it for those two months' worth of issues, from November 5 to December 31, 1991. And they're expecting those by May 31, 1993.

Getting back to the worksheet, let's move down to Line 11. Line 11 takes the actual inception-to-date loss ratio that you've experienced and adds in the credibility allowance. So you've restated your actual loss ratio. Line 12 adjusts the earned claims by taking the actual earned claims and adding in that same allowance for credibility tolerance. In other words, the earned premiums are multiplied by the new, adjusted loss ratio.

Finally, the refund that needs to be given is determined by comparing the earned premiums that you actually collected to the earned premiums that would have supported the adjusted loss ratio. The difference between those two earned-premium amounts is what needs to be refunded. There is a de minimus amount, however. If the calculation yields a refund that is less than one-half of 1% of annualized earned premium, you don't need to bother with it.

The worksheet that is used to calculate the benchmark loss ratio is the one that was used in the prior worksheet. This worksheet (Table 3) appears to be much more complicated than it actually is. The only column that you need to enter numbers in is column B.

TABLE 3

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

(Company Information)

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cummulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cummulative 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.

The footnotes explain what column A and column B represent. In column A, year 1 represents the current calendar year minus 1; year 2 is the current calendar year minus two, etc. For example, suppose this form had been around forever and we were filling this out for calendar year 1992. Year 1 would be calendar year 1991, year 2 would be calendar year 1990, etc. Looking at what has to be filled out in 1993, we need to be doing a 1992 filing. The only policies that will fall into this are those issued from November 5 to December 31, 1991.

The earned premium on those policies is what goes into column B, but only the earned premium on those policies in the first calendar year after they were issued. In other words, for 1991 issues, it's premium earned on 1991 issues in 1991. Any 1992 premium earned from those policies is ignored. In fact, it never comes into this form. That's because this worksheet is calculating the theoretical earned premium that you would have generated for policies issued in that year under a particular set of assumptions. But, I'll get into that in more detail later.

The mechanics of this worksheet are really very simple. In column B, you fill in the earned premium on policies issued during the year, just for the first calendar year of issue. The rest of the form is calculation. Column D is calculated as columns B times C, producing an estimate of the theoretical cumulative premium for each of those cells in the first two years after issue.

Then column H is an estimate of the cumulative earned premium for the third and subsequent policy years. I don't know why they separated out the first two policy years from the third and subsequent, but basically the process for columns C through F is repeated in columns G through J. Columns C through F apply to the first two policy years, and columns G through J apply to years three plus.

FROM THE FLOOR: I may be able to give some insight here. I was involved in the development of the form. The original intention was to tie into the 65% loss-ratio requirement in the third year. I'm sure that they now wish they hadn't designed the form this way.

MS. HELWIG: They also require you to show the third-year loss-ratio requirement in the annual filing. Because this a theoretical calculation, I think it's confused most people.

Back to the worksheet. Again, columns F and J are calculating the theoretical cumulative claims incurred. Grand totals are at the bottom identified as items k, l, m, and n, which add the theoretical premiums earned and the theoretical claims incurred. Dividing one by the other, you get the benchmark loss ratio, which is the number that goes onto the prior worksheet.

Next, I'd like to work through a numerical example. Table 4 is a hypothetical set of numbers, assuming the following: we have experience through calendar-year 1996; we started selling standardized plan A in 1993; and we have four years of experience to date. We're filling out the form in 1997 for calendar-year 1996. The three numbers that I have highlighted across the diagonal are the only three numbers that you need in filling out the benchmark worksheet. The numbers are $210,000, $415,520 and $511,921.

Table 5 is the completed benchmark page, with those same three numbers filled in to column B. Those are the only three numbers in this benchmark calculation sheet that are based on the company's own actual experience. Recall that we're doing this for calendar-year 1996, so year 1 reflects year 1995, year 2 reflects year 1994, and year 3 reflects year 1993. The rest of the worksheet is calculation. The result of going through the mechanics is a benchmark loss ratio of 48.6%.

The numbers that are highlighted on the lower right in Table 4 are the only numbers that you need for completing the refund worksheet. You need to know the actual 1996 earned premium and incurred claims on policies issued in 1996, and you need to know some grand totals, 1996 and cumulative.

In this particular example (see Chart 2), the company needed to refund about $134,000 of premium in this particular state. Their benchmark ratio was 48.6%, and its actual experience loss ratio was only 42.1%. Its adjusted loss ratio, after adding a 5% credibility tolerance margin, was really 47.1%. But that fell short of the benchmark of 48.6%, so it had to make a refund.

TABLE 4

Example of Rate Refund Calculation

Assume the following is the financial history for this policy type and benefit package:

1. Policies are assumed to be issued July 1 of each calendar-year;
2. "In force" is the annualized premium at year-end;
3. "LYE" is the number of life years exposed; and
4. No refunds have previously been paid.

Issue Year		Calendar Year				
		1993	1994	1995	1996	Total
1993	Premium	**$210,000**	$374,640	$302,938	$262,212	$1,149,790
	Claims	$73,500	$147,588	$143,237	$137,302	$501,627
	In Force	$420,000	$329,280	$276,595	$247,829	$247,829
	LYE	300	510	368	284	1,462
1994	Premium	$0	**$415,520**	$741,288	$599,412	$1,756,220
	Claims	$0	$151,704	$304,446	$304,021	$760,171
	In Force	$0	$831,044	$651,535	$547,289	$547,289
	LYE	0	530	901	649	2,080
1995	Premium	$0	$0	**$511,921**	$913,267	$1,425,188
	Claims	$0	$0	$186,899	$375,078	$561,977
	In Force	$0	$0	$1,023,841	$802,692	$802,692
	LYE	0	0	583	991	1,574
1996	Premium	$0	$0	$0	**$630,686**	$630,686
	Claims	$0	$0	$0	**$230,260**	$230,260
	In Force	$0	$0	$0	$1,261,373	$1,261,373
	LYE	0	0	0	641	641
Total	Premium	$210,000	$790,160	$1,556,147	**$2,405,577**	**$4,961,884**
	Claims	$73,500	$299,292	$634,582	**$1,046,661**	**$2,054,035**
	In Force	$420,000	$1,160,320	$1,951,971	$2,859,183	$2,859,183
	LYE	300	1,040	1,852	2,565	5,757

FROM THE FLOOR: Who is eligible for the refund? Is it only the lives covered during 1996, or 1995?

MS. HELWIG: There's a little leeway given to the company to come up with a plan. Policies in force at the end of the calendar year, in this case 1996, are eligible for that refund. That includes, however, any policyholders who are in their first policy year, even though their experience has been out of this. They have to be allowed to share in that refund. There is not much equity in that one.

This set of assumptions is used to develop the factors in the benchmark worksheet (see Table 6). They assumed that the lifetime loss ratios could be achieved over a 15-year period, that policies were issued uniformly throughout the calendar year, and that there was 10% annual trend in premiums and claims. There were specific assumptions regarding loss ratios by policy year (40%, 55%, 65%, 67%, 69%, 71%, 73%, 75%, 76% for three years, 77% thereafter [individual forms]) and lapse rates by policy year (30%, 25%, 20%, for three years, and 17% thereafter). The loss ratios by policy year are those that were used for individual forms. For group, you would take these loss ratios and multiply by 75 over 65.

TABLE 5

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year 1996

(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	$511,921	2.770	$1,418,021	0.442	$626,765	0.000	0	0.000	0	0.40
2	415,520	4.175	1,734,796	0.493	855,254	0.000	0	0.000	0	0.55
3	210,000	4.175	876,750	0.493	432,238	1.194	$250,740	0.659	$165,238	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)	4,029,567	(l)	1,914,258	(m)	250,740	(n)	165,238	

Benchmark ratio since inception: (l+n)/(k+m): 0.486

(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.

CHART 2

Medicare Supplement Refund Calculation Form
For Calendar Year 1996

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 Years Experience			
a. Total (All policy years)	$2,405,577	$1,046,661	
b. Current year's issues	$ 630,686	$ 230,260	
c. Net (1a-b)	$1,774,891	$ 816,401	
2. Past Year's Experience (All policy years)	$2,556,307	$1,007,374	
3. Total Experience (1c+2)	$4,331,198	$1,823,775	
4. Refunds Last Year (excluding interest)	0		
5. Previous Since Inception (excluding interest)	0		
6. Refunds Since Inception (excluding interest)	0		
7. Benchmark Ratio Since Inception (Ratio 1)	0.486		
8. Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.421		
9. Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), else stop	5,116		
10. Tolerance Permitted (from credibility table)	0.05		
11. Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)	0.471		If Line 11 > Line 7, a refund/credit is not
12. Adjusted Incurred Claims (Line 3, Col. a - Line 6) x Line 11	2,039,994		required
13. Refund (Line 3, Col. a - Line 6 - (Lines 12/7)) DeMinimus Amount (.005 x Annualized Premium IF at 12/31)	133,679		The refund is only paid if it exceeds 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 _____

TABLE 6
Medicare Supplement Rate-Refund Calculations
Assumptions Underlying the Development of Benchmark Loss Ratio

(1) Year	(2) Loss Ratio	(3) Persistency	(4) Cummulative Persistency	(5) Rate Level	(6) (4)x(5) Premium	(7) (2)x(6) Claims
1	40%	0.700	1.000	1.000	1.000	0.400
2	55	0.750	0.700	1.100	0.770	0.424
3	65	0.800	0.525	1.210	0.635	0.413
4	67	0.800	0.420	1.331	0.559	0.375
5	69	0.800	0.336	1.464	0.492	0.339
6	71	0.830	0.269	1.611	0.433	0.307
7	73	0.830	0.223	1.772	0.395	0.289
8	75	0.830	0.185	1.949	0.361	0.271
9	76	0.830	0.154	2.144	0.329	0.250
10	76	0.830	0.128	2.358	0.301	0.229
11	76	0.830	0.106	2.594	0.275	0.209
12	77	0.830	0.088	2.853	0.251	0.193
13	77	0.830	0.073	3.138	0.229	0.176
14	77	0.830	0.061	3.452	0.209	0.161
15	77	0.830	0.050	3.797	0.191	0.147
Total					6.430	4.182

Discounted Loss Ratio	
Interest Discount	Loss Ratio
0.0%	65.0%
3.0	63.8
5.0	62.9
8.5	61.6

FROM THE FLOOR: Are the premiums assumed to be annual?

MS. HELWIG: Yes, no modal loads are assumed.

At a 0% interest rate, the present value of the future claims (4.18) divided by the present value of the future premiums (6.43), results in the 65% required loss ratio. So there's really a little bit of leeway here. First of all, you are not required to incorporate any kind of interest rate assumption into this calculation. In addition, the assumptions regarding loss ratios by policy year are generally more favorable than most companies are experiencing, particularly if they're doing guaranteed issue or limited underwriting. The effect is really to delay when a rate refund would have to be given. If you have got a select curve that's much flatter than this, you're going to end up giving refunds in the later years. So most of these assumptions are really to the benefit of the company.

Although the NAIC ignores the effect of interest in the benchmark loss ratio, the draft compliance manual recommends that the current life- or health-valuation interest rate be used in doing the projections that are part of annual rate filings. So you are

required to bring interest into that, but interest is not really a part of the rate-refund calculation.

FROM THE FLOOR: So when you file rates, you can file your rates a little bit higher than they would otherwise be? Then when you run it through the refund calculations, it's giving you extra profits, because you're now using a zero rate of interest.

MS. HELWIG: Yes, but it's really just for purposes of calculating what refund is due and not what's going to go into your statements in any way. Does that answer your question?

FROM THE FLOOR: Yes.

MS. HELWIG: Table 7 is an example of how the factors in the benchmark worksheet were actually calculated. Just remember that the factors on the benchmark worksheet are intended to take premium earned for issues in a given calendar year and come up with the theoretical, cumulative premium or claims incurred on that block of business. So, by using our numerical example from 1992-96, the factors that are in that worksheet need to represent what you need to multiply your 1992 earned premiums by to get the theoretical cumulative premiums for that three-and-a-half or four-year period.

Let's now discuss some of the practical issues of performing the rate-refund calculations. First of all, all forms of a given type are combined separately. In other words, by using standardized plan A as an example, all individual plan A forms are combined. The same applies to all group plan A forms, all individual-select plan A forms, and all group-select plan A forms.

TABLE 7
NAIC Rate-Refund Calculation
Development of Factors for Benchmark Worksheet

Policy Year	Premium Pattern	Premium Earned (Pattern x 2)	Assumed Loss Ratio
1	1	2	40%
2	0.77	1.54	55
3	0.635	1.27	65
4	0.559	1.118	67
5	0.492	0.984	69

FROM THE FLOOR: What about the comment earlier in the presentation that group business is excluded?

MS. HELWIG: This would be individual or group that does fall within the regulations. So it wouldn't be true employer-employee types of groups, but other groups that do fall under the regulation.

All standardized forms of a given type in each plan are combined together for purposes of the rate-refund calculation. There's different treatment, however, for the

nonstandardized plans that were issued after November 5, 1991. Those have to be kept separate by policy form.

The rate-refund calculations are separate for every single state. To give you an idea of the amount of work involved, we have 35 nonSelect states. If you're selling all 10 plans in all 35 of those states, both individual and group, you have a potential of 35 times 2 times 10, or 700 rate-refund calculation forms that must be filled out. And then for the Select states, you potentially have four different types, in 15 Select states, and all 10 plans. That's another 600 forms. So there are potentially 1,300 forms to be filled out by May 31 each year. When Medicare Select is expanded to all 50 states, add another 700 to that number. So, you potentially have 2,000 forms to fill out.

If it's determined that you need to make a refund, you have to add in interest to the rate refund from December 31 to the date that you give the rate refund. The rate of interest is specified by the Department of Health and Human Services, but it at least has to equal the average rate on 13-year treasury notes.

The rate refund or the premium credit has to be consummated by September 30. So you really eliminate the potential to use premium vouchers, because there's no guarantee that they would be used by September 30. If you're giving premium credit, you have to make sure that any modes coming due after September 30 get that credit applied before then, because the whole transaction has to be completed by September 30.

I'd also like to mention how incurred claims and earned premiums are defined. Incurred claims must exclude all claims expenses and changes in guaranteed renewable (GR) reserves. Earned premiums must include modal loadings and policy fees. This is different from the traditional treatment of using the annual mode for earned premiums in loss-ratio calculations.

FROM THE FLOOR: By giving premium balance sheets, can't you simplify the process?

MS. HELWIG: You probably could not just hand out a premium voucher, because you wouldn't have any guarantee as to when it would be used. You would have to guarantee that if they didn't use it by September 30, you'd automatically give them the cash. That would be one way of doing it.

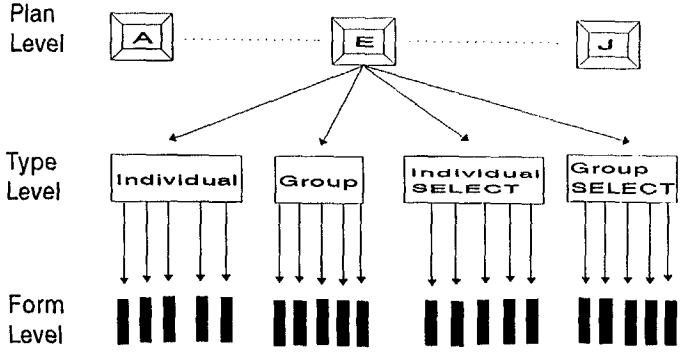
FROM THE FLOOR: What about claim reserves?

MS. HELWIG: Claim reserves are included, but recall that it's recommended that you use a run-off method so that your claims incurred are fluid. Your 1991 claims incurred, calculated in 1992, are going to be different than when they're recalculated in 1993. You use the claims that are incurred in a given calendar year, developed out through the end of the current year, plus the estimate of the remaining liability.

MS. SEAMAN: I'm going to take a few moments to discuss some of the other provisions of the model regulation, including the annual filing requirements.

As was mentioned a few moments ago, when you start multiplying out the number of combinations for rate-refund calculations, it's mind-boggling. The same is true of annual filings. Chart 3 is an example. You have the ten plans, four types, and within each of those categories, you can have up to five policy forms. If you multiply that out, the potential number of annual filings is five (forms) times four (types) times ten (plans). That's 200. On top of that, you would need to add state-specific forms that might be required.

CHART 3
Number of Medicare Supplement Policies Allowed
Standardized Plans



Potential Number of Annual Filings: 5 X 4 X 10 = 200, plus special state-specific exhibits for each form and state.

Potential Number of Rate Refund Calculations: 4 X 10 X 50 = 2,000

Next I'd like to touch on the policy-form variations that are allowed within each standardized plan. Once you've filed a policy form for a standardized plan, you're allowed four variations. Those variations can be based on either (1) inclusion of new or innovative benefits, (2) direct response versus agent marketing, (3) guaranteed issue versus underwritten, or (4) coverage of the Medicare eligibles due to disability.

One of the major objectives of standardization is to assist the consumer by standardizing the benefit options available and making it easier to compare prices. This leads us to the specifications on the variations you can have within your rates. The allowable variations in rating structures within the same form, per the draft compliance manual, are age, sex, family, smoking, and underwriting status, area, and rating methodology. An example of rating methodology would be attained age versus issue age. Only one rating methodology can be sold at one time.

FROM THE FLOOR: What about duration?

MS. SEAMAN: That's your rating methodology. The intent here is to prevent closing a block of business and then starting up a new block with the same benefits.

This leads us to the rules governing discontinuance of any given form. When you decide you want to issue a form, you can't issue it for a while, discontinue it, and

then try to get back into the market. If you're going to discontinue a form, you need to notify the commissioner at least 30 days before you do. You have automatic discontinuance if you don't actively market a form for 12 months. After you've discontinued a form, you cannot file another form of that type and plan for five years. In other words, you have a five-year marketing penalty.

FROM THE FLOOR: Does this work on a state-by-state basis then?

MS. SEAMAN: Yes. Note that the sale or transfer of a block of business would also be considered a discontinuance. You can't divest yourself of a block and then get right back in.

FROM THE FLOOR: What does "actively offer" mean?

MS. SEAMAN: That's a really good question. I don't think that it's well defined at this time.

MS. HELWIG: There has been some clarification though. If it's out there, but nobody has purchased it, it's still actively offered.

MS. SEAMAN: So if you have it available and it's not being purchased, it's not going to be deemed discontinued.

FROM THE FLOOR: What if the company got out of the Medicare supplement business prior to that November 5, 1991 date or actually prior to the implementation of standardization? Say they stopped selling in October 1991 so they never had any standardized business on the books. If they then divested the old block in 1993 and they want to get back into the Medicare supplement business, can they do that?

MS. SEAMAN: Yes. The discontinuance really applies only to standardized business.

Please note that a change in rating methodology could be construed as a discontinuance also. So you need to be really careful. The definition of change in rating methodology, direct from the draft compliance manual, is a "change in demographic rating process, which is actuarially equivalent to the current rating practice under reasonable assumptions." Examples include changing from issue age to attained age, from community to class rating, or from unisex to male-female. This does not include area factor changes.

A rating-methodology change is not a discontinuance if you've described the difference, and then from that point forward, the percentage difference between the "before" and "after" doesn't change. For example, say you issued policies on an attained age basis in 1992, and you then decided to go to an issue-age basis for 1993 issues. You would be pooling all of that business for purposes of filing and rate increases. Those two premium scales for your new business and your renewal business would need to move in step.

FROM THE FLOOR: How do they stay in unison when one's going up each year by attained age and the other is on an issue-age basis?

MS. SEAMAN: We're talking about the relationship in aggregate, not the individual insureds.

MS. HELWIG: The comment from the floor relates to the position that Florida has taken on this issue. It has decided that a change from issue age to attained age or vice versa is not permissible, because they can't go up by the same percentages going forward. Therefore, you can't ever change your rating methodology from one to the other in Florida. If you start out with issue age, you stay with issue age in Florida, or vice versa.

MS. SEAMAN: Annual rate filings are required for all forms, including existing business. So this is one of those areas that goes beyond standardized policy forms. You must file rates, a rating schedule and supporting documentation. Loss ratios by duration must be included, and you must demonstrate loss-ratio compliance over the lifetime of the policy and over the period for which the rates are computed. You must also demonstrate that the third policy-year loss-ratio requirement is met.

There are separate requirements for rate-increase filings. The annual filing and the rate-increase filing may be combined if you like, or they can stand separately. With the advent of the new filing requirements, automatic increases are no longer allowed. For example, if you had a deal with a department in the past, such that every year when the Part A deductible increased, say X%, your rates would automatically increase by Y%, that's not going to be permitted any longer.

FROM THE FLOOR: Is the annual filing at any time during the calendar year?

MS. SEAMAN: It's unclear. At least I haven't seen any specifics regarding timing. I think it will vary by state as to whether it's calendar year or any 12-month period.

MS. HELWIG: There are a few other miscellaneous issues that the model regulation covers that I'd like to briefly go over. One is commission standards. Many states had these regulations prior to the OBRA passage, but now they're officially part of the model regulation.

Specifically, you cannot have a first-year commission rate for a Medicare supplement policy that exceeds twice the renewal commission rate. Renewal commission must continue through renewal periods 2-6 at a minimum. Commissions can either be expressed in terms of percentages or dollars. That's left up to the company. In other words, the first-year dollar commission could be twice the renewal commission in dollars, or the first-year percentage could be twice the renewal percentage.

Renewal commission must be paid anytime a policy is replaced, unless the benefits of the new policy or certificate are substantially greater.

A technical-corrections amendment was passed through the House and the Senate in 1991, but it was vetoed by President Bush. I'm not sure what the current status is, but it's expected that the amendment is going to come up again. In the technical-corrections amendment, the phrase "unless benefits are substantially greater" was deleted. In other words, under no condition can anything other than renewal commission be paid upon replacement.

FROM THE FLOOR: Is that internal or any replacement?

MS. HELWIG: That is any internal or external replacement.

Also, compensation has been defined to include any kind of pecuniary or nonpecuniary remuneration. They're trying to prevent any kind of replacement situation. They want to get away from the churning of the Medicare supplement market that has taken place in the past.

FROM THE FLOOR: With the standardized plans, is there a list that ranks the plans by benefit content?

MS. HELWIG: Yes, it's in the draft compliance manual. They rank plan A at the low end, up to plan J. There's a whole hierarchy.

The OBRA legislation also required open enrollment for 65-year-olds. For the first six months after they enroll in Part B of Medicare, there can be no discrimination in the pricing or availability of policies due to medical conditions. In other words, you must guarantee issue to 65-year-olds.

This has been further clarified early in 1992. Earl Pomeroy, who was the head of the NAIC Task Force at the time, sent out a letter to all states telling them that he considered it an unfair trade practice for companies to do certain things to 65-year-olds. This was included in the draft compliance manual.

In pricing Medicare supplement policies, you're not allowed to charge a higher rate to 65-year-olds to reflect the guaranteed issue. In other words, if you're underwriting everybody else, but you're giving guaranteed issue to the 65-year-olds, you cannot charge all of that extra cost to the 65-year-old age group. You must spread it out over the entire block of policies.

You also are not allowed to pay lower commissions to agents who sell to a 65-year-old. You cannot reduce commissions for applicants in poor health, written because of the guaranteed-issue requirement. You can't just refuse to market to 65-year-olds.

FROM THE FLOOR: How enforceable is this compliance manual?

MS. HELWIG: That's a good question. At the moment, the manual is supposed to just be a guide to the states. I understand, however, that there is some talk of making the manual an enforceable document.

I'm not sure what the status is, but if it does become enforceable, it would obviously add another layer of regulation on top of the model regulation. But at the moment, it's just supposed to be a guideline for the states. I would guess that if it's out there, the states will probably use it and go by it.

MR. C. VICTOR KENSLER*: The draft has several correction-pending items that many people think need to be corrected. There is a group that is working on that, as you are probably aware. But the caveat there is that for states that are using this as a guideline, they may be using something that isn't really correct and that may be corrected in the future. So, it still is a draft in every sense of the word.

MS. HELWIG: I was aware of that, because I was asked to serve on that group, but I passed it on to somebody else in my office. I realize there are still many unclear issues in the draft. As I said, there are many things that it adds, that go well above and beyond what the regulation actually requires. I think there is a fair amount of concern about that.

FROM THE FLOOR: Right. There was an interpretation made that was inconsistent.

FROM THE FLOOR: Suppose an employer's trying to minimize its retiree medical liability (*SFAS 106* concerns), and retirees over age 65 are forced to purchase a Medicare supplement policy. Assume the employer provides an increased pension benefit to do that. Do those retirees have to satisfy the six-month elimination period?

MS. HELWIG: It's not really a six-month elimination period. It is a six-month window from when a person first becomes eligible for Part B, from age 65 to 65.5, when they are allowed to select any Medicare supplement policy on the market with no medical underwriting applied. But a preexisting condition exclusion may be applied.

FROM THE FLOOR: What if people are in their 70s at the time they're filling out the applications, and they have to buy their own policies.

MS. HELWIG: They could be subject to medical underwriting, yes.

FROM THE FLOOR: But is it really age-65-specific, or is it enrolled in Part B?

MS. HELWIG: It is enrolled in Part B.

FROM THE FLOOR: So, if they had coverage and they're not enrolled in Part B?

MS. HELWIG: If they were under the retiree medical plan and didn't enroll in Part B until a later date, then they would also be eligible for guaranteed issue.

FROM THE FLOOR: That would only be in the case where they are actively at work, right? Because if they were in the company's retiree medical plan, they would still have been eligible for Medicare Part B?

MS. HELWIG: It's not eligible, it's enrolled.

* Mr. Kensler, not a member of the sponsoring organizations, is Assistant Vice President and Manager/Actuarial at Mutual of Omaha Insurance Company in Omaha, Nebraska.

FROM THE FLOOR: It's a question of when you actually enrolled in the program (Medicare Part B).

FROM THE FLOOR: But most retiree medical plans require the retiree to enroll.

FROM THE FLOOR: So, therefore, if the plan ends, will they be within the open enrollment period?

MS. HELWIG: If they are enrolled already, and they didn't choose to participate in a Medicare supplement, then they could be out of luck.

FROM THE FLOOR: I have one question on the refund filing. Are you saying that we actually have to segregate the policies that are issued in the last month-and-a-half of 1991?

MS. HELWIG: Yes. The administrative difficulties of some of this are tremendous for a company; for example, providing experience by policy duration. Many companies don't have the facilities to do that on older blocks of business.

FROM THE FLOOR: If you rolled people from one policy form to another policy form, is that considered a new issue?

MS. HELWIG: Internal replacement?

FROM THE FLOOR: Right. You have two separate policies.

MS. HELWIG: You're talking about rolling them into a standardized form?

FROM THE FLOOR: No, I'm talking about during the period before standardization.

MS. HELWIG: I don't think it really matters from the standpoint of the model regulation.

MS. SEAMAN: Unless you rolled them in November or December.

MS. HELWIG: Right. If you rolled them starting with November or December, it might make a difference.

FROM THE FLOOR: I would think it depends on what issue date you carry on the record. You have to go by that issue date.

MS. HELWIG: The model regulation doesn't get into issue date assignment.

MS. SEAMAN: What if you then turned around and rolled them into the new standardized plans? Then they'd be new issues, right?

MS. HELWIG: I would think they would be considered standardized plans from that point with that issue date.

FROM THE FLOOR: We have a block of business where the median age is much older. For the people in the window, aren't we allowed to take into consideration that they're going to have to have a lower loss ratio, because the rate is really high due to the average age?

MS. HELWIG: People in the window have to be treated separately. They have to be put through the rate-refund calculation on their own.

FROM THE FLOOR: In other words, we're stuck because the rate wasn't designed for them. It was designed to support the block on a pooled basis, but we have to perform the refund calculation on them separately.

Would that window be until the state actually enacted the plan?

MS. HELWIG: That's right; any nonstandardized plan after November 5 until the state enacts standardization. So in your case, it's really November 5 through July.

I should also mention that the technical corrections bill would change the way that the existing business is handled. If the technical corrections amendment were to pass, it would make the entire regulation, including the refund calculation, applicable to all existing business, including policies issued before November 5.

In that case, what would happen? The draft compliance manual addresses that situation. It would be totally different from what happens right now. You would take all policies issued prior to your state's effective date, both standardized and prestandardized, add them all together and treat them as one block of business issued on the date that the regulation went into effect. Right now we're talking about a separate form-by-form filing for nonstandardized issues back to November 5. Under technical corrections, we'd be talking about one combined filing for all standardized and prestandardized added together, as though they were all issued on the state's effective date. It's a whole different ball game if that happens.

FROM THE FLOOR: You say that's one date for the whole company, based on your state's domicile, as opposed to each individual state?

MS. HELWIG: Right. If your state implemented it July 1, 1992, every single existing policy that you had in force as of that point in time is combined into one rate refund.

FROM THE FLOOR: State of domicile?

FROM THE FLOOR: The NAIC said that it varies state by state. It depends on where you were filing the forms.

MS. HELWIG: I thought it was the date that your state implemented the regulation.

FROM THE FLOOR: That way would make it much easier.

MS. HELWIG: Yes. Does anybody else have an opinion? That's how I read the draft compliance manual. It's the date your state made the regulation effective.

FROM THE FLOOR: I worked on the draft compliance manual and that was the intention. But, the example in the back is written as if technical corrections had been implemented. There's state A and state B, because they have two different effective dates.

MS. HELWIG: That adds another level of complexity to this.

FROM THE FLOOR: Are the technical corrections in the compliance manual?

MS. HELWIG: Yes. Let me just briefly mention some of the remaining issues from the model regulation. One of the important ones pertains to disclosure. The model regulation states that every single premium that is offered must be displayed in the outline of coverage. This presents some technical difficulties if you're going to offer many different plans and many different rating variables.

The model regulation also has some standards regarding claim-payment practices. You're not allowed to have preexisting conditions on replacement policies, or at least you have to provide continuation of coverage. There are also standards for reporting of multiple policies.

Then there are the technical corrections, which we've already discussed. With technical corrections, the model regulation applies to existing business in all respects. Without technical corrections, there still are certain specific sections of the model regulation that apply to existing business. You still have to go through that process as with all of your existing business.

You'll notice that the annual rate filings are required on a form-by-form basis, which is different from what is required for the rate-refund calculations, where you combine everything on a type-plan basis. There's a potential difficulty here. Say you have four or five forms that are all plan A. One particular form could be having excellent experience, and another one could be having very poor experience. In your annual rate filings, you want to take a rate increase on one, but a rate decrease is needed on the other one. But when you combine them all together to do your rate-refund calculation, it shows that you need a rate refund. So you have a potential for what I'll call roller coaster rates. You could request a rate increase on the form at year-end, and then as of May 31, you have to take a rate refund, etc. The model regulation specifies that each form be treated separately for the annual filings, but be combined for the rate refunds. It creates some complexity.

The compliance manual lists all of the things that must be included in the annual filings. I've listed the general topics that are included:

- Purpose of the filing
- General policy description
- Rate sheets and factors
- Rate history (5 years)
- In-force counts (since inception, by state, and nationwide)
- Historical claims incurred and earned premiums by duration (by state)

- Loss-ratio demonstration
  - past plus future
  - future only
  - third policy year
- Actuarial certification

I bet you see many things that most of you are not including in filings right now: for example, a five-year rate history; complete detail on in-force counts since inception, by state, and nationwide; and historical incurred claims and earned premiums by duration and by states.

I know that several companies just don't have that information available, and I'm not exactly sure what they're supposed to do. The model regulation requires it, but sometimes on older blocks of business, the information is just not there.

You have to make a loss-ratio projection. Again, this projection has to be done by state. And to demonstrate that your third-year, loss-ratio requirement is being met, you also are going to need to do it on an issue-year basis. That's considerably more detailed and complex than what most companies are doing right now.

There are some additional notes from the compliance manual. The manual gives some specific guidance on relationships between the claim costs by age and by plan, to give regulators some guidance on what the premiums by plan should look like.

On the new product filings, many of the same things are required. The thing I'd like to point out here is that for both the new product filings and the rate-increase filings, you have to present the date that your home state approved that filing. This requires that you have home-state approval before you can file anyplace else.

In your new product filings, you have to give complete details regarding expenses and commission assumptions, and you must certify that you're meeting the commission requirements.

For rate revisions, much of this is the same as the annual-rate filings. Most companies will probably be combining those two filings.

Here's something we haven't touched on yet. For rate-refund purposes, the policyholder is placed in the state of issue, not the state of residence. Again, this could cause some administrative problems for some companies. And as we said before, all policyholders, even the ones in their first year, have to participate in the refund.

MS. SEAMAN: I'm going to try to briefly outline what the compliance manual has to say about Medicare Select.

First, typical HMO plans cannot be offered after the implementation of standardization, except in certain cases. I'll let you read the exception categories on your own later.

There are some required product offerings. If you want to offer something other than plan A on a Select basis, you must also offer a Select plan A. You must offer a non-Select policy, which the issuer otherwise offers. As we discussed earlier, there's

provision for the continuation of coverage in the case that the three-year Select pilot program is not continued.

The filing requirements are substantially the same as on nonSelect business, namely new form and annual rate increase and refund-calculation filings.

There are a few special things that you might want to consider. The data that you would need to capture is different from a traditional HMO data capture. You need data by duration, rather than by capitation, etc. Also, in the incurred-claims definition, there's some recognition that there are expenses associated with delivering health-care services that would be included in your incurred claims, if you're dealing with an HMO. Capitations and withholds are examples of valid health-care expenses for an HMO that could be included in the incurred claims.

MS. HELWIG: The last thing I want to mention is that everything we've been talking about is for the Medicare supplement model act. There are many states that have implemented variations of the model, even though we supposedly have standardization.

We've already mentioned one of the things that Florida has done that's a little bit different. In addition, Florida has also taken the position that it already has technical corrections. In other words, this regulation applies to existing business as well as to the standardized plans. In some states, such as Pennsylvania, Massachusetts, New York, etc., doctors are not allowed to bill excesses. So the standardized plans that cover excesses are no longer applicable. Wisconsin and Minnesota were grand-fathered into the regulation. They had their own standardized plans already in place and were allowed to keep those. Arkansas requires uniage rates, one rate for all ages. Georgia and Washington don't allow attained-age rates.

So you can see there are many variations from state to state, the result being that we really don't have standardization.