RECORD, Volume 26, No. 1*

Las Vegas Spring Meeting
May 22–24, 2000

Session 10PD
Medicare Supplement Update

Track: Health

Moderator: JAY P. BOEKHOFF
Panelists: THOMAS H. LINDQUIST
CLIFFORD K. POWELL
DIANA S. WRIGHT
Recorder: JAY P. BOEKHOFF

Summary: Is Medicare Supplement a dying product? Or, is it thriving in the world of Medicare+Choice? Panelists discuss recent enrollment and cost trends and competitive dynamics with Medicare+Choice capitated plans. Expected future trends are also discussed.

Mr. Jay P. Boekhoff: We have three panelists to represent their views of the directions in Medical Supplements. Our first speaker will be Keith Powell. Keith will be talking about the state regulatory perspective. Keith is a senior manager with Deloitte & Touche. He works with both insurance companies and insurance departments, but he in particular does all the health actuarial work for the department in Indiana. So, he is very familiar with the state perspective on regulation on Medicare Supplement.

In addition to his actual work with the department, he has a variety of roles in providing actuarial services to HMOs and Blue Cross plans, and he previously worked at the Health Care Financing Administration (HCFA), so he represents a broad range of backgrounds.

Our second speaker will be Diana Wright. Diana has been an actuary with NAIC for five years. She has extensive experience in working with Medicare Supplement and maintaining the Medicare Supplement Compliance Manual, and now is working with the Health Working Group, which is responsible for many of the initiatives that the NAIC is taking.

Prior to joining the NAIC, Diane was in the industry, where she was involved in product development in the health area.

Our last speaker will be Tom Lindquist. Tom is the president of the American Association of Retired Persons (AARP) Operations for United Health Group (UHG). He wanted me to note that his employer is UHG, not AARP. He has been in that capacity for two years, and before joining UHG he worked for Prudential in the AARP program. So he is well-acquainted with the industry perspective.

____
*Copyright © 2000, Society of Actuaries

Note: The charts referred to in the text can be found at the end of the manuscript.

After you hear from these three, I will be joining you again for just a few comments about benefit changes as I see them, and we'll have time for questions.

Mr. Clifford K. Powell: What I'm going to do is comment on three topics that have been floating around in the last few months. Some of these are new to me. The first concept is what I call tiered-loss ratios. This particular loss-ratio approach is now close to being offered for consideration by the states in the case of long-term care (LTC). Has anybody heard of this? One person. Basically there is no requirement of a loss ratio on an initial filing, but if you ask for a rate increase later, you're tested on 58%, based on the initial rate over the lifetime of the form, and 85% on the increment on the increase.

This is close to being released in the LTC area. And there is some interest in trying to modify it for Medicare Supplement. Now obviously there would have to be some pretty serious modifications to bring this concept over into Medicare Supplement. The things that jump out at you would be the fact that LTC would be, for the most part, a heavily indemnified program, but with Medicare Supplement you have all the trend issues involved. Those are different. But this has been discussed.

I have quite a few thoughts on this, and there are pros and cons. I don't really know that I have anything near an overall opinion on it. The logic behind this proposal seems to be built on a strong preference for level rates, rather than increasing ones. It is believed rate increases happen partly because initial rates were set too low, primarily because of market pressures, and possibly also because of fixed-loss-ratio requirements.

This proposal is certainly interesting. It seems to me it comes more directly to grip with assumptions about cost increases on the nonbenefit part of the structure than almost any other proposal that I've heard about. That alone would warrant talking about it for awhile.

Price is very important in this market. Unless you're with the Blues or with some organization that has something to sell in addition to the insurance program per se, there does seem to be a lot of price pressure, and I can certainly believe there is a lot of pressure to lower the initial rates. Having said that, I'm not certain that other fixed-loss-ratio requirements per se cause quite as many problems.

I also keep coming back to the point that the initial rate in a trend-sensitive product was a very different kind of concept, and has different implications, as you look at it after the fact, than the initial rate on the product that is primarily geared to cover indemnified benefits.

In my experience, there is little question that complaints to the Departments of Insurance do have a great deal to do with the frequency and the level of rate increases. There's not much question about that at all. I also stress that if we clamp down really hard on rate increases, one response could be an increase in

initial rate levels. People will raise rates pretty fiercely, I think. Regulators ought to consider that initial rate levels also give rise to consumer complaints.

Even if we could come up with a fixed-rate level for a trend-sensitive product, I wonder if the idea that this is a good thing doesn't focus very strongly on one group of insureds rather than the entire insured population—in particular, those who plan to stay for a long time, those who want to stay for a long time, and those who cannot afford rate increases because they live on fixed income.

When I hear these ideas discussed, the point about how terrible the increases are over a long period of time for people who live on fixed incomes keeps coming up again and again. And I guess I just suggest for consideration that there's nothing wrong with concern about that segment of the population, but, arguably, there are people who are not into individual health products for as long a pull whose interests are also perfectly legitimate. We might want to consider theirs, too.

And is it a real trip to try to determine what part of the senior population really lives on a fixed income? I think you can make a very reasonable argument that to the extent that people's income comes primarily from Social Security, they are inflation-indexed. Now it's true that the inflation index doesn't really cover anything like the increases you might see on certain individual health products, but if the market basket is well-chosen, health-care cost increases might be offset by less-than-average increases in other areas. A very large part of the senior population seems to be committed to continued employment and I just sense a change in the volume of individuals selecting early retirement.

I also sense there is a large, and possibly growing, part of the senior population with a permanent commitment to equity investments arising out of their tax-qualified plans. I don't know if you could properly describe them as fixed-income at all. So I guess one of my concerns is that we want to be sure that we try to look at the entire situation and not just part of it when we are evaluating whether or not this is a good idea.

There is, as I see it, quite a difference between Medicare Supplement and LTC, in the sense you can expect a company to have a clear picture of initial cost levels versus ultimate cost levels. LTC is still fairly new compared to Medicare Supplement, and the modern generation of LTC policies are still experimental with less knowledge of experience at later durations than we probably have on Medicare Supplement. Not to say there are no changes in Medicare Supplement, but there have been quite a lot of changes in LTC over the past few years.

So it's again, useful, just to talk through exactly what we are targeting here and to at least address the question that rate increases, which without dispute raise complaints to insurance departments, might partly be something we might have to live with, given the uncertainty of ultimate cost levels on a relatively new product like LTC. While there is a somewhat similar situation in Medicare Supplement, although a trend is hard to predict over any period of time, the key interests appear to be the rate increases in the future. But it seems to me that they operate quite

differently. So, in particular, if you want to take the logic of this proposal and carry it over into Medicare Supplement, it seems to me we have to do a lot of thinking about that.

A couple of comments that have been voiced about rate stabilization lead to another interesting quandary if you look at a lot of old blocks of business. As I review rates, it seems that in many cases some of the best payback to the insured block overall comes in the presence of rather high rate increases. There are blocks of business out there, even Medicare Supplement blocks of business, seeing few or no rate increases over a very long period of time. And it is interesting to scratch your head sometimes and wonder what message the block really sends. One way to look at it is "these people really priced it right to start with". But I think a lot of what I see, when I see a block of business that is fairly stable and hasn't had rate increases for some time, is often very high lapsation in the first two, three, or four years of the life of that block, coupled with very low loss ratios at that time. So, on a lifetime basis, it is not all uncommon to see an old block of business with a current loss ratio around 80, 90, or 100%, which is still under the 60% lifetime standard.

Now, I often see the situation where the experience on the block of business measured from the starting point a few years after inception and onto the end of that block, has much higher loss ratios. You might expect it to be a little bit higher, but I've seen a lot higher than on the entire life of the block. And it could be in many cases that we're not even addressing a higher loss ratio for group, even individual cases; it could very well be that an 85% test for rate increases might not be as painful as it first sounds. I guess what you do when you're thinking about this is to test out some of your own blocks, and see what exactly they may have. Again, that doesn't even address the higher standard for a group product.

Second topic. Everyone is making a lot of noise today about coverage for drugs. There are some very good people who are talking about that, who can give you a lot of information. Strictly from the perspective of the State Insurance Department, there are lots of complaints about the lack of availability of a drug product. Someone did point out to me this morning that that really means lack of availability after the period of initial issue. There are products available, I guess in every state initially, but if you decide to move around after that time or come into the market new after that time, it can be hard to find a policy, or at least that's what all the phone calls say.

You're probably all familiar with quandaries you get into trying to cover drugs. I would suggest that the present policies of the drug companies have changed a lot in the last two or three years. If any of you have bought prescription drugs, you may be aware of that. If you've read much about this business, you may also be aware of this incredible change in drug products. And, it puts us kind of in a quandary when you're talking about what you'd expect to see filed as a drug product. Are you going to see a tightly constrained benefit, with what the public would see as a relatively small amount of coverage, which would cause problems and dissatisfaction there? Or, are you going to see a more open-ended product,

where you have all kinds of problems with selection? That could be a real problem. Other people are going to talk about that more than I am.

The third situation that I just want to mention is that the Academy, right now, is doing a lot of work in trying to get into what this country is spending, in claim cost terms, in the Medicare Supplement business. They have been asked to address several issues.

But just in case you haven't heard, they are looking at the five following points: Are there specific benefit components of Medicare Supplement Plans that are contributing to the recent significant rate increase, and if so, what are they? What additional costs are attributable to the guaranteed issue of Medicare Supplement Insurance Policies?

Do age distributions differ, based on rating methods, methodology, issue age, attained age, or community rating?

What is the relationship between Part B coinsurance paid by Medicare Supplement policies and the amount paid by Medicare for these benefits? And finally, has there been a change in the distribution of Medicare Supplement business that has been based on disability eligibility? If yes, what has been that impact on the claims experience?

Other people will give the details, but I understand that there might be a report out addressing these points fairly soon.

And I'm also hearing some of the congressional committees that are concerned about drug problems are going to be looking carefully at this. They need to get a good sense of how Medicare Supplement products fit into this.

Ms. Diana S. Wright: I'm with the NAIC, and I am going to come back and revisit that question in a minute.

Well, OK, let's ask it now. I'm curious. How many of you are familiar with the NAIC? How many of you are familiar with the structure and how it works? There's a difference there. Some conversations I've had with other people reveal that the NAIC isn't exactly what they think it is. So later on, I want to give you a little more information so that you can get more information about the NAIC.

First I would like to cover some national statistics, then go into a little bit about the federal activity, and then some NAIC activity.

The resident population ages 65 and older from 1994 to 1998 increased 3.7%. Now look at Table 1; for this source I went to the NAIC report. Since you all are so familiar with the NAIC, you probably know that for the annual reporting there is a Medical Supplement, insurance experience, which is required to be filed with the NAIC for people who sell Medical Supplement Insurance.

TABLE 1
MEDICARE SUPPLEMENT INSURANCE

	No. Covered Lives (in 000)'s	Percent Change: Prior Year	Cumulative
1994	14,248		
1995	12,840	-9.9%	-9.9%
1996	12,590	-1.9%	-11.6%
1997	12,005	-4.6%	-15.7%
1998	11,028	-8.1%	-22.6%

Source: NAIC Medicare Supplement Loss Ratio Reports

Table 1 is based on that report, or those reports, over those years. If you remember, the population grew 3.7%, from 1994 to 1998, but Medicare Supplement insurance has decreased a little more than 20%. Now this is based on the number of covered lives. That kind of raises an interesting question. Where are they going, and what is going on?

Then I wanted to see what was going on in the premium, comparably. Table 2 addresses the change in the premium rate. From 1994 to 1998, the cumulative premium increase was only 8.8%. That looks really good on the surface, but if you keep in mind that the insured lives dropped 20%, you're getting a little more of a rate increase than is indicated by the experience.

TABLE 2
MEDICARE SUPPLEMENT INSURANCE
CHANGE IN PREMIUM RATE

	Earned Premium (in 000,000)'s	Percent Change: Prior Year	Cumulative
1994	$ 12,637		
1995	$ 12,494	-1.1%	-1.1%
1996	$ 13,310	+6.5%	+5.3%
1997	$ 13,564	+1.9%	+7.3%
1998	$ 13,747	+1.4%	+8.8%

Source: NAIC Medicare Supplement Loss Ratio Reports

Going back and holding onto that thought of what's been going on with the people, are they just not getting insurance, additional insurance, or living off of Medicare?

I think what you will find in most of the numbers is that they are going to risk contracts (Medicare HMOs), which have been growing. In fact, they are now up to about 6.2 million Medicare HMO beneficiaries. That's approximately 14% of enrollment, but I think in a short period of time it's going to grow a little more than that. But it's around 14%, or something like that.

Also, in 1998, there were 347 Medicare risk contracts. That all sounds really great if you're an HMO, but then the environment changed. Everything was going well

and then suddenly there were some revisions, and you now have Medicare HMOs wanting to withdraw from the market.

Now, 43 of those 347 Medicare risk contracts completely withdrew from the marketplace in 1998. There were 41 more that withdrew in 1999. I didn't have any numbers for 2000, but I haven't heard a significant drop.

But that doesn't tell all the story. There are also reduced service areas. In 1998 there were 54 HMOs that reduced their service area, so it impacted 97 risk contracts. I think that's a significant number.

In 1998 there were approximately 400,000 enrollees affected. That kind of got the federal government's attention. In 1999, 58 reduced their service area, so you had 327,000. So, more than 700,000 people have been affected by the HMOs withdrawing.

I don't know if any of you are familiar with a publication called *Health Affairs*. I'm not on their board or trying to market these publications, but it is a very informative document, if you have access to it. In one of the reports, they indicated that there was an analysis done of the characteristics of the Medicare HMOs that withdrew. They were predominantly for-profit, a somewhat smaller-than-average Medicare enrollment, and relatively new in the Medicare market. And actually, in hindsight, really that's not surprising that they would be smaller, that they would get out of the market, and that they would be relatively new.

So then you say OK, let's look at the ones that reduced their service area. Again, predominantly for-profit. Those nonprofit people, they just hang in there tough, I guess.

And then you have a larger-than-average Medicare enrollment. Again, this is looking very logical, but apparently they did the study to confirm it.

Third, in Medicare markets they have been in about the same amount of time as those renewing.

The turmoil is not over. The impact is going on with the HMOs. As recently as April 28, 2000, Aetna announced that they planned to exit Medicare HMO insurance in several cities. And on July 1, 2000 they are going to identify what those cities are. Right now, Aetna has approximately 670,000 seniors. The reason they are giving for their withdrawal is the slow federal reimbursements. Last year Aetna had 62,000 of the 327,000 enrollees who were impacted by the reduction of the service area. So they should be having a big impact on this market.

As I mentioned, this has caught the attention of the federal regulators. What that leads us right into then is one of the recent proposals that was put forward by representatives from Pennsylvania and Florida, in which they are recommending that some of the $30 billion that Congress is looking to put toward Medicare in 2001 be used to increase the payments, help some of this managed care

reduction, and alleviate these contracts dropping out. I haven't heard of any type of response on that, but there are people on the Hill trying to do things to minimize the impact of the reduction.

There are other things that are going on at the federal level. For instance, I think you all are probably familiar with the Balanced Budget Act of 1997 (BBA). In it you have the requirement for guaranteed issue of Medicare Supplement Insurance for terminated Medicare+Choice Plans. I haven't seen any statistical analysis of the impact of that.

There's also the creation of the high-deductible option. Then there's the Balanced Budget Reduction Act (BBRA), and that revises the timing for the guaranteed issue. Some of our other panelists will be getting into some of the other issues associated with this.

What this is trying to say is right now there's a guaranteed issue and a BBA. The guaranty is if this contract terminated, individuals could not avail themselves of the guaranteed issue until they waited until the end of the year. That is going to be changing under the Reduction Act, where individuals could avail themselves of the guaranteed issue option earlier so they don't have to wait.

There are also a lot of prescription drug proposals. You're going to be hearing a lot about that today, and I think probably there will be a lot of conversation on that. You have President Clinton throwing out an option, you have Senate Republicans countering with another, and you have the Democrats introducing a proposal, so it's going to be very interesting to watch and see how it all comes out.

Another issue that is going on at the federal level is what they call Medicare Compare. The federal government, HCFA in particular, has gotten interested in trying to promote comparison of policies for seniors to inform consumers more and to give them more options. One of the things that they've come up with is what they call the Medigap Compare project. The system will use the Internet so that they can publish rates. An individual who is interested in a particular area can put in his or her zip code, or something like that, and the system will pop the various rates from the various carriers.

The NAIC has expressed concern, because often you run into issues at the state level. There will be a direct hot link to the state site. Approximately 50% of the states are already publishing Medigap premium rates on the Internet.

That way, the federal Web site would not be maintaining rates that would be different from the states, and the states are being encouraged to develop their own plans.

Another thing at the federal level is the Outpatient Prospective Payment System. That is going to be impacting you all quite a bit. That will be starting up July 1. That was delayed by the Y2K issues, but will now be coming on-line.

All these issues are going on at the federal level.

We have a lot of interest, then, at the NAIC level, which is very closely linked to that. One of those is the Medical Supplemental Insurance Issue Paper. Mike Abroe knows that better than anybody. Mike is in the audience, so he will have to keep me honest.

What happened is, back in 1998, prior to a lot of interest expressed by the federal government, the state regulators were very concerned about some of the rate increases that they were seeing. There were stories of rate increases being 20% and 30% in 1 year, and there were significant concerns by the regulators. They were trying to figure out why. When I was in product development, actually in this industry, there were always questions of "why is this going on?" But it was much more of an interest for the regulators, in the sense they are concerned for the consumers; and again, as Keith was talking about, there was concern for the individuals on fixed incomes.

What the Health Working Group wanted was to have the NAIC issue a paper on what's causing this, with the idea being to identify something to help with those rate increases, or at least to identify it so that someone else could change it, if it was by federal action.

In the process of doing this analysis, one of the issues that came up was trying to understand what has been the trend of the various proponents to Medicare Supplement Insurance. In the process of that, the Academy very considerately stepped forward and volunteered to assist in that charge. Mike Abroe is chairing a committee that is responsible for that issue paper.

They have been looking at various claim trends, and identifying some of the issues that Keith has mentioned, answering those questions. That final report is slated to be presented to the NAIC at their summer national meetings. I think it is going to be a very informative paper. That paper will be presented to two working groups at the NAIC. The actuarial working group will then take that information and incorporate it back into that issue paper that they started in 1998, and go from there.

Another thing that the NAIC is working on is updating the Medicare Supplement Compliance Manual to reflect the BBA. We're already behind; we're just trying to get the BBA now, which we need to revise for the BBRA. But that's the way it works.

And finally, the NAIC has decided to take a look, whether or not there is any way to redesign the standardized plan.

This is at the very beginning stages, it's not very far along at all. In fact, this probably is going to be moving pretty slowly, until they see a little more of what the federal government wants to do on prescription drugs. But you still might want to keep your eye on it.

Now, I wanted to talk about the NAIC. As you can see, there's a lot going on at the NAIC. I didn't have any clue about the structure before I actually got into the middle of it, and I think it's very informative and beneficial for you to understand.

The working group is the lowest level. And it is literally what it says it is. It is a working group. So if you all are interested in participating and tracking what is currently going on, I would highly recommend that you monitor or follow working groups. Working groups report to tasks forces, kind of like the vice president/president concept, in that you have a hierarchy. You have multiple working groups reporting to task forces and task forces reporting to committees. If anything is going to be adopted by the NAIC as an official NAIC model, it will go through this hierarchy and work its way up. It will go through executive, and finally a plenary—plenary being all of the commissioners. It has to go through that, or it's not official.

I want to identify public committees that I think are most beneficial for you. For the Accident and Health Working Group, under the Life and Health Actuary Task Force, most of the time people will be requesting minutes from the task force level. I don't think you can get them as far down as the working group. The Accident and Health Working Group are the Health Actuarial Regulators. They address any of the actuary issues. They are like the actuary task force.

The Medicare Supplement Working Group addresses, within the regulatory world, nonactuarial issues. They would be public policy decisions, except pricing. They are the ones that often get involved in the question of guaranteed issue. The actuary will price it and tell them the impact. So the actual policy decision will take place in the Medicare Supplement Working Group of the Seniors Task Force. And those both then roll up and report to the B Committee.

We have minutes, we have quarterly meetings, there are conference calls; all of which are open. Anyone can participate. You can check on the NAIC Web site. It will have a calendar of any upcoming conference calls, if anybody wants to participate. Hopefully this will give you some information of what is going on on the national level.

Mr. Thomas H. Lindquist: As Jay said, I work with UHG and the AARP Division. I'm responsible for doing the Medicare Supplement Insurance for AARP members

Jay asked me to do a company perspective of Medicare Supplement. I'm going to cover the background, a little bit about the marketplace, and then spend more time, as Diane alluded to, about upcoming talk around reforming Medicare Supplement, or Medigap Reform.

One of the interesting questions in the prematerials was, "Is Medicare Supplement a dying product? Or is it thriving within the Medicare+Choice environment?" I would say that it is neither. It has been declining, as Diane also pointed out, but it is still very viable in some geographical areas.

I think that most people have recognized that growth and Medicare+Choice is really concentrated in specific areas, and more in counties around urban areas. So I'd say that it hasn't really either been dying or thriving, but again, as Diane also pointed out, with recent activity with the Medicare+Choice environment, it is becoming a new topic of interest. In particular, with the pullouts, and even as recently as the first quarter release, is where a lot of companies have been indicating there will be even broader pullouts planned for the upcoming year.

To give a quick background, I think everyone understands the standardization that started in 1991. Generally, there are ten plans that are allowed, designated A–J, and there have been some changes since then, but that is generally what you see. Three states were granted waivers. They don't have Plans A–J; they have their own design plans. That's in Massachusetts, Minnesota, and Wisconsin. They have the same basic structure; they all have a basic plan, a more comprehensive plan, and typically a plan that also has prescription drugs on it.

I think everyone has seen Table 3, but I added it just for comparison. It shows you what benefit structure you see on Plans A–J. You can see that Plan A is typically the most basic. Plans B–G generally have the same kind of core benefit, but have add-on benefits. Plans H–J have prescription drug benefits on them.

TABLE 3
MEDICARE SUPPLEMENT UPDATE
Benefit Plans A-J

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	Plan G	Plan H	Plan I	Plan J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess 100%	Part B Excess 80%		Part B Excess 100%	Part B Deductible
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs $1,250 Limit	Basic Drugs $1,250 Limit	Basic Drugs $3,000 Limit
				Preventive Care					Preventive Care

Basic Benefits: Part A & B Coinsurance

Table 4 is really based on the data from UHG, and what it is trying to show is that while you have ten plans, if you break it down by benefit structure, you can see that the top portion, which includes A and B coinsurance, A and B deductible, skilled nursing benefit, and prescription drug, make up the super majority of the benefits; 100% obviously on Plan A, but as high as 98% on Plans A–J. I think what this

really shows is that if you go back to Table 3 and look at a lot of the benefits that are down below, those generally make up less than 1%; or in the case of the prescription drug plan, it's 2% of medical benefits. It implies that although we have ten different plans, when you look at the basic benefits and where the costs are coming from, the plans are not nearly as different as you would see at a first glance.

TABLE 4
MEDICARE SUPPLEMENT UPDATE
BENEFITS AS A PERCENTAGE OF TOTAL CLAIMS

	Plan A	**Plans B-G**	**Plans H-J**
Part A & B Coinsurance	100%	74%	54%
Part A & B Deductible	-	20%	12%
Skilled Nursing	-	5%	2%
Prescription Drugs	-		30%
Total Above	100%	99%	98%
All Other Benefits	0%	1%	2%

Since standardization, there have been some other changes that have been introduced: the Medicare Select Plan, recently the high-deductible plan, and the BBA.

Several states actually discourage the use of innovative benefits because it kind of goes against the basic nature of standardization. If you have a lot of innovative benefits, then you no longer have standardized plans.

To summarize, there really haven't been a lot of changes since standardization, particularly around the benefit design.

Just some quick data on the marketplace. Medicare Supplement is about 30% of the market share. This data is from 1998. As recent as 1994, the Medicare Supplement marketplace was closer to 40% or 41% of the total Medicare beneficiaries. So we've definitely been shrinking.

And I think, as Diane also alluded to, the majority of those people have been transferring over to Medicare+Choice or Medicare HMOs.

The Blue Cross/Blue Shield organizations, if you combine them altogether, have about 40% of the market share. My company has about 23%, and that's obviously through the AARP. The rest, which are commercial carriers, make up about 37% of the market share.

Chart 1 gives you an example of what plans are popular, again from the NAIC data. You can see a majority of where the plan holders are in A, C, and F. They don't have a lot in Plans H, I, and J, but there is a significant number. I think the total is about 500,000 covered on the standardized prescription drug plans.

One of the things that's interesting there is it's real hard to get data on prestandardized insureds. While 23% of the marketplace is within our company, 50% of the prescription drug plans are actually covered through the AARP program. So while UHG has only a quarter of the total market, they have half of the prescription drug plans that are in the marketplace.

Table 5 gives you a flavor of some of the different rating requirements. This is as of April 2000, and it sometimes can change daily. There are several states that require community rating; there are some that have banned attained age rating. In particular note Maine and Massachusetts; while they require community rating, they also allow discount structures and open enrollment periods other than when they initially sign up.

TABLE 5
MEDICARE SUPPLEMENT UPDATE
MEDICARE SUPPLEMENT RATING REQUIREMENTS AS OF APRIL 2000

State	Rating Requirements
Arkansas	Community rating required
Connecticut	Community rating required for plans A-G
Florida	Attained age rating prohibited
Georgia	Attained age rating prohibited
Idaho	Attained age rating prohibited
Maine	Community rating required (discounts permitted for open enrollees)
Massachusetts	Community rating required (discounts/surcharge permitted)
Minnesota	Community rating required
New York	Community rating required
Vermont	Community rating required
Washington	Community rating required

What is changing even more rapidly is the states that require sale of Medicare Supplement to the under-age-65 group, which is the disabled group: Connecticut, Kansas, Louisiana, Maine, Massachusetts, Maryland, Missouri, North Carolina, New Hampshire, New Jersey, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Washington, and Wisconsin. Some required some certain plans; some required all plans; some required only in the first six months of eligibility; some require open enrollment all the time; others require that you charge the same rate that you charge 65-year-olds. Some allow you to charge different rates. The rules are very different in each one of the states.

The one comment I want to make here that I find interesting is that I think most people agree that when the government felt that there should be an insurance program for people who were disabled and under 65, it made sense to put it inside of the Medicare program.

When you look at the financing of the Medicare program, a portion of it comes from members, but the majority of it comes from general revenues or taxes. So in reality what they have done is said that health coverage for people who are defined as Medicare Disabled really is supported by the general population from taxes. What I find interesting is that as we have moved into the Medicare Supplement world, almost by default a decision has been made that the financing or the subsidization for the Medicare disabled should be on the backs of seniors or people who are over 65.

That is kind of interesting that you see that. I understand people are trying to get the coverage for them, but it has changed the financial burden from the general population to the seniors who take on the responsibility of subsidizing rates for them. This is an interesting consequence that I think should be considered on Medigap reform.

Table 6 compares Medicare Supplement Plans and Medicare+Choice. These are really general cases. There are specific areas where it's not the case, for example End Stage Renal Disease (ESRD) beneficiaries, which is the category of individuals who have probably the highest cost per capita for individuals. You are not eligible for Medicare+Choice if you have ESRD. Medicare Supplement has a guaranteed six-month open enrollment period. The rating methodology in Medical Plus Choice requires community rating. For Medicare Supplement, while there are restrictions, the majority of carriers use some form of age rating, either attained or entry. Benefit design is variable in Medicare+Choice, but it's standardized in Medicare Supplement. They do permit innovative benefits, but as I discussed before, that is not really something that has been utilized a lot.

TABLE 6
MEDICARE SUPPLEMENT UPDATE
COMPARISON TO MEDICARE+CHOICE

	Medicare+Choice	**Medicare Supplement**
ESRD Beneficiaries	Not Eligible	Guaranteed 6 Month Open Enrollment
Rating Methodology	Requires Community Rating	Majority Age Rate (Attained or Entry)
Benefit Design	Variable	Standardized (Little or No Innovative Benefits)
Termination Rules	Allowed With 6 Month Notice	Guaranteed Renewable
Availability	Limited Markets	Nation and Statewide
Lives Covered	Growing	Shrinking

Termination rules currently have allowed a six-month notice on Medicare+Choice. Supplement plans are guaranteed renewable as long as individuals want to pay the premiums.
As for availability, Medicare+Choice is in limited markets. Medicare Care Supplement is national and statewide. The last one was more of the history that Medicare+Choice has been growing. Medicare Supplement has been shrinking, but I

don't know how many people follow the data as released by HCFA monthly. Risk plans actually showed a little decline again, so since the beginning of this year, for the first time I think in at least five years, the Medicare Risk Program has actually shrunk and stayed down.

The last area that I wanted to talk about was Medigap reform, which is something that Diane introduced. I have just thrown down a couple of thoughts to consider.

One of the things I think should be considered is whether we need ten plans or whether it makes more sense to have three or four, the concept being that you have a basic and a core, and a deluxe. I think the difference between core and deluxe has something to do with prescription drugs. The reason I said three or four is because currently we have two different drug benefits. One is a lower level and one is a higher, so it makes sense to consider continuing that structure.

Benefit design is an area where we can do a lot more. We need to take a close look at some of the benefits that we have, and determine whether it makes sense to have what I consider dollar-traded benefits. I think everyone's familiar with the Part B deductible, and Medicare right now is $100. If you really look down at most plans, you'll see that most people on a cost basis are charging between $90 and $96 a year for that benefit, and when you load it up with your expenses and your premium taxes and all those other things, people are paying about $110 and getting a $100 benefit, which seems a little unusual.

One of the other things that I think is really an interesting concept to explore is the use of co-payments. It has become very familiar to people. When you go to a doctor, pay $10 for your visit; if you go to an emergency room there's a co-payment structure. I think this could be an interesting way to look at Medicare Supplement Plans. Determine whether you could have lower premiums because of introduction of co-payments and whether it will have an impact on utilization. The theory goes that as people have more out-of-pocket costs, they take more care in deciding to go and visit a doctor.

Another interesting concept I've heard thrown around is whether the Medicare Supplement Plan should not pay the full 20%, but maybe something less; for example, 10%, with the added feature of having an out-of-pocket maximum. That way again, you may have impact of lower utilization if people have a bigger portion of what they're paying, but still protect them for the catastrophic coverages in case they have an event that is so high that you want to still have some decent coverage there.

Benefit definition. This was alluded to up here, too. One of the things that definitely needs to be looked at is making sure you define what is covered and what's not under Medicare Supplements. Maybe we can finally get the definition of that. If you paid 20% coinsurance, it's really 20% and not 50%, which is in some cases with the outpatient. There has been a lot of more recent activity, I guess it's more like a year or two ago, about long hospital stays, and what is owed when hospital days are exhausted under Medicare. Is there a limit still on what a provider can charge?

I know there has been lots of discussion and, in fact, several lawsuits that have gone around that.

The last category, by no means has this been exhausted, is benefit definitions for durable medical equipment, where the people are limited in those areas. These are the kinds of things that, as I've worked in the business, have been confusing, especially from the claims adjudication side. They may be well-defined for Medicare, and in most cases they are, but in some instances there is still some confusion around what Medicare Supplement Plans are required to pay, or should pay.

Under access, there are several points, such as the open enrollment period. It should be decided if six months is really the period of time that is appropriate for someone to decide what program they want to be in. What about a year, or something different? Maybe it is too long to begin with.

Should you explore annual open enrollment periods? One thing that is key is making sure that's consistent across all the Medicare programs, because I think it adds to confusion if you have one segment that says you have annual open enrollment periods, and another in which you have six months. It gets very confusing for beneficiaries if it's different from one to another.

The last one is one that I've already talked about, which is access for under-age-65 Medicare disableds. Is that really something that should be addressed by over-65 Medicare Supplement Insurance, or not?

Rating methodology. I know that there is a lot of work that is going on in this arena, and there are a lot of studies. It's very difficult to compare and say whether one is better or not, but I think there should still be some discussions on this. There are a lot of states which have already discussed the impact of mandating rating methodologies. But one other thing is to look at the fragmentation and confusion that comes along when more than one rating methodology is allowed. We standardized the benefits structure, but we didn't standardize the access of the rating methodology, so there's probably just as much confusion around seniors who are trying to understand actuarial issues of the difference between the attained age and entry age, community rating, etc. It's something that should be explored as far as standardization goes.

Prescription drugs. One thing I wanted to point out here is that there seems to be kind of a myth going around. Right now, in every state, there is at least one plan that is available, and it's available on a guaranteed issue basis for the first six months. That's happened since standardization. I hear a lot of people talking about an access problem, but I think really the problem is more around financing and education. Everyone has the chance to get a prescription filled, a drug plan, without having to answer any questions. It just happens to be it's under six months of eligibility. A lot of people really clamor to get the plan. They are on when they need it, so those are kind of the basics of insurance—buy it before you need it, not when you need it.

And again, I think one key thing there is consistency. If you're going to say that one group of Medicare beneficiaries is going to need to cover a prescription drugs benefit, I think it's important to make sure that's across the board. Otherwise, you just invite issues of selection, switching, and things that lead to problems for all of us in this room.

The last two areas that I've written about are Medicare Select modernization and quality care initiatives. I think there's an opportunity there to be more innovative. Today, what select plans have become is a hospital-deductible discount plan. Most programs have gotten hospitals to waive the Part A deductible, so you typically see a 10–15% discount on those programs. So when you look at the spectrum of products that are available out there, you look to one side and say you have traditional fee for service with Medicare Supplement, and you go to the other side and you look at Medicare+Choice going over to the HMO and PPO side, and you look at Medicare Select, and it's not really in the middle. It's really just one notch over from supplemental plans, and really the only net-worth element that you have there is on the hospital. That's typically what you see. I think there can be more innovation in talking about whether you can expand the availability of doing more contracting, as far as Medicare Select Plans and trying to get a plan that's not as far over, to where the HMO or Medicare+Choice are, but a little bit further away from where Medicare Supplement plans are.

The last one is one of great debate. I'm just reading the health section talk about whether quality care initiatives or disease management programs really have value and lower costs. One of the difficulties in supplemental plans is that you only pay 20%, so if you come up with a program that you think really has great impact and lower costs, sometimes the cost of those programs is not outweighed by the benefit that you see because you are only covering 20% of the benefit.

So I think it would be interesting to explore at least the opportunities that exist there, and whether you could have more partnerships with Medicare. It's a complicated issue, but one that I think needs addressing, because I think that's where a lot of the work is starting to move in the health-care field. It's moving toward quality initiatives and disease management programs at lower cost, better premiums, and things like that.

Mr. Boekhoff: Before we get to the questions, there are a couple of supplementary comments I wanted to make. Any discussion about an update on Medicare Supplement should have some discussion about likely pharmacy benefit changes in Medicare in total. I have a couple of other factors that have affected costs more recently.

When I was preparing for this, the Department of Health and Human Services Pharmacy Usage Report came out in March. I thought you may be interested in some of the statistics that are provided. The data is somewhat dated because it generally represents 1996 information. Costs have changed quite a bit since then,

but still these are statistics that are useful, so I thought it would be important to just pass along.

In the current marketplace the percentage of beneficiaries that had pharmacy coverage already in 1996 was a bit higher than I expected at 53%. One thing I should caution you about is that these statistics, and all those that follow, generally come from the Medicare Current Beneficiaries Survey, so the data is dependent on the respondents' knowledge of what their coverage really is, so it may be highly flawed. But still, that was an interesting statistic.

There also are some interesting statistics about who has coverage and what type of supplementary coverage they have. Here again, I think there are some potential flaws in the data. In particular, I was interested in this statistic of percentage of Medicare Risk, HMOs who didn't have coverage, which was 5.5%, assuming that was right at the time, which I doubt—the current value is much higher than that. I think many Medicare+Choice plans have gotten away from providing pharmacy coverage.

But then again, the other part of this that is very useful, I think, is that it points out the large number of employer plans which generally do provide pharmacy coverage and the importance that they have; 47% of those with pharmacy coverage had it through their employer-sponsored plan.

The other bit of data, which I think we will probably be talking about more as we proceed, is that pharmacy usage by health status of those who have and don't have coverage. One of the key issues that we always talk about is the selection effect. Table 7 provides an interesting look at what the impact is of the cost for those, by health status, who have coverage between the categories of those always covered, those sometimes covered, and those never covered. In general, the cost for those who have coverage is roughly twice as high as those who don't have coverage.

TABLE 7
AVERAGE TOTAL SPENDING FOR RX
(BY MEDICARE BENEFICIARIES
BY SELF-REPORTED HEALTH STATUS, 1996)

Health Status	Always Covered	Sometimes Covered	Never Covered
Total	$828	$626	$468
Excellent/Good	$635	$480	$386
Fair/Poor	$1,327	$1,003	$732

A final bit of data that I have in Table 8 relates to a continuance table that is designed around Medicare-eligible individuals. This is a source of data that I have always been anxious to see. Again, it is 1996 charge levels, if it's accurate at all, in that it is reflective of the respondents' answers, but still it gives, I think, an insight into the distribution of costs. I wanted to call that at least to your attention.

TABLE 8
MEDICARE SUPPLEMENT INSURANCE

	Total	**Covered**
No Spending on Drugs	13%	11%
$1 - $249	27%	26%
$250 - $499	17%	16%
$500 - $749	12%	12%
$750 - $999	9%	9%
$1,000 - $1,249	6%	6%
$1,250 - $1,499	4%	5%
$1,500 - $1,749	3%	3%
$1,750 - $1,999	2%	3%
$2,000 - $2,400	3%	3%
$2,500+	4%	5%

Source: Medicare Current Beneficiaries Survey

As we talked about Medicare Supplement plans and what may lay in store for Medicare Supplement plans in light of upcoming changes, the biggest thing, of course, is the likelihood that we will have some change in Medicare provider benefits for pharmacy. I listed this as a Clinton plan, but this is really the Democratic plan. In general, contrasting with Democratic or Republican plans, the Democratic plan tends to be more first-dollar, much like some of the supplement plans that are available now—50% coverage, $26 annual premium. They're trying to make some use of pharmaceutical benefit managers, and there will be some premium subsidy. But in general, they are going to provide coverage to a wider scope of people on first-dollar coverage. This is in contrast to the GOP plan, which will be more of a catastrophic level of coverage, picking it up at some level. At the time this was prepared, the level at which the proposed coverage begins has been determined, but it will provide some government subsidy of the premium that will generally cover a cost beyond some point. Some of the Medicare Supplement plans, particularly H and I, probably will need to be modified underneath the safety net of the excess plan.

One last point concerning recent changes in the BBA. We're starting to see the effects of the BBA. The key thing I think, from our perspective, will be the impact on the part the outpatient costs, and the fact that those costs will now be frozen at a level which will be the median of the 1999 costs. This will hopefully provide some stability in the supplemental costs associated with the outpatient hospital fees.

Physician fee increases were larger than they have been in the past. It's expected that the skilled nursing facility piece will decrease over the next four years, but then there were some other offsetting effects that increased the reimbursement, particularly for the home health-care workers going into skilled nursing, which will increase.

I don't see huge impacts associated with the BBRA and the Medicare Supplement plans, but there maybe some impacts on the horizon for that.

With that, are there any questions for our panelists?

Mr. William C. Weller: I always have questions. I want to make a couple of comments on what Keith talked about, with regard to the tiered-loss ratios. For those of you who are interested in getting a little bit more of it, it's going to be discussed in detail in Session 109IF "Long-term-care Rate Stability Issues."

The concept was designed to remove loss ratios on initial filings for level premium policies. The idea was to address the basis, from the guidelines that we have in many laws, that premiums are to be reasonable in relation to benefits. The question was, "how does the regulator determine that is true?"

For level premium policies, we came to the determination over a period of time that maybe we could trust competition to say that the premium would be kept low through competition, and that the individual could decide, for a level premium policy, on a premium for the set of benefits that were provided, that was reasonable for them because they purchased it. And that's the basic definition of reasonable.

And so, consequently, the regulators' role was to deal with what happened if the premium didn't stay level. When you get to Medigap, I think it's very unlikely that we're going to have a level premium for any extended period of time. I'm sure if the basic concept in a tiered-loss ratio works; it's not to say it couldn't, but because of the basis from which it came, I don't think it necessarily works.

I also did not hear any discussion, and I would like to get some comments, on what people think is the effect of the refund formula on some of the rate increases. We have plan- and state-specific refund formula calculations. So if your results are low in a state, you in essence have to defer rate increases for awhile. And then as soon as they catch up, you end up having maybe potentially higher rate increases as opposed to moving toward something which gets you to higher credibility by merging a number of states or a number of plans. Obviously, you would be able to spread the premium increase over those plans. There's no difference in the refund formula for issue age versus attained age. That's one of the things that's possibly being discussed that would encourage, possibly, more use of issue-age. So those are some things for Keith.

For Jay, I had some problems with that one table you had, too, which showed that 60% of Medigap people have no drug coverage or some drug coverage. But whether it's 40% or 60%, the number didn't match up with certainly the number of people in H, I, and J, and even if there are some prestandardized plans, it's hard for me to get there. I wonder if anyone else has some thoughts of where that came from.

I would also note that there was a recent story, and I'm afraid I can't remember it, which looked at the effect of people at various levels of drug coverage in one year and over the next several years, which showed that there was a high correlation of

high use in continuing years, which is something that, you know, I think you sort of expect. But there is a study that actually has verified that, and can give actuaries some assurance that the effects of selection when people are able to pick coverage and know they use it this year, there's a high correlation to the thought they're going to use it for several years.

Mr. Boekhoff: Keith, do you want to start? I noted the ones that pertain to me, so I'll come back to those.

Mr. Powell: I think two pertain to me. And I hope I said that meshing this tiered-loss ratio approach from its present proposal in LTC to a trend-sensitive product certainly would take some cutting and pasting, and I agree with that. I must say that in some discussions that I've heard, it is the problem with the rate increases, per se, that seem to generate interest in carrying over some of this logic, so I do think that you will see some interest in that. As for refunds, I'm not supposed to make a state-specific comment. I have not seen many refunds. And I recently heard a very good explanation from Jay, in fact, to the effect that maybe this is the way the process is constructed, with the refunds being a kind of safety net that engage with more power with the passage of time. The fact that there haven't been many so far doesn't mean there won't be any in the future.

But as for right now, there's practically nothing there, so I haven't really thought through much what impact it has on rating from a regulatory side, because there's no raw material to work with.

Mr. Boekhoff: My view on the issue of the tiered-loss ratio is that it seems to be based, as you say, on the premise that someone is starting out buying a level premium policy. They deserve a fair quote of what the rate is at that time, and if the rate needs to go up the regulator needs to be concerned.

For Medicare Supplement the situation is a little bit different, in that everyone who will have a policy probably has one now (other than those who age-in). And so, the need for it is maybe not quite as great as it might be with LTC, where the future market is so much greater than the Medicare Supplement.

But with regard to the refund question, Diana, Keith, and I conducted a session for the state regulators a couple of weeks ago. We had about 38 people from 20-or-so different states. I asked the question at that time: Who has seen a refund filing that resulted in an actual refund? There were two people who raised their hands, and in both cases it was a rather minimal amount. So my view is, that there haven't been many refunds, to this point, and as Keith said, my view is that the way the formula is structured, (with the low initial loss ratios that grade up to an eventual long-term loss ratio) eventually will provide the safety net. And we'll see some increases. I think your point about the credibility is a good one, in that many states do have a relatively small amount in each pocket, and you have 500 lives, as in life-years, so as the life-years increase, the credibility formula will decrease a little bit, and we'll see some more impact of that.

I know you were involved in the initial discussions of that whole formula, and it was a political trade-off between those that felt that on one hand maybe the 65% should be set policy-by-policy, year-to-year. Most who had some insurance knowledge realized that wasn't a possibility. Trying to find some kind of combination between ended up with what I think is basically a safety net that will eventually come up.

With regard to your question about the percentage of people reporting having pharmacy coverage, I agree that number is surprising, and I think it's more of a reflection of people not fully understanding what their policy is than what the market may truly have.

By the way, some of the statistics in there are useful if you take them with the right grain of salt.

Mr. Powell: Yes, I think on the prescription drug in particular people confuse the difference between a prescription insurance benefit and those who have access to sale, such as a discount prescription card, that's available through the plan that they have. And so, because they have those cards, they answer the question "yes, I have coverage"; in reality what they may have is just access to a network that gives a lower benefit on prescription drug costs.

Mr. Harvey Sobel: I have a question primarily for Tom on the United's experience with the drug plan. I was surprised to see such a low number of lives, but with these fixed dollar limits, I recognize this may well change, depending on what goes on congressionally. I'm just wondering to what extent you're seeing seniors hitting these limits, and also with the introduction of more coverage for the disabled, I'm wondering if you're seeing those limits also being strained.

Mr. Lindquist: Our experience is actually showing that we do have an open access policy in the first six months, but then we do underwrite a prescription plan later on. The majority of the people who are coming in to the program are coming in the first six months. We have, actually, a very low percentage of people who are maxing out. I don't remember the figure, but I want to say it's under 10% or 20% of the people. But, because the maximum is not changing, it will get higher and higher. So, for example, on our prestandardized plan, it is a much higher percentage, but for the maximum benefit on those plans, most of them are, on average, probably 15 years old. It's only $500, so more people are hitting the maximum.

Mr. Sobel: Any comment on the disabled coming in?

Mr. Lindquist: Someone just asked me this question earlier this morning about the experience on disableds, and when you look at the Medicare data, if you take out the ESRD, the average disabled is actually a better risk or morbidity risk than the aged individual.

However, the insured disabled is not a better risk. In that case, those people know who needs insurance, and in our case, you see probably 200–300% higher losses on disabled than you see on the aged population. But it varies, again, geographically.

Mr. Thomas C. Foley: I've been significantly involved with the two-tier rewriting of LTC. I've also been involved for 20 years as a company actuary pricing Medicare Supplement, and for the last 10 years reviewing Medicare Supplement. It's my observation that the prime problem that we have with pricing health insurance in this country, especially medical expense, is that we underprice initially. That gets us in the hole, and then we have no place to go but to an assessment spiral.

One of the things that a fixed-loss ratio does is it puts a cap on that initial premium. So it seems that's motivation enough to eliminate a fixed-loss ratio, in addition to the fact that from a regulator's viewpoint, and thinking about consumer issues downstream, that provide a fixed-loss ratio also provide fixed-expense margins, which you could argue may or may not be there.

It well may be the case that we don't end up with a similar two-tiered approach that we're proposing for LTC, with medical expense coverage, but it's my strong observation that we need to replace fixed-cost ratio. And I would specifically like to hear any comments about this initial underpricing. I've seen very few blocks in the last 30 years where I thought that the initial premium was sufficient; that even if you closed blocks, and even if you had significant inflation, that you were able to not get into a spiral mode, because the initial premium was maintained adequately all along.

Is it possible to do that with medical expense? I've seen a few examples where it has happened. If so, why in the world don't we get about changing it so more companies are encouraged to get the thing right?

Mr. Boekhoff: Do one of the panelists want to take a shot at it? Let me comment on the concept of the initial premium being capped. My understanding of what you mean by that is, particularly on policies that have a durational effect where in early periods the effect of underwriting of precondition exclusions might lower the claims' cost, if we have a defined ratio and the premium can't be any higher than what would justify that loss ratio, the effect is it creates a cap on what the premium charge can be.

My view on the answer to that is that what needs to happen is we need to be looking at the policies more in terms of durational loss ratios, so even though there may be a cap, it's capped in a loss ratio—for example, in Medicare Supplement—not at 65%, but at something lower early on, with the idea of long-term reaching, in a case of Medicare Supplement, the 65%.

And also, the corresponding effect of that is that the loss ratio and policy duration are much higher than the 65% if it's low enough, early on, to balance out, so that it may have some effect with dealing with that situation of assessment spirals.

My view is that's sufficient. I know you don't share that view, because we talked about it before, but I think that's a step in the right direction and for companies and regulators to emphasize anticipating what that impact will be will have some impact on the long-term financial viability.

Mr. Powell: This is a fairly new concept to me. I just heard the whole thing described recently by Tom, in fact. Here are two or three thoughts beyond those that are already given. It's hard to know what's in someone's head, and it's hard to look after the fact and know why a product started out priced low. My sense is, it's probably marketing where that's happening; it's probably market pressure as opposed to a fixed-loss ratio. I may be wrong about that, but that's my sense. I guess I don't agree that loss ratios aren't that useful, but maybe I'm wrong.

Something that I have found really interesting, like Tom, is that I've seen a few blocks of supposedly trend-sensitive business where the rates have not increased much, if at all. But what I found strange about them is that they all have rather low lifetime loss ratios. And sometimes the highest loss ratios accompany the highest increases. It's kind of an interesting question.

If you buy the idea that the lifetime loss ratio is a proxy for the value of the business, through the entire insured block, what does that tell you? Why is it that in quite a few cases those with the rates that have not changed much, actually have a low lifetime loss ratio, and at least by that test, are not a good value? Although Tom is certainly correct that the insureds who are around at the end and paying those fierce price increases are the ones who suffer, no doubt.

And that goes back to what I was getting at. That's kind of hard; it's almost like you have to look carefully at each corner of the population before you can answer some of these questions. Really, it's very difficult. These are very good questions. And I'll just say, I'm much indebted to Tom for giving me a fast education on this subject over a recent period of time.

Mr. Boekhoff: We have time for one last question. If no one else has it, I'll take it. And it's to Diana, which is more of an operational question about how a company should handle the high-deductible plans, in terms of refund filing.

Ms. Wright: The plans, I think they are F and J, would be included with the other F and J. They would not be rated separately, or for refund purposes, be treated separately.

CHART 1

Medicare Supplement Update **Marketplace**

Standardized Medicare Supplement Lives by Plan