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Session 7PD
Issues and Trends in Medicare Supplement Insurance

Track: Health

Moderator: KENNETH L. CLARK
Panelists: JOHN S. CATHCART
KENNETH L. CLARK
GARRY R. REED

Summary: What are some of the key issues and trends facing the Medicare supplement industry? Topics include emerging claim cost experience and trend, Medicare Select issues and challenges, and success in meeting rate increase/profitability objectives. Attendees gain insight into key issues currently facing the Medicare supplement industry.

MR. KENNETH L. CLARK: The panel will discuss three topics. First, I will present an overview of recent industry claim cost and trend experience, as well as some of the issues and considerations for reviewing company-specific experience. Then, John Cathcart will discuss the Medicare Select market. Finally, Garry Reed will talk about the issues and challenges of trying to achieve profitability in this business.

So let's begin with industry claim cost and trend experience. I want to focus on three areas. First I'll discuss recent industry experience from various sources. Then I'll talk about analysis of company-specific experience. Finally, I'll touch on what that means in terms of future expectations. With respect to recent industry experience, I'm going to provide some high-level summary information of various resources. One is an informal survey that we in the Chicago office of Milliman conducted over the last several years. There is also the Academy report (Report on Medicare Supplement Experience, years 1996-2000; American Academy of Actuaries; February 2003) that was released in February. I will also summarize NAIC data.

Over the last several years, we've conducted an informal Medicare supplement

trend survey. It's by no means a scientific survey. We don't ask for a great deal of detail in terms of what underlies the analysis. We basically ask companies what they believe they've experienced in terms of underlying claims trend. I think in our last survey, we had roughly 30 participating carriers. The results of our question about 2002 indicated that the majority responses were in the 8 to 10 percent range, and roughly 80 percent of those were less than 10 percent.

For those of you haven't read the Academy report, I would encourage you to do so. There's quite a bit more detail than I'm going to get into here, but I wanted to provide some summary information. This report was based on five years of claims data. The summarized trend results indicated, at least through the year 2000, that claim trend levels have dropped both in terms of the absolute level of trend, as well as what's called the excess of the expected or benchmark level. My understanding is that the benchmark level is based on, among other things, Medicare claims data reflective of Medicare cost sharing claims for the Medicare eligible population, excluding those enrolled in Medicare Select plans.

There are obviously many underlying causes for changes in claims trend. Some of the key drivers that were pointed out were the change in hospital outpatient payments to the Prospective Payment System (PPS), the increase in prevalence of disabled under 65 in the Medicare supplement population, and the high claims trend of prescription drug claims. The report defines claims trend as the change in annual claim cost per insured life. It's important, with whatever source you're looking at, to understand what the definition of claim trend is, since different companies have different definitions.

This analysis is limited. It represents a proxy for the market. It doesn't necessarily represent the entire market, although it is an extensive database. For a particular company, as you look at five years of data, you're going to have change in mix throughout the years of geography, plans and that sort of thing. So some of the trend results may reflect mix changes as well. The report discusses variation by plan and variation by region. Generally, Plan A indicates a higher trend level than other plans. As far as geography is concerned, the Northeast has a much higher claims trend and the West has a much lower trend. The report addresses Medicare + Choice disenrollment and seems to indicate that the result is anti-selective behavior resulting in Medicare + Choice terminations.

From the NAIC database, indications are that the overall industry loss ratios are around 80 percent. For 2001, the loss ratio dropped about a point and a half. Within that you've got a mix of immature blocks and mature blocks. But if you look at this as a proxy for an aggregate loss ratio level, it seems to indicate, at least overall, that competitive forces are certainly keeping Medicare supplement rates at a reasonable level. This is overall market, and obviously there's variation by company with a mix of A-rated companies and B-rated companies. So, the question is, what are the reasons for the improvement? Is this a one-time phenomenon or is this something that's going to continue?

With respect to company experience analysis, I've identified four steps that one would go through to dig out an implied claims trend level. The first step is to look at unadjusted loss ratio experience or just the incurred claims experience that's typically available. Second is to make a decision about what kind of detail you want to look at. Third, isolate what I'm going to call non-secular drivers—whatever you define as falling outside of your definition of underlying claims trend. And last, I will discuss the process of deriving a claim trend estimate.

For underlying claim experience, summarize incurred claims and exposure by incurral period, which generally would be available from typical experience reports. The incurral period ideally would be by month of incurral for the last two years. Then the question becomes what kind of detail do you want to look at? That's obviously going to be based on the particular circumstances of the company, including the availability of data, the amount of time and resources you want to put into it and whether or not you feel there's materiality involved. Issue year is important if you want to be able to identify any first-year selection and/or pre-existing condition limitations impact of your claims. Obviously for Medicare supplement, there's much more of a limited impact for most plans, so that hasn't been a big issue. But nevertheless, a company may want to isolate its experience by issue year. Some other details are by geography or attained age band, or if a company has different distribution systems, they might want to look at that separately.

Next is the isolation of non-secular drivers. People have different definitions of what they consider claims trend, and I wouldn't say there's a right or a wrong way to do it. But how you use it must be consistent with how you define it. Some companies might consider some of these items as part of their overall underlying claims trend. Nevertheless, it's a valuable exercise to attempt to isolate the impact based on these components. I've identified four components: aging, selection wearoff or first year versus renewal impact, rate increase anti-selection and seasonality. The exercise here is to make adjustments to normalize your claims and isolate the impact to your definition of claims trend.

With respect to aging, for given time periods, look at your attained age distribution, apply claim cost factors and develop an aging index from period to period. A company could use a claim cost slope that's assumed or a rate schedule. Generally, a claim cost slope would be preferable, because in many cases the rate slope itself isn't necessarily an indication of matching the true claim cost pattern.

With respect to selection wearoff, in a lot of cases this would have a minor impact due to open enrollment. A lot of it has to do with what plans are offered, as well as whether you've got a stable block of business or an immature, rapidly growing block. In the latter case, selection wearoff might have a significant impact.

With rate increase anti-selection, you need to try to quantify the anti-selective impact of corrective rate action. Corrective rate action, as I would define it, would

be rate increases above an underlying claims trend or an index level of something like 10 percent. It's a very subjective measurement, admittedly. We have used rule-of-thumb formulas where we look at the difference between the rate increase and a threshold level and assume x percent is claims anti-selection. Again, it's subjective, but to the extent that your past experience has reflected some significant corrective action, if you don't take it into account, you are in danger of overestimating your true underlying claims trend.

Medicare supplement exhibits significant seasonality based on the benefit structure. Generally it's very high in the first quarter, then it grades down and levels off in the second half of the year. If you're looking at experience by quarter or, ideally, by month, you want to try to normalize your experience for the seasonality.

Once you've gone through the exercise of identifying the impact of various components, you need to normalize your claim costs for the impact. If, on the other hand, you're including some of these components in your claim trend, then you wouldn't include them here. But it's still valuable to have an understanding of the impact of these components. For example, you adjust everything up to your current demographic mix, adjust up to the ultimate claims level and adjust to the cumulative claim anti-selection, backing out any seasonality.

The bottom line is you're trying to estimate restated claim costs where the change is your underlying claims trend. At that point, it's a very simple process of taking ratios of claim costs. You can look at it in different ways, by annual ratios, quarterly ratios or monthly ratios. You can look at rolling 12 months, rolling six months, and draw conclusions. Obviously, you need to view your results for reasonableness; that goes without saying. And you need to consider the credibility of your data, particularly if you are breaking up your experience into a lot of different components.

Now that you've looked at your historical claims trend, obviously you want to do something with that. We're in the business of forecasting the future. So, what does all that mean for future expectations? In our informal survey, we asked what expectations were for 2003 for Part B trend. The majority of responses were in the 5 to 7 percent range, with 95 percent of the responses expecting less than 10 percent.

Historical trend is obviously based on the past. What does it mean going forward? It's a starting point. And if you have an understanding of your historical trend, and an understanding of the components that make up that trend, then you are in a good position to focus on what's going to continue and what's going to change. There are some obvious things to look at: Are there any changes that are expected in utilization? What are your expected changes in benefit level? You also have to consider the mix of disabled under 65. Is that proportion of the market going to continue to rise? Is it going to flatten out?

You could potentially consider isolating Medicare + Choice enrollments and disenrollments at the front end. But if your historical experience has reflected some anti-selection based on past Medicare Choice enrollment, you need to consider the extent to which that's going to continue. To the extent that your business is in geographic areas where there is currently a high concentration of Medicare + Choice, you need to consider what's going to happen in the next year. Is there going to be a significant amount of disenrollment there? Based on all the information you have, you do the best you can to project what your future trends are.

Next, John Cathcart, vice president of Gen Re, is going to talk about the Medicare Select market.

MR. JOHN S. CATHCART: I'm going to give you some background on Medicare Select: what it is, its history, how it came to be and how we are in the position that we're in today. Once I give you that brief overview, I will present some experience at two different levels.

I'm going to talk about industry experience and present some statistics that we have derived from the NAIC data. Direct writing companies submit their Medicare supplement experience to the NAIC. They produce a summary report each year, but they also have a database that is available for purchase and has a lot more detail. We have extracted some information and calculated some of our own statistics from that data.

After that I will talk about some experience on Select business from a particular company that has a fairly good size block of Select as well as standard business. Some of the comparisons of experience between the Select and standard blocks for a particular company are interesting. One of the things I want to point out before I get into the statistics is that I haven't gone through a lot of adjustments for attained age or duration or anything else. So there are a lot of possible explanations for some of the data that you're going to see. I wouldn't call it a pure, controlled actuarial study by any stretch of the imagination.

What is Medicare Select? Basically, it is a type of Medicare supplement policy. The benefits to the beneficiary are the same as they would be under the standard plans if the insured chooses a specified network of providers. In a select plan, the insurance company has developed a network of providers. That network has typically agreed to waive the Part A deductible on the Medicare supplement policies for those policyholders who use that provider. Other than that, the plans are exactly the same as the corresponding standard supplement policy. In exchange for agreeing to use the network provider, the insured gets a lower premium than he or she would otherwise pay under the corresponding standard plan.

The Select business is subject to specific regulatory requirements. I won't go into all of those, but in general the insurance company has to submit a plan of

operation, which has to be approved by the insurance commissioner of the state in which they intend to operate the network. This plan must be able to demonstrate that the availability and accessibility of services are at least as good as what would be available under the standard plans. There has to be a grievance procedure. They have to have a list of network providers. There has to be disclosure to the insured that they are participating in a restricted network in order to get the full benefits.

In addition, the company has to be able to provide a standard plan to the insured of equal or lesser value than the corresponding Select plan. If an insured is within the first six months of participating in the Select plan, he or she a guaranteed issue right into the corresponding standard plan if they decide they don't want to participate in the restricted network. Also, if for some reason the network fails, if the commissioner decides that that network isn't functioning and disallows the Select plan, all the people who were enrolled in the Select plan have a guaranteed issue right at that point in time into a corresponding standard plan of lesser or equal value.

Medicare Select is not a Medicare HMO or Medicare + Choice plan. This is a Medicare supplement plan. It supplements traditional Medicare, just like the standard plans do. The Medicare HMO or Medicare + Choice are actually alternatives to traditional Medicare. As the standard Medicare supplement plans do, the Select plans supplement Medicare.

The Medicare Select business was initially allowed under the Omnibus Budget Reconciliation Act (OBRA) of 1990, which also provided for the standardization of Medicare supplement plans. That is the 10 plans, A through J, that we've all come to know and love. At that time, they provided for a three-year test program for Medicare Select business in 15 states. In 1994, Social Security Act amendments extended that test program to the middle of 1995. The following year, the amendments to OBRA extended the test program for another three years and expanded the test program to all 50 states. At that time, they also called for a study comparing the cost, quality of care and access to service under Medicare Select policies to that under other standard Medicare supplement policies.

That study was supposed to have been completed by the middle of 1997. At that time, the Secretary of Health & Human Services was supposed to make a determination as to whether or not these plans were meeting their objectives regarding cost, quality of care and access to service. I never saw the study, so I don't know if it was ever done. Obviously, Medicare Select is still being sold. Presumably the Secretary of Health & Human Services found that they were okay, but I never found anything official from him at the end of 1997.

Last year, the Centers for Medicare and Medicaid Services (CMS) issued a bulletin that provided some clarification on a number of issues. Among those issues were provider discounts, innovative benefits and then there was some discussion of Medicare Select business. With regard to Medicare Select, the Office of Inspector

General's safe harbor regulations allowed hospitals to waive cost sharing without violating any kickback statutes, but that did not extend to Part B benefits. That's why under the Medicare Select programs traditionally the only thing that got waived, the only benefit to the Select program, was the waiver of the Part A deductible.

There were proposed changes to the regulations that would have permitted participation of other providers in preferred networks, with those savings being passed onto the insureds. CMS was saying, at that point in time, that if those regulations are changed, you could have discounts provided for the Part B benefits. Or you could waive the Part B deductible, similar to the way the Part A deductible is waived, and that could be treated as an innovative benefit in a Medicare Select plan.

As I mentioned, direct companies submit experience data to the NAIC annually. They produce a summary report that has detail behind it. We've acquired that detail and generated some of our own summary statistics, including the relative volume of business. All my comparisons here are Select plans to standard business, so you can get a flavor for the differences in how it's being sold, how much of it's being sold and what some of the experience is. Ken mentioned some data that also came from this report on loss ratios. His loss ratios are a little bit higher than I'm showing, but actually both are right. The data that we analyzed is just the data that was submitted by the life companies. The summary report includes data submitted by life and property casualty companies, and I believe that's what Ken's is based on.

For the volume of business, we based all these distribution numbers on number of lives, not premium. About 6 percent of the business that was in force in 2001 was Select business. More of that was issued in the most recent three years than was prior to that. Of the business in force in 2001 and issued between 1999 and 2001, 12 percent was Select. Business in force in 2001 but issued prior to 1999 was only 3 percent Select. This probably reflects a number of different things. The older business would come from the test period, prior to 1997. So you're going to see less business in Select for that reason. In fact, prior to 1995, the business would have been limited just to the 15 states that were participating in the Select program at that point in time.

These data do seem to indicate, however, that the Select business may be becoming more popular. Or it may be that the persistency is getting worse on the Select business. When we look at some loss ratios, there are some interesting findings. If you've got higher rate increases on the older business, it's entirely possible that they have had worse persistency relative to the standard business, and, as such, the older business is less concentrated in Select.

Which plans are most popular in the Select market? In Table 1, the figures show that, as is the case in the standard market, the most popular plans are C and F.

What I found interesting is that, relative to the standard business, you have higher concentrations of Select business in Plans B and E. There may be a number of interpretations of this. The one that I think seems to make the most sense is that the people who are purchasing Select business are typically looking for bargains. Plan B is the cheapest Select plan with a benefit difference from standard. Plan A doesn't pay the Part A deductible. There really isn't a benefit difference between Select and standard business, and I'm not sure what's being sold under the Select Plan A to begin with. If you go to Plan B, then you have the cheapest plan with a benefit difference. That suggests people are just trying to get the cheapest plan they can find, or maybe they're being sold the cheapest because they can't afford anything else and the agent realizes this.

Table 1
2001 NAIC Experience Data: Distribution of Lives by Plan

Plan	Select	Standard
A	1.1%	3.5%
B	12.8%	5.3%
C	22.6%	21.2%
D	9.7%	8.2%
E	6.8%	2.6%
F	45.3%	46.4%
G	1.4%	5.0%
H-J	0.3%	7.8%

A similar situation exists with Plan E. I see Plan E as a cheap alternative to C and F. The main difference between Plans E and C and F is that Plan E does not pay the Part B deductible. You get the bargain hunters once again trying to find the cheapest version of a plan that has the somewhat richer benefits of C and F. Note that almost no business is being sold in the drug plans in the Select market. Only .3 percent of the Select market is in the drug plans, as compared to 7.8 percent in the standard market, once again suggesting bargain hunters. The people who are buying Select do not appear to be out there trying to find the richest plan.

Where is the Select business being sold? Table 2 shows that the three most popular states for selling Select business are the same as the three most popular for the standard business. However, there is significantly more business in those three states for Select business than there is for standard. In fact, those three states account for over 50 percent of the Select business and less than 25 percent of the standard business. Overall, 70.2 percent of the Select business is concentrated in seven states, whereas only 40.8 percent of the standard business is concentrated in seven states, the first three states being the same, the next four states being different.

Table 2

2001 NAIC Experience Data: Distribution of Lives by State

Select

Florida	26.4%
Illinois	16.4%
Texas	11.2%
Louisiana	4.7%
Kansas	4.6%
Idaho	4.0%
Tennessee	2.9%

Standard

Illinois	8.2%
Florida	8.1%
Texas	7.6%
Virginia	4.5%
Missouri	4.3%
Iowa	4.2%
Ohio	3.9%

There are a number of things that may account for this. Florida and Texas were two of the original test states, which may explain the relatively higher concentration in those two states. I'm not sure exactly why there is a higher concentration of Select business in Illinois. There may be regulatory differences. In addition, Florida and Texas, and perhaps Louisiana also, are states that have been subject to a fair amount of HMO disenrollments. Illinois may be also, though I'm not sure. People who are coming out of an HMO may be looking for the cheapest plan available. They're also used to dealing with restricted networks. So these plans may be appealing to them.

Table 3 illustrates the difference in loss ratios. Once again, there's no control over a lot of things that can affect loss ratios. These statistics raise more questions than they answer. Looking just at standard, you see a 75 percent loss ratio on business issued in the last three years. This is on a product that in general has a minimum lifetime loss ratio at 65 percent, so I'm wondering how people are going to make money on this.

Table 3

2001 NAIC Experience Data: Loss Ratios of Select vs. Standard

Issue Date	Select	Standard	Total
1998 & Prior	88%	77%	78%
1999-2001	65%	75%	74%
Total	74%	77%	77%

For Select business, the experience in 2001 on policies issued in 1998 and prior shows an 88 percent loss ratio, which would seem to reflect the aging. In the more recently issued policies, there is a 65 percent loss ratio. You would hope to see some selection in that period, but I guess 65 percent might be tolerable. So what's going on? Are we pricing business better recently because we've learned from some of the experience? Has the older business been subject to higher rate increases and some anti-selection, causing that block to deteriorate to 88 percent?

Some of this data may also be reflective of claim reserve allocations. I'm not sure how companies allocate their claim reserves between different blocks of business within Medicare supplement. So there are any number of explanations here. In general, in 2001, the Select business had a slightly better loss ratio at 74 percent, but there seems to be better selection anyway in the Select business than in the standard business.

I want to talk about the experience of one particular company: Company X. This company has significant, credible volume in both Select and standard business. Because they're the two most popular plans, I only looked at Plans C and F. Once again, I have not tried to adjust experience for age, duration or geographic differences. I took a look at the average premiums, and I tried to break down the claims by type of benefit to see what types of claim cost differences were emerging between Select and standard business for this company.

Table 4 shows the average earned premium for the 2001 experience year. The average earned premium on Plan C for the Select business was about 12.5 percent lower than the standard. The average Select premium for Plan F was about 13.5 percent lower than the standard. Another thing that we'll notice here, which we're all fairly used to now, is that while Plan F presumably has the richer benefits, Plan C has a higher premium and the higher claim cost, which is not atypical in the market.

Table 4

Company X Average Premium

Plan	Select	Standard
Plan C	1387	1581
Plan F	1157	1340

In Table 5, you see that for Plan C the loss ratios were equal between Select and standard. These are incurred claims in 2001—paid claims for 2001 losses plus remaining claim reserve. I don't know that these numbers reflect differences in claims, as opposed to unintended premium differences, i.e., too high a discount for Select business. As we can see, for this company the loss ratio on Plan F is significantly higher than it was for standard, although they are equal on Plan C.

Table 5

Company X Loss Ratios

Plan	Select	Standard
Plan C	75.6%	75.6%
Plan F	79.7%	69.3%

In Table 6, the first thing that you notice on Plan C, as is to be expected, the Part A deductible is significantly higher on standard than Select. You might ask why Select is greater than zero. The company will pay a Part A deductible on a Select plan if the beneficiary has to go to a non-network hospital for an emergency situation. So you do get some Part A deductibles.

Table 6

Company X Average Claim by Benefit—Plan C

Benefit	Select	Standard
Part A Ded	39	230
Part A Coins (inc. EHD)	21	8
Part A SNF	67	95
Part B Ded	101	100
Part B Coins	819	760
Other	1	2
Total	1048	1195

What becomes interesting after that is the Part A coinsurance is higher on Select. The Part B coinsurance is higher on Select. The skilled nursing facility has a lower

claim cost on Select. It could be that less healthy lives are buying Select plans, which would explain the higher coinsurance on Parts A and B. The higher Part B coinsurance amounts on Select may be a result of some possible cost shifting to outpatient on the part of the hospitals. If they're not going to get paid for something, then they treat them on an outpatient basis.

For Plan F, Table 7 shows some similar results. Although in general the claim costs are all lower on Plan F, you see similar patterns. You have higher Part A coinsurance on Select. You have higher Part B coinsurance on Select. For the Part B deductibles, you might ask how you can get a number greater than 100. I'd say that that's a statistical anomaly, because we didn't really go in and scrub the data. We were using average lives during the period, which can create some distortions in your average claim costs.

Table 7

Company X Average Claim by Benefit—Plan F

Benefit	Select	Standard
Part A Ded	45	163
Part A Coins (inc. EHD)	18	6
Part A SNF	39	37
Part B Ded	105	94
Part B Coins	714	627
Other	2	-
Total	923	927

FROM THE FLOOR: The $100 deductible is a calendar-year deductible, and policy year doesn't necessarily coincide exactly with calendar year.

MR. CATHCART: That could explain it. And I couldn't control for agents. You don't have the same agents selling both, although there may be some. An agent presumably is going to get a higher commission off a standard plan than he will off a Select. So he would presumably prefer to sell a standard plan unless he sees an opportunity to get a lot of easy volume on the Select business, because it's probably significantly lower. An agent may also realize that affordability could be an issue for some policyholders, particularly for a policyholder who is less healthy, and may be pushing the Select business toward less healthy policyholders because they can't afford anything more than that, and that's going to affect their experience.

The differences between C and F are that F pays 100 percent of the Part B excess. So you would expect the Plan F cost to be higher. However, I think it's more a matter of selection. People who know their doctors are accepting Medicare are perhaps the less healthy ones. They know their doctors really well, and they're going to select themselves into Plan B, which doesn't pay the excess, because they

know they're not going to get charged the excess anyway. That's my guess.

As I've been mentioning all along, there are a lot of variables that can impact these results. How a particular agent sells the business is one of those variables that I haven't listed. But there are other things that can impact your results: the distribution of the business by state and even within states, the distribution of the business by attained age, by duration, by relative volume of open enrollment and guaranteed issue business. And you also have the potential impact of rate increases and anti-selective lapsation, all of which were well controlled in the study that Milliman did for the Academy and that Ken referenced.

The data I've looked at consists of just one point in time. I think it would be interesting to try to study the Select business trends to see how those trends may be different from the standard business. Another thing that'll be interesting to keep our eye on is the impact of additional innovative benefits, particularly if carriers can start establishing networks that will waive the Part B deductible. Waiving a $100 deductible might not mean all that much, but the legislation that is working its way through Congress right now provides for increases in that Part B deductible starting in the year 2006. As that becomes more significant over time, it may be that the Select business that provides for that waiver may become more important. Also, Medicare reform in general could have an impact on what's happening. Of course, Medicare Select or supplement or Medicare itself may not be around in 2006. I think they will be, but they'll probably be a lot different than what we know right now.

MR. CLARK: Thanks, John. I want to make a qualifying statement about the Academy report. Even though most of the work came out of our office, I actually was not involved in that particular project. It goes without saying that most companies have a goal of profitability in Medicare supplement business, and, as we've seen from the industry loss ratio experience, that's quite a challenge in today's competitive environment. Garry Reed from Universal American will talk about that and hopefully provide some insight.

MR. GARRY R. REED: What's unique about Medicare supplement? We're going to talk about how to achieve and maintain profitability in the Medicare supplement market. Medicare supplement products are unique. It's a very large market, about 35 million seniors and people on Medicare, split about one-third, one-third, one-third. One-third of the people have employer-sponsored, Medicare supplement type plans. One-third of the people have private Medicare supplement type plans, individual plans. And about one-third either don't have any supplemental type insurance or they're in a Medicare HMO or Medicare + Choice plan where they really don't need any supplement.

The market for Medicare supplement is at least 10 million. Everyone knows we've got standardized plans. You can't invent new bells and whistles. As a result of that, the market is very competitive. To a large extent, for a lot of companies, price is

what sells. Service is great. Name is great. We can all sell on those as well, but price is probably the most important feature for most of us. These products are largely attained-age rated. There are states—Florida, Missouri and Idaho, that I know of—that require issue-age rating. There are also some community-rated states—Arkansas, New York, Connecticut, Vermont, you probably can think of others—but for the most part states are attained-age rated, which creates its own profitability challenges.

We have a guaranteed issue risk. We can underwrite a large portion of our people, but a large portion of them are allowed to just jump in. If they've been in a Medicare HMO, they can jump back into a Medicare supplement policy guarantee issue. We also have open enrollees, but obviously that can't be underwritten. This makes a challenge for profitability. Insurance departments tend to be fairly protective of seniors. That's my opinion, but I think that on a lot of other products, for example a cancer insurance product, the balance is more even between the insurance company and the consumer. For senior-type products, and particularly Medicare supplement, I think insurance companies are very protective of seniors. As a result, we've got low profit margins. I think everyone would agree that our profit margins are reasonably low. So we've got to work hard.

In terms of profit, what kind of measures do we typically look at? And here I'm talking about an initial pricing. Typically, I think present value of profit as a percent of premium is one of the most common measures when we price our lifetime projection. We say we're going to get 3 percent or 5 percent or 7 percent, whatever the number is. Internal rate of return and return on equity are also fairly commonly used. Break-even year is not a profit objective in and of itself, but it's something that needs to be communicated when we do our profit testing. On attained-age products, this can be eight, nine, 10 years for a break-even year on a statutory standpoint, because of the six-year flat commissions that most of us have. We need to consider before-tax versus after-tax results. Don't ignore the after-tax results. Another consideration is the surplus strain. And don't price without considering the impact of required surplus. It makes a big difference on the internal rate of return.

For initial pricing strategies, it's most important that you consider your rating classifications. I think I've hit the main ones here: age, sex, smoker/nonsmoker status and area are the important ones. Clearly, if you don't rate by sex, you're going to be selected against by policyholders. You're basically going to get all the males. But we continually see companies out there in the market that put themselves in that position. I see a lot of shadow pricing, which is very bad. Don't assume that just because somebody's out there with a rate that they know what they're doing or that their objectives are the same as yours. You can go into any state and find some company where you want to ask why they are so low. And then, sure enough, some other company will be down there with them. As actuaries, I don't think I need to tell you not to do shadow pricing, but it's surprising how much of it is out there.

Another strategy that I've seen is a conscious effort to price low initially, with the idea of raising rates more than trend later on. First of all, I think that goes against our Actuarial Standards of Practice. Your actuarial justification in your business plan or your pricing needs to be consistent, and I doubt if anyone's sending an actuarial memorandum in with this strategy on it. I know there are companies out there doing it, and it is a strategy that may be effective, but I don't think it's particularly ethical. An honest job is good.

As far as competitiveness versus rate adequacy is concerned, we get a lot of pressure to have our rates be low, to not go for the big rate increases, to start off low. There's a wide range of rates in the market. We get pressure from sales and marketing on initial pricing and on rate increases. Frankly, there is potential for huge sales results if you can go out there and be the low company in the market. The question is, when does the piper get paid? For most companies, adopting a strategy of pricing low and then hopefully making it up later will clearly shorten the life cycle of the product. As you're making it up, your lower rates are going to be higher than they need to be, and you're not going to be able to sell it anymore. So instead of having a product that has a life cycle of eight or 10 years, you're going to have a two- or three-year life cycle, and you're going to be worried about anti-selective lapsation. When you start getting into needing 15, 20, 25, 30 percent rate increases, your whole block is going to suffer as a result. I guess, as you can see, I'm pushing for reasonable pricing, reasonable rate increases; don't jump in and try to be the low person in the market. I don't think that's an antitrust point of view.

Experience monitoring is critical to maintaining profitability. You've got to have a good experience monitoring system. As the actuary, you've also got to be a part of the claim reserve setting process. When you're trying to decide what to do with rate increases, you've got to know how much margin you may or may not have in your claim reserves and how comfortable you are with those claim reserves. That claim reserve could mean a difference of several points in the rate increase request or the rate increase requirement, and you've got to be familiar with that. I recommend you always use restated experience. Financial loss ratios are good for the finance people, but they can really lead you astray if you're depending on them to determine your rate adequacy. You can be making up for past bad estimates of claim reserves, and it'll make your current period look bad when really, on a restated basis, your rates aren't bad.

Dig deeper if necessary to understand the results. We had a situation where we had some really horrendous loss ratios from one year to the next and we couldn't figure out why. We dug deeper and deeper, and we found out: We got hit by a huge amount of HMO disenrollment all in one area. It just killed us, and that was just in one particular state. But it helps to know, when you do dig deeper, what the causes are for your experience deterioration, or for whatever's going on with your experience. Then you can judge whether it's something that's going to continue or not, and maybe you can judge whether or not there's something you need to do to fix it. Otherwise, you're just guessing.

I like to use actual-to-expected analysis in a lot of what I do. A lot of times when you're digging down deeper and deeper, you run into cells that are so small that you just can't tell what's going on. So actual-to-expected tends help with that analysis of, for example, loss ratios. Pooling of plans helps with credibility issues. If you can pool Plans A through F, or sometimes you can pool states, that helps a lot.

Rate increases are the most critical part of profitability for Medicare supplement products. They are more critical than the initial pricing. For a typical life insurance product, you sit back, price it, do all of your magic, then watch the results come in. There's not much you can do after that. Medicare supplements are just the opposite. Whether or not we make money in Medicare supplement is dependent to a large extent on how we price initially, but, to a much greater extent, on how we manage the rates after that. We apply the experience results. The most important thing is that our annual filings must be timely. If we need a 5 percent rate increase or a 7 percent rate increase, and we let it go 18 months instead of 12 months, pretty soon we need a 12 or 15 percent increase, or something else has happened. Besides, we're required by law to file every year.

Know and follow your state requirements. A lot of people struggle with the state and get particularly frustrated with objections. Why are they asking that? That's a stupid question. Why do I have to give them this? Can't they see I need an 8 percent rate increase? The best advice I can give is to just answer the questions. A lot of times, the questions they're asking or the objections they're coming up with on your rate increase filings may be good ones, and you don't realize it. They may be bad ones, and they know they're bad ones. Maybe they're required by their statute or their regulation to ask a bad question, or to just check it off. Did they supply this? Did they supply the number of life years exposed in 1982? Yes, they did. They're not going to use it. Answer the questions.

Also, know what the state requirements are. Some of the states are easy; some of them are hard. But don't file a generic rate filing in Florida or Missouri. Know what the requirements are. You're just going to frustrate yourself and the state. There are some states you can file generic and some states you can't. The point is, you can get those results in Florida, too. Florida is one of the more difficult states. They do ask a lot of questions. I'm of the opinion that their rules are reasonable, and if every state used Florida's rules, we'd all be happy. It's just that they are unique, and they're a pain in the neck, but they are not unreasonable. The point is know what the state requirements are and just meet them, just answer the questions. You'll get much better results that way.

Obviously, use restated experience, as I said before. Don't be afraid to re-price a product that you priced four years ago. Now you've seen some experience, you know what the loss ratios are, and maybe now you need to re-price to say, hey, we need to lower our commissions. Maybe you know more about the expense allowances or what your expenses are. Don't be afraid to re-price your products and let management know where profitability is now, because clearly it changes

from year to year. Management may need to do something to get back on track. Timely rate increases will help you avoid the anti-selection spiral.

Under 65 disableds are roughly 10 percent of the market. It's something you need to consider. Claim costs are 150 to 175 percent of the 65-year-olds. The state rules vary widely. In some states, you don't have to sell to them at all. In some states, you have to sell to them whenever they walk up and ask for it, and you have to give them the age 65 rates. My advice is to charge adequate rates whenever you can, the 150 to 175 percent, and subsidize when necessary.

As far as HMO disenrollment is concerned, at one point up to 16 to 18 percent of the market was Medicare + Choice. Now we're down around 12 or 13 percent. The HMO disenrollment has hit us. Clearly, most of these people are coming back into our Medicare supplement business as guaranteed issue. There are some arguments that those people ought to be good risks because they were HMO people that supposedly were healthy. My experience has been that they're worse than normal risks. You need to ask yourself where the current HMO enrollees are. What states are they in? If they're in one of your states, there is a potential for next year or the year after to have a situation where your experience is going to deteriorate. You need to watch the reports coming out of Management Consultation Services (MCS) toward the end of the year on where the disenrollees are coming in.

Right now we're about 12 or 13 percent nationally in Medicare + Choice. The following states are over 30 percent: Arizona, California, Hawaii, Nevada, Oregon and Rhode Island. If you're heavily in Arizona, I would watch those HMO disenrollment numbers come out. Some states over 20 percent are Colorado, Florida, Massachusetts and Pennsylvania.

Because of the pricing pressure, we're seeing commissions in the market coming down. Know your expenses. Do expense studies. It's one thing to use your expenses and your pricing and to say these are my expense assumptions, but they ought to have something backing them up. You ought to feel fairly comfortable that that is what it's costing your company. Be efficient; use electronic receipt of claims. I think most companies now get their claims electronically in a fairly efficient way. Don't forget overhead in terms of considering profitability and pricing. Your salaries also need to be made up. And consider the effect of trend and rate increases. As you're getting these eight, 10, seven, six, 15, whatever rate increases, go through and do your re-pricing. See what that does for you in terms of your present value of future expenses. If you end up getting rate increases that are higher than you were originally anticipating, it's going to have an effect on your present value of expenses and your present value of profit.

Reinsurance, obviously, is sharing the risk. You have a good opportunity to leverage the reinsurer's expertise and experience with your own. We're heavily involved with several reinsurers, and we've gotten a lot out of those relationships. Try to maintain a good relationship where both parties are happy, and you've got a

better chance that you'll both be able to maintain profitability in Medicare supplement. And when you're pricing, don't forget the impact of deferred acquisition cost (DAC) tax when you're planning on reinsuring a block of business. If you price without reinsurance, you're paying all of the DAC tax effect. If you're pricing with 50 percent reinsurance, you end up paying most of that DAC tax, and the reinsurer gets a little bit of a break. A lot of people ignore reinsurance when they're pricing. Because of the DAC tax, you cannot do that. It really could mean a point or two on your profitability.

In conclusion, know the market, know to whom you're selling and what the market is. Price appropriately. Monitor your experience continuously and file timely rate increases.

MR. CLARK: We'd be glad to take questions or comments.

MR. WILLIAM LONDON: I have two quick questions, one for John. Is it difficult to find hospitals for Select that are willing to waive their deductible in some markets?

MR. CATHCART: Presumably. I haven't been involved in those types of negotiations directly. Obviously there's more Select business in some states than others, and it may make it easier to do that. In a state like Florida or Texas, there are a lot of seniors in those states, and there's a lot to be said for bringing volume to the hospitals. In other states, it's probably going to be harder.

MR. LONDON: The second question I have is for Garry. If you have a situation with HMO disenrollment where, for example, the HMO discontinues its Medicare contract, and there's no other HMO available in the area—in other words, it's not a situation in which another HMO is getting the good lives and you're getting the bad lives. Do you think you would still end up with bad selection?

MR. REED: Theoretically, no, but there must be something I don't understand about it, because we have had those situations. Maybe the HMOs somehow picked the bad risks when they got them into their program and we just inherited them.

MR. LONDON: I've had people tell me over the past couple of years that the HMOs are actually getting less healthy people.

MR. REED: Addressing the network question, my experience has been that it's not necessarily the insurance companies that are going out and recruiting the networks. There are network-building organizations that go around and sign up the hospitals. That may be part of the answer to your question about Florida, Texas and Illinois: They just happen to be where their organizations were effective in building the networks.

MR. CATHCART: Regarding the HMO anti-selection, it strikes me that these HMOs are going out of business now presumably because the government is not giving

them enough money. But that's only one part of the equation. Their costs are also high relative to how much money they're getting. If their costs are high, presumably it's because the people are unhealthy. So I would expect anybody coming out of an HMO to be less healthy than somebody who's not coming out of an HMO, and you're giving them guaranteed issue rights. It strikes me that you're probably going to get selected against.

MR. ANDREW PERKINS: (Gen Re.) I'd be interested in comments from any of the panelists about potential impacts on in force business—Medicare, regular Medicare supplement or Select business—of the reform proposals in Washington, either the drug benefit coverage or other things.

MR. CLARK: Does anybody really know what that impact is going to be?

MR. CATHCART: For what's currently going through the Senate and the House, I believe the primary impact would be on any drug plans. That's the main part of that legislation in both houses. Those proposals do allow for Medicare supplement plans to stay out there. The question is their impact on H, I and J: the drug plans. Presumably a company would not be able to continue selling H, I and J. If somebody selected the Medicare drug plan according to the Senate version anyway, they would have to drop their H, I and J coverage with a guaranteed issue right to the corresponding nondrug plan. That has the risk of creating some anti-selection on those corresponding nondrug plans, because the claim costs for the nondrug benefits on drug plans are higher than the same benefits on a nondrug plan. The people who use drugs are the unhealthy people, and those are the ones that select those plans. So it would be creating some anti-selection. Who knows what's going to pass? But my opinion is that a better proposal will be to allow those people to keep their H, I and J Plans, presumably for a lower premium without the drug benefit, but keep them as a separate rate class.

MR. REED: In our company, we've got about $450 million in Medicare supplement business, so this is a question that's been asked once or twice. I think the one thing that we feel comfortable with is that the people that currently have Medicare fee-for-service are going to get to keep it, and the people that, therefore, have the Medicare supplement are going to continue to need it. It may end up being a closed block of business, but our $450 million block of business is not going to just go away. It's going to continue to be out there. Beyond that, I think it's all up in the air.

MS. GAIL LAWRENCE: (American Republic Insurance Company). I'd like either of the panelists to comment on the relative profitability of standardized lines of business versus Select, particularly in light of your example where you had much lower premiums on the Select business, but the claim costs were the same. Also in Select business you have more expenses, and probably poorer persistency, because hospitals are leaving the network. Plus, you've got all the network management expenses.

MR. CATHCART: Those are all important issues. I think that the Select business can be just as profitable as standard business, but if you ignore some of these factors, you run the risk of being burned. Your expenses may well be higher because you're going to have to pay network fees. If you assume that your claim costs are lower across the board, or equal across the board but lower for the Part A deductible, you're going to miss something, and you're going to end up with some mispriced Select business. There's no reason that Select business can't be profitable, but I think it's important to keep these other things in mind when you're doing your pricing, rather than just assuming that everything is equal.

MR. REED: Just anecdotally, we try to get the same profit objectives between a standardized and Select. Frankly, our Select experience has been better than our standardized from a loss ratio standpoint. That has to be a little bit better because of the expense piece, but we haven't had any trouble, and we haven't had any of the network problems yet. I hope we don't, because I think I actually assumed a little bit better persistency in the Select because of the lower premiums and the lack of another option.

MR. CATHCART: I think it's not only important to make sure that you developed your assumptions separately, but you also need to monitor your experience separately. That goes not only to the morbidity experience, but probably also to persistency.

MR. ANDREW HERMAN: (Wakely Actuarial Services.) My question is for Garry. In your family of companies, you have several different companies, and I believe they may be actively marketing Medicare supplement in the same region. We've observed sometimes that there are different rates, and there may be inconsistencies. My question is how do you end up there? Are there different targets due to commission differences or product differences within the distribution channel? Or is it experience driven? How do you get into the situation where sister companies have very dissimilar premium rates?

MR. REED: That one's easy. It is a challenge. Some of our companies are agent-driven companies, and they don't see our other companies. Some of our companies are broker companies. We have situations where we've got companies competing against each other. The way we got to the situation was not planned. We acquired companies that were in the same states as some of our other companies. They got to be inconsistent because they were priced at different times. Different states allow different rate increases. Area factors were approved at different levels, but the rate increases were done at the pooled level for the state. In some cases, we've got companies that offer much lower commission levels than others. So there's actually a logical reason. There are probably 10 or 20 other reasons, but it is a challenge.

MR. KURT HANSEN: (WellPoint Health Networks.) This refers to the comment that Garry made about companies that intentionally set rates low with the intent of

raising them later. Hypothetically, if a company were to operate in a state where it requires issue-age rating or community rating, do you believe that the company should be required to set up active life reserves? I'd like to solicit comments from all the panelists.

PANELIST: In an issue-age rated state for guaranteed renewable product, I don't think there's any question you should set active life reserves. But I'd like to hear arguments otherwise.

PANELIST: For community-rated states, the issue is not as black and white. I've seen it done both ways, and the whole question is whether it's your intent in pricing to pre-fund the aging in your rates. Besides the regulatory requirements, some states may have requirements that you do have active life reserves on community-rated products, whether or not you intend to pre-fund the aging in your rates or your pricing is really more like a group pricing exercise, where you're always adjusting the rate to the current in force. And I don't know the answer to that.

PANELIST: I agree. The issue-age business should always have active life reserves. Community-rated business, to a large extent, depends on the extent to which you believe you'll always be able to get the rate increases you think you need. If you have some doubt about being able to get the rate increases that will maintain a level loss ratio, then you probably should be pre-funding.

MR. CLARK: Our stance, unless there's some argument otherwise, is that issue-age rated or even community-rated business would require active life reserves. I think the gray area is when you have rate banding. It's an attained-age structure, but within that you have banding. Generally, we put that in the attained-age category.