SOCIETY OF ACTUARIES

Article from:

Health Watch

January 2009 – No. 60

The Modernization of Medigap Plans

Managing the Change

by Gail M. Lawrence

Gail M. Lawrence, FSA, MAAA, is a consulting actuary. She can be reached at 515.224.4380 or at *LawrenceConsulting@mchsi.com*.

Even if we're trying to sit still, change still happens around us through our ever evolving environment. While some may see change as just lemons, others will seize the opportunity to try a new recipe for lemonade. The chance for a successful result can be improved with a thorough assessment of the options and careful attention to execution.

It's not too early to begin planning for the changes that will occur with the new Medigap policies, which will be effective on or after June 1, 2010. The modernization of the Medigap plans creates some unique opportunities for change that have not existed since their introduction beginning in 1991.

Critical Deadlines

Because few, if any, carriers currently use genetic testing in the medical underwriting of their Medigap coverage, the industry is probably already in compliance with GINA provisions. However, implementation of the new Medigap plans will take considerable effort as carriers will need to get new policy forms, rates and, if necessary, advertising approved by the state insurance departments.

It is important to note that the implementation date of the 2010 plans applies to the effective date of coverage. Seniors often shop for Medigap coverage well in advance of their desired effective date of coverage. This is especially true for seniors turning 65, who can apply for Medicare coverage up to three months in advance of their Medicare effective date.

To accommodate all possible effective dates, there will be a period of time when companies will want to market both existing and new Medigap plans, where the coverage placed will depend upon the desired effective date. In order to prevent a disruption to marketing, Medigap carriers may want to plan on having materials approved and ready for marketing at least six months prior to the June 1, 2010 effective date. This will allow sufficient time for the distribution of new materials, agent training and the continuation of marketing to new Medicare beneficiaries.

If states wait until the deadline of Sept. 24th, 2009 to adopt the new model regulations, filing and approval timelines may be very tight. However, it is anticipated that most states will not want to go through two sets of changes to their Medigap laws and regulations, one for GINA and one for the benefit changes. It is expected that many states will adopt both sets of changes by the GINA required deadline of July 1, 2009.

Assessing Options and Making Decisions

Some options are obvious. For example, will carriers want to offer the new benefit plans M and N? Based on the distribution of existing policyholders by benefit plan, the first dollar coverage offered with Plan F has been the preferred choice of seniors. This plan provides seniors with the peace of mind of complete protection for all Medicare Part A and B cost sharing and the hassle-free handling of all medical bills by their insurance carriers. The new plans M and N are lower benefit options where claim costs can expect to average around 84 percent and 69 percent of those for Plan F. Lower premium and benefit options are available today, so it remains to be seen if additional lower cost benefit plans will garner much marketplace interest.

Some options may be less obvious. There are no changes pertaining to rating requirements. Unless a state passes regulations that are more stringent than the new model, it appears that carriers will have the opportunity to re-price all plans using a new set of pricing assumptions and to implement changes to their rating methodology. It also appears that carriers will have the option to consider the 2010 plans to be separate blocks of business for experience rating purposes.

As the new 2010 plans hit the marketplace, it will be important for carriers to consider a retention strategy for existing business. This is true not only for alternatives that may come from competitors, but also for 2010 plans offered by the carrier that may be of interest to existing policyholders. A carrier will want to carefully consider the regulatory provision that gives carriers the option to offer all existing policyholders a 2010 plan, subject to "fairness" requirements for such an offer.

A change to a rating methodology is not a new concept with Medigap coverage as existing regulations allow rating changes that are actuarially equivalent. For example, companies have changed from unisex

to gender specific rates with lower female and higher male rates. In implementing this change, companies have been confronted by the issue of existing policyholders who could benefit from the rating change—specifically, the existing female policyholders. In this case, a conversion offer to all existing policyholders would invite anti-selection, causing degradation of experience on the existing block.

Similar issues have occurred as some companies have shifted their marketing focus from individual to group plans, from one standard plan to another, or from one subsidiary to another. Recently, with the elimination of the prescription drug benefit from Plan J a number of carriers have ramped up marketing efforts for Plan J by offering rates that were lower than those on other plans with fewer benefits.

In the case of the 2010 plans, transition dilemmas may be exacerbated by the fact that most of the new plans are very similar to the existing plans. For example, the 2010 Plan F does have an additional benefit to covered Medicare cost sharing on hospice benefits; however, the cost of providing this additional benefit is minimal. The 2010 Plan D also has the new hospice benefit, but the at home recovery benefit has been dropped.

Carriers may want to price the 2010 plans with lower compensation and expenses than the comparable existing plans in order to become more competitive. If the carrier then offers all existing policyholders the 2010 plans, it could disrupt otherwise content customers and alienate agents who may receive less compensation with the 2010 plan. If companies choose not to make the conversion offer, lapse rates could increase as discontent customers seek coverage with other carriers. Clearly, carriers will need to consider their options carefully in order to maximize retention of existing policyholders and to ensure a good partnership with agents.

Outstanding Transition Issues

Some carriers may want to comply with the new model regulation by filing entirely new policy forms while other carriers may want to modify existing approved policy forms through policy riders or endorsements. Filing options will ultimately be determined by the state regulatory authorities, so state variations can be expected. Actuaries may want to consider whether the format of the policy changes will impact their ability to implement rating changes and to gather experience data for the 1990 and 2010 blocks of business.

In recent years, a number of actuarial reports have been published advocating improvements to the refund formula process. However, the new model regulation contains no changes to the refund provisions and it is unclear as to what options may exist for the pooling of 1990 and 2010 experience within the refund calculation. Similar questions are outstanding with respect to the reporting requirements for the annual statement Medicare supplement policy experience exhibit. Further guidance on this topic may be forthcoming in the NAIC Medicare Supplement Compliance Manual, which will be updated by the NAIC Accident and Health Working Group.

Previously, states have determined the constitution of an appropriate innovative benefit. A new drafting note in section 9.1, "recommends that states consider making publically available all approved new or innovative benefits, and requests that states report the approval of these benefits to the NAIC Senior Issues Task Force who will maintain a record of these benefits for use by regulators and others. The Task Force intends to periodically review these approved benefits and consider whether to recommend that they be made part of standard benefit plan designs."

In Closing

Market leaders are most likely looking forward to the opportunity to refresh their product offerings and strategies. For others, Medicare supplement may be considered a distraction to their core business and this change may prompt some rethinking on their commitment to this market. Change can be less chaotic if managed well with thoughtful decisions and careful execution, helping to ensure a successful and smooth transition. ■

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