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Medicare Supplement: Critical Factors for Success

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The year 2010 is a milestone year for the Medicare Supplement industry. This is of course attributable to recent legislation called the "Medicare Improvements for Patients and Providers Act of 2008," referred to as MIPPA. While MIPPA regulation represents a significant change to the Medicare Supplement industry, the critical factors for success remain the same today as has been the case for as long as federal standardization has been around (starting in the early '90s) if not longer. This article will provide the background and basics of the Medicare Supplement product line and the critical factors of managing it to a profitable level.

Basics of Medicare Supplement

As the name implies, Medicare Supplement provides insurance benefits that supplement Medicare fee-for-service (FFS) benefits, typically known as Parts A and B. It is important to note that Medicare Supplement is not a replacement for Medicare FFS. Another way of saying this is that a Medicare Supplement policy covers much of the Medicare beneficiary obligation (Medicare doesn't cover everything after all!) that would otherwise result in out-of-pocket expenses. These expenses could consist of everything from manageable and budgetable deductibles or co-pays to expensive catastrophic hospital charges in the event Medicare benefits are exhausted. Medicare Supplement is also commonly referred to as "MediGap."

CONTINUED ON **PAGE 5**

So, in general, a Medicare Supplement policy could provide coverage for the various Medicare cost-sharing components provided below:

Part A
- Inpatient deductible ($1,100 for 2010)
- Inpatient coinsurance—days 61–90 ($275 for 2010)
- Inpatient coinsurance—lifetime reserve days ($550 for 2010)
- Skilled nursing facility (SNF) coinsurance—days 21–100 ($137.50 for 2010)
- Hospice coinsurance—limited amount for outpatient drugs and inpatient respite care
- First 3 pints of blood
- Inpatient charges beyond lifetime reserve days

Part B
- Part B deductible ($155 for 2010)
- Part B coinsurance—generally 20 percent of Medicare allowable
- Charges in excess of Medicare allowable

In addition, there are some potential non-Medicare-related benefits that typically only apply to certain older (1990 Standardized) policies. One such common benefit is the foreign travel benefit that provides coverage for emergency care outside the United States.

Some people confuse Medicare Supplement coverage with Medicare Advantage, also known as Part C. Medicare Supplement coverage is provided through a private insurance contract between the insured and the issuing carrier. This is independent of any arrangement with Medicare, although there is the prerequisite that the insured be signed up with Medicare as well as the fact that coverages and benefit terms do coordinate with Medicare benefits. This is unlike Medicare Advantage, which is essentially an arrangement with the Center for Medicare and Medicaid Services (CMS) as an alternative to traditional Medicare FFS provided through an independent insuring entity as a contractor for CMS.

Federal Standardization

Beyond just the general concept of Medicare Supplement is the reality that this line of business is heavily regulated at the federal level with respect to benefit design in terms of what standardized plans are allowed to be sold. This is often referred to as "standardization." Standardization has gone through various changes over the last several years, the most recent being effective June of last year with the implementation of MIPPA legislation passed in 2008. The scope of the change affects any policies sold with effective dates of June 1, 2010 or later. These policies are referred to as the 2010 Standardized Plans. However, in-force policies sold with effective dates prior to June 1, 2010 may be based on the standardization requirements in effect when they were sold. Table A provides a side by side overview of the allowed standardized plans designs, commonly referred to as the alphabet plans. Completely new for 2010 (actually since June) are low-cost plan options M and N. They join other low-cost options (such as A, K, L and a high-deductible version of F) which have not had much impact on the market overall up to this point. However, at this point there appears to be quite a bit of interest in these new plans as they are being introduced into the market. Plan N in particular has generated interest as a comparable alternative to Medicare Advantage due to the fact that it has office visit co-pay cost-sharing features.

Unique Aspects of Medicare Supplement Line of Business

The Medicare Supplement line of business has some unique features in comparison to commercial accident and health (A&H) business, which we will discuss briefly.

- **Access to and Eligibility for Coverage**
  Most Medicare Supplement policyholders enroll in Medicare Supplement under either open enrollment or guarantee issue provisions. Open enrollment applies to individuals who are first eligible to sign up for Medicare Part B, generally when they turn 65. Guarantee issue eligibility is triggered under various qualifying events, such as termination of employer coverage or the termination of a Medicare Advantage plan.

  The distinction is not important given that

CONTINUED ON **PAGE 6**

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the practical effect of both is that an applicant is not subject to medical underwriting for the purpose of rating and/or issuing a policy. In addition, prior creditable coverage can be used to satisfy any pre-existing condition exclusionary periods. Importantly, however, a Medicare Supplement policy itself is not considered creditable coverage. This effectively locks many Medicare Supplement policyholders into their existing Medicare Supplement policy.

And finally, all Medicare Supplement policies are guaranteed renewable.

- **Rating Structures and Limitations**
  Rate structures based on attained age, issue age and even community rates can be found in the marketplace. Most carriers rate on an attained age basis where allowed. There are as many as 15 states that do not allow attained age rating and some that require community rating or some form of modified community rating.

  One rating aspect of Medicare Supplement that is different from some commercial business is the inability to rate by duration within a policy form. In other words, there is no new business rate versus renewal rate distinction.

- **Loss Ratio Standards**
  Medicare Supplement business is subject to minimum loss ratio standards of 65 percent for individual plans and 75 percent for group plans. The applicable loss ratio must be met over the lifetime and by the third policy duration.

  In addition to filing rates every year, in every state, to certify that the minimum loss ratio standards are being met, a refund calculation form must be filed by plan and state. This refund calculation form is a formula-driven, credibility-adjusted calculation that indicates the amount, if any, of premium refunds that are required.

- **Impact of Health Care Reform**
  Interestingly, the health reform laws enacted in 2010 had minimal impact on Medicare Supplement policies. In fact, the largest impact will likely be the indirect impact to the extent health reform places greater restrictions on Medicare Advantage plans to the relative benefit of Medicare Supplement policies.

  The only section of the Patient Protection and Affordable Care Act (PPACA) that specifically addresses Medicare Supplement is Section 3210, which calls for the review and revision of Plans C and F to "include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B."

Pricing Implications

The primary pricing issue today facing existing Medicare Supplement carriers is the rating relationship between the 2010 Standardized Plans (policies sold with effective dates on or after June 1, 2010) and the 1990 Standardized Plans (the term used for all standardized plan policies sold with effective dates prior to June 1, 2010). There are benefit differences which vary in significance by plan, but these are relatively straightforward.
Of much greater significance is the regulatory environment, specifically the extent to which rates for the 2010 Standardized Plans must be consistent with the rates for the corresponding 1990 Standardized Plans. Language has been added to the *Draft NAIC Medicare Supplement Compliance Manual* which states that the experience of the 1990 Standardized Plans shall be pooled with the experience of the 2010 plans of the same letter designation for all rating purposes (or, NAIC-defined equivalents for plans without comparable letter designations). The phrase "rating purposes" includes both initial pricing as well as rate increases.

One of the key components of a pooling requirement will be how states interpret the *Compliance Manual* language. The intent of the language does not require identical rates between the 2010 Standardized Plans and the 1990 Standardized Plans. In fact, it seems clear that different rating structures should be allowed.

Additional language added to the *Compliance Manual* notes that rates should be equal between plans to the extent that all other factors are equal. The "other factors" noted, but presumably not exclusive, are lifetime target loss ratio and underwriting. Therefore, it seems clear that differences in the assumed impact of underwriting or commission/

expense levels can be utilized in the pricing process and provide adequate justification for rate level differences.

The *Compliance Manual* also notes that if initial 2010 Standardized Plan rates are equal to the comparable 1990 Plan rates, then subsequent rate adjustments will be uniform going forward. However, it goes on to state that if they are not equal (presumably due to these other factors), then the goal is for the rates to become identical over time, subject to state regulation. This appears to be inconsistent with the justification of initial rate differences in the first place. As an example, if rates are different because of justifiable differences in lifetime loss ratio (a specifically recognized exception in the *Compliance Manual*) then why would this require rates to become identical in the future? We can expect the interpretation of this language to vary significantly on a state-by-state basis.

With respect to claim-level analysis, it is important to recognize the geographic, demographic and, if significant, the durational mix of business in order to uncover the inherent claim cost levels for pricing new plans.

Of course, the second, but not any less important, stage of the proposed pooling requirement is for rate increases going forward. Again, it comes down to interpretation regarding the extent to which rate increases must be identical. An argument can be made that benefit differences could result in different claim trends, although the differences would most likely be minor.

Ongoing Rate Management

Successful Medicare Supplement plans should be profitable while delivering good value to policyholders. Important contributions to profitability for insurance companies include good underwriting, claims management, an efficient administrative process, investment income and an effective rate management process. Of these, the most important for Medicare Supplement business is having an effective rate management process.

Rate management requires regular analysis of pricing assumptions by conducting scenario testing, experience analysis, impact of rate increases on future experience (projections) and impact of inadequate rate management. Rate management should take into account regulatory and market considerations while reflecting changes in benefits, medical inflation, utilization and corrections to expected trends. Rate adjustments should not reflect aging and underwriting wear-off assuming that these components are properly reflected in the initial pricing. It is important to develop a regular process for reviewing experience, developing and filing annual rate increases, as well as rate implementation. The timing and amount of rate adjustments will not always equal claim trend increases due to many reasons including regulatory and market considerations as well as differences between actual and expected trends from prior rate filings.

Rate development and filing is affected by state-specific requirements, loss ratio standards, credibility standards, pooling, actuarial equivalence and turnaround time for the rate filing review and approval process. Unanticipated changes in federal or state regulations such as MIPPA, Health Care Reform, NAIC Model Regulations, etc., can also impact rate development.

Market considerations such as distribution channel issues can impact in-force and new business. To ensure a stable long-term presence in the market-

CONTINUED ON **PAGE 8**

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place, a carrier needs to strike a balance between reasonable and competitive yet adequate premium rates. Strategies need to be developed to deal with competitive pressures on commissions as well as other Medicare Advantage/Medicare Supplement products offered by carriers in the marketplace.

Scenario testing should include sensitivity analysis of lapse rates, claims trend and rate increase approvals relative to claims trend. A study of actual-to-expected claim experience should include cumulative claims since inception, by duration and by calendar year. A deeper study of claim trends, lapse rates and distribution of business can provide insights into action steps for future rate and business management actions.

Factors that affect experience include open enrollment/guaranteed issue, aging, underwriting, inflation, utilization, lapse rates, changes in Medicare and distribution of business. In-depth analysis of these factors will help shape a unique rate management strategy for individual organizations.

High rate increases, relative to claims trend and the marketplace, may lead to high lapses, resulting in an assessment spiral and eventual decline of the product line. On the other hand, low increases relative to claim trend may lead to higher-than-expected loss ratios, which are also not conducive to the profitable growth of business. Good rate management can have a positive impact on profitability leading to a stable block of business. It is therefore important to understand profit expectations and causes of deviation in experience, and to take appropriate and timely corrective actions.

Rate management is not an initial pricing action but an iterative process that involves analyzing variance of actual versus expected experience taking into consideration variance in assumptions and the interactions between these assumptions. Many forces like the commission structure and the regulatory environment can affect persistency and the profitability of the book of business. Therefore, to develop and maintain a profitable book of business, it is important to plan strategically, conduct key sensitivity analysis and remain vigilant to forces that can impact the book of business.

What Lies Ahead?

The impact of recent legislation has resulted in a renewed interest in the Medicare Supplement market. Some companies have taken notice of the Medicare Supplement market as a new opportunity and/or financial hedge relative to other lines of business. Of course, the Medicare Supplement market has its challenges, especially with respect to maintaining profitability in a very price-sensitive competitive market.

If history is any lesson, change is always on the horizon. This fact may never be more apparent than now, with the present focus in Washington on the health care financing crisis. Regardless of how the Medicare Supplement market changes and evolves, there is a good likelihood that the critical factors for success today will be just as relevant, if not more so. ■