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Medicare Supplement Filings from a Regulator's Perspective

Track: Health

Moderator: DENNIS K. HARE

Panelists: JOHN A. HARTNEDY
CRAIG S. KALMAN
LINDA P. ZIEGLER

Summary: In this session, presenters discuss how regulators evaluate Medicare Supplement filings and how carriers can improve their filings.

At the conclusion of this session, attendees gain regulators' points of view regarding Medicare Supplement filings.

MR. DENNIS K. HARE: I'm the health actuary at the National Association of Insurance Commissioners (NAIC), and I am happy to have regulatory actuaries from three states as panelists for this session: Linda Ziegler from Florida, Craig Kalman from Missouri and John Hartnedy from Arkansas. They're going to explain problems they are seeing from the regulatory side of Medicare Supplement filings, and give some helpful hints and pointers to companies to help the filing process go more smoothly.

Our first panelist, Linda Ziegler, is a graduate of Vanderbilt University. After several years of working in industry, she joined the Florida Department of Insurance in 1990. For most of her tenure, she has primarily had responsibility for the review of Medicare Supplement rate filings and related issues. For select intervals throughout the years at what is now called the Florida Office of Insurance Regulation, she has also had responsibility for other product lines, including life and annuities, long-term care, disability and individual major medical and hospital indemnity.

MS. LINDA P. ZIEGLER: My primary responsibility at the Florida Office of Insurance Regulations is Medicare Supplement filings and related issues.

Florida is home during part or all of the year to millions of senior citizens. Of the 17.1 million Floridians in 2003, 3.1 million were 65 or older. Although the Office of Insurance Regulation is very concerned with protecting all of its citizens, somewhat more focused attention is geared toward the senior citizens and the products that are available to them. For all health insurance products that are expected to be issued in markets of at least 50 percent senior citizens, the rate schedule must be on an issue age basis. This applies to all policies issued on or after October 1, 1993.

The majority of senior citizens are on fixed incomes and have greater difficulty dealing with rate increases than other segments of the population. We believe that to inflict age-based rate increases, as well as medical trend increases, on this section of the market was too great of a burden. We also seek to have a level playing field for companies, as we want to have fair competition. When new products are introduced in the market, we want them to be adequately priced such that if experience were to develop in the manner expected, annual rate increases need be no greater than medical trend.

I'm going to take a few minutes to look at how we process filings. In late 2001, the office introduced an electronic data management system (EDMS) through which filings are processed and tracked. Effective July 1, 2003, filings are accepted only through the I-portal into our EDMS. Filings may be submitted through the system for electronic rate and form filing (SERFF), and they're then fed into the EDMS. To submit a filing through this electronic process, go to the Florida Department of Financial Services home page at www.fldfs.com and follow the link to the I-file system. From here you can submit filings, search on closed filings and carry out similar activities. If you have any problems with the technical nature of the system, you would click on the "contact us" button among the six gray buttons at the top of the screen.

I want to briefly discuss our filing review process. We make a concerted effort to perform a review on a timely basis and to notify companies as soon as possible of items that need further clarification. Again, new products should be adequately priced, and the assumptions should reflect the experience of the company's existing similar products. Barring the availability of that, the assumptions should reflect applicable industry data. As a component of the review, we'll look at similar products issued by the company and also look at the proposed rate schedule in the context of the market. This comparison will take into account target loss ratio differences, differences in underwriting and other things.

I want to point out something, which isn't so much a problem with standardized benefit plans like Medicare Supplement, but it is something that comes up too often. Make sure that as a pricing actuary you get to read the policy form when a new product is submitted to make sure that the benefits agree with what you're

pricing. All too often I've seen new products come in where the policy form and the actuarial memorandum describe different benefits, different renewability provisions or other significant differences. Make sure you get a chance to look at the policy form.

Our statutes require the pooling of experience of similar forms. With Medicare Supplement, all forms within a series, such as individual standardized or individual select, are considered to be similar. We've allowed the pooling of standardized and select forms and have allowed the pooling of prestandardized and standardized forms when both blocks are closed. Once the experience of similar forms is pooled, it must remain pooled for all future filings. We will consider variations to a uniform rate increase on the pool if variations by plan are needed to restore premium relationships between plans to those relationships that exist between the benefits, but otherwise a uniform percentage should be sought.

A key principal in our regulatory process is that a company should be able to revise rates to get the future back to where it was expected to be, based on pricing. This is done primarily through the loss ratio tests. The Florida rules and the NAIC model for Medicare Supplement involve both the future and a lifetime test. Both must be met. You can't pass one test and not the other. As I mentioned, the review focuses on the actual to expected (A/E) analysis. With issue age rate structures, the expected loss ratio curve is generally continually increasing, and the future expected loss ratio is greater than the lifetime target loss ratio at all points after inception.

Chart 1 is a sample durational loss ratio curve illustrates this fact. The fact that the future will exceed the target lifetime after inception is a reflection of the underlying prefunding of the attained age claim cost increases being held in active life reserves. Because you can't include the active life reserves in the loss ratio in the incurred claims, you're left with just the claim portion of the total incurral. This continually increasing future expected loss ratio target is the proper reflection of the prefunding of the loss ratio standard for the issue age business. This is referred to in the *NAIC Medicare Supplement Model Regulations Compliance Manual*.

We've done extensive studies of very large blocks of Medicare Supplement business and analyzed the attained age claim cost by benefit. The Part A benefit claim costs always increase with age. The Part B coinsurance alone will reach a maximum at ages 80 to 85 and then drop off some, but only Plan A has sufficiently heavy Part B benefit concentration for the durational loss ratio curve to turn down to any appreciable degree in later years. For ease, most companies have traditionally filed one composite durational loss ratio curve for their entire block.

In a filing, the future projections are modeled with justifiable assumptions and then compared to the previously filed expected results. Those projections are to assume that no new business is issued and that future rate increases are equal to medical trend. The expected loss ratio is therefore equal to the weighted average of the

expected loss ratios for each duration for any particular experience year.

Looking at a sample experience display in Chart 2, these expected loss ratios are driven by the sample durational loss ratio curve that I showed earlier. I'll note again that for both the past and the future, each experience year's expected loss ratio is equal to the weighted average of the expected loss ratio at each duration where the weights are the earned premium at each duration. The loss ratio pattern that can be seen is caused by the constantly positive slope of the durational loss ratio curve inherent with issue age business, which means that as the average policy duration increases, the expected loss ratio likewise increases.

The future expected loss ratio, which equals the present value of the future stream of expected loss ratios in this example (see Chart 3), is thus 74.7 percent, not 65 percent, the statutory minimum lifetime loss ratio, or the original lifetime target loss ratio of 66.8 percent. Barring a heavy influx of new business in 2004, the future expected loss ratio for the next year's filing in this example will be a little higher than this year's 74.7 percent. The resulting future A/E is the basic indication of the rate increase, which would bring the future loss ratio to the expected level. Similarly, one can calculate the rate increase needed to bring the lifetime A/E back to 1. However it must be noted that the smaller indicated rate increase number identifies the constraining test.

We see some common mistakes in filings. First we'll look at the EDMS-related problems. The most common is a failure to hit the “submit” button at the end of the "add to a submitted filing" routine when you're making a response. When you submit a response you should receive two emails: one to confirm that something was received by the system and is being checked to make sure that it is virus-free and compatible and a second to say that the material was added to the filing.

One component of the initial submission is the universal standardized data letter (USDL). This data letter must be complete. It's a required component of the filing. Various data tables in our system are populated only through the USDL, and because we at the office can't change the data, if it isn’t filled in correctly, we can't process the filing. If it isn't complete or isn't correct, we need to return the filing incomplete.

Some of the sections that seem to cause the greatest problems are the rate filing history sections. This shows some data concerning the past few filings. The rate request by form section needs to be completed for both new products and rate revisions. You need to list the primary form and all of the other forms. If you have a block of standardized Medicare Supplement, you need to list each plan separately. You can't say "Form A et al." or "see attached page." Each form needs to be listed.

The additional data section also must be completed for both new filings and rate revisions. If it is a new product, the proposed premium or proposed loss ratio is the box where you'd put the material for your new product because your current values

would be zero for a new product. The loss ratio standard in item G is the target lifetime loss ratio for the block, not the minimum lifetime standard under the statutes.

Looking at the substance of the filing, I'd like to make several suggestions. Read the rules. The prime problems seem to arise from companies not reading Rules 69O-149 and 69O-156 and providing the information that's listed in those rules. Rule 69O-149.006 provides a detailed list of what we expect to see in the actuarial memorandum. Pay particular attention to Rule 69O-149.006(3)(b) 23 as it provides a description of the experience presentation that we want.

It's a good idea to take a look at last year's filing and be sure that the current filing addresses all the issues that needed further clarification in last year's filing.

Because the analysis and the review are based on the A/E behavior of the block, the durational experience is very important. We prefer to see that experience by duration within experience year as opposed to issue year within experience year.

We expect the calendar year quarter's experience to be available 45 days after the quarter end. For example, if a filing is received in the office on May 14, it need provide experience data only through year-end. However, if it were received on May 16, we would expect it to include data through the first quarter.

Rule 69O-149.0025 clearly sets out the credibility rules for Florida filings. The criteria for Medicare Supplement are based on policy count at the time of the filing. Florida experience is used to the degree credible and then combined with nationwide experience if Florida is not fully credible.

If even nationwide experience is not fully credible, the balance is based on justifiable medical trend. In determining the appropriate trend, we will look first at the medical trend experienced by the block taking into account its credibility. That's why we request the constant rate basis premium and use the expected durational loss ratio curve to adjust for the aging and underwriting wear-off.

Seasonality looks at the claim distribution within the year as there is a definite skewing of claim payments toward the beginning of the year in the plans that offer first-dollar coverage.

In looking at the rate pages, make sure that your current rates agree with the latest approved rates and make sure that the pages are clearly labeled. If you have had rate schedule changes, make sure that your pages clearly label the issue periods for which the rates are relevant.

Also make sure that you file your rates in the same form that your administration system uses. If your administration system uses rates that are rounded to dollars and cents, then file them that way because what you are approved to charge is

what you filed and had approved.

File every year. These products are subject to medical trend. Don't wait for your new block to get behind, as you won't be able to catch up. Ask for medical trend each year even if you've sold only a few policies and there is very little experience. Noncredible experience will still probably qualify for a medical trend rate increase even if you have totally noncredible experience. The blocks we see having the biggest problems are those which were initially adequately priced and didn't file any rate increases for a few years because they sold just a trickle of business. However, a few years down the line, they sold significant amounts of business but at then inadequate rates. Suddenly their A/Es are at 125 percent or higher, and they can't dig themselves out of that hole.

When you prepare your filing and your filing exhibits, label them well. I can't read your mind. I've seen exhibits that have just a column of a half a dozen numbers on the page, and I don't have any idea what you're trying to show. That requires more correspondence and slows down the progress of the filing.

To finish up we had some requests to address other issues with the new Medicare law. The new prescription drug program, as you all know, has an impact on the existing drug plans. By January 1, 2006, companies must have approval of their modifications to their existing Medicare Supplement plans, which currently have prescription drug benefits. I strongly suggest that companies don't wait until the last minute to make those filings and get them approved. We would expect such a filing to analyze the company's claims experience by major benefit to determine the impact of removing the drugs for the Medicare Part D enrollees. The analysis should look at maintaining premium relationship relativities between plans similar to the benefit relativities. With the new plans designated K and L, we would expect a filing to examine and discuss the impact of higher beneficiary cost sharing in the utilization of benefits.

MR. HARE: Craig Kalman is from the Missouri Department of Insurance. He's the health actuary there and has been for almost 10 years. Before that Craig worked for a national monoline health insurer. Craig is a member of the Health Section Council and also serves as its Web liaison. He has served on the Computer Science Section Council and the editorial board of *The Actuary*. You may have also seen Craig's name on several articles in *The Actuary* and in the *Health Section News*.

MR. CRAIG S. KALMAN: I'm going to talk a little bit about the staff at the Department. Linda has the advantage of being in a Department with a lot of actuaries. We have two actuaries on staff in Missouri: I'm the health actuary and Jeff Adams is our casualty actuary. We have retained a consulting actuary to do life insurance issues.

My goal is to give you a framework of what happens on the regulatory side. I've been involved on both the insurance company and the regulatory sides. When on

the company side, it's easy to not grasp what happens on the regulatory side. A filing can go smoothly, a positive, or not so smoothly, a negative. There's an expectation or a hope that everything will go smoothly when you submit a rate filing. When it does, things are quiet, but what that does is turn that positive into a neutral in our environment. Things are quiet then. When things aren't going well, the negatives are more prevalent than the positives because we get neutrals and negatives.

We spend a disproportionate amount of time on some filings. Face it, we as regulators have a thankless job. When all goes well, nobody says anything. However, when things go wrong, people start to complain. It would be easy for me to talk about specific situations that happen on some filings, but I want to talk about generalities.

The filings we receive are as unique as the companies that send them in. It may be easy for some of you to bring up in the question and answer time at the end of this session a situation that was not handled exactly as a specific situation I might describe, so I think we need to keep to generalities. You have to remember that regulators are not your enemies. We are there more as referees.

Let's talk about filing statistics. There will always be issues addressed during the filing process, but we're expending too much effort on issues that can be prevented. The regulatory review should be focused on the filing, not on what is missing. Forty percent of what we receive comes in incomplete. Think of your claims area for a minute. How would that impact the time that it takes to process the claim, how many more people would you need to hire to process the claims and what would your underlying cost to process the claims be?

Thirty percent of the filings have a recurrence of an issue discussed in a previous filing. Twenty percent have inconsistencies within the filing. But there's some good news here. About half of the filings have two or fewer correspondences that are actuarial-based. Unfortunately more than 75 percent of our work is on only 25 percent of the filings. You may remember people saying that 80 percent of claim dollars goes to 20 percent of the claimants. It's the same concept.

The filing and approval process is a partnership between the Missouri Department of Insurance and the companies. That's why we are having this session: to improve on that partnership. In a rate filing, which party of the two has the bigger vested interest? The company does, of course. There is always talk about return on investment. Think of the filing the same way. The more proactive you can be with the filing, the better the filing process will be.

The Missouri Department is constantly reviewing its filing procedures to improve the filing review process and to balance it with resource availability. Many companies are also being faced with limited resources, including hiring freezes and layoffs. Think about that from our side. We have a major budget issue within the state, as

do many states. We're not hiring anybody, and salaries have been frozen for many years. Even though the few of us who work on Medicare Supplement are still there, we're having to take on additional assignments that other people used to do.

We also attempt to be as all-inclusive as possible in correspondence. Keep in mind though that some parts of the review are dependent on the impact of other issues. In order to avoid expending more of our already limited resources, we don't want to invest our time on the next step because our work on the next step will just need to be re-done based on the information in the response.

Today's discussion is based on the current Missouri Department procedures. There are more than 130 Medicare Supplement carriers in Missouri. Compare this when you think about dealing with 50 states. We deal with two and a half times that level of differences. The filings vary between carriers, even though the reporting requirements are uniform. Just as there are variances between the states on how certain aspects of the reviews are done, there also are variances between the companies. Just as I sometimes can't respond to questions when I'm asked, "Why are you doing this differently than this other state?" you may not be able to answer when I ask you "Why are you doing this different than this other company?" Those questions aren't fair.

A few years ago an article appeared stating that even with the standardization of Medicare Supplement policies, there are variances in state review. It also mentioned that if a regulator moves from one state to another, the procedures in the second state may start looking similar to those in the regulator's previous state. The same analogy applies to the reverse viewing. There are differences between companies' filings that make one look different from the others. If an actuary moves from one company to another, the new company's filings will sometimes take on the flavor of the previous company. I think this is because we are all a product of our own knowledge base.

There is no relationship between the volume of a company's business and the quality of a filing. Another thing we found is that in the past many people have been with the same company for years, but turnover seems to have become more prevalent over the past couple years.

We're going to talk about the workflow. On the insurer side are a compliance department and an actuarial department. At the Missouri Department we have the Life and Health Section, which is basically the section in charge of our compliance, and the regulatory actuaries. On the company side there's usually not a common reporting relationship between the compliance department and the actuarial department, but both are involved in the filing. We have the same type of structure. I don't report to the Life and Health Section. I report to the Deputy Director, but most of my time is spent doing work for the Life and Health Section.

When a filing comes in it's received by the Life and Health Section, where the filing

is reviewed for completeness. This is the first phase. When the filing is complete, the actuarial review begins. That's the second phase. In the first phase you'll be receiving correspondence from John Howser, who is one of our life and health analysts. In the second phase you'll be receiving correspondence directly from me. If you have a question about a correspondence received, it's always best to go back to whoever sent you that correspondence. This goes back to separation of work. The other thing that ties into this is to send the correspondences back to whichever of the two parties is working on it at the time. When the actuarial review is complete, it is forwarded to the Life and Health Section for final approval.

The SERFF filings are funneled through the Life and Health Section. Are any of you experienced doing SERFF filings in our state on Medicare Supplement yet? How has that been going?

FROM THE FLOOR: It's slow sometimes.

MR. KALMAN: Yes. We still have a learning curve issue at our end. One of the ideas with SERFF is to get the response to the reviewer more quickly. The time from the company submission to its receipt by me is longer than it should be.

Now what does this all mean to your filing? First you're going to have additional correspondences within a filing if there are issues. Second, it extends our turnaround time for two reasons. One is that there are more filings queued for review. Do you remember queuing theory from the actuarial exams? I'm not sure if it's on the new syllabus or not. This is a good example of where that is used, as well as in your claims department. The other is that it slows us down because we have to go back and do some reverification. It means we're having to go back and double-check things for completeness and make sure that things didn't change that shouldn't have been changed. This lengthens the time from original submission to approval.

Here are some helpful hints, and some of them are similar to those Linda discussed. These helpful hints are the crux of our discussion, by the way. It's information you need to do your job better as a filing actuary. Check for completeness. Does the filing comply with regulations? Believe it or not, many filings come in that do not. Is there anything discussed in previous filings that may impact this one? The best way to get ready for a filing is not just to go back to the prior filing, but when one is approved, start making your notes for the next filing. Does the resubmission include all requested items? We receive filings in which a reduction in the rate increase is necessary. Companies may send in a new rate page but no new projections or no new rate-filing document that specifies what the rate change is. Double-check and make sure it's all there.

Implement peer review procedures. While our job as regulators is to perform the ultimate level of peer review, too often it's at the initial level of peer review. This ties back into my discussion about limited resources. Everybody's stretched thin. At

the same time you have to realize we are, too, and you are the ones with the vested interest in getting that filing approved. It's important to have those resources in-house. I had a casual conversation with somebody several years ago who had some issues in a filing that delayed approval by approximately a month from where the company wanted it to be. The company realized that with the amount of business it had in our state, that in one month the premium loss covered more than the cost of a person's yearly salary. This was just from one state for one month. If you're vying over limited resources, sometimes that cost-benefit analysis can be good.

Avoid rushed responses. Responses prepared quickly can easily be incomplete, or something else may be changed inadvertently and may be overlooked. Instead, let it sit for a day or two, and then double-check it. Another round of correspondence may be avoided.

Another area that some of the companies don't focus on is having a realistic timeframe between filing and implementation. Don't file in mid-December for a January 1 increase. Consider the timeline of past filings. How long did it take to get approval before? Consider avoiding busy times, and I mean this both in terms of what your company experiences and what our Department does. A lot of people want a January 1 implementation date because Medicare changes its benefit structure January 1. It's not a magic date. In fact, January 1 probably will be more of a magic date for your group business because most of your contracts generally renew January 1.

Always remember these helpful hints whenever making initial filings or responding to a correspondence from us. Try to be proactive, not reactive.

In closing, I'm going to cover some resources. The first several of these were in the materials available from the handouts located on the SOA Web site. First are our regulations (20 CSR 400-3.650 Medicare Supplement and 20 CSR 400-3.650(13)(G) Medicare Supplement rate filings). In 1999 we formalized our reporting requirements into regulation while doing some other regulatory changes.

Another is Missouri Form 375-0065. This version was drastically redesigned because the old form requested information that was not used, and we had other information that we wanted to see in one place on a filing. If you take a look at items that the form requests, they're consistent with what the *NAIC Medicare Supplement Model Regulations Compliance Manual* says needs to be in each filing. It gives us one place to look for them.

Actuarial certification. This is one of my pet peeves. I talked before about filings coming in that don't meet all the regulatory requirements. Remember you're signing off that the filing meets the requirements. That doesn't mean that the actuary has to be the one doing every aspect of the filing, but it does mean that you're signing off that you've looked through it and made sure everything looks

right. If not, that devalues what the certification means.

There's a series of illustrative exhibits that you'll find in the packet, including projections and durational experience exhibits. These illustrative projections were based on a composite of what we have been seeing from several companies' filings that were relatively consistent with what was coming in.

Our state Web site where you can find those forms is www.insurance.mo.gov.

The last resource is the *NAIC Medicare Supplement Model Regulations Compliance Manual*. The filing requirements that we have are consistent with what's in the Compliance Manual.

MR. HARE: I want to repeat a couple of things Craig mentioned in his presentation. The slides used are on the SOA Web site. They also will be on the CD-ROM that is sent out following the meetings and will include the forms that Craig mentioned for the State of Missouri and parts of its regulation. Also, the Compliance Manual that Craig mentioned is available through the NAIC on the insurance products services section of its Web site at www.naic.org.

Our final presenter is John Hartnedy. He is a deputy commissioner and a life and health actuary at the Arkansas Insurance Department. He has more than 35 years of experience as a life and health insurance executive and actuary. Deputy Commissioner Hartnedy is the chair of the Arkansas State Employee Benefits Board. He also represents Arkansas on a number of life and health insurance committees, task forces and working groups at the NAIC. On May 1, 2003, President Bush appointed Mr. Hartnedy to serve on the Department of Defense Retirement Board of Actuaries, a three-member panel charged with providing actuarially sound determinations to sustain the Department of Defense military retirement fund. Mr. Hartnedy is a fellow of the SOA and a member of the Academy.

MR. JOHN A. HARTNEDY: Eleven states require composite rating, and Arkansas is one of them. We don't allow any rating by age or by sex. We will allow it by zip code. We allow smoker and nonsmoker. That's a little deceptive because when it's guaranteed issue, you cannot do that. Well, you can, but you have to give everybody the nonsmoker rate, so it's only when you have the opportunity to underwrite that can you use a smoker versus nonsmoker differentiation. We prefer annual-only filings. That means you can have one filing a year based on your experience and one filing a year based on benefit changes in Medicare. Most companies put them together so that we deal with one filing. We do not compare the rates you file with us with your other products or with other companies. We have no maximum on the rate increase that you can ask for.

As I said, we're going to approve your rate changes for experience only once a year. We will not approve your asking to change by 6 percent this year and 8 percent next year. You're going to have to file every increase you want with us. We

will approve your rate increase request if you can show a lifetime loss ratio of 65 percent and a future loss ratio of 65 percent. We will not hold you to your expected results by duration if when you filed it the loss ratios in those durations were substantially greater than 65 percent.

What's interesting for us is 95 percent of our filings come in, and there's no needed correspondence except for us to respond and say you're approved. Occasionally a person new to our market will not realize that we are a composite rating state, so we have to go back and ask for rates on a composite basis. We have approximately 40 Medicare Supplement carriers in Arkansas. We don't have any suggestions for changes you should make when you file rates in our state. Therefore, I wasn't sure what to tell you during this presentation, and I knew that would be different from the other two presenters.

The area we look at a little more carefully is advertising — basically disclosure information. We don't want you taking credit for what is required by law, making it sound as though you're doing something great, for example, stating, "There's no charge for filing claims." The law says you can't do that, so we don't want consumers out there feeling that they have to buy your product because you don't charge for filing a claim. I asked the guy in charge of our filing about whether he has seen many problems with advertising. He said a few companies push the envelope on advertising. I asked for some examples of what the problems are, but he didn't have anything specific. He said it's like porn. He knows it when he sees it.

A problem I observed when I worked on the insurer side of the industry was that my company developed a product and filed it nationwide. The same product was filed everywhere. We received the same types of disapprovals from many states, so I asked my secretary to make a list of the reasons why the product was disapproved. In the next filing, which was coming up within a few weeks, I had those issues proactively addressed. This may not sound all that clever to you, but it turned out to be quite effective. We had more product approved more quickly. The marketing people thought I was a hero for getting product approved more quickly, and the solution was really quite simple.
There aren’t a lot of complaints about the way we handle your filings. We typically process filings within a week, or two weeks at the most. There's not a problem of filing rates in our state at least 95 percent of the time and we're an approval state. If you seem to be getting a lot of disapprovals, I would encourage you to take a look at your process. As both of the previous speakers said, you may not be filling the forms out properly or completely.

Our staff is concerned about the workload associated with the upcoming need to remove prescription drug benefits from plans H, I and J, and the addition of the two new Medicare Supplement plans, K and L. Companies will have to refile H, I and J and file K and L and do refund formulas that may be different for H, I and J. As you may know, we are not overly staffed in Arkansas. With all of these expected filings we're going to have all types of problems getting your products approved in a

timely manner, and I would assume that would give you a disproportionate amount of grief, too.

The Life and Health Actuarial Task Force at the NAIC has been requested by the Senior Issues Task Force of the NAIC to write principals on how to deal with adjusting premium and refund formulas for plans H, I and J, the prestandardized plans and the plans in the three grandfathered states. I hope that we can find a simplistic way to do this so it doesn't have to be filed because we're going to have a devil of a time with it.

You have a reason to get involved with the NAIC process or you're going to end up possibly filing all of these forms in all of the states. There are more smaller states with limited resources to review filings out there than there are big states, and the smaller states are not going to be able to handle these filings in a timely manner unless there's a streamlined way to do it. I think you have a vested interest in educating or working with the people who sit on the Life and Health Actuarial Task Force and who sit on the Senior Issues Task Force. Find out who those people are and visit with them, particularly if you can form a unified opinion on how to handle this.

This is one of the plusses with the American Academy of Actuaries. But with the Academy developing positions, the only disadvantage I see is it presents it positions to regulators as a group when we're at the NAIC meeting, while it needs to educate regulators on a one-on-one basis. A lot more can be done, and that's a place where you can make a major contribution. That's one of the places where I'm disappointed in the industry.

Another issue for us is credibility of past experience results because we're a small state. Often we depend on nationwide experience. If it takes longer for you to get approvals in other states, or if you aren't approved at the rate increase you asked for, your nationwide experience gets worse. Since we rely on the experience of other states, we end up funding this worse experience. We're not crazy about that, and we don't have a clue as to what to do about it.

It gets us to the point of saying that the idea of federal tools is not that bad. I'm not referring to a federal charter. An example of federal tools might be that the Feds set up criteria so that, for example, filings of rates and forms become a lot easier. I haven't heard anybody discuss exactly what that means or how that happens, but obviously it happens a lot easier. It's going to require similar criteria across the country; otherwise it isn't going to be any easier. If the same thing can happen state by state, in our mind, that's going to be an advantage. We are worried about the credibility issue. I'm not sure that you shouldn't be worried about that as much as I am because it's going to affect your results between blocks of business.

I asked our staff how many refunds have been paid. They can't recall that refunds have ever been paid. It's one major indication that you aren't overcharging. That

may be because there isn't anybody out there who wants to go through the grief of calculating a refund and mailing it out to all your customers. In our state, with the combination of the refund requirement and composite rating in a zip code, you have one rate per plan. I'm ignoring the smoker versus nonsmoker because I assume you seldom have a chance to underwrite and issue a smoker. Basically you have one rate, and that's going to be for new business and renewal business. We are an approval state, and I wonder why we need to require approval. That's my problem, and as fast as we turn it around, I'm not sure it's a problem for you.

Here's my point. Suppose we want the composite rates, which by the way I was an avid foe of when I was in the industry since my premise was you're raising the rates for the 65 year olds, and I wasn't sure that that was the right way to go. Now, I'm not so sure it isn't the right way to go. It's not as though you're in Plan A, and you're going to change to Plan Z or Q. The persistency on these is good from what I've seen because of the guaranteed issue. Perhaps I should say that it's difficult for this group of insureds to switch from product to product because of the underwriting requirements. Maybe composite isn't a bad idea. If it's not a bad idea and the refunds are required, which means you have to file every year, there shouldn't be a file and approval process for your rates, which would be the only reason for you to ever agree to composite.

These are things that I think need discussing, and I don't see it happening. You have a natural point of input to the commissioners of your state, and it's not that difficult to find out who sits on the NAIC committees. If it's an actuarial issue, you're going to want to contact the Life and Health Actuarial Task Force. If it's a health issue, you want to contact the B committee chaired by Sandy Praeger from Kansas. There's a limited number of people on each of these committees, so by contacting them you can have an influence. You can particularly if you educate those of us in the smaller states. The bigger states can study these issues in painstaking detail, and they'll tend to take the lead. Due to limited resources I don't have time to do that, but if I'm getting input from people I trust who have dealt with me before, I can help to carry the load if there's something else that needs to be done.

That's true of a number of us in the smaller states. I think what's going to happen with new plans K and L, and how we handle H, I and J might give you some administrative grief. You're making a big mistake if you don't get involved or pay attention to what's happening. I think where the industry lacks most is not what you file with us, at least not in Arkansas, it's your involvement. Most of our domestics visit us every year, and we have a good relationship with most of them. We've been able to defend them in public at the NAIC when what they were doing was questioned and when somebody needed to come in front of the financial committee to explain what they're doing. We knew what they were doing. They had informed us. We wrote a letter and sent it back. It's the last anybody heard of it. The company didn't even know that they were doing something that was being challenged until we told them about it six months or a year later. This worked

because they had kept us educated.

I think it's a huge failure if you companies don't keep us educated on what your issues are. You shouldn't come to us solely to complain. Rather, you need to say not only that something isn't going to work but that you have a better idea. You can accomplish what you want to accomplish this way. Some of you take time to do that with me. Most of you don't. I think you're making a mistake because communicating better would make this process a lot easier.

MR. HARE: I have a few follow up points. When we put this presentation together, we invited regulators from other states that couldn't be here to submit any information on this topic they wanted to share, and a couple of them did that. Montana and Vermont both submitted letters. You can go to the Web site and look at those letters.

John touched on some of the current Medicare Supplement issues that are going on at the NAIC. As he mentioned, the Senior Issues Task Force is considering a couple of issues with regard to changes required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) as part of its effort to update the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. They're trying to finalize a proposal by September 2004, and they've asked the Life and Health Actuarial Task Force and Accident and Health Working Group to look specifically at the refund formula and to make recommendations. We've had some conference calls on that topic and we will continue working on it through the summer. We have to finish it by September, and there could be a lot of work depending upon the level of changes that the regulators decide is necessary. Right now there isn't agreement by the regulators and the industry on the changes that are needed.

So far we only have received input from America's Health Insurance Plans. If you're interested in monitoring the progress of the project you can contact me at dhare@naic.org and I can help you obtain pertinent information available from the NAIC.

In addition to the refund formula, we're trying to develop guidance on how to adjust premiums for those plans that have prescription drug benefits in them so that all companies use a standardized approach. That way, if the filings need to be reviewed, they'll come in one way, making it easier for the regulators to review them.

MR. MAX KLICKER: I have a question, but first I want to make three comments. When I first started hearing Linda and Craig talk, one of my reactions in hearing some of these issues was, "I'm a professional, and I know these basic things. They're akin to the 10 most important things I need to know I learned in kindergarten." When I take a deep breath and say that although I'm a professional and should know all of these rules, I've probably been guilty of breaking every one

of them at some time or other in a filing. It probably would be nice to put the company's name on the filing. It would be nice to put what form you're filing on it, and maybe not leave out some experience and those sorts of things. I'm guilty of all those things, but like I said my first reaction was, "Wait a minute. You're talking down to me."

The other thing has to do with talking to regulators. Over the years I have been somewhat active in talking with you, and I found you almost always willing to listen. As a matter of fact, I have been asked by some of them how I would do something. You haven't always done it that way, but I have evidence that you have listened and have passed on what I said.

The other remark has to do with Craig and his comment about filing on December 15 for a January 1 increase. If I assume for a moment that I could pick up the phone and say, "I want this rate increase right now," and the answer comes back, "Yes, you have it," the next question becomes, “How soon could I realistically implement the increase?” I've seen filings that other people put out that if you had the okay right now, you couldn't put them into effect exactly when you wanted to.

I'd like an answer from each panelist. You indicated that it's not necessary to file effective January 1. I would guess your workload is somewhat seasonal. What would you like to see if you were to say, "I'd like you to file now."

MS. ZIEGLER: I would say over the years that the filing has become less seasonal; it's more evenly spread out through the year. While 15 years ago there was a definite concentration of filings coming in during October in anticipation of a January 1 date, they're fairly evenly spread out through the year at this point.

MR. KALMAN: We're seeing an interesting phenomenon that happens every fall, and the month is not consistently the same from year to year. But we all of a sudden end up with double or triple the number of filings coming in. The month varies, so one year it might be October, the next year it might be November and the next year it might be September, but for some reason it's as though everybody's rushing to get it done at the same time. Generally September through November is going to be the busiest time.

I guess one of the time constraints is that if somebody does one in December and there are issues that carry on in January and if you also work on annual statements, that may not be the best time to file. I'm starting to see companies wait until they have full calendar year data and file in March, April or May for a summer increase. Those seem to move faster.

MR. HARTNEDY: I asked our people when they were seeing most of their filings, and it was from four months before the end of the year to three months after, so we're apparently picking up the same phenomenon that Craig is. We don't do in-depth rate reviews, and basically we're looking for a few major things. If the

actuary signed the filing and addressed these major items, we're going to move that filing in and out quickly. It's spread over approximately seven months, and we aren't having a problem.

MR. KALMAN: I should also add that our work is seasonal. I spend a lot of time in March and April on small group certifications as an example. Even if we're not getting as many Medicare Supplement filings, the time has to be resourced elsewhere.

MS. EVA L W GABER: I have a question for Craig. I know your regulation requires state-specific projections, and a lot of times our Missouri state-specific experience is not credible. I want to know what would you suggest we do to make a projection. Do you want us to do nationwide loss ratios for our projection and show the Missouri experience, or is there anything else you'd like to see?

MR. KALMAN: That's a good question, and I'll answer it a different way. If you were to send it in using the nationwide loss ratio for state projections, we'll be requesting a change. What happens is that we take into consideration the credible level of experience, and that's also true with companies that have a handful of policies on Plan A and have a lot of Plan C. The same concept applies. Each projection needs to be based on its own experience. What will happen is we'll then look at the credibility level. About the time I started, we asked for historical information by plan both for state and national, and then if the state experience was credible, the company had to provide projections. This was going on before I started, and generally if C and F were credible, because those are the two that usually are, all of a sudden Plan G experience becomes credible for the state. We had to go back and say that we needed a state specific projection on G, and what we realized was we were getting to the point of adding in too many additional correspondences to a filing. It was better to get everybody to give full information on everything even if when we look at it we say, "The information is here, but it's not credible. We'll look at the counterparts that are to balance it with."

MR. HARE: Linda and Craig, in your presentations you suggested looking at the issues from prior filings to make sure those are addressed. When you receive a filing, do you pull up last year's filing for a company and look at it to review past issues as a starting point?

MS. ZIEGLER: I generally do. It helps to refresh my memory as to what the types of issues were that were relevant to that block of business, and I think that helps to jump-start my review process and brings my thinking up to date.
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MR. KALMAN: I do as well. I'll usually pull up past letters because that sends me in the right direction to where I might see problems. It also gives me an opportunity to see whether the company has decided to take advantage of the information. Another time I'll pull it up is if a company has multiple filings, such as select and non-select, and it decided that a good way to do its select is to wait until the non-

select is approved and see what happens there. Some companies will remember to adjust for this item, while others will not.

MR. LONNIE MILTON GRAUL: This is not a rate filing observation, but there was some discussion about refund calculations and whether there have been any in a given state. The company I'm working for is about to file a form that shows we have to make a refund in a state. Oddly enough it's on a prestandardized form. The refund calculations began to apply to prestandardized forms in 1996. As we run through this, we have a lifetime loss ratio well over the expected loss ratio of 60 percent in this particular state.

But because of the progress of taking nationwide increases on an ever-smaller block of prestandardized business, the loss ratio in this particular state has been good since 1996, and we will be making a refund this year. We're not going to send them a check. We're going to give them premium credits. We'll be making a refund of approximately one-third of an annual premium because we're talking a small percentage — the difference between the benchmark compared to our actual loss ratio. It's only 1.4 percent, but we're talking about premiums from 1996 until 2003. The block of business was considerably larger in 1996, and so on a base of approximately $300,000 annualized premium in-force, we're going to make a $100,000 refund, and that's not right.

It's clear to me that the refund formula should not have been applied to prestandardized business, certainly not in this way, particularly when even in that particular state the company's done the right thing. It's had a lifetime loss ratio well over the original expected loss ratio. I know the Academy has begun to do some work or has published a work that says we need to look at refund formulas and the whole regulatory structure for Medicare Supplement. At least I think that's what the Academy is getting at by having written this paper. I would just ask to the extent that you get involved in these activities that you consider refund formulas and the practice of calculating refunds where there should not be a refund. Next year we'll probably do two prestandardized refunds in two different places, and we'll probably do a Plan F refund next year under similar circumstances.

MR. HARTNEDY: Lonnie, the last remark you made lost me. Plan F is active. I can see your concern with the prestandardized, and this is the first time I've run into that. I haven't heard anything like that before. I don't know that it's an issue if it's happening basically one time to one company on one prestandardized form. Invariably when we start trying to set rules to fit things into, we can complicate more than help. I'm not sure I disagree with your logic, but I'm questioning whether we should look into it. Even for the amount of money that you're talking about, I don't know how big the company is, but I expect it isn't going to be a severe blow to the company.

MR. GRAUL: It's not a large company. It's a company that has been coming out of some problems, and it matters. Just for your information I have called around and

talked to some other big carriers. I've done work on Medicare Supplement before, and I've never worked with any refunds, so I did call some other major carriers, and refunds are rare. Most of them are doing premium credits for reasons that may be obvious.

MS. ZIEGLER: In Florida to date there has been only one block of business that has required refunds. It was a prestandardized block of fewer than 50 people.

MR. GRAUL: I think there are only 32 individuals in this case. It's prestandardized, which is usually issue age.

MR. KALMAN: In our department we had nonactuaries asking questions such as, "Can't we use information from the refund forms to help to determine what goes on on the increase side?" The answer is no because the refund formulas have a different set of assumptions. Because of that, I believe there's also the potential for a company to have justification for an increase on the loss ratio side but at the same time have to pay out a refund.

That may or may not be the case with Lonnie, but as the issues with the refund formulas are being debated at the NAIC level, I think it would be nice to gather information as to how many refunds have been done. We've never had any in Missouri, and when we had a forum similar to this one that the NAIC conducted several years ago, I think one of the questions that was asked was, “How many of the people in the room were involved in a situation where they had to refund premium?” As I recall only one company had that issue in one state.

MR. HARE: I would like to address a question that you asked about the Academy being involved in the refund review process. The NAIC has an ongoing project that started before the passage of MMA to review the refund formulas based on a study done by Reden and Anders for the Centers for Medicare & Medicaid Services (CMS) and an NAIC issue paper reviewing Medicare Supplement products. In both of those cases, the refund formula issue was pointed out as needing some review and potential refinement.

The NAIC has asked the Academy to provide information on the refund issue for review and discussion in hopes of determining whether changes are needed. That project has not stopped. It is still going to go forward, but the more immediate changes that need to be made as a result of MMA have taken the forefront. When that's resolved, it will go back and continue the review and discussion of the bigger refund formula project. The industry has the opportunity to provide information to the Academy task force that's working on this to make sure their issues are addressed.

Chart 1

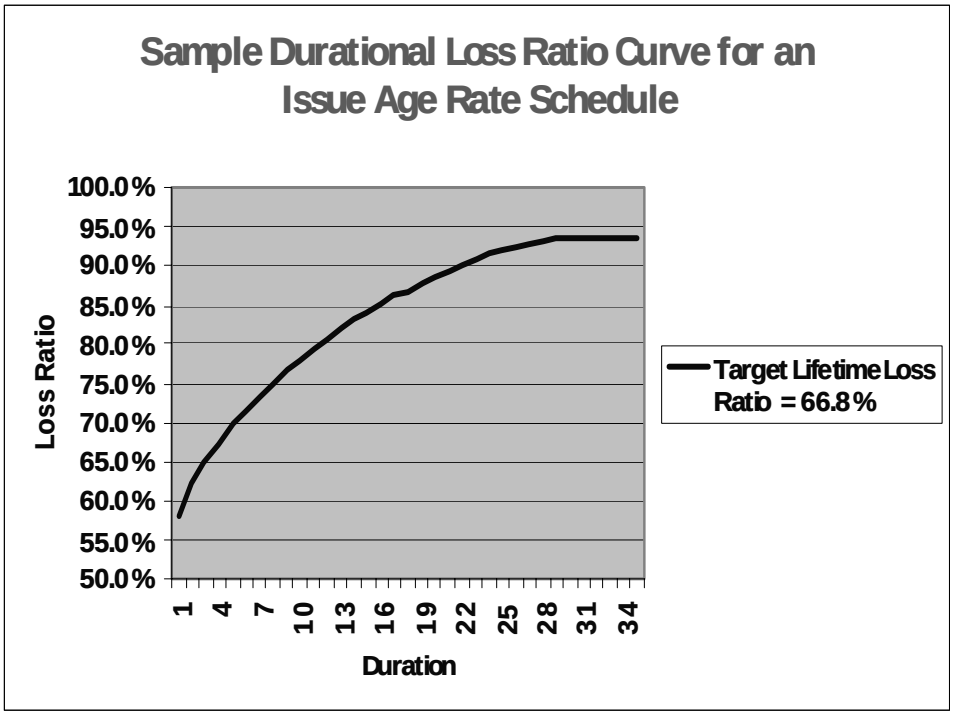

Chart 2

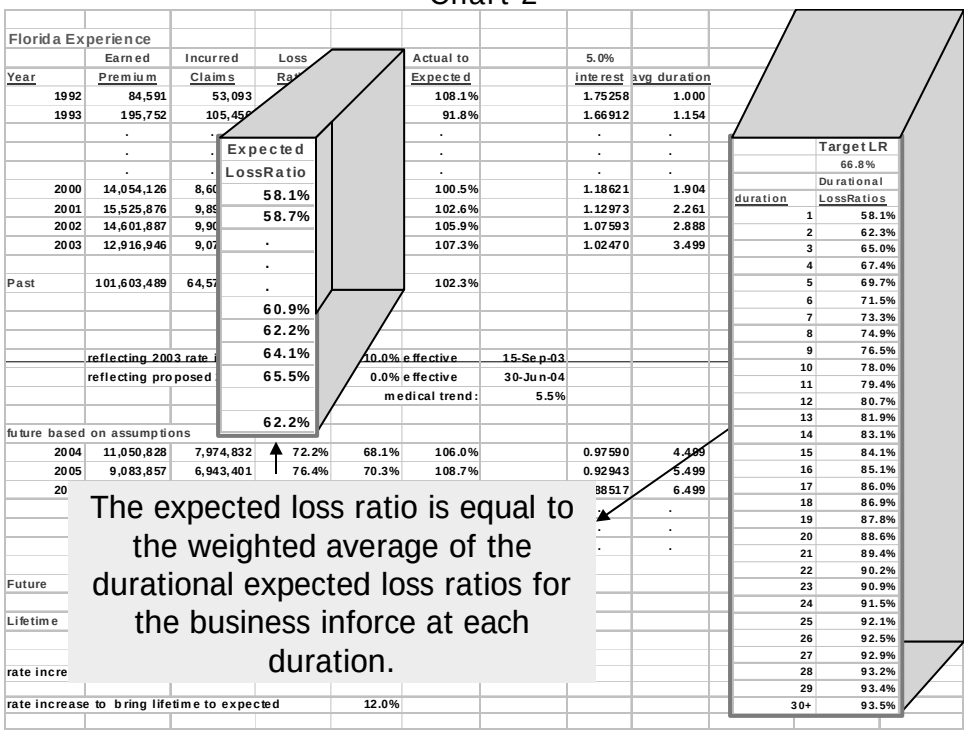

Chart 3

											Target LR
Florida Experience											66.8%
	Earned	Incurred	Loss	Expected	Actual to		5.0%				Durational
Year	Premium	Claims	Ratio	LossRatio	Expected		interest	avg duration		duration	LossRatios
1992	84,591	53,093	62.8%	58.1%	108.1%		1.75258	1.000		1	58.1%
1993	195,752	105,456	53.9%	58.7%	91.8%		1.66912	1.154		2	62.3%
	.	.	.	.	.		.	.		3	65.0%
	.	.	.	.	.		.	.		4	67.4%
	.	.	.	.	.		.	.		5	69.7%
2000	14,054,126	8,601,136	61.2%	60.9%	100.5%		1.18621	1.904		6	71.5%
2001	15,525,876	9,898,816	63.8%	62.2%	102.6%		1.12973	2.261		7	73.3%
2002	14,601,887	9,908,351	67.9%	64.1%	105.9%		1.07593	2.888		8	74.9%
2003	12,916,946	9,078,568	70.3%	65.5%	107.3%		1.02470	3.499		9	76.5%
										10	78.0%
Past	101,603,489	64,578,734	63.6%	62.2%	102.3%					11	79.4%
										12	80.7%
										13	81.9%
										14	83.1%
	reflecting 2003 rate increase of			10.0%	effective	15-Sep-03				15	84.1%
	reflecting proposed 2004 rate increase			0.0%	effective	30-Jun-04				16	85.1%
					medical trend:	5.5%				17	86.0%
										18	86.9%
future based on assumptions										19	87.8%
2004	11,050,828	7,974,832	72.2%	68.1%	106.0%		0.97590	4.499		20	88.6%
2005	9,083,857	6,943,401	76.4%	70.3%	108.7%		0.92943	5.499		21	89.4%
2006	7,666,775	6,021,463	78.5%	72.2%	108.7%		0.88517	6.499		22	90.2%
	.	.	.	.	.		.	.		23	90.9%
	.	.	.	.	.		.	.		24	91.5%
	.	.	.	.	.					25	92.1%
										26	92.5%
Future	53,797,563	43,544,231	80.9%	74.7%	108.3%					27	92.9%
										28	93.2%
Lifetime	155,401,052	108,122,965	69.6%	66.8%	104.2%					29	93.4%
										30+	93.5%
rate increase to bring future to expected				8.3%							
rate increase to bring lifetime to expected				12.0%							

The future expected loss ratio is 74.7%, not 65.0% or 66.8%!