AMERICAN ACADEMY OF ACTUARIES
MEDICARE SUPPLEMENT INSURANCE WORK GROUP

PRELIMINARY REPORT TO THE NAIC

March 1, 2000

The American Academy of Actuaries is the public policy organization for actuaries practicing in all specialties within the United States. A major purpose of the Academy is to act as the public information organization for the profession. The Academy is non-partisan and assists the public policy process through the presentation of clear and objective actuarial analysis. The Academy regularly prepares testimony for Congress, provides information to federal elected officials, comments on proposed federal regulations, and works closely with state officials on issues related to insurance. The Academy also develops and upholds actuarial standards of conduct, qualification and practice and the Code of Professional Conduct for all actuaries practicing in the United States.

At the spring 1999 National NAIC Meeting, the American Academy of Actuaries was asked to analyze Medicare Supplement insurance claims trends. This request was subsequently delineated by the Accident and Health Working Group as covering the following issues:

- Are there specific benefit components of Medicare Supplement insurance plans that are contributing to recent significant rate increases? If yes, what benefit components are they?

- What additional costs are attributable to the guarantee issue of Medicare Supplement insurance policies?

- Do age distributions differ based on rating methodology: (issue-age, attained-age, or community rating)?

- What is the relationship between Part B coinsurance paid by Medicare Supplement insurance and the amount paid by Medicare for Part B benefits?

- Has there been a change in the percentage of Medicare Supplement insurance business that has been issued based on disability eligibility? If yes, what has been the impact of this change on Medicare Supplement insurance claims experience?

This preliminary report presents results of analyses to date. The American Academy of Actuaries Medicare Supplement Work Group has identified additional analyses that are in the process of being completed. A final report from our Work Group is expected to be provided to the Accident and Health Working Group at the NAIC Summer National Meeting in June.

Working Group

The American Academy of Actuaries formed the Medicare Supplement Work Group to respond to the NAIC request. This preliminary report is the work product of the Work Group. The Academy thanks those volunteers for the significant time and effort provided on this project, especially those who volunteered for the Data and Analysis Subcommittees.

Contributing Companies

Attachment A lists the insurance companies that contributed data to the study. Not all of the company data was used in this study. The Academy would also like to express its appreciation to those insurers for their efforts in providing claims data.

Data Contributed

Data was contributed in two formats:

Select - detailed information by age, plan, state, type of benefit, etc. Not all companies contributed data for all select states. Attachment B provides an overview of the select data elements. The actual data elements reported by type of benefit (Benefit Indicator) varied from company to company based on the degree of detail maintained in their claims records.

Control - summary information by plan and state. Attachment C provides an overview of the control data elements

The following is an outline of the scope of the **Select** and **Control** data contributed:

- Data for each standardized plans A, C, F, and combined data for plans B, D, E, and G;
- Plans H, I and J were excluded;
- Medicare Select plans were not studied;
- data from "grandfathered states" (Minnesota, Wisconsin and Massachusetts) was not Included;
- select data was gathered in a limited number of states (California, Connecticut, Florida, Georgia, Illinois, Iowa, Indiana, Kansas, Mississippi, New Hampshire, North Carolina, Ohio, Pennsylvania, Rhode Island, South Dakota and Texas); and,
- data covers claims experience for calendar years 1996, 1997 and 1998 and issue years 1992 through 1998.

The volume of data contributed for the study is shown in Table 1.

Table 1
Contributed Data

	Covered Lives	Incurred Claims* ($ millions)
1996	2,138,057	1,677.2
1997	2,169,678	1,871.5
1998	2,093,301	1,926.4

*Claims paid through May/June 1999

Data was not audited. However, the Data Subcommittee reviewed the data for reasonableness. In addition, as the various data summaries and analyses were determined, data anomalies were discussed with each contributing company. In several situations, companies were asked to resubmit data. As a result, data for several companies was not compatible with the data requirements of the study and was not used.

Sources of Increasing Claim Costs

The Accident and Health Working Group in its May 24, 1999 report titled *Medicare Supplement Insurance Issue Paper* identified many areas that could be the cause of increasing claim costs.

The American Academy of Actuaries Medicare Supplement Work Group has identified some additional areas. Some of these issues may overlap, but they are all listed below:

1 Outpatient costs
2 Fraud
3 Cost shifting
4 Balance billing
5 Anti-selection
6 Risk adjustments
7 Duration from issue
8 Aging of the senior population
9 Attained-age vs. issue-age pricing
10 Prescription drugs (for Plans H, I, and J)
11 Ventilator dependent hospitalizations
12 Medicare risk contract enrollment[1]
13 Covering disabled individuals
14 Increased average age of insured person

There are some countervailing areas of decreasing claim costs that could also impact on overall trends. An example is based on anecdotal information for a Blues Plan. This example is local to the geography of the Blues Plan and should not be extended to all states.

A Medicare Health Maintenance Organization (HMO) with prescription drug coverage insured a disproportionate share of bad risks. Decreased enrollment and a negative trend resulted for the Blues Plan as individuals switched coverage. When the Medicare HMO exited the market another Medicare HMO with prescription drug benefits entered the market and, predictably, the bad risks went to the new HMO. If this HMO exits the market, the bad risks have nowhere to go but back into the Medicare Supplement market, thus reversing claims trends.

A note of caution is appropriate here. Although Medicare HMOs may have attracted relative poorer risks in certain geographic areas, available nationwide studies have indicated a better than average risk profile for Medicare HMO enrollees. The *1996 Annual Report of the Physician Payment Review Commission* reported on studies of Medicare enrollees and those leaving the health maintenance organization, and concluded that better than average risks enroll in such plans and worse than average risks leave the plan.

Applying the study results to nationwide Medicare HMO enrollment patterns to estimate the impact of enrollments into HMOs only implies a 0.5% to 0.9% adverse average annual addition to Medicare and Medicare Supplement claims trend for the period 1996 through 1998. The adverse impact may be growing, given the impact of the statutory changes contained in the Balanced Budget Act of 1997, and additional movement between Medicare+Choice health plans and Medicare Supplement plans. The issue needs refinement and further study as is noted in a following section of this report.

Claims Trend

Claims trend is measured as the change in annual claims cost per covered life. State claims trend for a contributing insurer is measured as the change in annual claim cost per covered life in a particular state. Composite claims trends for all insurers combined or for state combinations,

[1] Future analysis could also include Medicare+Choice enrollment patterns.

were then determined by aggregating claims trend using exposed lives. The data should be considered preliminary and additional analysis by the Work Group is anticipated.

Preliminary claims trend data is presented and discussed in this section. The analyses presented herein do not attempt to differentiate between the above listed potential causes of increasing or decreasing claims. Care should, therefore, be used when reviewing the preliminary claims trend data for several reasons:

- The influence of claims trend factors can vary by state, even by geographic area within a state.
- The influence of claims trend factors can vary by insurer.
- Combining insurers can affect claims trend calculations.
- The study is looking at changes for only three years (1996-1998), which may mask averages.

Table 2 presents an aggregated trend analysis by Medicare Supplement insurance standardized plan and by calendar year. Claims trend has averaged 8.8% per year, or 3.1% more per year than expected. Expected claims trend is based on Medicare enrollee experience adjusted to Medicare Supplement insurance benefits by Plan and on internal research by Milliman & Robertson. Expected trend assumes a nationwide age/sex distribution that is static as compared to the dynamic nature of Medicare Supplement insurance covered lives.

Please note the following while reviewing Table 2:

- As mentioned above, aggregating experience of several insurers over many states can affect trend calculations and may mask underlying trend levels.
- Plans C and F account for 79% of total exposure.
- Trend for Part A for 97/96 is significantly higher than Part A trend for 98/97.
- Part B trend is relatively more stable by year.
- Plan C has higher average annual claims trends (9.9%) than other Plans, although Plan A and Plans B,D,E and G combined average only 0.1% lower. Plan F has the lowest average annual trend (8.5%).

Table 2
Claims trend By Plan and Calendar Year
All States Surveyed
All Insurers Surveyed

Incurred Year	Plan A	Plan C	Plan F	Plan BDEG	Plan All
	Part A - Yearly Trend				
97/96	-10.4%	13.2%	16.4%	15.3%	13.6%
98/97	1.8%	8.7%	1.7%	0.6%	4.0%
98/96	-4.5%	10.9%	8.8%	7.7%	8.7%
	Part B - Yearly Trend				
97/96	13.1%	10.1%	8.6%	10.3%	9.3%
98/97	10.4%	8.8%	8.1%	10.9%	8.4%
98/96	11.7%	9.5%	8.4%	10.6%	8.8%
	Parts A & B (Total) - Yearly Trend				
97/96	10.1%	11.0%	10.7%	11.8%	10.5%
98/97	9.5%	8.8%	6.3%	7.8%	7.1%
98/96	9.8%	9.9%	8.5%	9.8%	8.8%
	Exposed Lives (Thousands)				
1996	127	857	862	291	2,138
1997	122	797	942	309	2,170
1998	108	705	950	330	2,093
	Distribution of Exposed Lives				
1996	6.0%	40.1%	40.3%	13.6%	100.0%
1997	5.6%	36.7%	43.4%	14.2%	100.0%
1998	5.2%	33.7%	45.4%	15.8%	100.0%
	Expected Total Trend				
97/96	8.7%	6.8%	6.6%	8.4%	7.1%
98/97	5.7%	4.5%	4.4%	3.3%	4.2%
98/96	7.2%	5.6%	5.5%	5.8%	5.6%
	Trend Variance (Actual minus Expected)				
97/96	1.5%	4.3%	4.1%	3.4%	3.3%
98/97	3.7%	4.2%	1.9%	4.5%	3.0%
98/96	2.6%	4.3%	3.0%	4.0%	3.1%
	Percentage Variance (Actual to Expected)				
97/96	16.9%	63.6%	62.8%	40.8%	46.9%
98/97	65.0%	93.6%	42.1%	137.7%	70.4%
98/96	36.3%	75.7%	54.2%	68.7%	55.7%

Table 3 presents an aggregate trend analysis by calendar year using several state groupings. All Medicare Supplement Plans and insurers were combined. The states were grouped into: (1) geographic areas; (2) states mandating or not mandating coverage for disabled individuals under age 65 and (3) by state rating requirements. Attachment D provides a listing of the various state groupings.

For purposes of this analysis, the trend rates presented represent a weighted average of company trends by their exposure by Plan. In addition, please note some data was not used due to nondisclosure of state specific information on some records

Please note the following while reviewing Table 3:

- As mentioned previously, aggregating experience of several insurers over many states can affect trend calculations and may not properly reflect underlying trend levels.

- Claims Trend by Geographic State Combination

  The Northeast states show the highest trend, averaging 2.7% annually (30% variance) in excess of that for all states surveyed. The West states show the lowest trend averaging 1.7% annually (20% variance) below that for all states surveyed.

- Claims Trend for States Mandating (not mandating) Coverage of Under 65 Medicare Eligible Individuals

  Please note this state grouping is based on state mandate and not company practice.

  Claims trend for states mandating coverage of under age 65 Medicare eligible individuals averages 0.8% in excess of that for all states surveyed whereas for states with no mandates, trend averages 0.5% below that for all states surveyed.

  The absolute difference in trend using these measures is small but degree of sophistication of analysis is minimal. Please refer to special studies in a following section.

- Claims Trend by State Rating Mandate

  Please note this state grouping is based on state mandate and not company practice. Connecticut and Washington were omitted from the "community rated states" in Table 3 but that data will be included as part of the final report submitted in June.

  There is significant variation by state mandate. However, 84% of exposure is in states with no rating mandate.

Table 3
Claims Trend By State Grouping and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

	Trend Period	Annual Trend	Exposed Lives Thousands	Variance From Mean Trend	Percentage Variance
All States Surveyed	97/96	10.5%	2,138.1	0.0%	0.0%
All States Surveyed	98/97	7.1%	2,169.7	0.0%	0.0%
	98/96	8.8%	2,093.3	0.0%	0.0%
Claims Trend By Geographic State Combination					
Northeast	97/96	13.6%	644.9	3.1%	29.8%
Northeast	98/97	9.3%	652.2	2.2%	30.1%
	98/96	11.5%	591.3	2.7%	30.3%
Midwest	97/96	10.5%	667.8	-0.0%	-0.1%
Midwest	98/97	5.1%	684.0	-2.1%	-29.0%
	98/96	7.8%	683.0	-1.1%	-12.0%
South	97/96	8.4%	637.7	-2.1%	-20.2%
South	98/97	7.7%	643.9	0.6%	8.1%
	98/96	8.0%	628.7	-0.8%	-8.8%
West	97/96	8.2%	184.6	-2.3%	-21.9%
West	98/97	6.0%	186.4	-1.2%	-16.5%
	98/96	7.1%	186.9	-1.7%	-19.8%
Claims Trend for States Mandating Under Age 65 Disabled Individuals					
Covering Disabled	97/96	11.7%	999.1	1.3%	12.0%
Covering Disabled	98/97	7.3%	1,015.0	0.2%	2.9%
	98/96	9.6%	958.3	0.7%	8.5%
Not Covering Disabled	97/96	9.6%	1,135.4	-0.9%	-8.4%
Not Covering Disabled	98/97	7.1%	1,150.9	-0.1%	-1.0%
	98/96	8.3%	1,131.1	-0.5%	-5.5%
Claims Trend by State Rating Requirement					
Community	97/96	11.2%	126.1	0.7%	6.6%
Community	98/97	9.8%	129.6	2.6%	36.9%
	98/96	10.5%	127.8	1.7%	18.7%
Entry Age	97/96	7.4%	220.2	-3.1%	-29.5%
Entry Age	98/97	5.9%	206.8	-1.2%	-16.8%
	98/96	6.7%	190.5	-2.1%	-24.1%
No Mandate	97/96	10.9%	1,788.3	0.5%	4.6%
No Mandate	98/97	7.2%	1,829.6	0.0%	0.4%
	98/96	9.1%	1,770.9	0.2%	2.8%

Table 4 presents claims trends ranked by state and calendar year for all Plans and contributing companies combined. The states are listed by exposure volume from contributing companies and is not meant to reflect actual total exposure in any state. For purposes of this analysis, the trend rates presented represent a weighted average of company trends by their exposure.

Please note the following while reviewing Table 4:

- As mentioned previously, aggregating experience of several insurers over many states can affect trend calculations and may not properly reflect underlying trend levels.

- Significant fluctuation of trend rates exists from state to state.

- There has not been any attempt to adjust for expected geographical cost differences.

Further study is currently underway to address various sources of these differences, for example: volatility and statistical fluctuations, state mandates, differences in provider practices and insurer administrative procedures. The findings to these analyses will likely be presented in a future update to this report.

Table 4
Claims Trend By State and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

State	Annual Trend	Exposed Lives	Variance From Mean Trend	Percentage Variance
All	10.5%	2,138,057	0.0%	0.0%
All	7.1%	2,169,678	0.0%	0.0%
	8.8%	2,093,301	0.0%	0.0%
Group 1 States: Top 6 Volume States				
	10.7%	1,047,844	0.2%	2.3%
	6.8%	1,048,803	-0.4%	-5.3%
	8.7%	977,555	-0.1%	-0.9%
CT	14.9%	304,753	4.5%	42.8%
CT	9.4%	328,427	2.3%	32.1%
	12.2%	287,642	3.4%	38.7%
KS	9.0%	270,567	-1.5%	-14.4%
KS	1.9%	268,582	-5.2%	-73.5%
	5.4%	266,990	-3.4%	-38.3%
FL	7.0%	178,907	-3.5%	-33.2%
FL	5.8%	163,479	-1.3%	-18.5%
	6.4%	147,309	-2.4%	-27.0%
OH	11.2%	104,271	0.7%	6.9%
OH	7.7%	98,975	0.5%	7.7%
	9.5%	89,868	0.7%	7.8%
NY	11.3%	94,556	0.8%	7.7%
NY	9.8%	95,892	2.7%	37.4%
	10.5%	94,848	1.7%	19.6%
TX	8.0%	94,790	-2.5%	-23.4%
TX	8.9%	93,448	1.8%	24.9%
	8.5%	90,898	-0.3%	-3.9%

Table 4 Continued
Claims Trend By State and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

Group 2 States: Next 10 Volume

	11.8%	586,195	1.3%	12.7%
	8.2%	588,775	1.0%	14.5%
	9.8%	581,460	1.0%	11.5%
NJ	12.4%	72,695	1.9%	18.2%
NJ	10.6%	76,459	3.5%	48.7%
	11.5%	74,619	2.7%	30.4%
PA	14.7%	80,912	4.3%	40.7%
PA	10.3%	68,732	3.2%	44.7%
	12.7%	61,125	3.9%	43.9%
IN	14.4%	65,139	4.0%	37.8%
IN	7.9%	69,864	0.8%	10.6%
	11.0%	75,481	2.2%	25.3%
IA	6.3%	49,221	-4.2%	-40.0%
IA	4.6%	62,563	-2.5%	-35.5%
	5.4%	73,467	-3.5%	-39.2%
CA	6.3%	60,113	-4.2%	-39.9%
CA	6.8%	57,908	-0.3%	-4.7%
	6.5%	55,806	-2.3%	-25.7%
NC	10.2%	52,328	-0.2%	-2.3%
NC	11.7%	56,448	4.5%	63.5%
	11.0%	57,444	2.2%	24.5%
IL	12.2%	56,702	1.8%	16.9%
IL	7.1%	54,039	-0.0%	-0.6%
	9.7%	51,351	0.9%	10.4%
MO	13.1%	50,083	2.6%	25.2%
MO	9.5%	53,770	2.4%	33.2%
	11.3%	52,431	2.5%	28.1%
RI	14.8%	57,721	4.3%	41.4%
RI	3.8%	45,718	-3.3%	-46.7%
	9.9%	36,524	1.1%	12.7%
GA	11.1%	41,281	0.7%	6.4%
GA	7.7%	43,274	0.5%	7.3%
	9.4%	43,212	0.6%	6.4%

Table 4 Continued
Claims Trend By State and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

Group 3 States: All Remaining States – Part 1

	10.9%	503,094	0.5%	4.5%
	8.6%	531,071	1.4%	19.8%
	9.8%	533,060	1.0%	11.4%
MS	8.2%	38,455	-2.3%	-21.6%
MS	5.6%	41,031	-1.6%	-22.2%
	6.9%	41,208	-2.0%	-22.2%
VA	15.0%	35,655	4.5%	43.2%
VA	4.0%	38,487	-3.1%	-43.4%
	9.4%	38,300	0.6%	6.9%
MI	7.7%	35,971	-2.8%	-26.5%
MI	9.3%	35,402	2.2%	30.2%
	8.5%	29,801	-0.4%	-4.0%
TN	11.4%	29,363	0.9%	8.5%
TN	8.2%	30,913	1.0%	14.5%
	9.8%	30,527	0.9%	10.7%
KY	13.0%	27,387	2.5%	24.0%
KY	11.0%	29,976	3.8%	53.6%
	11.9%	32,296	3.1%	35.4%
LA	9.0%	24,339	-1.5%	-14.3%
LA	10.9%	26,136	3.8%	52.8%
	10.0%	25,116	1.1%	12.9%
AZ	10.9%	24,497	0.4%	3.7%
AZ	5.8%	23,921	-1.4%	-19.0%
	8.3%	23,665	-0.5%	-5.4%
OK	12.8%	22,506	2.3%	21.8%
OK	13.3%	23,553	6.2%	86.9%
	13.1%	23,133	4.2%	48.1%
WV	7.2%	19,989	-3.3%	-31.2%
WV	10.7%	22,391	3.6%	50.2%
	9.0%	23,912	0.2%	2.6%
SC	6.4%	20,700	-4.1%	-38.9%
SC	13.1%	22,145	6.0%	83.5%
	9.8%	22,411	1.0%	11.4%
NE	11.5%	18,293	1.0%	9.4%
NE	11.2%	19,361	4.0%	56.4%
	11.3%	19,938	2.5%	28.3%

Table 4 Continued
Claims Trend By State and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

Group 3 States: All Remaining States – Part 2

MD	11.3%	18,779	0.9%	8.4%
MD	4.7%	18,071	-2.4%	-33.8%
	8.1%	17,947	-0.7%	-8.4%
CO	6.9%	17,842	-3.5%	-33.8%
CO	6.2%	17,776	-1.0%	-13.7%
	6.6%	17,500	-2.3%	-25.7%
WA	16.1%	16,752	5.6%	53.7%
WA	2.3%	16,621	-4.8%	-67.1%
	9.2%	16,654	0.4%	4.7%
SD	36.0%	13,269	25.5%	243.9%
SD	4.6%	17,061	-2.6%	-36.0%
	18.9%	19,227	10.1%	114.2%
AL	6.3%	14,222	-4.2%	-40.2%
AL	9.9%	15,726	2.8%	38.8%
	8.2%	16,536	-0.7%	-7.4%
OR	12.7%	14,513	2.3%	21.6%
OR	5.1%	14,430	-2.0%	-28.2%
	8.9%	14,541	0.1%	1.3%
NH	13.7%	13,749	3.2%	30.6%
NH	13.1%	14,450	6.0%	83.6%
	13.4%	13,976	4.6%	51.9%
ME	8.6%	12,878	-1.9%	-17.7%
ME	10.2%	13,902	3.0%	42.2%
	9.4%	13,186	0.6%	6.6%
AR	14.5%	10,662	4.1%	38.9%
AR	10.4%	10,846	3.2%	45.5%
	12.5%	10,674	3.6%	41.4%
NM	6.6%	9,541	-3.9%	-37.3%
NM	18.3%	10,436	11.2%	156.7%
	12.6%	10,617	3.8%	43.0%
MT	10.3%	8,400	-0.2%	-1.8%
MT	6.8%	9,809	-0.4%	-5.4%
	8.4%	10,419	-0.4%	-4.4%
UT	8.2%	8,423	-2.2%	-21.5%
UT	4.7%	8,660	-2.5%	-34.4%
	6.4%	9,836	-2.4%	-27.6%

Table 4 Continued
Claims Trend By State and Calendar Year
All Plans Surveyed Combined
All Insurers Surveyed Combined

Group 3 States: All Remaining States – Part 3

NV	15.7%	8,437	5.2%	50.1%
NV	4.9%	8,683	-2.2%	-30.8%
	10.3%	8,794	1.5%	16.5%
ID	13.1%	7,877	2.7%	25.4%
ID	8.9%	8,809	1.7%	24.0%
	10.9%	8,948	2.1%	23.9%
VT	5.8%	7,576	-4.7%	-45.0%
VT	14.9%	8,506	7.7%	107.9%
	10.5%	9,233	1.7%	19.4%
DE	6.7%	5,665	-3.8%	-36.2%
DE	9.9%	5,398	2.7%	38.0%
	8.2%	5,334	-0.6%	-6.5%
WY	11.2%	4,823	0.8%	7.2%
WY	8.7%	5,460	1.5%	21.6%
	9.9%	6,012	1.1%	12.1%
ND	9.3%	3,942	-1.2%	-11.2%
ND	14.3%	3,996	7.1%	100.1%
	11.8%	3,893	3.0%	33.7%
PR	-22.8%	2,704	-33.2%	-317.6%
PR	5.3%	2,772	-1.9%	-26.3%
	-8.6%	2,802	-17.4%	-197.9%
DC	6.1%	2,108	-4.4%	-41.6%
DC	11.0%	2,042	3.9%	54.3%
	8.5%	1,960	-0.3%	-3.3%
HI	15.1%	1,809	4.7%	44.6%
HI	12.3%	1,988	5.2%	72.4%
	13.7%	2,095	4.9%	55.2%
AK	3.1%	1,576	-7.4%	-70.3%
AK	6.9%	1,850	-0.2%	-3.0%
	5.1%	2,057	-3.7%	-41.6%
VI	22.1%	392	11.6%	110.9%
VI	8.1%	463	0.9%	13.3%
	14.6%	512	5.8%	65.9%

Special Studies

The Work Group has identified a number of "special studies" of the data to further refine its analysis of claims trends. These studies are based, in part, on issues raised by the Accident and Health Working Group and, in part, by the additional issues raised by the American Academy of Actuaries Medicare Supplement Insurance Work Group. The following is an outline of the status of those studies. Final results will be available at the 2000 Summer National Meeting.

- **Benefit Analyses**

  Note – studies in process.

- **Disability Issues**

  Note – study in process.

  Eighteen states have implemented laws requiring issue of Medicare Supplement insurance to disabled-eligible Medicare beneficiaries. The plans which must be offered and the duration of the guarantee issue period vary by state. A list of those states is outlined in Attachment D.

  Data has been collected which will allow us to compare the average cost of the guaranteed issue disabled population to the cost of age-eligible population. We will compare this ratio to the ratio of Medicare's costs for disabled and age-eligible population. We will also look at the change in the proportion of the Medicare population that is disabled, and the proportion of disabled persons in the companies that submitted disabled information. The proportion will vary by state, and the ramifications for Medicare Supplement trend will be explored. We will also examine the trend in per person costs for disabled persons from the submitted data; however, the sample size may be too small to determine whether the disabled-eligible claim cost trend is significantly different from the claim cost trend of the age-eligible.

  Disabled-eligible beneficiaries have significantly higher Medicare Supplement claim costs than age-eligible beneficiaries. Increases in the percentage of a Medicare Supplement block that is disabled-eligible will lead to increased trend. It may also be possible that the claim cost trend for the disabled-eligible is different from the claim cost trend for the age-eligible.

- **Rating methods**

  Note – study to begin.

- **Medicare risk contract enrollment**

  Note – study in process.

- **Part C costs more than Part F as is claims trend**.

Note – study in process.

- **Outpatient Hospital Claims**

Note – study in process.

The method for determining the amount payable by Medicare beneficiaries for medical services is different for inpatient and outpatient procedures. Hospital outpatient procedures are covered under Part B of Medicare, however, payment for these services is not handled electronically like most other Part B procedures. Medicare beneficiaries, or their Medicare Supplement insurers, are responsible for 20% of hospital outpatient charges at the time the service is provided. The Medicare payment amount is determined retrospectively based on the lesser of (a) aggregate costs, (b) charges, or (c) a blended payment amount, less the beneficiary coinsurance. Since hospital charges are generally much higher than costs, the beneficiary co-payment may be more than 20% of the total payment for the service. On average, beneficiaries currently pay about 50% of the total payment to the hospital for these services, compared with 20% in most other settings. In addition, there are no limits regarding the amount hospitals can increase the outpatient charges from year to year.

The Plan F outpatient claim cost trend for one Medicare Supplement insurer is shown below.

Incurred Year	Total Claim Cost Trend	Hospital Outpatient Claim Cost Trend	Total Claim Cost Trend if Hospital Outpatient Trend had Equaled Other Part B Coinsurance Claim Cost Trend	Hospital Outpatient Claims as a % of Total Claims
1995	6.9%	19.8%	4.6%	22.9%
1996	6.1%	19.2%	2.3%	25.7%
1997	8.8%	18.4%	5.4%	28.0%
1998	9.0%	15.3%	6.7%	29.6%
Average	7.7%	18.2%	4.8%	

For 1995 - 1998, the outpatient claim cost trend caused the overall claim cost trend to be 2.9% higher per year than it would have if the outpatient claim cost trend equaled the average claim cost trend of the other components.

Applying this 2.9% higher trend to Standardized Medicare Supplement claim costs (and resulting premiums) since inception (1992) suggests that the Standardized Medicare Supplement premiums are 25% higher in the year 2000 than they would have been without the excess outpatient claim cost trend.

The Health Care Financing Administration (HCFA) has proposed to fix this problem gradually, beginning at some point during 2000, with a prospective payment system (PPS) for the hospital outpatient payments. Both HCFA's payments and the remaining liability owed by the beneficiary or Medicare Supplement insurance carrier would be based on amounts set by HCFA,

rather than the hospital charge. Over the years, Medicare payment amounts will increase, and amount paid by the beneficiary will remain static, until Medicare pays 80% of the approved amount and the beneficiary pays 20%. The Medicare Payment Advisory Committee has estimated that it may take 40 years before beneficiaries are only paying 20% of the approved amount.

Because HCFA has chosen to fix this problem gradually, Medicare Supplement premiums will not be immediately affected by the PPS changes. Once the PPS is implemented, the impact to Medicare Supplement premiums will be realized in future years with lower claim trends resulting in lower annual premium rate increases. A provision in the Balanced Budget Act of 1997 to limit the liability of a Medicare beneficiary for outpatient hospital charges to the Part A deductible is an offset to this cost when effective.

- **Impact of drug coverage and prescription drug costs.**

  Note – study not yet started.

- **Medicare+Choice Plans and Guaranteed Issue Medicare Supplement Coverage**

  Note – study in process.

  HCFA has issued regulations implementing the contracting standards for the Medicare+Choice (M+C) program outlined in the Balanced Budget Act of 1997. These regulations expand the choice of private health plan options available to Medicare beneficiaries. One of the major changes that affected the Medicare Supplement market is the requirement of guaranteed issue coverage of Medicare Supplement insurance plans in certain situations, related to coverage under the M+C program.

  Prior to July 1, 1998, guaranteed issue coverage was only available during the first six months of Medicare eligibility. The new regulations require guarantee issue coverage of certain Medicare Supplement insurance policies to specified eligible individuals. The guaranteed issue coverage requirement applies when an individual has been continuously covered, terminates enrollment, and subsequently applies for a Medicare Supplement insurance policy. The application for coverage must be made within 63 days of termination. In addition, individuals must submit evidence of termination or disenrollment along with the application.

  The guaranteed issue coverage is extended to the following persons:

  1. An individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.

  2. A person enrolled with a M+C organization who leaves the plan other than during an annual election period because: (a) the termination of the health plan's certification as a M+C organization, (b) the individual moves outside of the health entity's service area, or (c) the individual leaves the health plan due to cause.

3. An individual enrolled with a risk or cost contract health maintenance organization, a similar organization operating under a demonstration project authority, a health care prepayment plan, or a Medicare Select policy, and enrollment ceases for the reasons noted above. This coverage is not required for Medicare Select policies if there is a provision in state law or regulation that provides for continuation of coverage or conversion to another Medicare Supplement policy.

4. An individual is covered by a Medicare Supplement insurance policy and enrollment ceases because: (a) the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable state law for the continuation of such coverage, (b) the issuer substantially violates a material provision of the policy, or (c) the issuer materially misrepresented the policy's provisions.

5. An individual who was enrolled under a Medicare Supplement insurance policy, subsequently terminates such enrollment and enrolls with a M+C organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare select policy, and terminates such enrollment during any period within the first 12 months during which the individual is permitted to terminate enrollment, but only if the individual was never previously enrolled with such an entity.

6. An individual who upon first becoming eligible for Medicare at age 65, enrolls in a M+C plan, and disenrolls from such plan within 12 months.

The guaranteed issue coverage is generally for plans A, B, C, or F. For persons described in paragraph (5) above, it refers to the same policy in which the person was previously enrolled, if available from the same insurer. For persons described in paragraph (6), guaranteed issue coverage is available for any Medicare Supplement insurance policy. There is a requirement for notification of the rights outlined in these provisions for individuals who lose coverage or cease enrollment.

As a result of these changes, Medicare Supplement insurance carriers can expect a certain amount of anti-selection from these individuals who can obtain coverage on a guaranteed issue basis. The level of anti-selection will be related to a number of factors, including other available M+C coverage in the area and the health status of the individuals.

If there are a number of other M+C options available in the area for individuals, it is expected that a good portion of these individuals will choose coverage under another M+C program. Those individuals who choose Medicare Supplement insurance coverage instead will include those who were dissatisfied with their prior M+C coverage. For example, those who were unhappy with the level of benefits provided under their M+C program (i.e., they had less than desired coverage or coverage limitations), or with the M+C program restrictions (choice of providers, for example) would likely choose Medicare Supplement insurance coverage.

Another factor, which would increase the expected level of anti-selection generated by individuals, is their health status. Because of some of the limitations present in M+C

programs, individuals with less than average health have an incentive to enroll in Medicare Supplement insurance plans, as this coverage is guaranteed issue, with no provider restrictions, and few limitations on the level of benefits available. For less healthy individuals, the additional coverage provided by Medicare Supplement insurance plans more than offsets the deterrent of higher Medicare Supplement insurance premiums. Those individuals who have better than average health would be expected to enroll in M+C programs, as they would be less concerned about benefit restrictions or limitations, and the lower (or zero) premiums for these plans would have more appeal.

Anti-selection may be limited somewhat due to the same carrier restriction in point 5), i.e., the GI is only for the same plan from the same insurer, and the limit of one disenrollment per enrollee (and in the first 12 months) in point 6).

- **Impact of Fraudulent Claims**

Note – study in process.

We know that fraud effects the cost of Medicare Supplement claims, however, we do not know how much fraudulent claims are currently impacting premium rate levels and the trend from year to year. According to the Government Accounting Office and the Office of the Inspector General of the Department of Health and Human Services, costs for fraud are believed to be 3-10% of health care expenditures. In 1996, this cost would have been anywhere from 6-20 billion dollars for Medicare. As a result, HCFA started a campaign in 1995 against fraud called Operation Restore Trust (ORT). This program is a demonstration project in five states: Texas, New York, Florida, California, and Illinois. More than 40% of all Medicare and Medicaid beneficiaries reside in these states. Four industries in particular are under observation: home health agencies, nursing homes, durable medical equipment suppliers and hospice care centers.

There are many procedures that HCFA has implemented including: encouraging citizens to report fraudulent activities, increased review of medical claims, and emphasizing high volume claims such as eye exams, chest X-rays, echocardiography, and colonoscopy tests. There have also been a number of recent legal judgements and settlements resulting from the efforts to crackdown on fraud activity. Currently, these settlements are being paid to the government and are not being shared with the Medicare beneficiaries or Medicare Supplement insurers. Nor are they providing sufficient information to Medicare Supplement insurers to allow them to preserve a separate cause of action. Thus, the fraudulent claims that have been paid in the past are not being offset with the settlement against these claims. The result is that Medicare trends will not increase as quickly as Medicare Supplement trends.

The overall crackdown on fraud could have an impact on Medicare trends to the extent that it deters future fraud. However, the impact is unknown since it is dependent upon the split between Part A and Part B and the volume of certain claims such as home health care.

- **Post 365 day costs**

Note- study in process.

- **Aging block**

  Note – study in process. The study will include an analysis of the duration effect and impact of aging policyholders.

- **Conclusion: Answer to the question "Why is supplemental trend greater than Medicare trend?"**

  Note: This section will be completed as an executive summary of all special studies

Attachment A

Companies Submitting Data

The following is a listing of companies that agreed to contribute. Some companies were only able to contribute control data. Two companies were not able to contribute data in the format specified.

Bankers Life and Casualty

BC/BS Arkansas

BC/BS Connecticut

BC/BS Florida

BC/BS Kansas

BC/BS Mississippi

BC/BS Rhode Island

Mutual of Omaha

Physicians Mutual

United Health Care

Wellmark

Attachment B

Select Record Layout

Field	Columns	Data Element	Description	All Data Right Justified/Data Keys
1	1-2	State of Residence	State of Residence Use standard 2 character abbreviation	
2	3-4	Plan	Standardized States - Standardized Plans Standardized States - Select Plans	A, B, ... AA, BB, ...
3	6-9	Benefit Indicator	Standardized Products Part A A Deductible A Co-pays Lifetime Reserve SNF Additional to 365 Days Home Health Care All Other Part A Part B Ded Part B All Other	Use Following Data keys: ADED ACOP ALTR ASNF A365 AHHC AOTH PTBD PTBO
4	11-13	Electronic Claims Received	Yes or no for the benefit	YES, NO
5	15-18	Attained Age	age last birthday	III

6	20	Sex	Male, Female, or Unisex	M, F, U
7	22-25	Issue Year	1992 through 1998	1992, 1993, ...
8	27-30	Incurred Year	1993 through 1998*	1992, 1993, ...
9	32-43	Exposure Count	Number of insured years exposed to risk	xxxxxxxxx.dd
10	45-56	Incurred Claims	Based on claims paid through June 1999**	xxxxxxxxx.dd
11	58-69	Remaining Liability	Dollars and cents	xxxxxxxxx.dd
12	71-74	Premium Type	Community, Entry Age or Attained Age	COMM, ENTA or ATTA
13	76-79	Underwriting Style		GUAR or MUND
14	81-92	Exposure with no claims	Two decimal places	xxxxxxxxx.dd

* Preferred, some carriers are submitting 1994 or 1996 through 1998.
** Some companies are basing incurred claims on payments through May, 1998

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Attachment C

Control Record Layout

Field	Columns	Data Element	Description	**All Data Right Justified/Data Keys**
1	1-2	State	State of Residence - Use standard 2 character abbreviation	
2	4-5	Plan	Standardized States - Standardized Plans Standardized States - Select Plans	A, B, ... AA, BB, ...
3	7-10	Benefit Indicator	Part A Part B	PTAA PTBB
4	12-14	Electronic Claims Received	Yes or no for the benefit	YES or NO
5	16-19	Issue Year	1992 through 1998	1992, 1993, ...
6	21-24	Incurred Year	1993 through 1998*	1992, 1993, ...
7	26-37	Exposure Count	Number of insured years exposed to risk	xxxxxxxxx.dd
8	39-50	Incurred Claims	Based on Claims Paid through June 1999**	xxxxxxxxx.dd
9	52-63	Remaining Liability		xxxxxxxxx.dd
10	65-68	Premium Type	Community, Entry Age or Attained Age	COMM, ENTA or ATTA
11	70-73	Underwriting Style	Guaranteed Issue or Medically Underwritten	GUAR or MUND

* Preferred, some carriers are submitting 1994 or 1996 through 1998.
** Some companies are basing incurred claims on payments through May, 1998

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Attachment D

Part 1 – Geographic Grouping of States

Northeast	Midwest	South	West
Maine	Ohio	Delaware	Montana
New Hampshire	Indiana	Maryland	Idaho
Vermont	Illinois	District of Columbia	Wyoming
Massachusetts	Michigan	Virginia	Colorado
Rhode Island	Wisconsin	West Virginia	New Mexico
Connecticut	Minnesota	North Carolina	Arizona
New York	Iowa	South Carolina	Utah
New Jersey	Missouri	Georgia	Nevada
Pennsylvania	North Dakota	Florida	Washington
	South Dakota	Kentucky	Oregon
	Nebraska	Tennessee	California
	Kansas	Alabama	Alaska
		Mississippi	Hawaii
		Arkansas	
		Louisiana	
		Oklahoma	
		Texas	

Includes all 50 states plus District of Columbia. Wisconsin, Massachusetts and Minnesota are excluded from the survey.. Puerto Rico and Virgin Islands are not included in the following geographic groupings.

Part 2 – Grouping By States Mandating /not Mandating Coverage of Under 65 Medicare Eligible Individuals

Mandating	Not Mandating
Connecticut	Rest of States
Kansas	(Includes VI,PR,
Maine	District of Columbia)
Massachusetts	
Minnesota	
New Hampshire	
New Jersey	
New York	
Oklahoma	
Oregon	
Pennsylvania	
Texas	
Washington	
Wisconsin	

Please note the Following:
1 - Some states implemented requirements during 1998 and were not included as disabled states.

2 - Massachusetts, Minnesota and Wisconsin are listed, but are not part of the survey.

3 - The classification is based on state requirements and not company practices.

Part 3 – Grouping By State Rating Requirement

Community Rated	**Entry Age**	**No Mandate**
Arkansas	Florida	All remaining states
Idaho	Georgia	
Maine		
Massachusetts		
Minnesota		
New York		

Please note the following: 1 - Massachusetts, Minnesota and Wisconsin are listed, but are not part of the survey. 2 - The classification is based on state requirements and not company practices.
3. Connecticut and Washington were omitted from the "community rated states" but that data will be included as part of the final report submitted in June.