AMERICAN ACADEMY *of* ACTUARIES

REPORT ON MEDICARE SUPPLEMENT EXPERIENCE, YEARS 1996-2000

PRESENTED TO THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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I. Executive Summary

The NAIC requested that the American Academy of Actuaries update the *Report To The National Association of Insurance Commissioners* on Medicare Supplement experience years 1996-1998, dated June 8, 2000, to include experience for two additional calendar years. The updated report includes experience from 1996 through 2000.

This updated report examines the relationships between various factors and Medicare supplement insurance claim cost trend. Factors examined in this report include:

- Annual claim cost trend nationwide, by geographic area, plan, and state (Sections III and IV)
- Hospital outpatient costs (Section V)
- Coverage for beneficiaries under age 65 (Section VI)
- Rating methods mandated by states (Section VII)
- Plan C compared to Plan F (Section VIII)
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- Guaranteed issue and Medicare + Choice plans (Section X)
- Average age of insured individuals (Section XI)
- Renewal lapse rates (Section XII)
- Aging effects on claim costs (Section XIII)

Claim cost trends from 1996 through 2000 were reviewed by plan (standardized plans as described in attachment J), state and some benefit types (e.g. Medicare Parts A and B and hospital outpatient) for the standardized Medicare supplement insurance plans of several large insurers who participated in the study. The aggregate nationwide annual claim trends, expected claim trends, and excess claim trends are shown in the following Table.

Table I-1
Aggregate Nationwide Claim Trends

Period	Academy Study	Expected	Difference
97/96	10.6%	8.4%	2.2%
98/97	9.0	3.8	5.2
99/98	7.0	3.1	3.9
00/99	6.1	4.5	1.6

This report discusses and seeks to quantify, where possible, the underlying causes of trend and the differential. The analyses presented in the report reveal that several of the above-mentioned factors affected claim cost trend significantly:

- Hospital outpatient costs had a major impact on claim cost trend between 1996 and the implementation of prospective payment in August 2000. Early indications are that this has provided for a one-time decrease in costs and for lower expected future trends.

- Individuals eligible for Medicare because of disability have significantly higher Medicare Supplement claim costs than those individuals eligible because of age. For all plans and experience periods combined, the rate is 65% higher. For Plan A only, claim costs are 273% higher.

- Prescription drug annual trend estimates range from 15% to 18.5% based on a survey of published studies, including the previous Academy report. From the previous Academy Report, the trend for prescription drug benefit costs is higher than the trend for non-prescription drug benefits within Plans H, I and J. National data for additional years were not available for this updated report.

- The average age at issue of Medicare Supplement insurance enrollees studied has remained relatively flat from 1996 through 2000. The average age for all enrollees in force that were studied with standardized plans has increased just over 1 year in average attained age from 1996 through 2000.

- A study of renewal lapse rates (including deaths) shows significant variance by 1) experience period, 2) plan, and 3) rating method.

- A study of aging effects on claim costs shows increases of 2.7% per age group for ages 72 through 77. The aging increases are higher at younger attained ages and lower for higher attained ages.

However, for several analyses presented in the report, definitive answers as to the impact on claim trend or claim cost levels could not be concluded:

- The average age and average duration of community and entry-age rated policies were greater than that of attained-age policies. However, the overall conclusion of the Work Group is that no definitive answer could be given as to whether a particular rating methodology consistently affects claim levels or trends.

- Data limitations prevented the Work Group from reaching conclusions on the effect of state rating mandates on trends.

- While it may be too early to evaluate the quantitative effects of the 1997 Balanced Budget Act requirements for the guaranteed issue of certain Medicare Supplement plans to individuals who lose Medicare + Choice health plan coverage, this requirement may provide opportunities for antiselection. The potential impact of such antiselection, if any, could be affected by a number of factors discussed in this report.

- Significant volatility of claim trend is exhibited at the state level. No attempt was made to identify local (state) factors causing the volatility.

Care should be taken not to draw conclusions from examination of a particular factor in isolation. No attempt was made to isolate the effects of individual factors.

Trends reflect claims experience for the insurers who participated in the study. For certain analyses, states where all of the major participating insurers were not in the market were not included in the study. Target markets varied considerably among participating insurers. Participating insurers have differing procedures with regard to which plans they underwrite; whether they sell to beneficiaries under age 65 in states where this coverage is not mandated; and whether they apply different rates to plans for beneficiaries under 65 in states where it is permitted.

Participating insurers apply pre-existing condition exclusions of varying lengths, or may waive the exclusion, depending on the circumstances and the particular insurer. The analyses combine statistics from group and individual insurance. To obtain the information used in the studies, it was necessary to combine data that the various insurers keep in widely varying formats.

For all of these reasons, this study should not be viewed as a rigorous attempt to quantify the effects on Medicare supplement claim cost trend of the factors it examines. Nevertheless, the analyses do provide a great deal of information that is useful in explaining the causes of recent Medicare supplement insurance rate trends.

II. Introduction

A. Updated Request

The NAIC requested that the American Academy of Actuaries update the ***Report To The National Association of Insurance Commissioners*** on Medicare Supplement experience years 1996-1998, dated June 8, 2000, to include experience for two additional calendar years (1999 and 2000). The updated report includes experience from 1996 through 2000.

In preparing the updated report, the Academy Work Group agreed to follow the same methodology and to replicate the same data analyses contained in the original report, to the extent possible.

B. Original NAIC Charge

At the Spring 1999 National NAIC Meeting, the American Academy of Actuaries was asked to analyze Medicare Supplement insurance claim trends. This request was subsequently delineated by the NAIC's Accident and Health Working Group to answer the following questions:

1. 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?

2. What additional costs are attributable to the guaranteed issue of Medicare Supplement insurance policies?

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

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

5. 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 claim experience?

C. Academy Work Group

The American Academy of Actuaries activated the Medicare Supplement Insurance Work Group (Work Group) to respond to the NAIC request for the report update. This report is the final work product of the Work Group. Attachment A lists members of the Work Group.

The Academy wishes to thank the members of the Work Group for the significant time and effort provided on this project, especially those who volunteered for the Data and Analysis Subcommittees.

In addition, the Academy appreciates the assistance provided by Mary Eichler of Milliman USA in mining and scrubbing the submitted data. Her able assistance was invaluable in the preparation of this report.

D. Contributing Organizations

Attachment B lists the insurance companies that contributed data to the study. Not all of the company data collected by the Work Group were used in this study. The Academy would like to express its appreciation to the insurers for the claim data they provided and for their contribution to this report.

E. Data Contributed

Data were contributed in several formats:

1. **Control Data** (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 control data contributed:

    a. Data for each of the standardized plans A, C, F, and combined data for plans B, D, E, and G were included.

    b. Plans H, I and J were excluded.

    c. Medicare Select plans were not studied.

    d. Data for policies issued in "grandfathered states" (Massachusetts, Minnesota, and Wisconsin) were not included. However, some companies contributed data by the state of residence of the enrollee so a small amount of business was included from those states for coverage originally issued in another state.

    e. Data cover claims experience for calendar years 1996 through 2000 for issue years 1992 through 2000.

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

Table II-E-1
Control Contributed Data

Incurred Year	Covered Lives	Claims	Claims per Life per Month
1996	1,828,510	$1,524,578,608	$69.48
1997	1,839,767	$1,670,793,164	$75.68
1998	1,799,688	$1,754,047,242	$81.22
1999	1,781,174	$1,842,031,831	$86.18
2000	1,839,713	$2,011,679,757	$91.12

2. **Select Data (**a more detailed data set in which information is broken down by age and sex in addition to state and plan). Attachment D provides an overview of the select data elements. The actual data elements reported by type of benefit (Benefit Indicator) varied by company, based on the degree of detail maintained in claims records. The following is an outline of the scope of the select data contributed:

   a. Data for each of the standardized plans A, C, and F, and combined data for plans B, D, E, and G were included.

   b. Plans H, I and J were excluded.

   c. Medicare Select plans were not studied.

   d. Data were 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).

   e. Not all companies contributed data for all select states.

   f. Data cover claims experience for calendar years 1996 through 2000 for issue years 1992 through 2000.

   The volume of select data contributed to the study is shown in Table II-E-2.

Table II-E-2
Select Contributed Data

Incurred Year	Covered Lives	Claims	Claims per Life per Month
1996	613,463	$495,155,410	$67.26
1997	606,220	$531,094,746	$73.01
1998	591,093	$613,824,167	$86.54
1999	552,224	$572,281,369	$86.36
2000	572,646	$623,659,002	$90.76

3. **Plans Providing Prescription Drug Benefits**. Summary information by plan and state was not available for this study. As a result, alternative data sources and studies were relied upon.

4. **NAIC Exposure Database**. 1998 experience from the 2000 NAIC Medicare Supplement Insurance Experience Exhibit (MSIEE) was used for several portions of this report to combine experience by state into nationwide and other geographic formats.

F. Data Audits

Data were not audited. However, the data were reviewed for reasonableness. The data for periods (96-98) used in the first study have changed between the June 2000 study and this current study. The current study restates the numbers used in the first study, and in the course of the restatement, data issues were identified. One example of data issues stemmed from the interpretation of the original request dealing with electronic claims versus paper claims. This led to some duplicated counts in the first study, and is one of the data improvements made with the updated study. Also, additional data are included in this study as additional carriers supplied data for this study. Finally, the 1996-1998 data for several companies were updated, and thus the data do not balance to the previous study.

G. Measuring Claim Trend

Claim trend is measured as the change in annual claim cost per covered life. State claim trend for a contributing insurer is measured as the change in annual claim cost per covered life in a particular state. Composite claim trend for all insurers, combined or for state combinations, were then determined by aggregating claim trend using exposed lives. All trend computations were performed before rounding to one decimal. As a result, trends may appear inconsistent across tables and difference calculations may seem inaccurate. Data underlying all calculations are reliable.

The analyses of claim trend presented herein do not attempt to differentiate between potential causes of increasing or decreasing claims. Care should, therefore, be used when reviewing the claim trend data for several reasons:

1. The influence of claim trend factors can vary by state, even by geographic area within a state.

2. The influence of claim trend factors can vary by insurer.

3. Since not all insurers contributed data, combining the data of contributing insurers can only approximate claim trend for the entire market.

4. The study examines changes for only five years (1996-2000), which may mask averages or longer-term trends.

5. In some cases, average trends for a combination of plans or subgroups may be higher or lower than the individual plans or subgroups involved. This can occur when the mix of business changes and shifts the weights toward higher or lower trend plans or subgroups.

6. When considering trends for disabled-eligible beneficiaries, note that state requirements vary greatly and some companies may offer more benefits than the minimum state requirements. Trends can vary by insurer, depending on underwriting, pre-existing condition exclusions, rating methods, marketing methods, group vs. individual markets, and other factors.

7. To avoid distortions from non-credible experience, the Work Group reviewed the data and eliminated cells with small exposures. It was determined that little additional credibility was gained from using a threshold number higher than 1,000 life-years while a substantial amount of data would have been eliminated. Using a number smaller than 1,000 life-years would have created excessive volatility. In fact, even at 1,000 life-years there appears to be substantial volatility for Plan A when looking at state-specific data or other subsets.

H. Expected Claim Trend Using Aggregate Medicare Experience

Using Medicare claim files, cost-sharing trends were developed for Medicare beneficiaries at all ages, except for those enrolled in a Medicare + Choice plan. The trends, presented in Table II-H-1, reflect beneficiary liability for Medicare deductibles, copayments, and coinsurance.

Table II-H-1
Expected Trend in Cost Sharing for Medicare Covered [1] Services
Medicare Beneficiaries of All Ages Not Enrolled in a Medicare + Choice Plan
By Benefit Category

	Medicare Cost Sharing Category						
Trend Period	Inpatient Ded.	Inpatient Coins.	Skilled Nurs. Coins.	Part B Ded.	Outpatient Coins.	Medical Coins.	Total
97/96	7.5%	3.5%	8.6%	0.4%	10.4%	9.5%	8.1%
98/97	1.7%	3.1%	-3.3%	0.4%	9.7%	3.3%	3.5%
99/98	0.7%	3.3%	-5.6%	0.5%	7.2%	3.8%	2.9%
00/99	1.4%	3.7%	3.6%	0.5%	-1.2%	11.0%	4.3%
4-year	2.8%	3.4%	0.7%	0.4%	6.4%	6.8%	4.7%

With the exception of inpatient coinsurance and the Part B deductible, the Balanced Budget Act of 1997 has significantly affected the trend for each category of service.

- Since 1997, increases in the inpatient hospital deductible have averaged only 1.3 percent per year, while increases in the utilization of inpatient services have been essentially flat.

- The trend for skilled nursing coinsurance decreased significantly in 1998 and 1999 due to the implementation of a prospective payment system (PPS) in July 1998.

- Similarly, the aggregate hospital outpatient trend dropped immediately once the PPS was implemented in August 2000. Please see Section V. for additional information regarding the impact of the hospital outpatient PPS.

[1] Medicare-covered services also include coverage for the 365 post-lifetime reserve day inpatient hospital care and exclude coverage for Part B excess charges above Medicare-approved amounts.

- The Medical Coinsurance category includes all Part B coinsurance, except for hospital outpatient. This trend has been affected by 1998 limits on fee schedule updates for physician, durable medical equipment, and drugs and biologicals. Additionally, limits of $1,500 per beneficiary were imposed on physical and speech therapy services in 1999, but subsequently removed in 2000.

- In aggregate, the cost-sharing trend averaged 4.7 percent over the study period. However, the trend for the last three years of the study averaged only 3.6 percent, compared to the first year trend of 8.1 percent.

An alternative illustration of the Medicare cost-sharing trend is by standardized plan. The trends, found in Table II-H-2, include experience for only the Medicare covered services insured by each specific plan. For example, the Plan A trend includes only coinsurance for hospital inpatient, hospital outpatient, and medical services.

Table II-H-2
Expected Trend in Cost Sharing for Medicare Covered [2] Services
Medicare Beneficiaries of All Ages Not Enrolled in a Medicare + Choice Plan
By Standardized Plan

	Standardized Plan			
Trend Period	A	B	C and F	D, E and G
97/96	9.4%	9.0%	8.1%	9.0%
98/97	5.7%	4.7%	3.5%	3.9%
99/98	5.1%	4.1%	2.9%	3.1%
00/99	5.7%	4.8%	4.3%	4.7%
4-year	6.5%	5.6%	4.7%	5.1%

The factors that influence the plan-level trends are as follows:

- The Plan C and Plan F combined trend matches the total trend in Table II-H-1, because the policies cover the cost sharing for all Medicare-covered services.

- The combined trend for plans D, E, and G is higher than the combined trend for plans C and F because plans D, E, and G do not cover the Part B deductible, which had a relatively low four-year trend.

- Likewise, the Plan B four-year trend is higher than that of plans D, E, and G due to the absence of skilled nursing coverage, which had a negative trend during two of the four years of the study period.

- Plan A had the highest four-year trend primarily because it does not cover the three benefit categories with the lowest four-year trends: inpatient deductible, skilled nursing coinsurance, and Part B deductible.

[2] Medicare-covered services also include coverage for the 365 post-lifetime reserve day inpatient hospital care and exclude coverage for Part B excess charges above Medicare approved amounts.

These data in table II-H-2 serve primarily as a baseline for expected Medicare supplement trends. There are numerous factors that can cause Medicare supplement experience to differ from the baseline. Such factors include, but are not limited to, selection, aging, induced utilization, impact of non-Medicare covered benefits, and restrictions on underwriting mandated by guaranteed issue provisions.

I. Final Report

This is intended to be the final report presented to the Accident and Health Working Group for their use in 2003. As this report essentially completes the charge to the Academy Work Group, we do not expect to do further analyses of the Medicare Supplement experience. As always, the members of the Academy Work Group stand ready to answer any questions that may arise.

III. Claim Trends

A. Nationwide Trends

Table III-A-1 and Table III-A-2 present aggregate nationwide annual claim trend by calendar year and Medicare Supplement Insurance standardized plan. The nationwide annual claim trend was constructed as follows:

- Annual claim trend for 97/96, 98/97, 99/98, and 00/99, two-year averages 98/96, 99/97, and 00/98, three year averages 99/96 and 00/97, and the four year average 00/96 was determined by plan and contributing company. Two-year, three-year, and four-year trends were calculated as the geometric mean of the individual years involved.
- To increase statistical credibility, a minimum requirement of 1,000 average lives was applied. Exposures were to average 1,000 lives over the period (1996-2000) for each product or product grouping in each state with a minimum of 750 lives in an individual year.
- As a result of the minimum exposure criteria stated above, the min/max of ± 33% applied in the June 2000 report has been eliminated from this study.
- State claim trends for all plans and companies were determined as the weighted average of all cells meeting the above tests using submitted exposure counts.
- Nationwide annual claim trend was then determined using NAIC market weights and state annual claim trend. The NAIC market weights were developed from the NAIC Medicare Supplement Insurance Experience Exhibit (MSIEE) by calendar year using 1998 member counts (the midpoint of the period) for all years. The Academy Work Group decided to use the NAIC weighting as opposed to weighting by contributed data, as this approach better reflects the market. This differs from the previous report in that 97/96 trends and 98/97 trends were calculated using 1997 and 1998 NAIC member counts respectively. A detailed analysis of the NAIC MSIEE showed that 1998 data would provide the most reliable results.
- CMS trends reflect Medicare experience related to deductibles, copayments and co-insurance for all beneficiaries in the Medicare fee-for-service program.
- The expected trends are based on internal research by Milliman USA, which relies on CMS data. The internal research develops cost and claim trend weighted by Medicare Supplement insurance plan.
- All tables presented in this Section III are based on the methodology described above.

Table III-A-1
Nationwide Trend
All Plans Combined

Year	Academy Study [1]	Expected [2]	Excess (Academy-Expected)
97/96	10.6%	8.4%	2.2%
98/97	9.0	3.8	5.2
99/98	7.0	3.1	3.9
00/99	6.1	4.5	1.6

[1] Includes data from Puerto Rico and the Virgin Islands
[2] Expected based on internal research by Milliman USA, which relied on CMS data

- The aggregate nationwide annual claim trend from 1996 through 2000 ranged from 6.1% to 10.6% for all plans A through G combined. This ranged from 1.6% above the expected for the period 00/99 to 5.2% greater than expected for 98/97.

- Plan A had a substantially higher trend until 00/99. This is likely influenced by: 1) the majority of Plan A benefits are Part B; and 2) the increasing proportion of the underage 65 disabled or those with end-stage renal disease in Plan A. The higher claim costs associated with these insureds (see Table VI-1) may impact Plan A more than other plans due to requirements that result in this plan having a higher percent of disableds compared to other plans. Policyholder anti-selection could also be affecting trend.

- Plan C exhibits a higher trend than Plan F for the period 00/96. However, in both one-year periods 99/98 and 00/99 the Plan C trend was less than Plan F trend. Please refer to Section VIII of this report for a more comprehensive comparison of Plan C and Plan F experience.

- The trend for all plans combined and by plan have declined in each of the four study periods.

Table III-A-2
Nationwide Trend Comparisons

		Standardized Plan				
	Year	**A**	**C**	**F**	**BDEG**	**A-G**
Academy Study	*One- Year Trend*					
	97/96	16.4%	11.5%	8.9%	14.7%	10.6%
	98/97	14.2%	10.7%	7.5%	10.9%	9.0%
	99/98	10.0%	6.4%	7.1%	8.5%	7.0%
	00/99	5.5%	5.6%	5.9%	6.4%	6.1%
	Two-Year Annualized					
	98/96	15.2%	11.1%	8.1%	12.7%	9.8%
	99/97	11.9%	8.5%	7.3%	9.6%	8.0%
	00/98	7.6%	5.9%	6.5%	7.4%	6.6%
	Three-Year Annualized					
	99/96	13.3%	9.5%	7.8%	11.3%	8.8%
	00/97	9.6%	7.5%	6.8%	8.5%	7.4%
	Four-Year Annualized					
	00/96	11.2%	8.5%	7.3%	10.0%	8.1%
Expected Trend	*One-Year Trend*					
	97/96	9.4%	8.1%	8.1%	9.0%	8.4%
	98/97	5.7%	3.5%	3.5%	3.9%	3.8%
	99/98	5.1%	2.9%	2.9%	3.2%	3.1%
	00/99	5.7%	4.3%	4.3%	4.7%	4.5%
	Two-Year Annualized					
	98/96	7.5%	5.8%	5.8%	6.4%	6.1%
	99/97	5.4%	3.2%	3.2%	3.5%	3.5%
	00/98	5.4%	3.6%	3.6%	3.9%	3.8%
	Three-Year Annualized					
	99/96	6.7%	4.8%	4.8%	5.3%	5.1%
	00/97	5.5%	3.6%	3.6%	3.9%	3.8%
	Four-Year Annualized					
	00/96	6.5%	4.7%	4.7%	5.1%	4.9%
Excess (Academy-Expected)	*One-Year Trend*					
	97/96	7.0%	3.4%	0.8%	5.7%	2.2%
	98/97	8.5%	7.1%	3.9%	7.0%	5.2%
	99/98	4.9%	3.5%	4.2%	5.3%	3.9%
	00/99	-0.2%	1.3%	1.6%	1.8%	1.7%
	Two-Year Annualized					
	98/96	7.6%	5.3%	2.3%	6.3%	3.7%
	99/97	6.5%	5.3%	4.0%	6.1%	4.5%
	00/98	2.2%	2.3%	2.9%	3.5%	2.8%
	Three-Year Annualized					
	99/96	6.6%	4.6%	3.0%	6.0%	3.8%
	00/97	4.1%	3.9%	3.2%	4.6%	3.6%
	Four-Year Annualized					
	00/96	4.7%	3.8%	2.6%	4.9%	3.2%

Table III-A-3 shows nationwide exposure from the NAIC database and for contributed company experience. Please note that if company experience for a plan and state cell did not exceed 750 lives in an individual year and average 1,000 lives per year from 1996-2000, the cell was excluded from the calculations.

Table III-A-3
Total Nationwide Exposure

Year	Standardized Plan A	C	F	BDEG	A-G
			NAIC Exposure		
1998	362,552	1,417,844	1,913,042	1,104,966	4,798,404
			NAIC Exposure as a % of All Plans Combined		
1998	7.6%	29.5%	39.9%	23.0%	100.0%
			Contributed Company Exposure		
1996	115,300	713,041	728,096	272,074	1,828,510
1997	108,563	659,871	779,134	292,199	1,839,767
1998	96,523	583,783	800,459	318,923	1,799,688
1999	89,477	532,578	821,625	337,493	1,781,174
2000	87,776	524,487	873,100	354,351	1,839,713
			Contributed Company Exposure as a % of All Plans Combined		
1996	6.3%	39.0%	39.8%	14.9%	100.0%
1997	5.9%	35.9%	42.3%	15.9%	100.0%
1998	5.4%	32.4%	44.5%	17.7%	100.0%
1999	5.0%	29.9%	46.1%	18.9%	100.0%
2000	4.8%	28.5%	47.5%	19.3%	100.0%

Please note that contributed data are concentrated in Plans C and F relative to NAIC market data. This reinforces the thoughts of the Academy Work Group that the analyses performed for this report are more statistically credible for plans C and F as compared to Plan A or plans B, D, E and G.

Table III-A-4 presents annual claim trend by Medicare Parts A and/or B.

Table III-A-4
Annual Claim Trend by Medicare Parts A and/or B and Calendar Year
All Insurers Surveyed Combined, Weighted on NAIC 1998 Exposure

Year	Standardized Plan A	C	F	BDEG	A-G
			Parts A & B Combined		
One-Year Trend					
97/96	16.4%	11.5%	8.9%	14.7%	10.6%
98/97	14.2%	10.7%	7.5%	10.9%	9.0%
99/98	10.0%	6.4%	7.1%	8.5%	7.0%
00/99	5.5%	5.6%	5.9%	6.4%	6.1%
Two-Year Annualized					
98/96	15.2%	11.1%	8.1%	12.7%	9.8%
99/97	11.9%	8.5%	7.3%	9.6%	8.0%
00/98	7.6%	5.9%	6.5%	7.4%	6.6%
Three-Year Annualized					
99/96	13.3%	9.5%	7.8%	11.3%	8.8%
00/97	9.6%	7.5%	6.8%	8.5%	7.4%
Four-Year Annualized					
00/96	11.2%	8.5%	7.3%	10.0%	8.1%
			Part A		
One-Year Trend					
97/96	19.7%	9.0%	8.0%	15.8%	9.6%
98/97	1222.9%	11.0%	2.8%	6.9%	6.9%
99/98	258.1%	5.9%	5.1%	6.2%	5.0%
00/99	4507.4%	4.7%	4.8%	3.0%	5.1%
Two-Year Annualized					
98/96	9.7%	9.9%	5.0%	10.9%	8.1%
99/97	75.4%	8.2%	3.8%	6.0%	5.9%
00/98	87.0%	4.8%	4.8%	4.1%	5.0%
Three-Year Annualized					
99/96	4.3%	8.3%	4.9%	9.0%	7.0%
00/97	23.7%	6.8%	4.0%	4.8%	5.6%
Four-Year Annualized					
00/96	7.3%	7.3%	4.8%	7.3%	6.5%
			Part B		
One-Year Trend					
97/96	17.4%	12.4%	9.2%	14.4%	11.0%
98/97	14.3%	10.6%	9.2%	12.5%	9.8%
99/98	10.1%	6.7%	7.8%	9.8%	7.7%
00/99	5.1%	6.0%	6.3%	7.8%	6.5%
Two-Year Annualized					
98/96	15.7%	11.5%	9.2%	13.4%	10.3%
99/97	12.1%	8.6%	8.5%	11.1%	8.7%
00/98	7.5%	6.3%	7.0%	8.8%	7.1%
Three-Year Annualized					
99/96	13.8%	9.9%	8.7%	12.1%	9.4%
00/97	9.7%	7.7%	7.7%	10.0%	7.9%
Four-Year Annualized					
00/96	11.5%	8.9%	8.1%	11.0%	8.7%

- Most Part A benefits are proportional to the Part A Initial Deductible, which would imply approximately 1.3% annual trend absent all other influences. Clearly, annual trends for Part A are significantly in excess of 1.3%.

- The volatility of Medicare Part A trend for Plan A is due to the small amount of claims per 1,000 exposed lives available for study. Plan A does not cover the Part A deductible. Plan A/Part A benefits cover extended hospital stays, which are generally low-frequency, high-dollar claims and, where reported, the ratio of these volatile average claim costs will generally not be reliable.

- For both Parts A and B, the average 00/96 annual claim trend for Plan C exceeds that for Plan F. The same relationship does not necessarily exist on a year-by-year basis.

- Part B trend declined by product over each of the four study periods with the exception of Plan F for the period 97/96 to 98/97, where it remained constant. While the Part A trend (except for Plan A) declined over the four-year period, it did not necessarily follow a similar pattern.

B. Trends by Geographic Region

Table III-B-1 presents an aggregate trend analysis by calendar year and geographic region. All Medicare Supplement plans and insurers were combined. Attachment E provides a listing of the states in each geographic region. Puerto Rico and the Virgin Islands are excluded.

For purposes of this analysis, the trends presented represent an average of company trends, weighted by their exposure in each Plan. In addition, some data were not used due to nondisclosure requirements of state specific information on some records.

Table III-B-1
Claim Trend By Geographic State Grouping & Calendar Year
All Plans, Benefits, & Carriers Combined

	Trend Period	Annual Trend	1998 Exposed Lives	Difference from All States	Percentage Difference
All Regions	*One-Year Trend*				
(CT is included)	97/96	10.8%	**NAIC**		
	98/97	9.0%	4,765,979		
	99/98	7.0%			
	00/99	6.2%	**Contributing**		
	Two-Year Annualized		**Companies**		
	98/96	9.9%	1,796,378		
	99/97	8.0%			
	00/98	6.6%			
	Three-Year Annualized				
	99/96	8.9%			
	00/97	7.4%			
	Four-Year Annualized				
	00/96	8.2%			

Table III-B-1 (Continued)

Region	Trend Period	Annual Trend	1998 Exposed Lives	Difference from All States	Percentage Difference
Northeast	*One-Year Trend*				
(CT is included)	97/96	13.4%	**NAIC**	2.6%	23.7%
	98/97	11.1%	1,322,345	2.1%	23.7%
	99/98	7.5%		0.5%	6.9%
	00/99	6.5%	**Contributing**	0.3%	4.2%
	Two-Year Annualized		**Companies**		
	98/96	12.3%	347,763	2.4%	23.9%
	99/97	9.3%		1.3%	16.4%
	00/98	7.0%		0.4%	5.7%
	Three-Year Annualized				
	99/96	10.6%		1.7%	19.3%
	00/97	8.3%		1.0%	13.0%
	Four-Year Annualized				
	00/96	9.6%		1.3%	16.4%
Midwest	*One-Year Trend*				
	97/96	10.7%	**NAIC**	-0.2%	-1.5%
	98/97	7.8%	1,340,545	-1.2%	-13.3%
	99/98	6.5%		-0.5%	-7.0%
	00/99	6.4%	**Contributing**	0.2%	3.6%
	Two-Year Annualized		**Companies**		
	98/96	9.2%	597,186	-0.7%	-7.0%
	99/97	7.1%		-0.8%	-10.5%
	00/98	6.5%		-0.1%	-1.9%
	Three-Year Annualized				
	99/96	8.3%		-0.6%	-7.0%
	00/97	6.9%		-0.5%	-6.5%
	Four-Year Annualized				
	00/96	7.8%		-0.4%	-5.0%
South	*One-Year Trend*				
	97/96	9.0%	**NAIC**	-1.8%	-16.8%
	98/97	9.0%	1,622,186	0.0%	0.2%
	99/98	6.8%		-0.2%	-2.5%
	00/99	6.4%	**Contributing**	0.2%	2.9%
	Two-Year Annualized		**Companies**		
	98/96	9.0%	666,242	-0.9%	-9.0%
	99/97	7.9%		-0.1%	-1.0%
	00/98	6.6%		0.0%	0.0%
	Three-Year Annualized				
	99/96	8.3%		-0.6%	-7.2%
	00/97	7.4%		0.0%	0.1%
	Four-Year Annualized				
	00/96	7.8%		-0.4%	-5.3%

Table III-B-1 (Continued)

Region	Trend Period	Annual Trend	1998 Exposed Lives	Difference from All States	Percentage Difference
	One-Year Trend				
West					
	97/96	10.4%	**NAIC**	-0.5%	-4.2%
	98/97	6.4%	480,903	-2.6%	-29.0%
	99/98	7.6%		0.6%	9.0%
	00/99	4.3%	**Contributing**	-1.9%	-31.2%
	Two-Year Annualized		**Companies**		
	98/96	8.3%	185,187	-1.6%	-15.7%
	99/97	7.0%		-1.0%	-12.5%
	00/98	5.9%		-0.7%	-10.2%
	Three-Year Annualized				
	99/96	8.1%		-0.8%	-9.2%
	00/97	6.1%		-1.3%	-17.9%
	Four-Year Annualized				
	00/96	7.1%		-1.1%	-13.5%

Observations from reviewing Table III-B-1:

- States in the Northeast show the highest trend over the period 00/96, as the excess averaged 1.3% annually (a 16.4% difference) above the all states value.

- States in the West show the lowest trend over the period 00/96, as the excess averaged -1.1% annually (a -13.5% difference) below the all states value.

- The Northeast shows the widest range of trends from 13.4% 97/96 to 6.5% 00/99.

Tables III-B-2, III-B-3 and III-B-4 present annual claim trend by geographic state grouping, plan and calendar year for all benefits, Part A benefits only, and Part B benefits only. Connecticut data are not included in tables III-B-3 and III-B-4 because hospital outpatient data from one of the contributing companies for Connecticut could not be split between Part A and Part B in the same manner that they are split for all other states. For comparison, trends without Connecticut can be found in Attachment I.

Table III-B-2
Claim Trend By Geographic State Grouping & Calendar Year
Part A & B Combined, Weighted on NAIC 1998 Exposure

		Standardized Plan				
	Trend Period	**A**	**C**	**F**	**BDEG**	**A-G**
All Regions						
(CT is included)	97/96	16.4%	11.6%	8.9%	14.7%	10.8%
	98/97	14.2%	10.5%	7.5%	10.9%	9.0%
	99/98	10.0%	5.9%	7.1%	8.5%	7.0%
	00/99	5.5%	6.0%	5.9%	6.4%	6.2%
Northeast						
(CT is included)	97/96	18.9%	12.6%	9.4%	19.8%	13.4%
	98/97	13.2%	12.2%	10.1%	11.8%	11.1%
	99/98	11.4%	4.8%	9.5%	10.1%	7.5%
	00/99	1.8%	5.4%	9.9%	5.0%	6.5%
Midwest						
	97/96	15.9%	11.0%	10.5%	12.9%	10.7%
	98/97	12.6%	10.4%	7.1%	9.4%	7.8%
	99/98	3.1%	5.9%	7.8%	6.8%	6.5%
	00/99	7.8%	7.0%	6.3%	8.1%	6.4%
South						
	97/96	14.0%	10.3%	7.1%	9.4%	9.0%
	98/97	18.4%	9.3%	7.9%	10.8%	9.0%
	99/98	16.3%	6.8%	6.1%	7.6%	6.8%
	00/99	10.1%	6.1%	5.8%	7.6%	6.4%
West						
	97/96	12.1%	12.7%	9.0%	13.2%	10.4%
	98/97	11.0%	6.8%	5.6%	9.5%	6.4%
	99/98	6.7%	8.7%	6.6%	6.5%	7.6%
	00/99	2.0%	5.6%	2.8%	4.8%	4.3%

Table III-B-3
Claim Trend By Geographic State Grouping & Calendar Year
Part A Only, Weighted on NAIC 1998 Exposure

		Standardized Plan				
	Trend Period	**A**	**C**	**F**	**BDEG**	**A-G**
All Regions						
(CT is excluded)	97/96	20.0%	9.3%	7.8%	15.7%	9.5%
	98/97	1232.5%	11.1%	2.7%	7.0%	6.8%
	99/98	259.9%	4.1%	5.0%	6.2%	4.8%
	00/99	4543.0%	5.5%	4.8%	3.0%	5.3%
Northeast						
(CT is excluded)	97/96	-5.2%	10.5%	2.3%	23.7%	11.8%
	98/97	-24.7%	14.0%	6.5%	6.0%	9.7%
	99/98	64.7%	2.0%	9.0%	8.6%	5.1%
	00/99	7.1%	4.2%	10.8%	-4.0%	4.1%
Midwest						
	97/96	18.5%	8.5%	11.5%	15.5%	10.5%
	98/97	87.7%	12.4%	2.1%	5.5%	5.4%
	99/98	582.7%	5.9%	6.6%	6.7%	5.3%
	00/99	84.4%	7.1%	5.4%	8.0%	6.2%
South						
	97/96	80.3%	7.9%	4.1%	7.0%	7.0%
	98/97	140.1%	7.8%	3.4%	8.9%	6.7%
	99/98	229.8%	5.6%	2.7%	3.1%	3.7%
	00/99	164.9%	7.0%	5.8%	8.9%	7.0%
West						
	97/96	-44.6%	11.3%	9.8%	8.6%	8.8%
	98/97	18502.8%	5.7%	0.6%	7.4%	3.3%
	99/98	265.1%	4.8%	5.2%	4.3%	6.2%
	00/99	69948.1%	2.5%	-2.6%	3.5%	0.1%

Table III-B-4
Claim Trend By Geographic State Grouping & Calendar Year
Part B Only, Weighted on NAIC 1998 Exposure

		Standardized Plan				
	Trend Period	**A**	**C**	**F**	**BDEG**	**A-G**
All Regions						
(CT is excluded)	97/96	17.4%	12.3%	9.2%	14.4%	11.2%
	98/97	14.3%	10.4%	9.2%	12.5%	9.8%
	99/98	10.1%	6.6%	7.8%	9.8%	7.7%
	00/99	5.1%	6.2%	6.3%	7.8%	6.5%
Northeast						
(CT is excluded)	97/96	20.5%	13.4%	10.2%	18.2%	13.9%
	98/97	15.8%	11.7%	11.3%	14.2%	11.7%
	99/98	10.2%	5.7%	10.8%	11.9%	8.4%
	00/99	1.8%	5.9%	11.1%	8.2%	7.3%
Midwest						
	97/96	16.3%	11.8%	10.2%	12.0%	10.8%
	98/97	10.8%	9.7%	8.9%	10.8%	8.7%
	99/98	5.9%	6.0%	8.1%	6.8%	6.9%
	00/99	7.1%	7.1%	6.6%	8.3%	6.5%
South						
	97/96	14.2%	11.1%	8.2%	10.5%	9.6%
	98/97	16.1%	9.9%	9.6%	11.6%	9.9%
	99/98	15.7%	7.5%	7.2%	9.3%	7.8%
	00/99	9.6%	5.9%	5.8%	7.4%	6.3%
West						
	97/96	14.0%	13.3%	8.8%	16.4%	10.9%
	98/97	11.9%	7.2%	7.5%	10.1%	7.5%
	99/98	5.0%	10.0%	7.0%	7.4%	8.1%
	00/99	0.3%	6.6%	4.5%	5.5%	5.6%

C. Trends by States Mandating Disabled Coverage

Table III-C-1 presents annual claim trend for states mandating coverage for under-65 disabled individuals.

Twenty-one states have implemented laws requiring issuance of Medicare Supplement insurance to disabled-eligible Medicare beneficiaries. Of the 21 states, three were grandfathered states and are not included in this report. Some of the remaining 18 states implemented requirements during 1998 and later and were included in this report (but were not included in the 2000 report) as states mandating coverage of Medicare-eligible disableds. Please refer to Attachment E for a list of states included.

Table III-C-1
Claim Trend for States Mandating Coverage of Under 65 Disabled Individuals
All Plans Surveyed Combined
All Insurers Surveyed Combined, Weighted on NAIC 1998 Exposure

	Trend Period	Annual Trend	1998 Exposed Lives	Difference from All States	Percentage Difference
All	*One-Year Trend*				
	97/96	10.6%	**NAIC**		
	98/97	9.0%	4,798,404		
	99/98	7.0%			
	00/99	6.1%	**Contributing**		
	Two-Year Annualized		**Companies**		
	98/96	9.8%	1,799,688		
	99/97	8.0%			
	00/98	6.6%			
	Three-Year Annualized				
	99/96	8.8%			
	00/97	7.4%			
	Four-Year Annualized				
	00/96	8.1%			
Covering	*One-Year Trend*				
Disabled	97/96	11.8%	**NAIC**	1.2%	11.4%
	98/97	9.7%	2,564,597	0.6%	7.1%
	99/98	7.2%		0.1%	1.9%
	00/99	6.5%	**Contributing**	0.4%	6.5%
	Two-Year Annualized		**Companies**		
	98/96	10.7%	857,800	0.9%	9.5%
	99/97	8.4%		0.4%	4.8%
	00/98	6.8%		0.3%	4.1%
	Three-Year Annualized				
	99/96	9.5%		0.7%	7.5%
	00/97	7.8%		0.4%	5.3%
	Four-Year Annualized				
	00/96	8.7%		0.6%	7.3%
Not Covering	*One-Year Trend*				
Disabled	97/96	9.3%	**NAIC**	-1.4%	-12.7%
	98/97	8.3%	2,233,807	-0.7%	-8.0%
	99/98	6.9%		-0.2%	-2.2%
	00/99	5.7%	**Contributing**	-0.4%	-7.0%
	Two-Year Annualized		**Companies**		
	98/96	8.7%	941,888	-1.0%	-10.7%
	99/97	7.6%		-0.4%	-5.5%
	00/98	6.3%		-0.3%	-4.5%
	Three-Year Annualized				
	99/96	8.1%		-0.7%	-8.4%
	00/97	6.9%		-0.4%	-5.9%
	Four-Year Annualized				
	00/96	7.5%		-0.7%	-8.1%

For the 00/96 period, the annual claim trend for covering disableds is 1.2% higher than the trend for not covering disabled individuals. However, the results may have more to do with geography than any marginal impact from disabled individuals. The Northeast, which had the largest trend for the period 00/96, had the largest concentration of states that cover the disabled. As of 1/1/2003, Rhode Island is the only Northeast state that does not mandate coverage for the disabled.

Section VI of this report discusses disability issues in more detail. Note that the above table shows only trends. Refer to table VI-1 for claim costs and exposure by plan.

D. Trends by State Rating Requirement

This subsection presents claim trend by mandated state rating requirements – community rating (six states studied), entry age rating (four states studied), and no rating mandate (balance of states studied). Please refer to Attachment E for the state groupings.

There is insufficient geographic diversity among the states that require community rating (high concentration of Northeast states) or entry age rating. In addition many states with rating requirements also have other mandates that may impact trend. Consequently the data presented below may show effects other than that related solely to state rating restrictions. Section VII of this report attempts to analyze the impact of rating methodology in states not mandating any rating requirements.

Table III-D-1
Claim Trend By State Rating Requirement
All Plans Surveyed Combined
All Insurers Surveyed Combined, Weighted on NAIC 1998 Exposure

	Trend Period	Annual Trend	1998 NAIC Exposed Lives	Difference from All States	Percentage Difference
All	*One-Year Trend*				
	97/96	10.6%	**NAIC**		
	98/97	9.0%	4,798,404		
	99/98	7.0%			
	00/99	6.1%	**Contributing**		
	Two-Year Annualized		**Companies**		
	98/96	9.8%	1,799,688		
	99/97	8.0%			
	00/98	6.6%			
	Three-Year Annualized				
	99/96	8.8%			
	00/97	7.4%			
	Four-Year Annualized				
	00/96	8.1%			
Community	*One-Year Trend*				
	97/96	11.4%	**NAIC**	0.8%	7.8%
	98/97	10.9%	529,213	1.8%	20.4%
	99/98	9.8%		2.7%	38.8%
	00/99	9.1%	**Contributing**	3.0%	48.7%
	Two-Year Annualized		**Companies**		
	98/96	11.1%	180,587	1.3%	13.8%
	99/97	10.3%		2.3%	28.6%
	00/98	9.4%		2.9%	43.6%
	Three-Year Annualized				
	99/96	10.7%		1.8%	20.6%
	00/97	9.9%		2.5%	34.4%
	Four-Year Annualized				
	00/96	10.3%		2.1%	26.0%
Entry Age	*One-Year Trend*				
	97/96	8.8%	**NAIC**	-1.9%	-17.5%
	98/97	7.6%	619,054	-1.4%	-15.3%
	99/98	5.2%		-1.9%	-26.4%
	00/99	4.5%	**Contributing**	-1.6%	-26.0%
	Two-Year Annualized		**Companies**		
	98/96	8.2%	252,111	-1.6%	-16.2%
	99/97	6.4%		-1.6%	-20.1%
	00/98	4.9%		-1.7%	-26.1%
	Three-Year Annualized				
	99/96	7.2%		-1.7%	-18.8%
	00/97	5.8%		-1.6%	-21.7%
	Four-Year Annualized				
	00/96	6.5%		-1.6%	-20.2%

Table III-D-1 (Continued)

	Trend Period	Annual Trend	1998 NAIC Exposed Lives	Difference from All States	Percentage Difference
No Mandate	*One-Year Annualized*				
	97/96	10.8%	**NAIC**	0.2%	2.1%
	98/97	9.0%	3,650,137	0.0%	-0.2%
	99/98	7.0%		-0.1%	-1.1%
	00/99	6.0%	**Contributing**	-0.1%	-2.3%
	Two-Year Annualized		**Companies**		
	98/96	9.9%	1,366,991	0.1%	0.9%
	99/97	8.0%		-0.1%	-0.6%
	00/98	6.5%		-0.1%	-1.7%
	Three-Year Annualized				
	99/96	8.9%		0.0%	0.4%
	00/97	7.3%		-0.1%	-1.1%
	Four-Year Annualized				
	00/96	8.1%		0.0%	-0.2%

Table III-D-2
Claim Trend By State Rating Requirement
Part A & B Combined, Weighted on NAIC 1998 Exposure

		Standardized Plan				
	Trend Period	**A**	**C**	**F**	**BDEG**	**A-G**
All	*One-Year Trend*					
	97/96	16.4%	11.5%	8.9%	14.7%	10.6%
	98/97	14.2%	10.7%	7.5%	10.9%	9.0%
	99/98	10.0%	6.4%	7.1%	8.5%	7.0%
	00/99	5.5%	5.6%	5.9%	6.4%	6.1%
	Two-Year Annualized					
	98/96	15.2%	11.1%	8.1%	12.7%	9.8%
	99/97	11.9%	8.5%	7.3%	9.6%	8.0%
	00/98	7.6%	5.9%	6.5%	7.4%	6.6%
	Three-Year Annualized					
	99/96	13.3%	9.5%	7.8%	11.3%	8.8%
	00/97	9.6%	7.5%	6.8%	8.5%	7.4%
	Four-Year Annualized					
	00/96	11.2%	8.5%	7.3%	10.0%	8.1%
Community	*One-Year Trend*					
	97/96	9.1%	11.2%	12.0%	15.2%	11.4%
	98/97	14.4%	14.1%	6.8%	15.7%	10.9%
	99/98	17.1%	7.5%	9.6%	8.8%	9.8%
	00/99	13.3%	6.9%	7.7%	9.4%	9.1%
	Two-Year Annualized					
	98/96	11.7%	12.5%	9.3%	15.5%	11.1%
	99/97	15.7%	10.6%	8.2%	12.2%	10.3%
	00/98	15.1%	7.2%	8.6%	9.1%	9.4%
	Three-Year Annualized					
	99/96	13.5%	10.8%	9.4%	13.2%	10.7%
	00/97	14.9%	9.4%	8.0%	11.2%	9.9%
	Four-Year Annualized					
	00/96	11.1%	9.8%	9.0%	12.2%	10.3%
Entry Age	*One-Year Trend*					
	97/96	17.3%	9.8%	6.1%	10.0%	8.8%
	98/97	7.8%	9.5%	6.7%	8.8%	7.6%
	99/98	6.7%	5.5%	4.1%	6.7%	5.2%
	00/99	6.5%	4.5%	4.7%	3.7%	4.5%
	Two-Year Annualized					
	98/96	12.4%	9.7%	6.4%	9.4%	8.2%
	99/97	7.1%	7.5%	5.4%	7.7%	6.4%
	00/98	6.4%	5.0%	4.4%	5.1%	4.9%
	Three-Year Annualized					
	99/96	10.4%	8.3%	5.6%	8.4%	7.2%
	00/97	6.8%	6.5%	5.1%	6.3%	5.8%
	Four-Year Annualized					
	00/96	9.3%	7.3%	5.4%	7.2%	6.5%

Table III - D - 2 (Continued)

		Standardized Plan				
	Trend Period	**A**	**C**	**F**	**BDEG**	**A-G**
No Mandate	*One-Year Trend*					
	97/96	17.4%	11.9%	9.1%	15.2%	10.8%
	98/97	15.9%	10.3%	7.7%	9.9%	9.0%
	99/98	10.3%	6.4%	7.4%	8.6%	7.0%
	00/99	4.4%	5.5%	6.0%	6.1%	6.0%
	Two-Year Annualized					
	98/96	16.5%	11.1%	8.3%	12.4%	9.9%
	99/97	12.8%	8.3%	7.5%	9.2%	8.0%
	00/98	7.2%	5.9%	6.7%	7.3%	6.5%
	Three-Year Annualized					
	99/96	14.2%	9.5%	8.0%	11.1%	8.9%
	00/97	9.9%	7.3%	7.0%	8.1%	7.3%
	Four-Year Annualized					
	00/96	11.6%	8.4%	7.5%	9.8%	8.1%

The 00/96 trend differences by plan are smaller in the community rated group than the other two. In fact, the normal expectation that Plan A trends would be the highest is not true for 97/96 and 98/97 in the community rated group of states.

IV. Volatility by State

Table IV-1 presents claim trend by state and plan for all contributing companies combined. Annual claim trend over the period 1996-2000 was computed using the methodology described in Section III of this report.

Please note the following while reviewing Table IV-1:

- Significant fluctuation of trend rates exists from state to state.
- If company experience for a plan and state cell did not exceed 750 lives in an individual year and average 1,000 lives per year from 1996-2000, the cell was excluded from the calculations.
- Numerous states did not meet minimum exposure criteria for Plan A, but may have met minimum exposure criteria for other plans. Blanks were used when minimum exposure criteria were not met.

Table IV-1
Claim Trend by State & Calendar Year
Part A & B - Annualized Trend, Weighted on 1998 NAIC Exposure

		Standardized Plan				
State	**Four-Year Annualized**	**A**	**C**	**F**	**BDEG**	**A-G**
AK	00/96			4.5%		6.3%
AL	00/96	1.1%	8.1%	7.1%	8.6%	6.9%
AR	00/96	9.1%	6.9%	8.4%	12.8%	10.1%
AZ	00/96	7.5%	6.6%	5.6%	7.8%	6.7%
CA	00/96	4.8%	5.1%	5.1%	6.7%	5.5%
CO	00/96	11.3%	6.5%	5.7%	0.6%	5.4%
CT	00/96	8.0%	8.0%	8.3%	10.5%	8.1%
DC	00/96					6.2%
DE	00/96				10.4%	11.1%
FL	00/96	5.4%	5.7%	3.8%	5.4%	4.9%
GA	00/96	11.6%	8.0%	5.5%	9.8%	7.2%
HI	00/96					
IA	00/96		4.7%	7.8%	8.8%	7.0%
ID	00/96		12.7%	4.2%		7.1%
IL	00/96	9.6%	7.5%	7.2%	9.1%	7.6%
IN	00/96	10.3%	10.5%	8.0%	8.1%	8.3%
KS	00/96	1.6%	3.6%	5.4%	12.7%	4.1%
KY	00/96	13.8%	10.1%	7.1%	7.5%	8.3%
LA	00/96	26.8%	10.6%	9.9%	12.9%	10.9%
MA	00/96					
MD	00/96	7.3%	6.8%	7.1%	9.0%	7.4%
ME	00/96		8.2%	9.1%	12.1%	9.1%
MI	00/96	11.4%	9.2%	9.9%	9.3%	8.3%
MN	00/96					
MO	00/96	11.0%	9.7%	8.4%	10.8%	8.7%
MS	00/96	10.9%	6.5%	4.9%	8.9%	5.8%
MT	00/96		11.2%	8.4%	8.0%	9.1%
NC	00/96	20.1%	11.0%	7.3%	11.1%	9.4%
ND	00/96		10.4%	9.5%		9.5%
NE	00/96		10.2%	8.9%	9.3%	9.0%
NH	00/96		12.8%	10.7%	8.1%	9.5%
NJ	00/96	10.7%	9.8%	9.2%	12.1%	9.8%
NM	00/96		9.7%	5.3%	9.6%	8.0%
NV	00/96		8.9%	7.4%	6.8%	8.2%
NY	00/96	13.8%	11.1%	10.6%	12.4%	11.2%
OH	00/96	9.0%	8.4%	7.2%	8.6%	7.9%
OK	00/96	23.0%	7.8%	7.8%	8.1%	8.6%
OR	00/96		8.3%	7.7%	15.1%	8.4%
PA	00/96	11.6%	8.0%	6.5%	11.0%	8.8%
PR	00/96		9.7%	12.2%		-4.1%
RI	00/96		6.5%	8.3%		6.4%
SC	00/96	13.7%	10.4%	7.3%	12.9%	9.1%
SD	00/96		17.0%	13.2%		13.4%
TN	00/96	17.0%	9.8%	7.9%	9.3%	9.4%
TX	00/96	30.2%	7.0%	6.1%	5.3%	7.4%
UT	00/96		8.6%	5.6%	13.6%	7.6%
VA	00/96	9.3%	10.3%	8.9%	10.2%	8.9%
VI	00/96					
VT	00/96		10.4%		9.5%	9.6%
WA	00/96	16.0%	10.8%	6.1%	11.6%	8.8%
WI	00/96					
WV	00/96	6.6%	8.7%	7.3%	9.7%	8.2%
WY	00/96		11.7%	7.8%		9.3%
All States	*Four-Year Annualized*					
	00/96	11.2%	8.5%	7.3%	10.0%	8.1%

V. Outpatient Hospital Claims

Since August 1, 2000, most hospital outpatient services covered under Medicare Part B have been reimbursed under a prospective payment system (PPS) methodology where predetermined payment levels are set for ambulatory payment classification (APC) groups. It was expected that these changes would result in a one-time decrease in hospital outpatient claim payments nationally (with some states seeing increases and some decreases), as well as provide for more moderate claim trends in the future.

A. Background

Effective October 1, 1997, the "formula-driven overpayments" that hospitals previously received for surgery, radiology, and other diagnostic services furnished in outpatient hospital departments, were eliminated, allowing Medicare to deduct the full amount of beneficiary coinsurance payments for the Medicare payment amount. Thus, beginning 10/1/97, hospitals could no longer increase revenues simply by increasing their charges for outpatient services.

Until August 1, 2000, a significant portion of Medicare Supplement trend had been attributable to the increase in coinsurance claim costs on outpatient hospital services. For most outpatient services, the Medicare beneficiary was liable for 20% of the hospital's **billed charges** once the annual Part B deductible had been satisfied.

No limits had been placed on the absolute level or amount of annual increase of hospital billed charges, so beneficiaries were subject to full medical inflation on their coinsurance liability (or potentially even greater than medical inflation, if the Medicare inflation rate was less than the medical inflation rate). Because hospital billed charges were generally much higher than Medicare's hospital payment basis, the aggregate beneficiary cost sharing accounted for, on average, 50% of the total payment to the hospital.

B. Medicare's Prospective Payment Methodology for Outpatient Services

Since August 2000, all hospital outpatient services covered under Medicare Part B have been reimbursed under a prescribed PPS methodology, where predetermined payment levels are set for ambulatory payment classification (APC) groups.

For hospital outpatient services, beneficiary coinsurance is limited to the greater of a geographically adjusted fixed-dollar amount per APC group, or 20% of the APC fee schedule or payment rate. Each year, the APC fee schedules will be updated, but the fixed-dollar amount will remain the same except for slight variations in the geographical adjustment. As a result, the beneficiary coinsurance will gradually decline as a percentage of the total hospital reimbursement until it reaches the 20% level. It was originally estimated that this could take up to 40 years, according to the Medicare Payment Advisory Commission.

There are several other factors that, with the changes to PPS, resulted in a one-time aggregate reduction in beneficiary coinsurance. Two of the major factors are 1) the

national unadjusted coinsurance amounts were frozen as of 1999 and did not reflect trend to August 2000, the OPPS implementation date, and 2) the coinsurance for each APC is limited to the Part A inpatient deductible, reducing the coinsurance liability for some procedures.

Attachment F contains CMS's estimates of the change in beneficiary copayments for 2000, due to the implementation of the OPPS. This report is similar to Attachment F of the original study. The primary difference is that this exhibit attempts to project the impact to 2000, using separate nationwide trends (1996-2000) for hospital costs and charges. Note that this attachment reflects the 1996 mix of services and does not consider new technologies. Also, the trends used are the same for all states; the figures do not reflect utilization changes resulting from the PPS implementation. As a result, the impact may be significantly different from that estimated (16% on a national basis).

In 2000, the Benefits Improvement and Protection Act (BIPA) provided additional limits on the coinsurance amount for each APC. With these limits, the coinsurance amount cannot exceed 57% of the APC in 2001. For 2002 and 2003, this limit will be 55% of the APC. The limit is scheduled to decrease to 50% in 2004, 45% in 2005, and 40% in 2006. These additional limits will decrease the time until the beneficiary coinsurance reduces to 20% of the APC amount.

C. Claim Cost Trends and Company Experience

When the OPPS was first implemented, the immediate impact was a reduction in the aggregate coinsurance costs nationwide (with results varying significantly by state) and a corresponding reduction in claim cost trends. Following this significant one-year reduction in trend, the OPPS is expected to provide for more moderate claim trends in the future.

Four carriers, two state-specific and two nationwide, were able to provide claim cost trends for hospital outpatient services. Trends for 1997 through 2000 are illustrated in Table V-C-1 below. Company experience annual trends are weighted by company exposure. As shown, hospital outpatient trends have decreased over the past year for these carriers, reflecting the implementation of the OPPS. This table also shows expected trend for Medicare covered services for hospital outpatient coinsurance.

Table V-C-1
Hospital Outpatient Claim Cost Trend
1997 through 2000

Calendar Year	Company Experience Annual Trend	Medicare Hospital Outpatient Coinsurance Expected Trend
1997	15.0%	10.4%
1998	13.7%	9.7%
1999	6.9%	7.2%
2000[3]	-0.5%	-1.2%

In the prior study, one carrier was able to isolate their Plan F's hospital outpatient claim cost trend for the period 1995-1998. These data have been updated for the period 1999-2000. Table V-C-2 below shows that the total claim cost trend for the period 1995-2000 ranged from 6.1% to 9.7%. The average outpatient claim cost trend was over 19% for the period 1995-1998, but has decreased considerably, with a trend of just over 6% in 2000.

The increase in outpatient claim costs (from 1995-1998) caused overall trends to be about 3% higher per year than they would have been if the outpatient trend had equaled the average of the other components. For this carrier, outpatient claim cost trends continued at high levels until the implementation of the OPPS in August 2000.

Table V-C-2

Incurred Year	Total Claim Cost Trend	Hospital Outpatient Claim Cost Trend	Other Part B Coinsurance Claim Cost Trend	Hospital Outpatient Claims as a % of Total Claims	Other Part B Coinsurance Claims as a % of Total Claims
1995	6.9%	19.8%	10.9%	22.9%	39.1%
1996	6.1%	19.2%	2.8%	25.7%	37.9%
1997	8.8%	18.4%	4.6%	28.0%	36.5%
1998	9.0%	19.4%	6.0%	30.6%	35.5%
1999	8.9%	10.9%	10.7%	31.2%	36.1%
2000	9.7%	6.2%	15.7%	30.3%	38.3%

To summarize, although early indications based on 2000 data are that the OPPS has provided for decreasing outpatient claim trends, CMS has not yet conducted a retrospective study of the OPPS impact. Company data specific to the period from August to December 2000 were not available. We expect hospital outpatient claim costs will increase after August 2000, but this increase will likely be smaller than those observed in the mid 1990s.

[3] 2000 trends reflect the introduction and implementation of OPPS at mid-year.

VI. Disability Issues

Twenty-one states have implemented laws requiring open enrollment of Medicare Supplement insurance to disabled-eligible and/or ESRD Medicare beneficiaries. The plans that must be offered and the duration of the guarantee issue period vary by state. Some insurers may also underwrite this coverage or charge higher rates. Many of these disabled individuals were underwritten so the relative claim costs for disabled and non-disabled individuals are understated for the purpose of assessing the impact of open enrollment of disabled individuals.

Table VI-1 compares annual claim costs for disabled and age-eligible populations. The data are developed from Attachment G. The disabled population was derived by assuming that everyone with an attained age of less than 64 qualified for Medicare by reason of disability (including ESRD). The age-eligible population was derived by assuming that everyone with an attained age equal to or greater than 64 qualified for Medicare by reason of age. Thus, an entry-age policy issued in January 1997 to a person age 62 would be in the disabled population for 1997 and 1998 but in the age-eligible population for 1999, even though in duration 3.

Table VI-1
Benefit Relativities By Plan
Disabled Eligible and Age Eligible
Annual Claim Cost

	Disabled Eligible	Age Eligible	Ratio	Disabled Exposure
Plan A	$ 2,352	$ 630	3.73	3,552
Plan C	2,605	1,210	2.15	6,721
Plan F	1,385	1,003	1.38	19,396
Plan BDEG	1,138	995	1.14	2,240
Plans A-G	1,732	1,050	1.65	31,909

Disabled-eligible beneficiaries have significantly higher Medicare Supplement claim costs than age-eligible beneficiaries for all plans. Some of the variations among plans may be explained by different state requirements as to the plans that must be offered. Increases in the percentage of a Medicare Supplement block that is disabled-eligible will lead to increased overall 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. In states limiting rates, age-eligible individuals are generally subsidizing disabled-eligible individuals.

The percentage of disabled individuals included in the survey increased 43% from 1996 to 2000 (from 0.87% to 1.24% of exposure for all plans combined). Although the percentage is small, the data include many states not mandating coverage for disabled individuals. Thus, the 43% indicates the potential growth rate for covering disabled individuals. According to the CMS website, in 1998, there are over 5 million disabled persons out of almost 39 million Medicare Enrollees for a 12.9% portion.

Table VI-2 shows annual claim cost relativities for individuals under 64 by calendar duration from issue. The data are developed from Attachment G. The Work Group assumed that once the individual's attained age was 64 years or greater, they would be eligible for Medicare and for Medicare Supplement coverage regardless of whether they were disabled.

Table VI-2
Claim Cost Relativities by Calendar Duration From Issue for Disabled Eligible

	1	2	3	4	5+	All	2+
Plan A	116%	113%	105%	88%	81%	103%	100%
Plan C	110%	111%	105%	99%	74%	103%	100%
Plan F	98%	103%	102%	92%	94%	99%	100%
Plan BDEG	120%	110%	114%	98%	72%	105%	100%
Plans A-G	100%	105%	102%	97%	86%	100%	100%

Please note the anti-selection by duration from issue (except for plan F). While not specifically studied, this may also be the result of higher claim costs by those with ESRD in the early durations. The portion of insured individuals with ESRD compared to those with other disabilities is expected to decrease as duration from issue increases. This trend would be expected to decrease composite claim costs over time, even if the overall costs for each subgroup increase.

VII. Rating Methods

The purpose of this section is to identify the impact of rating method on the level of claim costs.

Table VII-1 presents the claim cost relativities determined as the ratio of entry-age-rated and community-rated claim costs to attained age rated claim costs for incurred years 1996 through 2000 (claims trended to 2000 based on expected claim trends provided by Milliman USA). This table shows these ratios on both an unadjusted and an age-based morbidity-adjusted basis. A total of 31 states were included in this analysis. Only states with no rating mandate were included. In addition, if company experience for a plan and state cell did not exceed 750 lives in an individual year and average 1,000 lives per year from 1996-2000, the cell was excluded from the calculations.

For those states with select data contributed, claim costs per exposure and adjusted claim costs per exposure (that reflect a normalization based on age-based morbidity factors provided by Milliman USA) were developed by state, plan, and rating method. These values were weighted by 1998 NAIC weights to develop average nationwide claim costs by plan and rating method. The claim costs were then normalized to the attained-age claim costs by dividing each respective claim cost by the respective attained-age claim cost. This method differs from the procedure used in the 2000 report, but the results are consistent with the earlier findings.

Table VII-1
Claim Cost Relativities By Rating Method
Nationwide Ratio as a Percentage of Attained Age*

	Standardized Plan					
Rating Type	**A**	**C**	**F**	**BDEG**	**A-G**	**C&F**
			Unadjusted Claims			
Attained Age	100%	100%	100%	100%	100%	100%
Entry Age	94%	113%	121%	106%	114%	118%
Community Rated	99%	103%	114%	114%	115%	110%
			Adjusted Claims			
Attained Age	100%	100%	100%	100%	100%	100%
Entry Age	92%	108%	110%	104%	107%	110%
Community Rated	103%	100%	106%	105%	109%	103%

* Reflects 1998 NAIC Weights.

Overall, it appears that claim costs for entry-age and community-rated business are higher than those for attained age. One factor that may explain some of the difference is policy duration year (incurred year, less the issue year, plus one):

Table VII-2
Average of Policy Duration Year By Rating Method*

Rating Type	Standardized Plan A	C	F	BDEG	All	C&F
	Average of Policy Duration Year					
Attained Age	3.8	3.7	3.2	2.9	3.4	3.4
Entry Age	3.2	4.5	4.7	2.8	4.2	4.6
Community Rated	3.8	3.9	4.8	3.8	4.5	4.6

* Reflects 1998 NAIC Weights.

It appears that if higher average policy duration mix leads to higher claim costs (generally true, see Attachment G), proper reflection of the durational mix of business would bring the values in Table VII-1 even closer to 100% (with a few exceptions).

Table VII-3 shows various observations made from the data provided from the contributing companies that were included in this study:

Table VII-3
Various Data Observations For States/Plans Included

Rating Type	Exposure	Annual Claim Cost Per Insured*	Average Age	Average Duration
Attained Age	1,401,906	$ 948	70.79	3.65
Entry Age	237,492	1,146	75.10	4.48
Community	308,105	1,420	75.45	4.20

* Claim costs trended to 2000.

This table differs from the prior tables in that NAIC weights have not been applied. With that in mind, the differences in claim-cost relativities and durations between this table and the prior two suggest that the data provided may not represent the nation as a whole, or that rating method options are not available uniformly across the nation. Further investigation revealed that a majority of attained-age-rated data came from the Midwest, a majority of entry-age-rated data from the South, and community-rated data from the Northeast (an observation that may explain the remaining differences in claim costs).

The following Table VII-4 shows the states included in the rating study. Only states not mandating rating requirements were included.

Table VII-4
States Included in Rating Study

AL	KS	MT	PA
AZ	KY	NC	SC
CA	LA	NE	TN
CO	MD	NH	TX
IA	MI	NJ	VA
IL	MO	OH	WV
IN	MS	OK	

From this analysis, the Work Group was unable to reach a definitive answer to whether the use or state mandate of a particular rating methodology consistently affects claims levels or claim trend. Not considering the varying levels of data submitted by type and by state, there are many other dynamics that may either mask or offset the impact from the rating methodology.

VIII. Plan C Compared to Plan F

Plan C and F results are compared throughout this report because of the large exposure associated with these plans relative to the other plans. In this section, plans C and F are more closely examined. Claim-cost relativities by attained age are discussed for all rating methods and all states combined.

Table VIII-1 compares annual claim costs for Plans C and F. The data are from Attachment G, which shows claim costs by Plan, attained-age group, and calendar duration from issue. Please note this attachment is based on submitted select data, all contributing companies combined, all rating methods, and underwriting styles combined.

Based on discussions with contributing companies, attained-age 64 data is for age-eligible (versus disabled-eligible) persons and was included with 65-69 persons to form the 64-69 age grouping. Individuals under attained-age 64 were assumed to be disabled.

Table VIII-1
Plan C vs. Plan F
Annual Claim Cost by Attained Age

Attained Age	Plan C	Plan F	C to F Ratio
Under 64	$2,605	$1,385	188%
64-69	931	846	110
70-74	1,175	1,027	114
75-79	1,375	1,151	119
80-84	1,616	1,268	127
85+	1,518	1,369	111

In total, the data reveal a Plan C claim cost in excess of 20% higher than Plan F. Age-weighted morbidity adjustments and duration adjustments reduce this overage by four to five percentage points.

Also, note the data have not been adjusted for geographic differences, and data are listed for only the states for which select data was available. While the above patterns hold, even when the data are broken into the Northeast, Midwest, South and West regional groupings as defined elsewhere in the report, it is not clear if a true nationwide study would produce the same relationships by attained age.

Attachment G also indicates differing selection/underwriting patterns between Plans C and F. Please see Table VIII-2 below. While the prior report indicated some insured anti-selection exhibited by Plan C purchasers (or a different mix of open enrollment and underwritten business), the new data included in this study reversed that trend.

Table VIII-2
Claim Cost for Plan C and Plan F by Duration
Ages 64 and Older

Calendar Duration From Issue	Plan C Claim Cost	Plan C Ratio to 2+	Plan F Claim Cost	Plan F Ratio to 2+	Claim Cost Ratio C:F
1	$887.11	72%	$841.03	82	1.06
2	913.09	74	883.31	86	1.03
3	986.54	80	941.97	92	1.04
4	1,062.80	86	997.55	98	1.06
5+	1,465.47	119	1,125.59	110	1.32
All	1,210.14	98	1,002.64	98	1.21
2+	1,233.02	100	1,021.29	100	1.21

As in the previous study, updated data confirm a higher average claim cost for Plan C versus Plan F. The explanation is still unclear. The data collected did not allow for investigation of differing relationships between rural and urban market claim costs (a theory proposed in the previous report). Additional data elements would need to be included for further study.

Renewal lapse rates (see Table XII-4) for Plan C are substantially higher than Plan F. This may be part of the reason for Plan C's steeper slope by duration.

IX. Impact of Drug Coverage and Prescription Drug Costs

Prescription drug coverage for Medicare beneficiaries has been an important issue for the past several years. Outpatient drugs are generally not covered by Medicare, although many Medicare + Choice plans have included some benefits either within their normal cost or as part of supplemental coverage. Standardized Medicare supplement rules have included three plans with outpatient drug coverage since 1992 (Plans H, I and J, with Plan J recently becoming available with a high deductible). Many pre-standardized plans had varying levels of drug coverage.

The prior Academy report contained a substantial amount of national exposure for the Medicare Supplement plans with drug benefits. The data submitted for this report are much smaller. The largest amount is from a single state. As such, this report is not able to look at trends specific to Medicare Supplement plans in any substantive fashion.

Because of the importance of the drug issue, there have been a substantial number of studies on this subject. We present a summary of trend results or estimates from several of these as potentially useful in estimating the trend of Medicare Supplement drug coverage. Note that the Medicare Supplement drug plans all have a maximum benefit that may reduce the impact on the trend of total drug costs. Some of these studies have had to adjust 1995 or 1996 data to current periods using an assumed, estimated, or data-based trend. Table IX-1 provides a summary of several of these studies.

Table IX-1
Estimates of Drug Trend for Medicare Beneficiaries

Study or Report	Trend	Period for Trend
American Academy of Actuaries – *Providing Prescription Drug Coverage for Medicare Beneficiaries* – 2000	15.0%	Through 2005
CMS – *National Health Care Expenditure Projections: 2000-2010* – 2000	16.2%	1999-2000
(per capita)	16.4%	2000-2001
Health Affairs – *Growth in Prescription Drug Spending Among Insured Elders* – 2001	18.5%	1997 to 2000
Express Scripts – *1999 Drug Trend Report*	17.4%	1998 and 1999

The drug trend estimates above, plus others not shown, can be expected to differ because:

- The population base may be different, with some looking at only the Medicare population while others use a broader base.
- The trends may have been adjusted to reflect population changes (i.e., per capita trend) while others show trend in total costs.
- The trends may aggregate separate portions of the overall trend (unit price change, utilization change, and new drug effects) or focus on only one aspect.

X. Guaranteed-Issue Medicare Supplement Coverage and Medicare + Choice Plans

A. Background

The 1997 Balanced Budget Act (BBA) contained requirements for the guaranteed issue of certain Medicare Supplement plans (generally, plans A, B, C, and F) to individuals who lose Medicare + Choice (M+C), retiree medical, or other similar coverage. The guaranteed-issue coverage requirement applies when an individual has one of certain specified types of prior coverage, enrollment terminates, and the individual subsequently applies for a Medicare Supplement insurance policy. The application for coverage must ordinarily be made within 63 days of termination.

These requirements were expected to provide opportunities for anti-selection for all types of coverage described above. The level of anti-selection would be affected by individuals' health status, whether termination was voluntary or involuntary, the existence of viable M+C alternatives, and the ease of moving in and out of types of coverage. Another factor in evaluating anti-selection is the premium and benefit differentials between available Medicare Supplement options and the available M+C options.

There are many factors that drive the utilization, and there are alternate scenarios for the expected experience after individuals drop an M+C plan and enroll in a Medicare Supplement plan, another M+C plan, or rely on Medicare alone. Suggested drivers of possible anti-selection are:

- In one scenario, individuals with worse than average health have an incentive to enroll in Medicare and purchase Medicare Supplement insurance plans, as these plans are guaranteed issue with no provider restrictions and few limitations on the level of benefits available. For less-healthy individuals, the coverage provided by Medicare Supplement insurance plans may offset the deterrent of higher Medicare Supplement premiums.

  Assuming other factors (such as socioeconomic level) are equal, 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.

- In a second scenario, seniors with high prescription drug use select an M+C program offering even limited drug coverage, especially if there are no reasonably-priced Medicare Supplement drug plans available. Further, the lower premiums and (often) lower copays for M+C plans appeal to lower-income seniors who are willing to accept tight network restrictions to ensure some supplemental coverage. Both segments will generally have higher costs than the average beneficiary leaving a terminating M+C plan.

- In another scenario, 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) are more likely to choose Medicare Supplement insurance coverage, if it were available at a price that is competitive with the M+C plan. If there are a number of other M+C options available in the area, a good portion of those individuals satisfied with M+C Plans or without a basis

to be unhappy (e.g., minimal contact) will probably choose coverage under another M+C program. It should be noted that as more M+C plans leave the program, fewer individuals dropped by an M+C plan will have options other than Medicare Supplement available to them. In this scenario, the reasons relate to prior health care and may or may not indicate higher than average future health care needs.

This section of the report concentrates on experience with respect to anti-selection of Medicare Supplement plans. The reported results of two companies described in detail below differ from the anecdotal comments from two other companies. Any conclusions depend on specific market conditions of both the available M+C plans and the available, viable, Medicare Supplement plans, and the way other Medicare Supplement products are marketed.

B. Guaranteed-Issue Availability

The 1997 BBA provided that individuals losing M+C coverage could apply for guaranteed-issue Medicare Supplement coverage no later than 63 days after M+C termination.

In 1999, the Balanced Budget Refinement Act (BBRA) clarified that individuals could apply for guaranteed-issue coverage before M+C termination (though Medicare Supplement coverage cannot become effective before termination of M+C coverage). Then in 2000, the Benefits Improvement and Protection Act (BIPA) changed guaranteed-issue time limits for individuals terminated from employer-provided Medicare Supplement coverage and in certain situations for those terminated from M+C plans.

C. Historical Data on M+C Plan Terminations

The following table shows the number of M+C enrollees losing coverage between 1998 and 2001. The number losing coverage increased dramatically at year-end 2000, and remained relatively high at year-end 2001.

Table X-1
Number of Medicare + Choice Beneficiaries
Affected by Plan Terminations or Service Reductions[4]

Year	# M+C Affected
End of 1998	406,000
End of 1999	328,000
End of 2000	934,000
End of 2001	536,000
2002 Estimate[5]	198,000

[4] Source: CMS / Office of Strategic Planning Analysis of Medicare + Choice ACR Submissions.
[5] Source: http://cms.hhs.gov/healthplans/nonrenewal/reports2003.asp.

D. Experience

Although the experience generated by individuals losing their M+C coverage is still developing, there are some indications that the experience reflects at least some anti-selection, as could be expected under one of the scenarios listed. Two companies provided experience separating policies issued to BBA-eligible beneficiaries from all other policies (initial open enrollment or later underwritten issues). Both companies market attained-age rated products.

Companies that market guaranteed-issue, entry-age or community-rated products may generate different results than those shown below. For example, the average issue age for policies issued to individuals losing M+C coverage may be lower for a company with a community-rated product, resulting in somewhat better experience.

As shown in Table X-2 below, we have experience from two companies for business issued to individuals losing M+C coverage. The table shows experience, by issue year, for individuals losing M+C coverage for the period 1999-2001. With a 1999-2001 loss ratio of 86.6%, the experience for those policies that were guaranteed issue due to BBA requirements was significantly worse than the experience for all other policies (loss ratio of 67.2%). Although the experience by duration is fairly limited, there has been some improvement in the experience over time. Even with this improvement, however, the experience has remained worse than for all other policies.

Table X-2
Comparative Loss Ratios by Duration[6]
(in 000s)

Issue Year	Exp. Year	Policies Issued to BBA-Eligibles Earned Premium	Inc. Claims	LR	All Other Policies Issued Earn Premium	Inc. Claims	LR	Loss Ratio Comparison Difference	Ratio
1999	1999	1,168	1,147	98.2%	44,662	29,015	65.0%	33.2%	1.51
	2000	2,430	2,299	94.6%	77,183	53,593	69.4%	25.2%	1.36
	2001	2,180	1,866	85.6%	73,208	50,442	68.9%	16.7%	1.24
	Total	5,778	5,312	91.9%	195,054	133,050	68.2%	23.7%	1.35
2000	2000	5,316	4,636	87.2%	59,510	37,962	63.8%	23.4%	1.37
	2001	6,263	5,080	81.1%	111,887	77,439	69.2%	11.9%	1.17
	Total	11,579	9,717	83.9%	171,397	115,400	67.3%	16.6%	1.25
2001	2001	8,686	7,533	86.7%	82,111	52,828	64.3%	22.4%	1.35
	Total	8,686	7,533	86.7%	82,111	52,828	64.3%	22.4%	1.35
Grand Total		26,043	22,562	86.6%	448,563	301,278	67.2%	19.5%	1.29

Tables X-3 and X-4 show experience for one of the two companies contributing data. Table X-3 below shows the experience for plans that were issued on a guaranteed-issue basis (i.e., plans A, B, C, and F) compared to those plans that were underwritten. Since the guaranteed-issue requirements of BBA are limited to plans A, B, C, and F, the great majority of issues of plans D, E, and G, to individuals losing M+C coverage, were underwritten.

It is interesting to note that the experience for underwritten plans D, E, and G, for individuals losing M+C coverage, is very similar to the experience for the remainder of the population for these plans. It appears that the less healthy HMO disenrollees have enrolled in the guaranteed-issue plans.

[6] Policies issued to BBA-eligible individuals include those affected by plan terminations and service area reductions. All other policies include those medically underwritten and initial open enrollment.

Table X-3
Comparative Loss Ratios by Plan Group
(in 000s)

	Policies Issued to BBA-Eligibles			All Other Policies Issued			Loss Ratio Comparison	
Exp Year	Earn Premium	Inc. Claims	LR	Earned Premium	Inc. Claims	LR	Difference	Ratio
				Plans D, E & G				
1999	12	9	75.7%	9,828	6,537	66.5%	9.1%	1.14
2000	893	598	67.0%	30,527	20,645	67.6%	-0.6%	0.99
2001	1,352	947	70.1%	52,182	34,121	65.4%	4.7%	1.07
Total	2,257	1,555	68.9%	92,537	61,303	66.2%	2.6%	1.04
				All Others				
1999	692	686	99.2%	8,125	5,304	65.3%	33.9%	1.52
2000	2,268	2,234	98.5%	24,257	15,806	65.2%	33.4%	1.51
2001	4,968	4,109	82.7%	46,058	29,049	63.1%	19.6%	1.31
Total	7,927	7,030	88.7%	78,440	50,158	63.9%	24.7%	1.39
				All				
1999	704	696	98.8%	17,953	11,841	66.0%	32.8%	1.50
2000	3,160	2,833	89.6%	54,784	36,451	66.5%	23.1%	1.35
2001	6,320	5,057	80.0%	98,240	63,170	64.3%	15.7%	1.24
Total	10,185	8,585	84.3%	170,977	111,462	65.2%	19.1%	1.29

One potential indicator of anti-selection generated by individuals losing M+C coverage is the presence of M+C alternatives in an area. Table X-4 below includes experience for groups with a high or low concentration of M+C alternatives in the area. The high concentration group includes the experience in states where at least 80% of individuals (90%, on average) losing M+C coverage have at least one M+C alternative in the area. For the low concentration group, on average, only 64% have at least one M+C alternative in the area.

The experience for the group of states with a higher concentration of M+C alternatives in the area, with a 1999-2001 loss ratio of 88.7%, is significantly worse than the experience (76.5% loss ratio) for the group with the lower concentration.

Table X-4
Comparative Loss Ratios by Level of M+C Concentration
(in 000s)

Concentration of M+C Options	Policies Issued to BBA-Eligibles			All Other Policies Issued			Loss Ratio Comparison	
	Earn Premium	Inc. Claims	LR	Earn Premium	Inc. Claims	LR	Difference	Ratio
Low	3,668	2,807	76.5%	70,571	45,549	64.5%	11.99%	1.19
High	6,517	5,778	88.7%	100,406	65,913	65.6%	23.01%	1.35
Total	10,185	8,585	84.3%	170,977	111,462	65.2%	19.10%	1.29

As noted in the opening, the above results are not consistent with other unpublished findings.

XI. Aging Block

The tables in this section of the report present average age by the contributing company rating method. The select data set was used to determine the average age. Because we are calculating calendar year age, we have defined the attained age of 64 to be 65 for both grouping purposes and average-age calculation purposes. Additionally, it should be noted that we are using the actual calculated attained age rather than the midpoint of five-year age bands as we did in the previous report.

Table XI-1 shows the average age for all covered persons and Table XI-2 shows the average age for all persons age 65+.

Table XI-1
Average Age By Rating Method
All Plans Combined, All Ages

	Year				
Rating Type	**1996**	**1997**	**1998**	**1999**	**2000**
Average Age – Current Year Issue					
Attained Age (AA)	68.8	69.4	68.4	69.5	69.5
Entry Age (EA)	70.8	70.2	71.1	70.4	70.1
Community Rate (CR)	71.5	71.9	73.8	73.8	73.9
Composite	69.9	70.0	69.6	70.3	70.2
Average Age – Renewal					
Attained Age (AA)	70.2	70.5	71.2	71.5	71.9
Entry Age (EA)	72.5	73.1	73.6	74.2	74.5
Community Rate (CR)	73.8	74.2	75.8	75.2	75.8
Composite	72.0	72.3	72.8	72.8	73.3
Average Age – All Issues					
Attained Age (AA)	69.9	70.4	70.8	71.3	71.6
Entry Age (EA)	72.3	72.9	73.5	74.0	74.2
Community Rate (CR)	73.6	74.0	75.7	75.0	75.6
Composite	71.7	72.1	72.6	72.6	73.0
Rating Method Age Difference (All Issues)					
EA – AA	2.4	2.5	2.7	2.7	2.6
CR– AA	3.7	3.6	4.9	3.7	4.0

Table XI-2
Average Age By Rating Method
All Plans Combined, Ages 65+

Rating Type	1996	1997	1998	1999	2000
Average Age – Current Year Issues					
Attained Age (AA)	69.1	69.8	70.0	69.9	70.1
Entry Age (EA)	70.9	70.2	71.1	70.5	70.2
Community Rate (CR)	71.6	72.0	74.0	74.2	74.3
Composite	70.1	70.3	70.7	70.6	70.7
Average Age – Renewal					
Attained Age (AA)	70.4	70.8	71.3	71.8	72.2
Entry Age (EA)	72.5	73.1	73.7	74.2	74.6
Community Rate (CR)	73.9	74.2	75.9	75.3	75.9
Composite	72.2	72.5	73.0	73.1	73.4
Average Age – All Issues					
Attained Age (AA)	70.2	70.7	71.2	71.6	71.9
Entry Age (EA)	72.4	72.9	73.6	74.0	74.3
Community Rate (CR)	73.7	74.1	75.8	75.2	75.7
Composite	71.9	72.2	72.8	72.9	73.2
Rating Method Age Difference (All Issues)					
EA – AA	2.2	2.2	2.4	2.4	2.4
CR – AA	3.5	3.4	4.6	3.6	3.8

The following are some observations:

- The average age for community rated business over the entire time period from 1996-2000 is approximately 1 ½ years older than that for entry-age-rated business, which in turn is approximately 2 ½ years older than that for attained-age-rated business. If only 65+ ages are examined, the average age difference is approximately the same.

- The average issue age is relatively constant for entry-age and attained-age-rated business over the 1996-2000 periods. For community rated business, the average issue age increased 2.4 years from 1996 to 1998 and has remained stable at this higher level through 2000.

- The average age for current year issues for all rating methods is approximately between 70 and 75 years of age, which suggests that a substantial number of policies were issued outside the usual open enrollment period (i.e., when individuals are first eligible for Medicare coverage by reason of age). This may be due to the expansion of guaranteed-issue requirements such as Medicare + Choice individuals that lose

their coverage due to the carrier exiting the business in their area. Another potential cause is the phenomenon of individuals lapsing their existing plan and replacing it with another plan or company, resulting in a new issue at their current age.

- The average age for renewal business has increased approximately 1 ½ years from 1996 to 2000. Again, this may be due to the impact of the Medicare + Choice individuals, aging of the population, high retention rates, or other factors. Recall that the renewal business studied here is limited to new business starting in 1992, i.e., standardized plans. The average age of pre-standardized plans would follow a very different pattern. We would expect the average age of renewals to decrease moving forward because, assuming no other influences, the size of the incoming cohorts will be large relative to the existing population.

- As noted previously, the attained-age and entry-age methods result in a fairly consistent issue age over the 5-year period. The small change that does appear (attained age increasing 0.7 years and entry age decreasing 0.7 years) brings the average issue age approximately equal at 70.

XII. Renewal Lapse Rates

Renewal lapse rates are based on the exposure data used in developing yearly claims trends, namely exposed policy months by calendar year of issue and subsequent calendar year of experience.

By measuring the change in yearly exposed policy months, all causes of lapse (terminations) are included: deaths, conversions or exchanges, demographic mix, or voluntary withdrawals. Also, the data were not adjusted for demographic mix by age, sex or geography. Please note exposure data were not adjusted by NAIC weights.

Attachment H provides details supporting the development of renewal lapse experience and shows renewal lapse experience and underlying exposure data by: 1) Medicare Supplement plans A, C, F and BDEG; 2) issue year; 3) calendar experience year; 4) renewal duration and 5) rating method. The discussion of lapse experience in the body of the report will concentrate on aggregate lapse experience. It is left to the reader to study the detailed lapse experience shown in the Attachment.

For discussion purposes, renewal duration is defined as calendar year of exposure plus 1, less calendar year of issue. For example, [2000 exposure/1999 exposure] would determine 5/4 lapse rates (i.e., lapses from duration 4 to duration 5) for 1996 issues. Thus, the earliest renewal lapse rate calculated is labeled 3/2. The later renewal periods are limited by the earliest issue year of 1992.

Table XII-1 shows renewal lapse rates by experience period, all plans and rating methods combined. The composite lapse rate is the geometric average of all experience periods combined.

Table XII-1

Renewal Lapse Rates By Experience Period
All Rating Methods and Plans Combined
1996 through 2000 Experience

Duration	1997/1996	1998/1997	1999/1998	2000/1999
9/8				9.4%
8/7			11.9%	10.2%
7/6		14.1%	12.7%	10.5%
6/5	13.8%	16.6%	13.5%	10.5%
5/4	15.5%	17.4%	13.7%	11.9%
4/3	17.3%	17.6%	15.2%	12.3%
3/2	18.4%	17.9%	15.6%	12.9%

Renewal lapse rates vary by experience period. The following observations and comments can be made:

- Enrollments and disenrollments in Medicare + Choice plans could be influencing the lapse rates.

- Underlying rate increases are not known. This could be influencing lapse rates.

Table XII-2 shows renewal lapse rates by rating method, all plans and calendar experience years combined. The composite lapse rate is the geometric average of all durations combined.

Table XII-2
Renewal Lapse Rates By Rating Method
All Plans Combined
1996 through 2000 Experience

Duration	All Rating Methods	Entry Age Rated	Community Rated	Attained Age Rated
9/8	9.4%	8.5%	9.0%	10.8%
8/7	10.9%	10.7%	10.1%	12.6%
7/6	12.5%	9.3%	11.5%	16.1%
6/5	13.9%	15.5%	12.5%	16.1%
5/4	14.9%	16.9%	13.7%	16.4%
4/3	16.0%	18.2%	14.8%	17.7%
3/2	16.7%	18.3%	15.8%	17.6%
Composite	13.5%	14.0%	12.5%	15.4%

Table XII-3 shows the variance in lapse rates by rating method compared to lapse rates for all rating methods combined.

Table XII-3
Variance in Renewal Lapse Rates By Rating Method
All Plans Combined
1996 through 2000 Experience

Duration	Entry Age Rated	Community Rated	Attained Age Rated
9/8	(0.9%)	(0.4%)	1.4%
8/7	(0.2%)	(0.8%)	1.7%
7/6	(3.2%)	(1.0%)	3.6%
6/5	1.6%	(1.4%)	2.1%
5/4	2.0%	(1.2%)	1.5%
4/3	2.1%	(1.3%)	1.6%
3/2	1.7%	(0.8%)	0.9%
Composite	0.5%	(1.0%)	1.8%

The following observations and comments can be made:

- Composite renewal lapse rates for community-rated business exhibits the lowest composite lapse rate.

- Renewal lapse rates for entry-age-rated business are the highest during the earliest durations and the lowest at the later durations.

- Lapses due to death are not known. The average attained age for renewal business varies by rating method as demonstrated in Section XI. We did not attempt to estimate the impact on renewal lapse rates due to differences in the average attained age. However, we would expect renewal lapse rates to increase after year 9 due to an increasing death rate.

Table XII-4 shows renewal lapse rates, by plan, all calendar experience years combined. The composite lapse rate is the geometric average of all durations combined.

Table XII-4
Renewal Lapse Rates By Plan
All Rating Methods Combined
1996 through 2000 Experience

	Standardized Plan				
Duration	**A-G**	**Plan A**	**BDEG**	**Plan C**	**Plan F**
9/8	9.4%	13.9%	9.2%	12.7%	8.1%
8/7	10.9%	16.0%	11.3%	14.2%	8.9%
7/6	12.5%	17.9%	12.1%	15.3%	10.5%
6/5	13.9%	20.4%	16.2%	16.4%	10.8%
5/4	14.9%	21.3%	17.5%	17.6%	10.9%
4/3	16.0%	23.2%	18.6%	18.6%	11.7%
3/2	16.7%	25.8%	19.4%	19.3%	11.7%
Composite	13.5%	19.9%	15.0%	16.3%	10.4%

Table XII-5 shows the variance in lapse rates by Plan method compared to lapse rates for all Plans combined.

Table XII-5
Variance in Renewal Lapse Rates By Plan
All Rating Methods Combined
1996 through 2000 Experience

	Standardized Plan			
	A	**BDEG**	**C**	**F**
9/8	4.5%	(0.2%)	3.3%	(1.3%)
8/7	5.1%	0.4%	3.3%	(2.0%)
7/6	5.4%	(0.4%)	2.8%	(2.0%)
6/5	6.5%	2.3%	2.5%	(3.1%)
5/4	6.4%	2.6%	2.7%	(4.0%)
4/3	7.1%	2.6%	2.5%	(4.4%)
3/2	9.1%	2.7%	2.6%	(4.9%)
Composite	6.4%	1.5%	2.8%	(3.1%)

The following observations and comments can be made:

- Renewal lapse rates for Plan F are lower for all durations.

- Renewal lapse rates for Plan A are higher for all durations.

- Lapse rate variances between Plans C and F appear to be larger than would be attributed to rating method.

- Plan A is typically purchased by states for Medicaid and disabled-eligible individuals.

XIII. Aging Effects on Claim Costs

This section was developed in an attempt to understand age increases relative to trend. Attachment G provides claim costs for different age groupings on a consistent basis. This section uses those data to develop the average compound rate of change per year based on the change in claim costs from one age grouping to the next. This assumes that each age grouping can be "grouped" at the central age. While results could be developed for each duration, results are shown in table XIII-1 for "all durations" and, for comparison, duration 3. Data for ages under 64 were not considered in this section.

There are differences based on plan. Plan A has minimal aging effect after age 74 while the other Plans have continuing increases through age 84. The Plan A effects are due to proportional differences in Part B benefits and Part A benefits (i.e., Part A deductible is not covered by Plan A) versus other plans. Several companies have noticed that the Part B portion has a flatter slope than that of Part A.

In general, the effects of aging decrease with each advancing age grouping. The results for all durations/all plans show less of this decrease than when a single duration is compared:

Table XIII-1
Annual Implied Aging Increases

Age Group	All Durations	Duration 3
from central age 67 to central age 72	4.5%	3.4%
from central age 72 to central age 77	2.7%	2.7%
from central age 77 to central age 82	2.8%	1.5%

The values for ages 85+ are not directly usable since there is no central age for comparison purposes. Table XIII-1 below assumes a central age of 87 but without any basis. As the true central age for the group 85+ is likely to be higher, the number of age-years from 82 to the true central age is likely to be greater than 5, so the annual increase would be even less than shown.

Table XIII-2
Claim Cost & Rate of Change, All Durations vs. Duration 3
By Age Group and Plan

		All Durations		Duration 3 Only	
Age Group	Plan	Claim Cost	Per Year Change	Claim Cost	Per Year Change
64 - 69	A	$546.16	n/a	$572.46	n/a
	C	$1,162.77	n/a	$846.49	n/a
	F	$845.78	n/a	$828.86	n/a
	BDEG	$810.87	n/a	$812.02	n/a
	A-G	$851.42	n/a	$821.28	n/a
70 - 74	A	$673.56	4.30%	$687.92	3.70%
	C	$1,175.26	4.80%	$1,005.60	3.50%
	F	$1,026.76	4.00%	$979.86	3.40%
	BDEG	$1,042.76	5.20%	$951.62	3.20%
	A-G	$1,059.58	4.50%	$968.97	3.40%
75 - 79	A	$700.61	-0.30%	$678.87	0.80%
	C	$1,375.21	2.80%	$1,153.38	3.20%
	F	$1,151.39	2.80%	$1,126.78	2.30%
	BDEG	$1,151.75	2.80%	$1,091.48	2.00%
	A-G	$1,208.17	2.70%	$1,104.90	2.70%
80 - 84	A	$655.88	-1.30%	$657.65	-0.60%
	C	$1,616.30	3.30%	$1,210.07	1.00%
	F	$1,268.46	2.00%	$1,248.73	2.10%
	BDEG	$1,271.04	2.00%	$1,197.00	1.90%
	A-G	$1,389.64	2.80%	$1,189.38	1.50%
85+	A	$642.28	-0.40%	$613.61	-1.40%
	C	$1,518.17	-1.20%	$1,373.64	2.60%
	F	$1,368.85	1.50%	$1,343.35	1.50%
	BDEG	$1,340.48	1.10%	$1,250.52	0.90%
	A-G	$1,378.37	-0.20%	$1,291.31	1.70%

Attachment A
Medicare Supplement Work Group Participants

The following is a list of those who volunteered their time and skills toward producing this report. Contributions took many forms including participation in conference calls, analysis of data, writing and reviewing report sections, general management of the project, and technical data support.

Mike Abroe, David Bahn, Mark Bartorelli, John Bryson, Jason Cafaro, Mike Carstens, Susan Clark, Rich Coyle, Ryan Daniels, Randy Edwards, Mary Eichler, Aaron Ekstrom, Janet Falco, Doug Feekin, Pat Fleming, Bill Gilmore, Christopher Hall, Patty Huffman, Nancy King, Tim Koenig, Diana Long, Karl Madrecki, Steve Meier, Stacey Mueller, Geysa Munyon, Joanna Ossinger, Dotti Outland, Carol Pawlak, Paul Ricard, Amber Rinehart, Gina Sahagian, Zach Smith, Don Thoms, David Walker, Bill Weller, Byron Wingo, and Lynnwa Zheng.

Attachment B
Companies Contributing Data

The following companies contributed data for study. Companies varied with respect to the amount, type, and format of data submitted. Not all data submitted were used in final analyses.

Bankers Life and Casualty

Blue Cross and Blue Shield of Alabama

Blue Cross and Blue Shield of Arkansas

Blue Cross and Blue Shield of Connecticut

Blue Cross and Blue Shield of Florida

Blue Cross and Blue Shield of Kansas

Blue Cross and Blue Shield of Mississippi

Blue Cross and Blue Shield of Oklahoma

Blue Cross and Blue Shield of Rhode Island

Central States Health and Life

Mutual of Omaha Insurance Company

Physicians Mutual Insurance Company

Standard Life and Casualty

Trigon

United HealthCare Insurance Company

Wellmark, Inc.

Wellpoint

Attachment C
Control Data 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 leceived	Yes or no for the benefit	YES or NO
5	16-19	Issue year	1992 through 2000	1992, 1993, ..., 2000
6	21-24	Incurred year	1996 through 2000	1992, 1993, ..., 2000
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

Attachment D
Select Data 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 Part B	Use following data keys: PTAA PTBB
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 2000	1992, 1993, ..., 2000
8	27-30	Incurred year	1996 through 2000	1992, 1993, ..., 2000
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

Attachment E
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 and District of Columbia; Wisconsin, Massachusetts, and Minnesota are excluded from the survey. Puerto Rico and Virgin Islands are not included in the geographic groupings.

Attachment E
Part 2

Grouping By States Mandating/Not Mandating Coverage (2)
of Under 65 Medicare-Eligible Individuals

Implemented Mandate 1997 and Prior(1)	Implemented Mandate 1998 and Subsequent	Not Mandating
Connecticut	California	Rest of States
Kansas	Louisiana	(Includes VI,PR,
Maine	Maryland	District of Columbia)
Massachusetts	Missouri	
Minnesota	Mississippi	
New Hampshire	North Carolina	
New Jersey	South Dakota	
New York		
Oklahoma		
Oregon		
Pennsylvania		
Texas		
Washington		
Wisconsin		

The above state groupings were used in developing summaries in Section III of the report. For Section VI, of the 16 states for which select data were contributed (see Section II-D), the 5 states mandating coverage of under 65 Medicare eligible individuals are Connecticut, Kansas, New Hampshire, Pennsylvania and Texas. The remaining 11 states are classified as "Not Mandating".

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.

Attachment E
Part 3

Grouping By State Rating Requirement

Community Rated	Entry Age	No Mandate
Arkansas	Florida	All remaining states
Connecticut	Georgia	
Maine	Idaho	
Massachusetts	Missouri	
Minnesota		
New York		
Vermont		
Washington		

Please note the following:

1 - Massachusetts and Minnesota are listed, but are not part of the survey.
2 - The classification is based on state requirements and not company practices.
3 - Georgia, Idaho, and Missouri prohibit attained age rating practices (Missouri most recently prohibited attained-age rating).

Attachment F

Centers for Medicare and Medicaid Services
Estimated Difference between Proposed[1] and Current Law[2] Beneficiary Copays
By State and Urban/Rural area
Does Not Include Copay Ceiling
Reflects Service Mix in 1996

1 Proposed beneficiary copays frozen in CY 1999 dollars
2 Current law beneficiary copays inflated to CY 2000

Attachment F

STATE	URBAN/RURAL AREA	PERCENT CHANGE
NATIONAL		-16.0
ALABAMA	RURAL	-30.8
ALABAMA	URBAN	-32.9
ALASKA	RURAL	-0.8
ALASKA	URBAN	8.8
ARIZONA	RURAL	-16.2
ARIZONA	URBAN	-27.4
ARKANSAS	RURAL	-19.8
ARKANSAS	URBAN	-12.4
CALIFORNIA		-1.1
CALIFORNIA	RURAL	-23.1
CALIFORNIA	URBAN	-28.7
COLORADO	RURAL	-4.9
COLORADO	URBAN	-12.8
CONNECTICUT	RURAL	-12.3
CONNECTICUT	URBAN	2.1
DELAWARE	RURAL	-21.0
DELAWARE	URBAN	7.1
DISTRICT OF COLUMBIA	URBAN	-19.3
FLORIDA	RURAL	-29.6
FLORIDA	URBAN	-32.9
GEORGIA	RURAL	-17.9
GEORGIA	URBAN	-12.6
HAWAII	RURAL	-16.7
HAWAII	URBAN	-20.7
IDAHO	RURAL	13.1
IDAHO	URBAN	20.1
ILLINOIS	RURAL	-14.2
ILLINOIS	URBAN	-23.6
INDIANA	RURAL	-14.9
INDIANA	URBAN	-5.9
IOWA	RURAL	-7.6
IOWA	URBAN	-1.0
KANSAS	RURAL	-12.4
KANSAS	URBAN	-23.5
KENTUCKY	RURAL	-21.0
KENTUCKY	URBAN	-16.4
LOUISIANA	RURAL	-29.6
LOUISIANA	URBAN	-26.5
MAINE	RURAL	-16.3
MAINE	URBAN	-2.1
MASSACHUSETTS	RURAL	-20.5
MASSACHUSETTS	URBAN	-10.1
MICHIGAN	RURAL	-5.7
MICHIGAN	URBAN	-15.5
MINNESOTA	RURAL	-5.8
MINNESOTA	URBAN	3.9

Attachment F

STATE	URBAN/RURAL AREA	PERCENT CHANGE
MISSISSIPPI	RURAL	-18.3
MISSISSIPPI	URBAN	-17.6
MISSOURI	RURAL	-16.4
MISSOURI	URBAN	-24.2
MONTANA	RURAL	-5.4
MONTANA	URBAN	12.0
NEBRASKA	RURAL	-2.0
NEBRASKA	URBAN	-6.7
NEVADA	RURAL	-21.9
NEVADA	URBAN	-26.6
NEW HAMPSHIRE	RURAL	0.8
NEW HAMPSHIRE	URBAN	0.2
NEW JERSEY	URBAN	-6.1
NEW MEXICO	RURAL	-13.9
NEW MEXICO	URBAN	-9.1
NEW YORK	RURAL	2.9
NEW YORK	URBAN	5.4
NORTH CAROLINA	RURAL	-14.0
NORTH CAROLINA	URBAN	-2.1
NORTH DAKOTA	RURAL	-14.8
NORTH DAKOTA	URBAN	-10.7
OHIO	RURAL	-9.6
OHIO	URBAN	-5.2
OKLAHOMA	RURAL	-14.1
OKLAHOMA	URBAN	-16.1
OREGON	RURAL	11.4
OREGON	URBAN	20.4
PENNSYLVANIA	RURAL	-10.9
PENNSYLVANIA	URBAN	-25.9
PUERTO RICO	RURAL	32.3
PUERTO RICO	URBAN	14.1
RHODE ISLAND	URBAN	-3.1
SOUTH CAROLINA	RURAL	-17.0
SOUTH CAROLINA	URBAN	-18.1
SOUTH DAKOTA	RURAL	0.7
SOUTH DAKOTA	URBAN	10.7
TENNESSEE	RURAL	-15.1
TENNESSEE	URBAN	-14.9
TEXAS	RURAL	-22.2
TEXAS	URBAN	-27.0
UTAH	RURAL	15.1
UTAH	URBAN	9.9
VERMONT	RURAL	-8.3
VERMONT	URBAN	40.9
VIRGIN ISLANDS		6.9
VIRGINIA	RURAL	-13.2
VIRGINIA	URBAN	-16.2

Attachment F

STATE	URBAN/RURAL AREA	PERCENT CHANGE
WASHINGTON	RURAL	7.0
WASHINGTON	URBAN	5.5
WEST VIRGINIA	RURAL	-10.8
WEST VIRGINIA	URBAN	0.7
WISCONSIN	RURAL	-4.3
WISCONSIN	URBAN	-5.4
WYOMING	RURAL	-0.1
WYOMING	URBAN	-9.9
GUAM		-14.2

Attained Age Claims Analysis

Attachment G is derived from the select data of the contributing companies (see Section II.E., Data Contributed). Using the trend assumptions detailed (see Section II.I., Expected Claim Trend Using Aggregate Medicare Experience), the claim data are trended to 2000. Other than trending the claim data to 2000, no screening of the data was done for minimal values per cell nor was any NAIC weighting by state performed. Duration is defined as experience year – issue year + 1.

Age Group: Under Age 64

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	2,651.28	2,574.97	2,408.73	2,002.81	1,861.55	2,351.67	2,285.70
Plan C	2,801.06	2,818.62	2,659.74	2,505.01	1,879.32	2,605.32	2,538.84
Plan F	1,361.54	1,436.98	1,417.37	1,277.08	1,316.37	1,384.76	1,394.66
Plan BDEG	1,303.52	1,185.23	1,237.99	1,065.79	781.67	1,138.10	1,082.17
All Plans	1,734.40	1,820.85	1,767.89	1,682.09	1,490.02	1,732.17	1,731.33
Plans C+F	1,688.56	1,772.46	1,714.93	1,676.12	1,514.18	1,698.86	1,703.02
Annual Claim Cost Ratio to Duration 2+							
Plan A	116%	113%	105%	88%	81%	103%	100%
Plan C	110%	111%	105%	99%	74%	103%	100%
Plan F	98%	103%	102%	92%	94%	99%	100%
Plan BDEG	120%	110%	114%	98%	72%	105%	100%
All Plans	100%	105%	102%	97%	86%	100%	100%
Plans C+F	99%	104%	101%	98%	89%	100%	100%
Incurred Claims ($)							
Plan A	1,699,469	2,659,948	1,876,400	1,013,421	1,103,901	8,353,139	6,653,670
Plan C	4,773,011	5,310,282	3,505,537	2,044,092	1,877,439	17,510,361	12,737,350
Plan F	7,892,841	8,442,258	5,931,699	2,164,646	2,427,380	26,858,824	18,965,983
Plan BDEG	737,791	752,622	485,293	254,724	318,921	2,549,351	1,811,560
All Plans	15,103,112	17,165,110	11,798,929	5,476,883	5,727,641	55,271,675	40,168,563
Plans C+F	12,665,852	13,752,540	9,437,236	4,208,738	4,304,819	44,369,185	31,703,333
Exposure (Lives)							
Plan A	641	1,033	779	506	593	3,552	2,911
Plan C	1,704	1,884	1,318	816	999	6,721	5,017
Plan F	5,797	5,875	4,185	1,695	1,844	19,396	13,599
Plan BDEG	566	635	392	239	408	2,240	1,674
All Plans	8,708	9,427	6,674	3,256	3,844	31,909	23,201
Plans C+F	7,501	7,759	5,503	2,511	2,843	26,117	18,616
Annual Claim Cost Ratio to Age 64-69							
Plan A	512%	492%	421%	369%	325%	431%	415%
Plan C	356%	362%	314%	268%	162%	280%	268%
Plan F	174%	184%	171%	145%	138%	164%	163%
Plan BDEG	187%	154%	152%	123%	86%	140%	130%
All Plans	230%	237%	215%	191%	149%	203%	200%
Plans C+F	216%	227%	205%	186%	146%	194%	192%

Age Group: 64 through 69

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	517.67	523.45	572.46	543.21	572.01	546.16	551.17
Plan C	785.81	777.60	846.49	935.03	1,162.77	931.28	946.86
Plan F	781.94	780.02	828.86	879.63	954.65	845.78	856.68
Plan BDEG	696.95	769.23	812.02	866.60	907.32	810.87	833.96
All Plans	753.15	767.47	821.28	881.77	1,002.68	851.42	867.04
Plans C+F	782.93	779.30	834.98	899.68	1,038.77	874.89	888.52
Annual Claim Cost Ratio to Duration 2+							
Plan A	94%	95%	104%	99%	104%	99%	100%
Plan C	83%	82%	89%	99%	123%	98%	100%
Plan F	91%	91%	97%	103%	111%	99%	100%
Plan BDEG	84%	92%	97%	104%	109%	97%	100%
All Plans	87%	89%	95%	102%	116%	98%	100%
Plans C+F	88%	88%	94%	101%	117%	98%	100%
Incurred Claims ($)							
Plan A	3,217,814	5,575,800	5,339,903	4,244,087	4,358,149	22,735,753	19,517,939
Plan C	23,799,915	49,399,875	58,453,854	60,599,500	99,355,453	291,608,597	267,808,682
Plan F	69,179,198	115,503,626	107,620,018	100,530,621	120,234,750	513,068,213	443,889,015
Plan BDEG	25,699,960	42,744,540	35,471,517	32,154,276	41,366,530	177,436,823	151,736,863
All Plans	121,896,887	213,223,841	206,885,292	197,528,484	265,314,882	1,004,849,386	882,952,499
Plans C+F	92,979,113	164,903,501	166,073,872	161,130,121	219,590,203	804,676,810	711,697,697
Exposure (Lives)							
Plan A	6,216	10,652	9,328	7,813	7,619	41,628	35,412
Plan C	30,287	63,529	69,054	64,810	85,447	313,127	282,840
Plan F	88,471	148,077	129,841	114,287	125,947	606,623	518,152
Plan BDEG	36,875	55,568	43,683	37,104	45,592	218,822	181,947
All Plans	161,849	277,826	251,906	224,014	264,605	1,180,200	1,018,351
Plans C+F	118,758	211,606	198,895	179,097	211,394	919,750	800,992
Annual Claim Cost Ratio to Age 64-69							
Plan A	100%	100%	100%	100%	100%	100%	100%
Plan C	100%	100%	100%	100%	100%	100%	100%
Plan F	100%	100%	100%	100%	100%	100%	100%
Plan BDEG	100%	100%	100%	100%	100%	100%	100%
All Plans	100%	100%	100%	100%	100%	100%	100%
Plans C+F	100%	100%	100%	100%	100%	100%	100%

Age Group: 70 through 74

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	531.36	636.92	687.92	710.94	693.15	673.56	686.63
Plan C	881.64	950.07	1,005.60	1,057.88	1,319.39	1,175.26	1,191.43
Plan F	835.27	941.34	979.86	1,021.94	1,078.03	1,026.76	1,040.39
Plan BDEG	825.15	930.42	951.62	1,024.73	1,140.18	1,042.76	1,068.06
All Plans	827.01	925.53	968.97	1,020.27	1,148.41	1,059.58	1,077.03
Plans C+F	851.01	944.68	990.73	1,036.77	1,173.10	1,085.50	1,100.69
Annual Claim Cost Ratio to Duration 2+							
Plan A	77%	93%	100%	104%	101%	98%	100%
Plan C	74%	80%	84%	89%	111%	99%	100%
Plan F	80%	90%	94%	98%	104%	99%	100%
Plan BDEG	77%	87%	89%	96%	107%	98%	100%
All Plans	77%	86%	90%	95%	107%	98%	100%
Plans C+F	77%	86%	90%	94%	107%	99%	100%
Incurred Claims ($)							
Plan A	1,566,992	3,109,428	3,358,418	3,625,075	11,949,210	23,609,123	22,042,131
Plan C	11,226,792	24,782,583	32,396,323	39,818,752	178,477,390	286,701,840	275,475,048
Plan F	20,698,772	39,670,917	43,211,019	54,759,463	224,378,527	382,718,698	362,019,926
Plan BDEG	12,524,146	19,563,005	15,788,292	16,646,807	87,427,593	151,949,843	139,425,697
All Plans	46,016,702	87,125,933	94,754,052	114,850,097	502,232,720	844,979,504	798,962,802
Plans C+F	31,925,564	64,453,500	75,607,342	94,578,215	402,855,917	669,420,538	637,494,974
Exposure (Lives)							
Plan A	2,949	4,882	4,882	5,099	17,239	35,051	32,102
Plan C	12,734	26,085	32,216	37,640	135,273	243,948	231,214
Plan F	24,781	42,143	44,099	53,584	208,138	372,745	347,964
Plan BDEG	15,178	21,026	16,591	16,245	76,679	145,719	130,541
All Plans	55,642	94,136	97,788	112,568	437,329	797,463	741,821
Plans C+F	37,515	68,228	76,315	91,224	343,411	616,693	579,178
Annual Claim Cost Ratio to Age 64-69							
Plan A	103%	122%	120%	131%	121%	123%	125%
Plan C	112%	122%	119%	113%	113%	126%	126%
Plan F	107%	121%	118%	116%	113%	121%	121%
Plan BDEG	118%	121%	117%	118%	126%	129%	128%
All Plans	110%	121%	118%	116%	115%	124%	124%
Plans C+F	109%	121%	119%	115%	113%	124%	124%

Age Group: 75 through 79

Plan	1	2	3	4	5+	all	2+
			Calendar Duration				
			Annual Claims Cost ($)				
Plan A	512.90	624.43	678.87	706.96	779.82	700.61	721.34
Plan C	995.87	1,058.21	1,153.38	1,188.73	1,582.03	1,375.21	1,397.97
Plan F	971.59	1,103.21	1,126.78	1,120.44	1,207.82	1,151.39	1,166.87
Plan BDEG	982.84	1,078.35	1,091.48	1,119.56	1,280.59	1,151.75	1,179.06
All Plans	953.94	1,057.00	1,104.90	1,123.32	1,343.86	1,208.17	1,230.83
Plans C+F	980.31	1,085.02	1,138.45	1,149.95	1,380.44	1,249.84	1,269.92
			Annual Claim Cost Ratio to Duration 2+				
Plan A	71%	87%	94%	98%	108%	97%	100%
Plan C	71%	76%	83%	85%	113%	98%	100%
Plan F	83%	95%	97%	96%	104%	99%	100%
Plan BDEG	83%	91%	93%	95%	109%	98%	100%
All Plans	78%	86%	90%	91%	109%	98%	100%
Plans C+F	77%	85%	90%	91%	109%	98%	100%
			Incurred Claims ($)				
Plan A	1,132,492	2,237,950	2,388,267	2,493,449	7,300,674	15,552,832	14,420,340
Plan C	9,182,949	19,120,801	24,796,573	29,036,019	141,890,769	224,027,111	214,844,162
Plan F	15,981,688	29,368,678	31,010,079	35,961,651	126,510,338	238,832,434	222,850,746
Plan BDEG	10,096,692	15,044,112	11,851,331	10,954,906	37,056,529	85,003,570	74,906,878
All Plans	36,393,821	65,771,541	70,046,250	78,446,025	312,758,310	563,415,947	527,022,126
Plans C+F	25,164,637	48,489,479	55,806,652	64,997,670	268,401,107	462,859,545	437,694,908
			Exposure (Lives)				
Plan A	2,208	3,584	3,518	3,527	9,362	22,199	19,991
Plan C	9,221	18,069	21,499	24,426	89,689	162,904	153,683
Plan F	16,449	26,621	27,521	32,096	104,743	207,430	190,981
Plan BDEG	10,273	13,951	10,858	9,785	28,937	73,804	63,531
All Plans	38,151	62,225	63,396	69,834	232,731	466,337	428,186
Plans C+F	25,670	44,690	49,020	56,522	194,432	370,334	344,664
			Annual Claim Cost Ratio to Age 64-69				
Plan A	99%	119%	119%	130%	136%	128%	131%
Plan C	127%	136%	136%	127%	136%	148%	148%
Plan F	124%	141%	136%	127%	127%	136%	136%
Plan BDEG	141%	140%	134%	129%	141%	142%	141%
All Plans	127%	138%	135%	127%	134%	142%	142%
Plans C+F	125%	139%	136%	128%	133%	143%	143%

Age Group: 80 through 84

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	496.49	630.93	657.65	663.72	696.41	655.88	672.16
Plan C	1,100.46	1,167.15	1,210.07	1,266.91	1,811.93	1,616.30	1,636.60
Plan F	1,079.11	1,192.90	1,248.73	1,254.52	1,317.68	1,268.46	1,282.23
Plan BDEG	1,104.45	1,190.49	1,197.00	1,255.06	1,394.12	1,271.04	1,296.52
All Plans	1,053.89	1,147.79	1,189.38	1,225.55	1,554.74	1,389.64	1,413.13
Plans C+F	1,087.31	1,181.95	1,231.09	1,260.10	1,607.16	1,452.05	1,472.05
Annual Claim Cost Ratio to Duration 2+							
Plan A	74%	94%	98%	99%	104%	98%	100%
Plan C	67%	71%	74%	77%	111%	99%	100%
Plan F	84%	93%	97%	98%	103%	99%	100%
Plan BDEG	85%	92%	92%	97%	108%	98%	100%
All Plans	75%	81%	84%	87%	110%	98%	100%
Plans C+F	74%	80%	84%	86%	109%	99%	100%
Incurred Claims ($)							
Plan A	613,667	1,336,315	1,408,020	1,458,203	3,931,255	8,747,460	8,133,793
Plan C	5,187,571	11,278,209	14,455,459	17,617,676	152,660,910	201,199,825	196,012,254
Plan F	8,146,169	15,572,179	17,770,703	21,247,734	78,529,481	141,266,266	133,120,097
Plan BDEG	6,095,432	8,884,639	7,334,027	7,175,190	23,396,184	52,885,472	46,790,040
All Plans	20,042,839	37,071,342	40,968,209	47,498,803	258,517,830	404,099,023	384,056,184
Plans C+F	13,333,740	26,850,388	32,226,162	38,865,410	231,190,391	342,466,091	329,132,351
Exposure (Lives)							
Plan A	1,236	2,118	2,141	2,197	5,645	13,337	12,101
Plan C	4,714	9,663	11,946	13,906	84,253	124,482	119,768
Plan F	7,549	13,054	14,231	16,937	59,597	111,368	103,819
Plan BDEG	5,519	7,463	6,127	5,717	16,782	41,608	36,089
All Plans	19,018	32,298	34,445	38,757	166,277	290,795	271,777
Plans C+F	12,263	22,717	26,177	30,843	143,850	235,850	223,587
Annual Claim Cost Ratio to Age 64-69							
Plan A	96%	121%	115%	122%	122%	120%	122%
Plan C	140%	150%	143%	135%	156%	174%	173%
Plan F	138%	153%	151%	143%	138%	150%	150%
Plan BDEG	158%	155%	147%	145%	154%	157%	155%
All Plans	140%	150%	145%	139%	155%	163%	163%
Plans C+F	139%	152%	147%	140%	155%	166%	166%

Age Group: 85+

Plan	Calendar Duration 1	2	3	4	5+	all	2+
Annual Claims Cost ($)							
Plan A	577.49	667.65	613.61	580.64	676.25	642.28	648.02
Plan C	1,283.97	1,349.67	1,373.64	1,354.59	1,636.43	1,518.17	1,529.93
Plan F	1,172.95	1,265.91	1,343.35	1,356.11	1,420.82	1,368.85	1,381.63
Plan BDEG	1,188.66	1,331.38	1,250.52	1,290.73	1,422.97	1,340.48	1,359.06
All Plans	1,167.43	1,269.41	1,291.31	1,300.41	1,469.63	1,378.37	1,393.30
Plans C+F	1,217.22	1,302.11	1,356.95	1,355.43	1,523.43	1,437.46	1,450.29
Annual Claim Cost Ratio to Duration 2+							
Plan A	89%	103%	95%	90%	104%	99%	100%
Plan C	84%	88%	90%	89%	107%	99%	100%
Plan F	85%	92%	97%	98%	103%	99%	100%
Plan BDEG	87%	98%	92%	95%	105%	99%	100%
All Plans	84%	91%	93%	93%	105%	99%	100%
Plans C+F	84%	90%	94%	93%	105%	99%	100%
Incurred Claims ($)							
Plan A	416,949	817,874	805,059	833,797	2,823,332	5,697,011	5,280,062
Plan C	3,660,600	7,934,706	9,934,165	11,847,270	57,209,666	90,586,407	86,925,807
Plan F	5,042,502	9,775,349	11,923,602	14,651,453	54,704,438	96,097,344	91,054,842
Plan BDEG	3,914,262	6,278,803	5,154,658	5,630,186	19,503,192	40,481,101	36,566,839
All Plans	13,034,313	24,806,732	27,817,484	32,962,706	134,240,628	232,861,863	219,827,550
Plans C+F	8,703,102	17,710,055	21,857,767	26,498,723	111,914,104	186,683,751	177,980,649
Exposure (Lives)							
Plan A	722	1,225	1,312	1,436	4,175	8,870	8,148
Plan C	2,851	5,879	7,232	8,746	34,960	59,668	56,817
Plan F	4,299	7,722	8,876	10,804	38,502	70,203	65,904
Plan BDEG	3,293	4,716	4,122	4,362	13,706	30,199	26,906
All Plans	11,165	19,542	21,542	25,348	91,343	168,940	157,775
Plans C+F	7,150	13,601	16,108	19,550	73,462	129,871	122,721
Annual Claim Cost Ratio to Age 64-69							
Plan A	112%	128%	107%	107%	118%	118%	118%
Plan C	163%	174%	162%	145%	141%	163%	162%
Plan F	150%	162%	162%	154%	149%	162%	161%
Plan BDEG	171%	173%	154%	149%	157%	165%	163%
All Plans	155%	165%	157%	147%	147%	162%	161%
Plans C+F	155%	167%	163%	151%	147%	164%	163%

All Ages

Plan	1	2	3	4	5+	all	2+
			Calendar Duration				
			Annual Claims Cost ($)				
Plan A	618.95	669.84	691.08	664.21	704.99	679.54	687.18
Plan C	940.12	941.78	1,001.93	1,070.63	1,466.43	1,220.43	1,240.73
Plan F	861.51	896.67	950.67	999.62	1,126.24	1,007.98	1,025.38
Plan BDEG	823.78	902.36	930.44	991.37	1,148.08	995.93	1,023.94
All Plans	857.24	898.49	950.65	1,006.30	1,236.32	1,057.85	1,080.22
Plans C+F	884.66	911.98	970.41	1,027.73	1,277.36	1,092.17	1,112.91
			Annual Claim Cost Ratio to Duration 2+				
Plan A	90%	97%	101%	97%	103%	99%	100%
Plan C	76%	76%	81%	86%	118%	98%	100%
Plan F	84%	87%	93%	97%	110%	98%	100%
Plan BDEG	80%	88%	91%	97%	112%	97%	100%
All Plans	79%	83%	88%	93%	114%	98%	100%
Plans C+F	79%	82%	87%	92%	115%	98%	100%
			Incurred Claims ($)				
Plan A	8,647,383	15,737,316	15,176,065	13,668,032	31,466,521	84,695,317	76,047,934
Plan C	57,830,836	117,826,455	143,541,910	160,963,309	631,471,631	1,111,634,141	1,053,803,305
Plan F	126,941,170	218,333,008	217,467,119	229,315,567	606,784,915	1,398,841,779	1,271,900,609
Plan BDEG	59,068,284	93,267,722	76,085,118	72,816,087	209,068,950	510,306,161	451,237,877
All Plans	252,487,673	445,164,501	452,270,212	476,762,995	1,478,792,017	3,105,477,398	2,852,989,725
Plans C+F	184,772,006	336,159,463	361,009,029	390,278,876	1,238,256,546	2,510,475,920	2,325,703,914
			Exposure (Lives)				
Plan A	13,971	23,494	21,960	20,578	44,634	124,637	110,666
Plan C	61,514	125,110	143,265	150,345	430,618	910,852	849,338
Plan F	147,347	243,493	228,751	229,403	538,771	1,387,765	1,240,418
Plan BDEG	71,704	103,360	81,773	73,450	182,103	512,390	440,686
All Plans	294,536	495,457	475,749	473,776	1,196,126	2,935,644	2,641,108
Plans C+F	208,861	368,603	372,016	379,748	969,389	2,298,617	2,089,756
			Annual Claim Cost Ratio to Age 64-69				
Plan A	120%	128%	121%	122%	123%	124%	125%
Plan C	120%	121%	118%	115%	126%	131%	131%
Plan F	110%	115%	115%	114%	118%	119%	120%
Plan BDEG	118%	117%	115%	114%	127%	123%	123%
All Plans	114%	117%	116%	114%	123%	124%	125%
Plans C+F	113%	117%	116%	114%	123%	125%	125%

Age 64 and Older

Plan	1	2	3	4	5+	all	2+
				Calendar Duration			
				Annual Claims Cost ($)			
Plan A	521.22	582.23	627.91	630.46	689.42	630.48	644.00
Plan C	887.11	913.09	986.54	1,062.80	1,465.47	1,210.14	1,233.02
Plan F	841.03	883.31	941.97	997.55	1,125.59	1,002.64	1,021.29
Plan BDEG	819.96	900.61	928.96	991.13	1,148.90	995.31	1,023.72
All Plans	830.52	880.60	939.02	1,001.63	1,235.50	1,050.44	1,074.45
Plans C+F	854.72	893.48	959.23	1,023.42	1,276.66	1,085.20	1,107.60
				Annual Claim Cost Ratio to Duration 2+			
Plan A	81%	90%	98%	98%	107%	98%	100%
Plan C	72%	74%	80%	86%	119%	98%	100%
Plan F	82%	86%	92%	98%	110%	98%	100%
Plan BDEG	80%	88%	91%	97%	112%	97%	100%
All Plans	77%	82%	87%	93%	115%	98%	100%
Plans C+F	77%	81%	87%	92%	115%	98%	100%
				Incurred Claims ($)			
Plan A	6,947,914	13,077,368	13,299,665	12,654,611	30,362,620	76,342,178	69,394,264
Plan C	53,057,825	112,516,173	140,036,373	158,919,217	629,594,192	1,094,123,780	1,041,065,955
Plan F	119,048,329	209,890,750	211,535,420	227,150,921	604,357,535	1,371,982,955	1,252,934,626
Plan BDEG	58,330,493	92,515,100	75,599,825	72,561,363	208,750,029	507,756,810	449,426,317
All Plans	237,384,561	427,999,391	440,471,283	471,286,112	1,473,064,376	3,050,205,723	2,812,821,162
Plans C+F	172,106,154	322,406,923	351,571,793	386,070,138	1,233,951,727	2,466,106,735	2,294,000,581
				Exposure (Lives)			
Plan A	13,330	22,461	21,181	20,072	44,041	121,085	107,755
Plan C	59,810	123,226	141,947	149,529	429,619	904,131	844,321
Plan F	141,550	237,618	224,566	227,708	536,927	1,368,369	1,226,819
Plan BDEG	71,138	102,725	81,381	73,211	181,695	510,150	439,012
All Plans	285,828	486,030	469,075	470,520	1,192,282	2,903,735	2,617,907
Plans C+F	201,360	360,844	366,513	377,237	966,546	2,272,500	2,071,140
				Annual Claim Cost Ratio to Age 64-69			
Plan A	101%	111%	110%	116%	121%	115%	117%
Plan C	113%	117%	117%	114%	126%	130%	130%
Plan F	108%	113%	114%	113%	118%	119%	119%
Plan BDEG	118%	117%	114%	114%	127%	123%	123%
All Plans	110%	115%	114%	114%	123%	123%	124%
Plans C+F	109%	115%	115%	114%	123%	124%	125%

Attachment H

Renewal Lapse Rates

This section provides actual company exposures in life years and renewal lapse rates (all voluntary and involuntary terminations) by issue year, calendar year, plan, and rating method.

Attachment H

Plan A

Issue Year	Calendar Year 1996	1997	1998	1999	2000	Renewal Lapse Rates 1997/ 1996	1998/ 1997	1999/ 1998	2000/ 1999
Attained Age Rated									
1992	693	563	447	356	293	18.8%	20.6%	20.3%	17.7%
1993	1,747	1,309	935	778	655	25.1%	28.6%	16.8%	15.8%
1994	1,582	1,221	938	749	629	22.8%	23.2%	20.2%	16.0%
1995	1,335	953	672	523	427	28.6%	29.5%	22.2%	18.3%
1996		2,148	1,628	1,288	1,053		24.2%	20.9%	18.2%
1997			2,256	1,756	1,412			22.2%	19.6%
1998				1,718	1,392				19.0%
Community Rated									
1992	10,808	8,310	6,360	5,171	4,425	23.1%	23.5%	18.7%	14.4%
1993	17,937	13,618	10,431	8,484	7,225	24.1%	23.4%	18.7%	14.8%
1994	20,031	14,964	11,396	9,214	7,868	25.3%	23.8%	19.1%	14.6%
1995	24,116	17,620	13,086	10,464	8,823	26.9%	25.7%	20.0%	15.7%
1996		21,091	14,992	11,705	9,805		28.9%	21.9%	16.2%
1997			11,600	8,796	7,236			24.2%	17.7%
1998				7,852	6,187				21.2%
Entry Age Rated									
1992	3,028	2,395	2,057	1,747	1,544	20.9%	14.1%	15.1%	11.6%
1993	3,991	3,086	2,406	2,018	1,762	22.7%	22.0%	16.1%	12.7%
1994	4,327	3,323	2,597	2,161	1,858	23.2%	21.8%	16.8%	14.0%
1995	4,453	3,273	2,474	2,012	1,713	26.5%	24.4%	18.7%	14.9%
1996		3,228	2,416	1,945	1,678		25.2%	19.5%	13.7%
1997			1,965	1,539	1,304			21.7%	15.2%
1998				1,403	1,181				15.8%
All Rating Methods									
1992	14,529	11,268	8,865	7,274	6,262	22.4%	21.3%	17.9%	13.9%
1993	23,675	18,013	13,772	11,279	9,641	23.9%	23.5%	18.1%	14.5%
1994	25,940	19,507	14,931	12,123	10,354	24.8%	23.5%	18.8%	14.6%
1995	29,905	21,846	16,232	12,999	10,963	26.9%	25.7%	19.9%	15.7%
1996		26,467	19,036	14,939	12,537		28.1%	21.5%	16.1%
1997			15,821	12,090	9,952			23.6%	17.7%
1998				10,973	8,760				20.2%

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Plan BDEG

Issue Year	Calendar Year 1996	1997	1998	1999	2000	Renewal Lapse Rates 1997/ 1996	1998/ 1997	1999/ 1998	2000/ 1999
Attained Age Rated									
1992	2,145	1,551	1,121	818	646	27.7%	27.7%	27.1%	21.0%
1993	5,598	4,281	3,327	2,612	2,125	23.5%	22.3%	21.5%	18.6%
1994	8,458	6,351	4,829	3,706	3,021	24.9%	24.0%	23.3%	18.5%
1995	16,268	9,614	6,938	5,134	3,942	40.9%	27.8%	26.0%	23.2%
1996		17,193	13,069	10,204	8,112		24.0%	21.9%	20.5%
1997			19,056	15,040	12,073			21.1%	19.7%
1998				22,869	17,965				21.4%
Community Rated									
1992	32,146	27,385	23,082	20,094	18,034	14.8%	15.7%	12.9%	10.3%
1993	46,194	38,391	31,706	27,530	24,698	16.9%	17.4%	13.2%	10.3%
1994	26,473	21,945	18,037	15,776	14,219	17.1%	17.8%	12.5%	9.9%
1995	31,755	26,002	21,034	18,107	16,203	18.1%	19.1%	13.9%	10.5%
1996		42,438	33,548	27,541	23,829		20.9%	17.9%	13.5%
1997			38,206	31,582	27,667			17.3%	12.4%
1998				47,372	41,586				12.2%
Entry Age Rated									
1992	15,233	12,787	12,799	11,587	10,824	16.1%	-0.1%	9.5%	6.6%
1993	16,150	13,089	9,850	8,675	7,921	19.0%	24.7%	11.9%	8.7%
1994	11,048	8,957	6,557	5,703	5,220	18.9%	26.8%	13.0%	8.5%
1995	10,505	8,524	5,843	4,980	4,577	18.9%	31.5%	14.8%	8.1%
1996		6,851	6,087	5,175	4,741		11.2%	15.0%	8.4%
1997			6,536	5,395	4,866			17.5%	9.8%
1998				5,937	5,213				12.2%
All Rating Methods									
1992	49,523	41,722	37,003	32,498	29,503	15.8%	11.3%	12.2%	9.2%
1993	67,942	55,761	44,883	38,817	34,744	17.9%	19.5%	13.5%	10.5%
1994	45,980	37,253	29,424	25,185	22,460	19.0%	21.0%	14.4%	10.8%
1995	58,527	44,140	33,816	28,221	24,722	24.6%	23.4%	16.5%	12.4%
1996		66,482	52,703	42,920	36,681		20.7%	18.6%	14.5%
1997			63,799	52,017	44,605			18.5%	14.2%
1998				76,178	64,763				15.0%

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Plan C

Issue Year	Calendar Year 1996	1997	1998	1999	2000	Renewal Lapse Rates 1997/ 1996	1998/ 1997	1999/ 1998	2000/ 1999
Attained Age Rated									
1992	20,170	14,964	10,954	8,070	6,235	25.8%	26.8%	26.3%	22.7%
1993	40,448	29,034	20,686	14,873	11,113	28.2%	28.8%	28.1%	25.3%
1994	47,599	34,114	24,363	17,518	13,166	28.3%	28.6%	28.1%	24.8%
1995	33,469	22,655	16,042	11,635	8,820	32.3%	29.2%	27.5%	24.2%
1996		28,417	21,095	15,732	12,268		25.8%	25.4%	22.0%
1997			17,538	13,292	10,414			24.2%	21.7%
1998				11,967	9,545				20.2%
Community Rated									
1992	33,954	28,912	24,299	21,232	19,260	14.8%	16.0%	12.6%	9.3%
1993	81,109	68,220	57,041	49,843	45,136	15.9%	16.4%	12.6%	9.4%
1994	95,630	79,946	66,077	58,277	53,111	16.4%	17.3%	11.8%	8.9%
1995	115,788	96,246	79,546	69,741	63,639	16.9%	17.4%	12.3%	8.7%
1996		74,754	61,647	53,968	49,071		17.5%	12.5%	9.1%
1997			36,552	31,716	28,755			13.2%	9.3%
1998				24,443	22,081				9.7%
Entry Age Rated									
1992	7,320	5,962	5,481	4,735	4,223	18.5%	8.1%	13.6%	10.8%
1993	16,481	13,290	10,749	9,163	8,039	19.4%	19.1%	14.8%	12.3%
1994	22,681	17,733	13,877	11,817	10,564	21.8%	21.7%	14.8%	10.6%
1995	22,456	16,815	12,843	10,848	9,733	25.1%	23.6%	15.5%	10.3%
1996		12,986	9,962	8,350	7,504		23.3%	16.2%	10.1%
1997			5,490	4,602	4,099			16.2%	10.9%
1998				3,339	2,938				12.0%
All Rating Methods									
1992	61,444	49,838	40,735	34,037	29,718	18.9%	18.3%	16.4%	12.7%
1993	138,039	110,544	88,476	73,879	64,288	19.9%	20.0%	16.5%	13.0%
1994	165,911	131,793	104,316	87,612	76,841	20.6%	20.8%	16.0%	12.3%
1995	171,713	135,716	108,430	92,224	82,192	21.0%	20.1%	14.9%	10.9%
1996		116,157	92,704	78,050	68,844		20.2%	15.8%	11.8%
1997			59,579	49,611	43,268			16.7%	12.8%
1998				39,749	34,564				13.0%

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Plan F

Issue Year	Calendar Year 1996	1997	1998	1999	2000	Renewal Lapse Rates 1997/ 1996	1998/ 1997	1999/ 1998	2000/ 1999
Attained Age Rated									
1992	55,282	51,122	42,820	38,833	35,692	7.5%	16.2%	9.3%	8.1%
1993	85,638	78,692	68,740	61,943	56,463	8.1%	12.6%	9.9%	8.8%
1994	41,477	37,566	34,011	30,252	27,292	9.4%	9.5%	11.1%	9.8%
1995	52,575	48,182	43,983	38,876	34,538	8.4%	8.7%	11.6%	11.2%
1996		64,604	58,254	50,136	43,917		9.8%	13.9%	12.4%
1997			59,644	51,677	45,271			13.4%	12.4%
1998				53,203	47,072				11.5%
Community Rated									
1992	78,795	69,871	61,711	55,740	51,317	11.3%	11.7%	9.7%	7.9%
1993	85,718	75,821	66,969	60,847	56,366	11.5%	11.7%	9.1%	7.4%
1994	77,896	68,667	60,631	55,067	51,033	11.8%	11.7%	9.2%	7.3%
1995	80,821	70,827	61,543	55,379	51,100	12.4%	13.1%	10.0%	7.7%
1996		58,301	49,901	44,761	41,113		14.4%	10.3%	8.2%
1997			45,935	41,019	37,629			10.7%	8.3%
1998				40,852	37,186				9.0%
Entry Age Rated									
1992	14,960	12,876	12,090	10,679	9,719	13.9%	6.1%	11.7%	9.0%
1993	24,261	20,327	16,554	14,547	13,227	16.2%	18.6%	12.1%	9.1%
1994	23,608	19,980	16,601	14,658	13,389	15.4%	16.9%	11.7%	8.7%
1995	21,675	18,134	15,089	13,286	12,156	16.3%	16.8%	12.0%	8.5%
1996		12,772	10,617	9,303	8,432		16.9%	12.4%	9.4%
1997			8,546	7,442	6,786			12.9%	8.8%
1998				6,329	5,712				9.8%
All Rating Methods									
1992	149,037	133,869	116,621	105,252	96,728	10.2%	12.9%	9.7%	8.1%
1993	195,617	174,840	152,264	137,337	126,056	10.6%	12.9%	9.8%	8.2%
1994	142,981	126,213	111,243	99,976	91,714	11.7%	11.9%	10.1%	8.3%
1995	155,071	137,143	120,615	107,542	97,795	11.6%	12.1%	10.8%	9.1%
1996		135,677	118,772	104,200	93,462		12.5%	12.3%	10.3%
1997			114,126	100,137	89,686			12.3%	10.4%
1998				100,385	89,970				10.4%

Attachment H

Plans A-G

Issue Year	Calendar Year 1996	1997	1998	1999	2000	Renewal Lapse Rates 1997/ 1996	1998/ 1997	1999/ 1998	2000/ 1999
Attained Age Rated									
1992	78,290	68,199	55,343	48,077	42,866	12.9%	18.9%	13.1%	10.8%
1993	133,431	113,317	93,687	80,206	70,356	15.1%	17.3%	14.4%	12.3%
1994	99,116	79,251	64,141	52,224	44,107	20.0%	19.1%	18.6%	15.5%
1995	103,646	81,403	67,635	56,169	47,728	21.5%	16.9%	17.0%	15.0%
1996		112,362	94,046	77,360	65,349		16.3%	17.7%	15.5%
1997			98,495	81,764	69,169			17.0%	15.4%
1998				89,757	75,974				15.4%
Community Rated									
1992	155,703	134,478	115,453	102,236	93,035	13.6%	14.1%	11.4%	9.0%
1993	230,959	196,050	166,147	146,704	133,425	15.1%	15.3%	11.7%	9.1%
1994	220,031	185,522	156,142	138,334	126,231	15.7%	15.8%	11.4%	8.7%
1995	252,481	210,695	175,209	153,691	139,765	16.5%	16.8%	12.3%	9.1%
1996		196,583	160,088	137,975	123,818		18.6%	13.8%	10.3%
1997			132,293	113,113	101,286			14.5%	10.5%
1998				120,519	107,040				11.2%
Entry Age Rated									
1992	40,540	34,020	32,428	28,748	26,310	16.1%	4.7%	11.3%	8.5%
1993	60,884	49,792	39,560	34,403	30,948	18.2%	20.6%	13.0%	10.0%
1994	61,664	49,993	39,632	34,338	31,031	18.9%	20.7%	13.4%	9.6%
1995	59,089	46,747	36,250	31,126	28,179	20.9%	22.5%	14.1%	9.5%
1996		35,837	29,081	24,773	22,356		18.9%	14.8%	9.8%
1997			22,537	18,978	17,055			15.8%	10.1%
1998				17,008	15,044				11.5%
All Rating Methods									
1992	274,533	236,697	203,224	179,061	162,211	13.8%	14.1%	11.9%	9.4%
1993	425,274	359,159	299,394	261,313	234,729	15.5%	16.6%	12.7%	10.2%
1994	380,811	314,766	259,915	224,897	201,369	17.3%	17.4%	13.5%	10.5%
1995	415,216	338,846	279,094	240,986	215,672	18.4%	17.6%	13.7%	10.5%
1996		344,782	283,215	240,108	211,524		17.9%	15.2%	11.9%
1997			253,325	213,855	187,511			15.6%	12.3%
1998				227,284	198,058				12.9%

Attachment I

Impact of State of Connecticut Data

This exhibit provides trends for the Northeast region and all regions combined, excluding data from the state of Connecticut. Trends should be compared with those provided in Table III-B-2 to understand the effect of omitting Connecticut data when calculating Part A and Part B trends separately.

Attachment I

Claim Trend By Geographic State Grouping & Calendar Year
Part A & B Combined, Weighted on NAIC 1998 Exposure

		Standardized Plan				
	Trend Period	A	C	F	BDEG	ABCDEFG
All Regions (CT is excluded)	97/96	16.5%	11.6%	8.8%	14.7%	10.8%
	98/97	14.2%	10.5%	7.4%	10.9%	9.0%
	99/98	10.0%	6.0%	7.1%	8.5%	7.0%
	00/99	5.5%	6.0%	5.9%	6.4%	6.2%
Northeast (CT is excluded)	97/96	19.1%	12.6%	8.4%	19.9%	13.4%
	98/97	13.1%	12.3%	10.2%	11.9%	11.2%
	99/98	11.3%	4.8%	10.4%	10.2%	7.6%
	00/99	1.9%	5.4%	11.0%	4.9%	6.5%

Attachment J

Benefit Plan Description

The following table, taken from the NAIC Medicare Supplement Model Regulations, provides a description of benefits included in Medicare Supplement plans A through J.

Attachment J

Medicare Supplement Insurance can be sold in only 10 standard plans plus two high-deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan A. Some plans may not be available in a given state.

Basic Benefits *Included in all Plans.*
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (Generally 20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

Plan A	**Plan B**	**Plan C**	**Plan D**	**Plan E**	**Plan F**	**Plan *F**	**Plan G**	**Plan H**	**Plan I**	**Plan J**	**Plan *J**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance		Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	Skilled Nursing Co-insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
								Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)	
				Preventive Care						Preventive Care	

* Plans F and J also have an option called a High-Deductible Plan F and a High-Deductible Plan J. These high-deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1,620 deductible. Benefits from High Deductible Plans F and J will not begin until out-of pocket expenses are $1,620. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.