National Association of Insurance Commissioners

January 2019

NAIC Medicare Supplement Insurance Model Regulation Compliance Manual

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SECTION I: INTRODUCTION

OVERVIEW AND PURPOSE OF THE MANUAL

This manual has been produced by the NAIC for use by the states in their review of Medicare supplement rate filings, experience reports, and refund calculations. The manual was written to assist the states in complying with the directives set forth in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) amendments to Section 1882 of the Social Security Act. The passage of the Social Security Amendments Act of 1994 (SSAA-94) necessitated an update of this manual, completed in 1996. The passage of the Balanced Budget Act of 1997 (BBA-97) created a new Part C of Medicare, commonly known as Medicare Advantage, and created new standards for Medicare supplement insurance. Passage of the Balanced Budget Refinement Act (BBRA) in 1999 resulted in additional changes. Passage of the Medicare Modernization Act of 2003 (MMA) created a new Medicare Part D, added prescription drug coverage and affected certain other aspects of Medicare supplement plans. The BBA-97, BBRA and MMA changes have necessitated an update of this manual. This manual addresses many of the issues associated with Medicare supplement standardization and filing requirements, as outlined in the *Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act* (#651).

The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA) created a new set of standardized plans that differ from those adopted by the NAIC as a result of the above laws. Model #651 adopts terminology to differentiate the plans by naming the original standardized plans as 1990 Standardized Benefit Plans (1990 SB Plans) and the new plans (effective June 1, 2010) as 2010 Standardized Benefit Plans (2010 SB Plans). Several of the new plans have the same letter designation as the original plans even though there have been changes in benefits. Four of the original plans (E, H, I and J) are no longer available. Two new plans (M and N) have been added so that the new available plans will be: A, B, C, D, F, F (high deductible), G, K, L, M and N.

Model #651 as amended Aug. 29, 2016, defines a newly eligible individual for Medicare on or after January 1, 2020 ("newly eligible") as an individual who becomes eligible for Medicare on or after January 1, 2020, by reason of attaining age 65 on or after January 1, 2020, or by reason of entitlement to benefits under Part A pursuant to Section 226(b) or Section 226A of the Social Security Act or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) changed the available Medicare supplement plans with respect to those who become newly eligible for Medicare on or after January 1, 2020. MACRA requires that Medicare supplement plans that cover the Medicare Part B deductible cannot be available to those who become newly eligible for Medicare on or after January 1, 2020. Plan C and Plan F may not be issued to those who become newly eligible for Medicare on or after January 1, 2020, but may be available to anyone eligible before January 1, 2020. In addition, MACRA revised the plans that must be offered to those who become newly eligible for Medicare for guaranteed issue under Model #651 Section 12, effective January 1, 2020. Finally, Model #651 provides for the availability of Plan G (high deductible) effective January 1, 2020.

As a public document, this manual may be useful to issuers of Medicare supplement coverage. However, it should be understood that its exclusive purpose is to be a tool for the states; specifically, it is not intended to be the definitive source of a state's regulatory requirements for Medicare supplement insurance policies. It should be expected that some states may modify the procedures, data requests or other aspects of their review from what is included in this manual, as the ultimate responsibility for approval of the rates, reporting and refunds rests with the states. In this connection, it should be noted that while this manual discusses recent changes to Model #651 as adopted by the NAIC, many states have enacted their own variations of the changes made pursuant to BBA-97. Therefore, the states need to be aware of variations in their own laws and regulations.

Model #651 provides limitations on groups of benefits, uniform language and definitions, uniform format and other standards as specified in OBRA-90, as well as subsequent amendments and legislation. This introduction provides insight into interpretation of Model #651.

The second section of this manual, "Issues and Comments," addresses a number of questions that have been raised by state insurance departments in their review of the initial rate filings of standardized plans. These issues are discussed with reference to the guiding principles set forth below and Model #651.

The final sections of this manual provide specific recommendations for the review of the various types of filings and a discussion of Medicare SELECT issues.

GUIDING PRINCIPLES OF MODEL #651

#1: Simplification

A clear intent of Model #651 is to reduce consumer confusion by simplifying the marketplace. Benefit options that may be offered have been standardized. Also, the number of form option variations for features other than benefit options (e.g., underwriting) are limited.

#2: Medicare Supplement Policies Must Be Guaranteed Renewable

In addition to the contractual requirements of guaranteed renewability, Model #651 intends to ensure that policies are renewable "in effect." This means that sub-blocks of policies are not exposed to large rate increases. This is accomplished by restrictions on closing blocks of business and by limiting the number of Medicare supplement forms that an issuer can write (displayed in Diagram 1).

Within each of the Medicare standardized plans, four "types" of coverage may be offered:

- Individual policy
- Group policy
- Individual Medicare SELECT policy
- Group Medicare SELECT policy

When the companies file policy forms for the 2010 SB Plans, the new forms may be a replacement for the 1990 SB Plan policy form (or may not if the form is for one of the new 2010 SB Plans with no comparable 1990 SB Plan). For a short transition period, there can be two policy forms approved for each type above, prior to the variations noted in the next paragraph. However, the effective date of coverage precludes the actual availability of multiple forms in the same plan type combination.

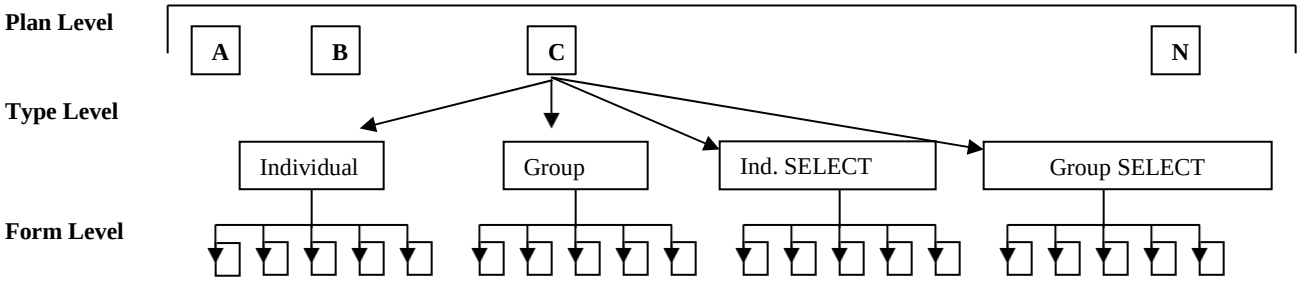
MACRA has no requirement for new policy forms, as the benefits under each plan remain unchanged.

Within each type of policy, an issuer is permitted up to five policy forms with variations based on inclusion of innovative benefits, marketing method, underwriting method and eligibility for Medicare (aged versus disabled). These forms represent "reporting classes," which are the level at which experience will be presented to the states for experience rating purposes.

NOTE: Refund calculations are made at the "type" level. A discussion of refund calculations for 1990 SB Plans and 2010 SB Plans with the same plan letter is included elsewhere in this manual. (See Section II, "Refund Issues.")

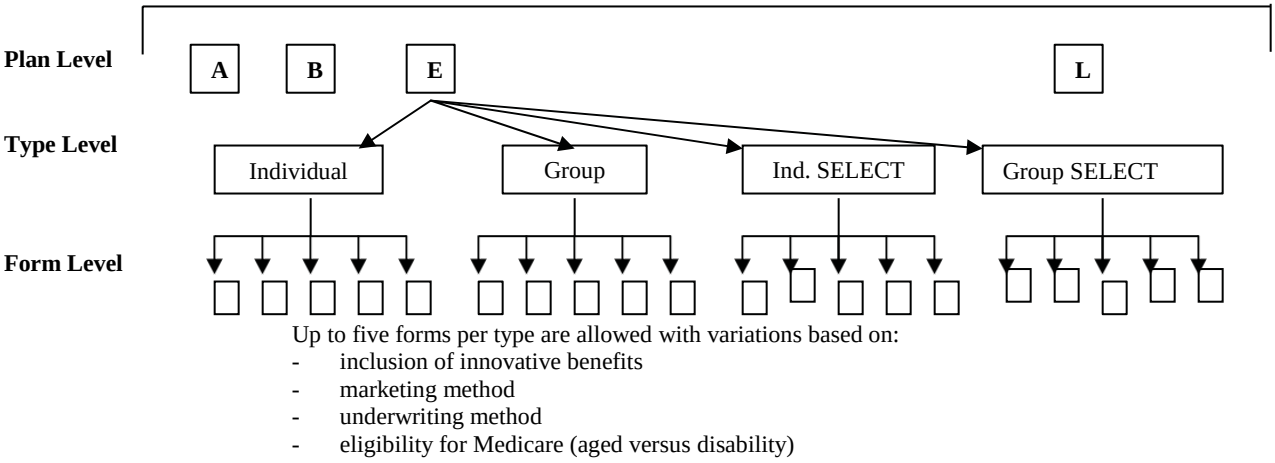
Diagram 1
Medicare Plans

2010 Standardized § 8.1



Up to five forms per type are allowed with variations based on:
- inclusion of innovative benefits
- marketing method
- underwriting method
- eligibility for Medicare (aged versus disability)

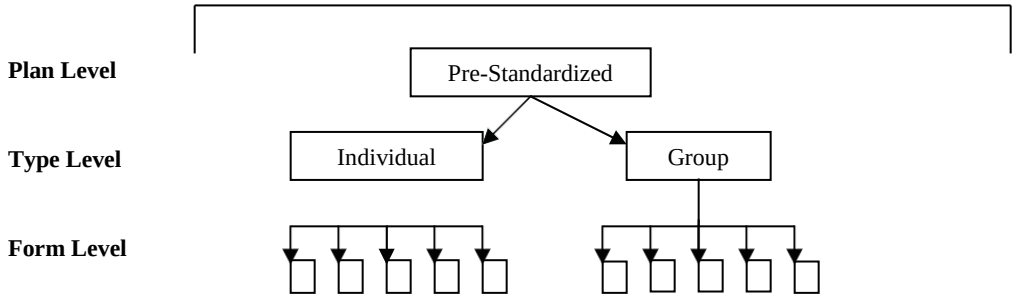
1990 Standardized § 8



Up to five forms per type are allowed with variations based on:

- inclusion of innovative benefits
- marketing method
- underwriting method
- eligibility for Medicare (aged versus disability)

Pre-Standardized



Additionally, SSAA-94 created two "type level" categories for pre-standardized plans: individual and group.

The BBA-97 amendments added two high-deductible options as variations of Plan F and Plan J. As such, these two high-deductible options should be reported with the experience of Plan F and Plan J. The high-deductible options are not considered as "filling" the form level limit of five forms.

Finally, three states (Massachusetts, Minnesota and Wisconsin) were grandfathered by OBRA-90 from certain of its provisions. They were not required to change to the 10 standardized plans, but they were subject to the regulation of rates (filing approval and refunds), the Medigap open enrollment and guaranteed issue provisions, and the rules regarding duplication of Medicare or Medicare supplement policies. They were also allowed to be involved in the Medicare SELECT program.

#3: Medigap Open Enrollment

As a result of OBRA-90, Model #651 required a Medigap open enrollment period for individuals 65 years and older during the first six months of initial enrollment in Medicare Part B. SSAA-94 added a Medigap open enrollment for any individual who attains age 65 and has been receiving, or has ever received, Medicare Part B due to disability or end-stage renal disease (ESRD) prior to age 65. All plans the carrier offers for sale must be available during these open enrollment periods. Both the federal Centers for Medicare & Medicaid Services (CMS) and the Social Security Administration have always held that an individual "attains age 65" as of the first day of the month in which the individual turns 65 unless the individual's birthday occurs on the first day of the month, in which case the individual is deemed to be 65 as of the first day of the preceding month. In the case of an applicant whose application for a policy or certificate is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B, an issuer is prohibited from discriminating in the availability, sale or pricing of a policy because of the health status, claims experience, receipt of health care or medical condition of the applicant. For this open enrollment period to be "real," the offered rates during the Medigap open enrollment period must be calculated by a method that is consistent with the method used for underwritten business. Consistency would not be maintained if the rate charged during Medigap open enrollment effectively discourages new entrants, or if it reflects the full load for anti-selection and individuals are allowed to "re-enter" a specific block of business after the Medigap open enrollment period ends.

#4: Portability/Use of Preexisting Condition Exclusions

While OBRA-90 limited the use of preexisting condition exclusions to a six-month period, and eliminated their use for replacement Medicare supplement coverage, BBA-97 includes HIPAA-like language dealing with portability issues. The concept of portability is only applicable to the Medigap open enrollment period. If a beneficiary applying during Medigap open enrollment has a continuous period of prior creditable coverage that is less than six months (defined in Model #651, Section 4E and Section 4F), the carrier must credit such prior creditable coverage against the preexisting condition exclusion period. If the beneficiary has six months or more of prior creditable coverage, then a preexisting condition exclusion is not allowed.

#5: Medigap Guaranteed Issue Rights for Certain Eligible Persons

BBA-97 provides for a 63-day Medigap guaranteed issue period following any of the events listed in item #1 through item #6 below. (See Model #651, Section 12.) Persons eligible for guaranteed issue are entitled to purchase certain Medigap plans (if otherwise offered by an issuer) on the same underwriting and premium basis as apply during open enrollment. Additionally, a preexisting condition exclusion cannot be applied to a guaranteed issue policy.

1. Termination of an employee welfare benefit plan in its entirety, or benefits under the plan that are supplemental to Medicare.

2. Termination of Medicare Advantage coverage, movement of the beneficiary out of the service area, violation of a material provision of the contract, marketing abuse or failure to provide quality care.

3. Cessation of enrollment in a Medicare cost contract, demonstration project or Medicare SELECT contract.

4. Loss of Medicare supplement coverage due to the issuer's insolvency or substantial violation of a material provision.

5. A person dropped Medicare supplement coverage, enrolled in a Medicare Advantage contract and terminated such contract within 12 months.[1]

6. A beneficiary enrolled in a Medicare Advantage plan, when first eligible for Medicare at age 65, then disenrolled within the first 12 months.

7. A Medigap Rx insured enrolled in Part D during the initial enrollment period and terminated the Medigap Rx policy.

Following any event listed in item #1 through item #4, eligible persons are entitled to Plan A, Plan B, Plan C or Plan F available from any issuer. Following the event described in item #5, an eligible person is entitled to the Medicare supplement plan the individual had just prior to enrolling in Medicare Advantage, if that plan is still available from the original issuer. If that plan is not available, the individual is entitled to Plan A, Plan B, Plan C or Plan F available from any issuer. Following the event described in item #6, eligible persons are entitled to any plan available from any issuer. Following the event described in item #7, eligible persons are entitled to Plan A, Plan B, Plan C, Plan F, Plan K or Plan L from the same issuer. Effective January 1, 2020, Plan D replaces Plan C and Plan G replaces Plan F for all the events where offering Plan C or Plan F is required with respect to newly eligible individuals who may not be issued Plan C or Plan F.

For this guaranteed issue option to be "real," the offered rates during the Medigap guaranteed issue period must be calculated by a method that is consistent with the method used for underwritten business. Consistency would not be maintained if the rate charged during the Medigap guaranteed issue period effectively discourages new entrants or if it reflects the full load for anti-selection and individuals are allowed to "re-enter" a specific block of business after the Medigap guaranteed issue period ends.

#6: Requirements Under the Medicare Modernization Act of 2003 Prohibition Against Use of Genetic Information and Requests for Genetic Testing

Effective May 21, 2009, the Genetic Information Nondiscrimination Act of 2008 (GINA) limits the information a company may ask a prospective policyholder about the insured or the insured's family members. (See Model #651, Section 24.) These limitations apply to new issues and any request for replacement after that date. The limitations apply to issuing the policy, the effectiveness of the policy, the application of preexisting conditions and the pricing of coverage. These rules apply to the company, as well as any third-party administrator a company may use.

#7: Rates Must Be Reasonable in Relationship to Benefits

Another guiding principle is that rates must be reasonable in relationship to benefits. This principle has not changed from that in most individual rate filing requirements. However, the loss ratio standards implemented are both prospective and retrospective in nature.

Prospectively, the expected loss ratio (i.e., the present value of incurred claims divided by the present value of earned premiums) over the period for which the rates are computed to provide coverage must meet or exceed the minimum standard. These minimum standards are 65% for individual policies and 75% for group policies. These loss ratios now apply to **all** Medicare supplement policies, including pre-standardized policies still in effect that were issued prior to the implementation of OBRA-90. For the pre-standardized plans, minimum loss ratios apply to experience of the policy after the SSAA-94 effective date. Policies issued as a result of mass media advertising are deemed to be individual policies under OBRA-90; however, the NAIC has encouraged the states to retain a 75% loss ratio for group policies issued on this basis. Many state regulations have implemented this change. The target loss ratios are not intended to apply to each rating cell. Expense levels may vary by rating cell, and some rating cells may be expected to subsidize others (e.g., the cost of Medigap open enrollment may be spread over all policyholders). One of the roles of the initial rate review is to ensure that the subsidies by rating cell are reasonable and appropriate.

Retrospectively, the issuer of a policy must provide for a refund or credit of the amount necessary to comply with refund targets representing minimum thresholds of incurred claims (as compared to premiums) by duration. The refund requirement provides a sound foundation to protect policyholders from excessive rates. However, it was never intended to replace existing rate review practices.

Loss ratio standards provide guidance in determining when a rate is not reasonable in relation to benefits because it is too high. An equally important issue is when the rate is not reasonable because it is inadequate. Model #651 does not provide any basis by which to measure adequacy. This manual provides some guidance in this area (e.g., what is considered a reasonable rate relationship by age).

#8: Annual Filing and Approval of Rates

Model #651 provides that an issuer must annually file its rates, rating schedules and experience by policy duration for approval by the states according to each state's filing and approval requirements. This filing is required regardless of whether an issuer is seeking a rate revision.

#9: Permitted Compensation Arrangements

Model #651 discourages compensation arrangements that would promote churning Medicare supplement policies. This is done by "levelizing" commission schedules so that the first-year commission can be no more than twice the commission in renewal years two through six. In addition, only renewal commissions are payable when a policy is replaced after October 31, 1994, even if benefits are upgraded.

WHAT ARE THE REGULATOR'S RESPONSIBILITIES?

OBRA-90, SSAA-94, BBA-97, BBRA, MMA2003, MIPPA, GINA and MACRA amended Section 1882 of the Social Security Act, which provides for federal certification of Medicare supplement insurance policies unless a state's regulatory program is approved by CMS. In order for a state to qualify for approval it must, among other things:

- Provide for the application and enforcement of Medicare supplement standards that are at least as stringent as the standards in Model #651.
- Meet or exceed notice and reporting standards.
- Require periodic reporting of experience.
- Provide to CMS a list of the names and addresses of issuers of Medicare supplement policies in the state.
- Report to CMS on the implementation and enforcement of standards and requirements of Section 1882 of the Social Security Act as amended (including information regarding loss ratios of policies sold in the state and state programs implementing consumer protection).
- Maintain a file for public access of each issuer's experience loss ratios, rates, forms and advertising.
- Provide for a process of approving or disapproving initial rates and proposed rate revisions.

If a state wishes to regulate Medicare supplement insurance, it must have been initially approved by CMS and will be periodically reviewed for reapproval.

WHAT ARE AN ISSUER'S RESPONSIBILITIES?

In addition to complying with the regulation in the state regarding the marketing, disclosure, policy provisions, pricing and administration of Medicare supplement policies, an issuer of Medicare supplement policies must provide state insurance departments with:

Annual Filing of Premium Rates

Each issuer must file its historical and proposed rates, rating schedules, historical and projected loss ratio analysis, and supporting documentation.

Refund or Credit Calculation

By May 31 of each year, each issuer must file in each state, for each refund class, the Medicare Supplement Refund Calculation Form. If a refund is indicated, the refund must be made (with interest from the end of the calendar year) before September 30 following the reporting year.

Additional Experience Reports

Each issuer must file several experience reports as required by OBRA-87 and OBRA-90. These include:

- Medicare Supplement Insurance Experience Exhibit, which is filed with the annual financial statement.
- Form for Reporting Medicare Supplement Policies (Model #651, Appendix B).

SECTION II: ISSUES AND COMMENTS

MEDIGAP OPEN ENROLLMENT ISSUES AND MEDIGAP GUARANTEED ISSUE

What is the difference between Medigap open enrollment and Medigap guaranteed issue?

Medigap open enrollment is the six-month period following initial eligibility for Medicare Part B. Medigap open enrollment was created by OBRA-90 and entitles a beneficiary to the issuance of any Medigap plan offered by an insurer and available to the individual. Benefits under a Medigap plan issued during the open enrollment period may be subject to preexisting condition exclusions, though the exclusion must be reduced or waived if there is prior creditable coverage.

Medigap open enrollment should not be confused with the Medigap guaranteed-issue period provided for by the Balanced Budget Act of 1997, and modified by the Balanced Budget Refinement Act of 1999. A beneficiary is eligible for a 63-day Medigap guaranteed-issue period following the occurrence of certain events specified in Model #651, Section 12. (See Section I, "Guiding Principles of Model #651," guiding principle #5.) During the guaranteed-issue period, an eligible beneficiary is entitled to the issuance of certain specified Medigap plans. Unlike plans issued during open enrollment, preexisting condition exclusions cannot be applied to benefits under plans sold on a guaranteed basis.

NOTE: Medical underwriting is prohibited under both the Medigap open enrollment and guaranteed issue periods.

Medigap Open Enrollment

There is a six-month Medigap open enrollment period following initial eligibility for Medicare Part B (at age 65 or older in accordance with Model #651; some states also require open enrollment following initial Part B eligibility for beneficiaries younger than 65). During this period, the issuer may not deny or condition coverage due to health status, claims experience, receipt of health care or medical condition. (See Model #651, Section 11.)

Can the issuer charge higher rates at age 65 (when most of the Medigap open enrollment is expected) to cover the anticipated anti-selection?

No. To do so would violate the principle of Medigap open enrollment and be contrary to statute. Those insureds who could pass medical underwriting would then simply be reissued at age 66. This also means there cannot be a higher rate for insureds age 65 compared to age 65½.

Issuers are required by federal law and Model #651, Section 11 to issue any currently available policies to eligible individuals during the Medigap open enrollment period. In addition to other federal and state penalties, many states have made it an unfair trade practice if an issuer did not market to individuals who are in their Medigap open enrollment period. This means that an issuer cannot:

- Reduce commissions at age 65.
- Reduce commissions from a policy issued during the Medigap open enrollment period where the insured is in poorer health.
- Eliminate individuals age 65 from mass marketing efforts.
- Engage in other activities that treat insured applicants who are in their Medigap open enrollment period more restrictively than other applicants of like characteristics.

Medigap Open Enrollment and Medigap Guaranteed Issue Rate Differentials

What, if any, rate differentials may be imposed during Medigap open enrollment and Medigap guaranteed issue?

In 1993, the NAIC Medicare Supplement and Other Limited Benefit Plans (B) Task Force determined that allowable rate differentials during the Medigap open enrollment and guaranteed issue periods include, but are not limited to, those for age, gender and geographic area; coverage of more than one life; and modal payment. Rates must be at least as favorable as those offered outside of open enrollment and guaranteed issue. There is no explicit guidance from the federal government or any other regulatory body whether discounts should be permitted for non-tobacco users during the open enrollment period.

If an insured first enrolled in Medicare Part B at his/her 65th birthday but does not enroll in a Medicare supplement plan until after the Medigap open enrollment period, the insured may be underwritten for rating and issue purposes.

The cost of Medigap open enrollment should be spread over all policyholders of the form. This means that issue-age groups that are more likely to be exposed to Medigap open enrollment entrants are likely to have higher loss ratios.

EFFECTIVE DATE ISSUES

What are the important effective dates for various parts of Model #651?

Each state will have several dates that are important in the regulation of Medicare supplement policies in that state. The first one is the state's effective date for the 1990 SB Plans (OBRA-90 date). This effective date defines the starting date for the new loss ratios and the refund requirements for standardized Plan A through Plan J. The second date is the effective date of the state's changes dealing with the new loss ratios for pre-standardized Medicare supplement policies (SSAA-94 date). The third date is the effective date of the new requirements under the Medicare Modernization Act of 2003, including addition of two new standardized plans—Plan K and Plan L—and stripping all prescription drug benefits from plans with such benefits for insureds who enroll in Medicare Part D. (This includes Plan H, Plan I, Plan J, high-deductible Plan J and pre-standardized plans with drug benefits, as well as the prescription drug plans in Minnesota, Wisconsin and Massachusetts.)

The effective date of the 2010 SB Plans is June 1, 2010, except in unusual cases. The 1990 SB Plans cannot be issued with an effective date after May 31, 2010. Both the 1990 plan policy forms and the 2010 SB Plan policy forms will likely be marketed for a period prior to June 1, 2010. Which form is used depends on the effective date of coverage.

There are several areas of regulation for which applicable dates are not based on the state's action. For example, the effective dates for new rules relating to compensation patterns are set by federal law. Appendix E provides a historical context for the development of effective dates and notes that some effective dates were applicable in the past for a limited period of time.

Is there any flexibility in the effective dates?

Generally, no. The change from 1990 SB Plans to 2010 SB Plans is to occur on June 1, 2010, in all states. The requirements relative to the grandfathered states (Massachusetts and Wisconsin) are:

Massachusetts:	The state will not offer the new coverages.
Wisconsin:	The new coverages will be effective on June 1, 2010. Coverages eliminated must not be included in policies issued with effective dates after May 31, 2010.

However, administrative flexibility is allowed to carriers in two instances where the policyholders will benefit:

- If a carrier wishes to use a common SSAA-94 effective date for a group of states (all of which have a SSAA-94 date equal to or later than the one chosen by the carrier for administrative simplicity) in the accumulation of experience for loss ratios and/or refunds, this should be acceptable.

- If a carrier has included business in refund calculations that would not normally need to be included (standardized policy forms written before the state's OBRA-90 date), that practice should be allowed to continue. The alternative of requiring transfer of these policies' experience from the standardized benefit plan to the pre-standardized pool is not in the policyholders' interests.

GENERAL RATING ISSUES

Rate Schedules

How many different rate schedules may apply to any policy form?

Model #651 designates a maximum of five policy forms within each type of a standard plan that may be offered at any one time. A new policy form is allowed to replace an existing form, and it is expected that some companies will use this to make the change from 1990 SB Plans to 2010 SB Plans as smooth as possible. Model #651 lists the bases on which the forms may vary. The clear intent of Model #651 is to simplify the number of options available to a consumer. (See Section I, "Guiding Principles of Model #651," guiding principle #1.)

Although Model #651 does not specify the criteria by which rates may vary, the following are commonly used:

- Age
- Gender

- Family status
- Smoking status or use of tobacco
- Underwriting class (standard or substandard)
- Area
- Rating methodology (if there has been a change, with new issues only on the new methodology)
- For Plan F, Plan G and Plan J, separate rates for the normal and high-deductible options

There may be quite a variation between issuers as to how substandard rates and area rates are determined. Some may apply separate schedules by area, while others apply area factors. Substandard rates may be a single new rate schedule, multiple schedules (depending on the degree of expected extra morbidity), or a flat dollar amount or a percentage adjustment.

MACRA modifies which SB plans must be available to applicants who become newly eligible for Medicare on or after January 1, 2020, and have a guaranteed issue right, requiring Plan D and Plan G be offered in place of Plan C and Plan F. That change does not provide issuers any new opportunity to create an additional policy form or use different rate schedules for policies issued after the MACRA changes apply. The states should evaluate any requests for new policy forms or rate schedules against the allowances under their respective state laws and regulations.

Model #651, Section 17C(3) requires disclosure of all possible premium rates offered to the applicant on either the cover page or the next page following. Regulators must require and examine this aspect of the form to ensure clarity.

Subsidies

What rate subsidies are allowed or encouraged between plans or rate cells?

One cell or rating class subsidizes another if they are pooled for refund or re-rate purposes and the loss ratio of the first is less than the other (after adjustment for expected underwriting and expense differences). Nothing in Model #651 explicitly prohibits subsidies. In fact, some subsidy of the Medigap open enrollment age groups is expected.

Subsidies of In-Force Blocks

What rate subsidies are permitted between policies in force when the Medicare supplement regulation became effective and policies issued after that date?

While subsidies between standardized and pre-standardized blocks of Medicare supplement policies are not prohibited, each block is subject to certain requirements. This also applies to the new 2010 SB Plan policies versus the 1990 SB Plan policies.

All Medicare supplement policies must meet the new minimum loss ratio requirements (regardless of whether it was a standardized benefit plan or not). Policies issued prior to November 5, 1991 (pre-standardized policies) are now subject to the regulation's requirements on refunds or credits if the loss ratios do not meet the regulation's standards. (See Appendix E for additional explanations concerning effective dates.)

Therefore, the loss ratio cannot be lower than the thresholds, even if the excess is used to subsidize another block of business.

Rating Methodology Options

Can an issuer offer more than one rating methodology on a single policy form at the same time?

Each state should decide this question. This manual does not advocate the use of multiple rating methodologies. However, if more than one rating methodology on a single policy form at the same time is allowed, the following regulatory provisions should be applied in such circumstances:

1. Under individual insurance policies, the individual policyholder should have a choice as to whether to elect an issue-age or attained-age rating methodology. For a group policy, it is the group policyholder, not the certificateholder, who has this choice.

2. The dollar level of first-year commissions should be no more than twice the dollar level of second-year commissions and shall not vary based on the rating methodology selected by the policyholder. Renewal commissions for years two through six may be a constant dollar amount that does not vary based on the rating methodology or may be defined as a constant percentage of the issue-age premium.

3. Consumers should be allowed to switch from an attained-age rating basis to an issue-age rating basis. However, consumers should not be allowed to switch from an issue-age rating basis to an attained-age rating basis.

4. The review of rates would be done in the following fashion:

   a. New business rates
   Essentially, the company would make two demonstrations. First, for the attained-age rating structure, it would demonstrate that the discounted value of future claims divided by the discounted value of future premiums was at least at the 65% level (75% for group). The company would make a second demonstration that this loss ratio requirement was met for an issue-age rating structure. Assuming the company had other policy forms that were issued on the proposed rating bases, the company would be expected to modify that other experience (if it were credible) to fit the benefit structure of the new policy form. If the company had credible experience under other policy forms but did not have credible experience under the proposed rating structures, then the initial relativities would have to be established, assuming that the morbidity and other pricing assumptions under all of the proposed rating methodologies were the same as the experience for the other forms. If the company had no credible experience, then outside sources of credible data would be utilized to produce the morbidity and other pricing assumptions, which would again be assumed to be the same for all rating methodologies.

   b. Renewal business
   Three tests would be required for renewal business. First, all experience for issue-age and attained-age rating structures would be combined. The total accumulated past claims would be added to the present value of future projected claims, and that sum would be divided by the accumulated value of past premiums plus the present value of premiums on the new rating structure. This first ratio would be compared against the 65% standard. The second and third tests are comparable to the tests described for new business. Both the attained-age and issue-age rating structures would have to be shown to be meeting the 65% loss ratio prospectively. For the issue-age rating structure, some estimate of the active life reserve would need to be incorporated in the demonstration that the 65% loss ratio was anticipated to be met.

5. Insurers will develop materials that disclose both rating options, an explanation of how they differ both in the near term and the long term, as well as an explanation of the policyholder's right to switch from one rating option to another.

Changes to Rating Characteristics

Can a policy form change characteristics (e.g., mass-marketed, agent-produced, guaranteed issue)?

Generally, no. The clear intent of Model #651 is to prohibit an issuer from closing a block of business and selling another in its place. If an issuer were allowed to change the characteristics of a policy form, this could effectively be accomplished. An issuer is allowed to change the characteristics of its standardized plan offer by introducing a new form with the revised characteristics (for up to five forms per type). In situations where new statutory requirements (federal or state) would require a change or elimination of one or more rating characteristics, a company may use new rating characteristics for new issues of the policy form. Experience of old and new issues must be combined for reporting and rate filings. The aim would be to avoid the necessity of filing new policy forms for approval.

Definition of Claims/Premium

What specific items are to be included or excluded from the loss ratio calculation?

Incurred claims should exclude claims expenses and claims management expenses; i.e., only paid claims and liabilities for unpaid claims should be included. Earned premiums should include modal loadings and policy fees. Active life reserves should be excluded from all calculations. Premiums and claims should be reported for direct business only, and should not reflect adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.

What types of items are not to be included in the loss ratio calculations?

Issuers may offer discount cards or other offers that allow the insured to receive lower-than-normal prices for certain services (e.g., drugs, eyeglasses, etc.) when specific providers are used. Because the insured is responsible for the full amount of the discounted charges for all such services, there is no real insurance. Consequently, any charges for such discount cards or offers are not insurance premiums to be added as a separate component in the Medicare supplement forms experience, and no payments by the issuer are to be considered part of the plan's benefit package.

Period for Which Rates Computed

Model #651 states that loss ratio standards must be met over the period for which rates are computed to provide coverage. What is this period?

Because the policies are guaranteed renewable, it is reasonable to define this period as the total life of the policy. This does not detract from the ability to reflect reasonable assumptions for persistency, interest, medical inflation and rate revisions.

Reporting Basis

Can the rate refund exhibits be used as the basis for filing rate revisions?

No. The rate refund filing is distinct from the annual experience filing or any filing for a rate revision. The refund filing is retrospective in comparing emerged experience to benchmark assumptions. The rate filing must be prospective in its analysis of whether expected experience now differs from the assumed target experience used in the current premium rates based on issuer-specific assumptions as to lapse, selection, durational loss ratios and trend rates.

Rate Revisions

May renewal rates be based on the state of residence?

Companies must adopt a consistent approach to renewal premiums when the state of residence is different from the state of issue. The company is to document in the original filing and with each annual rate filing whether its applicable rates will be based on state of issue or if rates will be revised to reflect the state of residence. If the company will be basing the rates on the state of residence, an explanation of the approach to be used must be included in the documentation. The approach to be used may not be revised without the approval of the commissioner.

NOTE: The experience for refund purposes is to be included based on the state of issue.

What are some alternative approaches to reflect the state of residence in renewal rates?

One method is to use a table of geographical factors to determine a ratio of new residence to original state. This ratio would be applied to the approved renewal rate for the state of issue. The table is not expected to be subject to approval. Another method would be to use the approved rate in the state of residence.

Are Medicare supplement issuers restricted as to when rate revisions may be implemented?

Model #651, Section 14C requires an issuer "to annually file its rates, rating schedule and supporting documentation." Regulators may use their own judgment in interpreting whether this means once per calendar year or once per 12-month period. The commissioner is directed to approve the rates "in accordance with the filing requirements and procedures prescribed by the commissioner." This provides flexibility to permit rate filings more often than annually where appropriate.

In the event of changes in Medicare benefits, an issuer shall file rate adjustments "as soon as practicable" and before the change takes effect, if possible.

INNOVATIVE BENEFIT ISSUES

The guidance provided in this section is intended to assist states and is **not** binding on any state or party. It is anticipated that some states may use an alternative decision-making process. The decision to approve or deny a proposed new or innovative benefit, according to the federal law, rests solely with each state where the benefit is filed.

Model #651 allows for "new or innovative benefits" as set forth in federal law only with the approval of the commissioner. Federal law requires that new or innovative benefits do not adversely impact the goals of Medicare supplement insurance simplification and that they be offered in a manner consistent with the goal of simplification of Medicare supplemental policies. New or innovative benefits should not otherwise be available and should be cost-effective to the delivery of health care services in the Medicare program.

What are "new or innovative benefits"?

New or innovative benefits are benefits that are not available as part of the standardized Medicare supplement benefit design. Examples of new or innovative benefits may include, but are not limited to, the following services not already covered by Medicare:

- Coverage for hearing services
- Coverage for vision services
- Coverage for dental services
- Coverage for preventive care services

Benefits such as discounts for eyeglasses or frames, discounts for hearing aids, membership in health clubs, or other types of ancillary services or programs should not be considered new or innovative benefits. Insurance companies should be aware of individual state insurance department policy before offering the benefits, discounts or services.

Alternative cost-sharing provisions from those in the applicable standard plan designs—such as deductibles, copays, coinsurance and out-of-pocket maximums—**should not** be considered new or innovative benefits and **should not** be approved as a new or innovative benefit. Alternative cost-sharing could severely impact the successes of standardization and simplification of Medicare supplement policies.

How should new or innovative benefits be filed and approved?

New or innovative benefits should be filed and approved according to the states' policy form and rate filing and approval requirements and consistent with Model #651, Section 15. The benefit should be easily understood by the customer and add value to the standard benefit plan designs.

The states should review the filings in the context of the definition of new or innovative benefits as set forth in the Social Security Act, Section 1882(p)(4)(B), and Model #651, Section 9.1(F). Review standards should include those that pertain to the policy form being filed, but should also take into account the goal of simplification and standardization of Medicare supplement policies as contemplated in the federal law and Model #651.

How should new or innovative benefits be added to the existing benefit plan designs?

The states should consider adopting practices and developing materials to provide information to consumers about any new or innovative benefits approved for sale. For example, the states should consider developing state-produced materials describing any new or innovative benefits.

The states should consider whether new or innovative benefits take the form of a rider that is added to an existing benefit plan design or are an integral part of the underlying standardized policy form. In either case, the cost/premium for the new or innovative benefit should be disclosed to the customer separately from the cost/premium for the standardized benefits.

If the issuer does not provide coverage without the innovative benefit for any of its plans, the states should require a clear disclosure by the issuer that the coverage without the innovative benefit is available in the marketplace from other issuers. The states should require issuers selling products that include innovative benefits to separately identify the new or innovative benefits in the individual plan description of benefits.

New or innovative benefits are part of the policy even if added by rider, so open enrollment provisions as set forth in Model #651, Section 11 and guaranteed issue provisions as set forth in Model #651, Section 12 shall apply. Subsequent purchases of plans with new or innovative benefits could be subject to a company's underwriting standards.

The limitation on the number of policy forms an insurer is allowed to sell contained in Model #651, Section 15 also applies. This means that, for example, an issuer that sells a Plan F with innovative benefits imbedded in the contract could not offer a Plan F with different innovative benefits imbedded in the contract. Under Model #651, there can be only one policy with innovative benefits per plan/type combination.

How are the premiums, premium changes and claims experience of new or innovative benefits to be handled?

It cannot be determined at this time that all new or innovative benefits will be easily segregated from the basic benefits of Medicare supplement plans, although some will (e.g., coverage for vision, hearing or dental services). Some new or innovative benefits will, of necessity, be interwoven with the plan benefits (e.g., alternative treatment options).

It is possible that for some new or innovative benefits, the same benefits can be easily attached to multiple plans, while others coordinate with only certain plans.

As such, companies that request approval of a form with new or innovative benefits will need to provide the following information with respect to the initial premium and the intended basis for changes to the premiums for the policies containing the new or innovative benefits (or the riders providing them):

- The initial premium for the new or innovative benefit should not be inconsistent with the rating basis for the policy to which it is to be attached (e.g., attained-age rates for rider attached to an issue-age rated policy). It can be expected that the pattern of claims for some new or innovative benefits could have some differences from the assumptions for the basic coverage. In situations where there is expected to be only minimal change in the assumed claims for the new or innovative benefit by age or duration, a simple rating structure should be allowed (e.g., a single rate for all ages and durations) even though the basic coverage premiums vary. Sufficient documentation of assumptions should be provided by the company to demonstrate that the premium scale is reasonable and that the minimum lifetime loss ratio will be met.

- Experience reporting for demonstration of loss ratio compliance and rate revisions shall be consistent with state requirements. To the extent consistent with state requirements, it should be specified where the company desires to have the same new or innovative benefit with the same premium be available with multiple Medicare supplement plans. In this case, the experience of the new or innovative benefit should be combined for all plans to which it is attached, and premium changes based on such combined experience, which would be subject to the loss ratio requirements. Alternatively, it should also be specified where the company's desire is to have the premium for the innovative benefits coordinated with the premium for the basic plan, in which case the experience of the new or innovative benefit is reviewed as part of the basic plan experience.

- Both as a result of the possible differences in claims patterns noted in #1 above and the potential impact of policyholder selection of a plan with or without the new or innovative benefits, it is likely that the experience for the basic coverage of the policies with versus without the additional benefits may diverge. The company's choice per #2 above, as allowed by state law, should be reflected in the regulatory review of premium changes. If the experience of the new or innovative benefit is being kept separate, the experience of the basic coverage should be combined. If the experience of the new or innovative benefit is combined with the experience of the basic coverage, and there are two unique policy forms, then the experience of each should be the basis for the premiums for that policy form.

- For refund calculation purposes, the premiums and claims for innovative benefits are to be included with the premiums and claims for the plan and state of each policy. Because many anticipated new or innovative benefits will be relatively small, reasonable approximations and allocations should be allowed.

Availability of new or innovative benefits in the marketplace

In order to maintain standardization and simplification in the Medicare supplement marketplace, states who approve new or innovative benefits should report each such approval to the NAIC Senior Issues (B) Task Force. The Task Force will maintain a record of all new or innovative benefits approved throughout the country. States and insurers will have access to these records in order to evaluate their possible use in their market. The Task Force will periodically review the new or innovative benefits approved in the states and will determine, in collaboration with CMS and other interested parties, whether any of the new or innovative benefits approved for use in the states should be made part of the standard benefit designs and benefit plan designs contained in Model #651.

In addition, each state should consider publishing all the new or innovative benefits it has approved in order for the benefits to be available to all insurers in the marketplace. An expeditious review and approval process might be considered for those Medicare supplement carriers that wish to provide already-approved new or innovative benefits and that certify the benefit they are filing for approval is exactly the same as a previously approved new or innovative benefit.

CHANGE IN RATING METHODOLOGY ISSUES

Change in Methodology

Model #651, Section 15D(3) indicates that a change in rating methodology shall be considered a discontinuance unless certain criteria are met. What constitutes a "change in rating methodology"?

Model #651 does not define what events constitute a change in rating methodology. A reasonable definition would be a change in demographic rating classes, which is actuarially equivalent to the current rating practice under reasonable assumptions. Examples of different rating structures that could produce the same overall revenue requirements are:

- Age structure (community rates versus issue-age rates versus attained-age rates).
- Class structure (single class versus smoker/non-smoker classes, unisex versus male/female classes).
- Rates for each age versus age-banded rates.

Such a change in methodology does not change the experience pool (i.e., the form) that an insured is in. It changes the rate that new entrants into the pool must pay.

If a state has allowed more than one rating methodology on a single policy form at the same time and an individual elects to switch from an attained-age rating basis to an issue-age basis, that switch should not be viewed as a change in rating methodology, because the mechanics for allowing this switch has already been built into the policy.

Rating Methodology Requirements

What requirements must be met in order to change the rating methodology?

An issuer must clearly state in its rate revision request if it is changing rating methodology. The issuer must provide an actuarial memorandum supporting the new rating structure. Also, the rates must always remain in the same relativity from that time forward (unless the commissioner deems it in the public interest to change the differential). This effectively means that both blocks will receive the same rate increases.

There is no federal statutory requirement to maintain a rating relationship applicable for a 1990 SB Plan(s) to a 2010 SB Plan with the same plan letter. It is anticipated that, all other factors being equal (e.g., lifetime target loss ratio, underwriting, etc.), the initial rates for a 2010 SB Plan will be equal to those for a comparable 1990 SB Plan. If so, the subsequent rate adjustments will be uniform between plan generations throughout the lifetime of the policies. If the initial rates are not equal, then the goal over time is for the premiums for a 1990 SB Plan to become identical to those of the same plan/type 2010 SB Plan. Any variations from this goal are subject to the regulation(s) of the state(s) in which the rates are filed.

In reviewing a change in methodology, a state must ensure that the new methodology:

- Does not adversely affect existing insureds.
- Is actuarially equivalent to the existing structure based on reasonable demographic assumptions that exclude the effect of aging or selection.

The intent of these requirements is to protect insureds in closed blocks of business. If the experience of the eliminated rating structure were not included with the new rating structure, insureds could be "closed" out of coverage, with potential enormous future rate increases. If an issuer changes rating methodology, the rate revision filing must include a demonstration that the relative ratio for the two methodologies is equivalent. Each rate revision filing and annual rate filing thereafter must include a certification that the relative ratio for the two (or more) methodologies has not changed.

Area Factors

Is a change in area factors a change in rating methodology?

No. If changing area factors was a change in rating methodologies, the revised rates could only be applied to new insureds, and the relationship between the two schedules would have to be maintained. However, different geographic areas may experience different trends in health care costs. Issuers should be able to reflect different trend rates to all insureds in different areas within a state, as they are able to reflect different trends between states. In reviewing a requested change, a regulator should ensure that the resulting rate relativities by area are reasonable as demonstrated by credible experience, industry data or CMS data.

NOTE: It may be appropriate to take the effect of large claims into consideration. Also, the requested change should not close off issues in a particular geographic area, either explicitly or in effect.

COMPENSATION ISSUES

Compensation Arrangements

Model #651, Section 16B requires that the commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year. Does this mean the same dollar amount or the same rate?

An issuer may demonstrate compliance with Model #651, Section 15 through a commission schedule that is leveled by either amount or percentage rate. When an issuer anticipates increasing rates in its rate filing, a flat percentage rate renewal would result in an actual increase in commission as a dollar amount. This is not prohibited by Model #651. Additional information concerning policies having multiple rating methodologies is located elsewhere in this manual. (See Section II, "General Rating Issues," "Rating Methodology Options.")

Replacement Compensation

Model #651, Section 16C requires an issuer to pay the renewal level of compensation for replacement business. How does this work if an issuer pays renewal commissions at a level dollar amount?

If an issuer pays renewal commissions as a level dollar amount, the commission payable for business that has been replaced will depend on the original year of issue. If an issuer is replacing its own business, the original issue year of the replaced policy must be used for purposes of determining commission amounts. If another issuer is being replaced, the commission must be no more than the commission in the second year for a policy issued one year prior.

Until October 31, 1994, Model #651 and federal law permitted first-year commissions if "benefits of the new policy or certificate are clearly and substantially greater than the replaced policy." For replacements after this date, only renewal commissions are payable.

GROUP ISSUES

Group-Specific Rates

If an issuer offers a group Medicare supplement policy, may the rates for each group policyholder be experience-rated?

Nothing in Model #651 explicitly prohibits group rating practices. However, it should be noted that, in 1993, the NAIC Medicare Supplement and Other Limited Benefit Plans (B) Task Force sent a letter to CMS stating, "The task force believes that the prohibition of experience rating is in the best interest of the consumer and is most consistent with NAIC models. … This interpretation is consistent with federal statutes and regulations, including OBRA-90."

Some carriers might file a group rate manual with rates that vary by certain demographic variables, which are composited for purposes of a group's rates. For example, for a specific group, carriers might use unisex rates that are equivalent to the filed rates based on the distribution by sex of the group. As long as the rates charged to the group are equivalent to the filed rates based on the group's demographics, the prohibition against experience rating would not be violated.

Conversion Requirements and Rates

Group Medicare supplement insurance is required to offer certificateholders certain conversion rights. Can an issuer charge a much higher rate for the conversion policy, or should there be a limit to the price differential between the group policy and the conversion policy?

There are two circumstances under which a conversion may occur, and the required conversion rights differ for each. In both cases, an individual policy with benefits comparable to those in the group policy must be available. It is assumed that the 2010 SB Plan of the same plan letter is "comparable" to the 1990 SB Plan. For 1990 SB Plans that are being discontinued, the following are deemed "comparable" for conversion purposes:

- 1990 SB Plan E is comparable to 2010 SB Plan D.
- 1990 SB Plan H is comparable to 2010 SB Plan D.
- 1990 SB Plan I is comparable to 2010 SB Plan G.
- 1990 SB Plan J is comparable to 2010 SB Plan F.
- 1990 SB Plan J (high deductible) is comparable to 2010 SB Plan F (high deductible).

(a) If a standardized group policy is terminated and is not replaced, the issuer must offer each certificateholder two choices of coverage: i) an individual policy with comparable benefits; and ii) the core benefits policy (Package A).

(b) If a pre-standardization group policy is terminated and is not replaced, the issuer must offer each certificateholder two choices of coverage: i) a standardized policy currently offered by the issuer with benefits most comparable to the benefits in the terminated policy; and ii) the standardized core benefits policy (Package A).

(c) If an individual leaves the group, the same conversion benefits must be offered, or the group policyholder may elect to continue coverage under the group policy.

The purpose of a conversion provision is to provide permanent coverage, regardless of the status of the group policy or membership in the group. In order to be a legitimate option, the cost for these conversion policies should be reasonable. Because conversion policies often experience morbidity 50% to 100% higher than the group policies, passing on the actual morbidity

cost of the converted certificateholders may result in rates that are much higher than the original group policy. This can create a conversion policy whose cost is not affordable to the insured.

If the insured is allowed to continue coverage under the group contract [see (c) above], the morbidity experience for individuals with continued coverage should be combined with the rest of the group experience for the purpose of rate revisions and refunds. There would not be separate, higher rates charged.

If the insured is converted to an individual policy form (either with similar benefits or another standardized benefit plan), the experience for individuals exercising conversion should be combined with the rest of the individuals having that policy form for the purpose of rate revisions and refunds. If the pool of individuals covered under that policy form are composed primarily of non-conversions, conversion rates should be kept reasonable by subsidies from the overall population. Furthermore, rates should bear a reasonable relationship to the original group rates through this subsidization. Differences will be due to the different loss ratio standards for individual and group forms, a different experience base and, potentially, a different benefit plan if the individual so elected.

If the pool of individuals covered under that policy form is composed substantially of conversions, it is possible that rates for that form may become unaffordable. An example of this would be where the issuer actively markets only group policies. Model #651 provides no direct means of controlling the rate relationships between the group policy and individual conversions in this situation. The grouping of policies at the form level for experience rating purposes limits the level of subsidy available from other forms. However, the rate relationship between conversions and group policies can be reviewed for reasonableness at the initial rate filing (because the issuer is required to have an individual policy available with similar benefits). Thereafter, it may be possible to maintain this relationship in situations where there are few converted policies (and, therefore, the experience alone is not credible) by reviewing the group's experience and rate relationships when determining the conversion policy's rates.

If both the group contract and the conversion policy are rated based on issue-age, the premium rate charged to the converted individual should be based on the original issue-age under the group contract and should not be based on the attained age at time of conversion.

Conversion Policies

Issuers who only market group coverage must have individual policies available that meet the conversion requirements. If there are no conversions for a period of time, doesn't Model #651 deem that conversion policy an inactive policy form?

Model #651, Section 15D(1) states that a policy form is considered inactive "unless the issuer has actively offered it for sale in the previous 12 months." Even if there were no actual conversions that took place, a plan developed purely for conversions should be considered as "actively offered for sale." That is, it is being used for the purpose for which it was intended and should not be considered a discontinued form.

REFUND ISSUES

Refund

What are the criteria for determining when refunds or premium credits must be given?

Model #651 provides for refunds or premium credits to be given if the cumulative actual experience loss ratio is less than the benchmark ratio. For standardized policies, the experience begins with inception. To achieve optimal credibility, the experience for 1990 SB Plans and 2010 SB Plans with the same plan letter must be combined.

For pre-standardized policies, the experience begins with the SSAA-94 effective date. (See Appendix E for additional explanations concerning effective dates). Both of these ratios exclude the business issued in the most recent calendar year. The calculated experience loss ratio is adjusted for credibility based on the life years. There is also a *de minimus* test to avoid small refunds/credits.

The filing is made for each type within any plan on a state-by-state basis. For example, an issuer licensed in 10 states with three standardized plans, one pre-standardized plan, and both individual and group forms must complete eight forms for each state, or a total of 80 forms.

Filing Timing

When must the refund/credit worksheets be filed with the state insurance regulators?

These forms must be filed by May 31 for the prior year's experience.

Credibility

Is a refund filing required if the experience is not credible?

The refund form must be completed (through line 10) even if the experience is not credible (i.e., less than 500 life years exposed) because it may ultimately become credible, and subsequent reports build on data from prior reports.

Payment

If necessary, when must the refunds/credits be delivered?

Issuers have until September 30 to give refunds/credits on the prior year's experience. Interest on the amount must be given from December 31 of the reporting year until the date of the refund/credit. The rate of interest is specified by the secretary of the U.S. Department of Health and Human Services at a rate not less than the average rate of interest for 13-week Treasury notes. This rate will be established by CMS[1] by regulation.

Recipients

If the filing indicates that a refund/credit is required, which policyholders receive the refund/credit?

Section 1882(r)(2)(B) of the Social Security Act as amended by OBRA-90 states that all policyholders in that state/plan/type cell on December 31 of the year being reported should receive a refund/credit payment. The Social Security Act does not address whether refund/credit amounts need to be the same if the 1990 SB Plans are combined with the 2010 SB Plans, and the experience for some subset (of the combined 1990 SB Plan and 2010 SB Plan pool) was distinctly favorable and justifies a larger proportion of the amount of refund required. CMS has stated that the requirement for a payment applies to policyholders who have been in force less than one year, even though their experience was not included in the experience calculation.

Refund State

If a policyholder moves between states, in which state should the experience for the policy be assigned for the refund filing?

The experience for the policy should be filed in the state of original issue, not the state of current residence.

For pre-standardized policies, the insurer may use the individual's state of residence at the time of the SSAA-94 effective date as the state of origin for reporting purposes, or the insurer may choose to report based on the state of original issue. This is a one-time option and may not be changed once a state has been identified, regardless of whether the individual moves to another state at a later time. However, the premiums actually charged the individual should be based on the state of residence.

Escheat

What should be done if the policyholder cannot be located for the refund?

Model #651 does not specify what should be done under these circumstances. It is reasonable to assume that whatever rules the state normally uses for money due policyholders who cannot be located should apply also in this case.

Premium Credit

What are valid approaches for granting premium credits?

Model #651 provides for premium credits as an alternative to cash refunds. It does not specify valid methodologies. A description of the refund/credit approach is required as part of the filing. You should review this carefully to determine if you have any concerns. This review should ensure that provision is made for policies which have terminated between December 31 and the date the refund/credit is made.

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[1] CMS (formerly the Health Care Financing Administration) has published the basis to be used for calculating the interest rate in the *Federal Register*, Vol. 59, No. 100, dated May 25, 1994. At the time of the update of this manual, this is still the methodology to be used; however, for later dates, please verify with CMS that this methodology still applies.

Data

What data must be available to complete the refund filing?

The worksheet is shown in Model #651, Appendix A—Medicare Supplement Refund Calculation Form. It requires the following types of information to be captured by the issuer (all data by issue state for each plan/type):

- Incurred claims by issue year
- Earned premium by issue year
- Number of lives exposed by issue year
- Amount of earned premium in the calendar year of issue for policies issued in each year preceding the reporting year
- Annualized premium in force at December 31 by issue year
- Refunds/credits granted each year (excluding interest)

Life Years Exposed

What is meant by "life years exposed"?

Life years exposed is used to determine the credibility of the block of business. It is a measure of the number of policyholders covered by the plan/type on a cumulative basis. As an example, if 600 policies are issued on July 1 and are still in force on December 31, 300 life years were exposed during that calendar year. One way to capture this data is to sum the number of policyholders covered each month and divide by 12. An adjustment would be necessary if the policy covered more than one life.

Experience Loss Ratio

How is the experience loss ratio calculated?

The experience loss ratio is calculated as (a)/(b), where:

(a) = the cumulative incurred claims for the plan/type excluding the business issued in the year being reported.
(b) = the cumulative earned premiums for the plan/type excluding the business issued in the year being reported less the cumulative refunds/credits (excluding interest).

The worksheets refer to this calculation as Ratio 2.

Benchmark Ratios

How is the benchmark loss ratio calculated?

There are two separate worksheets included in the appendices to Model #651 that are used to calculate the benchmark ratio, referred to as Ratio 1. One is used for Individual, Individual SELECT and Pre-standardized Individual. The other is used for Group, Group SELECT and Pre-standardized Group. The factors in column (c), column (e), column (g) and column (i) are the same for all filings of the same type. These factors are estimates of persistency and loss ratios based on a set of assumptions. They are applied to the earned premium reported in each prior calendar year on policies issued in that calendar year. The reporting calendar year value is excluded in column (b).

The worksheet illustrates the estimated experience in the first three years separately from subsequent years. This was done to illustrate that the target loss ratio (65% individual and 75% group) was met by the third year. Column (c) through column (f) show estimated experience in the first three policy years, and column (g) through column (j) show estimated experience in subsequent years. An example of the derivation of the factors is displayed in Appendix C.

Pre-Standardized Plans

Are refunds/credits required on pre-standardized Medicare supplement plans?

Yes. Passage of SSAA-94 provides that if the pre-standardized policies do not meet certain loss ratio requirements, then refunds or premium credits must be given to the policyholders. Similar rules apply to these pre-standardized plans as they do to standardized plans, except that pre-standardized plans are aggregated into only two types within each state: 1) individual including group policies subject to individual loss ratios if permitted by the state; and 2) group policies subject to group loss ratios. (See Appendix E for additional explanations concerning refunds for pre-standardized policies.)

SECTION III: ANNUAL FILING OF PREMIUM RATES AND LOSS RATIO PROJECTIONS

INTRODUCTION

Model #651 requires that all new product premium rates and requests for rate revisions be approved by the states in accordance with the filing requirements and procedures prescribed by the commissioner (Section 15A and Section 15B). Model #651 also requires the annual filing of premium rates that include demonstrations of compliance with loss ratio standards (Section 14C).

Forms Subject to Annual Filing

The annual rate and loss ratio filing requirement applies to all Medicare supplement forms. This filing must be made for each Medicare supplement form, regardless of whether a rate revision will be requested. The experience of all 1990 SB Plans shall be pooled with the experience of all 2010 SB Plans of the same letter and type designation for all rating purposes. It is anticipated that filings for all forms in a pool will be submitted as one filing or as concurrent filings.

Distinction from Rate Revision Filing

Although it is likely that many issuers will combine their requests for rate revisions with their experience filings (in fact, this may be required by some states), it is useful to draw a distinction between the purpose of a rate revision request and the annual loss ratio demonstration. The annual rate and loss ratio filing fulfills two purposes: 1) demonstrate compliance with loss ratio standards; and 2) obtain approval for the proposed rates for the upcoming year. These rates may or may not be the same as the current year rates. If the rates are not the same, the filing elements of a rate revision filing must be met.

Section III addresses the filing requirements for the annual rate and loss ratio filing and may be a subset of a combined rate filing. The additional information needed if a rate revision is requested is provided in Section IV. (Section IV also addresses the information to be provided for a new policy filing.) If a rate revision is requested, the revised rate must be used in the loss ratio projections discussed in this section.

Loss Ratio Standards

Model #651 discusses five loss ratio standards that must be met, if applicable:

1. A Medicare supplement policy form or certificate form shall not be issued unless the form can be expected to return to policyholders aggregate benefits that are greater than or equal to the applicable percentage of aggregate premiums. This loss ratio requirement must be demonstrated for new form filings.

2. For all policies or certificates in force less than three years, the expected third-year loss ratio is greater than or equal to the applicable percentage (Section 13C). A new form must demonstrate expected values that meet this standard.

3. The accumulated value of experienced claims plus the present value of expected future claims is greater than or equal to the applicable percentage times the sum of the accumulated value of experienced premiums and the present value of expected future premiums. For standardized policies, the accumulated experience premiums begin with inception (Section 14A(2)). For pre-standardized policies, the accumulated experience premiums begin with the effective date of the state's revised regulation (Section 14A(4)).

4. Over the entire future period for which the rates are computed, the ratio of the present value of claims to the present value of premiums is greater than or equal to the applicable percentage (Section 14A(2) and Section 14A(4)). For rate structures that include some prefunding, the future loss ratio standard should be revised, as appropriate, to properly reflect the prefunding.

5. For pre-standardized policies, the lifetime accumulated value of experience claims plus the present value of expected future claims is greater than or equal to the originally filed loss ratio times the sum of the lifetime accumulated value of experience premiums and the present value of expected future premiums (Section 14A(4)).

NOTE: In accumulating experience for the above loss ratios, a carrier may use a date prior to the SSAA-94 date for any state if, for administrative convenience, the carrier uses a common date for a group of states—none of which actually has an earlier SSAA-94 effective date.

Applicable Ratios

The applicable loss ratios are 75% for group policies and 65% for individual policies. Mass-marketed group policies are required to meet a 65% loss ratio; however, many states have accepted the suggestion in the Model #651 drafting note and require a 75% loss ratio. Policies sold prior to November 5, 1991, must also meet these loss ratios, as well as continue to meet the originally filed loss ratio. This includes all pre-standardized plans. (See Appendix E for additional explanations concerning pre-standardized loss ratio requirements.)

Timing and Approval

This filing must be made annually, but Model #651 does not specify whether this filing must be done on a calendar-year basis or some other annual basis. Each filing must be filed for approval by the state, according to each state's filing requirements and procedures. The purpose of this filing is to monitor compliance with minimum loss ratio requirements. If these standards are not met, the state should disapprove the filing, and the issuer should demonstrate what actions it intends to take in order to comply with the requirements. Latitude may be given for small blocks of business that, by themselves, do not meet all loss ratio requirements based on their non-credible experience.

FILING REQUIREMENTS

Model #651 requires that demonstrations of loss ratio compliance be prepared "in accordance with actuarial standards of practice." Therefore, the filing must be certified by a qualified actuary and would be subject to the actuarial standards of practice developed by the Actuarial Standards Board. The term "qualified actuary" as used in this regulation means an actuary who is a member of the American Academy of Actuaries.

Experience reporting for demonstration of loss ratio compliance and rate revisions shall be consistent with state requirements. To the extent consistent with state requirements, separate filings should be prepared for each policy form offered by the issuer (e.g., if an issuer offers both a direct response and agent-sold Plan A policy under different policy forms, the experience of each should be provided separately). Experience reporting on pre-standardized policy forms that are consistently combined to increase credibility may also be approved.

Model #651 specifically requires issuers to provide rates and rate schedules and to file the ratios of incurred losses to earned premiums by policy duration. The specific information that should be included in the filing is described below and summarized in Appendix B.

Purpose of the Filing

There should be a statement that the filing has been prepared to demonstrate loss ratio compliance and to request approval for the rates. If a rate revision is also requested, this should be clearly indicated.

General Description

A general description of the policy and benefits should be provided, including:

- Issuer name
- Form number
- Type of policy (e.g., individual, group, individual SELECT, group SELECT, pre-standardized individual, pre-standardized group)
- Benefit description
- Renewal provision
- Marketing approach
- Underwriting method
- Preexisting condition exclusion
- Issue-age limits (including availability to individuals eligible for Medicare due to a disability)
- Premium basis (e.g., attained-age or issue-age)
- Name, actuarial credentials, address and phone number of the actuary rendering the certification
- Target lifetime loss ratio for which the insurer is pricing

Rate Sheets and Rating Factors

The rates appropriate for the state—including any additional rating factors such as area factors, smoker/non-smoker factors, standard/substandard factors, etc.—must be filed. The assumed period for which the rates apply must also be noted.

Companies should document the approach used to deal with the situation where the state of residence is no longer the state of issue.

Rate History

The history of rate changes in the past five years applicable to policyholders for the form in the state and the implementation dates of these changes should be shown. If rate revisions were not applied uniformly across all rating factors, this should also be noted. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1, upon policy renewal or anniversary).

In-Force Counts

The number of policies for the state and nationwide in-force for the policy form should be included (both current counts and historical counts since inception). Where historical counts for pre-standardized policies have not been requested, the data should start with the SSAA-94 effective date. For use in comparing data with that reported for refunds, current counts and historical counts can be replaced with life years exposed.

Historical Incurred Claims by Duration

Incurred claims should be shown for each prior calendar year (and for the most recent partial year, if available). These incurred claims should be split either by policy duration (e.g., the experience in each calendar year relating to policies in their first year of duration, second year of duration, etc.) or on a calendar year of issue basis (e.g., the experience in each calendar year grouped by the year in which the policies were originally issued). This data must be provided for the experience of the policies issued in the state for which the filing is submitted. In addition, if the projected state experience is based on national experience, the national data must also be provided.

Incurred claims must be restated based on the claims paid plus change in the unpaid claim reserve. Use of actual runoff of claims should be indicated. Changes in active life reserves or claims expenses should not be included in incurred claims.

Historical Earned Premium by Duration

Earned premium by calendar year should be illustrated, split either by policy duration or calendar year of issue within each calendar year. The basis of reporting durational earned premium should be consistent with that used to provide incurred claims. State data should be provided in all cases. National data may also be appropriate, as noted above, for the incurred claims.

Earned premium for calendar years after 1991 must include modal loadings and policy fees. An adjustment for premium refunds should also be made. The change in active life reserves should not be subtracted from the earned premium.

Experience and Loss Ratio Projection

Future experience (premiums, claims and loss ratios) must be projected. The filing must clearly state the assumptions used to prepare such projections, including:

- Definition of loss ratio.
- Base period of projection and whether based on state or national experience.
- Lapse rates.
- Trend and rationale for trend.
- Method for incorporating attained-age changes and wearing-off of selection.
- Assumptions regarding future premium rate revisions.
- Interest rates for discounting and accumulating.

One implication of the availability of two options of Plan F and Plan J is that the respective experience (including potentially different percentage premium increases) for a policy form must be combined in the demonstration of loss ratio compliance. Otherwise, the basis for loss ratios and refunds will not be based on consistent experience.

Premium Adjustment for Medicare Supplement Forms with Prescription Drug Benefits Issued Prior to January 1, 2006

Beginning January 1, 2006, there were three subsets of individuals covered under Medicare supplement plans that covered prescription drugs (this includes Plan H, Plan I, Plan J, high-deductible Plan J and pre-standardized plans with drug benefits, as well as the prescription drug plans in Minnesota, Wisconsin and Massachusetts):

- Those who do not enroll in Medicare Part D, but keep their existing policy with the prescription drug benefits.

- Those who do enroll in Medicare Part D and retain their policy with the prescription drug benefits removed.
- Those who purchase Plan H, Plan I, Plan J, high deductible Plan J, or prescription drug plans in Minnesota, Wisconsin or Massachusetts after December 31, 2005, and before June 1, 2010, without prescription drug benefits. (There may be no individuals in this category if the states do not require these plans to be offered, because federal law does not require issuers to make these plans available.)

Experience for all subsets of insureds covered under each standardized plan must be combined for purposes of demonstrating compliance with the loss ratio standards. For purposes of determining premium rates, issuers should separate experience for prescription drug benefits from the experience for non-prescription drug benefits. Premiums for non-prescription drug benefits should be determined based on the non-prescription drug benefit experience of all insureds with the plan. Premiums for prescription drug benefits should be based on the prescription drug experience of those who kept their policy with prescription drug benefits.

Issuers should submit the experience and assumptions used in determining premium rate adjustments separately for prescription drug coverage and non-prescription drug coverage. An issuer may use reasonable approximations to separate prescription drug claim experience from other claims experience, if such experience is not obtainable for incurral dates prior to January 1, 2006.

Non-credible Experience and Closed Blocks

If an issuer's statewide experience is not credible for purposes of projecting expected future experience, the projection should be based on a larger block. In some cases, particularly in-force business and comparable standardized plans, combining the experience of several plans within the state may be appropriate. In other cases, the projection should be made based on national experience. State historical experience should be provided in all filings, even if nationwide experience is used to demonstrate compliance with the loss ratio requirements and to develop premium adjustments.

If state and national experience for a plan is not credible, judgment is needed to determine reasonable premiums and premium adjustments. Examples of data sources and methods for determining the premiums for such plans include the following:

- Pooling with other comparable Medicare supplement plans.
- Benefit relativities between plans.
- Any potential refunds that may be required for a plan.
- Medicare data.
- Intercompany studies.

The states should use latitude in requiring future premium adjustments when the combined historical and projected experience is below the applicable percentage for non-credible plans, particularly in early durations or for closed blocks of business.

Loss Ratio Demonstration

Currently, targeted loss ratios should not be lower than the originally filed anticipated loss ratios unless explicit approval has been granted by the commissioner. For policy forms with in-force in durations of three years or less, loss ratio standard 2 must be met. For all existing policy forms, loss ratio standard 3 and loss ratio standard 4 must be met. For pre-standardized policy forms, loss ratio standard 5 must additionally be met. That is:

- **Loss ratio standard 1** – The lifetime minimum loss ratio required by federal law and applied by state laws and regulations.

- **Loss ratio standard 2** – Policies in force less than three years will generate their applicable lifetime loss ratio in the third year.

- **Loss ratio standard 3** – The sum of accumulated past incurred claims and the present value of projected future claims must equal or exceed the applicable ratio times the sum of accumulated past earned premiums and projected future earned premiums. For standardized policies, the accumulated experience begins with inception (Section 14A(2)). For pre-standardized policies, the accumulated experience begins with the SSAA-94 effective date (Section 14A(4)).

- **Loss ratio standard 4** – The ratio of the present value of future claims to the present value of future premium equals or exceeds the applicable ratio.

- **Loss ratio standard 5** – For pre-standardized policies, the sum of the lifetime accumulated past incurred claims and the present value of projected future claims must equal or exceed the originally filed loss ratio times the sum of the lifetime accumulated past earned premiums and projected future earned premiums.

As noted previously, it may be necessary to modify loss ratio standard 4 to properly reflect any prefunding in the rate structure. The anticipated loss ratio when the policy was filed should also be stated.

Actuarial Certification

The actuarial certification should state that, to the best of the actuary's knowledge and judgment, the following items are true with respect to the filing:

- The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing.
- The anticipated lifetime loss ratio, future loss ratios and third-year loss ratio all exceed the applicable ratio.
- The filed rates maintain the proper relationship between policies that had different rating methodologies.
- The filing was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board.

A SAMPLE OF HOW AN ISSUER CAN DEMONSTRATE LOSS RATIO COMPLIANCE

An example of how an issuer can demonstrate loss ratio compliance for a standardized policy is shown below:

1. Present policy year durational loss ratios.

2. Develop calendar year expected loss ratios (by issue year) based on the assumed issue month and the policy year expected loss ratio.

3. Present historical earned premium and incurred claims by issue year and experience year.

4. Project the future experience using trend. Projected premium increases beyond any currently filed increase should be comparable to the trend assumptions used in projecting incurred claims. (See Section III, "Regulatory Checklist," question #4.) Verify that the expected third policy year loss ratio is at least the applicable percentage and that calendar year loss ratios are calculated consistently with the policy year ratios.

5. Calculate the accumulated and present values. If the ratio of claims to premiums exceeds the applicable loss ratio, then loss ratio standard 3 is met.

6. Calculate the ratio of the present value of future claims to the present value of future premiums. If this exceeds the applicable percentage, then loss ratio standard 4 is met. (As noted previously, if the rate structure includes prefunding, loss ratio standard 4 should be revised to reflect this.)

7. Based on the projected premium by calendar issue year for the prior three issue years, calculate the claims that would be required to meet the expected calendar year loss ratios for the second and third years following the calendar year of issue. Compare this total to the projected claims for these calendar issue years developed in step #4.

8. Verify that the historical experience in the second and third years following the calendar year of issue has exceeded the calendar equivalents of the policy year applicable percentages. If the expected claims in step #7 meet or exceed levels necessary to comply with the third-year loss ratio requirement and historical experience has met this test (step #8), then loss ratio standard 2 is met.

NOTE: The foregoing is only a sample of how compliance can be demonstrated. This sample should not be considered to be a limit on other appropriate actuarial methodologies.

HOW DOES A REGULATOR KNOW IF ASSUMPTIONS ARE REASONABLE?

Many of the critical assumptions for a Medicare supplement policy—such as the trend rate, investment income rate and lapse rate—will vary over time and among issuers. Therefore, it is not possible to present reasonable ranges in this manual. Each state will have its own process for compiling critical assumptions for purposes of developing its own database that can then be used to compare new filings. It is not expected that historical values for these assumptions will change materially with the advent of the 2010 SB Plans. A summary assumption form that would be useful for this purpose is displayed in Appendix A.

Relative Costs by Age

The relative cost by age is also subject to differences among carriers and changes over time. However, it is likely to be somewhat more stable than the other factors. The relative cost by attained age (in five-year age groups), as may have been applicable in the 1990s for the basic kinds of Medicare supplement plans, may be found in Section VIII.

Attained-age rates, in particular, should be reviewed to ensure that the slope by age is not too steep. If this were to occur, older insureds would be subsidizing younger insureds. The shape of the attained-age premium curve should be comparable to the shape of the ultimate claim cost curve. Differences from the slope could be expected. However, if an issuer's slope is much steeper than that shown, the reason for the steepness should be investigated.

Relative Costs by Benefit

Rate relativities may not match benefit relativities for the different Medicare supplement plans due to differences in actual claims experience by plan. This is because premium refunds are based on claims experience by plan, so issuers need to consider this experience in developing premium rates. However, benefit relativities should be *considered* in determining rate relativities, particularly for plans without credible experience.

REGULATORY CHECKLIST

The following items should be considered when reviewing these policy forms:

1. **Has all the information outlined above been provided?**

2. **Can rates be compared to those of other plans sold by the insurer to establish reasonableness?**

   The logic of the Medicare supplement loss ratio standards, as well as the refund requirement, requires that a plan's rates be based on its own credible experience. Experience may be combined for plans with similar benefits to enhance credibility. (See also item #7.)

3. **Does the policy comply with minimum loss ratio standards?**

   The filing must demonstrate that all relevant loss ratio standards are met.

4. **Is trend assumed in the loss ratio projection?**

   The filing requirements provide for disclosure of how the loss ratio is calculated, and the projected experience should include trend adjustments for premiums and claims. Except for short-term (i.e., no more than 24 months), immediate lower premium trend assumptions that are consistent with filed rates (and presumably are intended to keep loss ratios in compliance), the projected trend assumptions for premiums and claims should follow these rules:

   a. For an attained-age rated policy, the increase in premiums should be at least as large as the increase in claims.

   b. For an issue-age rated policy, the trend in claims may exceed the increase in premiums by no more than the average assumed increase in claim costs for one additional attained age plus any underwriting wear-off at early ages.

   The elements of the premium and claim trend rates (inflation, aging, etc.) should be reviewed in conjunction with the methodology used to determine their respective trend rates to ensure that certain factors, such as aging, are properly counted (i.e., not excluded or double-counted).

   Trend assumptions should be reasonable compared to past experience or other sources. For the high-deductible variations of Plan F and Plan J, it should be expected that different trend assumptions will be used and the result is that rate increases for the normal variations will not be the same percentage as the high-deductible variations.

5. **Are the interest rates used to discount cash flows reasonable?**

   Interest must be considered in calculating the anticipated lifetime and future loss ratios, otherwise loss ratios will be overstated. The interest rates should be reasonable; a minimum level would be appropriate valuation interest rates.

6. **Are the lapse rates used for the loss ratio projection reasonable?**

The issuer should state the basis of lapse rates and whether they consider mortality. If mortality is not considered separately, the ultimate lapse rate used should equal or exceed mortality rates.

7. How has the filing addressed non-credible experience?

To the extent that a plan lacks credible experience, issuers should provide an explanation of and justification for any premium adjustments. (See Section III, "Filing Requirements," "Non-credible Experience and Closed Blocks.")

8. Is the premium adjustment for removal of prescription drug benefits reasonable?

Claims costs for non-prescription drug benefits of plans with prescription drug coverage stripped out may have historically been higher than claims cost for the same benefits of plans without prescription drug coverage. Therefore, the premiums for plans with prescription drug coverage stripped out may be higher than premiums for similar plans.

Claims experience after December 31, 2005, for the plans with prescription drug coverage will depend on the plan selection choices made by insureds covered under those plans. These plans may have been closed to new business prior to June 1, 2010, so they may have experienced greater anti-selection effects than previously. However, insureds may move to other plans, which could result in adverse experience for the other plans. Such movement may also result in improved experience for the remaining insureds in the plans with prescription drug coverage.

Claims projections should be based on historical experience of the plans to the extent it is statistically credible. The issuer should provide an explanation of and justification for any premium adjustments when a plan does not have credible experience.

Regulators should recognize the potential effects of pooling different plans on future refund requirements, as the refund formula is based separately on experience for each of the standardized plans.

SECTION IV: FILINGS OF PROPOSED RATES

EXTRA REQUIREMENTS FOR A RATE FILING

While many issuers may prepare a joint filing of rate revisions with demonstration of loss ratio compliance, these are theoretically separate issues. The annual premium rate and loss ratio filing requires that issuers demonstrate compliance with minimum loss ratio standards. For a new policy form or a rate revision request, the issuer must provide additional data to demonstrate that the requested rates are reasonable, equitable, adequate, and in compliance with standards. The experience of all 1990 SB Plans shall be pooled with the experience of all 2010 SB Plans of the same letter and type designation for all rating purposes. It is anticipated that filings for all forms in a pool will be submitted as one filing or as concurrent filings.

In filing its initial rates for a 2010 SB Plan, the company should describe the relationship of those rates to the filed renewal rates for the comparable 1990 SB Plan. It is anticipated that, all other factors being equal (e.g., lifetime target loss ratio, underwriting, etc.), the initial rates for a 2010 SB Plan will be equal to those for a comparable 1990 SB Plan. If so, the subsequent rate adjustments will be uniform between plan generations throughout the lifetime of the policies. If the initial rates are not equal, then the goal over time is for the premiums for a 1990 SB Plan to become identical to those of the same plan/type 2010 SB Plan. Any variations from this goal are subject to the regulation(s) of the state(s) in which the rates are filed. The rate increase for specific forms within a pool may be adjusted, on a revenue neutral basis, to avoid violation of federal lifetime loss ratio standards for specific forms within the pool.

Similarly, premium rates for Plan D and Plan G (based on experience prior to 2020) may need to have a different level of change than other plans for 2020 and thereafter. Under MACRA, Plan D and Plan G starting in 2020 will be subject to the guaranteed issue right for newly eligible individuals under Model #651, Section 12. This may require a reasonable assumption for higher incurred claims than would result from just medical inflation. If the open enrollment and guaranteed issue components are expected to be a substantial part of the new business, then the prior experience for these plans may need adjustment to still be an appropriate assumption for rate revisions.

Reasonable

The filing must demonstrate that the proposed premium rates are correctly derived from reasonable assumptions and that the resulting anticipated loss ratios are correctly derived from these assumptions and rates.

Equitable

The proposed rates should be equitable among policyholders with the same policy form. If an issuer is changing rating methodologies, the new methodology must be actuarially equivalent to the old.

Adequate

Rates should be adequate to provide for the benefits in accordance with the rating methodology used and reasonable assumptions regarding claim costs by duration. Rates based strictly on early duration favorable experience would generally not be considered adequate.

In Compliance with Standards

The loss ratios required by Model #651 are outlined in Section III. A new policy filing must demonstrate that these standards are met. A rate revision filing must demonstrate that the standards are met, including a higher lifetime loss ratio if the originally filed loss ratio exceeded the minimum. In addition, both filings must indicate compliance with commission limits and other requirements (such as limits on multiple forms per plan/type or changes in rating methodology).

Each state must adopt filing procedures to implement these standards. To assist state insurance regulators, this section of the manual presents guidelines for each type of rate filing, an outline of the filing requirements, and a checklist for regulators of items and issues to consider when evaluating these filings.

Consistency in Format

Information provided in a new product rate filing should be presented in a format consistent with the requirements of the rate revision filings and annual premium rate and loss ratio filings so that consistency among filings can be checked.

Consolidated Policy Filings

The states may wish to allow groupings of pre-standardized policy forms for rate filings to avoid the consequences of many small closed blocks. If they do, they have to publish it in their regulations and have it approved by CMS. (See drafting note to Model #651, Section 14(A)(4)).

NEW PRODUCT RATE FILING

Actuaries preparing regulatory filings for rates must comply with general actuarial guidelines for professional conduct and actuarial standards of practice developed by the Actuarial Standards Board. You should expect a competently prepared actuarial filing to contain the following information. Appendix B contains a summary of the items described below.

Purpose of the Filing

The filings will often contain a statement such as, "The purpose of this rate filing is to demonstrate that the anticipated loss ratio of the product meets the minimum requirements of your state. This rate filing is not intended to be used for other purposes." The information included in the rate filing must "demonstrate"—not just "certify"—that the filing is in compliance.

General Description

A general description of the policy and benefits should include the same items outlined in Section III for the annual rate filing, plus:

- The date the form being submitted was approved by the issuer's domiciliary state (if it was filed in that state).
- An indication of whether the proposed rates are for a type of plan (i.e., individual, individual SELECT, group, or group SELECT) for which the issuer already has a form. (If so, the issuer should provide the total number of forms within the type, the difference between these forms, the reason for the new form, and when the plan was last sold, if it was previously sold). The issuer should note whether the filing is related to new 2010 SB Plans intended to replace existing 1990 SB Plans.
- The method of group conversion if the policy is a group policy. The individual form number for conversions should also be provided.

Methodology and Assumptions Used to Determine Rates

This methodology section should include:

- The general rate methodology used to calculate the rates.
- The degree to which provisions for inflation trends, aging, and the wearing-off of the effects of selection have been provided for in the pricing.
- The timing and magnitude of future rate revisions that are anticipated in the filing.
- The commission schedule.
- The commission level and methodology for policyholders who are replacing other coverage.
- Actuarial assumptions, including:
  - Lapse rates, including the basis for choosing lapse rates.
  - Morbidity assumptions, including the source of the assumptions and the effects of selection year by year.
  - Interest rate used to discount cash flows.
  - Expense assumptions by general expense application categories (e.g., percentage of premium, cost per policy, percentage of claims).

Rate Sheets and Rating Factors

The proposed rates for the state must be provided. This should include all rating factors such as area, smoker/non-smoker, standard/substandard, etc. There should also be a clear description of which rates will apply at Medigap open enrollment and the expected period of time for which the rates will apply.

Loss Ratio Projections

The same information as described in Section III for the loss ratio projection must be provided (with the exception of a definition of the base period).

Loss Ratio Demonstration

Loss ratio standard 1 and loss ratio standard 2 must be demonstrated. The anticipated loss ratios should be provided, including:

- The average durational loss ratio expectation for at least the first 10 years.
- The anticipated loss ratio by age or age band and other rating factors if the loss ratios by factor are expected to differ.

Actuarial Certification

The actuarial certification should cover the same items outlined in Section III (excluding the item pertaining to a change in rating methodology), plus statements that:

- The filing is in compliance with applicable laws and regulations in the state.
- The rates are reasonable in relationship to the benefits.

NEW FORM REGULATORY CHECKLIST

Except for question #7, the "Regulatory Checklist" in Section III applies for new policy form filings, as well. In addition, the following items should be considered during the review:

1. **Can the proposed rates support the anticipated expenses at the anticipated loss ratio?**

   For example, it would be difficult for a policy with a 30% renewal commission rate to meet an expected 65% loss ratio. If expenses seem out of line, restatement of expenses on a level percentage of premium basis using the same methodology as the loss ratio calculation can be requested.

2. **Are the proposed rates adequate?**

   The issue of rate adequacy is important to consider, as consumers who buy policies that are underrated during their Medigap open enrollment period may be faced with large rate increases when open enrollment is no longer an option. When evaluating adequacy, the regulator may consider whether the rates make sense compared to competition, with appropriate adjustments for differences in loss ratio, underwriting, etc. If you suspect that rates are inadequate, you could request that the issuer compare the rates for the proposed plan with rates charged for existing, credible blocks of business with suitable adjustments for benefits.

3. **Do the proposed commission rates comply with standards?**

   Commission rates must comply with the following:

   - First-year commissions less than or equal to twice the renewal commissions (years 2 through 6).
   - Rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.
   - Duration years 2 through 6 must be level.

   Also, the commission rate calculation for replacement situations must clearly be stated.

RATE REVISION FILING

Model #651 requires that all rate revisions be filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner. Model #651 leaves the methodology up to the commissioner regarding the information to be provided.

When requesting a rate revision, the issuer should demonstrate that the requested rates are consistent with the loss ratios originally anticipated for the policy. The issuer should also demonstrate continued compliance with loss ratio standards after the implementation of the proposed rate revision.

It is likely that many issuers will incorporate their rate revision requests into their annual premium rate and loss ratio filing. If an issuer chooses not to do this and files for a rate revision at a later date, the issuer must demonstrate in a manner consistent with the annual premium rate and loss ratio filing that the appropriate loss ratio standards will continue to be met.

FILING REQUIREMENTS

Because premium rates can differ by policy form within type of policy (e.g., medically underwritten Plan A premiums can differ from guaranteed-issue Plan A premiums), a premium rate revision request should be submitted separately for each policy form. The filing guidelines described here allow each filing to be evaluated on its own, without access to information from previous filings. Refer to Appendix B for a summary of the recommended data to include in the filing.

Purpose of the Filing

There should be a statement that the purpose of the filing is to request a rate revision and demonstrate compliance with loss ratio standards.

General Description

A general description of the policy and the benefits should include the items outlined in Section III, plus:

- The date the rate request submitted was approved by the issuer's domiciliary state (if applicable).
- Disclosure of whether the policy form is open or closed.

Scope and Reason for Rate Request

The reason for the rate revision must be clearly described. The scope of the rate revision, whether it applies to all rates uniformly or differs by rating attribute (area, etc.) should be clearly indicated. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1, or upon policy renewal or anniversary).

Methodology and Assumptions Used to Determine the Rates

The description of the methodology, and assumptions used to determine the rates, should include the same items as a new policy filing (excluding expenses other than commissions).

The rate methodology should properly reflect the prefunding of future incurred claims inherent in the rating methodology. The filing should include explicit statements that make clear the extent of the prefunding.

Model #651 directs the commissioner to prescribe the filing requirements and procedures that will be used to approve rates. (See Model #651, Section 14C, Section 15A and Section 15B.) One important element in determining the appropriateness of a requested rate revision is to determine the degree of recognition of any prefunding inherent in the prior rate that should be incorporated into the analysis of future loss ratios. Given the complexity and controversial nature of this issue, groups interested in this issue—such as the NAIC Life Actuarial (A) Task Force and the Health Actuarial (B) Task Force—should study methods for recognizing this prefunding.

Demonstration of Equivalence for Change in Rating Methodology

If an issuer is proposing a change in the rating methodology (e.g., change in attained-age relationships, introduction of new rating factor), the issuer must clearly describe the change. The two rating methodologies must produce equivalent expected results as of the estimated effective date of the change, although the commissioner may approve changes in rate differentials that are in the public interest. Future rate revisions must maintain this percentage relativity.

Rate Sheets and Rating Factors

The current rate schedule and the proposed rate schedule for the state must be attached, including all rating factors such as area, smoker/non-smoker, standard/substandard, etc. The expected period of time for which the rates will apply must also be stated.

Companies should document the approach that is used to deal with the situation where the state of residence is no longer the state of issue.

Rate History

The history of rate changes in the past five years (with implementation dates) for the form in the state should be included. If rate revisions were not applied uniformly across all rating factors, this should also be noted. Also, the effective date and timing of the rate revision should be described (e.g., effective January 1, or upon policy renewal or anniversary).

In-Force Policy Counts

The number of policies for the state and nationwide in-force for the policy form should be included (both current counts and historical counts since inception). Where historical counts for pre-standardized policies have not been requested, the data should start with the SSAA-94 effective date. For use in comparing data with that reported for refunds, current counts and historical counts can be replaced with life years exposed.

Historical Incurred Claims

Historical incurred claims by duration must be included. These should be included for each historical calendar year on either a policy-duration basis or a calendar-year-of-issue basis. The incurred claims should not include claims expenses or active life reserves. State experience should always be provided. If the proposed rates are based on national experience, the national data must also be provided. State and national data should be reported consistently on either a policy-duration or calendar-duration basis. Claims should be reported on a direct basis only, and should not reflect the adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.

Historical Earned Premiums

Historical earned premium by duration must be provided either on a policy-duration or calendar-year-of-issue basis. This must be provided on a basis consistent with the reporting of incurred claims. An adjustment should also be shown for premium refunds. The earned premium should include all modal loadings and policy fees. The change in active life reserves should not be subtracted from the earned premium. State experience should always be provided. If the proposed rates are based on national experience, the national data must also be provided. Premiums should be reported on a direct basis only and should not reflect the adjustments for assumed or ceded reinsurance arrangements except assumption reinsurance.

Experience and Loss Ratio Projection

The information provided for the experience and loss ratio projection should be the same as outlined in Section III. Also, this projection should be made both with and without the proposed rate revision.

Loss Ratio Demonstration

The loss ratio demonstration is similar to that described in Section III, except that the demonstration must show that the originally filed loss ratios are met.

Actuarial Certification

The actuarial certification should cover the same items outlined in Section III, plus statements that:

- The filing is in compliance with applicable laws and regulations in the state.
- The rates are reasonable in relationship to the benefits.

RATE REVISION REGULATORY CHECKLIST

The items in the regulatory checklist for the annual loss ratio filing (see Section III) are also applicable for rate filings. Additional items for consideration are the following:

1. **Are the proposed rates adequate?**

   The issue of rate adequacy is important to consider, as consumers who buy policies that are underrated may be faced with large rate increases. When evaluating adequacy, the state insurance regulator may consider whether the rates make sense compared to competition, with appropriate adjustments for differences in loss ratio, underwriting, etc. If you suspect that rates are inadequate, you could request that the issuer compare the rates for the proposed plan with rates charged for existing, credible blocks of business with suitable adjustments for benefits.

2. **Do the proposed commission rates comply with standards?**

   Commission rates must comply with the following:

   - First-year commissions less than or equal to twice the renewal commissions (years 2 through 6).
   - Rates for Medigap open enrollment at age 65 must be no less than the ages 66 through 69 commission.
   - Duration years 2 through 6 must be level.

Also, the commission rate calculation for replacement situations must clearly be stated.

3. Does the rate methodology properly reflect any prefunding inherent in the rating methodology?

Some rating structures (e.g., issue-age rates) are intended to prefund for increases solely due to aging. The proposed rate methodology should reflect this.

4. Does the filing propose a change in rating methodology?

If the filing requests a change in rating methodology, you must confirm that the new rating structure applies only to new issues and that the proposed rating structure is actuarially equivalent to the current rating structure.

SECTION V: MEDICARE SUPPLEMENT REFUND CALCULATION FORM

INTRODUCTION

An integral part of OBRA-90 and Model #651 is the requirement to file annually a comparison of the cumulative loss ratio to benchmark targets to determine if the loss ratio requirements are met. If the actual loss ratio is below the benchmark loss ratio, the issuer is required to give refunds or premium credits. The premium refund is determined so that the ratio of cumulative incurred claims to cumulative premiums (including modal loadings but excluding policy reserves) net of refunds equals the benchmark. This calculation is made on a cumulative basis, but excludes the experience of policies issued in the reporting year.

The experience refund form calculation includes an adjustment for credibility through a tolerance factor for small blocks of experience. The Medicare Supplement Refund Calculation Form should be completed even if the form does not have credible experience (i.e., less than 500 life years). If the refund is less than 0.5% of the annualized premium in force at December 31, the refund is deferred.

The specific requirements are discussed in the remainder of this section.

Filing Date

The refund calculation must be completed for each type by May 31 following the end of the reporting year.

Distribution Date

The issuer then has until September 30 to make the refund or credit. Interest must be credited from December 31 until the date of the refund or premium credit. The interest rate is specified by the secretary of the U.S. Department of Health and Human Services (but it will not be less than the average rate of interest for 13-week Treasury notes).[2]

Business Covered

Refund calculations must be completed for all Medicare supplement policies. The standardized plans issued on or after the OBRA-90 effective date must be reported separately for each unique plan/type combination. Experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan in both the 1990 SB Plans and the 2010 SB Plans shall be combined for the refund or credit calculation.

The experience of policies issued during the reporting year is excluded from the actual-to-expected comparison (but would be captured retroactively in the next reporting year).

Beginning with the SSAA-94 effective date, the experience for all Medicare supplement policies issued prior to the OBRA-90 effective date are aggregated under one of the two pre-standardized policy types—group or individual—as if they had been issued on the SSAA-94 effective date. Because the experience in the year of "issue" is excluded, these policies would not be included in the first reporting year. (See Appendix E for additional explanations.)

Assigned State

If an insured moves from one state to another, the experience of a policy remains with the state in which it was issued, although the rates may change to reflect costs and utilization in the new state. (See Section II, "General Rating Issues," "Rate Revisions.")

For pre-standardized policies, the insurer may use the individual's state of residence at the time of the SSAA-94 effective date as the state of origin for reporting purposes, or the insurer may choose to report on the state of original issue. This is a one-time option and may not be changed once a state has been identified, regardless of whether the individual moves to another state at a later time. However, the premiums actually charged the individual should be based on the state of residence.

CALCULATIONS

Individual and Group Benchmark Worksheets

[2] CMS (formerly the Health Care Financing Administration) has published the basis to be used for calculating the interest rate in the *Federal Register*, Vol. 59, No. 100, dated May 25, 1994. At the time of the update of this manual, this is still the methodology to be used; however, for later dates, please verify with CMS that this methodology still applies.

Model #651, Appendix A—Medicare Supplement Refund Calculation Form contains two worksheets that are to be used to calculate the benchmark loss ratios. The individual benchmark worksheet was developed assuming that the expected lifetime loss ratio is 65% and that this is achieved by the third policy year. The group benchmark worksheet was developed with the factors adjusted to a loss ratio of 75%. Policies issued as a result of mass media advertising in a state that allows the use of individual loss ratios for these policies should be included on the individual benchmark worksheet. The factors contained in these worksheets are also based on assumptions regarding the effects of selection, trend and policy terminations, which produce values that are less than those anticipated for most issuers. Consequently, the resulting values should be considered "floor" assumptions and not necessarily expected values for a particular issuer. The assumptions underlying these factors are outlined in Appendix C.

Medicare Supplement Refund Calculation Form

Appendix A to Model #651 contains the Medicare Supplement Refund Calculation Form, which:

- Presents the actual incurred loss ratio.
- Applies a credibility adjustment (tolerance).
- Compares the result to the benchmark loss ratio calculated by the worksheet.
- Determines the amount of refund/premium credit, if any.
- Contains a certification of the truth and accuracy of the refund calculation.

The mechanics of completing the worksheets and the form are described in this section.

Benchmark Loss Ratio

The example in Appendix D contains copies of the benchmark loss ratio worksheets. The calculation of the benchmark is a straightforward calculation in the worksheets. The worksheets look more complicated than they really are because the calculations were split into pieces that separately illustrate the expected experience in the first two policy years and the later policy years. The factors used to develop the composite benchmark ratio are fixed. The only item required to complete the worksheet is the earned premium in each calendar year of issue.

The worksheet is computed by entering the amount of earned premium in the calendar year of issue for policies issued in each year preceding the reporting year. These are entered in column (b), beginning with the year preceding the reporting year and working backward.

Multiplying the issue-year earned premiums by the factors in column (c) and column (g) give the benchmark cumulative earned premiums to date in the first two policy durations [column (d)] and in the third and later durations [column (h)]. These amounts are totaled to compute the benchmark earned premium, which forms the denominator of the benchmark loss ratio.

Multiplying the cumulative earned premiums in column (d) and column (h) by the factors in column (e) and column (i) produces the benchmark cumulative incurred claims for the first two policy durations [column (f)] and the third and later durations [column (j)]. These amounts are totaled to compute the benchmark incurred claims, which form the numerator in the benchmark loss ratio calculation.

The benchmark loss ratio calculation looks only at the earned premium in the year of issue, not the earned premium in subsequent durations. The calculation assumes a standard set of assumptions (lapse, trend, etc.). Therefore, actual earned premiums will differ from benchmark amounts because of differences in assumptions.

Expected earned premiums are used in place of actual earned premiums so that high experience lapse rates would not distort the calculations. The expected cumulative incurred claims for the cumulative earned premium are calculated through appropriate factors. Column (o) is not used, but provides the base policy year factors used to develop the cumulative factors.

The benchmark loss ratio is then calculated as the ratio of the benchmark incurred claims to the expected earned premium (both excluding issues in the most recent policy year).

Experience Loss Ratio

Line (1) through line (3) of the Medicare Supplement Refund Calculation Form develop the actual cumulative loss ratio. (See Appendix D for a sample form.) Line (1) presents the experience in the reporting year and deducts the experience for policies issued in that year. Line (2) presents all cumulative experience through the year preceding the reporting year. Line (3) is the sum of line (1c) and line (2). The premiums entered in these lines should include total earned premium, including modal

loadings and policy fees. The incurred claims entered in these lines should not include active life reserves or claims expenses. The incurred claims should be the current best estimates based on claim runoff data and an amount to estimate the remaining amount to be paid.

Cumulative Refund Credits

Line (4) through line (6) calculate the cumulative refunds/premium credits, which are to be netted against the earned premium reported in line (3). The amount of refunds/premium credits in the year preceding the reporting year is entered in line (4). The amount from all earlier reporting years is entered in line (5). Line (6) is the sum of line (4) and line (5). **NOTE**: The amounts entered here do not include the interest that was credited to the refunds.

Ratio 1

The benchmark loss ratio that was computed by the worksheet is entered in line (7). The Medicare Supplement Refund Calculation Form refers to this as Ratio 1.

Ratio 2 and Ratio 3

Line (8) calculates the actual experience loss ratio as the ratio of incurred claims to earned premium net of refunds (both incurred claims and earned premiums exclude the most recent policy year). This amount is referred to as Ratio 2. A tolerance adjustment is added to Ratio 2 that is based on the credibility as represented by the number of life years exposed on a cumulative basis. The tolerance-adjusted ratio is referred to as Ratio 3 and is shown on line (11).

Credibility

In the comparison of the experience loss ratio to the benchmark, there is a credibility adjustment. This adjustment is based on cumulative exposures. Line (9) of the Medicare Supplement Refund Calculation Form indicates the number of life years exposed. This is the sum of the average number of lives covered each year through the reporting year (excluding policies issued in the reporting year). This is not the same thing as the number of policyholders in force at December 31 of the reporting year, nor even the sum of the policyholders in force at the end of all prior years. For pre-standardized policies, exposure begins with the SSAA-94 effective date in the state.

If the number of life years exposed is less than 500, the rest of the form does not need to be completed. There would not be any refund/premium credit required regardless of the relationship between the benchmark loss ratio and the actual experience loss ratio. When the form is completed in each subsequent year, the number of life years exposed will increase and might eventually reach the minimum credibility level of 500 life years.

The credibility table included in the form is mandatory. Issuers may not apply their own credibility factors.

Refund Calculation

There is a test following line (11) of the Medicare Supplement Refund Calculation Form to determine if a refund is required. Line (12) and line (13) calculate the amount of premium refund, if any.

Refund Test

If the experience loss ratio adjusted for credibility (Ratio 3) is equal to or greater than the benchmark loss ratio (Ratio 1), no refund is required.

Refund Amount

If the experience loss ratio adjusted for credibility (Ratio 3) is less than the benchmark loss ratio (Ratio 1), a refund is required. The refund amount is the total amount that the premium must be reduced (by refund) so that the experience loss ratio based on the net premium balances with the benchmark and tolerance factors. The refund amount is increased with interest from December 31 to the payment date.

De Minimus Test

The final step in the process is the *de minimus* test, which is used to avoid small refunds. It is not in the policyholder's best interest to require very small refunds because the cost of issuing the refund/premium credit would outweigh any benefit gained. The test used is that the total amount of the refund must be at least as great as .005 times the annualized premium in force (including modal loadings and policy fees) at December 31 of the reporting year. If the calculated refund is less than this

amount, no refund is required for that reporting year. If experience continues to be favorable, the *de minimus* test would eventually fail and the refund would be paid.

WHO GETS REFUND/CREDIT

Section 1882(r)(2)(B) of the Social Security Act as amended by OBRA-90 provides for the refund or premium credit, if any, to be paid to the policyholders in force on December 31 of the reporting year. CMS has stated that policies issued in the reporting year are also eligible for the refund/credit even though they were excluded from the calculation of the total amount to be refunded.

Pre-Standardized Plans

Pre-standardized policies in force on the SSAA-94 effective date are grouped together by type and treated as if they were issued on the SSAA-94 effective date. It is unlikely that they will generate a refund, as the benchmark calculation will presume they are in the early years (with expected low loss ratios) when the experience will be in advanced years. It was not practical to do anything different, but the refund calculation is required for these policies.

REGULATOR'S CHECKLIST

When the filing is received, the regulator should be satisfied that the worksheets and refund forms have been completed accurately. Some of the checks that should be made are listed below:

Number of Forms

1. **Was the number of forms filed at least as high as in previous years?**

   The number of refund forms will depend on the number of plans a particular company offers. In most cases, the implementation of the 2010 SB Plans will create an increase in the number of refund forms because of the addition of two new plan letters (M and N). The fact that certain 1990 SB Plans are not continued to be offered for sale does not mean that there is no refund form for that plan letter.

Correct Date

2. **Is the correct date being used to segment the new standardized plans?**
   This should be measured from the OBRA-90 effective date in your state. If 1990 SB Plans were issued prior to the OBRA-90 effective date, they are included with the pre-standardized in-force block with a SSAA-94 effective date for refunds, except when a carrier has already included these policies in their 1995 refund calculations (and prior calculations). That practice should be continued.

   The effective date of the new 2010 SB Plan M and Plan N should be June 1, 2010, or later, regardless of when the state's regulation was changed.

Individual versus Group Worksheets

3. **Is the correct worksheet used to calculate the benchmark loss ratios?**

   All individual policies must use the individual worksheet (with a 65% loss ratio expectation) and all group policies should use the group worksheet (with a 75% loss ratio expectation). The form for mass-marketed group policies will depend on your state's regulation. You should also check that the factors have not been modified (i.e., they cannot be based on issuer assumptions; the factors are fixed for everyone). You should also check that the calculated benchmarks are correctly transferred to the appropriate Medicare Supplement Refund Calculation Form.

Earned Premium

4. **Is the earned premium in the issue year in column (b) of the benchmark worksheets consistent with prior filings?**

   The amounts shown in column (b) should be shifted down each reporting year. Also, the amount shown in line (1b) of the Medicare Supplement Refund Calculation Form in the prior reporting year is the amount that should be shown

in Year 1 of the benchmark worksheet for the current reporting year. In the first reporting year, you may want to see if the amounts shown appear to be consistent with the annual rate/experience filing.

Consistency of Experience

5. Is the reported experience consistent with prior filings?

The cumulative experience in the Medicare Supplement Refund Calculation Form should be consistent with prior years. The earned premium amount in line (2) should equal the sum of line (1b) and line (3) from the prior reporting year. This relationship will not necessarily hold for incurred claims because the claim experience is restated, but there should be a close relationship. In addition, the experience should be consistent with the annual rate/experience filing. **NOTE**: The rate/experience filings are completed at the form level, and the experience for multiple forms may need to be added to develop the amount at the type level.

Prior Refunds

6. Is the amount of prior refunds consistent with prior filings?

The amount on line (4) of the Medicare Supplement Refund Calculation Form should equal the amount from line (13) in the prior reporting year. The amount shown in line (5) should equal the amount from line (6) of the prior reporting year. Check that the amounts shown do not include the interest that was paid.

Life Years Exposed

7. Does the amount shown for life years exposed appear to be reasonable?

This number should increase with successive reporting years. One reasonableness test that could be performed is based on the number of policies in force at the end of the prior year. The increase should be approximately equal to the number of policies covered at the end of the prior year after adjusting for an assumed level of lapses and new issues.

NOTE: The Medicare Supplement Refund Calculation Form does not include this information directly. It should be available from the annual rate filing (but you may need to add several forms to develop the amount at the type level). If you are not satisfied that this amount has been correctly determined, you should ask for additional information.

Tolerance Factor

8. Has the tolerance been correctly determined?

Check that the tolerance amount on line (10) of the Medicare Supplement Refund Calculation Form is correct based on the life years exposed. The credibility table included on the form must be used; issuers may not use their own credibility table.

De Minimus Test

9. Was the *de minimus* test made correctly?

If a refund is not paid because the amount is considered to be *de minimus*, the worksheet should show the calculation. You should confirm that the premium used for the test is annualized premium in force at December 31 of the reporting year (including modal loadings and policy fees).

Distribution Methodology

10. If a refund is required, are you satisfied with the distribution methodology described?

The Medicare Supplement Refund Calculation Form requires the method of distribution to be included with the filing. This description must include the rate of interest to be credited and the amount of time for which the interest is to be applied. The rate of interest credited must be no less than: 1) that specified by the secretary of the U.S. Department of Health and Human Services; and 2) the average rate of interest for 13-week Treasury notes. If no interest rate has been specified by regulatory authorities, the issuer should use its best judgment as to the average rate. The methodology must result in a completed transaction by September 30.

NOTE: This deadline applies to a premium credit methodology also. For this reason, premium vouchers should not be used, as there is no guarantee as to *when* they would be used. Likewise, premium adjustments could not be used for modal premiums coming due after September 30.

Potential Forms

You should also review how the refund/premium credits are allocated to the individual policyholders. Some potential methodologies are:

- Equal amount or percentage based on the premium in the reporting year. This may be the most reasonable approach.
- Equal percentage based on the length of time the policy is in force. This may be a reasonable approach if the refund has been delayed due to the *de minimus* test or low credibility.
- Unequal amounts/percentages. If this type of approach is used, justification for the unequal distribution must be provided. For example, was there one policy form within the type that contributed more to generating the refund?

It is recommended that the refund formula be consistent within a policy form, but variations of the formula may be justifiable between forms. However, it is not anticipated that the refund/credit would ever be completely eliminated for any subset of policyholders.

Certification

11. Has the certification been completed?

This section of the Medicare Supplement Refund Calculation Form must be completed showing an individual's name and title, not the issuer's name.

SECTION VI: OTHER FILING REQUIREMENTS

Each issuer must file the following experience reports on an annual basis. These reports are required by Model #651 and by federal statute.

Annual Financial Statement Experience Exhibit

The Medicare Supplement Insurance Experience Exhibit

This exhibit is contained in the annual financial statement and filed with the statement by March 1 each year. It contains information relative to loss ratios by policy form and state of issue. The form also includes information to satisfy the requirements of 42 U.S.C. § 1395ss(b)(1)(E). This section of the federal code requires each state to periodically (but at least annually) provide the secretary of the U.S. Department of Health and Human Services with a list containing the name and address of each issuer of Medicare supplement insurance in their state, including the name and number of such policies (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval because the previous list was provided). This information is collected directly by the NAIC, compiled, and mailed to the states for comments and verification. The NAIC submits the report, including the states' comments and corrections, to CMS on behalf of the states.

Duplicative Policies

The Form for Reporting Duplicative Medicare Supplement Policies

Model #651, Section 22 requires issuers to report on or before March 1 each year the policy and certificate number and date of issue of any policyholder who has more than one Medicare supplement policy. This information should be used by the state insurance departments to determine compliance with the non-duplication provisions found in Model #651, Section 21B.

SECTION VII: MEDICARE SELECT

INTRODUCTION

The OBRA-90 amendments gave CMS authorization to designate 15 states that could approve Medicare SELECT policies. Federal legislation passed in 1995 extended the Medicare SELECT program to any of the 50 states that adopt the SELECT program, and to be effective until 1998. This was changed to permanent status in 1998.

Any benefit plan that conditions the payment of benefits on which providers are used may only be offered under the SELECT program. Therefore, typical health maintenance organization (HMO) or preferred provider organization (PPO) plans could not be offered as supplemental coverage to Medicare Part A and Part B after the effective date of OBRA-90. The following types of coverage are available as alternatives to Medicare Part A and Part B but are not subject to regulation as Medicare supplement coverage:

- Medicare risk contracts under Medicare Part C
- Medicare cost contracts
- Employer or union plans

SELECT BENEFIT PLANS

The SELECT program provides a means of offering different delivery systems. SELECT policies do not offer additional benefits compared to non-SELECT policies. The usual standardized benefit plans apply for SELECT products. The benefit plan is defined by the benefits paid when network providers are used. That is, the in-network benefits must follow one of the standardized plans outlined in Model #651. The benefits that apply when non-network providers are used may be less than the network benefits.

For example, if Plan G is offered, the in-network benefits cover "core" services, the Part A deductible, skilled nursing coinsurance for day 21 to day 100, 100% of any Part B balance billing, and 80% of medically necessary foreign travel. The out-of-network benefits could cover any part of these costs. For example, the Part A deductible and Part B balance billing costs may not be paid if non-network providers are used. Alternatively, a SELECT policy may not cover **any** services if non-network providers are used.

Required Offers of Coverage

Model #651, Section 10L states that at the time of initial purchase, a SELECT issuer must make available to each applicant for a SELECT policy or certificate the opportunity to purchase any non-SELECT Medicare supplement policy or certificate *otherwise offered by the issuer*. Clearly, if the issuer provides both SELECT and non-SELECT products, then the non-SELECT plans offered by the issuer must be made available to SELECT applicants at the time of initial purchase. If the SELECT issuer does not otherwise offer non-SELECT Medicare supplement coverage, such as an HMO, it would not be required to offer non-SELECT Medicare supplement coverage to SELECT applicants at the time of initial purchase.

Model #651, Section 10M states that at the request of the individual insured under a SELECT plan, the SELECT issuer shall make available to the individual the opportunity to purchase a non-SELECT Medicare supplement policy or certificate *offered by the issuer* that has comparable or lesser benefits. The issuer is prohibited from requiring evidence of insurability if the request is made within six months after the effective date of the SELECT plan. If the SELECT issuer does not otherwise offer non-SELECT Medicare supplement coverage, such as an HMO, it would not be required to provide non-SELECT Medicare supplement coverage to SELECT insureds. A SELECT policy may not offer a plan to newly eligible individuals that covers any part of the Medicare Part B deductible.

Because some SELECT issuers do not otherwise offer non-SELECT Medicare supplement coverage, it is important that, in those cases, the SELECT applicants be made clearly aware of the coverage limitations of these plans. For example, if a SELECT insured is afforded coverage through an HMO and the HMO does not offer non-SELECT Medicare supplement coverage, the insured should know that if he or she moves out of the HMO's service area or wants to change providers to one that is not a panel provider, the SELECT coverage will not be available to the insured. However, Medicare coverage would still continue. Model #561, Section 10I requires such disclosures, and SELECT states should strongly require such disclosures.

REQUIREMENTS

The requirements a SELECT product must meet are:

Plan of Operation

- File a plan of operation. This plan covers such topics as access, quality assurance, and disclosure of policy restrictions and coverage options. In addition, proposed changes to the plan of operation must be filed prior to implementing the changes.

Network List

- File updated lists of network providers quarterly.

Non-SELECT Option

- Allow an applicant any non-SELECT policy that the issuer offers. Also, allow an insured, upon request made after at least six months of coverage, the opportunity to change to any non-SELECT plan the issuer offers that has comparable or lesser benefits without evidence of insurability. **NOTE**: The issuer may not offer any non-SELECT policy; this is not interpreted to be a violation of requirements of Model #651.

Continuation of Coverage

- Provide for continuation of coverage if the SELECT program is discontinued. If the issuer's license with the state allows a non-SELECT policy to be offered, the issuer must meet this requirement. However, some states do not allow HMOs to offer indemnity types of benefits. Prior to approval of a carrier to offer a SELECT program, provisions must be in the plan of operation to allow for the continuation of coverage if the SELECT program is not renewed federally, either with the HMO or outside the HMO (with another carrier, for example).

New Form Filing

- File anticipated loss ratios and rate development for a new policy form. This requirement is the same as for non-SELECT plans.

Annual Filing

- File rates and experience annually. This requirement is the same as for non-SELECT plans.

Rate Increase Filing

- File for rate increases. This requirement is the same as for non-SELECT plans.

Refund Filing

- File the rate refund form. This requirement is the same as for non-SELECT plans.

Special data considerations for these filings are discussed for the remainder of this section.

DATA CONSIDERATIONS

SELECT policies are distinguished from non-SELECT policies only in that they provide for reduced benefits if non-network providers are used. Therefore, the same types of data and information should be available for both types of policies. This may present a departure from traditional data captured by an HMO.

New Form Filing

For example, the rate filing for a new policy form must demonstrate that the anticipated loss ratio over the life of the policy and the expected loss ratio in the third policy year both meet the minimum required. This means that data must be presented on a policy duration basis, not the capitation premium development used by an HMO. If underwriting is performed, the assumed selection factors and lapse rates must be identified in order to make the demonstrations required.

Annual Filing/Rate Revision Filing

Requests for rate revisions and the annual rate/experience filing will also require data to be presented in a manner other than the traditional capitation methodology. As noted in Section III and Section IV, historical experience by policy year or calendar year of issue is required for these filings.

Refund Filing

The refund filing will require that data by issue year be available to complete both the benchmark ratio and experience ratio calculations.

Incurred Claims Definitions

Loss ratios in Model #651 are defined to be the ratio of incurred claims experience or incurred health care expenses to earned premium. Model #651, Section 5D defines "health care expenses" as those expenses associated with the delivery of health care services and expressly excludes the following costs: home office and overhead; advertising; commissions; taxes; capital; administrative; and claims processing.

It is recognized that some HMO expenses are valid health care expenses, but are not readily allocated to an issue-year basis. Examples are capitations, withholds, and physician incentive payments based on non-physician services (e.g., hospital utilization).

Capitations

A capitation could be allocated on the same basis as it is paid to specific policies that have been previously assigned to a calendar year of issue. This approach would not give any recognition to any anticipated durational difference in claims (i.e., it will not recognize any selection impact). An issuer may wish to identify in advance a more refined method of allocation that would recognize expected selection. Any method used should be consistent from year to year.

Withholds and Other Incentive Payments

Withhold and other incentive payments are paid based on each physician's experience. It is generally not possible to allocate the amount paid to a specific member or, therefore, issue year. For these types of payments, an acceptable method of allocation would be a pro rata amount based on the total amount of withhold or incentive to total incurred claims or capitation. In order to assess if a more refined methodology could be possible, a complete description of how the withhold or incentive payment is made should be requested.

SECTION VIII: HISTORICAL MATERIAL

The following material was a part of prior versions of this manual. It may have some limited relevance when reviewing the prior operations of a block of Medicare supplement business. As such, it has been retained by moving it from the location noted to this "Historical Material" section so that the material is not lost.

Relocated from Section I

OVERVIEW AND PURPOSE OF THE MANUAL

#6: Requirements under the Medicare Modernization Act of 2003

In 2004 the Model Regulation was revised to reflect requirements of the MMA applicable to beneficiaries who enroll in Part D (the new Medicare prescription drug program) of Medicare. Changes to the Model include:

- Stripping all prescription drug benefits from any Medicare supplement plan with an insured that enrolls in Part D after December 31, 2005.
- Prohibiting Medicare supplement issuers from offering prescription drug benefits to new enrollees after December 31, 2005. (This includes plans H, I, J, high-deductible J, and the prescription drug plans in Minnesota, Wisconsin, and Massachusetts.)
- Creating two new Medicare supplement plans, "K" and "L."

If an individual is covered under a Medicare supplement plan with prescription drug benefits and *does not* enroll in Part D, the issuer must continue to renew the plan with the prescription drug benefits.

If an individual is covered under a Medicare supplement plan with prescription drug benefits and *does* enroll in Part D, the issuer must give the insured two options:

1. Lapsing the existing policy and purchasing Plan A, B, C, F, K or L on a guaranteed issue basis.
2. Keeping the existing policy and eliminating the drug benefits effective with the date their drug coverage starts under Part D.

If option 2 is selected, the issuer must adjust the premium of the stripped-out plan appropriately to reflect the reduced benefits (see section III of this manual). Note that if the insured does not notify the issuer in advance, the issuer is required to refund the portion of premiums paid for prescription drug benefits from the effective date of Part D coverage for the insured. The refund may be reduced by claims already paid on prescription drug benefits incurred after the effective date of Part D coverage, but not below zero.

Relocated from Section II

EFFECTIVE DATE ISSUES

Is there any flexibility in the effective dates? *[pertaining to effective dates of 1990 Plans versus pre-standardization plan]*

Generally, no. However, administrative flexibility is allowed to carriers in two instances where the policyholders will benefit.

If a carrier wishes to use a common SSAA-94 effective date for a group of states (all of which have a SSAA-94 date equal to or later than the one chosen by the carrier for administrative simplicity) in the accumulation of experience for loss ratios and/or refunds, this should be acceptable.

Relocated from Section III

HOW DOES A REGULATOR KNOW IF ASSUMPTIONS ARE REASONABLE?

Relative Costs by Age *[These* were *originally developed in 1992 and updated in 1996 but have not been updated thereafter. Thus, they have historical relevance but may not be appropriate for current use.]*

The relative cost by age is also subject to differences among carriers and changes over time. However, it is likely to be somewhat more stable than the other factors. The relative cost by attained age (in five-year age groups) is shown for the basic kinds of Medicare supplement plans in the following table.

These tables are intended to be illustrative and are for comparison purposes.

Medicare Supplement Claim Costs by Attained Age (Relative to Age Group 75-79)				
	Hospital	Part B	SNF	R_x
65-69	0.76	0.68	0.30	1.00
70-74	0.90	0.91	0.54	1.00
75-79	1.00	1.00	1.00	1.00
80-84	1.19	1.05	1.76	1.00
85+	1.36	1.05	3.83	1.00

Note that the relative slope of the costs varies dramatically by kind of benefit. Therefore, the rate relativities by age for a standardized plan will depend upon which benefits are included. This is illustrated in the following table.

Relative Attained Age Cost (by Standardized Plan)			
	Plan A	Plan C and Plan F	Plan J
65-69	0.69	0.69	0.78
70-74	0.91	0.89	0.93
75-79	1.00	1.00	1.00
80-84	1.06	1.11	1.07
85+	1.08	1.25	1.14

APPENDIX A
Medicare Supplement Assumption Summary

Company Name				
Plan(s)				
Form Number				
Rating Period				
Issue or Attained				
Loss Ratio Std (65% or 75%)				
Trend Rate				
Investment Income Rate				
Commission Schedule				
Year 1				
Year 2-6				
Year 7 +				
Lapse Rates				
Year 1				
Year 2				
Year 3				
Year 4				
Year 5				
Year 10				
Year 15				
Average Annual Premium				
Durational Loss Ratios				
Year 1				
Year 2				
Year 3				
Year 4				
Year 5				
Year 7				
Year 10				
Year 15				

APPENDIX B
Summary of Information to Include in Annual Rate and Loss Ratio Filing, New Policy Filing and Rate Revision Filing

Description	Annual Rate/Loss Ratio Filing	New Policy Filing	Rate Revision Filing
Purpose of Filing (a)	X	X	X
General Description			
Issuer Name	X	X	X
Form Number	X	X	X
Policy Type	X	X	X
Benefit Description	X	X	X
Renewal Provision	X	X	X
Marketing Method	X	X	X (b)
Underwriting Method	X	X	X
Preexisting Condition Excl.	X	X	X
Issue-Age Limits	X	X	X
Premium Basis	X	X	X
Actuary's Name, etc.	X	X	X
Domicile State Approval		X	X
Multiple Forms by plan/type?		X	
Group Conversion (Method/Form)		X	
Rate Methodology/Assumptions			
General Method		X	X
Priced w/ Trend/Selection?		X	X
Priced w/ Rate Increases?		X	X
Commission Rates		X	X
Replacement Commissions		X	X
Lapse Assumption		X	X
Morbidity Assumption		X	X
Interest Assumption		X	X
Expense Assumptions		X	
Reflect Pre-funding?			X
Equivalence of Change in Rating Methodology			X
Scope/Reason for Request			
Overall Increase			X
Variations by Cell			X
Effective Date			X
Timing			X
Rates and Rating Factors			
Current	X		X
Proposed		X	X
Period Rates Apply	X	X	X
Average Annual Premium (incl. mix by cell)		X	X (c)

Description	Annual Rate/Loss Ratio Filing	New Policy Filing	Rate Revision Filing
Rate History (5 yrs.) (amount and timing)	X		X
In-Force Counts			
Since Inception	X		X
State and National	X		X
Historical Incurred Claims			
By Iss. Yr and Cal. Yr (d)	X		X
State Basis	X		X
National Basis (e)	X		X
Historical Earned Premium			
By Iss. Yr and Cal. Yr (d)	X		X
State Basis	X		X
National Basis (e)	X		X
Loss Ratio Projection			
Definition	X	X	X
Base Period	X		X
Lapse Assumption	X	X	X
Claim Trend Assumption	X	X	X
Att.-Age/Selec. Adjustments	X	X	X
Future Rate Increases?	X	X	X
Interest Assumption	X	X	X
With and w/o rate change			X
Loss Ratio Demonstration (f)	X (Min./Filed)	X (Min.)	X (Filed)
Actuarial Certification	X	X	X

Notes to Appendix B:

(a) Each filing serves a different purpose. The annual rate and loss ratio filing must file the rates for approval and demonstrate loss ratio compliance with the minimum standards in the regulation. A new policy filing must describe the rate development and demonstrate compliance with minimum loss ratios. A rate revision filing must describe how and why the rate revision is requested and demonstrate compliance with the originally filed loss ratios.

(b) The rate revision filing must also indicate whether the policy is a closed block of business.

(c) This should be shown both before and after the rate revision.

(d) Alternatively, the data could be presented by calendar year of issue and calendar experience.

(e) The national data need only be provided if the projections and/or rates are derived from national experience.

(f) The loss ratio demonstration varies for each filing. The new form filing and annual filing must both demonstrate compliance with the minimum standards. Because the annual filing also covers approval of rates, it should also indicate the anticipated loss ratio when the policy form was filed. The rate revision filing must demonstrate compliance with the anticipated loss ratio when the policy form was filed. The new form filing must also illustrate the expected loss ratio for at least the first 10 years and indicate any variations by age.

APPENDIX C
Refund Calculation Factor Development

Assumptions

1. Loss ratios achieved over 15 years.
2. Policies are issued July 1 of the issue year.
3. 10% trend in premiums and claims.
4. Loss ratios by policy year: 40%, 55%, 65%, 67%, 69%, 71%, 73%, 75%, 76% for three years, and 77% for the remainder.
5. Lapse rates for each year: 30%, 25%, 20% for three years and 17% thereafter. Lapses are assumed to occur at the end of the year.

Methodology

The earned premium factor is applied to the first calendar year earned premium (1/2 policy year) to derive the appropriate cumulative expected earned premium based on the above assumptions. The benchmark incurred claims are derived by applying the assumed loss ratios by duration, and the cumulative loss ratio is the ratio of the sums.

Sample Factor Calculation (Year 3)

For example, for each dollar of earned premium in the issue year, the expected cumulative earned premium factor (4.175) and the cumulative loss ratio (.493) in the third calendar year are calculated as follows:

Calendar Year	Benchmark Earned Premium	Loss Ratio	Benchmark Incurred Claims
1 (1/2 year assumed)	1.000	.40	.4000
+ 2, 1st Half	+ 1.000	.40	.4000
+ 2, 2nd Half premium rate 1.100 x persistency rate x .7	+ .770	.55	.4235
+ 3, 1st Half premium rate 1.100 x persistency rate x .7	+ .770	.55	.4235
+ 3, 2nd Half premium rate 1.210 x persistency rate .7 x .75	+ .635	.65	.4128
Total	4.175		2.0598
Cumulative Loss Ratio Factor (Year 3)		.493	

APPENDIX D
Refund Filing Example

ASSUMPTIONS

This example assumes that the information in this manual is being adhered to as shown. Both the data that the issuer has and the completion of the benchmark worksheets and Medicare Supplement Refund Calculation Forms are provided. The assumptions underlying this example are:

> Company ABC is licensed in two states (A and B). The new Medicare regulation became effective on July 1, 1992, in State A and on May 1, 1992, in State B. Besides a block of pre-standardized business, Company ABC began issuing standard Plan A and Plan F on May 1, 1992. Plan A and Plan F are marketed to individuals on both an agency basis and direct response basis. No business has been issued in Plan A through direct response.

Each year, Company ABC would file three refund forms in each state: In-Force; Plan A; and Plan F (all individual).

Reporting Year 1992

Table 1 presents Company ABC's experience data at the end of 1992. Because this is the year in which the refund provision of the new regulation became effective, no refund filing is required (all first-year business is excluded from the refund calculation).

Reporting Year 1993

Table 2 presents Company ABC's experience data at the end of 1993. **NOTE**: The incurred claims estimates for 1992 are different from Table 1. This is because the incurred claims should be restated based on claim runoff plus an amount for claims not yet paid.

Table 3 represents the benchmark worksheets and Medicare Supplement Refund Calculation Forms that should be filed in State A. There are two pages for each of the three "plans" being filed (In-Force, Plan A and Plan F). Table 3.1 is the benchmark worksheet and Table 3.2 is the Medicare Supplement Refund Calculation Form.

For simplicity of presentation, the filings in State B are not included here. The primary difference from State A is the earlier effective date, which would result in the issues from May 1, 1992, through June 30, 1992, being included with the standardized forms instead of the in-force block.

NOTE: No refund is required for the in-force block, as Ratio 2 exceeds Ratio 1. No refund is required for Plan A, as Ratio 3 exceeds Ratio 1. A refund is required for Plan F (and it exceeds the *de minimus* test).

Reporting Year 1994

Table 4 presents Company ABC's experience data at the end of 1994. **NOTE**: Incurred claims have been restated.

Table 5 presents the benchmark worksheets (Tables 5.1) and Medicare Supplement Refund Calculation Forms (Tables 5.2) that should be filed in State A.

No refund is required for the in-force block, as Ratio 2 exceeds Ratio 1. No refund is required for Plan A, as Ratio 3 exceeds Ratio 1. A refund is again required on Plan F. **NOTE**: This may not have occurred if the annual rate filing had resulted in a premium reduction.

TABLE 1
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1992

Policy Group	Issue Dates	Description	Cal. Yr. Exper. – State A 1992	Cal. Yr. Exper. – State B 1992
Pre-Standardized	All	Earned Premium	5,013,720	7,520,580
		Incurred Claims	3,504,890	5,257,335
		Life Yrs Exposed	5,530	8,295
		Annzd. Prem. IF	4,726,000	7,089,000
Plan A (Indiv)	5/1/92 – 6/30/92*	Earned Premium	70,000	105,000
		Incurred Claims	24,500	36,750
		Life Yrs Exposed	100	150
		Annzd. Prem. IF	140,000	210,000
	7/1/92 – 12/31/92	Earned Premium	141,000	211,500
		Incurred Claims	49,250	73,875
		Life Yrs Exposed	200	300
		Annzd. Prem. IF	281,400	422,100
	Total**	Earned Premium	141,000	316,500
		Incurred Claims	49,250	110,625
		Life Yrs Exposed	200	450
		Annzd. Prem. IF	281,400	632,100
	Total w/o Current Yr	Earned Premium	0	0
		Incurred Claims	0	0
		Life Yrs Exposed	0	0
		Annzd. Prem. IF	0	0
Plan F (Indiv. Agency)	5/1/92 – 6/30/92*	Earned Premium	140,000	210,000
		Incurred Claims	49,000	73,500
		Life Yrs Exposed	200	300
		Annzd. Prem. IF	280,000	420,000
	7/1/92 – 12/31/92	Earned Premium	282,000	423,000
		Incurred Claims	98,500	147,750
		Life Yrs Exposed	400	600
		Annzd. Prem. IF	562,800	844,200
	Total**	Earned Premium	282,000	633,000
		Incurred Claims	98,500	221,250
		Life Yrs Exposed	400	900
		Annzd. Prem. IF	562,800	1,264,200
	Total w/o Current Yr	Earned Premium	0	0
		Incurred Claims	0	0
		Life Yrs Exposed	0	0
		Annzd. Prem. IF	0	0
Plan F (Indiv. Dir. Resp.)	5/1/92 – 6/30/92*	Earned Premium	245,000	367,500
		Incurred Claims	85,750	128,625
		Life Yrs Exposed	350	525
		Annzd. Prem. IF	490,000	735,000

TABLE 1
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1992

Policy Group	Issue Dates	Description	Cal. Yr. Exper. – State A 1992		Cal. Yr. Exper. – State B 1992
	7/1/92 –	Earned Premium	493,500		740,250
	12/31/92	Incurred Claims	172,375		258,563
		Life Yrs Exposed		700	1,050
		Annzd. Prem. IF	984,900		1,477,350
	Total**	Earned Premium	493,500		1,107,750
		Incurred Claims	172,375		387,188
		Life Yrs. Exposed		700	1,575
		Annzd. Prem. IF	984,900		2,212,350
	Total w/o	Earned Premium		0	0
	Current Yr	Incurred Claims		0	0
		Life Yrs Exposed		0	0
		Annzd. Prem. IF		0	0

*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.
**Excludes 5/92–6/92 issues for State A, as those issues are included with the pre-standardized policies.

TABLE 2
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1993

			Cal. Yr. Exper. – State A		Cal. Yr. Exper. – State B	
Policy Group	Issue Dates	Description	1992	1993	1992	1993
Pre-Standardized	All	Earned Premium	5,013,720	4,331,854	7,520,580	6,497,781
		Incurred Claims	3,680,135	3,266,273	5,520,202	4,899,410
		Life Yrs Exposed	5,530	4,424	8,295	6,636
		Annzd. Prem. IF		4,083,264		6,124,896
Plan A (Indiv)	5/1/92 –	Earned Premium	70,000	125,000	105,000	187,500
	6/30/92*	Incurred Claims	25,725	49,150	38,588	73,725
		Life Yrs. Exposed	100	170	150	255
		Annzd. Prem. IF		109,650		164,475
	7/1/92 –	Earned Premium	141,000	251,010	211,500	376,515
	12/31/92	Incurred Claims	49,788	98,885	70,181	148,328
		Life Yrs Exposed	200	342	300	513
		Annzd. Prem. IF		220,620		330,930
	1993	Earned Premium		415,520		623,280
		Incurred Claims		151,704		227,556
		Life Yrs Exposed		530		795
		Annzd. Prem. IF		831,040		1,246,560
	Total**	Earned Premium	141,000	666,530	316,500	1,187,295
		Incurred Claims	46,788	250,589	108,769	449,609
		Life Yrs Exposed	200	872	450	1,563
		Annzd. Prem. IF		1,051,660		1,741,965
	Total w/o	Earned Premium	141,000	251,010	316,500	564,015
	Current Yr	Incurred Claims	46,788	98,885	108,769	222,053
		Life Yrs Exposed	200	342	450	768
		Annzd. Prem. IF		220,620		495,405
Plan F	5/1/92 –	Earned Premium	140,000	250,000	210,000	375,000
(Indiv. Agency)	6/30/92*	Incurred Claims	46,550	99,000	69,825	148,500
		Life Yrs Exposed	200	350	300	525
		Annzd. Prem. IF		220,601		330,902
	7/1/92 –	Earned Premium	282,000	500,000	423,000	750,000
	12/31/92	Incurred Claims	93,575	198,000	140,363	297,000
		Life Yrs Exposed	400	700	600	1,050
		Annzd. Prem. IF		441,202		661,803
	1993	Earned Premium		830,000		1,245,000
		Incurred Claims		375,000		562,500
		Life Yrs Exposed		600		900
		Annzd. Prem. IF		950,000		1,425,000
	Total**	Earned Premium	282,000	1,330,000	633,000	2,370,000
		Incurred Claims	93,575	573,000	210,188	1,008,000
		Life Yrs Exposed	400	1,300	900	2,475
		Annzd. Prem. IF		1,391,202		2,417,705
	Total w/o	Earned Premium	282,000	500,000		1,125,000
	Current Yr	Incurred Claims	93,575	198,000		445,500
		Life Yrs Exposed	400	700		1,575
		Annzd. Prem. IF		441,202		992,705

TABLE 2
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1993

			Cal. Yr. Exper. – State A		Cal. Yr. Exper. – State B	
Policy Group	Issue Dates	Description	1992	1993	1992	1993
Plan F	5/1/92 –	Earned Premium	245,000	430,805	367,500	646,208
(Indiv. Dir. Resp.)	6/30/92*	Incurred Claims	77,175	120,000	115,763	180,000
		Life Yrs Exposed	350	585	525	878
		Annzd. Prem. IF		378,670		568,005
	7/1/92 –	Earned Premium	493,500	874,160	740,250	1,311,240
	12/31/92	Incurred Claims	155,138	325,000	232,706	487,500
		Life Yrs Exposed	700	1,190	1,050	1,785
		Annzd. Prem. IF		768,320		1,152,480
	1993	Earned Premium		1,038,880		1,558,320
		Incurred Claims		379,260		568,890
		Life Yrs. Exposed		1,325		1,988
		Annzd. Prem. IF		2,077,600		3,116,400
	Total**	Earned Premium	493,500	1,913,040	1,107,750	3,515,768
		Incurred Claims	155,138	704,260	348,469	1,236,390
		Life Yrs Exposed	700	2,515	1,575	4,650
		Annzd. Prem. IF		2,845,920		4,836,885
	Total w/o	Earned Premium	493,500	874,160		1,957,448
	Current Yr	Incurred Claims	155,138	325,000		667,500
		Life Yrs Exposed	700	1,190		2,663
		Annzd. Prem. IF		768,320		1,720,485

*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.
**Excludes 5/92–6/92 issues for State A, as those issues are included with the pre-standardized policies.

TABLE 3.1 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1993

TYPE: In-Force SMSBP(p): n/a
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	5,468,720	2.770	15,148,354	0.442	6,695,573	0.000	0	0.000	0	0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			15,148,354		6,695,573		0		0	

Benchmark Ratio Since Inception 0.442

TABLE 3.2 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1993

TYPE: In-Force SMSBP(p): n/a
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

		(a) Earned Premium	(b) Incurred Claims
1.	Current Year's Experience		
	a. Total (all policy years)	5,137, 659	3,534,423
	b. Current year's issues	0	0
	c. Net (1a – 1b)	5,137, 659	3,534,423
2.	Past Year's Experience (all policy years)	5,468,720	3,829,585
3.	Total Experience (1c + 2)	10,606,379	7,364,008
4.	Refunds Last Year (excluding interest)	0	
5.	Previous Since Inception (excluding interest)	0	
6.	Refunds Since Inception (excluding interest)	0	
7.	Benchmark Ratio Since Inception (Ratio 1)	0.442	
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.694	
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	11,709	
10.	Tolerance Permitted (from credibility table)		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11		
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))		The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.

De minimus Amount
(.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

TABLE 3.1 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1993

TYPE:	Individual	SMSBP(p):	Plan A
For the State of:	State A		
Company Name:	Company ABC		
NAIC Group Code:	0001	NAIC Co. Code:	0001
Address:	123 Anystreet, Kansas City, MO		
Person Completing This Exhibit:		John Doe	
Title:	Chief Actuary	Telephone Number:	(123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	141,000	2.770	390,570	0.442	172,632	0.000	0	0.000	0	0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			390,570		172,632		0		0	

Benchmark Ratio Since Inception 0.442

TABLE 3.2 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1993

TYPE: Individual SMSBP(p): Plan A
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

		(a) Earned Premium	(b) Incurred Claims	
1.	Current Year's Experience			
	a. Total (all policy years)	666,530	250,589	
	b. Current year's issues	415,520	151,704	
	c. Net (1a – 1b)	251,010	98,885	
2.	Past Year's Experience (all policy years)	141,000	46,788	
3.	Total Experience (1c + 2)	392,010	145,673	
4.	Refunds Last Year (excluding interest)	0		
5.	Previous Since Inception (excluding interest)	0		
6.	Refunds Since Inception (excluding interest)	0		
7.	Benchmark Ratio Since Inception (Ratio 1)	0.442		
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.372		
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	542		
10.	Tolerance Permitted (from credibility table)	0.150		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)	0.522		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11			
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))			The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.

De minimus Amount
(.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

TABLE 3.1 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1993

TYPE: Individual SMSBP(p): Plan F
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	775,500	2.770	2,148,135	0.442	949,476	0.000	0	0.000	0	0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			2,148,135		949,476		0		0	

Benchmark Ratio Since Inception 0.442

TABLE 3.2 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1993 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1993

TYPE:	Individual	SMSBP(p):	Plan F
For the State of:	State A		
Company Name:	Company ABC		
NAIC Group Code:	0001	NAIC Co. Code:	0001
Address:	123 Anystreet, Kansas City, MO		
Person Completing This Exhibit:		John Doe	
Title:	Chief Actuary	Telephone Number:	(123) 456-0000

		(a) Earned Premium	(b) Incurred Claims	
1.	Current Year's Experience			
	a. Total (all policy years)	3,243,040	1,277,260	
	b. Current year's issues	1,868,880	754,260	
	c. Net (1a – 1b)	1,374,160	523,000	
2.	Past Year's Experience (all policy years)	775,500	248,713	
3.	Total Experience (1c + 2)	2,149,660	771,713	
4.	Refunds Last Year (excluding interest)	0		
5.	Previous Since Inception (excluding interest)	0		
6.	Refunds Since Inception (excluding interest)	0		
7.	Benchmark Ratio Since Inception (Ratio 1)	0.442		
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.359		
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	2,990		
10.	Tolerance Permitted (from credibility table)	0.075		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)	0.434		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11	932,952		
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))	38,908		The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.
	De minimus Amount (.005 x Annualized Prem. IF at 12/31)	6,048		

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

TABLE 4
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1994

			Cal. Yr. Exper. – State A			Cal. Yr. Exper. – State B		
Policy Group	Issue Dates	Description	1992	1993	1994	1992	1993	1994
Pre-Standardized	All	Earned Premium	5,013,720	4,331,854	4,288,536	7,520,580	6,497,781	6,432,803
		Incurred Claims	3,680,135	3,200,948	3,168,938	5,520,202	4,801,422	4,753,408
		Life Yrs Exposed	5,530	4,424	3,982	8,295	6,636	5,972
		Annzd. Prem. IF			3,859,682			5,789,523
Plan A (Indiv)	5/1/92 –	Earned Premium	70,000	125,000	123,750	105,000	187,500	185,625
	6/30/92*	Incurred Claims	25,725	48,167	47,685	38,588	72,251	71,528
		Life Yrs. Exposed	100	170	153	150	255	230
		Annzd. Prem. IF			105,188			157,781
	7/1/92 –	Earned Premium	141,000	251,010	248,500	211,500	376,515	372,750
	12/31/92	Incurred Claims	46,788	96,907	95,938	70,181	145,361	143,907
		Life Yrs Exposed	200	342	308	300	513	462
		Annzd. Prem. IF			211,225			316,837
	1993	Earned Premium		415,520	741,288		623,280	1,111,932
		Incurred Claims		148,670	302,221		223,005	453,332
		Life Yrs Exposed		530	900		795	1,350
		Annzd. Prem. IF			607,856			911,784
	1994	Earned Premium			511,921			767,882
		Incurred Claims			186,899			280,349
		Life Yrs Exposed			583			875
		Annzd. Prem. IF			1,023,840			1,535,760
	Total**	Earned Premium	141,000	666,530	1,501,709	316,500	1,187,295	2,438,188
		Incurred Claims	46,788	245,577	585,058	108,769	440,616	949,115
		Life Yrs Exposed	200	872	1,791	450	1,563	2,916
		Annzd. Prem. IF			1,842,921			2,922,163
	Total w/o	Earned Premium	141,000	666,530	989,788	316,500	1,187,295	1,670,307
	Current Yr	Incurred Claims	46,788	245,577	398,159	108,769	440,616	668,767
		Life Yrs Exposed	200	872	1,208	450	1,563	2,041
		Annzd. Prem. IF			819,081			1,386,403
Plan F	5/1/92 –	Earned Premium	140,000	250,000	247,500	210,000	375,000	371,250
(Indiv. Agency)	6/30/92*	Incurred Claims	46,550	89,100	88,209	69,825	133,650	132,214
		Life Yrs Exposed	200	350	315	300	525	473
		Annzd. Prem. IF			210,375			315,563
	7/1/92 –	Earned Premium	282,000	500,000	495,000	423,000	750,000	742,500
	12/31/92	Incurred Claims	93,575	178,200	176,418	140,363	267,300	264,627
		Life Yrs Exposed	400	700	630	600	1,050	945
		Annzd. Prem. IF			420,750			631,125
	1993	Earned Premium		830,000	1,485,250		1,245,000	2,227,875
		Incurred Claims		337,500	602,100		506,250	903,150
		Life Yrs Exposed		600	450		900	675
		Annzd. Prem. IF			326,125			489,188
	1994	Earned Premium			1,022,100			1,533,150
		Incurred Claims			350,000			525,000
		Life Yrs Exposed			1,150			1,725
		Annzd. Prem. IF			2,050,800			3,076,200
	Total**	Earned Premium	282,000	1,330,000	3,002,350	633,000	2,370,000	4,874,775
		Incurred Claims	93,575	515,700	1,128,518	210,188	907,200	1,825,091
		Life Yrs Exposed	400	1,300	2,230	900	2,475	3,818
		Annzd. Prem. IF			2,797,675			4,512,075

TABLE 4
COMPANY ABC
MEDICARE SUPPLEMENT EXPERIENCE – DECEMBER 31, 1994

Policy Group	Issue Dates	Description	Cal. Yr. Exper. – State A 1992	1993	1994	Cal. Yr. Exper. – State B 1992	1993	1994
	Total w/o Current Yr	Earned Premium	282,000	1,330,000	1,980,250	633,000	2,370,000	3,341,625
		Incurred Claims	93,575	515,700	778,518	210,188	907,200	1,300,091
		Life Yrs Exposed	400	1,300	1,080	900	2,475	2,093
		Annzd. Prem. IF			746,875			1,435,875
Plan F (Indiv. Dir. Resp.)	5/1/92 – 6/30/92*	Earned Premium	245,000	430,805	426,497	367,500	646,208	639,745
		Incurred Claims	77,175	108,000	106,920	115,763	162,000	160,380
		Life Yrs Exposed	350	585	527	525	878	790
		Annzd. Prem. IF			362,522			543,784
	7/1/92 – 12/31/92	Earned Premium	493,500	874,160	865,418	740,250	1,311,240	1,298,128
		Incurred Claims	155,138	292,500	289,575	232,706	438,750	434,363
		Life Yrs Exposed	700	1,190	1,071	1,050	1,785	1,607
		Annzd. Prem. IF			735,606			1,103,408
	1993	Earned Premium		1,038,880	1,854,100		1,558,320	2,781,150
		Incurred Claims		341,334	761,481		512,001	1,142,222
		Life Yrs Exposed		1,325	2,255		1,988	3,383
		Annzd. Prem. IF			1,629,625			2,444,438
	1994	Earned Premium			1,280,420			1,920,630
		Incurred Claims			450,500			675,750
		Life Yrs Exposed			1,458			2,187
		Annzd. Prem. IF			2,560,835			3,841,253
	Total**	Earned Premium	493,500	1,913,040	3,999,938	1,107,750	3,515,768	6,639,653
		Incurred Claims	155,138	633,834	1,501,556	348,469	1,112,751	2,412,714
		Life Yrs. Exposed	700	2,515	4,784	1,575	4,650	7,966
		Annzd. Prem. IF			4,926,066			7,932,882
	Total w/o Current Yr	Earned Premium	493,500	1,913,040	2,719,518	1,107,750	3,515,768	4,719,023
		Incurred Claims	155,138	633,834	1,051,056	348,469	1,112,751	1,736,964
		Life Yrs Exposed	700	2,515	3,326	1,575	4,650	5,779
		Annzd. Prem. IF			2,365,231			4,091,630

*These issues are included with the pre-standardized block for State A and with the standardized plans for State B.
**Excludes 5/92–6/92 issues for State A, as those issues are included with the pre-standardized policies.

TABLE 5.1 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1994

TYPE: In-Force SMSBP(p): n/a
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	0	2.770	0	0.442	0	0.000	0	0.000	0	0.40
2	5,468,720	4.175	22,831,906	0.493	11,256,130	0.000	0	0.000	0	0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			22,831,906		11,256,130		0		0	

Benchmark Ratio Since Inception 0.493

TABLE 5.2 In-Force
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1994

TYPE: In-Force SMSBP(p): n/a
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

		(a) Earned Premium	(b) Incurred Claims
1.	Current Year's Experience		
	a. Total (all policy years)	5,086,282	3,411,753
	b. Current year's issues	0	0
	c. Net (1a – 1b)	5,086,282	3,411,753
2.	Past Year's Experience (all policy years)	10,606,379	7,275,799
3.	Total Experience (1c + 2)	15,692,662	10,687,552
4.	Refunds Last Year (excluding interest)	0	
5.	Previous Since Inception (excluding interest)	0	
6.	Refunds Since Inception (excluding interest)	0	
7.	Benchmark Ratio Since Inception (Ratio 1)	0.493	
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.681	
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	16,685	
10.	Tolerance Permitted (from credibility table)		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11		
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))		The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.

De minimus Amount
(.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 –4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

TABLE 5.1 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1994

TYPE:	Individual	SMSBP(p):	Plan A
For the State of:	State A		
Company Name:	Company ABC		
NAIC Group Code:	0001	NAIC Co. Code:	0001
Address:	123 Anystreet, Kansas City, MO		
Person Completing This Exhibit:		John Doe	
Title:	Chief Actuary	Telephone Number:	(123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	415,520	2.770	1,150,990	0.442	508,738	0.000	0	0.000	0	0.40
2	141,000	4.175	588,675	0.493	290,217	0.000	0	0.000	0	0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			1,739,665		798,955		0		0	

Benchmark Ratio Since Inception 0.459

TABLE 5.2 Plan A
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1994

TYPE: Individual SMSBP(p): Plan A
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

		(a) Earned Premium	(b) Incurred Claims	
1.	Current Year's Experience			
	a. Total (all policy years)	1,501,709	585,058	
	b. Current year's issues	511,921	186,899	
	c. Net (1a – 1b)	989,788	398,159	
2.	Past Year's Experience (all policy years)	807,530	292,365	
3.	Total Experience (1c + 2)	1,797,318	690,524	
4.	Refunds Last Year (excluding interest)	0		
5.	Previous Since Inception (excluding interest)	0		
6.	Refunds Since Inception (excluding interest)	0		
7.	Benchmark Ratio Since Inception (Ratio 1)	0.459		
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.384		
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	2.280		
10.	Tolerance Permitted (from credibility table)	0.100		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)	0.484		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11			
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))			The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.

De minimus Amount
(.005 x Annualized Prem. IF at 12/31)

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

TABLE 5.1 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR 1994

TYPE:	Individual	SMSBP(p):	Plan F
For the State of:	State A		
Company Name:	Company ABC		
NAIC Group Code:	0001	NAIC Co. Code:	0001
Address:	123 Anystreet, Kansas City, MO		
Person Completing This Exhibit:		John Doe	
Title:	Chief Actuary	Telephone Number:	(123) 456-0000

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss Ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss Ratio	(j) (h)x(i)	(o) Policy Yr Loss Ratio
1	1,868,880	2.770	5,176,798	0.442	2,288,145	0.000	0	0.000	0	0.40
2	775,500	4.175	3,237,713	0.493	1,596,192	0.000	0	0.000	0	0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+		4.175		0.493		8.684		0.725		0.77
Total:			8,414,510		3,884,337		0		0	

Benchmark Ratio Since Inception 0.462

TABLE 5.2 Plan F
COMPANY ABC
BENCHMARK/REFUND CALCULATIONS – REPORTING YEAR 1994 (STATE A)

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR 1994

TYPE: Individual SMSBP(p): Plan F
For the State of: State A
Company Name: Company ABC
NAIC Group Code: 0001 NAIC Co. Code: 0001
Address: 123 Anystreet, Kansas City, MO
Person Completing This Exhibit: John Doe
Title: Chief Actuary Telephone Number: (123) 456-0000

		(a) Earned Premium	(b) Incurred Claims	
1.	Current Year's Experience			
	a. Total (all policy years)	7,002,288	2,630,074	
	b. Current year's issues	2,302,520	800,500	
	c. Net (1a – 1b)	4,699,768	1,829,574	
2.	Past Year's Experience (all policy years)	4,018,540	1,398,247	
3.	Total Experience (1c + 2)	8,718,308	3,227,821	
4.	Refunds Last Year (excluding interest)	38,908		
5.	Previous Since Inception (excluding interest)	0		
6.	Refunds Since Inception (excluding interest)	38,908		
7.	Benchmark Ratio Since Inception (Ratio 1)	0.462		
8.	Experienced Ratio Since Inception (Ratio 2) (Line 3, Col. b)/(Line 3, Col. a – Line 6)	0.372		
9.	Life Years Exposed Since Inception If (Line 8 < Line 7) AND (Line 9 > 500), proceed; else stop.	9,321		
10.	Tolerance Permitted (from credibility table)	0.050		
11.	Adjustment to Incurred Claims for Credibility (Ratio 3 = Ratio 2 + Tolerance)	0.422		If Line 11 > Line 7, a refund/credit is not required.
12.	Adjusted Incurred Claims (Line 3, Col. a – Line 6) x Line 11	3,662,707		
13.	Refund (Line 3, Col. a – Line 6 – (Line 12/Line 7))	751,463		The refund is only paid if it exceeds the *De minimus* Amount. The distribution methodology must be filed also.
	De minimus Amount (.005 x Annualized Prem. IF at 12/31)	15,561		

Medicare Supplement Credibility Table	
Life Yrs Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 – 9,999	5.0%
2,500 – 4,999	7.5%
1,000 – 2,499	10.0%
500 – 999	15.0%
If less than 500, no credibility	

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature _____

Name (type) _____

Title _____

Date _____

APPENDIX E
Effective Dates and Loss Ratio Time Periods

When the U.S. Congress enacted OBRA-90, the law included a number of effective dates. The most common effective date for various provisions was the date each state made Model #651 effective (hereafter referred to as the OBRA-90 effective date). The calendar date of this effective date is different in each state. After the OBRA-90 effective date for any particular state, only standardized policies could be issued. Some companies in anticipation of the forthcoming standardized policy requirements began issuing policies prior to the OBRA-90 effective date that would qualify as standardized policies after the OBRA-90 effective date. Other companies continued to issue policies until the OBRA-90 effective date that would not qualify under the standardized criteria. This inconsistency becomes an important issue when considering the loss ratio and the refund requirements.

OBRA-90 also had a November 5, 1991, effective date for application of the new loss ratio and refund requirements. This November 5, 1991, date was independent of the OBRA-90 effective date and applied to any policy issued after November 5, 1991, pre-standardized or standardized, in any state. This made for some inconsistent reporting. States recognized the application of the loss ratio minimums and refund requirements on policies issued after their OBRA-90 effective date, but policies issued after November 5, 1991, and before that state's OBRA-90 effective date fell into a "semi-regulated" category. These policies were semi-regulated because they were subject to the loss ratio and the refund requirements of the federal regulation, but they were not subject to the standardization requirements. In theory, the experience for these policies was supposed to have been reported separately. In practice, however, the experience on these semi-regulated policies was sometimes combined with the standardized experience if the policies would have qualified as standard policies. In other cases, the experience on these semi-regulated policies was ignored because it was too small to be credible or treated as pre-standardized. These problems were recognized and addressed in the technical corrections of SSAA-94. With the adoption of SSAA-94, the November 5, 1991, date was retroactively removed. Instead, the effective date for application of the loss ratio and refund requirements was changed to be the OBRA-90 effective date for each state. Reporting the experience for loss ratio and refund requirements still remains an issue. Technically, after the SSAA-94 effective date, the experience for these semi-regulated policies should be combined with pre-standardized group or pre-standardized individual policies. (SSAA-94 defined two type levels for combining pre-standardized plans for refund purposes: group pre-standardized and individual pre-standardized.) For semi-regulated policies that had already been included with the standardized reporting, it did not seem practical to change experience already reported. This issue is addressed in the compliance manual in Section II, "Effective Dates Issues," under the question, "Is there any flexibility in the effective dates?"

SSAA-94 additionally required the pre-standardized policies to be subject to loss ratio and refund requirements similar to those required for standardized policies. One major difference for pre-standardized policies is that the time period to satisfy the refund and 65%-75% loss ratio requirements does not begin at inception as it does for standardized policy forms. Rather, the time period begins at the SSAA-94 effective date, and pre-standardized policies are treated in the benchmark calculation similar to newly issued policies (beginning with duration 0) even though the policies have actually been in force for some time. These new loss ratio/refund standards are in addition to a lifetime loss ratio requirement. This last requirement is that the lifetime (since inception) loss ratio must meet or exceed the originally filed lifetime loss ratio for that policy.

MIPPA has a single effective date for the change from 1990 SB Plans to 2010 SB Plans. As such, the date a state enacts the 2008 revisions to Model #651 will not be a problem so long as the effective date of the change is June 1, 2010.

MACRA has a single effective date for the changes to which Medicare-eligible individuals may be offered Plan C and Plan F and when Plan D and Plan G replace Plan C and Plan F for open enrollment, etc., for newly eligible individuals on or after January 1, 2020. Also, Plan G (high deductible) is first available January 1, 2020, or such later date the state enacts the 2016 revisions to Model #651.