INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Medicare Supplement Insurance

Adopted Amendments: N.J.A.C. 11:4-23.3 and 23.11

Proposed: June 16, 2003 at 35 N.J.R. 2562

Adopted: June 7, 2004 by Holly C. Bakke, Commissioner, Department of Banking and Insurance

Filed: June 8, 2004 as R.2004 d. 246, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

Authority: N.J.S.A. 17:1-8.1 and 17B:26A-5.

Effective Date: July 6, 2004

Expiration Date: November 30, 2005

Summary of Public Comments and Agency Responses:

The Department of Banking and Insurance received timely comments from one trade association, Health Insurance Association of America and from one insurance company, United American Insurance Company.

COMMENT: One commenter suggested the elimination of the phrase "totally estimated values for incurred claims and earned premiums for periods more than three months from the filing date" from N.J.A.C. 11:4-23.11(c)1. The commenter stated that the rule authorizes the use of estimated values but limits them to periods within three months of the date of filing. The commenter further stated that, as written, the insurer is expected to file incurred claims -- paid plus unpaid and the incurred but not reported -- while these values carry beyond the three month period.

RESPONSE: The comment is correct that "incurred claims" for a period shortly preceding the filing date are based on estimates of claims incurred but unpaid. However, it was not the intent of the rule to prohibit this form of estimation. The rule is revised on adoption to clarify that estimations of incurred claims are not limited to the three-month period.

COMMENT: One commenter objected to the use of the term "policy duration" when describing data on terminations, trend and claims. The commenter stated that, in many cases, average policy duration in a calendar year allows for much more rapid use of more current information, as the actual entire policy year does not need to be completed for all policies.

RESPONSE: As the comment implies, duration data by calendar year can be more current. Further, the Department does not require that duration be defined in a specific way. Therefore, upon adoption, the term "duration" will replace the term "policy duration."

In addition, a typographical error in N.J.A.C. 11:4-23.11(c)5i which resulted in the inclusion of the word "of" instead of the word "or," will be corrected upon adoption. Further, additional text is included upon adoption to emphasize that duration can be calculated in more than one way. Specifically, the phrase "or year of issue" is being added to N.J.A.C. 11:4-23.11(c)5ii, iii, iv and vii.

COMMENT: One comment requested that, as "there is a very realistic chance that Plans H, I and J will be eliminated by federal act at some future date," alternatives to the use of 100% persistency assumption for future years be provided for N.J.A.C. 11:4-23.11(c)5vii.

RESPONSE: It was the intent of the proposal that the 100 percent persistency assumption would not be required if a plan were no longer being sold. The Department anticipates that some future

changes to this rule will be necessary or appropriate in response to recent Federal legislation. However, as such changes would constitute substantial changes requiring proposal and notice, none will be made at this time.

COMMENT: One commenter disagreed with N.J.A.C. 11:4-23.11(c), which prohibits the adjustment of information on a national basis to reflect the difference, if any, between New Jersey rate levels and national rate levels. The commenter cited Section 5.5 of Actuarial Standards of Practice No. 8 (ASOP No. 8), which concerns regulatory filings for rates and financial projections for health plans, and stated that ASOP No. 8 "specifically mentions premium levels as requiring adjustments for any material difference." The commenter further stated that failure to make this adjustment creates a disconnect between New Jersey rates and actual experience. The commenter stated its belief that this failure could perpetuate the overcharging or undercharging of New Jersey residents when New Jersey experience is not a material part of the insurer's nationwide experience.

RESPONSE: The Department respectfully disagrees with this comment. This question was the subject of a case before the New Jersey Office of Administrative Law. In Commissioner's Final Order and Decision, A01-145, dated July 25, 2001, the Commissioner concurred with the finding of the Administrative Law Judge that to adjust national premium to the New Jersey basis would ratify the claim that prior rate relief granted by the Department was inadequate. The Commissioner also accepted the argument of the Department finding that the adjustments to which ASOP No. 8 refers are not geographical adjustments but adjustments which reflect different premium rate levels over time. Further, the Department is aware of no definitive

actuarial guidance stating that such a premium difference between New Jersey and the national average requires such an adjustment.

COMMENT: One commenter objected to the proposed regulation N.J.A.C. 11:4-23.11(g), stating that projected experience should not be used to determine its own credibility. The commenter believed that this could lead to inappropriate premium adjustments by placing reliance on unreliable experience.

RESPONSE: The Department respectfully disagrees with this comment. The comment states that the Department's proposed rule places reliance on unreliable experience. However, the comment does not state a standard for credibility or weighting which is violated by this proposal.

The Department is clarifying an explicit standard for when rates shall be based on New Jersey experience alone. That standard is that 12,000 life years of experience will be developed over the life of the policy. The question was the subject of a case before the New Jersey Office of Administrative Law. The Commissioner's Final Order and Decision, A01-145, dated July 25, 2001 concurred with the finding of the Administrative Law Judge that the rule, as written at that time, should be interpreted to only use past exposure in determining whether to use New Jersey only experience. However, the decision interpreted the existing rule. The Department anticipates that some changes to this rule may be necessary or appropriate in response to recent Federal legislation.

Summary of Agency-Initiated Changes

In order to be consistent with N.J.A.C. 11:4-23.11(c)5ii and iii, the Department is changing the word "sex" found in N.J.A.C. 11:4-23.11(c)5iv,v and vi to "gender."

The word "claim" is being corrected to "claims" in N.J.A.C. 11:4-23.11(c)5ii. In addition, the word "or" is being replaced by "and" in N.J.A.C. 11:4-23.11(c)5ii through iv. This clarification is consistent with the requirement to specify the components which have been used in calculating the anticipated loss ratios and, where applicable, the impact of the various factors listed in subparagraphs (c)5 ii, iii, and iv. This clarification reflects the industry practice of using multiple components for such calculations.

Federal Standards Statement

The adopted amendments comply with and do not exceed the standards or requirements imposed by Federal law concerning Medicare Supplement coverage (42 U.S.C. § 1395ss). Therefore, a Federal standards analysis is not required.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation

(a) - (b) (No change from proposal.)

(c) Every carrier shall submit its rates annually for filing by the Commissioner. A filing for the revision of rates pursuant to (d) below shall satisfy this filing requirement. An annual rate filing shall specify an effective date for use of the rates, which date shall be after the date the filing is made but no later than six months following such date. The filing shall constitute compliance with the annual rate filing requirement for one year from the effective date

for the use of the rates specified in the filing. Each subsequent annual rate filing shall specify an effective date for the use of the rates that is on or before one year from the effective date specified in the previous filing. Supporting documentation, as described below, shall be submitted with the annual rate filing. The supporting documentation shall use reasonable assumptions and shall demonstrate that the anticipated and aggregate loss ratios are at least as great as the originally anticipated loss ratio. The demonstration shall provide the following information and assumptions for each policy form used, and shall do so on a New Jersey basis and, if required by (g) below, on a national basis as well. Information on a national basis shall not be adjusted to reflect the difference, if any, between New Jersey rate levels and national rate levels.

1. For each prior calendar year, or portion of a prior calendar year, in which the policy form has been sold, the carrier shall provide actual or estimated values of paid claims; paid or written premiums (specify which); incurred claims; earned premiums; and months exposed, and shall indicate whether the values provided are actual or estimated values. Estimated values may only be used for periods within three months of the date of the filing ***except for estimates of incurred claims and earned premiums***. If the carrier uses duration-specific trend in projecting future claims or premiums, the data shall be subdivided by year of issue or duration. If the carrier does not use duration-specific trend in projecting future claims or premiums, the data may be subdivided by year of issue or duration at the option of the carrier.

2. - 4. (No change from proposal.)

5. The carrier shall use reasonable assumptions in calculating the anticipated loss ratio, and shall specify the components used, including:

i. Months exposed by year and, at the option of the carrier, duration *****[of]*** *(or*** year of issue***)***;

ii. Paid claim***s*** per month exposed, including the impact, if any, of selection, duration ***(or year of issue)***, age *[or]* ***and*** gender;

iii. Paid or written premium per month exposed, including the impact, if any, of selection, duration***(or year of issue),*** age *[or]* ***and*** gender;

iv. Total termination rates by *[policy]* duration*[and]* ***(or year of issue),*** age *[or]* ***and*** *[sex]* ***gender***, including the impact of mode of premium payment, for the year for which the filing is effective;

v. New business to be issued, by age and *[sex]* ***gender***, for year for which the filing is effective;

vi. Trend factors in paid claims, by *[policy]* duration***(or year of issue)***, age and *[sex]* ***gender***, which trend factors shall only reflect the impact of aging and wear-off of selection after the year for which the filing is effective;

vii. - viii. (No change from proposal.)

6. - 7. (No change from proposal.)

(d) - (g) (No change from proposal.)

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