RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 84c]

Valuation of Life Insurance Policies

The Insurance Department (Department) amends Chapter 84c (relating to valuation of life insurance policies), to read as set forth at 30 Pa.B. 23 (January 1, 2000). The Department is publishing the amendment of the regulation as a final-form rulemaking.

Statutory Authority

The final-form regulation is adopted under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) and section 301(c)(1) and (3) of The Insurance Department Act of 1921 (40 P. S. § 71(c)(1) and (2)) (act).

Comments and Response

A notice of proposed rulemaking was published at 30 Pa.B. 23 with a 30-day comment period ending January 31, 2000. During the 30-day comment period, comments were received from Insurance Federation of Pennsylvania, Inc. (IFP) in favor of the proposal and requesting a retroactive effective date of January 1, 2000.

In preparing the final-form rulemaking, the Department did not modify the effective date as suggested by the IFP, due to concerns about the constitutionality of retroactive application of the amendments. This rulemaking will be effective upon final publication in the *Pennsylvania Bulletin*.

During its regulatory review, the Independent Regulatory Review Commission (IRRC) did not submit comments to the Department.

Affected Parties

The final-form rulemaking applies to all insurers and fraternal benefit societies marketing life insurance policies and who are licensed to do the business of life insurance in this Commonwealth.

Fiscal Impact

State Government

There will be no increase in cost to the Department due to the adoption of the rulemaking. The Department currently reviews valuation filings submitted by domestic life insurance companies and fraternal benefit societies for compliance with the minimum standards of valuation. The select mortality factors and the interpretation of the minimum reserve standard for plans with nonlevel premiums or benefits and for plans with secondary guarantees will not affect the time required to review a valuation filing.

General Public

Consumers will benefit from the advantages of purchasing life insurance from an insurance industry that is establishing sound and reasonable reserves to fulfill contractual obligations. Insurers may increase premium rates for policies sold after May 6, 2000, because of an increase in the required reserves.

Political Subdivisions

Adoption of the rulemaking will not impose additional costs on political subdivisions. Because this rulemaking promotes stability and sound reserves in the insurance industry, political subdivisions' tax revenues may benefit as a result of fewer insurance company insolvencies. Fewer insolvencies may also result in less unemployment.

Private Sector

The specific select factors and the rules for using the segmented reserve valuation method in the rulemaking do not apply to policies issued prior to May 6, 2000. An insurance company may need to increase reserves on policies issued on and after May 6, 2000. The rulemaking does permit an insurance company to recognize the company's specific mortality experience in calculating deficiency reserves. This should ensure that the reserves for a company are sound and reasonable.

Paperwork

The adoption of the rulemaking will not impose additional paperwork on the Department or the insurance industry. The select mortality factors and the interpretation of the minimum reserve standard affect an insurance company's reserve calculation but will not result in additional paperwork.

Effectiveness/Sunset Date

This rulemaking becomes effective upon final publication in the *Pennsylvania Bulletin*. No sunset date has been assigned.

Contact Person

Questions regarding these amendments should be directed to Peter J. Salvatore, Regulatory Coordinator, Office of Special Projects, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429. In addition, questions or comments may be E-mailed to psalvato@ins.state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on December 21, 1999, the Department submitted a copy of the notice of proposed rulemaking, published at 30 Pa.B. 23 to IRRC and to the Chairpersons of the Senate Banking and Insurance Committee and the House Insurance Committee for review and comment. In addition to the submitted proposal, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." A copy of that material is available to the public upon request.

In preparing this final-form rulemaking, the Department considered all comments received from IRRC, the Committees and the public. This final-form rulemaking was approved by the Senate and House Committees on April 4, 2000. In accordance with 5(g) of the Regulatory Review Act, IRRC met on April 13, 2000, and the final-form rulemaking was deemed approved.

Findings

The Department finds that:

(1) Public notice of intention to adopt this rulemaking as amended by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No.

240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of this rulemaking in the manner provided in this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Commissioner, acting under the authorizing statutes, orders that:

(1) The regulations of the Department, 31 Pa. Code, are amended by adding §§ 84c.1—84c.7 and Appendix A to read as set forth at 30 Pa.B. 23.

(2) The Commissioner shall submit this order and 30 Pa.B. 23 to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(3) The Commissioner shall certify this order and 30 Pa.B. 23 and deposit them with the Legislative Reference Bureau as required by law.

(4) The order shall take effect upon final publication in the *Pennsylvania Bulletin*.

(*Editor's Note*: A correction to the proposed rulemaking was published at 30 Pa.B. 312 (January 15, 2000) replacing § 84c.4(b)(1)(i) with corrected text.)

M. DIANE KOKEN,
Insurance Commissioner

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 30 Pa.B. 2176 (April 29, 2000).)

Fiscal Note: Fiscal Note 11-196 remains valid for the final adoption of the subject regulations.

[Pa.B. Doc. No. 00-740. Filed for public inspection May 5, 2000, 9:00 a.m.]

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

The Insurance Department (Department) amends § 89.790 and Appendix E and adopts § 89.777a, to read as set forth in Annex A. The Department adopts the amendments under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412).

Purpose

Chapter 89, Subchapter K (relating to Medicare Supplement Insurance minimum standards), was initially promulgated to establish certain minimum standards for Medicare Supplement Insurance. The Department has modified Subchapter K to allow for the sale of "Medicare Select" products (previously a Federal pilot program) which is intended to expand the health care choices of Medicare eligible insureds. Generally, Medicare Select will allow consumers to purchase Medicare Select products for lower premiums than standard Medicare supplement policies. The major difference between standard Medicare supplement policies and Medicare Select policies is that each Medicare Select issuer will have a network of specific hospitals, and possibly specific doctors, that must be utilized to receive full benefits, except in the case of an emergency. It is similar in concept to preferred provider organizations (PPOs) for accident and health insurance. However, Medicare Select policies are not PPO policies and are not subject to section 630 of The Insurance Company Law of 1921 (40 P. S. § 764a). In addition, because Medicare Select policies do not meet the definition of "managed care plans" in Act 68 of 1998 (40 P. S. §§ 991.2101—991.2193), the provisions of that act, including those relating to complaints and grievances, do not apply to Medicare Select policies. This Commonwealth is one of the few remaining states that has not authorized the sale of the Medicare Select products. The Department believes this puts consumers and issuers at a competitive disadvantage in comparison with neighboring states. The Department has received numerous inquiries and letters of support for Medicare Select from consumers, the insurance industry and providers alike. The Department has also clarified and revised language to improve the readability and understandability of the regulations.

Comments and Response

Notice of proposed rulemaking was published at 29 Pa.B. 650 (February 6, 1999) as a proposed rulemaking with a 30-day public comment period. No comments were received from the public or the insurance industry.

On April 8, 1999, the Independent Regulatory Review Commission (IRRC) responded with comments.

IRRC noted that the amendments were not clear regarding what constitutes a complaint, how complaints are to be distinguished from grievances, and the procedures an insurer must follow when a complaint is received. IRRC also commented that the definition of "complaint" in § 89.777a(c)(1) does not provide a clear distinction between a complaint and a grievance.

Complaints are more general and less formal than grievances. Grievances are more formal and focused on the administration, claims practices or provision of services of a Medicare Select issuer or its network providers. The Department believes that both complaints and grievances need to be included in the amendments. Based on its review of this comment, the Department revised the definition to clarify that a complaint can be expressed "orally or in writing" and can be filed by an individual "insured under a Medicare Select policy or certificate."

IRRC commented that subsection (f)(3) requires a Medicare Select issuer to provide a description of the grievance procedure. It questioned why there was not a similar requirement for complaints.

The Department agrees and a new subsection (f)(4) has been added requiring that Medicare Select issuers provide a description of the complaint procedure to be utilized.

IRRC further commented that the scope of subsection (f)(7), which required a proposed plan to contain "other information requested by the Commissioner," was too broad and should be narrowed to information pertinent to the plan of operation.

The Department agrees and subsection (f)(7) has been renumbered as subsection (f)(8) and revised to include that the other information requested by the Commissioner shall be "pertinent to the plan of operation."

IRRC commented that the requirements for hearing complaints and resolving written grievances in subsection (l)(1)—(6) should apply to both complaints and grievances.

The Department agrees and subsection (l)(1)—(5) have been revised to include these requirements for both complaints and grievances. Subsection (l)(6) has not been revised to include complaints. Because complaints are a less formal process than grievances and can be expressed orally, the Department believes it would be an unnecessary regulatory burden to require issuers to track and formally report on complaints to the Department. The Department has the authority under the examination law to review insurers' files. Examinations can be performed at any time to determine if an insurer is properly classifying complaints and grievances if the Department determines that an examination is necessary.

IRRC further commented regarding subsection (l) that the Department should require issuers to explain how an individual may initiate a complaint or grievance.

The Department believes that this issue is addressed by the proposed language in subsection (l)(2).

IRRC further commented on the timeframes for consideration of and notification to concerned parties in subsection (l)(3)—(5). IRRC was concerned that this subsection does not provide clear guidance for when the actions are expected to occur.

Medicare Select is a Medicare supplement product that pays after Medicare pays based on Medicare's benefit determination and the use of participating Medicare Select providers. Time frames for the consideration of complaints and grievances have been added. The time frames for action by the issuer do not start until after a benefit determination has been made by Medicare. The Department has clarified this in subsection (l)(3)—(5).

Persons Regulated

These amendments apply to all insurance companies that issue Medicare Supplement products in this Commonwealth and that choose to offer Medicare Select policies.

Fiscal Impact

The Department currently has the capacity to review the new Medicare Select filings in the course of normal business and should experience minimal or no cost increases in reviewing these new products.

The insurance industry will incur minimal additional costs in filing for the approval of the new forms, if they choose to offer Medicare Select products. Most issuers should be able to submit forms either identical, or very similar to, variations approved in other states because these amendments are adopting the NAIC model language.

Consumers could experience additional savings based on greater product availability.

Paperwork

Adoption of these amendments will require additional paperwork in the product development area only if issuers choose to market Medicare Select products. Paperwork requirements should not be burdensome for the Department because the new Medicare Select products can be reviewed during the normal course of business.

Effectiveness/Sunshine Date

This rulemaking will become effective upon final adoption and publication in the *Pennsylvania Bulletin* as final rulemaking. No sunset date has been assigned.

Contact Person

Questions or comments regarding this final-form rulemaking may be addressed to Peter J. Salvatore, Regulatory Coordinator, Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429. Questions and comments may also be E-mailed to psalvato@ins.state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on January 27, 1999, the Department submitted a copy of the proposed rulemaking, published at 29 Pa.B. 650, to IRRC and to the Chairpersons of the Senate Committee on Banking and the Insurance and the House Insurance Committee. In addition to the submitted proposed rulemaking, the Department has provided IRRC and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the Department in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." Under section 5(c) of the Regulatory Review Act, the Department also provided IRRC and the Committees with copies of the comments received. In preparing these final-form regulations, the Department has considered all comments from IRRC, the Committees and the public. A copy of that material is available to the public upon request.

These final-form regulations were deemed approved by the Senate Committee on Banking and Insurance and the House Insurance Committee on March 28, 2000, in accordance with section 5.1(d) of the Regulatory Review Act (71 P. S. § 745.5a(d)). IRRC met on April 13, 2000, and approved the final-form regulations in accordance with section 5.1(e) of the Regulatory Review Act.

Findings

The Department finds that:

(1) Public notice of intention to adopt this rulemaking as amended by this order has been given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) The adoption of this rulemaking in the manner provided for in this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Department, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 31 Pa. Code Chapter 89, are amended by amending § 89.790 and Appendix E; and adding § 89.777a to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Commissioner shall submit this order and Annex A to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(c) The Commissioner shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) The amendments adopted by this order shall take effect publication in the *Pennsylvania Bulletin*.

M. DIANE KOKEN,
Insurance Commissioner

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 30 Pa.B. 2176 (April 29, 2000).

Fiscal Note: Fiscal Note 11-193 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

§ 89.777a. Medicare Select policies and certificates.

(a) This section applies to Medicare Select policies and certificates, as defined in this section.

(b) A policy or certificate may not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(c) For the purposes of this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Complaint—Dissatisfaction expressed orally or in writing by an individual insured under a Medicare Select policy or certificate concerning a Medicare Select issuer or its network providers.

Grievance—Dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate concerning the administration, claims practices or provision of services with a Medicare Select issuer or its network providers.

Medicare Select issuer—An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

Medicare Select policy or *Medicare Select certificate*—A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

Network provider—A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

Restricted network provision—A provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Service area—The geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(d) The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, under this section, and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (42 U.S.C.A. § 1395b-2) if the Commissioner finds that the issuer has satisfied the requirements of this section.

(e) A Medicare Select issuer may not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Commissioner.

(f) A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(ii) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, to either:

(A) Deliver adequately all services that are subject to a restricted network provision.

(B) Make appropriate referrals.

(iii) There are written agreements with network providers describing both parties' specific responsibilities.

(iv) Emergency care is available 24 hours per day and 7 days per week.

(v) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the complaint procedure to be utilized.

(5) A description of the quality assurance program, including the following:

(i) The formal organizational structure.

(ii) The written criteria for selection, retention and removal of network providers.

(iii) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(6) A list and description, by specialty, of the network providers.

(7) Copies of the written information proposed to be used by the issuer to comply with subsection (j).

(8) Other information pertinent to the plan of operation requested by the Commissioner.

(g) A Medicare Select issuer shall file:

(1) Proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers with the Commissioner at least quarterly, if changes occur.

(h) A Medicare Select policy or certificate may not restrict payment for covered services provided by non-network providers if the following apply:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.

(2) It is not reasonable to obtain services through a network provider.

(i) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(j) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(i) Medicare supplement policies or certificates offered by the issuer.

(ii) Other Medicare Select policies or certificates.

(2) A description, including the address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase another Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(k) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (j) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(l) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The complaint and grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a complaint or grievance may be registered with the issuer.

(3) Complaints and grievances shall be considered within 45 days. If a benefit determination by Medicare is necessary, the 45-day review period may not begin until after the Medicare determination has been made. The complaint or grievance shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a complaint or grievance is found to be valid, corrective action shall be taken within 45 days.

(5) The concerned parties shall be notified about the results of a complaint or grievance within 45 days of the decision.

(6) The issuer shall report by March 31 to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of the grievances.

(m) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(n) For purposes of this section the following apply:

(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for 6 months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(o) Medicare Select policies and certificates shall provide for continuation of coverage in the event the United States Department of Health and Human Services Secretary determines that Medicare Select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(p) A Medicare Select issuer shall comply with reasonable requests for data made by State or Federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

§ 89.790. Guaranteed issue for eligible persons.

* * * * *

(b) *Eligible persons*. An eligible person is an individual described in paragraphs (1)—(6):

* * * * *

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan within 12 months after the effective date of enrollment.

* * * * *

APPENDIX E

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR ______________

TYPE [1] ______________ SMSBP [2] ______________

For the State of ______________

Company Name ______________

NAIC Group Code ______________ NAIC Company Code ______________

Person Completing This Exhibit ______________

Title ______________ Telephone Number ______________

		(a) Earned Premium [3]	*(b) Incurred Claims* [4]
1	Current Year's Experience		
	a. Total (all policy years)	______	______
	b. Current year's issues [5]	______	______
	c. Net (for reporting purposes = 1a - 1b)	______	______
2	Past Years' Experience (All Policy Years)	______	______
3	Total Experience (Net Current Year + Past Years' Experience)	______	______
4	Refunds Last Year (Excluding Interest)	______	
5	Previous Since Inception (Excluding Interest)	______	
6	Refunds Since Inception (Excluding Interest)	______	
7	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)	______	
8	Experienced Ratio Since Inception (Ratio 2)	______	

$$\text{Ratio 2} = \frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6)}}$$

9	Life Years Exposed Since Inception	______	

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10	Tolerance Permitted (obtained from credibility table)	______	
11	Adjustment to Incurred Claims for Credibility (Ratio 3)	______	

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =

(Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6)) x Ratio 3 (line 11)

13 Refund = Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) -
{Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1) (line 7)}

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premium to be used must be attached to this form.

MEDICARE SUPPLEMENT CREDIBILITY TABLE

Life Years 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.

[1] Individual Group, Individual Medicare Select, and Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized plans.
[3] Includes modal loadings and fees charged.
[4] Excludes Active Life Reserves.
[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

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

____
Signature

____
Name—Please Type

____
Title

____
Date

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

TYPE [1] ______________________ SMSBP [2] ______________________

For the State of ______________________

Company Name ______________________

NAIC Group Code ______________________ NAIC Company Code ______________________

Person Completing This Exhibit

Title ______________________ Telephone Number ______________________

(a)[3]	(b)[4] 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)[5] Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		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:		(k):		(l):		(m):		(n):		

Benchmark ratio since inception (Ratio 1): (l + n)/(k + m):

[1] Individual Group, Individual Medicare Select, and Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized plans.

[3] Year 1 is the current calendar year—1
Year 2 is the current calendar year—2 (etc.)
(Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR __________

TYPE [1] ____________________ SMSBP [2] ____________________

For the State of ____________________

Company Name ____________________

NAIC Group Code ____________________ NAIC Company Code

Person Completing This Exhibit ____________________

Title ____________________ Telephone Number ____________________

(a)[3]	(b)[4] 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)[5] Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark ratio since inception (Ratio 1): (l + n)/(k + m):

[1] Individual, Group, Individual Medicare Select, and Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized plans.
[3] Year 1 is the current calendar year—1
Year 2 is the current calendar year—2 (etc.)
(Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[5] These loss ratios are not explicitly used in computing the benchmark loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

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