| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *UHLC-128612421* | ***State Tracking #:*** | | ***Company Tracking #:*** | *RERATE 2013 - PRE -STD* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *UnitedHealthcare Insurance Company* |
| ***TOI/Sub-TOI:*** | *MS02G Group Medicare Supplement - Pre-Standardized/MS02G.000 Medicare Supplement - Pre-Standardized* | | |
| ***Product Name:*** | *GROUP MEDICARE SUPPLEMENT PRE-STANDARDIZED PLANS* | | |
| ***Project Name/Number:*** | *RATE/RERATE 2013 - PRE -STD* | | |

## Rate Information

Rate data applies to filing.

| | |
|---|---|
| **Filing Method:** | SERFF |
| **Rate Change Type:** | Increase |
| **Overall Percentage of Last Rate Revision:** | 0.000% |
| **Effective Date of Last Rate Revision:** | 01/01/2012 |
| **Filing Method of Last Filing:** | SERFF |

### Company Rate Information

| Company Name: | Overall % Indicated Change: | Overall % Rate Impact: | Written Premium Change for this Program: | # of Policy Holders Affected for this Program: | Written Premium for this Program: | Maximum % Change (where req'd): | Minimum % Change (where req'd): |
|---|---|---|---|---|---|---|---|
| UnitedHealthcare Insurance Company | 2.500% | 2.500% | $8,910 | 200 | $495,474 | 2.600% | 0.000% |

| | | | | | |
|---|---|---|---|---|---|
| ***SERFF Tracking #:*** | *UHLC-128612421* | ***State Tracking #:*** | | ***Company Tracking #:*** | *RERATE 2013 - PRE -STD* |

| | | | |
|---|---|---|---|
| ***State:*** | *District of Columbia* | ***Filing Company:*** | *UnitedHealthcare Insurance Company* |
| ***TOI/Sub-TOI:*** | *MS02G Group Medicare Supplement - Pre-Standardized/MS02G.000 Medicare Supplement - Pre-Standardized* | | |
| ***Product Name:*** | *GROUP MEDICARE SUPPLEMENT PRE-STANDARDIZED PLANS* | | |
| ***Project Name/Number:*** | *RATE/RERATE 2013 - PRE -STD* | | |

## Rate/Rule Schedule

| Item No. | Schedule Item Status | Document Name | Affected Form Numbers (Separated with commas) | Rate Action* | Rate Action Information | Attachments |
|---|---|---|---|---|---|---|
| 1 | | Rate Schedule and Rate Attachments | G-26000-4 | New | | DC Rate Schedule (Pre).pdf<br>DC 2013 Attachments (Pre).pdf |

UNITEDHEALTHCARE INSURANCE COMPANY
AARP MEDICARE SUPPLEMENT PORTFOLIO

**RATE SCHEDULE**

FOR

**DISTRICT OF COLUMBIA**

GROUP POLICY NUMBER G-36000-4

| Plan | Proposed 2013 Monthly Rate | 2012 Monthly Rate | Diff. (%) |
|---|---|---|---|
| M1/J1/P1 | $110.50 | $107.75 | 2.6% |
| M2/J2/P2/MC/MH/MM/MS/DA/DB | $179.50 | $175.00 | 2.6% |
| M3/J3/P3 (with drugs) | $253.50 | $247.25 | 2.5% |
| M3/J3/P3 (without drugs) | $214.25 | $209.00 | 2.5% |
| M4 (with drugs) | $317.75 | $310.00 | 2.5% |
| M4 (without drugs) | $279.50 | $272.50 | 2.6% |
| M5/J5/P5 | $146.50 | $142.75 | 2.6% |
| M6/J6/P6/DC/DE/DF | $200.25 | $195.25 | 2.6% |
| M7/P7 (with drugs) | $300.00 | $292.50 | 2.6% |
| M7/P7 (without drugs) | $261.00 | $254.50 | 2.6% |
| MA/PA | $129.25 | $126.00 | 2.6% |
| AD/DP | $4.00 | $4.00 | 0.0% |

** Discounts available for Multi-Insured, Electronic Funds Transfer, and Annual Pay.*

# UNITEDHEALTHCARE INSURANCE COMPANY

## PRE-STANDARDIZED MEDICARE SUPPLEMENT RATE FILING

## GROUP POLICY NUMBER G-36000-4

## District of Columbia

## EFFECTIVE 1/1/2013

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6. Attachment 4 – Average Annualized Premiums (1 page)
7. Attachment 5 – Rate History (1 page)
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9. Attachment 7 – Benefit Description Charts (5 pages)
10. Attachment 8 – Trend Development (1 page)
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August 2012

**DISTRICT OF COLUMBIA - LOSS RATIO PROJECTIONS**

Company: UnitedHealthcare Insurance Company
Policy Form: G-36000-4 Pre-Standardized Plans*

**TOTAL PRE-STANDARDIZED**

**HISTORICAL EXPERIENCE**

| | Premium | Incurred Claims | Loss Ratio | Average Lives |
|---|---|---|---|---|
| 1994 | $2,510,668 | $2,751,399 | 109.6% | 3,718 |
| 1995 | $2,387,423 | $2,414,334 | 101.1% | 3,282 |
| 1996 | $2,683,000 | $2,072,129 | 77.2% | 2,673 |
| 1997 | $2,549,486 | $2,248,828 | 88.2% | 2,275 |
| 1998 | $2,493,764 | $1,880,819 | 75.4% | 1,907 |
| 1999 | $2,293,926 | $1,691,808 | 73.8% | 1,631 |
| 2000 | $2,094,603 | $1,561,607 | 74.6% | 1,450 |
| 2001 | $1,882,096 | $1,671,509 | 88.8% | 1,297 |
| 2002 | $1,613,193 | $1,697,431 | 105.2% | 1,108 |
| 2003 | $1,547,431 | $1,427,835 | 92.3% | 987 |
| 2004 | $1,501,656 | $1,259,971 | 83.9% | 845 |
| 2005 | $1,392,619 | $1,233,303 | 88.6% | 734 |
| 2006 | $1,195,415 | $1,112,493 | 93.1% | 636 |
| 2007 | $1,107,520 | $1,000,247 | 90.3% | 552 |
| 2008 | $951,933 | $745,283 | 78.3% | 453 |
| 2009 | $844,099 | $634,811 | 75.2% | 383 |
| 2010 | $776,534 | $561,297 | 72.3% | 331 |
| 2011 | $670,577 | $510,098 | 76.1% | 278 |
| 2012 | $576,820 | $449,149 | 77.9% | 238 |
| Total Historical | $31,072,762 | $26,924,352 | 86.6% | n/a |
| With Interest | $56,776,286 | $49,717,838 | 87.6% | n/a |

**PROJECTED EXPERIENCE - WITH 2013 RATE CHANGE**

| | Premium | Incurred Claims | Loss Ratio | Average Lives |
|---|---|---|---|---|
| 2013 | $493,622 | $392,090 | 79.4% | 200 |
| 2014 | $453,854 | $358,174 | 78.9% | 174 |
| 2015 | $414,596 | $327,192 | 78.9% | 151 |
| 2016 | $378,733 | $298,890 | 78.9% | 132 |
| 2017 | $345,973 | $273,036 | 78.9% | 115 |
| 2018 | $316,046 | $249,418 | 78.9% | 100 |
| 2019 | $288,708 | $227,844 | 78.9% | 87 |
| 2020 | $263,735 | $208,135 | 78.9% | 76 |
| 2021 | $240,922 | $190,132 | 78.9% | 66 |
| 2022 | $220,082 | $173,685 | 78.9% | 57 |
| Total Projected | $3,416,271 | $2,698,597 | 79.0% | n/a |
| Discounted with Interest | $2,799,997 | $2,212,183 | 79.0% | n/a |

**PROJECTED EXPERIENCE - WITHOUT 2013 RATE CHANGE**

| | Premium | Incurred Claims | Loss Ratio | Average Lives |
|---|---|---|---|---|
| Total Projected | $3,336,076 | $2,698,597 | 80.9% | n/a |
| Discounted with Interest | $2,734,759 | $2,212,183 | 80.9% | n/a |

**LIFETIME EXPERIENCE - WITH 2013 RATE CHANGE**

| | Premium | Incurred Claims | Loss Ratio | Average Lives |
|---|---|---|---|---|
| Total Lifetime | $34,489,033 | $29,622,949 | 85.9% | n/a |
| Discounted with Interest | $59,576,283 | $51,930,021 | 87.2% | n/a |

*Excludes AD/DP Experience.

# District Of Columbia
# Pre-Standardized Medicare Supplement Exhibit

**Total**

| Calendar Year | Incurred Claims | Earned Premiums | Loss Ratio | Average Lives |
|---|---|---|---|---|
| **1994** | 2,760,077 | 2,552,290 | 108.1% | 3,718 |
| **1995** | 2,420,396 | 2,412,676 | 100.3% | 3,282 |
| **1996** | 2,079,751 | 2,704,982 | 76.9% | 2,673 |
| **1997** | 2,252,338 | 2,568,098 | 87.7% | 2,275 |
| **1998** | 1,886,669 | 2,510,203 | 75.2% | 1,907 |
| **1999** | 1,693,488 | 2,308,175 | 73.4% | 1,631 |
| **2000** | 1,568,537 | 2,107,349 | 74.4% | 1,450 |
| **2001** | 1,674,509 | 1,893,557 | 88.4% | 1,297 |
| **2002** | 1,701,091 | 1,623,295 | 104.8% | 1,108 |
| **2003** | 1,429,275 | 1,556,289 | 91.8% | 987 |
| **2004** | 1,260,541 | 1,509,299 | 83.5% | 845 |
| **2005** | 1,234,053 | 1,399,021 | 88.2% | 734 |
| **2006** | 1,113,783 | 1,201,123 | 92.7% | 636 |
| **2007** | 1,000,247 | 1,112,348 | 89.9% | 552 |
| **2008** | 745,283 | 956,119 | 77.9% | 453 |
| **2009** | 634,811 | 847,792 | 74.9% | 383 |
| **2010** | 562,497 | 779,480 | 72.2% | 331 |
| **2011** | 510,232 | 672,948 | 75.8% | 278 |

**Pre-Standardized Plans 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.*

***Includes AD/DP experience.*

**PRE-STANDARDIZED PLANS**
**DISTRICT OF COLUMBIA BENEFIT COSTS**

| | Per Member Per Month Costs* | | | | | |
|---|---|---|---|---|---|---|
| | 2008 | 2009 | 2010 | 2011 | Proj 2012 | Proj 2013 |
| Part B | $88.80 | $91.10 | $96.69 | $103.23 | $103.80 | $107.60 |
| Part A | $46.30 | $44.86 | $43.07 | $48.29 | $51.89 | $54.27 |
| Prescription Drugs | $28.67 | $31.77 | $26.84 | $21.84 | $25.08 | $25.01 |
| Other | $0.07 | $0.01 | $0.10 | $0.00 | $0.09 | $0.10 |
| Total PMPM Cost** | $137.25 | $138.15 | $141.83 | $153.04 | $157.45 | $163.65 |
| *Trend* | | *0.7%* | *2.7%* | *7.9%* | *2.9%* | *3.9%* |

*"Other" includes foreign care and/or private duty nursing benefits.*

** The per member per month claim costs are equal to the incurred claims divided by the number of lives with that specific benefit.*

*** Beginning in 2006, some insureds enrolled in plans that offer prescription drug coverage will not have the drug benefit.*

# District Of Columbia Average Annualized Premiums*

| Plan | Proposed 2013 | 2012 |
|---|---|---|
| M1/J1/P1 | $1,300 | $1,270 |
| M2/J2/P2/MC/MH/MM/MS/DA/DB | $2,123 | $2,075 |
| M3/J3/P3 | $2,636 | $2,573 |
| M4 | - | - |
| M5/J5/P5 | $1,728 | $1,688 |
| M6/J6/P6/DC/DE/DF | $2,370 | $2,313 |
| M7/P7 | $3,146 | $3,070 |
| MA/PA | $1,524 | $1,488 |
| AD/DP | $48 | $47 |

**Average premiums are net of discounts.*

**District Of Columbia**
**Pre-Standardized Plans Rate History**

| | 1/2008 | 1/2009 | 1/2010 | 1/2011 | 1/2012* | Proposed 1/2013** | 2009/2008 | 2010/2009 | 2011/2010 | 2012/2011* | Proposed 2013/2012** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **M1/J1/P1** | $95.50 | $99.50 | $105.00 | $107.75 | $107.75 | $110.50 | 4.2% | 5.5% | 2.6% | 0.0% | 2.6% |
| **M2/J2/P2/MC/MH/MM/MS/DA/DB** | $155.25 | $161.75 | $170.50 | $175.00 | $175.00 | $179.50 | 4.2% | 5.4% | 2.6% | 0.0% | 2.6% |
| **M3/J3/P3 (with drugs)** | $219.00 | $228.25 | $240.75 | $247.25 | $247.25 | $253.50 | 4.2% | 5.5% | 2.7% | 0.0% | 2.5% |
| **M3/J3/P3 (without drugs)** | $185.50 | $193.25 | $203.75 | $209.00 | $209.00 | $214.25 | 4.2% | 5.4% | 2.6% | 0.0% | 2.5% |
| **M4 (with drugs)** | $275.00 | $286.50 | $302.00 | $310.00 | $310.00 | $317.75 | 4.2% | 5.4% | 2.6% | 0.0% | 2.5% |
| **M4 (without drugs)** | $241.50 | $251.75 | $265.50 | $272.50 | $272.50 | $279.50 | 4.2% | 5.5% | 2.6% | 0.0% | 2.6% |
| **M5/J5/P5** | $126.50 | $131.75 | $139.00 | $142.75 | $142.75 | $146.50 | 4.2% | 5.5% | 2.7% | 0.0% | 2.6% |
| **M6/J6/P6/DC/DE/DF** | $173.25 | $180.50 | $190.25 | $195.25 | $195.25 | $200.25 | 4.2% | 5.4% | 2.6% | 0.0% | 2.6% |
| **M7/P7 (with drugs)** | $259.25 | $270.25 | $285.00 | $292.50 | $292.50 | $300.00 | 4.2% | 5.5% | 2.6% | 0.0% | 2.6% |
| **M7/P7 (without drugs)** | $225.75 | $235.25 | $248.00 | $254.50 | $254.50 | $261.00 | 4.2% | 5.4% | 2.6% | 0.0% | 2.6% |
| **MA/PA** | $111.75 | $116.50 | $122.75 | $126.00 | $126.00 | $129.25 | 4.3% | 5.4% | 2.6% | 0.0% | 2.6% |
| **AD/DP** (Recuperation Care Rider) | $4.00 | $4.00 | $4.00 | $4.00 | $4.00 | $4.00 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

* The 2012 rates were deferred until April 1, 2012.

** We are proposing to defer the implementaion of the 2013 rate changes to April 1, 2013.

Attachment 5

# District Of Columbia Average Lives

| Plan | 2013 | 2012 |
|---|---|---|
| M1/J1/P1 | 7 | 8 |
| M2/J2/P2/MC/MH/MM/MS/DA/DB | 13 | 16 |
| M3/J3/P3 | 40 | 47 |
| M4 | - | - |
| M5/J5/P5 | 3 | 3 |
| M6/J6/P6/DC/DE/DF | 78 | 97 |
| M7/P7 | 45 | 53 |
| MA/PA | 13 | 16 |
| AD/DP | 39 | 45 |

# National Average Lives

| Plan | 2013 | 2012 |
|---|---|---|
| M1/J1/P1 | 2,889 | 3,458 |
| M2/J2/P2/MC/MH/MM/MS/DA/DB | 6,601 | 8,338 |
| M3/J3/P3 | 14,428 | 17,496 |
| M4 | 132 | 153 |
| M5/J5/P5 | 2,604 | 3,088 |
| M6/J6/P6/DC/DE/DF | 83,768 | 101,682 |
| M7/P7 | 13,566 | 16,139 |
| MA/PA | 6,355 | 7,384 |
| AD/DP | 11,018 | 13,338 |

| Service | Benefit | AARP's Medicare Supplement (M1, P1, J1) | AARP's Medicare Supplement Plus (M2,P2,J2) |
|---|---|---|---|
| **HOSPITAL EXPENSES** (for covered expenses each benefit period*) semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes lab tests, diagnostic x-rays, meals, special care units, drugs, medical supplies, operating and recovery room, anesthesia and rehabilitation services. | Days 1 through 60 | Actual charges up to $297 | Actual charges up to $1188 |
| | Days 61 through 90 | to $297/day | to $297/day |
| | Days 91 and after when using a Lifetime Reserve Day | $594/day | $594/day |
| | Days 91 and after when LTR's are available but not used | $594/day for up to 60 days | $594/day for up to 60 days |
| | Days 91 and after when all 60 LTR's have been used | 100% of Medicare eligible expenses (unlimited # of days) | 100% of Medicare eligible expenses (unlimited # of days) |
| **SKILLED NURSING FACILITY STAYS** (for covered services each benefit period*) in a facility approved by Medicare. Insured must have been in a hospital for at least 3 days and enter SNF within 30 days after hospital discharge- same condition. | Days 1 through 20 | No benefit | No benefit |
| | Days 21 through 100 | $148.50/day | $148.50/day |
| | Days 101 through 365 | $297/day | $297/day |
| **MEDICAL CARE** (for covered expenses each calendar year) Physician services, medical services and supplies, physical and speech therapy, ambulance, etc. | In-Hospital and Out of Hospital | 20% of Medicare eligible expenses not paid in full by Medicare after a $200 medical deductible** | 20% of Medicare eligible expenses not paid in full by Medicare after a $200 medical deductible** |
| **IN-HOSPITAL PRIVATE DUTY NURSING CARE** | In-Hospital Care by an RN or LPN | RN-actual charges up to $30 per 8hr shift. LPN-actual charges up to $25 per 8hr shift. MAX.- 3 shifts/day; 60 shifts/benefit pd. | RN-actual charges up to $30 per 8hr shift. LPN-actual charges up to $25 per 8hr shift. MAX.- 3 shifts/day; 60 shifts/benefit pd. |
| **BLOOD** - 1st 3 pints of blood or equivalent quantity of packed red blood cells. | | The reasonable cost under Parts A and B | The reasonable cost under Parts A and B |
| **PRESCRIPTION DRUGS** | Purchased Out-of-Hospital and outside of a SNF | No benefit | No benefit |
| **FOREIGN HOSPITAL & MEDICAL CARE** Hospital, physician and medical services received in a foreign country which are of a type considered eligible when provided in the U.S. | Days 1 through 60 of each trip period (1) | 80% of reasonable charges after first $50 up to $25,000 per trip period | 80% of reasonable charges after first $50 up to $25,000 per trip period |

* A benefit period begins the first day of confinement in a hospital and ends when 60 consecutive days have passed without confinement.

** Medical deductible- first $200 (Plans M1 & M2) or first $153 (Plans M3 to MA) each calendar year of Medicare eligible expenses not paid by Medicare.

(1) A trip period begins on the day you leave the U.S. and ends on the day you return to the U.S.

| Service | Benefit | AARP's Extended Medicare Supplement (M3,P3,J3) | AARP'S Comprehensive Medicare Supplement (M4) |
|---|---|---|---|
| **HOSPITAL EXPENSES** (for covered expenses each benefit period*) semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes lab tests, diagnostic x-rays, meals, special care units, drugs, medical supplies, operating and recovery room, anesthesia and rehabilitation services. | Days 1 through 60 | Actual charges up to $1188 | Actual charges up to $1188 |
| | Days 61 through 90 | to $297/day | to $297/day |
| | Days 91 and after when using a Lifetime Reserve Day | $594/day | $594/day |
| | Days 91 and after when LTR's are available but not used | $594/day for up to 60 days | $594/day for up to 60 days |
| | Days 91 and after when all 60 LTR's have been used | 100% of Medicare eligible expenses (unlimited # of days) | 100% of Medicare eligible expenses (unlimited # of days) |
| **SKILLED NURSING FACILITY STAYS** (for covered services each benefit period*) in a facility approved by Medicare. Insured must have been in a hospital for at least 3 days and enter SNF within 30 days after hospital discharge- same condition. | Days 1 through 20 | No benefit | No benefit |
| | Days 21 through 100 | $148.50/day | $148.50/day |
| | Days 101 through 365 | $297/day | $297/day |
| **MEDICAL CARE** (for covered expenses each calendar year) Physician services, medical services and supplies, physical and speech therapy, ambulance, etc. | In-Hospital and Out of Hospital | 20% of Medicare eligible expenses not paid in full by Medicare after a $153 medical deductible** | 100% of Medicare eligible expenses not paid in full by Medicare, up to the limiting charge set by Medicare, after a $153 medical deductible** |
| **IN-HOSPITAL PRIVATE DUTY NURSING CARE** | In-Hospital Care by an RN or LPN | 80% of usual and prevailing charges | 80% of usual and prevailing charges |
| **BLOOD** - 1st 3 pints of blood or equivalent quantity of packed red blood cells. | | The reasonable cost under Parts A and B | The reasonable cost under Parts A and B |
| **PRESCRIPTION DRUGS** | Purchased Out-of-Hospital and outside of a SNF | 50% of usual and prevailing charges after $50 deductible; Max benefit of $500/yr. | 50% of usual and prevailing after $50 deductible; Max benefit of $500/yr. |
| **FOREIGN HOSPITAL & MEDICAL CARE** Hospital, physician and medical services received in a foreign country which are of a type considered eligible when provided in the U.S. | Days 1 through 60 of each trip period (1) | 80% of reasonable charges after first $50 up to $25,000 per trip period | 80% of reasonable charges after first $50 up to $25,000 per trip period |

* A benefit period begins the first day of confinement in a hospital and ends when 60 consecutive days have passed without confinement.

** Medical deductible- first $200 (Plans M1 & M2) or first $153 (Plans M3 to MA) each calendar year of Medicare eligible expenses not paid by Medicare.

(1) A trip period begins on the day you leave the U.S. and ends on the day you return to the U.S.

| Service | Benefit | AARP's Medicare Supplement (M5,P5,J5) | AARP'S Medicare Supplement Plus (M6,P6,J6) |
|---|---|---|---|
| **HOSPITAL EXPENSES** (for covered expenses each benefit period*) semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes lab tests, diagnostic x-rays, meals, special care units, drugs, medical supplies, operating and recovery room, anesthesia and rehabilitation services. | Days 1 through 60 | Actual charges up to $297 | Actual charges up to $1188 |
| | Days 61 through 90 | to $297/day | to $297/day |
| | Days 91 and after when using a Lifetime Reserve Day | $594/day | $594/day |
| | Days 91 and after when LTR's are available but not used | $594/day for up to 60 days | $594/day for up to 60 days |
| | Days 91 and after when all 60 LTR's have been used | 100% of Medicare eligible expenses (unlimited # of days) | 100% of Medicare eligible expenses (unlimited # of days) |
| **SKILLED NURSING FACILITY STAYS** (for covered services each benefit period*) in a facility approved by Medicare. Insured must have been in a hospital for at least 3 days and enter SNF within 30 days after hospital discharge- same condition. | Days 1 through 20 | No benefit | No benefit |
| | Days 21 through 100 | $148.50/day | $148.50/day |
| | Days 101 through 365 | $297/day | $297/day |
| **MEDICAL CARE** (for covered expenses each calendar year) Physician services, medical services and supplies, physical and speech therapy, ambulance, etc. | In-Hospital and Out of Hospital | 20% of Medicare eligible expenses not paid in full by Medicare after a $153 medical deductible** | 20% of Medicare eligible expenses not paid in full by Medicare after a $153 medical deductible** |
| **IN-HOSPITAL PRIVATE DUTY NURSING CARE** | In-Hospital Care by an RN or LPN | RN-actual charges up to $30 per 8hr shift. LPN-actual charges up to $25 per 8hr shift. MAX.- 3 shifts/day; 60 shifts/benefit pd. | RN-actual charges up to $30 per 8hr shift. LPN-actual charges up to $25 per 8hr shift. MAX.- 3 shifts/day; 60 shifts/benefit pd. |
| **BLOOD** - 1st 3 pints of blood or equivalent quantity of packed red blood cells. | | The reasonable cost under Parts A and B | The reasonable cost under Parts A and B |
| **PRESCRIPTION DRUGS** | Purchased Out-of-Hospital and outside of a SNF | No benefit | No benefit |
| **FOREIGN HOSPITAL & MEDICAL CARE** Hospital, physician and medical services received in a foreign country which are of a type considered eligible when provided in the U.S. | Days 1 through 60 of each trip period (1) | 80% of reasonable charges after first $50 up to $25,000 per trip period | 80% of reasonable charges after first $50 up to $25,000 per trip period |

* A benefit period begins the first day of confinement in a hospital and ends when 60 consecutive days have passed without confinement.

** Medical deductible- first $200 (Plans M1 & M2) or first $153 (Plans M3 to MA) each calendar year of Medicare eligible expenses not paid by Medicare.

(1) A trip period begins on the day you leave the U.S. and ends on the day you return to the U.S.

| Service | Benefit | AARP'S Comprehensive Medicare Supplement (M7,P7) | AARP's Medicare Supplement (MA, PA) |
|---|---|---|---|
| **HOSPITAL EXPENSES** (for covered expenses each benefit period*) semi-private room and board, general nursing and miscellaneous hospital services and supplies. Includes lab tests, diagnostic x-rays, meals, special care units, drugs, medical supplies, operating and recovery room, anesthesia and rehabilitation services. | Days 1 through 60 | Actual charges up to $1188 | No benefit |
| | Days 61 through 90 | to $297/day | to $297/day |
| | Days 91 and after when using a Lifetime Reserve Day | $594/day | $594/day |
| | Days 91 and after when LTR's are available but not used | $594/day for up to 60 days | $594/day for up to 60 days |
| | Days 91 and after when all 60 LTR's have been used | 100% of Medicare eligible expenses (unlimited # of days) | 100% of Medicare eligible expenses (unlimited # of days) |
| **SKILLED NURSING FACILITY STAYS** (for covered services each benefit period*) in a facility approved by Medicare. Insured must have been in a hospital for at least 3 days and enter SNF within 30 days after hospital discharge- same condition. | Days 1 through 20 | No benefit | No benefit |
| | Days 21 through 100 | $148.50/day | $148.50/day |
| | Days 101 through 365 | $297/day | $297/day |
| **MEDICAL CARE** (for covered expenses each calendar year) Physician services, medical services and supplies, physical and speech therapy, ambulance, etc. | In-Hospital and Out of Hospital | Medicare eligible expenses not paid in full by Medicare. Up to the usual & prevailing charge set by Medicare after a $153 medical deductible** | 20% of Medicare eligible expenses not paid in full by Medicare after a $153 medical deductible** |
| **IN-HOSPITAL PRIVATE DUTY NURSING CARE** | In-Hospital Care by an RN or LPN | 80% of the usual and prevailing charges | RN-actual charges up to $30 per 8hr shift. LPN-actual charges up to $25 per 8hr shift. MAX.- 3 shifts/day; 60 shifts/hospital stay |
| **BLOOD** - 1st 3 pints of blood or equivalent quantity of packed red blood cells. | | The reasonable cost under Parts A and B | 100% of the cost not paid by Medicare |
| **PRESCRIPTION DRUGS** | Purchased Out-of-Hospital and outside of a SNF | 50% of usual and prevailing charges after $50 deductible; Max benefit of $500/yr. | No benefit |
| **FOREIGN HOSPITAL & MEDICAL CARE** Hospital, physician and medical services received in a foreign country which are of a type considered eligible when provided in the U.S. | Days 1 through 60 of each trip period (1) | 80% of reasonable charges after first $50 up to $25,000 per trip period | 80% of reasonable charges after first $50 up to $25,000 per trip period |

* A benefit period begins the first day of confinement in a hospital and ends when 60 consecutive days have passed without confinement.

** Medical deductible- first $200 (Plans M1 & M2) or first $153 (Plans M3 to MA) each calendar year of Medicare eligible expenses not paid by Medicare.

(1) A trip period begins on the day you leave the U.S. and ends on the day you return to the U.S.

| Service | Benefit | AD/DP |
|---|---|---|
| ***Nursing Home Stays*** | Days 1-20 per calendar year* | $60/day |
| | Days 21 and after | No Benefit |
| ***Home Health Care Visits*** | Visits 1-40 per calendar year* | $30/visit; 3 hr. minimum/visit |
| | Visits 41 and after | No Benefit |

** Days and visits which are covered (wholly or partly) by Medicare are days and visits not eligible for benefits under this rider.*

**District Of Columbia Medicare Supplement**
**Pre-Standardized Plans Trend Development**

The components of the composite trend are shown below.

**Part B Coinsurance**.

| | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Medicare Fee Update | *1.0%* | *0.3%* | *-0.2%* | *1.0%* |
| Utilization Trend | *5.2%* | *6.4%* | *0.7%* | *2.6%* |
| Composite Trend | *6.2%* | *6.7%* | *0.5%* | *3.6%* |

The net change in the cost for Part B services in 2012 was -0.2%. For 2013, we assume a net increase of 1.0%.

Utilization trend considers changes in the number of services used as well as the intensity of services. Our assumed utilization trends for 2012 and 2013 are 0.7% and 2.6%, respectively.

**Part B Excess.** Projected claim costs for 2012 and 2013 are $2.64 and $2.70 respectively.

**Part A Deductible.**

| | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Medicare Part A Deductible | *$1,100* | *$1,132* | *$1,156* | *$1,188* |
| % Change in Part A Deductible | *3.0%* | *2.9%* | *2.1%* | *2.8%* |
| Utilization Trend | *6.5%* | *-0.3%* | *0.7%* | *0.3%* |
| Composite Trend | *9.7%* | *2.6%* | *2.9%* | *3.0%* |

**Hospital Co-Payments.** Hospital Co-payments are paid for days 61 and after for long hospital stays.

| | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Medicare Daily Coinsurance Amount | *$275* | *$283* | *$289* | *$297* |
| % Change in Daily Coinsurance | *3.0%* | *2.9%* | *2.1%* | *2.8%* |
| Utilization/ Length of Stay Trend | *n/a* | *n/a* | *73.4%* | *-2.7%* |
| Composite Trend | *n/a* | *n/a* | *77.1%* | *0.0%* |

**Skilled Nursing**. Medicare Supplement plans which have a skilled nursing facility stay benefit pay the Medicare cost sharing amount for days 21-100. These plans also cover an additional 265 days.

| | 2010 | 2011 | 2012 | 2013 |
|---|---|---|---|---|
| Medicare Daily Coinsurance | *$138* | *$142* | *$145* | *$149* |
| % Change in Daily Coinsurance | *3.0%* | *2.9%* | *2.1%* | *2.8%* |
| Utilization/Length of Stay, days 21-365 | *-24.4%* | *21.9%* | *10.0%* | *4.1%* |
| Composite Trend | *-22.1%* | *25.5%* | *12.3%* | *6.9%* |

**Foreign Care / Private Duty Nursing.** In aggregate, these benefits represent less than 0.1% of the total District Of Columbia claim cost.

**Prescription Drugs.** Our assumed composite trends for plans M3, M4, and M7 are 14.8% for 2012, and -0.3% for 2013.

**District of Columbia Pre-Standardized**
**Accumulated Premium and Incurred Claims since Inception**

| | | Accumulated to 2012 | Cumulative Value |
|---|---|---|---|
| 1990 Premium | $2,360,467 | $7,075,500 | $7,075,500 |
| 1990 Incurred Claims | $2,328,815 | $6,980,623 | $6,980,623 |
| 1990 Loss Ratio | 98.7% | 98.7% | 98.7% |
| 1991 Premium | $2,950,834 | $8,423,929 | $15,499,430 |
| 1991 Incurred Claims | $2,430,523 | $6,938,564 | $13,919,187 |
| 1991 Loss Ratio | 82.4% | 82.4% | 89.8% |
| 1992 Premium | $3,294,231 | $8,956,425 | $24,455,854 |
| 1992 Incurred Claims | $2,952,855 | $8,028,284 | $21,947,471 |
| 1992 Loss Ratio | 89.6% | 89.6% | 89.7% |
| 1993 Premium | $3,100,446 | $8,028,150 | $32,484,005 |
| 1993 Incurred Claims | $2,858,497 | $7,401,659 | $29,349,130 |
| 1993 Loss Ratio | 92.2% | 92.2% | 90.3% |
| 1994 Premium | $2,552,290 | $6,294,077 | $38,778,082 |
| 1994 Incurred Claims | $2,760,077 | $6,806,490 | $36,155,620 |
| 1994 Loss Ratio | 108.1% | 108.1% | 93.2% |
| 1995 Premium | $2,412,676 | $5,666,459 | $44,444,541 |
| 1995 Incurred Claims | $2,420,396 | $5,684,590 | $41,840,210 |
| 1995 Loss Ratio | 100.3% | 100.3% | 94.1% |
| 1996 Premium | $2,704,982 | $6,050,451 | $50,494,992 |
| 1996 Incurred Claims | $2,079,751 | $4,651,947 | $46,492,157 |
| 1996 Loss Ratio | 76.9% | 76.9% | 92.1% |
| 1997 Premium | $2,568,098 | $5,470,736 | $55,965,728 |
| 1997 Incurred Claims | $2,252,338 | $4,798,082 | $51,290,239 |
| 1997 Loss Ratio | 87.7% | 87.7% | 91.6% |
| 1998 Premium | $2,510,203 | $5,092,765 | $61,058,493 |
| 1998 Incurred Claims | $1,886,669 | $3,827,724 | $55,117,963 |
| 1998 Loss Ratio | 75.2% | 75.2% | 90.3% |
| 1999 Premium | $2,308,175 | $4,459,890 | $65,518,383 |
| 1999 Incurred Claims | $1,693,488 | $3,272,184 | $58,390,147 |
| 1999 Loss Ratio | 73.4% | 73.4% | 89.1% |
| 2000 Premium | $2,107,349 | $3,877,955 | $69,396,338 |
| 2000 Incurred Claims | $1,568,537 | $2,886,430 | $61,276,577 |
| 2000 Loss Ratio | 74.4% | 74.4% | 88.3% |
| 2001 Premium | $1,893,557 | $3,318,603 | $72,714,941 |
| 2001 Incurred Claims | $1,674,509 | $2,934,705 | $64,211,282 |
| 2001 Loss Ratio | 88.4% | 88.4% | 88.3% |

**District of Columbia Pre-Standardized**
**Accumulated Premium and Incurred Claims since Inception**

| | | Accumulated to 2012 | Cumulative Value |
|---|---|---|---|
| 2002 Premium | $1,623,295 | $2,709,474 | $75,424,415 |
| 2002 Incurred Claims | $1,701,091 | $2,839,325 | $67,050,607 |
| 2002 Loss Ratio | 104.8% | 104.8% | 88.9% |
| 2003 Premium | $1,556,289 | $2,473,936 | $77,898,351 |
| 2003 Incurred Claims | $1,429,275 | $2,272,030 | $69,322,638 |
| 2003 Loss Ratio | 91.8% | 91.8% | 89.0% |
| 2004 Premium | $1,509,299 | $2,284,990 | $80,183,342 |
| 2004 Incurred Claims | $1,260,541 | $1,908,386 | $71,231,023 |
| 2004 Loss Ratio | 83.5% | 83.5% | 88.8% |
| 2005 Premium | $1,399,021 | $2,017,177 | $82,200,519 |
| 2005 Incurred Claims | $1,234,053 | $1,779,318 | $73,010,341 |
| 2005 Loss Ratio | 88.2% | 88.2% | 88.8% |
| 2006 Premium | $1,201,123 | $1,649,369 | $83,849,888 |
| 2006 Incurred Claims | $1,113,783 | $1,529,434 | $74,539,776 |
| 2006 Loss Ratio | 92.7% | 92.7% | 88.9% |
| 2007 Premium | $1,112,348 | $1,454,729 | $85,304,616 |
| 2007 Incurred Claims | $1,000,247 | $1,308,123 | $75,847,899 |
| 2007 Loss Ratio | 89.9% | 89.9% | 88.9% |
| 2008 Premium | $956,119 | $1,190,868 | $86,495,485 |
| 2008 Incurred Claims | $745,283 | $928,267 | $76,776,165 |
| 2008 Loss Ratio | 77.9% | 77.9% | 88.8% |
| 2009 Premium | $847,792 | $1,005,661 | $87,501,146 |
| 2009 Incurred Claims | $634,811 | $753,021 | $77,529,186 |
| 2009 Loss Ratio | 74.9% | 74.9% | 88.6% |
| 2010 Premium | $779,480 | $880,599 | $88,381,744 |
| 2010 Incurred Claims | $562,497 | $635,468 | $78,164,654 |
| 2010 Loss Ratio | 72.2% | 72.2% | 88.4% |
| 2011 Premium | $672,948 | $724,044 | $89,105,789 |
| 2011 Incurred Claims | $510,232 | $548,974 | $78,713,628 |
| 2011 Loss Ratio | 75.8% | 75.8% | 88.3% |
| 2012 Premium | $578,944 | $593,242 | $88,974,986 |
| 2012 Incurred Claims | $450,473 | $461,598 | $78,626,252 |
| 2012 Loss Ratio | 77.8% | 77.8% | 88.4% |
| 2013 Premium | $495,474 | $483,534 | $89,458,519 |
| 2013 Incurred Claims | $393,050 | $383,577 | $79,009,829 |
| 2013 Loss Ratio | 79.3% | 79.3% | 88.3% |

# 2013 RATES FOR PLANS NOT ISSUED IN DISTRICT OF COLUMBIA

| Plan | Monthly Rate |
|---|---|
| S1 | $110.50 |
| S2 | $179.50 |
| S3 (with drugs) | $253.50 |
| S3 (without drugs) | $214.25 |
| S4 (with drugs) | $317.75 |
| S4 (without drugs) | $279.50 |
| S6 | $200.25 |
| S7 (with drugs) | $300.00 |
| S7 (without drugs) | $261.00 |
| SA | $129.25 |
| TA/XA/HA/YA | $129.25 |
| NA/QA | $125.75 |
| N6/Q6 | $194.25 |
| N3/Q3 (with drugs) | $59.25 |
| N3/Q3 (without drugs) | $20.00 |
| N7/Q7 (with drugs) | $105.75 |
| N7/Q7 (without drugs) | $66.75 |
| M8/P8 | $143.00 |
| M9/P9 | $197.50 |
| D6/D7/D8/D9 | $14.75 |

## 2013 Rates for Pre-Baucus Coverages

| | |
|---|---|
| AG | $56.75 |
| W (with drugs) | $288.50 |
| W (without drugs) | $266.50 |
| X | $185.50 |
| Y | $112.25 |

**State:** District of Columbia **Filing Company:** UnitedHealthcare Insurance Company
**TOI/Sub-TOI:** MS02G Group Medicare Supplement - Pre-Standardized/MS02G.000 Medicare Supplement - Pre-Standardized
**Product Name:** GROUP MEDICARE SUPPLEMENT PRE-STANDARDIZED PLANS
**Project Name/Number:** RATE/RERATE 2013 - PRE -STD

## Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| Satisfied - Item: | Actuarial Justification | | |
| Comments: | SEE ATTACHED ACTURIAL MEMORANDUM. | | |
| Attachment(s): | | | |
| DC Memo (Pre).pdf | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| Satisfied - Item: | Cover Letter | | |
| Comments: | SEE ATTACHED COVER LETTER. | | |
| Attachment(s): | | | |
| DC Cover Letter (Pre).pdf | | | |

# UnitedHealthcare Insurance Company

# Actuarial Memorandum

# AARP Medicare Supplement Portfolio

# Group Policy Number G-36000-4

District of Columbia

## A. Purpose of Filing

The purpose of this filing is to request approval of 2013 rate revisions for Pre-Standardized Medicare Supplement plans offered to AARP members and to demonstrate compliance with loss ratio standards.

## B. General Description

1. Issuer Name – The Prudential Insurance Company of America. UnitedHealthcare assumed this risk effective January 1, 1998, through an assumptive reinsurance agreement with Prudential.

2. Form Number – Group Policy Number G-36000-4
   Prescription Drug Elimination Rider: CRA 1664

3. Policy Type – Pre-Standardized Group Medicare Supplement.

4. Benefit Description – See Attachment 7 for plan specific benefit descriptions. These Medicare Supplement plans were sold prior to standardization and met Baucus requirements.

   Prescription drug benefits will be discontinued for insureds covered by Plans M3, M4, and M7 who enroll in Medicare Part D. Prescription drug benefits will continue for insureds covered by Plans M3, M4, and M7 who do not enroll in Medicare Part D.

5. Renewal Provision – Guaranteed renewable. If the group policy is terminated by the group policyholder and not replaced by another group policy by the same policyholder, an individual policy will be offered.

6. Marketing Method – This is a closed block of business. Plans were marketed through the mail to members of AARP.

7. Underwriting Method – The Pre-Standardized Plans and Rider AD/DP were available on a guaranteed issue basis.

8. Pre-Existing Conditions Exclusion – This is a closed block of business; the maximum exclusion on any of these plans was 6 months/6 months.

9. Issue Age Limits – This is a closed block of business.

10. Premium Basis – Premium is earned on the first of the month for the entire month in which it is due. Premiums do not vary by age and contain no pre-funding components.

    Discounts Available – The discounts currently available to AARP Medicare Supplement members will remain:

    a) Payment by Electronic Funds Transfer ($2.00 per household per month).

    b) Annual Pay ($24 per household for those that pay their entire calendar year premium in January).

    c) Multi-Insured - 5% when two or more insureds on one account have at least one plan of insurance issued under a group master policy between the Trustees of AARP and UnitedHealthcare Insurance Company.

11. Actuary's Name: Timothy A. Koenig, ASA, MAAA
    Director, Actuarial Services
    UnitedHealthcare Insurance Company
    Post Office Box 130
    Montgomeryville, PA 18936
    (215) 902-8429

12. Domicile State Approval – UnitedHealthcare Insurance Company is domiciled in Connecticut. The Connecticut Department of Insurance does not require these rates to be filed for your state. We file Connecticut specific rates (i.e., rates charged to Connecticut residents) with the Connecticut Department of Insurance. Proposed 2013 Connecticut specific rates will be filed for approval with the Connecticut Department of Insurance in August, 2012.

## C. Rate Methodology/Assumptions

1. General Method – Projections used in developing the 2013 rates are shown in Attachment 1. Based on historical claim patterns, per member per month net claim costs are developed by benefit and trended to the end of the 2013 rating period (also see Attachment 3).

   The rate increase percentage for these certificates represents the average increase needed for the plans when grouped together. This approach should result in more moderate increases for all of the insureds.

   The rates are based on state of residence. When notification of a change of residence is received, rates are adjusted accordingly.

2. Priced with Trend/Selection – Claim cost trends are projected for 2012 and 2013. The trend assumptions are based on the historical experience of the AARP Medicare Supplement Plans in your state. These certificates have been inforce since 1992 or prior; no explicit adjustment for selection is included in the pricing.

3. Priced with Rate Increases – We anticipate future annual rate increases similar to future medical trend levels for most plans.

4. Commission Rate – None.

5. Replacement Commissions – None.

6. Lapse Assumption – Lapse assumptions are based on actual experience in your state. For 2012 and 2013, the assumed annual lapse rates (including death) are 14.2% and 16.1%, respectively.

7. Morbidity Assumption – Morbidity assumptions are based on actual experience in your state and are incorporated into the trend projections and base claim costs.

8. Interest Assumptions – 5.0%.

9. Pre-Funding – These plans are community-rated. The rates are projected to be effective until December 31, 2013 and reflect no pre-funding.

**D. Scope/Reason for Request**

1. Overall Increase – The overall increase is 2.6%.

2. Variations by Cell – The requested rate increases represent the average increase needed for the plans when grouped together (see enclosed Rate Schedule).

3. Effective Date – January 1, 2013.

4. Timing – These plans are rated on a calendar year basis. For 2013, we propose to defer the rate revision until April 1, 2013, and have rates effective through December 31, 2013.

**E. Rates and Rating Factors**

1. Current – See Rate Schedule.

2. Proposed – See Rate Schedule.

3. Period Rates Apply – Effective January 1, 2013. We anticipate filing rates for January 1, 2014.

**F. Average Annualized Premium -** $2,492. See Attachment 4 for annualized premiums by plan.

**G. Rate History** – See Attachment 5.

**H. In Force Counts** – See Attachment 1.

**I. Historical Incurred Claims** – See Attachment 1.

**J. Historical Earned Premium** – See Attachment 1.

**K. Loss Ratio Projection**

1. Definition – Loss ratios are calculated as incurred claims divided by premium.

2. Base Period – Claim cost projections are based on claim data incurred through 2011.

3. Lapse Assumption – Lapse assumptions are based on actual AARP Medicare Supplement experience in your state. For 2012 and 2013, the assumed annual lapse rates (including death) are 14.2% and 16.1%, respectively.

4. Claim Trend Assumption – Claim trend projections are based on actual AARP Medicare Supplement experience in your state and reflect changes made to the Medicare program. See Attachment 3 and Attachment 8 for projected claim trends.

5. Attained Age/Selection Adjustments – These plans are community rated. Demographic and selection differences are built into the historical claim costs.

6. Future Rate Increases – We anticipate future annual rate increases similar to future medical trend levels for most plans.

7. Interest Assumption – 5.0%.

8. With and Without Rate Change

    - The anticipated loss ratio with the rate change implemented on April 1, 2013 is 87.2%.
    - Without a change to the 2012 rates, the anticipated loss ratio is 87.3%.

## L. Loss Ratio Demonstration

All Pre-Standardized plans have been inforce at least three years. The anticipated loss ratio for these plans is 87.2% (See Attachment 1). This anticipated loss ratio meets or exceeds the loss ratio presumed reasonable by District of Columbia law.

## M. Actuarial Certification

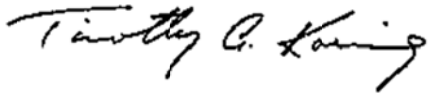
1. The assumptions within this filing present my best judgment as to the expected value for each assumption and are consistent with UnitedHealthcare's business plan at the time of the filing.

2. The anticipated lifetime loss ratio, future loss ratios, and third-year loss ratios all meet or exceed the applicable ratio.

3. This filing was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board including the data quality standard of practice. I relied on prior audits of the source data used in this filing and compared the data contained in prior comparable submissions to verify its reasonability.

4. To the best of my knowledge, this filing is in compliance with the applicable laws and regulations of the state of District of Columbia. I relied on direction and advice from other UnitedHealth Group staff regarding legal and compliance requirements.

5. The rates determined in this filing are reasonable in relationship to the benefits provided.



_____ August 1, 2012

Timothy A. Koenig, ASA, MAAA Date
Director, Actuarial Services

UnitedHealthcare®
UnitedHealth Group
P.O. Box 130
Montgomeryville PA 18936

August 1, 2012

William P. White
Commissioner
Government of the District of Columbia
Department of Insurance, Securities, and Banking
810 First Street, N. E., Suite 701
Washington, DC 20002

RE: Rate Revision Filing
Rates for Pre-Standardized Medicare Supplement Plans
UnitedHealthcare Insurance Company
NAIC #0707-79413

Dear Commissioner:

The attached filing is made to obtain approval for rates effective January 1, 2013 for Pre-Standardized Medicare Supplement Plans, issued to members of AARP.

The proposed rates include an average rate increase of 2.6%. With these increases we project an anticipated loss ratio of 87.2%.

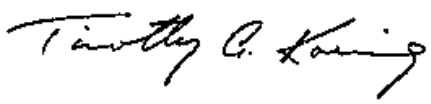
The enclosed actuarial memorandum provides supporting information. Certification regarding compliance with loss ratio standards for your state is also provided.

The rates are proposed to be effective January 1, 2013 through December 31, 2013. For 2013, we propose to defer the implementation of the January 1, 2013 rate revision until April 1, 2013, and have the rates effective through December 31, 2013. We anticipate that the next rate revision will be effective January 1, 2014 through December 31, 2014.

We would appreciate your acting expeditiously on this request so that we can provide AARP members with adequate notice of their 2013 rates.

If you need any further information regarding this matter, please contact me at (215) 902-8429, or via fax at (215) 902-8802. If you prefer to e-mail me, my address is Timothy_A_Koenig@uhc.com.

Sincerely,



Timothy A. Koenig, ASA, MAAA
Director, Actuarial Services