Substantiation of Advertising Claims Concerning AARP Medicare Supplement Insurance Plans

2019

REPORT PREPARED FOR:
UnitedHealthcare
Insurance Company
December 2019

WB26909ST (12-19)

Background

UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for NY residents), together herein shown as "UnitedHealthcare," insures the AARP Medicare Supplement Insurance Plans marketed to AARP members. Additionally, UnitedHeathcare provides Medicare Advantage Plans as part of its Medicare Portfolio. In promoting these plans, UnitedHealthcare wishes to make certain advertising claims, and has asked Gongos, Inc. to substantiate their truthfulness.

About Gongos, Inc.

As a decision intelligence company, Gongos, Inc. brings a consultative approach in developing growth strategies grounded in operationalizing customer centricity. Partnering with insights, analytics, marketing, strategy, and CX groups, Gongos serves as a translator to help cross-functional teams fuel the competency to gain and apply consumer wisdom, transform decisions into action, and navigate organizational change. Coalescing enterprise data with primary research and curating insights for multiple audiences ensures information is designed to influence actions and behaviors from executives to the frontline.

Gongos, Inc. Qualifications for Claim Substantiation

Gongos, Inc. has been conducting primary research and applying analytic testing techniques for more than 25 years. Our sophisticated data analytics team has a proven track record of crafting and applying test methodologies to complex enterprise data and other data forms. As a company, Gongos has been analyzing, interpreting, and translating data into meaningful insights using a system-agnostic approach for over 25 years. Core areas of expertise include: data fusing and imputing, data mining, modeling and other analytics techniques.

Claim: <u>The Number of Insured Members of AARP Medicare Supplement Insurance Plans Equals or Exceeds 4 Million</u>

Overview of the Substantiation Process

To audit this claim, a random sample of all insured members on file was created, and payment records were examined for each of the insured members who fell into the sample. As of the last day of December 2018, the total of insured members on file was 4,528,767. For the audit of this total to be considered successful in substantiating the claim, every person in the selected sample had to pass inspection in the following ways: 1) the payment record for the selected insured members had to show a recent payment, and 2) there had to be no duplication among the insured members on file.

Considerations Leading to the Specification of the Sample Size

Records for 200 insured members chosen at random were examined in detail. This sample size was selected because it is sufficiently large to provide 95% confidence that at least 98% of the insured members on file are unduplicated persons whose account was current at the time the audit was made.

Method of Sampling

The following procedure was used in this analysis:

- A file was supplied in which the count of the corresponding members was sorted by zip code.
- The zip codes were arranged in ascending order and the count of these members was listed in each zip code.
- A sampling interval was then determined to provide a sample of 200 zip codes for each group.
- For each of the 200 selected zip codes, one record of payment was selected for detailed examination, the middle one in the order of its member number.

To audit the number of insured members active on the last day of December 2018, a sampling interval of 22,644 was used to select the 200 zip codes. The selected zip codes contained 123,701 unique members.

Note that any change in address (e.g. out of the zip code) from the randomly selected members had a record of such change provided with the corresponding screenshot. These changes had no impact on the random selection process.

Any unique cases found were verified by UHC and include an explanatory note with the corresponding screenshot.

Results of the Audit

Each of the selected records satisfied the requirement that there was a record of recent payment. This was established by examining a screenshot of the actual record. The absence of any duplication of persons in the sample of zip codes selected to represent the entire list was ascertained by checking that there were 123,701 unique member numbers in the selected zip codes, matching the counts provided for the 200 zip codes in the sample.

Since none of the 200 records selected at random duplicated any other record, and since each one turned out to identify a specific person whose payment record was actually examined, the audit validated the veracity of the entire list of 4 million plus insured members. Thus the claim that the number of AARP Medicare Supplement Insurance insured members equals or exceeds 4 million is substantiated as of the end of December 2018.

Claim: <u>From Year to Year, 95% of Active Members Currently Renew Their AARP Medicare Supplement Insurance Plans</u>

Overview of the Substantiation Process

The following counts were provided for the audit of this claim:

A. Total members active on last day of 2017 ---------- 4,448,235
B. Less: Members known to have died during 2018 ---------- 163,657
C. Balance: Members in a position to renew ---------- 4,284,578
D. Members active on the last day of 2017 who were still active on the last day of 2018 ---------- 4,094,230
E. D divided by C equals ---------- 95.6%

Method of Sampling

The following procedure was used for each key group in the analysis:

- A file for each key group was supplied in which the count of the corresponding members was sorted by zip code.
- The zip codes were arranged in ascending order and the count of these members was listed in each zip code.
- A sampling interval was then determined to provide a sample of 200 zip codes for each group.
- For each of the 200 selected zip codes, one record of payment was selected for detailed examination, the middle one in the order of its member number.

To audit the number of **members active on the last day of 2017**, a sampling interval of 22,241 was used to select the 200 zip codes. The selected zip codes contained 132,696 unique members.

To audit the number of **members known to have died during 2018**, a sampling interval of 818 was used to select the 200 zip codes. The selected zip codes contained 4,274 unique members.

To audit the number of **members active on the last day of 2017 still active on the last day of 2018**, a sampling interval of 20,471 was used to select the 200 zip codes. The selected zip codes contained 117,218 unique members.

Results of the Audit

Each of the selected records as of the last day of 2017 satisfied the requirement that there was a record of recent payment. This was established by examining a screenshot of the actual record. The absence of any duplication of persons in the sample of zip codes selected to represent the entire list was ascertained by

checking that there were no duplicate member numbers in the selected zip codes, and matching the counts provided for the 200 zip codes in the sample.

The 200 records drawn at random from those known to have died in 2018[1] established that according to the files at UnitedHealthcare for each of these former plan holders, the reason for termination is listed as "death" or "deceased." These records had no duplicate member numbers in the selected zip codes, and matched the counts provided for the 200 zip codes in the sample.

The 200 members selected at random from the 4,094,230 members active at the end of both 2017 and 2018 each satisfied the requirement that there was a record of recent payment. Again, these records had no duplicate member numbers in the selected zip codes, and matched the counts provided for the 200 zip codes in the sample.

Note that any change in address (e.g. out of the zip code) from the randomly selected members had a record of such change provided with the corresponding screenshot. These changes had no impact on the random selection process.

Any unique cases found were verified by UHC and include an explanatory note with the corresponding screenshot.

Having thus audited counts A, B, and D (referring to the counts listed at the beginning of this section), the claim that 95% of active members renew their plan has been substantiated with respect to the year to year comparison of 2018 with 2017. Since this substantiation is specific to the most recent years, it is recommended that the claim include the word "currently" as shown at the head of this section, or else that it be made clear in the text that the claim applies to the year 2018.

[1] Records for those members who have died during 2018 span the dates of 12/2017 through 11/2018.

Claim: 98% of AARP Medicare Supplement Insurance Plan Claims are Processed in 10 Days or Less

Overview of the Substantiation Process

UnitedHealthcare has processed 145 million claims for AARP Medicare Supplement Insurance Plans in 2018. The vast majority of these claims are submitted and are processed electronically, but some categories of claims arrive on paper and require keypunching. It can be expected that processing time would vary by how claims arrive as well as by other charges for prescription drugs. It was therefore decided that a sample of the 145 million claims processed would be examined stratified by the claim source and claim type. A count would then be made of the number of claims across the total of all types that took more than 10 days to process.

Method of Sampling

A random sample of 200 claims was selected from each of 7 categories, from Medicare EC (comprising 81.34% of the claims processed in 2018), Medicare Part B front-end keyed claims (comprising 3.42%), down to front-end keyed claims for prescription drugs (comprising only 0.005%). The sampling process made use of the Random Selection function of the Oracle database program. For each of these 1,400 randomly selected claims for the stratified sample, the following statistics were supplied:

- Claim number (position one is the normal calendar year, and positions 2-4 reflect the Julian day of year received).
- Receipt date in normal calendar notation.
- Process date in normal calendar notation.
- Service days.

Service days were computed so as to count one day for the date of receipt, one for the processing date, and one day for each intervening workday. Weekends and holidays were not counted in service days.

For the category of front-end keyed prescription drug claims, the “cross-reference” date was used, since this is earlier than the date of receipt, which records the electronic delivery of the keypunched data.

Results of the Audit

Of the 1,400 claims examined, 81 took more than 10 days to process. These 81 claims were unequally distributed across the claim types. The most numerous claims type category -- Medicare EC -- comprising 81.34% of the claims processed in 2018, had zero claims taking more than 10 days to process. The three categories which between them contained 64 of the 81 claims that took more than ten days to process, FEK Unkeyables, Fastrieve Manual, and Part B FEK, accounted for only 4.51% of the total categories of claims.

A weighted average was computed across the sample of 1,400 claims that removed the distortion in the composition of these claims created by the stratification of the sample. The composite percent of claims

requiring more than 10 days to process resulting from these calculations was 0.98%. Conversely, 99.02% of the 1,400 claims were processed in 10 days or less.

The calculations are shown below:

2018 Breakdown by Claim			More than 10 Days to Process		
Claim Type	**Claim Volume**	**Distribution**	**#**	**Proportion of 200**	**Weighted Average**
Fastrieve Manual	1,344,774	0.92%	23	11.50%	0.11%
FEK Rx	6,600	0.005%	2	1.00%	0.00%
FEK Unkeyables	232,631	0.16%	28	14.00%	0.02%
Medicare EC	118,256,843	81.34%	0	0.00%	0.00%
Part A FEK	375,959	0.26%	6	3.00%	0.01%
Part B FEK	4,977,915	3.42%	13	6.50%	0.22%
Clearinghouse EC	20,195,971	13.89%	9	4.50%	0.63%
Total	145,390,693	100.00%	81		0.98%

In the sample examined the weighted average figure is 99.02% (1 minus 0.0098). The sample value substantiates a claim that 98% of claims are processed in 10 days or less.

Claim: AARP Medicare Supplement Insurance Plan Annual Rate Increases Have Been 2.8% on Average between 2014 and 2018

Overview of the Substantiation Process

Base rate increases for each year from 2014 through 2018 were tabulated by specific plan within each state. Rates for a year across plans and across states were weighted by the number of insured members. From year to year, base rate increases by state and for the total US were computed as if the number of insured members had remained the same from the earlier year to the later year. Thus, the computed average base rate increases were not influenced by a change in the number of people enrolled in a specific plan within any specific state, or across states.

All standardized plans A through L and N were included in the analysis where currently or previously available. In addition, waiver plans in Massachusetts, Minnesota, and Wisconsin are included in the state of sale only. Pre-standardized plans are not included.

Results of the Audit

On average, base rates increased by 2.8% annually between 2014 and 2018.

The base rate increases varied over this range of years. In 2014, base rates increased by 3.6% versus the previous year, whereas in 2015, they increased by 0.7%. For the latest year in the range, 2018, the increase was 4.6%.

The base rate increases varied among the many plans that were included in the analysis. In 2018, 22% of insured members experienced a base rate increase of 3% or less, 37% experienced a base rate increase between 3% up to 5%, and 41% experienced a base rate increase between 5% up to 10%. 0.1% of members experienced a base rate increase over 10%.

Thus, while it is true that the average base rate increase was 2.8% from 2014 through 2018, there is variation around this average. This is why, when publicizing the accurate claim that the average rate increase was 2.8%, mention is made that base rate increases vary by specific plan, by state, and by year.

It should be noted that the claim was audited and substantiated for base rates. The total amounts being charged to insured members may vary more than the base rates. This is because some insured members receive discounted rates for early enrollment, and these discounts wear off over the years.

The audit therefore substantiated a claim being made specifically for base rate increases. The substantiated claim is that, on average, base rates have increased by 2.8% annually from 2014 through 2018, while varying by specific plan, state and year.

The audit also substantiated the following average base rate increase from 2014 through 2018 on a state by state basis:

AK	3.5%		KY	2.6%		OH	3.0%
AL	3.0%		LA	2.9%		OK	4.6%
AR	3.9%		MA	0.7%		OR	5.9%
AZ	2.0%		MD	3.3%		PA	2.9%
CA	2.4%		ME	5.2%		PR	1.0%
CO	2.3%		MI	1.8%		RI	3.3%
CT	2.4%		MN	2.0%		SC	2.5%
DC	2.3%		MO	3.3%		SD	4.3%
DE	3.3%		MS	3.7%		TN	2.7%
FL	1.8%		MT	3.4%		TX	3.5%
GA	4.1%		NC	3.4%		UT	4.7%
GU	1.7%		ND	2.8%		VA	3.7%
HI	3.7%		NE	3.3%		VI	3.2%
IA	3.4%		NH	3.6%		VT	4.6%
ID	3.3%		NJ	2.5%		WA	4.9%
IL	2.1%		NM	4.7%		WI	4.0%
IN	2.9%		NV	2.6%		WV	3.7%
KS	3.2%		NY	2.3%		WY	3.9%

Claim: <u>The Average Tenure for Insured Members of AARP Medicare Supplement Insurance Plans is equal to 11 Years</u>

Overview of the Substantiation Process

The average tenure for insured members of AARP Medicare Supplement insurance plans was determined using persistency rates calculated by plan duration. Persistency for a given plan duration is calculated from the lapse rate for that plan duration: 100% minus the lapse rate yields the proportion of plans that persist into the next time period, i.e., the persistency rate.

The lapse rate is calculated as the proportion of plans terminated in a given plan tenure divided by the number of plans persisting from the previous plan tenure (e.g. the number of terminated plans with a tenure of two months divided by the number of plans with a tenure of one month that remained active into their second month). If an insured member pays for 1 month of coverage beginning in January and then terminates the policy, they are considered 1 paid certificate in January and 1 terminated certificate in February. A plan is considered as terminated after at least 1 month of coverage has been paid for and can be the result of death, voluntary termination, or termination for non-payment of premium. Plans terminated the same month in which the plan was issued are not included in the lapse rate calculation.

Plan tenure was computed as the number of months between the issue date of the Medicare Supplement policy (or the earliest issue date of a Medicare Supplement policy where plan changes have occurred but continuous Medicare Supplement coverage with UHC has been maintained) and the coverage month being considered for the computation. An experience window of five years, spanning coverage months January 2014 through December 2018, was used. This window allowed consideration of plan tenures as short as a single month and as long as thirty years.

The following levels of activity were considered in the analysis:

- New plans added (i.e. the first effective month of a plan).
- Plans added due to a plan change or a plan added to an insured member who holds another product.
- Plans receiving a payment or plans becoming delinquent due to non-payment, following a 60-day grace period.
- Plans terminated after at least 1 month of coverage has been paid, which could be the result of death, voluntary termination, or termination for non-payment of premium.

Method of Sampling

The following procedure was used for this analysis:

- A file was provided containing the counts of plans receiving payment and the counts of terminated plans for each combination of plan issue date and experience month, for plans having such activity over the past five years
- 200 total random combinations of plan issue date and experience month were selected (e.g. a plan issue date of 'January 2001' and an experience month of 'August 2018' is one such combination)
- These 200 sampled combinations were stratified by the proportions of the activity levels present in the data provided
- For each level of activity included in the lapse rate calculation, a sampling interval was determined to provide the desired number of plan issue date and experience month combinations. This amounted to the following sample sizes for each of level of activity:
    - Plans receiving payment or becoming delinquent: 590,669
    - Plans terminated after at least one month of coverage: 3,558
    - Plans terminated as the result of a plan change: 459
    - New plans added: 28,537
    - New plans added as the result of a plan change: 601
- For each selected combination of plan issue date and experience month, one record was selected for detailed examination, the middle (or median) in the order of its member number.
    - For the plan activities that indicate a payment, a record of recent payment was provided.
    - For the other plan activities that indicate a termination, a record of termination was provided.

Results of the Audit

Using monthly persistency, the average tenure for insured members of AARP Medicare Supplement Insurance plans is equal to 135.5 months (11.29 years). This figure was obtained by summing the individual persistency rates within the experience window defined above. Dividing the sum of monthly persistency rates by 12 yields the average tenure in years.

A similar figure of 11.25 years was obtained using annual persistency values derived from the monthly persistency values.

Claim: More people choose UnitedHealthcare for their Medicare coverage than any other company, making them the #1 provider of Medicare plans in the nation.

Data Sources

A combination of data extracts from the Health Coverage Portal™ (provided by Mark Farah Associates (MFA)) and a summary report from Centers for Medicare and Medicaid Services (CMS) were used to substantiate this claim.

The MFA data regards the 2018 Medicare Supplement (MS) Insurance Experience Exhibits filed with the National Association of Insurance Commissioners (NAIC) as of March 8, 2019. Data was provided with the following caveats:

- The data elements are valid indicators of Medicare Supplement business but are not necessarily complete or all-revealing.
- Compliance and levels of reporting are unknown; the data is presented as provided in electronic data files that MFA licenses from the NAIC.

The CMS data was collected from 12/1/2017 to 12/1/2018, last refreshed on June 28, 2019. This data regards aggregate Medicare Advantage (MA) enrollment.

Method of Substantiation

Both data sources contain aggregate enrollment counts at the parent company level.

Companies with the highest enrollment volume in both files were matched to obtain a single total of MS and MA enrollment.

Result of the Audit

From these enrollment totals, the total number of MA and MS enrollees for UnitedHealthcare was found to be greater than any other company, 10,045,636. The company with the second largest enrollment had 3,775,853 enrollees. The claim that more people choose UnitedHealthcare for their Medicare coverage than any other company is therefore substantiated.