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Substantiation of Advertising Claims Concerning AARP Medicare Supplement Insurance Plans

➢ 2012 ➢

REPORT PREPARED FOR:

UnitedHealthcare
Insurance Company
March, 2012

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. In promoting these plans, UnitedHealthcare wishes to make certain advertising claims, and has asked ORC International to substantiate their truthfulness.

About ORC International

ORC International, originally Opinion Research Corporation, was founded in 1938 and is now a leading global research and information services company with focused industry expertise in:

- Healthcare & Pharmaceutical
- Legal: Survey/Trademark & Claims Substantiation
- Technology
- Energy and Utilities
- Financial Services & Private Equity
- Industrial
- Public Services
- Advertising & Professional Services
- Consumer Products & Services

Guideline Research Corporation, a predecessor company, formally became part of ORC International in 2011.

ORC International Qualifications for Claim Substantiation

ORC International has been substantiating advertising claims for more than 20 years. In the U.S., guidelines for substantiating advertising claims were first published by the three largest TV networks. Starting in 1971, under the sponsorship of the Federal Trade Commission, the National Advertising Division of the Council of Better Business Bureaus Inc., (NAD) has adjudicated disputes concerning such claims as the advertising industry's self-regulation arm. ORC International is a subscribing member (under the name Guideline) and has reviewed and retained the decisions which the NAD has published over the years.

Much of the company's experience in claims substantiation studies has been in the areas of consumer products, having conducted more than 200 successful studies to substantiate advertising claims about food and beverage products, health and beauty aids, household products and electronics. ORC International has substantiated advertising claims for UnitedHealthcare previously, in December 2010.

Qualifications of the Report's Author

The author of this report is Robert N. Reitter, the Senior Vice President of the company's Claim Substantiation practice. As detailed in his bio which is attached to this report, Mr. Reitter has been accepted as an expert witness and has testified in court and at NAD proceedings on many occasions.

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

Overview of the Substantiation Process

UnitedHealthcare has processed 95 million claims for AARP Medicare Supplement Insurance Plans in 2011. 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 variables, such as whether the claims are submitted for hospital charges, doctors' fees or charges for prescription drugs. It was therefore decided that a sample of the 95 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 70 claims was selected from each of 7 categories, from Medicare EC (comprising 81.54% of the claims processed in 2011), Medicare Part B front-end keyed claims (comprising 9.83%), 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 490 randomly selected claims for the stratified sample, the following statistics were supplied:

Claim number (positions 2-4 reflect 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. Thus if a claim were received on January 5, 2011 and the response was sent on January 10, 4 service days would have elapsed -- January 5, 6, 7 and 10. Weekend and holiday days 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 490 claims examined, 53 took more than 10 days to process. These 53 claims were very unequally distributed across the claim types. The most numerous claims type category -- Medicare EC -- comprising 81.5% of the claims processed in 2011, had no claims at all taking more than 10 days to process. The two categories which contained between them 45 of the 53 claims that took more than ten days to process, Fastrieve Manual and FEK Unkeyables, accounted for only 3.5% of the sampled claims.

A weighted average was computed across the sample of 490 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 1.49%. Conversely, 98.51% of the 490 claims were processed in 10 days or less.

The calculations are shown below:

2011 Breakdown by Claim Type			**More than 10 days to Process**		
Claim Type	**Claim Volume**	**Distribution %**	**#**	**%**	wtd. Avg.
Fastrieve Manual	1,957,097	2.06%	20	0.285714	0.005890
FEK Rx	4,678	0.00%	2	0.028571	0.000001
FEK Unkeyables	1,385,120	1.46%	25	0.357143	0.005211
Medicare EC	77,409,110	81.54%	0	0	0
Part A FEK	883,542	0.93%	3	0.042857	0.000399
Part B FEK	9,329,384	9.83%	2	0.028571	0.002808
Clearinghouse EC	3,968,713	4.18%	1	0.014286	0.000597
Total	**94,937,644**	**100.0**	**53**		**0.014906**

A claim that 98% of claims are processed in 10 days or less is supported by this data. The standard error of the weighted average of 1.5% is .25%. Thus when 98% of claims are processed in 10 days or less, sample values between 97.5% and 98.5% are within the expected range of variation with the stratified sample design used. The actual sample value of 98.51% is just past the upper limit of this range, giving 95% confidence that the proportion of claims processed in 10 days or less is at least 98%.

Claim: AARP Medicare Supplement Insurance Plan Annual Rate Increases Have Been 4% on Average between 2008 and 2012

Overview of the Substantiation Process

Base rate increases for each year from 2008 through 2012 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. In addition *Medicare Select* plans and *Waiver* plans in Massachusetts, Minnesota and Wisconsin were included. Not included in the analysis were pre-standardized plans which were sold before 1992 and are no longer made available.

Results of the Audit

On average, base rates increased by 4.0% annually between 2008 and 2012.

These base rate increases varied over time as well as among the many insured members whose base rates were examined. For example, in 2008 while 52.3% of insured members experienced a rate increase of less than 4%, 12.7% experienced rate increases of 8% or more. By 2012, these figures had shifted greatly, with 81.7% of members experiencing a rate increase of less than 4% and no members at all experiencing a rate increase of 8% or more.

Thus while it is true that the average base rate increase was 4% from 2008 through 2012, there is considerable variation around this average. This is why, when publicizing the accurate claim that the average rate increase was 4%, 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 do 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 4% annually from 2008 through 2012, while varying by specific plan, state and year.

The audit also substantiated the following base average rate increases from 2008 through 2012 on a state by state basis:[1]

AK	4.6%		KY	4.8%		OH	4.8%
AL	4.6%		LA	1.7%		OK	4.4%
AR	4.8%		MA	4.9%		OR	3.6%
AZ	6.5%		MD	4.8%		PA	3.2%
CA	3.2%		ME	4.8%		PR	3.9%
CO	3.9%		MI	5.0%		RI	3.8%
CT	5.6%		MN	4.8%		SC	4.2%
DC	3.3%		MO	2.8%		SD	4.2%
DE	3.5%		MS	4.2%		TN	4.6%
FL	3.1%		MT	4.2%		TX	3.7%
GA	4.9%		NC	4.2%		UT	5.1%
GU	4.2%		ND	6.1%		VA	4.7%
HI	4.7%		NE	4.5%		VI	5.3%
IA	4.9%		NH	4.9%		VT	4.6%
ID	5.2%		NJ	4.0%		WA	4.2%
IL	4.0%		NM	2.9%		WI	5.2%
IN	5.8%		NV	4.6%		WV	3.9%
KS	5.3%		NY	2.6%		WY	4.5%

[1] The calculations assume approval of the proposed base rate increases in Massachusetts.

Claim: <u>The Number of Insured Members of AARP Medicare Supplement Insurance Plans Equals or Exceeds 3.0 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 2011, the total of insured members on file was 3,056,698. 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 150 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.

The proof for this is as follows. Suppose that as many as 2% of the supposed insured members on file are nonexistent, or have not made recent payments, or are duplicated in the file. Then the probability that a sample of 150 will miss all of these fake or defective records is 1-(0.98 to the power of 150) or 5%.

Thus a sample size of 150 is sufficiently large to provide 95% certainty that if the claim is inflated at all, it is not inflated by as much as 2%.

Method of Sampling

The 3 million insured members on record as of the last day of 2011 were sorted by their zip code of residence. The 36,666 zip codes in the U.S were arranged in ascending order and the number of insured members in each was listed. Then the number of insured members was cumulated from the number in the first, lowest numbered zip code to the cumulative number of 3 million in a zip code designated in the file as 99999.[2]

[2] There is no zip code 99999, but this designation was used where an insured member of record provided a zip code so new it had not yet registered in the system, or provided a foreign address.

The sampling interval was set at 20,250, since this approximates the total number of insured members, 3,056,698 divided by the specified sample size, 150. Using the column of the cumulative number of insured members, a zip code was flagged for selection if it contained in the cumulative column a multiple of the number 20,250. The resulting sample of 150 zip codes is a random sample weighted by the population of insured members across all U.S. zip codes.

The 150 zip codes selected contained no duplicates, because none of them had as many insured members as the sampling interval, 20,250. They contained anywhere from 5 to 6,308 insured members. In total, the 150 selected zip codes contained 72,732 records, for an average of 485 each. Just one record of payment was selected for detailed examination in each zip code, the middle one in the order of its "tag" number.

Results of the Audit

Each of the selected records satisfied the requirement that there was a record of recent payments. 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 exactly as many unique member identification numbers in each zip code as the count provided for that zip code.

Since none of the 150 records selected at random duplicated any other record, and since each one turned out to identify a named person whose payment record was actually examined, the audit validated the veracity of the entire list of over 3 million insured members. Thus the claim that the number of AARP Medicare Supplement Insurance insured members equals or exceeds 3 million is substantiated as of the end of 2011.

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 2010 ---------- 2,933,067

B. Less: Members known to have died during 2011---------- 132,332

C. Balance: Members in a position to renew---------- 2,800,735

D. Members active on the last day of 2010 who were still active on the last day of 2011 ---------- 2,683,731

   D divided by C equals---------- 95.8%

E. Total members active on the last day of 2011 ---------- 3,056,698

Method of Sampling

To audit the number of members known to have died during 2011, an n-th name random sample of 150 names was drawn from the total of 132,332.

To audit the number of members active on the last day of 2010 who were still active on the last day of 2011, a file was supplied in which the count of these members was sorted by zip code. The zip codes were arranged in ascending order and the count of insured members active as of the last day in both 2010 and 2011 was listed in each zip code. Then the number of such insured members was cumulated from the number in the first, lowest numbered zip code to the cumulative number of 2.7 million in the highest numbered zip code. The sampling interval was set at 107,350 so as to provide a sample of 20 zip codes weighted by the population of such members across all zip codes.

The reason for selecting just 20 zip codes is that an identical procedure had already been used to audit the total of active members at the end of 2011. Since this audit established the validity of a count of 3,056,698 members as of then, it simultaneously validated the great majority of the count of members active at end of 2010 as well as 2011, since almost 90% of members active on the last day of 2011 were also active on the last day of 2010.

It can be expected that of the 150 records examined to validate the count of members active at the end of 2011, about 130 were also active at the end of 2010. Thus a supplement of 20 records of members active at the end of both years was deemed sufficient to validate the total count of such members.

For each of the 20 selected zip codes, one record of payment was selected for detailed examination, the middle one in the order of its "tag" number.

Results of the Audit

The 150 records drawn at random from those known to have died in 2011 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." This sample size was selected because it is sufficiently large to provide 95% confidence that at least 98% of the deceased members on file are so registered in the records of the Company.

The proof for this is as follows. Suppose that as many as 2% of the supposed deceased members on file are nonexistent or are not registered as deceased. Then the probability that a sample of 150 will avoid all of these missing or inaccurately characterized records is 1-(0.98 to the power of 150) or 5%. Thus a sample size of 150 is sufficiently large to provide 95% certainty that if the number of deceased member is inflated at all, it is not inflated by as much as 2%.

The 20 members selected at random from the 2.7 million active at the end of both 2010 and 2011 each satisfied the requirement that there was a record of recent payment. It was also ascertained that there was no duplication of persons listed as members within these 20 zip codes by seeing that there were exactly as many member identification numbers in each of these zip codes as the count provided for that zip code.

Combined with the audit of all members active at the end of 2011, this audit establishes with 95% confidence that the reported count of members active on the last day of 2010 who were still active on the last day of 2011 is within 2% of being an accurate count.

Having thus audited counts B, D and E (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 2011 with 2010. 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 2011.

APPENDIX

Biography of Report's Author

Robert N. Reitter

Employment: 1990- Present

Senior Vice-President, ORC International, formerly Guideline

- Designed and supervised more than five hundred surveys intended to withstand adversarial scrutiny, including Claims Substantiation, Trademark, Trade Dress, and Advertising Perception studies.

- Accepted on numerous occasions as an expert witness, and has had many surveys credited by Federal and State courts, by the U.S.P.T.O., Federal Trade Commission, the NAD (National Advertising Division of the Council of Better Business Bureaus, Inc.) and the NARB (National Advertising Review Board).

Employment: Prior to 1990

President, Reitter, Wilkins & Associates, Inc.

- Planned and interpreted market research for companies in the food, beverage, fashion, and travel industries

Associate, Land-Reitter Associates

Assistant Director of Research, PKL Advertising

Product Research Assistant, General Foods Corporation

Education

Master of Industrial Administration, Yale University

French National Scholar, University of Paris

Bachelor of Arts *cum laude*, Yale College

Testimony as an Expert at Trial or by Deposition since 2008

2011	Coryn Group v. O.C. Seacrets	USDC Northern District of MD
2010	TestMasters v. Test Masters	U.S.P.T.O.
2009	Coryn Group v. O.C. Seacrets	USDC Southern District of NY
2009	GAP Inc. v. G.A.P. Adventures	USDC Southern District of NY
2009	LG Electronics v. Whirlpool Corporation	USDC Northern District of IL
2009	Playtex Products v. Procter & Gamble	USDC Southern District of NY
2008	ComponentOne v. ComponentArt	USDC Western District of PA
2008	University of Kansas v. Joe College	USDC for the District of KS

Publications and Speeches since 2001

What You Need to Know to Be Successful before the NAD The 8th National Advanced Forum for Advertising Law, New York, 2001

ASTM Standards for Claim Substantiation from a Research Practitioner's Perspective Presentation to an ASTM Committee, Salt Lake City, 2004

Survey Research and Dilution Presentation to the Practicing Law Institute, New York, 2004