AMERICAN ACADEMY of ACTUARIES

March 20, 2009

To: Mr. Dennis Julnes, Chair, NAIC Health RBC Working Group

From: James Braue, Chair, American Academy of Actuaries, Medicare Part D RBC Subgroup

Re: Report Recommending Changes to RBC Risk Factors for Medicare Part D Coverage.

Dear Mr. Julnes,

The American Academy of Actuaries' Medicare Part D RBC Subgroup wishes to present the attached as our report recommending changes to RBC Risk Factors for Medicare Part D coverage. This report was written by our Subgroup in response to your charge, given in March 2008.

We appreciate the opportunity to provide this report and look forward to your feedback. If there are any questions regarding this report, I invite you to contact Melissa Lawler, staff liaison to the Subgroup, at (202) 785-7880 or lawler@actuary.org.

Sincerely,

James Braue
Chair, Medicare Part D RBC Subgroup
American Academy of Actuaries

CC: Crystal Brown, NAIC Staff Liaison
Alfred Bingham, Vice President, Academy Health Practice Council

Attachments: Report on Risk Factors for Medicare Part D

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AMERICAN ACADEMY *of* ACTUARIES

Report Recommending Changes to RBC Risk Factors for Medicare Part D Coverage From the American Academy of Actuaries' Medicare Part D RBC Subgroup

Presented to the National Association of Insurance Commissioners'
Health RBC Working Group

March 2009

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Medicare Part D Industry Survey.

I. The Charge to the Subgroup.

In 2005, the NAIC's Capital Adequacy Task Force ("the Task Force") asked the American Academy of Actuaries ("the Academy") to recommend an appropriate Risk-Based Capital ("RBC") treatment for Medicare Part D coverage, which was scheduled to commence on January 1, 2006. For the purpose of responding to this request, the Academy's Task Force on Health Risk-Based Capital formed a Medicare Part D RBC Subgroup ("the Subgroup").

In September of 2005, the Subgroup provided recommendations to the Task Force regarding changes to the RBC formula structure and instructions that would address the risk considerations that are specific to Medicare Part D. Changes were recommended for both the Health RBC formula and the Life RBC formula. These changes involved the introduction of several additional factors for Medicare Part D. In December of 2005, the Subgroup recommended values for those additional factors, which were subsequently adopted by the NAIC.

One of the most important aspects of the Medicare Part D coverage, from the standpoint of RBC, is the risk-mitigation features that the federal government incorporated into the program. (These features are described in the Appendix to this report, "Risk-Mitigation Features of Medicare Part D.") As noted in our December 2005 report, one of the risk-mitigation features, the Risk-Corridor Protection, was scheduled to change effective in 2008. The scheduled change was expected to significantly reduce the risk-mitigation value of that particular feature. However, companies writing Medicare Part D coverage were expected to be less dependent on such risk mitigation by that time, given their additional knowledge about pricing and managing the coverage. We advised, therefore, that the RBC factors be updated to reflect both the change in the Risk-Corridor Protection and the improvement in company knowledge. We reiterated that recommendation in a letter to the Task Force's Health Risk-Based Capital Working Group ("the Working Group"), dated May 3, 2007.

In March of 2008, the Working Group asked the Subgroup to re-evaluate the reasonableness of the Medicare Part D factors, in light of the changes to the Risk-Corridor Protection and the industry's additional experience with Medicare Part D.

In this report, we recommend changes to the numerical values of the factors for 2009 and later years, and provide the rationale for our recommendations. Given the deadlines for changes to the structure of the RBC formulas, we did not revisit the structural aspects of the formulas as they apply to Medicare Part D; however, at the end of this report, we do offer some suggestions regarding changes that might be considered at a later time.

Many of the capitalized terms used in this report are defined in the RBC instructions that were submitted to the Task Force in September of 2005.

II. Recommendations.

In this section, we give a summary description of the RBC factors required for Medicare Part D and recommend factors to be used for 2009 and later.

A. Required Factors.

The RBC formula structure for Medicare Part D requires the following factors.

- There are two Underwriting Risk Factors applicable to Standard Coverage: a factor applicable to annual premium up to a specified dollar breakpoint ($25 million), and another factor applicable to annual premium in excess of that breakpoint. Below, we refer to those factors as the Underwriting Risk Initial Factor and the Underwriting Risk Excess Factor, respectively. These factors are used on page XR012 of the Health RBC formula and page LR018 of the Life RBC formula.

- There are four discount factors that reduce the required Underwriting Risk RBC for Standard Coverage, depending on which of the federal risk-mitigation features are applicable (see the Appendix for more details). However, only two factors are expected to be applicable during the period 2006-2011, viz., the factor for payments subject to both the Reinsurance Coverage and the Risk-Corridor Protection, and the factor for payments subject to only the Risk-Corridor Protection. These factors are used on page XR017 of the Health RBC formula and page LR020 of the Life RBC formula.

- There is another Underwriting Risk Factor applicable to premium received for Supplemental Benefits. No discount factors are applicable. This factor is used on page XR014 of the Health RBC formula and page LR017 of the Life RBC formula.

Note that these factors apply only to business written as stand-alone coverage by a PDP Sponsor (i.e., a legal entity providing Medicare Part D as a stand-alone coverage, rather than as part of a Medicare Advantage plan). Medicare Part D coverage that is integrated with a Medicare Advantage plan is included in Comprehensive Medical coverage along with the non-Part-D portion of the coverage (including any drug coverage outside of Part D that the plan may provide). Government-subsidized employer-based prescription drug coverage either is included with Comprehensive Medical coverage, if it is part of an insured medical plan, or is treated as "Other Health" if it is a stand-alone insured coverage. Note also that the factors for Standard Coverage also will apply to coverage that is actuarially equivalent to Standard Coverage.

B. Recommended Factors for 2009 and Later.

We recommend the following factor values for 2009 and later. A comparison of these factors to the current factors is presented in section II.C.

Underwriting Risk Factors for Standard Coverage:

- Initial Factor 0.251
- Excess Factor 0.151

Discount Factors for Standard Coverage:

- Risk-Corridor Protection only 0.667
- Reinsurance Coverage and Risk-Corridor Protection 0.767

Underwriting Risk Factor for Supplemental Benefits 0.350

- To be phased in:

  0.200 for 2009
  0.280 for 2010
  0.350 for 2011 and later

Note that the discount factors are expressed as reductions of the RBC that would otherwise be required. For example, the factor of 0.667 means that the required RBC would be reduced by 66.7%.

We are recommending a phase-in of the new Underwriting Risk Factor for Supplemental Benefits, for reasons discussed in section III.C.4 below.

C. Comparison of Recommended Factors to Current Factors.

We offer the following comparisons of our recommended factors to the factors currently in effect, as they would apply in practice.

In regard to the tables immediately following, please note:

- Factors for business without either Reinsurance Coverage or Risk-Corridor Protection (as described in the Appendix to this report) are not presented here. Please recall that, at least at present, there is no Medicare Part D business to which such factors would actually apply.
- The "initial" factors are those applicable to premium below the $25 million breakpoint.
- The "excess" factors are those applicable to premium in excess of the $25 million breakpoint. They are not the weighted average factors that would apply to the total premium of an entity with more than $25 million of premium.
- Factors "with risk corridors only" would apply to business with Risk-Corridor Protection but no Reinsurance Coverage (namely, the Payment Demonstration business, as described in the Appendix under "Reinsurance Coverage").
- Factors "with risk corridors & reinsurance" would apply to business with both Reinsurance Coverage and Risk-Corridor Protection.

TABLE 1.

Recommended factors

	Initial	Excess
With risk corridors only (Payment Demonstration business)	0.0836	0.0503
With risk corridors & reinsurance	0.0585	0.0352

TABLE 2.

Current factors

	Initial	Excess
With risk corridors only (Payment Demonstration business)	0.0705	0.0545
With risk corridors & reinsurance	0.0494	0.0382

TABLE 3.

Ratio of recommended factors to current factors

	Initial	Excess
With risk corridors only (Payment Demonstration business)	119%	92%
With risk corridors & reinsurance	119%	92%

We believe that these results are reasonable. For smaller blocks of business, with their greater potential variability, an improved understanding of the business may not be enough to offset the reduction in the Risk-Corridor Protection. For larger blocks with less potential variability, the Risk-Corridor Protection should not be as important, and the knowledge gained since 2005 could be expected to decrease the overall risk.

For a "large" block of business, defined here as a block with $150 million of annual premium, the following results would occur. (The basis for considering a $150 million premium volume is discussed in section III.C.1 below.) The factors shown are weighted averages of the initial and excess factors, reflecting the $25 million breakpoint.

TABLE 4.

Comparison for a $150 million block of business:
Recommended factors vs. current factors

Blended recommended factors:	
With risk corridors only	0.0558
With risk corridors & reinsurance	0.0391
Blended current factors:	
With risk corridors only	0.0572
With risk corridors & reinsurance	0.0400
Ratio, recommended to current:	
With risk corridors only	98%
With risk corridors & reinsurance	98%

We note, finally, that the proposed factor for Supplemental Benefits (0.350) is 292% of the current factor (0.120). We believe that this increase is appropriate. In 2005, there was essentially no basis for developing a new factor for Medicare Part D Supplemental Benefits, so the 0.120 factor was carried over from the "Other Health" component of the Life RBC formula. (That was the factor that presumably would have applied to all of Medicare Part D, as stand-alone prescription drug coverage, if separate factors for the Standard Coverage had not been developed.) Now, the industry has some experience both with the form that such benefits are likely to take and the difficulties inherent in pricing such benefits. That experience, as reflected in the responses to an industry survey (discussed at length in section III.B below), indicates a much higher potential for adverse deviation than the current factor would allow for.

For reasons cited below (in section III.A), we did not perform any detailed analysis of historical experience in this regard. However, such actual experience as we are aware of tends to confirm that Supplemental Benefits should be considered more risky than Standard Coverage. Therefore, it also seems appropriate that the factor for Supplemental Benefits should be higher than the undiscounted factors for Standard Coverage.

However, while we believe that the increase is appropriate, we also recognize that it represents a very material change in the capital requirement for this form of coverage. As noted above in section II.B and discussed below in section III.C.4, we believe that an increase of this magnitude should be phased in. Our proposed phase-in would produce the following results.

TABLE 5.

Comparison of factors for Supplemental Benefits: Effect of recommended phase-in

Effective period	Factor	Ratio of effective factors: Vs. 2006-08	Year over year
2006-2008	0.120	–	–
2009	0.200	167%	167%
2010	0.280	233%	140%
2011 and later	0.350	292%	125%

Stated another way, the phase-in would result in successive annual increases of 67%, 40%, and 25%, as opposed to the immediate 192% increase that would occur without the phase-in.

D. Impact of Factor Change on Individual Entities.

We also wanted some indication of how the recommended changes would affect individual entities' RBC charges. For this purpose, we used information from the Medicare Part D Supplement to PDP Sponsors' 2007 Annual Statements, provided by the NAIC as discussed in section III.A.1 below. As noted in that later discussion, there were several data quality issues related to the Supplement data; however, those issues did not preclude the use of the Supplement data for this comparative purpose.

However, there are some caveats that need to be stated regarding the information that follows.

- The measurements discussed below pertain only to the underwriting risk charges for Medicare Part D business. They are not necessarily reflective of the impact on any entity's total Company Action Level RBC, as Medicare Part D may constitute only a small portion of the entity's business. Even so, it seems appropriate to consider the separate impact on Medicare Part D RBC because that will affect the economics of Medicare Part D as a business.

- These measurements do not reflect the covariance adjustment in the RBC formulas, the effect of which varies considerably by company. If an entity had significant asset risk, as measured by the RBC formulas, then the impact of the Medicare Part D underwriting risk charge would probably be substantially less than is indicated here. It will be seen that several of the entities writing Medicare Part D business in 2007 were filers of the Life and Accident and Health Statement. It is plausible that some of those "Blue Blank" entities fall into the category of entities that have significant non-underwriting risk charges.

- The data being used are from 2007, which was the latest year available when this analysis was undertaken. There have been significant changes in the type and distribution of Medicare Part D business since that time. In particular, supplemental benefits currently are less common or more limited than they were in 2007. That may serve to ameliorate the effect of the large change recommended for the Underwriting Risk Factor for Supplemental Benefits.

Those limitations having been stated, we offer the following for consideration.

For each entity, we calculated underwriting risk charges based on that entity's mix of business, namely: Standard Coverage subject to Reinsurance Coverage and Risk-Corridor Protection, Standard Coverage subject to Risk-Corridor Protection only, and Supplemental Benefits. We performed those calculations using both the current underwriting risk factors and the new factors recommended in this report, and then calculated the ratio of the risk charges based on recommended factors to the risk charges based on current factors.

The overall impact of the recommended changes (with no phase-in of the factor for Supplemental Benefits) was to raise the Medicare Part D charges in the aggregate by about 16.5%. However, the impact on an entity-by-entity basis varied widely, as shown in the attached Exhibit 1. The main body of the table in Exhibit 1 shows the number of entities in each "cell" created by the categorizations described in the exhibit. It may be seen that the impact on individual entities ranged from a 10% decrease to a 140% increase. However, the most typical increase (30 of the 83 entities included) was around 20%, similar to the 19% increase in the initial factors for Standard Coverage (as shown in section II.C). Twenty-five entities experienced a smaller increase or a decrease, and 28 entities experienced a larger increase.

As previously noted, in order to limit the impact of the recommended increase in the Underwriting Risk Factor for Supplemental Benefits, we are suggesting a three-year phase-in. The results of such a phase-in are shown in attached Exhibits 2a, 2b, and 2c, representing the three successive years of the phase-in. These exhibits are formatted in the same manner as Exhibit 1. It can be seen that the (rounded) increase in the aggregate underwriting risk charges would not exceed 50% in the first year (when in most cases the charges for Standard Coverage would also be increasing), 30% in the second year, and 20% in the third year. The overall increase in the aggregate risk charges would be, respectively, 2.9% (when some of the largest entities' risk charges for Standard Coverage would actually decrease), 7.1%, and 5.8%. These results may be useful in judging the likely effectiveness of the phase-in.

In considering the results presented here, it is important to keep in mind that increased capital requirements for Medicare Part D will increase an entity's cost of operating that business. As noted above, in cases where the RBC covariance adjustment has a large impact, looking at the Medicare Part D RBC on a stand-alone basis could be misleading even from the standpoint of treating Medicare Part D as a distinct business. However, many of the entities offering Medicare Part D coverage are likely to be health-insurance-oriented, and changes in underwriting risk charges will be mitigated very little by the covariance adjustment. For

those entities, a change in capital requirements may be a significant factor in evaluating whether Medicare Part D is a viable and attractive business.

III. Methodology.

The primary basis for the Subgroup's recommendations was information obtained through a survey of selected companies. This survey was similar to the survey performed in 2005, which was the basis for the Subgroup's recommendations at that time. Further details about data sources and data analysis are given in the remainder of this section.

A. Data Sources.

The NAIC provided data from the Medicare Part D Supplement to the Annual Statement for 2006 and 2007. (Company identifications were deleted by the NAIC.) Unfortunately, there were evident problems with the data. For example, many companies reported very high or very low loss ratios for Standard Coverage, but no risk-corridor adjustments to premium, making it appear that the loss ratios incorporated into their pricing were close to those anomalous actual loss ratios, which seems unlikely. In other cases, companies reported zero or a negative amount for their non-claim expenses, which seems obviously erroneous and would interfere with an attempt to estimate realistic profit margins from the data. Follow-ups by NAIC staff determined that in many of these cases, there was a misunderstanding as to what was supposed to be reported in the Supplement, or a simple failure to insert the requested information. These problems with data quality precluded our using the Supplement data as the primary basis for our analysis. However, we were able to use the Supplement data for limited purposes, as discussed in section III.C.1 below and in section II.D above.

The NAIC Health RBC Working Group sponsored, on the Subgroup's behalf, a survey of PDP Sponsors, similar in form to the survey that the Academy undertook in 2005. This was our primary data source. The survey is discussed in more detail in section III.B immediately following.

In addition, we requested information from the federal Centers for Medicare and Medicaid Services ("CMS"). The information requested would have provided the Subgroup with summaries of the plan-specific experience provided to CMS for 2006 and 2007. This additional information would have allowed us to analyze actual plan experience subject to a variety of criteria. Unfortunately, this information was not available in time to be used in this analysis. We will continue to pursue the possibility of obtaining data from CMS in the future, recognizing that there is an inherent advantage in using such data as a primary basis for analysis or as a check on data from other sources.

B. The 2008 Survey.

The 2008 survey was similar to the survey used by the Subgroup in 2005. However, for 2008, the Subgroup omitted some of the questions from the 2005 survey that we deemed no

longer significant; modified other questions; and added questions that we thought would be provide valuable information for our review. More details regarding the survey are described in the remainder of this section. A copy of the survey document is attached to this report.

1. Purpose of Survey.

In the past, the Academy's recommendations of underwriting risk factors for health coverages have typically been developed using models based on historical experience. The Academy was able to gather large volumes of relatively homogeneous loss ratio experience for the relevant category of health coverage, comprising several years of data from a broad cross-section of contributing companies. The data were analyzed using rigorous statistical modeling techniques, to estimate the minimum capital levels needed to avoid ruin over a specified period at appropriate confidence levels.

However, Medicare Part D is a relatively new coverage, and as noted above only limited information about actual experience was available to the Subgroup. Also, any historical experience would have pertained only to 2006 and 2007, and one of the important factors to be considered by the Subgroup is the increase in knowledge about this coverage since pricing was performed for those years. Therefore, as we did originally in 2005, the Subgroup adopted a more judgment-based approach to the analysis. This approach is not unprecedented, even beyond the Subgroup's 2005 work. The underwriting risk factors for "Other Health" — the factors that presumably would have applied to Medicare Part D if the RBC formulas had not been revised — were developed using actuarial judgment, taking into account the relative levels of the factors that had been statistically derived for the other, more specific categories of coverage. As already noted, the Subgroup also took this kind of approach in developing our 2005 recommendations of the underwriting risk factors currently being used for Medicare Part D. Given the increase in companies' knowledge about the coverage, we believed that responses to the updated survey would have greater credibility than the responses provided in 2005, and that therefore it was reasonable to update the factors based on such a survey.

Accordingly, the Subgroup requested that the NAIC sponsor a survey to seek opinions from companies that offered Medicare Part D coverage. We developed a set of questions, based in large part on the original 2005 survey, that we felt would enable us to identify a consensus viewpoint, or at least a central tendency of views, while also providing us the opportunity to analyze some of the key factors underlying the responses to the questions.

2. Solicitation Criteria and Response Rate.

The survey was sent by the NAIC to companies that had submitted Medicare Part D Supplements to their 2007 Annual Statements (excluding Supplements that indicated no such business was being written by the submitting companies). Ninety-four companies received the survey. It was made clear to the recipients that participation in the survey was optional, not an NAIC requirement.

Complete or partial responses were received from eighteen of the survey recipients in time to be included in our analysis. Responses to the survey were received and compiled by NAIC staff, in order to maintain the confidentiality of the information provided, and no identification of the respondents was provided to the Subgroup. The Subgroup reviewed the responses for reasonableness, and follow-up calls were made by NAIC staff to clarify any apparent inconsistencies or other anomalies within each company's response.

We consider the responses to be sufficient in number for our purpose. (Note that in 2005, the Subgroup's recommendations were based on twelve responses to the 2005 survey.) We note in particular that the responses provided a reasonably wide range of results on the most significant questions.

C. Analysis Methods and Results.

Our methods of analysis and our development of the recommended factors are described immediately below.

1. Underwriting Risk Factors for Standard Coverage: Factors Reflecting Reinsurance Coverage and Risk-Corridor Protection.

The discounted factors are the ones that are meaningful for practical purposes. It makes sense, then, to build the factors backward, starting from the factors that will be applied in practice and then working up to the undiscounted factors. Those basic Underwriting Risk Factors per se, without adjustment, do not apply to any business, but are needed within the current structure of the RBC formulas as a basis to which the Discount Factors will be applied.

We began by selecting a risk factor that would be appropriate to "large" entities (entities with Medicare Part D premium in excess of the $25 million breakpoint) that were subject to both reinsurance and the risk corridors. In order to develop that factor, we analyzed the results of survey question #1. As part of that analysis, we considered the following two scenarios, which also served as the foundation of the Subgroup's 2005 analysis:

(a) a single year of the "reasonably worst case scenario" as defined in the survey;

(b) three years of experience, where a single year at expected benefit cost levels is followed by two years of the "moderately adverse case scenario," as defined in the survey.

For both scenarios, we took into account the fact that the adverse experience would first reduce reported profits below the expected level, and only after profits were totally eliminated would the adverse experience have an effect on statutory net worth. Our estimate of expected profitability was based on the responses that we received to survey question #4.

For each response within each scenario, we imposed a minimum adverse result of 2% of claims (i.e., if the response would have produced a result of less than 2% for a particular scenario, then we replaced that result with 2% in our analysis). The 2% minimum value was also used in the 2005 analysis. It was chosen because it is the factor that the RBC formulas apply to the Federal Employees Health Benefits Program; the Subgroup believed that this factor represented a reasonable floor for a risk charge applicable to Medicare Part D.

Having reviewed the results for each scenario, we tried to select factors that were representative of the responses provided, without giving much weight to obvious outliers. Our primary focus was on the responses at the plan level, given that the risk corridors are applied at that level; however, we also considered the effects of "rolling up" multiple plans within a reporting entity.

Based on our analysis, we concluded that a factor of approximately 3.9% would be appropriate as a large-entity factor. However, this factor represents a weighted average of an initial factor (applicable to premium volumes below the $25 million breakpoint) and an excess factor (applicable to the excess of the premium volume above the breakpoint). In order to determine the initial and excess factors, we had to make two other determinations first: the proper proportionality between the initial and the excess factors; and a typical premium volume for an entity with premium in excess of the breakpoint.

For the current factors, the ratio of the excess factor to the initial factor is approximately 77%. (Note that this proportionality is preserved regardless of which Discount Factor, if any, is applied.) Our review of the responses to the survey suggested that the ratio should be much lower, perhaps 55% at most. We also considered the comparable ratios that the RBC formulas incorporate into the experience fluctuation risk charges for Comprehensive Medical, Medicare Supplement, and Dental and Vision: respectively, 60%, 64%, and 63%. We did not feel that the diversification benefit of large volumes of Medicare Part D business should be greater than was assumed for these other coverages. To reflect that belief, while giving some weight to the survey results, we decided that we should use the lowest of those ratios, 60%.

To determine a typical premium volume, we reviewed the information from the 2007 Medicare Part D Supplements. We considered the premium volumes for standard (or actuarially equivalent) coverage under individual plans only, excluding any risk-corridor adjustments. We used several different measurements, to limit the impact of outliers. Our conclusion was that, for companies with Standard Coverage premium in excess of the $25 million breakpoint, $150 million was a reasonable value for a typical premium volume.

In order to have a ratio of 60% between the initial and excess factors, and a weighted average factor of 3.9% for an entity with $150 million of premium, it is necessary (given the $25 million breakpoint) for the initial factor to be 5.85% and the excess factor to be 3.51%.

Keep in mind that the 3.51% factor is a marginal factor applicable only to the portion of premium in excess of the breakpoint. It serves as an asymptotic limit to the effective average factor for a volume of business, so that even for extremely large volumes of business the effective factor is never as low as 3.51% (though for very large volumes the difference is negligible).

2. Discount Factors for Standard Coverage.

We compared the results of survey questions #1 and #2 to determine an appropriate proportionality between factors reflecting Risk-Corridor Protection alone and factors reflecting both Reinsurance Coverage and Risk-Corridor Protection. Again, we made use of the two scenarios described in section III.C.1 immediately above. Not all of the respondents to question #1 provided responses to question #2, so to avoid any resulting distortion of the proportionality, for this purpose we considered question #1 responses from only the respondents to question #2.

Note that, in their answers to question #2, the respondents may have been reflecting different demographic mixes or benefit structures than were reflected in their responses to question #1, because they believed business without Reinsurance Coverage was likely to be different in such respects from the business to which Reinsurance Coverage applies. Such a distinction would be appropriate for our present purposes, because it would reflect the respondents' views as to real differences between those categories of business, which should be incorporated into the RBC requirements. However, it may therefore be inappropriate to use these responses, and our analysis, to draw broader conclusions about how the Reinsurance Coverage per se affects the potential for adverse deviations in Medicare Part D experience.

For the current factors, the ratio of factors reflecting Risk-Corridor Protection alone to those reflecting both Reinsurance Coverage and Risk-Corridor Protection is approximately 143%. Based on our analysis of the survey responses, we feel that this ratio continues to be reasonable, and we retained it for our development of our recommended factors.

We then considered the question #2 responses, still employing the two scenarios previously described, with and without application of the risk corridors. We concluded that adverse fluctuations unmitigated by the risk corridors would be approximately three times as large as the fluctuations after application of the risk corridors. This 300% ratio is, equivalently, the ratio of the undiscounted risk factors to the risk factors reflecting Risk-Corridor Protection only; accordingly, the factors reflecting Risk-Corridor Protection should be one-third of the undiscounted factors.

To accord with the foregoing conclusions, the Discount Factors should be:

- for Risk-Corridor Protection only, 0.667 (= 1 - 1/3);

- for Reinsurance Coverage and Risk-Corridor Protection, 0.767 (= 1 - [1/3 ÷ 1.43]).

3. Underwriting Risk Factors for Standard Coverage: Initial Factor and Excess Factor.

If the underwriting risk factors reflecting both Reinsurance Coverage and Risk-Corridor Protection are to be those indicated in section III.C.1 above, and the Discount Factors are to be those indicated in section III.C.2 above, it follows that:

- the Underwriting Risk Initial Factor should be 25.1% (0.251, as it will appear in the RBC formula); and,

- the Underwriting Risk Excess Factor should be 15.1% (0.151).

These are the factors that we recommend in section II.B, above.

Note again that these Underwriting Risk Factors themselves, without any discount, are not expected to apply to any business in the foreseeable future. These factors only serve as a basis to which the Discount Factors will be applied.

4. Underwriting Risk Factor for Supplemental Benefits.

To determine an Underwriting Risk Factor for Supplemental Benefits, we reviewed the responses to survey question #5. Again, we made use of the two scenarios described above in section III.C.1 above, including the profit margin considerations and the 2% floor. Unlike the factors for Standard Coverage, which are effectively applied to incurred claims (in the structure of the RBC formulas, premium multiplied by a claims ratio), the factor for Supplemental Benefits is applied to premium. We therefore also had to give consideration to likely loss ratios for this business.

Taking into account all of the considerations just described, we concluded that a factor of 35% would be appropriate. Note, however, that this represents almost a tripling of the current 12% factor. We were concerned about the magnitude of this increase, for the following reasons.

- An increase in the factors for Standard Coverage could have been anticipated, given the known changes in the risk-corridor structure. An increase in the factor for Supplemental Benefits may not have been as foreseeable.

- The magnitude of the increase in factors for Standard Coverage might have been roughly estimated, since the changes in the risk-corridor structure were already known. There was no similar basis for estimating the magnitude of any change in the factor for Supplemental Benefits.

- Pricing of Supplemental Benefits is already locked in for 2009, and pricing for 2010 may be complete, or nearly so, by the time any new factors are adopted.

Companies will want to earn a reasonable rate of return on the capital that is required for these benefits, but may have difficulty in accommodating an immediate large change in that requirement.

To address those concerns, we are recommending that the new Underwriting Risk Factor for Supplemental Benefits be phased in over a three-year period, in a roughly linear fashion, as indicated in section II.B above. Please recall that the potential 2012 change in the risk-corridor structure should not directly impact the experience for Supplemental Benefits, which are not subject to risk-corridor adjustments. Therefore, the fully phased-in factor can be expected to be applicable for an extended period.

IV. Future Considerations.

Ultimately, the RBC factors applicable to Medicare Part D should be based on an analysis of actual experience for the coverage. Such experience may be obtainable from the Annual Statement Supplement, if reporting accuracy can be improved. We also believe there is much value in continuing to seek data from CMS, particularly as more years of experience become available. CMS data would contain details that are unavailable from the Supplement. In addition, we believe it will be useful to perform another survey such as the one used for this analysis, as a basis for evaluating ongoing improvements in pricing arising from more extensive experience with this coverage. The latter may be especially important with respect to Supplemental Benefits, which may undergo significant design changes as companies obtain more experience with how enrollees make use of various types of benefits. Also, any significant changes to the definition of Standard Coverage will require prospective, rather than retrospective, evaluation.

At a minimum, we believe that additional analysis should be performed to address whatever changes in Risk-Corridor Protection occur in 2012, if CMS decides to alter the current corridor thresholds and risk-sharing percentages at that time. In addition, it may be useful to begin consideration of changes in the structure of the RBC formulas as they apply to Medicare Part D. Such changes take longer to implement than factor changes, so development of any such changes should be initiated as early as possible. Some areas of possible change include the following.

- Consider adjusting the breakpoint between the initial and excess factors. The consensus of the respondents to the 2008 survey appeared to be that a $25 million breakpoint is still reasonable. However, as prescription drug unit costs and utilization change over time, and especially if Standard Coverage is redefined, it may be appropriate to reconsider the breakpoint.

- Under the current structure, the proportionality of the excess factor to the initial factor remains the same regardless of which Discount Factor is to be applied. It may be desirable to have a structure where that relationship can be varied depending on whether Reinsurance Coverage applies, since the decrease in risk as premium volume increases may be different for blocks with and without Reinsurance Coverage. It may also be

desirable to have distinct breakpoints for business with and without Reinsurance Coverage.

- As discussed previously, the factor for Supplemental Benefits is applied to premium, whereas the factors for Standard Coverage are applied to claims. The Supplemental Benefits factor could also be applied to claims, in order to make the underwriting risk charge more responsive to each entity's experience. This formula change would require a corresponding change in the factor, to make the change neutral on average.

- Some consideration might also be given as to whether a factor should be established for employer-based coverage. As noted in section II.A above, employer-based stand-alone coverage is subject to the "Other Health" factor, which may not be appropriate for this type of benefit.

Appendix: Risk-Mitigation Features of Medicare Part D.

The federal statute that established Medicare Part D contains several features that are intended to mitigate the financial risk to those entities that provide Medicare Part D coverage. This section provides summary descriptions of those features.

A. Health Status Risk Adjustment.

Medicare Part D premiums for Standard Coverage are adjusted to reflect the relative anticipated levels of benefit costs for individual enrollees. This risk adjustment is based on individual health status and is intended to align the premiums more closely with the expected benefit costs of the specific enrolled population. Accordingly, the risk adjustment should reduce the chances that an entity providing Medicare Part D coverage will experience adverse financial results simply because an above-average number of high-cost individuals enroll with that particular entity. The adjustment factors, or "risk adjusters," will be determined annually in advance of the annual coverage period. Premiums for Supplemental Benefits do not receive this risk adjustment.

B. Reinsurance Coverage.

Generally, when benefit costs under Standard Coverage exceed a specified out-of-pocket threshold, the federal government is financially responsible for 80% of those excess costs. The enrollee pays 5% of the excess (or specified co-payments, if greater); the remainder of the excess (typically 15%) is the responsibility of the entity providing the Medicare Part D coverage. The federal government's assumption of 80% of the excess costs is referred to as "Reinsurance Coverage." (Note, however, that this feature is not accounted for as reinsurance for statutory financial reporting purposes. Instead, pursuant to Interpretation INT 05-05 in the NAIC's *Accounting Practices and Procedures Manual*, the excess costs are considered to be part of a government-sponsored uninsured plan.)

Some coverage providers may participate in a Part D Payment Demonstration, pursuant to which they would receive a pre-determined additional per-enrollee payment in lieu of the 80% Reinsurance Coverage. These entities would therefore not receive the risk-mitigation benefit of the Reinsurance Coverage. Note, however, that the additional costs borne by these entities would be subject to the Risk-Corridor Protection described in section III.C, below.

C. Risk-Corridor Protection.

The federal government adjusts its payments to each entity providing Medicare Part D coverage, based on the degree to which actual benefit costs vary from the level that was anticipated (the "target amount") in the entity's bid for its Medicare Part D contract. The government establishes thresholds for symmetric risk corridors above and below the target amount, defined as percentages of that target amount. Depending on where the actual benefit costs fall within those corridors, a specified percentage of the deviation (favorable or

adverse) from the target amount is retained by the entity providing the coverage, and the remaining benefit or cost is passed on to the government.

The law creating Medicare Part D provided specific risk-corridor thresholds and risk-sharing percentages for 2006-2007, and a different set of thresholds and percentages for 2008-2011. The law provides that the risk-corridor protection will continue after 2011, but that the corridors may be redefined at the discretion of federal regulators.

For 2006-2007, the risk-corridor thresholds were set at ±2.5% and ±5.0%. If actual benefit costs to the entity fell within ±2.5% of the target amount, the entity retained the full deviation. If actual benefit costs fell between the 2.5% and 5.0% thresholds, then 75% (although potentially 90% under certain specified circumstances) of the deviation between those thresholds was assumed by the government; i.e., if experience was worse than anticipated, the government made an additional payment to the entity equal to 75% of the deviation beyond 2.5%, and if experience is better, then the entity paid 75% of the deviation beyond 2.5% to the government. If actual benefit costs fell beyond either of the 5.0% thresholds, then in addition to the 75% payment there was a payment of 80% of the deviation beyond that second threshold.

For 2008-2011, the risk corridors are widened to ±5.0% and ±10.0%, and the 75% factor is reduced to 50%; the 80% factor is unchanged. For 2012 and later, the thresholds can be reset, but the threshold percentages must be at least 5.0% and 10.0% respectively.

In the context of RBC, the importance of the risk corridors arises from their impact when benefit costs are greater than expected. For example, during the 2008-2011 period, if actual benefit costs are 120% of the target amount, the PDP Sponsor does not bear the entire 20% adverse deviation. Instead, its costs are limited to 9.5% (the first 5.0% of the target amount, plus 50% of the next 5.0%, plus 20% of the additional 10% deviation). Clearly, the Risk-Corridor Protection can substantially reduce the risk borne by an entity that provides Medicare Part D coverage.

Note that Risk-Corridor Protection does not apply to Supplemental Benefits (that is, benefits in excess of what the federal government has defined as Standard Coverage or coverage that is actuarially equivalent to Standard Coverage). Neither does it apply to employer-based Medicare Part D coverage.

Medicare Part D Industry Survey

We are requesting your response to this survey by **Monday, December 1, 2008**. Please send the completed survey to:

Crystal Brown
Insurance Reporting Analyst - NAIC
cbrown@naic.org
816-783-8489

If you have any questions regarding this survey, please contact:

Crystal Brown
Insurance Reporting Analyst – NAIC
cbrown@naic.org
816-783-8489

The survey questions are stated below, preceded by introductory and explanatory material.

Survey Purpose

In 2005, the NAIC adopted changes to its Risk-Based Capital (RBC) formulas to accommodate the Medicare Part D program that became effective in 2006. The adopted changes apply solely to stand-alone Medicare Part D Prescription Drug Plan (PDP) business. Medicare Part D benefits offered as part of a Medicare Advantage plan are considered part of a comprehensive medical plan, and do not receive the separate treatment accorded to stand-alone PDPs.

The RBC formula changes were based on recommendations made by the American Academy of Actuaries' Medicare Part D RBC Subgroup. Because there was no historical experience on which to base RBC factors, a survey was undertaken to elicit opinions from actuaries who were involved in the pricing of Medicare Part D benefit plans at that time. An analysis of the survey responses was the primary basis for the subgroup's recommendations.

Since that time, two changes have occurred that may significantly affect the risk profile of the Medicare Part D business.

- Effective for 2008, the "risk corridor adjustments" that reduce the impact of both favorable and unfavorable claim experience have been changed per statute. The new structure, effective until at least 2011, incorporates wider risk corridors and lower risk-sharing factors. All else being equal, this change would tend to make companies' financial results for Medicare Part D more volatile.
- Many of the companies that write Medicare Part D business now have actual experience on which to base pricing assumptions. Presumably, this should lead to more accurate pricing and less volatility in financial results.

Accordingly, the NAIC is considering changing the RBC factors applicable to Medicare Part D, with the changes (if needed) to be effective for 2009 and going forward.

In order to reflect the two changes just described, as well as to gauge the accuracy of the assumptions made in 2005, the NAIC has requested that the Academy's subgroup update its 2005 analysis to include new information. In part, the updated analysis will be based on historical data for 2006-2007. However, during that period, Medicare Part D pricing was still based on very limited data, and so would not reflect the improved pricing accuracy that would be expected for 2009 and going forward.

This survey is intended to gather information that can be used to adjust the historical experience to reflect anticipated improvements in pricing accuracy. Given the nature of the survey questions, the information gathered through this survey will be subjective to a large degree (as was true of the survey responses in 2005). It is all the more important, then, to obtain a broad-based response, so that outliers can be identified and their effects mitigated.

In order for the NAIC to adopt any needed changes to the RBC formulas in a timely fashion, we are asking for your responses to be submitted no later than **Monday, December 1, 2008**.

Use of the Survey Responses

The responses to this survey will be used solely for the purpose of reviewing and adjusting the RBC formulas. No company-identified data will be published, or provided to any state regulatory agency. The responses will be collected by NAIC staff personnel, and all data provided to other parties, including the Academy, will be "blinded" (company names and other identifying information will be eliminated and replaced with generic identifiers created solely for use in this undertaking).

Explanation of Terminology

You probably are already familiar with most of the terms used in this survey. However, to minimize the likelihood of misunderstandings, we offer the following explanations of particular terms:

> Health status risk adjustment: The Medicare Part D premiums received by a carrier are adjusted to reflect the relative anticipated benefit costs for individual beneficiaries. These health status risk adjustments are prospective rather than retrospective, and are based on individual health status as reflected in the prior year's hospital and physician encounter information.
>
> Low-income cost-sharing subsidy: Medicare Part D beneficiaries who meet certain criteria receive financial subsidies from the federal government. These subsidies take two forms. The premium portion of the subsidy is an additional payment by the Centers for Medicare and Medicaid Services (CMS) that reduces the monthly premium that the

beneficiary must pay to the Medicare Part D carrier. The cost-sharing portion of the subsidy is an amount of claims that would normally be the responsibility of the beneficiary, but is instead paid by the carrier, and for which the carrier is then reimbursed by CMS.

Reinsurance coverage: This is the federal government's assumption of financial responsibility for 80 percent of a beneficiary's claims above a specified dollar threshold. In the original 2006 benefit structure, the threshold was $5,100. For 2009, the threshold will be $6,153.75. "Reinsurance coverage" for purposes of this survey does not include any reinsurance ceded by a company to a non-governmental reinsurer. Note that, pursuant to statutory accounting principles, this reinsurance coverage is actually reported in statutory financial statements as uninsured business rather than as reinsurance.

Reinsurance payment demonstration: Companies that participate in the reinsurance payment demonstration forgo the federal reinsurance coverage described above. Such companies assume financial responsibility for the 80 percent of over-threshold claims that would otherwise be payable by the federal government. As compensation for taking on this risk, the companies receive additional premium from CMS.

Risk corridor protection: The Medicare Part D program limits the extent to which a company will benefit or suffer from large deviations in actual claim experience versus the experience that was anticipated in the pricing documentation submitted to CMS. If the actual experience falls within a certain range or "corridor," defined in percentage terms, around the anticipated experience, no adjustment is made. When experience falls outside that range, a specified percentage of the deviation, whether favorable or unfavorable, is reimbursed to or by (respectively) the federal government. "Risk corridor protection" means the reduction in a company's claim expense that arises from this sharing of adverse experience between the company and the federal government. For companies that participate in the reinsurance payment demonstration, the relevant experience includes the additional claims for which the company has assumed responsibility. The experience subject to risk corridor protection excludes any supplemental benefits, i.e., those in excess of the standard (or actuarially equivalent) Medicare Part D coverage.

Company Information

Company Name_____
NAIC Company Code_____
Company Contact Name_____
Company Contact Phone Number_____
Company Contact E-mail address_____

Survey Questions

This survey relates solely to stand-alone Medicare Part D PDPs. Medicare Part D benefits that are integrated with Medicare Advantage plans are outside of the scope of this survey.

Note that, for several of the questions below, responses are requested at two levels: "Plan" and "Legal Entity." For this purpose, "Plan" means a distinct Medicare Part D benefit design, i.e., a separate plan as CMS would recognize it. If your company writes multiple plans, please answer with respect to your average plan, meaning one with a size that is roughly average for the plans that your company writes, with a benefit structure that is most typical. "Legal Entity" means a distinct entity licensed by one or more state regulatory agencies and filing a separate statutory financial report with its regulatory overseers. A legal entity may write more than one plan, and we are interested in your perspective on how the responses to the questions would be altered by aggregating all of the plans that a particular legal entity writes.

Please provide your opinions in response to the following questions:

1. Define X to be the target benefit ratio (i.e., loss ratio) that your company has filed in a bid with CMS for standard (or actuarially equivalent) coverage. What would you consider to be reasonably worst case (95 percent confidence level) and moderately adverse case (70 percent confidence level) scenarios for the experience expressed as a percent of X (not of premium)? That is, an answer of 150 percent of X would mean that actual ultimate claims costs would be 50 percent greater than was assumed in the bid. In answering this question, consider that CMS uses health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population, but ignore the risk corridor protection. Also assume that the carrier does not participate in the reinsurance payment demonstration and receives the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage.

	(i) Plan level	(ii) Legal Entity level
a. Reasonably worst-case scenario	_____	_____
b. Moderately adverse-case scenario	_____	_____

2. Please provide revised responses to Question #1 for plans that participate in the reinsurance payment demonstration. That is, the applicable fully insured coverage includes both the standard (or actuarially equivalent) benefit and the additional 80 percent of catastrophic claims in excess of $6,153.75 (the 2009 threshold) per individual per year. As in Question #1, again consider that CMS will use health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population, and again ignore the risk corridor protection. Also assume that the carrier receives the average premium calculated in the pricing of the catastrophic coverage for the reinsurance payment demonstration and the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage.

	(i) Plan level	(ii) Legal Entity level

a. Reasonably worst-case scenario	_____	_____
b. Moderately adverse-case scenario	_____	_____

3. In answering the above questions, what volume of business did you have in mind? (Indicate a range, as defined below, rather than a specific dollar amount.) For this purpose, "annual premium" would include revenue from CMS (including the premium portion of the low-income cost-sharing subsidy) and from the individual enrollee. "Annual premium" would exclude payments made pursuant to the federal reinsurance coverage and the "cost-sharing" (i.e., benefit reimbursement) portion of the low-income cost-sharing subsidy. Assume no revenue related to the risk corridor protection.

	(i) Plan level	(ii) Legal Entity level
Less than $25 million of annual premium	_____	_____
More than $25 million of annual premium	_____	_____

4. In developing your company's stand-alone Part D product (PDP), what was the average profit and/or risk margin assumed in aggregate (all products and regions combined) for your bid submission? The amount should be provided on a pre-income-tax basis. The response to this question is not applicable at the "Plan" level, and should be given on a "Legal Entity" basis. Please indicate one of the following ranges.

_____ Less than 2 percent
_____ 2-4 percent
_____ 4-6 percent
_____ Greater than 6 percent

5. Some carriers provide supplemental benefits to enrollees, covering costs that under the standard Part D coverage would be the enrollees' responsibility (co-pays, deductibles, coinsurance, and/or the coverage gap). What do you believe would be the reasonably worst-case and moderately adverse- case, as defined in Question #1, for the experience on such supplemental benefits? Respond for the supplemental benefits only, not the combination of standard coverage and supplemental benefits.

	(i) Plan level	(ii) Legal Entity level
a. Reasonably worst-case scenario	_____	_____
b. Moderately adverse-case scenario	_____	_____

6. In your responses to Questions #1, #2, and #5, you may have assumed that some portion of the Medicare Part D benefits was paid in the form of a capitation to another party. For each of those responses, please indicate the percentage of the claim payments that you were assuming were in the form of such a capitation.

For Question #1: _____percent
For Question #2: _____ percent
For Question #5: _____percent

7. With regard to your answers to Questions #1 and #2, how much improvement would you expect to see for the 2009 coverage year vs. the 2007 coverage year, now that there is additional historical experience to use as a basis for pricing? For example, if your answer would have been 120 percent of X for 2007 but 115 percent of X for 2009, the improvement would be stated as 25 percent (a reduction from 20 percent adverse experience to 15 percent adverse experience). Once again, ignore the risk corridor protection.

   Improvement with respect to Question #1:

	(i) Plan level	(ii) Legal Entity level
a. Reasonably worst-case scenario	_____	_____
b. Moderately adverse-case scenario	_____	_____

   Improvement with respect to Question #2:

	(i) Plan level	(ii) Legal Entity level
a. Reasonably worst-case scenario	_____	_____
b. Moderately adverse-case scenario	_____	_____

8. Currently, the Medicare Part D RBC risk factors are tiered, with a higher factor applying to the first $25 million of premium revenue, and a lower factor applying to amounts in excess of $25 million (so that for total volumes greater than $25 million, the applicable factor is a weighted average of the two stated factors). This formula structure presumes that smaller volumes of business experience more volatility than higher volumes, and that a premium level of $25 million is approximately where the size-related advantage becomes significant. We expect that this $25 million breakpoint will remain in effect at least through 2009.

   a. Please indicate whether you feel that this breakpoint will be appropriate for 2010, or whether the breakpoint should be changed; and in the latter case, what alternative breakpoint you would recommend.

      _____ $25 million is an appropriate breakpoint.

      _____ A more appropriate breakpoint would be $_____.

   b. For the breakpoint that you indicated in response to Question #8a (whether $25 million or otherwise), please indicate the approximate number of Medicare Part D enrollees to which that dollar amount would correspond.

      Corresponding number of Medicare Part D enrollees: _____