



AMERICAN ACADEMY *of* ACTUARIES

September 19, 2008

Dennis Julnes
Chair, Health RBC Working Group
NAIC Capital Adequacy Task Force

Subject: Medicare Part D Survey

Dear Mr. Julnes:

The NAIC, through its Health RBC Working Group, has asked the American Academy of Actuaries'¹ Medicare Part D RBC Subgroup for a recommendation as to whether, and how, the Risk-Based Capital factors for Medicare Part D should be changed effective 2009. As you are aware, the subgroup's analysis will be based in part on historical data. However, because of limitations regarding the historical data, we wish to supplement it with additional information gathered from a survey of carriers writing Medicare Part D business, as was used to develop the original RBC factors in 2005.

Attached is a draft of the proposed survey. We request that your working group act as the sponsor and distributor of this survey. We prefer that you sponsor the survey, rather than our subgroup, to alleviate any concerns about the Academy directly receiving potentially confidential data. It also will likely increase the response rate (as surveyed companies may be more likely to respond if it is clear that the survey serves a specific regulatory purpose and is supported by the regulators).

We are proposing that the response deadline for the survey be about four weeks from when it is mailed.

If you would like further information about the purpose of the survey or about any specific question included in the survey, we would be happy to discuss the matter with you. Please let us know if you are unable to sponsor the survey.

Sincerely,

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

¹ The American Academy of Actuaries is a professional association with over 16,000 members, whose mission is to assist public policymakers by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Medicare Part D Industry Survey

We are requesting your response to this survey by [four weeks from mailing]. Please send the completed survey to:

[submission info]

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

[contact info]

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 [four weeks from mailing].

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.

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. Assume that a carrier has filed a bid with CMS with a target benefit ratio (e.g., loss ratio) of X. 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 the actuaries assumed in their pricing. 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.

	<u>(i) Plan level</u>	<u>(ii) Legal Entity level</u>
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.

	<u>(i) Plan level</u>	<u>(ii) Legal Entity level</u>
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.

	<u>(i) Plan level</u>	<u>(ii) Legal Entity level</u>
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.

	<u>(i) Plan level</u>	<u>(ii) Legal Entity level</u>
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:

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

Improvement with respect to Question #2:

	<u>(i) Plan level</u>	<u>(ii) Legal Entity level</u>
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: _____