



AMERICAN ACADEMY *of* ACTUARIES

June 11, 2014

To: Mr. Patrick McNaughton, Chair, NAIC Health Risk-Based Capital (RBC) Working Group

From: Brian Collender, Chair, American Academy of Actuaries, Medicare Part D RBC Subgroup

Re: Report on RBC Risk Factors for Medicare Part D Coverage.

Dear Mr. McNaughton,

The American Academy of Actuaries' Medicare Part D RBC Subgroup wishes to present the attached report recommending the RBC Risk Factors for Medicare Part D coverage remain the same based on a recent analysis of detailed carrier experience. This report was written by our subgroup as a follow-up to our report released in March 2009.

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 Tim Mahony, the Academy's state health policy analyst at (202) 785-7880 or mahony@actuary.org.

Sincerely,

Brian Collender, MAAA, FSA
Chairperson, Medicare Part D RBC Subgroup
American Academy of Actuaries

CC: Crystal Brown, NAIC Staff Liaison

Attachment: Report on RBC Risk Factors for Medicare Part D



AMERICAN ACADEMY *of* ACTUARIES

**Report on Risk-Based Capital (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 Risk-Based Capital Working Group

June 2014

The American Academy of Actuaries is a 18,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels 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.

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I. The Charge

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

In September 2005, the subgroup provided recommendations to the NAIC's 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 to 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 2005, the subgroup recommended values for those additional factors, which were subsequently adopted by the NAIC.

One of the most important aspects of 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 Appendix 1 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 the risk corridors. However, issuers 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. The subgroup advised, therefore, that the RBC factors be updated to reflect both the change in the risk corridor protection and the improvement in issuers' knowledge as the program evolved. The subgroup reiterated this recommendation in a [letter](#)¹ to the Task Force's Health Risk-Based Capital (HRBC) Working Group, dated May 3, 2007.

In March 2008, the HRBC Working Group asked the subgroup to re-evaluate the reasonableness of the Medicare Part D factors, in light of changes to the risk corridor program and the additional industry experience with Medicare Part D.

In a letter dated March 20, 2009, the subgroup proposed changes to the Medicare Part D RBC factors for both standard coverage and supplemental coverage Part D benefits based on the HRBC Working Group request. Standard coverage refers to the Part D benefit design that conforms to certain standards prescribed by the government. Supplemental coverage refers to benefits in excess of the standard coverage. The factors were developed using a survey submitted to issuers that participated in the Part D marketplace. . The recommended factors for standard coverage were not a significant change from those initially recommended, but the recommended supplemental coverage factor increased by 292 percent (compared to the initial supplemental coverage factor). These changes were eventually approved and became effective with the 2009 RBC calculation.

¹See Academy letter from the Medicare Part D RBC Subgroup to the NAIC Health Risk-Based Capital Working Group: <http://actuary.org/files/publications/ltr%20to%20NAIC%20on%20Medicare%20Part%20D%20risk%20factors%20050307.pdf> (May 3, 2007).

In the March 20, 2009 report, the subgroup recommended that certain factors be revisited in the near future. Specifically, the subgroup made a recommendation to try to use actual experience from either NAIC Annual Statement Filings or the Centers for Medicare and Medicaid Services (CMS) to further refine the RBC factors. This included determining if the supplemental coverage factor was reasonable given that the 35 percent recommended factor was based on a survey of actuaries within the industry, instead of actual supplemental coverage experience.

Over the past few years, the subgroup attempted to gather data and experience to verify the reasonability of the Medicare Part D RBC factors based on actual industry experience. Such sources analyzed included data pulled from NAIC Annual Statement Filings and data provided by CMS. However, given a number of issues with these data sources, the NAIC issued a survey on behalf of the subgroup to collect summaries of experience from Part D plans to determine the reasonability of the current factors. The issue that the subgroup encountered with the CMS data source was that the data was not at the level needed to develop the appropriate analysis. The data had been requested in a certain format; however, CMS was only able to provide summarized data that the subgroup did not believe was adequate for the level of analysis needed. The issue with the NAIC data centered on the fact that many companies did not include their risk corridor payment adjustments, which were needed to better determine what RBC factors were appropriate. The following summarizes the subgroup's process, results, and conclusions regarding the current Medicare Part D RBC factors. The subgroup also includes recommendations for future enhancements to further validate the factors.

Many of the capitalized terms used in this report are defined in the RBC instructions that were [submitted](#)² to the NAIC task force in September 2005.

II. Recommendations

This section includes a summary description of the RBC factors required for Medicare Part D and the subgroup's recommendation regarding factors to be used for 2014 and later.

A. *Required Factors*

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

- Two underwriting risk factors applicable to standard coverage—a factor applicable to annual premium up to a specified dollar breakpoint (\$25 million) and a factor applicable to annual premium in excess of that breakpoint. Below the subgroup refers 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 LR020 of the Life RBC formula.

²See Academy letter from the Medicare Part D RBC Subgroup: to the NAIC Health Risk-Based Capital Working Group: <http://actuary.org/files/publications/Memo%20to%20NAIC%20from%20Medicare%20Part%20D%20Subgroup.pdf> (Sept. 10, 2005).

- Four discount factors to reduce the required underwriting risk RBC for standard coverage, depending on which of the federal risk mitigation features are applicable (see Appendix 1 for more details). However, the factor for payments subject to both the reinsurance coverage and the risk corridor protection is the only discount factor currently used. This factor is used on page XR017 of the Health RBC formula and page LR022 of the Life RBC formula. The subgroup expects the single factor to be the only one used in the future, but note this is dependent on CMS’ decision to continue reinsurance coverage and risk corridor protection.
- An 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 LR019 of the Life RBC formula.

Note that these factors apply only to business written as stand-alone individual coverage by a prescription drug plan (PDP) sponsor (i.e., a legal entity providing Medicare Part D as 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 pharmacy coverage outside of Part D that the plan may provide). Government-subsidized employer-based pharmacy coverage (commonly provided through employer group waiver plans (EGWPs)) 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 2014 and Beyond

The subgroup recommends no change to the factors currently being used. These factors are summarized below with discussion regarding the reason for the subgroup’s conclusion to maintain the current factors in section II.C.

Table 1

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
--	-------

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

Please note:

- Factors for business without either reinsurance coverage or risk corridor protection (as described in Appendix 1) are not presented here. At least currently, there is no Medicare Part D business to which such factors would 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 Appendix 1 under “Reinsurance Coverage”). These plans no longer exist because the demonstration program expired; however, the subgroup maintained this factor since it was previously included in prior subgroup reports and in case the structure of the Medicare Part D program changes (i.e., in case such a factor could be needed again); and
- Factors with risk corridors & reinsurance would apply to business with both reinsurance coverage and risk corridor protection.

C. Result of the Survey and Reasons for Maintaining the Current Factors

The survey, discussed in Section III (Methodology), was designed to collect the experience of 16 Part D plans to better assess if the current RBC factors were reasonable in relation to actual experience. For the standard coverage plans, the subgroup determined the current factors were reasonable in relation to the results of the survey. The following table shows the current factor as well as the estimated factor based on the survey results.

Table 2

Initial and Excess Factors for Business subject to Risk Corridors and Reinsurance – Standard Coverage

	<u>Current Factor</u>	<u>Survey Factor</u>
Initial	0.05850	0.05142
Excess	0.03510	0.03505

Based on the above analysis, utilizing the factors developed using the survey data would result in an approximate 5 percent reduction in the net underwriting risk RBC for a Part D plan that had \$75 million in revenue and an 85 percent loss ratio. The survey factors used to develop those shown in Table 2 for large groups (those with excess of \$25 million in premium) were based on the maximum observed potential loss in any one year indicated

within the survey results. This breakpoint was chosen due to the lack of volatility in actual losses within the large groups participating in the survey.

For small groups (those under \$25 million in premium), the average potential loss over a three-year period (in which it is assumed two of the three years would produce an actual-to-expected level equal to the average of the two worst performance years, and the third year would produce a profit equal to the expected profit level) was chosen. The small group data was more volatile than the large group data, and it appeared to make more sense to use an average than the maximum of any one year. It is noted that for this second methodology a three-year period was used to be consistent with prior years. Further, since Medicare Part D is a relatively new product, it was determined by the subgroup that using more than three years of experience may not be reasonable in the approach for developing the RBC factors being studied.

Lastly, the one-year methodology was used for large group because the three-year methodology produced results indicating that the average loss over the two worst years was less than 2 percent, which was the minimum loss that the subgroup wanted to use in the calculation. Therefore, the subgroup assumed it to be more appropriate to look at single year risks for large group. Given that 16 plans participated in the survey and the survey factors were relatively close to the current factors, the subgroup concluded the current factors still remain reasonable.

For the supplemental coverage plans, the subgroup concluded there was not enough evidence that the 35 percent factor currently being used should be adjusted at this time. Of the three years of data obtained, the first two years of data (2009 and 2010) indicated an actual-to-expected ratio of 170.3 percent when excluding data that appeared unreasonable. The 2011 actual-to-expected was 106.2 percent when excluding unreasonable data and plans that offered supplemental coverage for the first time (actual-to-expected was 137.7 percent when including the one plan that offered supplemental coverage for the first time).

Since a large improvement was seen in the actual-to-expected ratios, there was a concern that using the data provided would not produce representative results for future supplemental coverage experience. In addition, 2011 was the first year of the Manufacturer Coverage Gap Discount Program (CGDP), which required pharmaceutical manufacturers to pay 50 percent of the cost of their Part D covered brand medications that are incurred by non-low income beneficiaries within the Part D coverage gap. This new benefit provision could result in an improvement in actual-to-expected pricing for supplemental coverage, indicating that a factor lower than 35 percent may be reasonable. The improvement in experience could be the result of reduced anti-selection as all members would have access to greater coverage in the coverage gap. The coverage gap is the allowable cost level under standard coverage in which a member was 100 percent responsible for claim costs prior to the introduction of the CGDP. The reduction of the coverage gap could result in a smaller difference in premium between plans with and without supplemental coverage, hence the possible reduction in anti-selection. Given the volatility in the observations of the actual-to-expected ratios, the subgroup determined a change in the factor was not warranted at this time. It is also noted that the supplemental coverage factor is not heavily used since fewer issuers offer substantial

supplemental coverage benefits due, in part, to the closing of the coverage gap. As the coverage gap continues to close, it is possible that supplemental coverage will be offered even less in future years.

III. Methodology

The primary basis for the subgroup's recommendations was information obtained through a survey of selected companies. The 2013 survey was different than prior survey approaches because it collected historical actual experience versus expected experience from respondents. Further details about data sources and data analysis are provided in the remainder of this section.

A. Data Sources

Initially, the subgroup received information from CMS that included summaries of experience from 2007 through 2010 in the form of decile distributions of actual over targeted experience on a per-member per-year (PMPM) basis by year. The CMS data did not contain sufficient detail to analyze historical results by various sub-segments of organizations offering Medicare Part D coverage (e.g., group/individual, premium size, with and without risk sharing, etc.).

After reviewing and considering CMS data, the NAIC provided data from the Medicare Part D Supplement to the Annual Statement from 2007 to 2011. Unfortunately, there were concerns with the NAIC data. Specifically, observed historical loss ratios for many companies were very high or low compared to the subgroup's expectations. These concerns about data quality precluded the subgroup from using the supplemental data as the primary basis for its analysis.

To obtain a reliable and sufficiently granular data source, the NAIC HRBC Working Group sponsored, on the subgroup's behalf, a survey of PDP sponsors to collect historical actual and expected experience submitted to CMS in Medicare Part D bid pricing tools. This was the primary data source.

B. The 2013 Survey

The 2013 survey was a departure from the surveys issued in 2005 and 2008 as a part of the evaluation of Medicare Part D RBC. These factors historically have been based on a survey of actuaries who were involved in the pricing of Medicare Part D benefit plans. However, with the 2013 survey, several years of actual plan experience was available to better evaluate the reasonableness of the current RBC factors for Part D coverage. More details regarding the survey are described in the remainder of this section. A copy of the survey document is included as Appendix 2 in this report.

1. Purpose of Survey

In 2005 the NAIC adopted changes to its RBC formulas to accommodate the Medicare Part D program that became effective in 2006. The adopted changes apply solely to stand-alone PDP business. Medicare Part D benefits offered as part of a Medicare Advantage plan that are considered part of a comprehensive medical plan and do not receive the separate treatment accorded to stand-alone PDPs. EGWPs are either included with comprehensive medical coverage, if they are part of insured medical plans, or they are treated as “Other Health” if they are stand-alone insured coverage. The RBC formula changes were based on recommendations made by the subgroup. Because the subgroup did not have historical experience on which to base RBC factors, a survey of actuaries who were involved in the pricing of Medicare Part D benefit plans at that time was undertaken. An analysis of the survey responses was the primary basis for the subgroup’s recommendations.

As a result of the 2008 change in the risk corridor adjustments, the NAIC again considered changing the RBC factors applicable to Medicare Part D and implemented changes effective for 2009 and later. Consistent with the basis of the original RBC factors, the subgroup based its recommendations on a survey of actuaries involved in pricing the benefit plans.

In its report to the NAIC, the subgroup indicated it would revisit the Part D RBC factors again when experience could be maintained to verify the reasonableness of the factors. The supplemental benefit factor was specifically identified as a concern given the large increase of this factor between the time the factor was initially developed and the time it was adjusted effective in 2009. Credible historical experience now exists for this coverage, that can be used to verify the current factors. To gauge the accuracy of the assumptions made in 2009, the subgroup, working in conjunction with the NAIC analyzed recent experience to refine the factors as needed. The subgroup engaged the NAIC to survey current writers of Part D stand-alone coverage to gather the experience necessary to complete the study.

2. Solicitation Criteria and Response Rate

The survey was sent by the NAIC to companies that had submitted Medicare Part D supplemental filings to the Annual Statements. It was made clear to the recipients that participation in the survey was optional, not an NAIC requirement.

Responses were received from 16 of the survey recipients in time to be included in the analysis. Responses to the survey were received and compiled by NAIC staff (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 communications were made to NAIC staff to clarify apparent inconsistencies or other anomalies within each company’s submission.

The responses were considered to be sufficient in number for the subgroup to study. The subgroup notes, in particular, that the responses provided a reasonably wide range of results for the most significant questions.

C. Analysis Methods and Results

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

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

The discounted factors, reflecting the reinsurance coverage and risk corridor projection discounts, and the differentiation of risk and associated RBC based on premium magnitude matter the most for practical and analytical purposes. As a result, the component factors required for the structure of the RBC calculation are built backwards, starting from the factors that will be applied in practice and working up to the undiscounted factors. Those basic underwriting risk factors, without adjustment, do not apply to any business but are needed within the current structure of the RBC formulas as a basis on which the discount factors will be applied.

To assess the appropriateness of the factors established in 2009, historical actual to expected experience was evaluated. This experience formed the basis for selecting updated risk factors for small and large groups subject to both reinsurance and the risk corridors. To develop these factors, the expected ratios based on the following data from historical bid pricing tools were analyzed. Experience was aggregated to the plan level.

Basic Plan

Without Risk Sharing: Adjusted Basic Claims / Target Basic Claims

With Risk Sharing: Adjusted Basic Claims / Medical Revenue after Risk Sharing

Supplemental Plan

Supplemental Plan Liability / Target Supplemental Claims

Where:

- Target Basic Claims = The plan's revenue multiplied by the plan's expected loss ratio per its submitted bid
- Adjusted Basic Claims = Actual paid non-supplemental claims divided by the plan's estimated induced utilization factor
- Medical Revenue after Risk Sharing = Target basic claims adjusted for the CMS risk corridor adjustment

- Target Supplemental Claims = The plan's supplemental revenue multiplied by the plan's expected loss ratio per its submitted bid
- Supplemental Plan Liability = Total actual paid claims less adjusted basic claims

As part of the analysis, the following two scenarios were considered (similar scenarios served as the foundation of the subgroup's 2009 analysis):

- (a) a single year of the worst or highest actual-to-expected ratio as defined above; and
- (b) three years of experience, in which a single year at expected benefit cost levels is followed by two years of the average of the two worst or highest actual-to-expected ratios as defined above.

For both scenarios, the adverse experience was assumed to 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. Similar to the 2009 analysis, the calculations assumed the target profit was 4.9 percent, which is near the average profit margin for the Part D stand-alone product, although the median profit margin may be less than 4.9 percent. Given a 4.9 percent profit level, it is assumed that the 2014 medical loss ratio (MLR) requirement would not impact profit levels in the future. This is because administrative costs for Part D plans typically are less than 10 percent, indicating an 85 percent loss ratio would still be attainable on average. Further, the MLR is going to be a non-issue since the reinsurance subsidy for Part D counts in both the numerator and the denominator. With that reinsurance subsidy increasing in recent years, reaching an MLR of 85 percent or greater will not be a concern for any substantive carrier.

A minimum adverse result of 2 percent of claims was assumed (i.e., if the historical experience would have produced a result of less than 2 percent for a particular scenario, then the result was replaced with 2 percent in the analysis). The 2 percent minimum value also was used in the 2005 and 2009 analyses. The minimum was chosen because it is the factor that the RBC formulas apply to the Federal Employees Health Benefits Program. The subgroup believed this factor represented a reasonable floor for a risk charge applicable to Medicare Part D.

Metrics from each scenario, including the minimum, mean, median, maximum, and standard deviation were considered for varying subsets of the experience. The following attributes and combinations of each were considered in creating subsets of experience:

- Basic, supplemental, and basic / supplemental combined experience;
- With and without risk sharing (basic only); and
- Small (less than \$25 million in premium) and large (greater than \$25 million in premium) (basic only).

Based on the analysis, the subgroup concluded the continued use of the 2009 factor of approximately 3.9 percent would be appropriate as a large group factor. 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). To determine the initial and excess factors requires the determination of the proper proportions between the initial and the excess factors, as well as 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 60 percent. This was established by considering the comparable ratios that the RBC formulas incorporated into the experience fluctuation risk charges for comprehensive medical, Medicare supplement, and dental/vision: 60 percent, 64 percent, and 63 percent, respectively. In setting the current factors, the subgroup determined that the diversification benefit of large volumes of Medicare Part D business should be greater than was assumed for these other coverages, and thus chose 60 percent. Partitioning historical experience into small versus large groups based on the \$25 million premium breakpoint, the subgroup evaluated the current 60 percent factor based on the implied excess to initial factors and determined the continued use of 60 percent to be reasonable. No change was made to the assumed \$25 million premium breakpoint or the \$150 million typical premium volume.

As a result of confirming the reasonableness of the continued use of the current large group factor and the excess-to-initial factor, the subgroup concluded that the continued use of the current initial factor of 5.85 percent is appropriate. The initial factor is determined such that a ratio of 60 percent between the initial and excess factors, and a weighted average factor of 3.9 percent for an entity with \$150 million of premium (assuming a \$25 million premium break point) are preserved.

It should be noted that no studies were performed to verify that the \$25 million and \$150 million breakpoints were unreasonable, and the subgroup decided to maintain the prior determined breakpoints.

The 3.51 percent 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 percent (though for very large volumes the difference is negligible).

2. Discount Factors for Standard Coverage

Since there currently are not any plans in force for which only reinsurance coverage is applicable, the subgroup did not study whether the reinsurance coverage discount factor needed to be refined. Further, since the underwriting RBC factor is ultimately based on the results of the subgroup's analysis, it was assumed that the reinsurance coverage and risk corridor protection discount factor were appropriate based on prior survey results and backed into the necessary initial and excess factors.

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

The initial and excess factors are driven by the ultimate underwriting risk factors and discount factors. Therefore, the initial and excess factors are backed into based on the assumed estimates of these factors.

Note these underwriting risk factors, 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

A similar methodology was used to determine an underwriting risk factor for supplemental coverage, and the formulas used are outlined in Section III.C. 1. of this report. It should be noted that not all plans offered supplemental coverage or reported reliable supplemental coverage data in development of the survey responses. Therefore, only 11, 11, and 12 responses for 2009, 2010, and 2011, respectively were used from the 16 responses that were received for each year.

IV. Future Considerations

In this updated analysis, the subgroup used actual experience to verify the reasonability of the current RBC factors. The subgroup attempted to utilize various sources before determining the most beneficial source would be data obtained through a survey submitted to plans who participate in the Medicare Part D market. Due to the changing dynamics of the Medicare Part D program, including the closing of the coverage gap, the subgroup believes that there is much value in continuing to seek updated data through additional surveys to verify the need for potential changes in the Medicare Part D RBC factors.

In particular, the subgroup recommends an updated survey be developed after the submission and approval of the 2015 calendar year bids, which are due to CMS in June 2014. The reason for this recommendation is that this will allow the subgroup to analyze three years of data under the CGDP, which could have an impact on the actual-to-expected results of the supplemental coverage program and allow the refinement to the current supplemental coverage RBC factor to a level more in line with future expectations under this changing program. In addition, gathering more than three years of data will allow the subgroup to better refine the standard coverage RBC factors. The subgroup also would recommend an additional survey field be added to collect each plan's anticipated profit by year to be incorporated into the analysis instead of using the assumption of a flat profit target across all plans.

Further items that may be revisited include the following:

- Determine whether the 4.9 percent assumed profit margin is a reasonable assumption based on actual emerging experience;

- Consider adjusting the breakpoint between the initial and excess factors. A \$25 million breakpoint has been used since the inception of the Medicare Part D program. If a new survey is used to gather additional data and a large amount of credible information is received, this assumption can be further analyzed;
- The factor for supplemental benefits is applied to premium, whereas the factors for standard coverage are applied to claims. The supplemental benefits factor also could be applied to claims 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; and
- Some consideration also might be given as to whether a factor should be established for employer-based coverage. Employer-based stand-alone coverage is subject to the "Other Health" factor, which may not be appropriate for this type of benefit. The number of employer-based coverage PDP members has grown over 350 percent between December 2010 and April 2014, and annual growth rates between 2011 and 2013 have ranged from 40 percent to 115 percent. Information around employer-based coverage was not collected in the survey and could be added as another data collection point.

Appendix 1: Risk Mitigation Features of Medicare Part D

The federal statute establishing Medicare Part D contains several features intended to mitigate the financial risk to entities providing Medicare Part D coverage. This section provides a summary description 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 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,” are 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 percent of those excess costs. The enrollee pays 5 percent of the excess (or specified co-payments, if greater); the remainder of the excess (typically 15 percent) is the responsibility of the entity providing the Medicare Part D coverage. The federal government’s assumption of 80 percent of the excess costs is referred to as “reinsurance coverage.” (Note, however, 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).

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 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.

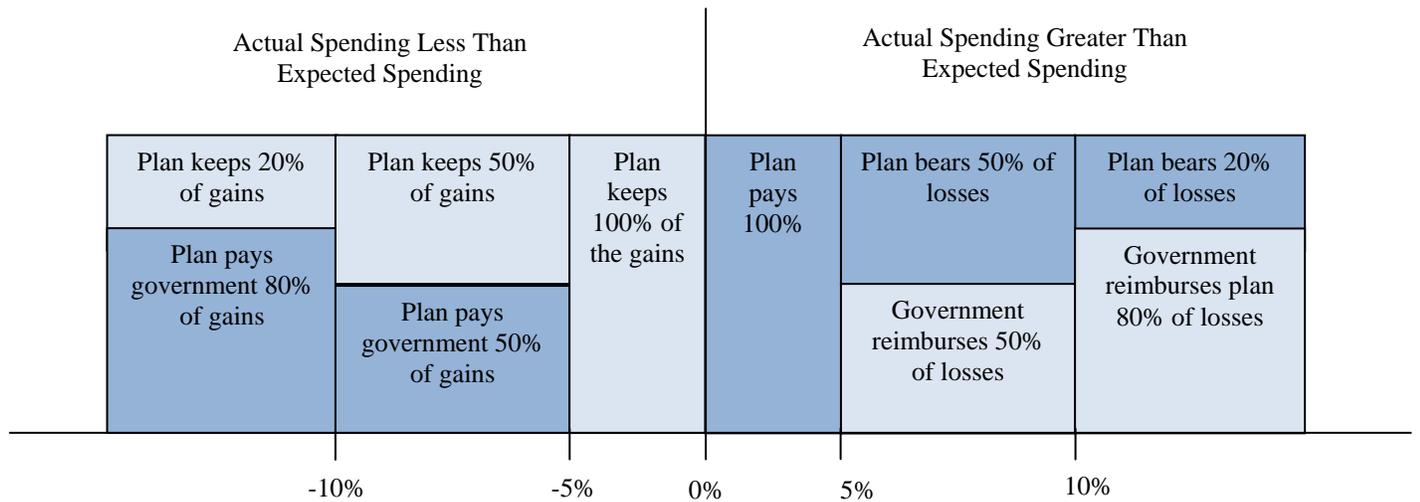
The law creating Medicare Part D provided specific risk corridor thresholds and risk-sharing percentages for 2006-2007 and a different set of thresholds and percentages for 2008-2011. The law provides that the risk corridor protection will continue after 2011 but that the

corridors may be redefined at the discretion of federal regulators. The risk corridors remain in place through at least 2015 based on current regulations.

For 2006-2007, the risk corridor thresholds were set at ± 2.5 percent and ± 5.0 percent respectively. If actual benefit costs to the entity fell within ± 2.5 percent of the target amount, the entity retained the full deviation. If actual benefit costs fell between the 2.5 percent and 5.0 percent thresholds, then 75 percent (although potentially 90 percent under certain specified circumstances) of the deviation between those thresholds was assumed by the government. If actual benefit costs fell beyond either of the 5.0 percent thresholds, then in addition to the 75 percent payment, there was a payment of 80 percent of the deviation beyond that second threshold.

For 2008-present, the risk corridors were widened to ± 5.0 percent and ± 10.0 percent, the 75 percent factor is reduced to 50 percent, and the 80 percent factor is unchanged. For 2012 and later, the thresholds can be reset, but the threshold percentages must be at least 5 percent and 10 percent respectively. CMS has chosen not to change the thresholds through at least 2015.

The following chart illustrates the percentage of risk the plan and CMS take on.



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 percent of the target amount, the PDP sponsor does not bear the entire 20 percent adverse deviation. Instead, its costs are limited to 9.5 percent (the first 5.0 percent of the target amount, plus 50 percent of the next 5.0 percent, plus 20 percent of the additional 10 percent deviation). Clearly, the risk corridor protection can 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). It also does not apply to employer-based Medicare Part D coverage.

D. Coverage Gap Discount Program

Section 3301 of the Affordable Care Act (ACA) established the CGDP in contract year 2011. Under this program, pharmaceutical manufacturers provide a 50 percent discount to non-low income subsidy eligible (non-LIS) beneficiaries receiving applicable (brand) medications in the coverage gap phase of the Part D benefit. The discounts made available under this program are considered incurred costs and, therefore, are applied towards each beneficiary's true out-of-pocket costs and eligibility for reinsurance.

Appendix 2: Medicare Part D Industry Survey

August 2, 2013

TO: Statutory Statement Contact

FROM: Dennis Julnes

Chair, Health Risk-Based Capital (E) Working Group of the NAIC Capital Adequacy (E) Task Force

Re: Medicare Part D Survey

The NAIC Health Risk-Based Capital (E) Working Group adopted new factors in 2009 for stand-alone Medicare Part D coverage. A report from the American Academy of Actuaries (Academy) was sent to the Health Risk-Based Capital (E) Working Group that recommended the factors for stand-alone Medicare Part D coverage be raised. In the Academy's original report, it was also recommended that the prescription drug plan (PDP) factors be reviewed after companies had several additional years of experience.

Several years of actual plan experience are now available to better evaluate the reasonableness of the current RBC factors for Part D coverage. In order to gather the necessary information to develop the PDP RBC factors, which are based on actual vs. expected experience, the attached spreadsheet has been developed and will pull data from the filed bid pricing tools (BPTs) that were submitted to the U.S. Centers for Medicare and Medicaid Services (CMS). The "Instructions" tab of the attached spreadsheet indicates the steps needed to extract the needed information from the stand-alone PDP BPTs.

Before starting, the plan should ensure that all BPTs for the same year are contained within the same directory. The user should also ensure that a fresh spreadsheet is being used for each run that is necessary in filling out the spreadsheet. (Please Note: It is recommended that the user only include one "S" contract within any one spreadsheet.) Some manual entry may be required if a bid was discontinued or mapped to another bid. If that is the case, follow step #6 through step #9 on the "Instructions" tab of the spreadsheet to ensure that the correct information is captured.

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. The responses will be collected by NAIC staff personnel and all data provided to outside parties, including the Academy, will be "blinded" (i.e., company names and other identifying information will be eliminated and replaced with generic identifiers created solely for use in this undertaking).

We are asking for your help to ensure that we have the most accurate data possible in which to review the RBC factors for the PDP coverage. Please forward this letter and the attached Excel file to be completed by the person responsible or actuary in charge of Medicare Part D reporting. If you have any problems opening the attached Word document or Excel file, they will be posted

on the NAIC website at http://www.naic.org/committees_e_capad_hrbc.htm under the Related Documents and Resources tab.

We ask that you send the completed survey (Excel file) back to the NAIC by **Friday, September 13, 2013**. Please send all responses to frssurvey@naic.org. If you have any questions regarding the completion of the survey or completing the Medicare Part D Coverage Supplement, please feel free to contact Crystal Brown at cbrown@naic.org or 816-783-8146.

Thank you for your help with this matter.

Overview

The NAIC Health Risk-Based Capital (E) Working Group is reviewing the Medicare Part D Prescription Drug Plan RBC factors, with assistance from the American Academy of Actuaries Medicare Part D RBC Subgroup. These factors have historically been based on a survey of opinions from actuaries who were involved in the pricing of Medicare Part D benefit plans. Several years of actual plan experience are now available to better evaluate how reasonable the current RBC factors are for Part D coverage. To facilitate this effort, the NAIC Health Risk-Based Capital (E) Working Group asks for current writers of Part D coverage to complete the survey that captures their historical experience in order to refine the factors. The following letter details the background and purpose of the survey; how the NAIC intends to use the survey results; and the detailed data request. Also accompanying this letter is a spreadsheet to be populated by each respondent in order to capture data in a consistent manner.

Survey Purpose

In 2005, the NAIC adopted changes to its 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 Academy's 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 Academy's Subgroup's recommendations.

As a result of the 2008 change in the risk corridor adjustments, the NAIC again considered changing the RBC factors applicable to Medicare Part D and implemented changes effective for 2009 and after. Consistent with the basis of the original RBC factors, the Academy's Subgroup based their recommendations on a survey of the opinions of the actuaries involved in pricing the benefit plans.

In the Academy's Subgroup's report to the NAIC, it indicated that it would revisit the Part D RBC factors again when it was able to obtain experience to verify how reasonable the factors are. The supplemental benefit factor was specifically identified as a concern given the large increase of this factor between the time the factor was initially developed and the time it was adjusted effective in 2009. Any changes identified would be effective for RBC filings. Credible historical experience now exists for this coverage that can be used to verify the current factors. In order to gauge the accuracy of the assumptions made in 2009, the Academy's Subgroup, working to assist the NAIC, would like to analyze recent experience to refine the factors where needed.

Responses to this survey will be held in confidence by the NAIC and will be passed on to the Academy's Subgroup only after any proprietary or confidential information—including information that would identify a company, a product, or an individual—has been removed.

No member of the Academy's Subgroup will have access to the raw data. Instead, the NAIC will compile the information and provide a blind summary of the data results for the Academy's Subgroup to use in fulfilling the NAIC's request. The Academy's Subgroup cannot guarantee any confidentiality of any information it receives from the NAIC, and the survey responders should provide their responses accordingly. The American Academy of Actuaries does not accept any confidential or proprietary information from any company in preparing its reports.

This survey is intended to gather information that can be used to review and update (if needed) the RBC factors applicable to PDP products. In order for the NAIC to adopt any needed changes to the RBC formulas in a timely fashion, we are asking for survey responses to be submitted no later than Sept. 13, 2013. Upon completion of the survey and collection of the data, the NAIC will provide a blind summarized version of the information to the Academy's Subgroup to perform the required analysis to refine the necessary RBC factors.

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. The responses will be collected by NAIC staff personnel and all data provided to other parties, including the Academy's Subgroup, will be "blinded" (company names and other identifying information will be eliminated and replaced with generic identifiers created solely for use in this undertaking).

Data Request

The requested items are enumerated below. For each item, please provide information from the most recent five years of PDP bids. A spreadsheet accompanies this letter that includes the data requested (summarized below). The spreadsheet contains macros that will read in the required information with the exception of experience related to bids that were discontinued or not aggregated with other bids. For this information, we are requesting that the company manually enter the information for those bids as you would enter such information in worksheet 1 of the PDP bids.

Note that if the company participated in the reinsurance demonstration program they should exclude data/information from those bids/experiences in the survey. This program was discontinued after 2010 and the NAIC will not be analyzing the experience of the reinsurance demonstration program in this study.

- I. General Data Items
 - a. Bid year
 - b. Contract number
 - c. Plan ID
 - d. Segment ID
 - e. Organization name
 - f. Prescription Drug region
 - g. Plan Type (Defined Standard, Actuarial Equivalent, Basic Alternative, or Enhanced Alternative)

- II. Basic Experience Items – List of items that will be pulled from worksheet 1 (Drug Plan Base Financials) relating to the experience period. Note that the study will only utilize experience from 2009, 2010 and 2011. This information will be pulled from the 2011, 2012 and 2013 PDP bids.
- a. Plan Crosswalk – Includes 1 through 8 plans that may have been aggregated to make up the current PDP plan. This would include the plan ID and the member months from the crosswalked plans.
 - b. Total Member Months.
 - c. The Centers for Medicare & Medicaid Services (CMS) Part D Payment – This is the direct subsidy amount received from CMS.
 - d. Basic Member Premium – This is the amount paid directly by the member to the health plan related to the defined basic benefit.
 - e. LI Premium Subsidy – This is the amount that is paid as premium by CMS on behalf of low-income members related to the defined basic benefit.
 - f. Supplemental Member Premium – This is the amount of supplemental premium paid to the health plan.
 - g. Basic Net Plan Liability – This is the amount of claims incurred relating to the defined standard benefit.
 - h. Supplemental Cost Sharing Reduction – This is the amount of claims paid by the insurance company that relate to cost sharing that would normally be part of the defined standard benefit but are paid by the health plan instead.
 - i. Net Cost of Supplemental Drugs – This is the amount of supplemental claim costs paid by the insurance company in excess of the supplemental cost-sharing reduction.
- III. Projection Period Items – The following amounts are extracted from the “Alternative Coverage” and “Summary” tabs contained within the PDP bid. Note that the amounts will be pulled for 2009, 2010 and 2011 experience periods and will be pulled from the respective year’s bids.
- a. Target Amount – This is the target loss ratio for the PDP bid.
 - b. Induced Utilization Adjustment – This is the amount of additional utilization that is expected to be incurred due to the fact that a supplemental benefit is offered.
 - c. Type of Gap Coverage – This summarizes whether or not there is gap coverage and if so, what type of gap coverage.