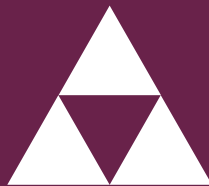


A PUBLIC POLICY PRACTICE NOTE

# Medicare Part D Accounting Practice Note

*April 2008*

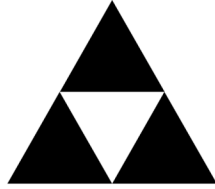
American Academy of Actuaries'  
Medicare Part D Accounting Practice Note Subgroup  
of the Health Practice Financial Reporting Committee



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This Practice Note was prepared by the Medicare Part D Accounting Practice Note Subgroup of the Health Practice Financial Reporting Committee of the American Academy of Actuaries.<sup>1</sup> The subgroup was charged with developing a description of some of the current practices used by U.S. health actuaries in 2007 with respect to work involving valuation, accounting, and financial reporting for Medicare Part D products.

The practices presented here represent the views of the subgroup, comprised of actuaries working at insurance companies, consulting firms, and public accounting firms who are involved in issuing actuarial opinions relating to balances recorded by U.S. health insurance companies for Medicare Part D products. The purpose of this practice note is to assist actuaries involved in valuation, accounting, and financial reporting work relating to Medicare Part D products. The Subgroup makes no representation of completeness; other approaches may also be in use. It should also be recognized that while this practice note provides guidance, it is not a definitive statement of generally accepted practice. Nothing in this practice note is intended to provide accounting advice. The authors are not accountants. Actuaries should consider the facts and circumstances specific to their situations, including the views of independent auditors, in making a determination of appropriate practice. Events occurring subsequent to the date of publication of this practice note may make the practices described herein irrelevant or inappropriate. This practice note has not been promulgated by the Actuarial Standards Board, nor is it binding on any actuary.

The members of the subgroup responsible for the drafting of this practice note include: Darrell Knapp, F.S.A, M.A.A.A., Chairperson; Rowen Bell, F.S.A, M.A.A.A.; Brian Collender, F.S.A, M.A.A.A.; Troy Filipek, F.S.A, M.A.A.A., F.C.A.; Jim Galasso, F.S.A, M.A.A.A.; Harry Hotchkiss, F.S.A, M.A.A.A.; J. Patrick Kinney, F.S.A, M.A.A.A.; Barbara Lawson, A.S.A, M.A.A.A.; Timothy Meyers, F.S.A, M.A.A.A.; Rob Pipich, F.S.A, M.A.A.A.; and Russ Willard, A.S.A, M.A.A.A.. The subgroup would also like to thank the following individuals for their assistance in this project: Bob Coons; Karen Levine; and Mike Koeberlein.

Comments on the appropriateness of the practice note, frequency of updates, and substantive disagreements, are welcome. They should be sent to the Academy's State Health Policy Analyst at [StateHealthAnalyst@actuary.org](mailto:StateHealthAnalyst@actuary.org), or American Academy of Actuaries, 1100 17th Street NW, 7th Floor, Washington, DC 20036.

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<sup>1</sup> The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

## Table of Contents

|   |    |
|---|----|
| 1. Which operational aspects of the Part D program lead to noteworthy accounting and/or financial reporting issues.....   | 1  |
| 2. What are the primary balance sheet items that an insurer participating in the Part D program may need to recognize?.....   | 3  |
| 3. Where in the insurer’s statutory financial statements should the various balance sheet items relating to Part D be recognized? .....   | 5  |
| 4. What balance sheet items relating to Part D should, and should not, be included in the insurer’s statutory actuarial opinion? .....  | 6  |
| 5. How does the Part D program typically affect an insurer’s income statement? .....  | 7  |
| 6. In what manner does the seasonal pattern of Part D claim costs affect the insurer’s interim period income statements? .....  | 8  |
| 7. What methodologies do insurers typically use to estimate risk-sharing liabilities/receivables? .....   | 9  |
| 8. Do all Medicare Advantage – Prescription Drug (MA-PD) and PDP plans participate in the risk-sharing program?.....  | 11 |
| 9. What methodologies do insurers typically use to estimate the LICS liability/receivable? .....  | 11 |
| 10. What methodologies do insurers typically use to estimate the reinsurance liability/receivable? .....  | 12 |
| 11. What methodologies do insurers typically use to estimate the unpaid claim liability for Part D? .....   | 13 |
| 12. How do pharmaceutical rebates factor into the estimation of balance sheet items relating to Part D? .....   | 13 |
| 13. How does the information provided above differ for insurers participating in the Part D Reinsurance Demonstration program? .....  | 14 |
| 14. What adjustments may the insurer need to make to the Part D items reported in its statutory financial statements when preparing its Risk-Based Capital (RBC) Report?.....   | 14 |
| 15. At what level (aggregate, contract level, or plan level basis) should the Part D risk-sharing, LICS, and reinsurance subsidy payables/receivables be calculated?.....   | 15 |
| 16. How should revenue and claims be treated if they are not realized until after reconciliation of the risk-sharing, LICS, and reinsurance amounts with CMS? .....   | 16 |
| 17. When should P2P and S2P settlement amounts be recognized? How should P2P and S2P data be incorporated into estimates for financial statements?.....   | 16 |
| 18. How should defined-standard, actuarial-equivalent, basic-alternative, and enhanced-alternative claims be treated differently in the calculation of the risk-share settlement amount?.....   | 16 |
| 19. When should revenue and claims be recognized for members who do not appear on the MMR but are enrolled in the company’s membership system? .....  | 17 |
| 20. Are there any differences in financial reporting approaches if the program is a PDP or a MA-PD plan? ..   | 17 |
| 21. For which items should additional provision for adverse development be held? How should potential offset between various components be addressed (i.e. lower unpaid claim liability might result in an offsetting change in risk share liabilities? ..... | 18 |
| Glossary .....  | 21 |

**Q1: Which operational aspects of the Part D program lead to noteworthy accounting and/or financial reporting issues?**

**A1:**

In the commercial marketplace, a typical prescription drug insurance product involves relatively few distinct types of cash flows to or from the insurance carrier. The table below describes the types of cash flows seen for a commercial prescription drug insurance contract that does not have any retrospective rating features.

| <b>Prospectively-Rated Commercial Prescription Drug Insurance</b>  |  |
|--|--|
| <b>Carrier's Cash Inflows</b>  | <b>Carrier's Cash Outflows</b>   |
| <ul style="list-style-type: none"> <li>• Monthly premiums from insureds</li> </ul>   | <ul style="list-style-type: none"> <li>• Benefit payments on behalf of insureds</li> </ul>                           |
| <ul style="list-style-type: none"> <li>• Rebate payments from pharmaceutical manufacturers / pharmacy benefit manager (PBM)</li> </ul> | <ul style="list-style-type: none"> <li>• Administrative costs (including commissions &amp; premium taxes)</li> </ul> |

As such, the general accounting treatment employed by the insurance carrier for this type of drug insurance product is relatively clear-cut, namely:

- The carrier recognizes premiums as revenue, and thus records accruals to adjust premiums from a cash basis to an incurred basis (e.g., unearned premium liability, due and unpaid premium asset);
- The carrier recognizes benefit payments and administrative costs as an expense, and records accruals to adjust from a cash basis to an incurred basis (e.g., unpaid claim liability);
- The carrier recognizes rebate payments as a reduction to expense and records accruals to adjust from a cash basis to an incurred basis (e.g., pharmaceutical rebate receivable).

There may be a number of technical nuances to the accounting and/or financial reporting depending on the applicable accounting literature (for example, under the National Association of Insurance Commissioners' (NAIC) Statutory Accounting Principles [SAP], there are admissibility criteria under Statement of Statutory Accounting Principles (SSAP) 84 for pharmaceutical rebate receivables), but these nuances are relatively well understood by practitioners.

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173), often abbreviated as the MMA, introduced a new type of prescription drug insurance product to the U.S. marketplace, known as Medicare Part D. Medicare Part D products have a number of features that are very different from typical commercial drug insurance products, and these differences raise a number of questions regarding accounting and financial reporting.

As shown in the table below, a Medicare Part D insurance product can lead to many more distinct types of cash flows than a typical commercial drug insurance product due to the operational complexity of the Medicare Part D program. Many of the terms used in the table below and throughout this practice note are defined in greater detail in the glossary.

| <b>Medicare Part D Prescription Drug Insurance</b>   |  |
|--|--|
| <b>Carrier's Cash Inflows</b>  | <b>Carrier's Cash Outflows</b>   |
| <ul style="list-style-type: none"> <li>• Monthly <b>beneficiary premium</b> payments from insureds</li> </ul>  | <ul style="list-style-type: none"> <li>• Benefit payments on behalf of insureds, for benefits where the carrier is ultimately liable</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Monthly <b>low-income premium subsidy (LIPS) payments</b> from CMS, in lieu of beneficiary premiums for low-income enrollees</li> </ul>   | <ul style="list-style-type: none"> <li>• Benefit payments on behalf of insureds, for benefits where CMS is ultimately liable</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Monthly <b>direct subsidy</b> payments from CMS, supplementing the beneficiary premiums</li> </ul>  | <ul style="list-style-type: none"> <li>• Benefit payments on behalf of insureds, for cost-sharing elements of the benefit design with respect to low-income enrollees who are exempted by CMS from paying these elements themselves</li> </ul> |
| <ul style="list-style-type: none"> <li>• Monthly <b>reinsurance subsidy</b> payments from CMS, reflecting estimated claim costs for risks retained by CMS</li> </ul>   | <ul style="list-style-type: none"> <li>• Administrative costs</li> </ul>   |
| <ul style="list-style-type: none"> <li>• Monthly <b>late-enrollment penalty</b> payments from insureds</li> </ul>  | <ul style="list-style-type: none"> <li>• Payments to CMS equal to any late-enrollment penalties received from insureds</li> </ul>  |
| <ul style="list-style-type: none"> <li>• Monthly <b>low-income cost sharing (LICS) subsidy payments</b> from CMS, reflecting estimated cost-sharing elements that CMS is funding for low-income enrollees</li> </ul>   |  |
| <ul style="list-style-type: none"> <li>• Rebate payments from PBM</li> </ul>   |  |
| <ul style="list-style-type: none"> <li>• Annual <b>reinsurance subsidy settlement</b> with CMS, reflecting the difference between reinsurance subsidies received, and actual benefit payments corresponding to the reinsurance subsidies - can be an inflow or an outflow</li> </ul> |  |
| <ul style="list-style-type: none"> <li>• Annual <b>LICS subsidy settlement</b> with CMS, reflecting the difference between LICS subsidies received, and actual cost-sharing payments corresponding to the LICS subsidies - can be an inflow or an outflow</li> </ul>                 |  |
| <ul style="list-style-type: none"> <li>• Annual <b>risk-sharing settlement</b> with CMS, reflecting the risk corridor gain/loss sharing aspects of the carrier's contract with CMS - can be an inflow or an outflow</li> </ul>   |  |
| <ul style="list-style-type: none"> <li>• Monthly <b>Medicare Part C rebates</b> from CMS that are applied to the Medicare Part D Premium, supplementing the beneficiary premiums.</li> </ul>   |  |

(In addition to the various cash flows listed in the above table, many Part D insurance carriers have experienced additional types of cash flows in the early years of the program, related to settlements among carriers and settlements between carriers and state agencies. See the discussion in Answer 2 regarding Plan-to-Plan and State-to-Plan liabilities for further information).

For each of these cash flow types, decisions need to be reached as to the appropriate accounting treatment and the appropriate financial reporting treatment. This process is made more ambiguous by the fact that many of the cash flows associated with Medicare Part D products do not have clear parallels in commercial products.

Another facet of the Medicare Part D program that poses interesting accounting issues is the disconnect that exists between the timing of the carrier's cash inflows and its cash outflows. The nature and magnitude of these timing differences are much more significant than in commercial drug insurance coverage, due not only to the operational complexity of the Medicare Part D program, but also to the unusual nature of most Medicare Part D benefit designs.

For example, although the carrier receives level per-member reinsurance subsidy payments on a monthly basis, the benefit payments associated with the reinsurance subsidies are heavily weighted towards the later months of the calendar year. Additionally, the benefit payments for which the insurance carrier is ultimately liable will typically emerge by incurral month throughout the calendar year in a very unusual fashion. Many carriers report that these benefit costs increase by month through the first couple of months of the year, and then steadily decrease by month throughout the remainder of the year. This pattern of seasonality is not generally observed with commercial health insurance products and it raises questions as to how the carrier's financial reporting should reflect this seasonality.

**Q2: What are the primary balance sheet items that an insurer participating in the Part D program may need to recognize?**

**A2:**

Some of the balance sheet items that an insurer may need to recognize in connection with its Part D coverage are the same items that it would need to recognize in connection with its commercial prescription drug coverage, including:

- ***Unpaid claim liability.***
- ***Claim adjustment expense (CAE) liability.***
- ***Premium assets and/or liabilities.*** If the insurer believes that there are individuals who were enrolled in Part D coverage as of the financial statement date but for whom the insurer's premium receipts are not current, then the insurer would establish a ***due and unpaid premium asset.*** Conversely, if the insurer has received premium payments prior to the financial statement date that pertain to coverage periods after the financial statement date, then the insurer would establish an ***advance premium liability*** and/or ***unearned premium liability.***
- ***Pharmaceutical rebate receivable.*** This represents rebate payments not yet received by the insurer from its PBM in connection with prescriptions filled prior to the financial statement date.

However, in light of the many unique features of the Part D program relative to commercial prescription drug coverage, as discussed in Answer 1, there are a number of additional balance-sheet items that arise uniquely with Part D products:

- **Reinsurance subsidy deposit liability** or **reinsurance subsidy receivable**. As discussed earlier, the insurer may receive monthly reinsurance subsidy payments from CMS, reflecting a level funding over the contract year of those expected claims for which CMS is ultimately liable but that are physically paid by the insurer on CMS' behalf. After the conclusion of a contract year, there is a true-up mechanism under which either the insurer returns any excess reinsurance subsidies to CMS or CMS makes additional payments to the insurer, depending on the relationship between the reinsurance subsidies and actual experience. To the extent that the insurer's reinsurance subsidies received to date exceed the benefit payments that it has made to date on CMS' behalf, the insurer needs to establish the difference as a liability. Conversely, to the extent that the benefit payments made to date on behalf of CMS exceed the reinsurance subsidies received to date, the insurer should establish a receivable.
- **LICS deposit liability** or **LICS receivable**. This is analogous to the situation discussed in the previous bullet point, except that it involves the monthly LICS subsidies received by the insurer from CMS instead of the monthly reinsurance subsidies.
- **Risk-sharing liability** and/or **risk-sharing receivable**. As discussed earlier, the insurer's Part D contract with CMS has a retrospective rating component. If the insurer's ultimate claims experience for the contract year is higher than originally expected, then CMS may need to make additional payments to the insurer, subsidizing the insurer's losses. Conversely, if the insurer's ultimate claims experience for the contract year is lower than originally expected, then the insurer may need to make payments to CMS. As is generally called for under accounting principles for retrospectively-rated insurance contracts, the insurer may need to establish a liability or a receivable relative to this situation. This need is not only for a completed contract year where the risk-sharing settlement has not yet occurred, but also for the contract year currently in progress.

In addition, due to difficulties arising from the administration of the Part D program, many insurers participating in Part D have also needed to establish additional balance-sheet amounts of the following types:

- **Plan-to-plan (P2P) claim liability** and/or **P2P claim receivable**. In many cases, an individual arriving at a pharmacy has indicated that they have Part D coverage from Carrier A and Carrier A has processed the claim, but in the fullness of time it was determined that the individual actually had Part D coverage from Carrier B at that time. For this particular claim, Carrier B owes money to Carrier A. Until such time as the carriers settle with one another, Carrier B, in theory, would record an additional liability as part of its unpaid claim liability for the amount it owes to Carrier A, while Carrier A would record a receivable.
- **State-to-Plan (S2P) claim liability**. When the Medicare Part D program took effect in January 2006, all individuals who previously received prescription drug benefits under state Medicaid programs and were also eligible for Medicare were to be enrolled in an insured Part D product. In practice, in the earliest months of the program, some of these individuals were unable to get their prescriptions covered under Part D due to administrative difficulties. Some state Medicaid programs decided to keep paying for these individuals' prescriptions in early 2006, seeking repayment from the insurers to which these individuals had been assigned as Part D enrollees at a later date. Consequently, until such time as settlements between insurers and state Medicaid programs have been finalized, the insurer may need to establish an additional liability as part of its unpaid claim liability for the claims paid by Medicaid on the insurer's behalf. This liability is

frequently called the “state-to-plan” or “S2P” liability, although “plan-to-state” or “P2S” is sometimes used and may be more accurate.

Finally, there is a possibility that an insurer may need to recognize a *premium deficiency reserve* (PDR) for its Medicare Part D business. This would be needed to the extent that the insurer believes that its Part D coverage will likely produce losses in periods after the financial statement date. (Since Medicare Part D bids are due the June prior to the benefit year, based upon experience for the year two-years prior to the benefit year, on occasion a company may realize it has underbid for the upcoming benefit year and may need to hold a PDR.) There may be a difference of opinion among actuaries as to whether or not an insurer should consider its Medicare Part D business as a separate product grouping for PDR recognition purposes. For further discussion of PDR grouping considerations, please refer to the Academy’s Premium Deficiency Reserves Work Group March 2007 *Premium Deficiency Reserves Discussion Paper*.<sup>2</sup>

**Q3: Where in the insurer’s statutory financial statements should the various balance sheet items relating to Part D be recognized?**

**A3:**

For those Part D balance sheet items that are also found under commercial prescription drug coverage, such as the unpaid claim liability, the statutory financial reporting treatment is already well understood. As such, we will focus our attention on items that are unique to Part D coverage.

In December 2005, the Emerging Accounting Issues Working Group (EAIWG) of the NAIC issued INT 05-05, “Accounting for Revenues Under Medicare Part D Coverage.” INT 05-05 provides accounting guidance for insurers under NAIC SAP relating to the Part D program. The conclusions of INT 05-05 include the following:

- The reinsurance subsidies and LICS subsidies received by the insurer represent payments under the uninsured portion of a partially insured plan (in the language of SSAP 47, “Uninsured Plans”). In particular, balance sheet amounts relating to the reinsurance and LICS subsidies are not insurance liabilities. Also, in light of SSAP 47, paragraph 8, the insurer should not record an unpaid claim liability for benefits that it expects to pay after the financial statement date for prescriptions filled prior to the financial statement date and for which CMS, rather than the insurer, is ultimately liable.
- The beneficiary premiums, direct subsidies, and low-income premium subsidies received by the insurer represent premium revenue under a retrospectively-rated insurance plan. In particular, balance sheet amounts relating to the risk-sharing aspects of the insurer’s contract with CMS are covered under the provisions of SSAP 66, “Retrospectively Rated Insurance Contracts.”

These accounting conclusions would appear to have the following implications with respect to statutory financial reporting:

- The insurer’s reinsurance subsidy deposit liabilities and/or LICS subsidy deposit liabilities should be reported in the “liability for amounts held under uninsured plans”<sup>3</sup> item of the liabilities page. Similarly, if the insurer has assets rather than liabilities relating to the reinsurance and/or LICS subsidies, these assets should be reported in the “amounts receivable relating to uninsured plans”<sup>4</sup> item of the assets page.

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<sup>2</sup> [http://www.actuary.org/pdf/health/pdr\\_march07.pdf](http://www.actuary.org/pdf/health/pdr_march07.pdf)

<sup>3</sup> Line 20 of the Orange Blank liabilities page, or line 24.6 of the Blue Blank liabilities page

<sup>4</sup> Line 15 of the Orange/Blue Blank assets page



- If the insurer recognizes a liability relating to the risk-sharing with CMS, that liability should be reported in the same place as the insurer's other SSAP 66 liabilities for retrospective premium adjustments. For a company filing the Orange Blank, the liability would be reported in line 4 ("reserve for rate credits or experience rating refunds") of the Underwriting & Investment Exhibit, Part 2D, and would roll up into the "aggregate health policy reserves" item (line 4) of the liabilities page. For a company filing the Blue Blank, the most likely place to report the liability would be the "provision for experience rating refunds" item (line 9.2) of the liabilities page.
- If the insurer recognizes an asset relating to the risk-sharing with CMS, that receivable should be reported in the same place as the insurer's other SSAP 66 assets for retrospective premium adjustments, namely in the "accrued retrospective premiums" item (line 13.3) of the assets page.<sup>5</sup>

An area where the statutory financial reporting treatment may be less clear-cut involves P2P and S2P balances. Since P2P and S2P liabilities represent amounts that would have been reported as claims expense if they had originally been paid by the insurer instead of by another party, many insurers believe that it is logical to include these liabilities within the insurer's unpaid claim liability. Under this theory, a P2P receivable likely would be reported within the "health care receivables"<sup>6</sup> line item of the assets page, similar to other items that, when paid, will ultimately affect incurred claims expense (e.g., claim overpayment receivables). Other insurers, however, have taken a different view and have reported P2P and S2P items within the "aggregate write-ins"<sup>7</sup> lines of the assets and/or liabilities pages.

**Q4: What balance sheet items relating to Part D should, and should not, be included in the insurer's statutory actuarial opinion?**

**A4:**

For an insurer filing the Orange Blank, the insurer's statutory actuarial opinion generally includes a prescribed set of line items from the liabilities page. As such, to a certain extent the statutory financial reporting issues discussed in Answer 3 dictate what the actuary should or should not include in the scope of the opinion. In particular:

- Liabilities relating to the reinsurance subsidies and/or LICS subsidies would not need to be included in the opinion scope, since they are reported within "liabilities for amounts held under uninsured plans;"
- Liabilities relating to the risk-sharing with CMS would be included in the opinion scope, since they are reported within "aggregate policy reserves;"
- To the extent that the insurer has classified its P2P and/or S2P liabilities as being unpaid claim liabilities, they would be automatically included in the opinion scope.

The scope of the Orange Blank actuarial opinion is also supposed to include, at the opining actuary's discretion, other actuarial liabilities not included within the prescribed set of the line items. As such, even if items such as risk-sharing liabilities or P2P liabilities have not been reported by the insurer in the manner discussed above and are not automatically within the opinion scope, the opining actuary may

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<sup>5</sup> Insurers offering multiple Part D products may find that they need to record a liability with respect to some products and an asset with respect to others. In this situation, many insurers appear to have taken the position that it is not appropriate to establish both a risk-sharing liability and a risk-sharing asset, but instead it is permissible to net these balances and record either a liability or an asset but not both. However, other insurers may have taken the position that the offsetting of risk-sharing assets and risk-sharing liabilities is inappropriate here.

<sup>6</sup> Line 22 of the Orange/Blue Blank assets page.

<sup>7</sup> For a receivable, Line 23 of the Orange Blank assets page; for a payable, Line 21 of the Orange Blank liabilities page, or Line 25 of the Blue Blank liabilities page.

believe it appropriate to include those liabilities within the opinion scope. Similarly, although items found on the insurer's assets page are typically not included within the opinion scope, the opining actuary may feel that it would be appropriate to include within the opinion scope certain assets arising from Part D which have an actuarial character, such as risk-sharing receivables or P2P receivables.

For an insurer filing the Blue Blank, there is a possibility that the risk-sharing liability would not automatically be included in the opinion scope, since it does not reside in either Exhibit 5, Exhibit 6, Exhibit 7, or Exhibit 8, Part 1. It would be reasonable for the opining actuary to explicitly add the risk-sharing liability to the opinion scope in this situation, on the grounds that it would have been included in the opinion scope if the insurer instead filed the Orange Blank.

**Q5: How does the Part D program typically affect an insurer's income statement?**

**A5:**

| <b>Cash Flow</b>                       | <b>Examples</b>  | <b>Recorded on the Income Statement As</b> |
|--|--|--|
| From CMS                               | Risk-adjusted direct subsidy, low-income premium subsidy, risk-share payment | Revenue                                    |
| From CMS                               | Reinsurance subsidy, low-income cost-sharing subsidy                         | N/A  |
| From members                           | Part D premiums  | Revenue                                    |
| From members/CMS                       | Late enrollment penalty  | N/A  |
| From pharmaceutical manufacturers/PBMs | Rebates  | Reduction to expenses                      |
| To pharmacies                          | Paid claims  | Expense or N/A (see next paragraph)        |
|  | Claims adjustment expenses, overhead/administration                          | Expense                                    |

Note that the reinsurance subsidy, late enrollment penalty, and LICS subsidy are not recognized on the income statement, based on NAIC INT 05-05 and SSAP 47. Instead, these pass-through cash flows are reflected using deposit accounting. This approach mitigates potentially large net income swings within a given year. It involves setting up balance sheet accounts into which the uniform monthly reinsurance and LICS amounts received are deposited. These subsidy accounts are then used to pay claims for reinsurance and LICS claims when incurred; as such, when reinsurance and LICS claims are paid, those cash outflows are not recognized as expenses on the income statement. The remaining balance/shortfall in the account is due to/from CMS at the end of the year as a Part D year-end settlement.

For the late enrollment penalty, a deposit account should be set up to accumulate the monthly amounts collected from beneficiaries, against which CMS can deduct the amount from its monthly subsidy payments to the insurer.

**Q6: In what manner does the seasonal pattern of Part D claim costs affect the insurer's interim period income statements?**

**A6:**

The standard Part D benefit and equivalent benefit designs are “front-loaded” in terms of the insurer's Part D incurred claim costs. This benefit design means that the insurer is responsible for roughly two-thirds of the gross costs, up to the initial coverage limit (ICL), none of the gross costs between the ICL and catastrophic coverage point when the insured reaches the true out-of-pocket limit (TrOOP), and 15 percent of the gross costs beyond the catastrophic coverage point. The net impact is that insurers tend to incur higher-than-average claim costs early in the year, until members begin reaching the ICL, and then have lower-than-average claim costs as the year progresses.

Deposit accounting is employed for the LICS and reinsurance subsidies, which magnifies the impact of claims seasonality on the insurer's income statement. Over the course of the calendar year, gross costs per member may be relatively static. However, there will be significant variation by month in how the gross costs are split among:

- Benefits for which the insurer is ultimately liable;
- Benefits that correspond to LICS subsidies; and
- Benefits that correspond to reinsurance subsidies.

Incidence of LICS claims tend to increase in later months of the year, as member cost share increases. Reinsurance claims will be even more heavily weighted towards the later months, as members will not typically reach TrOOP until late in the year. With all activities relating to LICS subsidies and reinsurance subsidies being excluded from the insurer's income statement, the remaining portion demonstrates a strong front-loaded seasonal pattern unlike those typically seen with other health insurance products.

The retrospective-rating component of the Part D program introduces another important nuance to the discussion of income statement seasonality.

Many insurers have selected an accounting policy under which the estimate of the risk-sharing liability/asset at an interim reporting date is based on the insurer's incurred loss ratio (prior to risk-sharing) for the calendar year to date (YTD). For reasons discussed above, at any interim period of the year, the YTD incurred-loss ratio for a Part D product will be typically higher than the expected calendar year loss ratio. Consequently, the insurer could record a significant risk-sharing asset, even in situations where the insurer's expectation for the full calendar year is that no cash will ultimately change hands in the annual risk-sharing settlement. This accounting policy has the impact of shifting the recognition of some premium revenue to early months of the calendar year from later months, thereby muting, but not completely flattening, the seasonality pattern of incurred loss ratios for Part D products.

On the other hand, some insurers have selected an accounting policy under which risk-sharing balance estimates at interim reporting dates are based on the insurer's current expectations of full year experience. This accounting policy is typically more conservative, as it involves less recognition of risk-sharing assets in early portions of the calendar year, shifting fewer premiums to earlier portions of the year.

The collective understanding of the actuaries involved in drafting this document is that both of these accounting policies have been acknowledged by audit firms as acceptable interpretations of GAAP and SAP.

Some insurers have argued that it would be more representationally faithful to allow an insurer to completely smooth its Part D incurred loss ratio over the course of the calendar year, thereby eliminating the impact of benefit design seasonality on the insurer's income statement. However, based on the prior experience of the actuaries involved in drafting this document, it appears that audit firms and regulators have taken the position that such an approach is not permissible under current accounting literature.

**Q7: What methodologies do insurers typically use to estimate risk-sharing liabilities/receivables?**

**A7:**

These cash flows are recorded as accrued retrospective premiums on the balance sheet and are estimated over time using the following generalized approach (More precise details of the calculation are available in the *CMS Prescription Drug Event Data Training Participant Guide* – the actuary should use a level of granularity in the estimation that reflects the materiality of the liability of the insurer.):

- a. Calculate the target amount (TA), summing actual direct-subsidy cash flows from CMS and actual basic member premiums, while subtracting administrative costs and profit margins assumed in the bids.
- b. Calculate the adjusted allowable risk corridor costs (AARCC), summing covered plan paid (CPP) amounts and reducing these amounts for direct and indirect remuneration (DIR), reinsurance subsidies, and induced utilization resulting from a plan design that differs from the standard Part D design.
- c. Compare the TA and the AARCC and apply the following risk corridor structure (2006 and 2007):
  - i.  $97.5\% \text{ of TA} < \text{AARCC} < 102.5\% \text{ of TA} \rightarrow$  no payment made
  - ii.  $102.5\% \text{ of TA} < \text{AARCC} < 105\% \text{ of TA} \rightarrow$  CMS owes 75% of (AARCC less 102.5% of TA)
  - iii.  $105\% \text{ of TA} < \text{AARCC} \rightarrow$  CMS owes 75% of (2.5% of TA) plus 80% of (AARCC less 105% of TA)
  - iv.  $95\% \text{ of TA} < \text{AARCC} < 97.5\% \text{ of TA} \rightarrow$  Plan owes 75% of (97.5% of TA less AARCC)
  - v.  $\text{AARCC} < 95\% \text{ of TA} \rightarrow$  Plan owes 75% of (2.5% of TA) plus 80% of (95% of TA less AARCC)

The following table illustrates how these thresholds widen in 2008 and the risk-sharing percentage decreases, exposing plans to additional risk.

| <b>Part D Risk-sharing Parameters</b> |  |                            |
|---------------------------------------|--|----------------------------|
| <b>Thresholds</b>                     | <b>2006 – 2007</b>                           | <b>2008</b>                |
| First level of protection             | +/- between 2.5% and 5.0% of “target” amount | +/- between 5.0% and 10.0% |
| Second level of protection            | +/- greater than 5.0%                        | +/- greater than 10.0%     |
| <b>Risk-sharing Percentage</b>        | <b>2006 – 2007</b>                           | <b>2008</b>                |
| First level of protection             | 25% plan responsibility                      | 50% plan responsibility    |
| Second level of protection            | 20% plan responsibility                      | 20% plan responsibility    |

Note that the risk-share calculation is done at the plan level and not at the contract level. For a nationwide prescription drug plan (PDP) with three plans in each PDP region (34 total, if in all 50 states), this calculation would be performed 102 times. The following table illustrates how performing the calculation at the plan level can lead to a much different result than if calculated at the contract level.

| <b>2006/2007 Part D Risk Share Calculation Example</b>               |                 |               |               |
|--|-----------------|---------------|---------------|
| <b>Item</b>  | <b>Contract</b> | <b>Plan 1</b> | <b>Plan 2</b> |
| Basic Member Premium and Direct Subsidy Revenue (A)                  | \$1,000,000     | \$400,000     | \$600,000     |
| Administration Load and Profit Margin in Premium (B, from Bid)       | 20.00%          | 20.00%        | 20.00%        |
| Reinsurance (C, only if demo plan)                                   | \$0             | \$0           | \$0           |
| Target Amount (D = A x (1 - B) + C)                                  | \$800,000       | \$320,000     | \$480,000     |
| Unadjusted Risk Corridor Costs (E, URCC = CPP)                       | \$964,000       | \$413,000     | \$551,000     |
| Induced Utilization Ratio (F, from Bid)                              | 1.000           | 1.000         | 1.000         |
| AARCC (G = (E - DIR - Reins Subsidy) / F, includes Reins for Demos)  | \$819,400       | \$351,050     | \$468,350     |
| Profit / (Loss) Amount Used for Risk-sharing Calculation (H = D - G) | (\$19,400)      | (\$31,050)    | \$11,650      |
| Profit / (Loss) Amount as a Percentage of Target Amount (I = H / D)  | -2.4%           | -9.7%         | 2.4%          |
| Loss Sharing Received from or (Profit Sharing Refunded to) CMS       | \$0             | \$18,040      | \$0           |

**Q8: Do all Medicare Advantage – Prescription Drug (MA-PD) and PDP plans participate in the risk-sharing program?**

**A8:**

The risk-sharing program is not an optional program for MA-PDs or PDPs. All plans participate as a condition of submitting bids to CMS. Exceptions to this rule include private fee-for-service plans, employer group waiver plans (800 series plans), limited risk plans, and fallback plans. For enhanced alternative plans, the risk-sharing only applies to the standard Part D portion of the benefit and not the enhanced portion.

**Q9: What methodologies do insurers typically use to estimate the LICS liability/receivable?**

**A9:**

Plans have had difficulty in reconciling their estimated LICS liability/receivable estimates with those developed by CMS. The formula used by CMS in performing the settlement is described in the *CMS Prescription Drug Event Data Training Participant Guide*. In the calculation of these amounts, judgment may be required in order to determine how claims should be treated.

The LICS liability/receivable, or the LICS reconciliation amount, is equal to the sum of plan-reported actual LICS dollars in the coverage year less the sum of all prospective LICS subsidy payments (including any adjusted payments) in the coverage year.

The sum of plan-reported actual LICS dollars in the coverage year can be computed in different manners, depending on the data available to the insurer. The method most commonly observed in practice is to use data provided by CMS in conjunction with any Part D claim information submitted to CMS. CMS-provided information includes P2P LICS claim information, as well as accepted prescription drug event (PDE) data. In addition to accepted PDE data, there may be a number of PDE records that will be rejected by CMS when the settlement amount is calculated, due to data submission errors or inconsistencies. These rejected records should be further analyzed before including them in the sum of LICS dollars. These amounts should not necessarily be excluded from the settlement calculation. If it is believed that any of the rejected records should be included in the total, they should be added in and the issues regarding the records should be discussed with CMS. Insurers have approached including rejected PDE records in different manners. Some insurers have included all rejected PDE claims in their settlement calculations, assuming they would all eventually be accepted, while other insurers have applied a credibility weighting to the rejected claims and only assumed a percentage would be accepted. Also, it is not unreasonable to add a margin for adverse deviation to the accepted claim levels to account for those that may or may not be accepted in the future. In applying a margin for adverse deviation, the actuary should ensure that the full impact of the margin is understood. For example, adding a margin to the claims used in the risk-sharing calculation will result in a lower payable to CMS or a larger receivable. Therefore, the insurer may want to make sure that the margin added to the risk-sharing calculations are consistent with any claim liability margins in order to ensure that the insurers profits are reasonable stated. In working with the accepted PDE records, the insurer should remove any records that may have been paid on behalf of another company. Failing to do so will result in a sum of LICS dollars in excess of the actual amount.

Once all of the data has been gathered, the sum of plan-reported actual LICS dollars should equal the LICS amounts shown in the accepted PDE records, the plan's P2P LICS amounts as reported by CMS,

and the LICS amounts contained within the rejected PDE records that should be included in the total, less any P2P LICS amounts contained in the accepted records that the plan paid on behalf of another company. Plans should record settlement amounts based on the amount that can be proven to CMS as the correct amount.

Companies may use a claim database along with the monthly membership report (MMR) in order to calculate their estimate of the LICS dollars. It should be noted that only accepted PDE information will be used to determine the LICS reconciliation amount. If a company uses its own data instead of CMS-accepted data, the plan should perform regular reconciliations in order to ensure that the calculations are reasonable.

The sum of all LICS subsidy payments received prior to the valuation date in the coverage year can be derived from the MMR provided by CMS. Plans should be sure to include any adjusted payments received from CMS.

Once these amounts are determined, the LICS reconciliation amount is calculated. This amount should be recorded as a receivable/asset if the sum of the plan-reported actual LICS dollars exceeds the LICS subsidy payments, and as a payable/liability otherwise.

**Q10: What methodologies do insurers typically use to estimate the reinsurance liability/receivable?**

**A10:**

Similar to the LICS liability/receivable, plans have had difficulty in reconciling their estimated reinsurance liability/receivable estimates to those developed by CMS. The formula used by CMS in performing the settlement is described in the *CMS Prescription Drug Event Data Training Participant Guide*. In the calculation of these amounts, judgment may be required in order to determine how claims should be treated.

The reinsurance liability/receivable, or the reinsurance reconciliation amount, is equal to the reinsurance subsidy less the sum of all prospective monthly reinsurance subsidy payments. The reinsurance subsidy, the amount that the federal government pays once the member has exceeded the TrOOP, is equal to 80 percent of the allowable reinsurance costs.

In order to determine the reinsurance subsidy, insurers should be sure to adjust the allowable reinsurance costs for the reinsurance portion of direct and indirect remuneration (DIR). The allowed reinsurance costs are equal to the gross drug costs above (GDCA) the out-of-pocket threshold, less the reinsurance portion of DIR.

The GDCA can be computed in a number of ways, depending on the data available to the insurer. The method most commonly observed in practice uses data provided by CMS in conjunction with Part D claim information submitted to CMS. CMS-provided information would include P2P GDCA claim information, as well as accepted PDE data. The methodology for this calculation is similar to that as described in Answer 9 above.

Since DIR may not be fully known until months after pharmacy claims are incurred, the plan should estimate the DIR until actual information is available. There are numerous methods in which DIR can be estimated using prior experience, but the methods used are outside the scope of this paper. It should not be assumed that DIR is zero, unless that will truly be the case. In the calculation of the DIR, the plan

should ensure it is following CMS guidance. CMS indicated that the amount for pharmaceutical rebates may include the amount received from the manufacturer, even though the health plan does not receive the full rebate. In the calculation of the settlement amount, it would be prudent to utilize CMS's most recent guidance involving the derivation of this item.

GDCA is also calculated differently for enhanced alternative plans, as compared to defined standard plans, actuarial equivalent plans, and basic alternative plans. The insurer should be sure that the GDCA is being calculated in accordance with CMS guidelines before finalizing the reinsurance reconciliation amount.

The sum of all reinsurance subsidy payments received prior to the valuation date can be derived from the MMR provided by CMS. Insurers should be sure to include any adjusted payments received from CMS.

Once the amounts are determined, the reinsurance reconciliation amount is calculated. This amount should be booked as a receivable, if the reinsurance subsidy exceeds the reinsurance subsidy payments, and as a payable/liability otherwise.

**Q11: What methodologies do insurers typically use to estimate the unpaid claim liability for Part D?**

**A11:**

Unpaid claim liabilities for Part D should be held if the actuary believes that claims exist that have been incurred but not yet paid. Companies use different methods to calculate Part D unpaid claim liability amounts, depending upon the information that is available.

In calculating this liability, it is important to take into account the seasonal change in claim costs from month to month, as members enter different phases of the Part D benefit (e.g., incurred claims will decrease as members enter the coverage gap). Also, it is important to analyze Part D claims separately from Part C claims, since each will experience different seasonality as the year progresses.

Commonly used methods of calculating the unpaid claim liability for pharmacy claims include the inventory method and the developmental method. The inventory method estimates the amount of outstanding pharmacy claims based on the average amount paid over a recent time period and the remaining unpaid days between the last payment and the valuation date. A description of the developmental method is outside the scope of this paper.

If plans are using gross claims in the estimation of this liability, they should ensure that they make an adjustment that reflects the company's responsibility for the net amount outstanding. This requires removing any member cost sharing, LICs subsidy amounts, reinsurance subsidy amounts, etc.

**Q12: How do pharmaceutical rebates factor into the estimation of balance sheet items relating to Part D?**

**A12:**

Pharmaceutical rebates should be treated as an offset to pharmacy claim costs. Some companies have recorded pharmaceutical rebates as revenue, but this method is inconsistent with how rebates are treated in the calculation of the reinsurance reconciliation amount and the risk-share calculation, as well as how rebates are treated in statutory financial reporting.



In the calculation of the reinsurance reconciliation and the risk-share calculation, rebates should be taken into account and treated as an offset to pharmacy expenses. It is most likely that the actual rebate amount will not be known at year-end, so an estimate, based on prior/expected experience, should be used until the actual rebate amount is determined.

Insurers should also record a receivable for the unpaid portion of rebates currently owed to them.

As mentioned earlier, companies should ensure that they are recording pharmaceutical rebates consistent with the current guidance from CMS. This is because CMS has indicated that there is a lack of clarity on whether plans should be recording amounts that they actually receive or amounts that are paid by the manufacturer.

**Q13: How does the information provided above differ for insurers participating in the Part D Reinsurance Demonstration program?**

**A13:**

For those insurers participating in the Part D Reinsurance Demonstration program, there will not be a reinsurance reconciliation since the reinsurance claims are covered by the reinsurance capitation payment made by CMS. In addition, the reinsurance claims are treated differently in the risk-share calculation and are included in both the target and covered Part D plan paid (CPP) amounts calculated in order to determine the risk-share reconciliation amount.

It should be noted that the Part D reinsurance demonstration program, including the MA rebate demonstration plan, has an additional liability that must be recorded. This liability is known as the budget neutrality requirement (BNR), and is based on the number of members covered per year. The BNR should be recorded as an offset to revenue. The amount is published by CMS, but the stated value could change prior to the settlement process. Unless better information is available, we would expect that each plan would set up their liability based on the current published CMS-estimated BNR amount.

**Q14: What adjustments may the insurer need to make to the Part D items reported in its statutory financial statements when preparing its Risk-Based Capital (RBC) Report?**

**A14:**

The revenue and claims for MA-PD and stand-alone PDP products are treated differently in preparing the RBC report. All MA-PD products report claims in total and do not separate medical and pharmacy claims. Stand-alone PDP products claims are reported separately from MA-PD claims. If the plan is offering enhanced alternative benefits, it is required to split premium and claims between those claims that are considered defined standard versus those that are considered supplemental.

For RBC purposes, stand-alone PDP Employer Group Waiver Plans (EGWP) are not treated like other stand-alone PDP plans in the underwriting risk calculation. Therefore, they should not be reported as Medicare Part D coverage in the calculation of underwriting risk.

In the calculation of the managed care credit, insurers must be able to separate paid claims into the following categories:

- Claims in which there is no risk corridor protection and no reinsurance subsidy protection;

- Claims in which there is no risk corridor protection (this is not intended to include EGWP experience);
- Claims in which there is risk corridor protection but no reinsurance subsidy protection (e.g., Part D reinsurance demonstration plans);
- Claims in which there is both risk corridor protection and reinsurance subsidy protection.

It should also be noted that stand-alone PDPs cannot take the premium stabilization reserve (PSR) credit for amounts held in connection with this coverage. As of the 2006 RBC calculation, the instructions did not explicitly indicate that credit should not be taken for risk-sharing liabilities relating to stand-alone PDP products. The intent of the NAIC was that risk-sharing liabilities would not qualify for the PSR credit. The Academy's Committee on State Health Issues, Health Practice Financial Reporting Committee, and Medicare Part D RBC Subgroup submitted a joint comment letter in June 2007 that noted this discrepancy and recommended that the 2007 RBC formula be modified to accurately reflect this intent.<sup>8</sup> The NAIC subsequently acted on that recommendation.

**Q15: At what level (aggregate, contract level, or plan level basis) should the Part D risk-sharing, LICS, and reinsurance subsidy payables/receivables be calculated?**

**A15:**

CMS will calculate the final risk-sharing reconciliation at the plan level. Therefore, risk-sharing asset/liability calculations should be performed at the plan level in order to avoid interaction between the calculations of the risk-sharing for various plans. An example of such interaction is shown in Answer 7. Similar interactions are not a concern for the LICS and reinsurance subsidy payables/receivables, so these reconciliation amounts may be calculated at any level the actuary deems appropriate.

Part D risk-sharing, LICS, and reinsurance subsidy payables/receivables should be calculated at a level that is no broader than the level at which they will be reported on financial statements. In an ideal environment, complete data would be available at the individual claim level. Wherever possible, calculations should be performed at the individual claim level and rolled up to the desired reporting level. When this approach is taken, the LICS subsidy and the reinsurance subsidy may be treated as pass-through items with no gain or loss.

Where individual claim calculations are not practical, aggregated assumptions and calculations should be made at the plan level. However, practical considerations may dictate that calculations be performed at a higher level. The credibility of lower levels of detail should also be considered. While no explicit level of credibility has been set, most plans are assuming that full credibility for claim projection purposes is reached at less than 24,000 member months. CMS has defined 24,000 member months as a credibility standard for medical products and has voiced the expectation that pharmacy products should require fewer member months to be credible. Credibility thresholds may be substantially lower for assumptions on the portions of a claim that fall into various buckets affecting payables and receivables.

Calculations should be made at lower levels of detail when contracts and plans are expected to have material differences. These differences may include, but are not limited to, differences in demographics, low income penetration, benefits, presence of an MAPD, retention, or marketing strategies.

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<sup>8</sup> This comment letter may be found at [http://www.actuary.org/pdf/medicare/rbc\\_june07.pdf](http://www.actuary.org/pdf/medicare/rbc_june07.pdf).

Practical limits may prevent the complete calculations from being performed at a low level of detail; however, the actuary may choose to use assumptions derived from larger sets of data and apply those to smaller sets with similar characteristics. This approach allows the actuary to vary those assumptions that are expected to vary by plan, based on the specific differences that exist between plans.

**Q16: How should revenue and claims be treated if they are not realized until after reconciliation of the risk-sharing, LICS, and reinsurance amounts with CMS?**

**A16:**

Plans should treat revenue and claims realized after final reconciliation with CMS in a similar manner as unexpected claim run-out on a standard insured commercial population. To the extent that the plan adjusts revenue or claims after settlements are finalized with CMS, the plan is responsible for the full difference from the settlement figures. Settlements are performed on an annual basis and considered one year at a time. No consideration is given for rollover of claim run-out from prior periods.

**Q17: When should P2P and S2P settlement amounts be recognized? How should P2P and S2P data be incorporated into estimates for financial statements?**

**A17:**

Best estimates of P2P and S2P settlement amounts should be estimated and recognized as soon as credible estimates can be made, but not before they are incurred. In making projections of P2P and S2P settlement amounts, plans should consider prior experience, error codes from PDE files, MMR retroactivity levels, and PDE rejection rates, if available.

P2P and S2P estimates should be consistent with the other data used to project a plan's financials. For example, it would be appropriate to not consider P2P and S2P in separate calculations if projections are based upon total expected claims and revenue. However, if actual non-settled claims are used as the basis for the projections, these claims should be adjusted for P2P and S2P.

Use of prior experience should consider the differences inherent between prior time periods and the projection time period. For example, the first quarter of 2006 had a large amount of S2P activity that is not expected to be repeated in future years. Additionally, because 2006 was the first year of the program and enrollment rules were less strict, members are not expected to continue to switch plans as much as they did during 2006. This is expected to have a significant impact upon P2P reconciliation levels in the future.

P2P settlement amounts may be significantly offset by changes in LICS subsidy amounts and reinsurance subsidy amounts. Consideration should be given to these interactions and their seasonality. P2P claims that are submitted after the final reconciliation with CMS will not be considered for settlement.

**Q18: How should defined-standard, actuarial-equivalent, basic-alternative, and enhanced-alternative claims be treated differently in the calculation of the risk-share settlement amount?**

**A18:**

The calculation of the risk-sharing settlement amount is calculated based upon covered claims. Per Section 1860D-15(e) of the Social Security Act, CMS does not share in the risk of supplemental benefits or administrative expenses. CMS only shares in the final reimbursed cost of drugs. This amount does not include any drug price spread charged by a PBM or other intermediary. Additionally, these costs are

calculated after rebates. In no circumstances will CMS share risk on claims paid in excess of the Standard Part D plan. Per the PDE Data Training Participant Guide, for the Defined Standard, Actuarial Equivalent and Basic Alternative plans, the CPP amount is calculated based on the plan-paid amount since these three types of plans are considered to be actuarially equivalent. For enhanced plans, CMS will share in the risk of the portion of the claims that would have been paid under the standard plan. CMS does not share risk on non-Part D drugs and over-the-counter drugs, even when they are a part of a CMS approved step-therapy program. CMS does not share in the risk of induced utilization claims.

The PDE files include a field called the Covered D Plan Paid Amount (CPP). This field represents the plan-paid amount for a Part D covered drug claim and, therefore, is useful in calculating risk-sharing settlement payables and receivables. For enhanced plans, the standard Part D benefit is used to populate this field and the enhanced benefit coverage is included in the non-covered plan paid amount (NPP) field.

**Q19: When should revenue and claims be recognized for members who do not appear on the MMR but are enrolled in the company's membership system?**

**A19:**

There have been numerous issues with enrollment in early stages of the program. In many situations, there has been a significant delay between when a subscriber is enrolled and when they appear on the MMR from CMS. To the extent an individual is known to be enrolled, the preferred method would be to approximate monthly revenue and to recognize incurred claims. This would be analogous to recognizing revenue from a group contract prior to it being set up on the system. The other side of the premium entry would be a receivable from CMS and the subscriber.

However, for simplicity a number of plans use the MMR as the ultimate authority on enrollment and do not recognize premiums or claims until a member shows up as enrolled in the CMS reports. This approach should not result in a material difference from the first approach—the net income impact would be the foregone revenue less projected claims (and, as discussed in prior sections, the early duration projected claims may be close to revenue).

When addressing membership differences between a company's membership system and the MMR, the critical element is consistency in treatment of revenue and claims. If the premium is recognized, claims should also be projected. If the premium is not recognized, claims should also be deferred.

**Q20: Are there any differences in financial reporting approaches if the program is a PDP or a MA-PD plan?**

**A20:**

From the perspective of accounting balances for Part D, there are no differences between a Part D program that is part of an MA-PD plan and a Part D program that is part of a PDP. There is a difference in RBC reporting treatment of MA-PD plans and PDP plans, which has been discussed above in Answer 14.

There are some presentation differences in the statutory blank. For example, for the Orange blank in the analysis of operations by line of business, PDP plans would be reported as Other-Health while the Part D portion of a MA-PD plan would be included together with the Part C portion in the Title XVIII – Medicare section. Also, PDPs need to complete an additional orange blank exhibit, the Medicare Part D Supplement, whereas MA-PD plans do not.

**Q21: For which items should additional provision for adverse development be held? How should potential offset between various components be addressed (i.e. lower unpaid claim liability might result in an offsetting change in risk share liability)?**

**A21:**

For statutory accounting, Actuarial Standard of Practice (ASOP) No. 22, *Statements of Opinion Based on Asset Adequacy Analysis by Actuaries for Life and Health Insurers*,<sup>9</sup> and ASOP No. 28, *Compliance With Statutory Statement of Actuarial Opinion Requirements for Hospital, Medical, and Dental Service or Indemnity Corporations, and for Health Maintenance Organizations*,<sup>10</sup> state that liabilities need to be adequate to cover obligations under moderately adverse conditions. This would include the unpaid claim liability and any risk-sharing liability. For GAAP the guidance is less clear, but in practice, entities rarely have GAAP/statutory differences on these liabilities.

The provision for adverse development on the unpaid claim liability for Part D drugs should be determined in a fashion consistent with other unpaid claim liabilities. The risk-sharing liability provision is much less straightforward. Adverse development for this liability would primarily arise from one of the following:

- Incurred claims develop more favorably than expected. If this occurs, the company would also have favorable development of the unpaid claim liability.
- The actual risk share calculation develops a different result than the model used to estimate the liability. Often, this is driven by the model using a simplified approach to address rebates.
- PDEs are less than the paid claims used to estimate the liability, or claims are miscategorized between NPP and CPP liabilities.
- Revenue projections develop differently than anticipated. This can occur through a number of factors including retroactive enrollment changes and retroactive adjustments to risk-adjustment factors.

For the first item, most companies are using the recorded unpaid claim liability in projecting risk-sharing liabilities. Adverse deviation is sufficiently addressed, as any unfavorable development in risk-share liabilities would be more than offset by the favorable development in the unpaid claim liability. It should be noted that any conservatism in the unpaid claim liability may affect the risk-sharing liability in the opposite direction but would be limited in effect to the marginal risk-sharing percentage. A limited number of companies add some additional provision by using the unpaid claim liability without provision for adverse deviation in estimating the risk share liability.

For the second item, most companies used a model in estimating the risk share calculation that is very close to what they believe the ultimate calculation to be. A limited number of carriers are making significant approximations or simplifications to that calculation. If a company's risk-share projection model includes significant approximations or simplifications, it would be appropriate to include either implicit (through conservative assumptions) or explicit provisions for adverse deviation for statutory reporting. The level of the provision should be based on the observed variability between the risk-share projection model and actual results.

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<sup>9</sup> [http://www.actuarialstandardsboard.org/pdf/asops/asop022\\_083.pdf](http://www.actuarialstandardsboard.org/pdf/asops/asop022_083.pdf)

<sup>10</sup> [http://www.actuarialstandardsboard.org/pdf/asops/asop028\\_054.pdf](http://www.actuarialstandardsboard.org/pdf/asops/asop028_054.pdf)

For the third item, most companies periodically have some level of paid claims which have not been accepted as PDEs. However, most companies report that they believe these outstanding claims will be resolved prior to the risk-sharing settlement calculation. Since CMS will calculate the ultimate risk share based on PDEs, any unresolved difference could adversely affect the risk share. Few companies are currently holding an additional provision for this potential occurrence. However, companies should review prior experience with respect to reconciliation of paid claims to PDEs and determine if some potential for adverse development exists for this item.

For the fourth item, companies may project anticipated revenue adjustments. Few companies appear to be holding an additional provision for potential deviations from the projected adjustments.

The reinsurance asset/liability and LICS asset/liability are both essentially deposit funds in which the balance is based on the difference between income and outgo. The opportunity for adverse development in these account balances is primarily related to rejected PDEs or to the miscategorization of NPP and CPP liabilities. Relatively few companies are recording an additional provision related to reinsurance or LICS.

# GLOSSARY

## Definitions and Acronyms

1. **Adjusted Allowable Risk Corridor Costs (AARCC)** — The prescription drug claim costs eligible for inclusion in a plan sponsor’s risk-sharing / risk corridor calculation. Note: risk-sharing / risk corridor payments are a function of the AARCC and the target amount (see below).
2. **Basic Member Premium** — The portion of the premium paid by a beneficiary to a plan sponsor for the national average bid amount. See “Premium Components of Part D PDP” (below).
3. **Benefit Plan Offerings**
  - a) **Standard PDP** — The standard benefit plan design defined by the MMA
    - (1) **Deductible** — annual dollar amount that beneficiary must pay before any benefit is payable
    - (2) **Coinsurance** — percentage (i.e., 25 percent) of prescription drug cost paid by beneficiary between deductible and initial coverage limit
    - (3) **Initial Coverage Limit (ICL)** — Dollar amount at which beneficiary’s coinsurance increases from 25 percent to 100 percent (i.e., commencement point of the coverage gap)
    - (4) **Catastrophic Limit (or, Catastrophic Attachment Point)** — The dollar amount at which beneficiary’s coinsurance decreases from 100 percent to roughly 5 percent (i.e., termination point of the coverage gap), subject to certain other limitations.
    - (5) **Coverage Gap** — The gap between the initial coverage limit and the catastrophic limit where the beneficiary is responsible for 100 percent of all prescription drug expenses (often referred to as the “doughnut hole”).
  - b) **Actuarially Equivalent Cost Sharing Benefit Plan** — PDP with the same benefit design elements as the standard PDP (e.g., same deductible and initial coverage limits) but with alternative actuarially equivalent cost sharing provisions (e.g., tiered co-pays versus the standard Part D benefit plan’s 25 percent coinsurance provision). A given enrollee might pay more or less than the standard PDP’s 25 percent coinsurance, but the actuarially equivalent PDP must be designed such that the average enrollee would be expected to pay 25 percent of the total cost for the drugs subject to the 25 percent standard PDP cost-sharing provision.
  - c) **Basic Alternative Coverage PDP** — PDP with the same actuarial value as the standard Part D benefit plan but for which the deductible and initial coverage limit may differ.
  - d) **Enhanced Alternative Coverage PDP** — PDP with an actuarial value greater than the standard Part D benefit plan. For example, the initial coverage limit might be defined at a level higher than that for the standard PDP. Note: To the extent the initial coverage limit is increased, the catastrophic limit must be correspondingly increased (since CMS will not assume additional liabilities for an enhanced alternative coverage benefit plan).

#### 4. **Bid Submission Terminologies**

- a) **Standardized Bid** — The bid developed by a plan sponsor to cover:
    - (1) Prescription drug costs for the standard PDP
    - (2) Non-pharmacy costs (e.g., administrative expenses)
    - (3) The plan sponsor's profit margin
    - (4) A risk adjustment factor of 1.00
  - b) **National Average Bid Amount** — The national average of all standardized bids received by CMS, according to an averaging methodology promulgated by CMS.
5. **Bid Pricing Tool (BPT)** — A software tool prepared by CMS to assist plan sponsors prepare PDP bids, to standardize the bid response format, and to facilitate the aggregation by CMS of the bid details they submit. The BPT calculates the plan sponsors' bids, enrollee premiums, and CMS payment rates.
  6. **Budget Neutrality Requirement (BNR)** — This is the per-beneficiary per-year dollar reduction in capitation payments for demonstration programs that is estimated as being required to maintain budget neutrality. This amount is calculated annually by CMS. [see also Reinsurance Demonstration Program for Part D]
  7. **Centers for Medicare & Medicaid Services (CMS)** — The federal government agency responsible for administering the federal government's Medicare and Medicaid programs.
  8. **Claim Adjustment Expense (CAE) liability** — This represents a provision for future administrative costs associated with the processing of the prescriptions covered by the unpaid claim liability.
  9. **Coordination of Benefits** — CMS has defined specific procedures and specific organizations with which plan sponsors must coordinate the administration of coordination of benefits provisions.
  10. **Covered D Plan Paid (CPP) amount** — This is the portion of a PDE that would have been paid had the beneficiary been covered by a standard PDP. [see also non-covered plan paid (NPP) amount]
  11. **Cumulative Beneficiary Summary (CBS)** — Summary for each Medicare beneficiary of the accumulated totals in PDE amount fields with accumulated totals for drug payments. CBS reports are prepared for overall drug totals, for drugs covered by an enhanced alternative coverage PDP, and for over-the-counter drug payments.
  12. **Direct and Indirect Remuneration (DIR)** — In order for covered drug costs to count towards allowable reinsurance or risk corridor costs, such costs must be net of any direct or indirect remuneration, including discounts, chargebacks or rebates, cash discounts, free goods contingent on a purchase agreement, upfront payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers from any source (including manufacturers, pharmacies, enrollees, or any other person), that would serve to decrease the costs incurred by the plan sponsor. It will also include any retroactive payments or repayments that plans make as part of capitated arrangements with providers.
  13. **Direct Subsidy Payments** — The portion of the national average bid amount paid by CMS (adjusted for reinsurance). The direct subsidy payment for a plan sponsor beneficiary equals:  
standardized bid x (risk adjustment factor for beneficiary) - basic member premium



- a) Monthly Direct Subsidy Payments — Prospective monthly direct subsidy payment estimates paid to plan sponsors
  - b) Annual Settlement of Direct Subsidy Payments — The retroactive annual settlement for the aggregation of monthly direct subsidy payments and the actual annual amount that should have been paid to the plan sponsor.
14. **Drug Data Process System (DDPS)** — DDPS is the information system that collects, validates, and stores PDE data received from plan sponsors or their designee.
15. **Employer/Union Only Group Waiver Plans (EGWP)** (sometimes referred to as 800 series plans) — Medicare Advantage plans that are specific to an employer group. These plans can cover Part C only, Part D only or both Part C and Part D benefits. EGWPs can either be established by the employer contracting directly with CMS (in essence, becoming an MA-PD or PDP itself) or through the employer contracting with a PDP or MA-PD insurer that offers EGWPs to offer a plan specific to the employer's population only.
16. **Excess Member Premiums** — Member premiums paid to plan sponsors due to their bid for the standard PDP being in excess of the national average bid amount.
17. **Gross Drug Costs Above the Out-of-Pocket Threshold (GDCA)** — A mandatory PDE field for the prescription drug cost that equals the portion of ingredient cost paid + dispensing fee paid + total amount attributed to sales tax falling above the TrOOP threshold. The remaining portion, if any, is reported in GDCB.
18. **Gross Drug Costs Below the Out-of-Pocket Threshold (GDCB)** — A mandatory PDE field for the prescription drug cost that equals the portion of ingredient cost paid + dispensing fee paid + total amount attributed to sales tax falling at or below the TrOOP threshold. The remaining portion, if any, is reported in GDCA.
19. **Late Enrollment Penalties** — People who turn 65 during or between annual enrollment periods can join a Medicare prescription drug plan as soon as they sign up for Medicare. The effective date of prescription drug coverage will begin on their Medicare eligibility date. If they don't join a plan within the required time period, or don't have creditable coverage and decide to join later, they'll pay the standard monthly premium plus a 1 percent penalty of the base beneficiary premium per month. This higher premium will stay with them for as long as they are enrolled in the program. While the government keeps the late enrollment penalty fees, CMS has indicated a willingness to consider the sharing of such fees with plan sponsors if actuarial justification is presented.
20. **Low Income Cost Sharing Subsidy Payments (LICS)** — A mandatory PDE field that equals the amount the plan reduced patient liability due to a beneficiary's LIS (low income subsidy) status. The MMA provides for Medicare payments to plans to subsidize the cost-sharing liability of qualifying low-income beneficiaries at the point of sale. This amount counts towards a beneficiary's TrOOP costs.
- a) Monthly low-income cost-sharing subsidy payments — Prospective monthly payment estimates to reimburse plan sponsors for LICS payments.
  - b) Annual settlement of low-income cost-sharing subsidy payments — The retroactive annual settlement for the aggregation of monthly LICS payments and the actual annual LICS payments that should have been paid to the plan sponsor.

21. **Low Income Premium Subsidy (LIPS)** — For qualifying low-income members, the government pays some portion or all of the members' monthly premiums to plan sponsors on the members' behalf.
22. **Medicare Advantage Prescription Drug Plans (MA-PDs)** — A Medicare Advantage plan that offers a prescription drug benefit in accordance with Medicare Part D benefit plan provisions.
23. **Medicare Part C Rebates** — Medicare Advantage Part C revenue amounts available to enhance benefits or lower member premiums. These rebates only apply for plans offering Part C benefits. They can be used to enhance Part C benefits, reduce the Part B premiums, or reduce the Part D basic and supplemental premiums.
24. **Medicare Part D** — The federal prescription drug program established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
25. **Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)** — The act that established, among several other government programs, the Part D prescription drug benefit for Medicare beneficiaries.
26. **Monthly Membership Reports (MMR)** — A monthly report prepared by CMS that lists every Part D member for a plan sponsor and provides details about the payments and adjustments for each such member. Plan sponsors must reconcile their own membership and payment data files with the MMR data.
27. **National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard** — The standard to be used for transmitting prescription drug eligibility inquiries and responses between dispensers and plan sponsors. The NCPDP SCRIPT standard is also used to communicate the key elements of a prescription between the prescribing physician and the dispenser.
28. **National Drug Code (NDC)** — A national system for coding prescription drugs. An NDC consists of a total of 10 digits, broken into three segments where the first segment is a labeler code (e.g. manufacturer or distributor), the second segment is a product code (e.g. strength and dosage form), and the third segment is a package code (e.g. package size and type).
29. **Non-covered Plan Paid (NPP) amount** — This is the difference between what is actually paid for a PDE versus what would have been paid by a standard PDP (see also Covered D Plan Paid Amount [CPP]). This field includes non-Part D drugs (e.g., OTC drugs) and enhanced benefit coverage.
30. **Patient Liability Reduction Due to Other Payer Amount (PLRO)** — A required PDE field for amounts by which patient liability is reduced due to payment by other payers that are not TrOOP-eligible and do not participate in Part D. Examples of non-TrOOP-eligible payers include: group health plans, governmental programs (e.g. VA, TRICARE), workers' compensation, auto/no-fault/liability insurances.
31. **Pharmaceutical Rebates**
  - a) From drug manufacturers — rebates provided to payers from drug manufacturers
  - b) From PBMs — rebates provided by PBMs to their clients (e.g. plan sponsors).
32. **Pharmacy Benefit Managers (PBMs)** — Corporations that negotiate drug prices with drug manufacturers and administer the drug programs for many health care insurers (e.g. plan sponsors).

- a) Lock-in pricing — Plan sponsors that use the services of a PBM are often not made privy to the PBM’s actual drug-specific price and rebates negotiated with the drug manufacturer. The PBM often charges plan sponsors an amount in excess of the actual negotiated price (the difference is referred to as the “spread,” and the price charged the plan sponsor is referred to as the “lock-in” price) and may also rebate only a portion of the total rebates received from the drug manufacturers. CMS reluctantly permitted plan sponsors to use, as an alternative to pass-through pricing, lock-in pricing for PDE amounts until such time as CMS mandates the use of pass-through pricing (currently established for bids attributable to prices charged for calendar year 2009).
  - b) Pass-through pricing — The pricing methodology whereby PDE amounts reflect the actual price charged by the drug manufacturer, whether such amount is negotiated directly by the plan sponsor or by an agent of the plan sponsor (e.g. a PBM).
  - c) A plan sponsor must elect either a lock-in or pass-through pricing methodology and must use such methodology as the basis for each of the following items:
    - (1) Calculating beneficiary cost-sharing,
    - (2) Accumulating gross covered drug costs,
    - (3) Calculating TrOOP,
    - (4) Reporting drug costs on the prescription drug event (PDE) records,
    - (5) Developing bids submitted to CMS.
33. **Plan Benefit Package (PBP)** — PBP refers to both the prescription drug benefit plan itself and the software tool developed by CMS that plan sponsors must use to submit benefit packages to CMS during the annual bidding process. The PBP software tool is also used by CMS to review and communicate the marketing materials that a plan sponsor uses to inform Medicare beneficiaries about its plans.
34. **Plan Sponsors** — This paper uses the term to refer to any entity offering a PDP. Most commonly, a plan sponsor will be a managed care organization or an insurance company offering a PDP.
35. **Plan-to-Plan (P2P) financial reconciliation** — P2P financial reconciliation is a settlement process by which the plan sponsor of record repays any plan sponsor that paid for Part D drugs in good faith when Part D plan enrollment data were not up-to-date. Following the initial confusion at inception of the Part D program in calendar year 2006, it can be anticipated that P2P settlement amounts will decrease significantly over time.
36. **Premium Components of Part D PDP** (break-down of combined premiums paid by beneficiary and government). Note: Listed below are premiums for which the reinsurance subsidy is applicable must be adjusted for such subsidy.
- a) Basic member premium (paid by beneficiary)
  - b) Direct subsidy payment (paid by government)
  - c) Excess member premiums (paid by beneficiary)
  - d) Supplemental premiums; for enhanced alternative coverage PDP (paid by beneficiary)
  - e) Additional premiums for late enrollee (paid by beneficiary)
  - f) Change in premium due to risk adjustment; may be positive or negative (paid by government)

37. **Prescription Drug Event (PDE)** — A summary record that a plan sponsor must submit to CMS every time a beneficiary fills a prescription covered by a PDP. The summary record consists of almost 40 fields mandated for completion by CMS. The PDE record contains prescription drug cost and payment data that will enable CMS to make payments to plans and otherwise administer the Part D benefit.
38. **Prescription Drug Plan (PDP)** — A stand-alone plan sponsor (in contrast to a MA-PD plan sponsor) that offers only prescription drug coverage to Medicare beneficiaries. Note: The term also refers to one or more prescription drug plan benefit packages that may be offered by a plan sponsor.
39. **Program of All Inclusive Care for the Elderly (PACE)** — PACE is an optional benefit under both Medicare and Medicaid that focuses entirely on older people who are frail enough to meet their state's standards for nursing home care. It features comprehensive medical and social services that can be provided at an adult day health center, home, and/or inpatient facilities. For most patients, the comprehensive service package permits them to continue living at home while receiving services, rather than be institutionalized.
40. **Reinsurance Demonstration Program for Part D** — A demonstration program that mitigates the disincentive to offer supplemental benefits due to the standard PDP's catastrophic reinsurance payment provision. Specifically, a plan sponsor may elect to receive government capitations that are actuarially equivalent to capitations for a standard PDP. For such capitations, a plan sponsor would offer an enhanced PDP with a benefit design in accordance with one of the following three alternatives:
  - a) Flexible capitated option — Enhanced alternative coverage where the OOP threshold is extended by the provision of the enhanced alternative cost share in the coverage gap. Companies participating in this demonstration plan receive a capitated reinsurance payment and are then at risk for any reinsurance sufficiency/deficiency.
  - b) Fixed capitated option — Enhanced alternative coverage where the OOP threshold remains at the level in which the catastrophic coverage phase is reached under the defined standard benefit. Companies participating in this demonstration plan receive a capitated reinsurance payment and are then at risk for any reinsurance sufficiency/deficiency.
  - c) MA rebate option — Enhanced alternative coverage with a supplemental benefit in the coverage gap paid for with MA Part A/B rebate dollars, which count toward the TrOOP threshold.
41. **Reinsurance Subsidy** — The amounts payable by CMS to plan sponsors for each beneficiary with TrOOP costs in excess of the catastrophic limit for that beneficiary. CMS pays 80 percent of such costs, the plan sponsor is responsible for 15 percent, and the beneficiary is responsible for 5 percent (or \$2 generic / \$5 brand co-pay, if greater).<sup>11</sup>
  - a) Monthly reinsurance subsidy payments — Prospective monthly payment estimates to reimburse plan sponsors for the reinsurance subsidy payments.
  - b) Annual settlement of reinsurance subsidy payments — The retroactive annual settlement for the aggregation of monthly reinsurance subsidy payments and the actual annual reinsurance subsidy payment that should have been paid to the plan sponsor.

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<sup>11</sup> These are 2006 numbers and are indexed annually.

42. **Retiree Drug Subsidy (RDS)** — In lieu of establishing an EGWP, an employer or union may also apply to maintain or enhance their current drug program and receive a 28 percent federal subsidy for allowable retiree costs between \$275 and \$5600 (2008 thresholds). RDS plans need not submit data to CMS at the PDE levels, but they are subject to their own set of stringent approval and reporting criteria.
43. **Risk Adjustment Factor** — In addition to limiting a plan sponsor's program risk via the reinsurance subsidy and the risk-sharing provisions, the Part D program also uses a health status risk adjustment factor. Capitation payments that reflect a plan sponsor's enrollment risk profile are adjusted via a PDP-specific health status risk adjustment factor.
44. **Risk Corridor (or Risk-Sharing)** — CMS may participate in both the gains and losses for each plan sponsor's Medicare Part D program financial results. The degree of CMS participation varies by the extent to which actual payments for prescription drugs differs from the expected results, as defined by a plan sponsor's standardized bid. CMS participation will also vary by calendar year, decreasing over time.
45. **State Pharmaceutical Assistance Programs (SPAP)** — A state program for which some of the prescription drug program funding comes from private sources (e.g. charities or independent foundations). Payments made by SPAPs count toward an enrollee's TrOOP.
46. **State-to-Plan (S2P) PDE Reporting** — CMS took numerous actions to ensure that full-benefit dual-eligible individuals and other beneficiaries entitled to a low-income subsidy continued to receive needed medications during the transition to drug coverage under the new Medicare Part D drug benefit. As part of this initiative, CMS worked directly with the States to reimburse them for costs incurred during the transition period. The appropriate Plan Sponsor, however, retained primary payer liabilities for these claim costs. Once claim identification was determined, CMS required that the claims be adjudicated and booked as a liability by the appropriate Plan Sponsor. The "payments" attributable to these adjudicated claims are recouped by CMS from future payments to the Plan Sponsor. This CMS-defined reporting and reconciliation procedure is called S2P. While potential S2P liabilities are limited to the initial 2006 Part D program year, liability settlements for calendar year 2006 may extend to calendar years 2007 and later.
47. **Supplemental Premium** — The additional premium paid by or on behalf of a beneficiary enrolled in an enhanced alternative coverage benefit plan.
48. **Target Amount for Risk-sharing/Risk Corridor Calculation (TA)** — A plan sponsor's expected prescription drug claim costs for the standard PDP (i.e., basic member premium + excess member premium plus + subsidy payment) + supplemental premium - non-pharmacy costs - the plan sponsor's profit margin. All such amounts are obtained from the plan sponsor's bid submission. Note: risk-sharing / risk corridor payments are a function of the target amount and the AARCC (see above).
49. **True Out-Of-Pocket (TrOOP) Costs** — Costs incurred by a beneficiary that accumulate towards the catastrophic limit (i.e., are creditable towards a beneficiary's out-of-pocket threshold).
50. **Unpaid Claim Liability** — Representing drug prescriptions where: (a) the insurer is ultimately liable; (b) the prescription was filled before the financial statement date; and (c) the insurer did not pay for the prescription until after the financial statement.