February 8, 2011

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

Subject: Medicare Part D Survey

Dear Dennis:

The National Association of Insurance Commissioners (NAIC), through its Health RBC Working Group, asked the American Academy of Actuaries'[1] Medicare Part D RBC Subgroup in 2005 for a recommendation as to whether and how the risk-based capital factors for Medicare Part D should be changed. The Academy's subgroup issued a report to the NAIC on March 20, 2009, recommending certain changes to the 2006 formula. In that report, we indicated it would be prudent to revisit the development of the factors, based on updated information, given the fairly recent implementation of Medicare Part D in 2006.

As you may know, the subgroup's goal is to base any future analysis on historical data. Because of certain limitations in the available historical data, however, we wish to supplement it with additional information gathered from a survey of carriers writing Medicare Part D business. This approach is consistent with that used to develop the original RBC factors in 2006 and the updated factors in 2009.

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

We are proposing that the response deadline for the survey be approximately four weeks from when it is mailed and we hope to have the survey distributed in the near future.

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[1] The American Academy of Actuaries ("Academy") is a 17,000-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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If you would like further information about the purpose of the survey or about any specific question included in the survey, we would be happy to discuss the matter with you.

Sincerely,

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

Medicare Part D Industry Company Survey

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

[submission info]

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

[contact info]

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

Survey Purpose

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

The 2005 RBC formula changes were based on recommendations made by the American Academy of Actuaries' Medicare Part D RBC Subgroup. Because there was no historical experience on which to base RBC factors, a survey was undertaken in 2005 to elicit views from actuaries who were involved in the pricing of Medicare Part D benefit plans at that time. An analysis of the survey responses was the primary basis for the subgroup's recommendations to the NAIC.

Since the original survey was administered, the Medicare Part D RBC Subgroup revisited the formula in 2008 to determine if the original factors were still reasonable based on actual Part D experience, emerging views of the product, and changes in the "risk corridor adjustments" implemented by the Centers for Medicare & Medicaid Services (CMS). Effective with the 2009 RBC formula, the factors related to Part D in the RBC formula were adjusted based on emerging experience. Once again, a survey was released and the survey was the primary basis for the subgroup's recommended changes to the formula because actual data was not able to adequately be obtained.

When the Medicare Part D RBC Subgroup proposed the changes of the formula to the NAIC during this most recent effort, the Academy subgroup indicated that it would revisit the factors at a

future date in order to evaluate ongoing improvements in pricing arising from more extensive experience with this product.

With this survey, we expect to receive better analysis of improvements in pricing methodology over the past few years as well as be able to gauge how close expected claims have been to actual results. This survey is intended to gather information that can be used to adjust the historical experience to reflect anticipated improvements in pricing accuracy. Given the nature of the survey questions, the information gathered through this survey will be subjective to a large degree (as was true of the two prior survey responses). It is all the more important, then, to obtain a broad-based response, so that outliers can be identified and their effects mitigated.

In order for the NAIC to adopt any needed changes to the RBC formulas in a timely fashion, we are asking for your responses to be submitted no later than [four weeks from mailing].

Use of the Survey Responses

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

Explanation of Terminology

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

Health status risk adjustment: The Medicare Part D premiums received by a carrier are adjusted to reflect the relative anticipated benefit costs for individual beneficiaries. These health status risk adjustments are prospective rather than retrospective, and are based on individual health status as reflected in the prior year's hospital and physician encounter information.

Low-income cost-sharing subsidy: Medicare Part D beneficiaries who meet certain criteria receive financial subsidies from the federal government. These subsidies take two forms. The premium portion of the subsidy is an additional payment by the Centers for Medicare & and Medicaid Services (CMS) that reduces the monthly premium that the beneficiary must pay to the Medicare Part D carrier. The cost-sharing portion of the subsidy is an amount of claims that

would normally be the responsibility of the beneficiary, but is instead paid by the carrier, and for which the carrier is then reimbursed by CMS.

Reinsurance coverage: This is the federal government's assumption of financial responsibility for 80 percent of a beneficiary's claims above a specified dollar threshold. In the original 2006 benefit structure, the threshold was $5,100. For 2011, the threshold is $6,447.50 per individual per year. (Note that the actual catastrophic level will depend on the mix of generic/brand drugs above the initial coverage limit due to the 7 percent generic benefit in the gap). "Reinsurance coverage" for purposes of this survey does not include any reinsurance ceded by a company to a non-governmental reinsurer. Note that, pursuant to statutory accounting principles, this reinsurance coverage actually is reported in statutory financial statements as uninsured business rather than as reinsurance.

Reinsurance payment demonstration: Companies that participate in the reinsurance payment demonstration forgo the federal reinsurance coverage described above. Such companies assume financial responsibility for the 80 percent of over-threshold claims that otherwise would be payable by the federal government. As compensation for taking on this risk, the companies receive additional premium from CMS. The reinsurance payment demonstration program has been suspended beginning with the 2011 plan year.

Risk corridor protection: The Medicare Part D program limits the extent to which a company will benefit or suffer from large deviations in actual claim experience versus the experience that was anticipated in the pricing documentation submitted to CMS. If the actual experience falls within a certain range or "corridor" around the anticipated experience and defined in percentage terms, no adjustment is made. When experience falls outside that range, a specified percentage of the deviation—, whether favorable or unfavorable—, is reimbursed to or by (respectively) the federal government. "Risk corridor protection" means the reduction in a company's claim expense that arises from this sharing of adverse experience between the company and the federal government. For companies that participate in the reinsurance payment demonstration, the relevant experience includes the additional claims for which the company has assumed responsibility. The experience subject to risk corridor protection excludes any supplemental benefits, i.e., those in excess of the standard (or actuarially equivalent) Medicare Part D coverage. Beyond 2011, it is unknown whether CMS will change the risk corridor protection formula or if the risk- sharing program will be discontinued.

Survey Questions

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

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

Please provide your opinions in response to the following questions:

1. Define X to be the target benefit ratio (i.e., loss ratio) that your company has filed in a bid with CMS for standard (or actuarially equivalent) coverage. What would you consider to be reasonably worst case (95 percent confidence level) and moderately adverse case (70 percent confidence level) scenarios for the experience expressed as a percent of X (not of premium)? That is, an answer of 150 percent of X would mean that actual ultimate claims costs would be 50 percent greater than was assumed in the bid. In answering this question, consider that CMS uses health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population, but ignore the risk corridor protection. For this question, assume that the carrier is reimbursed by CMS for any applicable claims in excess of the catastrophic limit and that the carrier receives the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage. In your response, assume 7 percent generic coverage in the gap and a 50 percent manufacturer discount on brands, per the current discount program. Note, for questions No. #1, No. 2, and No. 3 that the reasonably worst-case scenario response should be greater than the moderately adverse-case scenario response. In addition, we would expect that the plan level responses would be greater than or equal to the legal entity level responses. Last, the responses to questions No. 1, No. 2, and No. 3 should all be greater than 100 percent.

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

2. Please provide revised responses to question No.1 for plans that participate in the reinsurance payment demonstration. That is, the applicable fully insured coverage includes both the standard (or actuarially equivalent) benefit and the additional 80 percent of catastrophic claims in excess of $6,447.50 (the 2011 threshold) per individual per year. (Note that the actual catastrophic level will depend on the mix of generic/brand drugs above the initial coverage limit due to the 7

percent generic benefit in the gap). As in question No.1, again consider that CMS will use health status risk adjustment to adjust revenue to account for the risk profile of the actual enrolled population, and again ignore the risk corridor protection. In addition, even though the reinsurance demonstration is not available in 2011, assume that the carrier receives the average premium calculated in the pricing of the catastrophic coverage for the reinsurance payment demonstration and the average premium calculated in the pricing of the product and filed with CMS for standard (or actuarially equivalent) coverage. Note that, given the fact that the plan would be responsible for a larger portion of the claims compared to question No. 1, we would expect that the responses for this question would be greater than the responses for question No.1.

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

3. Please provide revised responses to questions No.1 and No. 2 reflecting how the perceived risk changes with the closing of the coverage gap and the fully implemented manufacturer coverage gap discount program. That is, assume generics are covered at 75 percent in the gap and that the manufacturer brand discount in combination with the amount covered by the government will also will be covered at 75 percent. That is, the benefits would be adjudicated as would be expected in 2020 under the current regulation. Provide a response assuming the current risk corridor and under a scenario in which the risk corridor protection is removed. Note that we would assume that the scenarios would be worse, percentages greater, when the risk corridor protection is removed.

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

	(i) Plan level	(ii) Legal entity level
c. Reasonably worst-case scenario without risk corridor protection	_____	_____
d. Moderately adverse-case scenario without risk corridor protection	_____	_____

4. In answering the above questions, what volume of business did you have in mind? (Indicate a range, as defined below, rather than a specific dollar amount.) For this purpose, “annual

premium" would include revenue from CMS (including the premium portion of the low-income cost-sharing subsidy) and from the individual enrollee. "Annual premium" would exclude payments made pursuant to the federal reinsurance coverage and the "cost-sharing" (i.e., benefit reimbursement) portion of the low-income cost-sharing subsidy. Assume no revenue related to the risk corridor protection.

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

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

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

6. Some carriers provide supplemental benefits to enrollees, covering costs that under the standard Part D coverage would be the enrollees' responsibility (co-pays, deductibles, coinsurance, and/or the coverage gap). What do you believe would be the reasonably worst- case and moderately adverse- case, as defined in question No. 1, for the experience on such supplemental benefits? Respond for the supplemental benefits only, not the combination of standard coverage and supplemental benefits. Similar to questions No. 1, No. 2, and No. 3, the reasonably worst-case scenario response should be greater than the moderately adverse-case scenario response, the plan level response should be greater than or equal to the legal entity level response, and the responses should all exceed 100 percent.

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

7. In your responses to questions No.1, No.2, No. 3, and No.6, you may have assumed that some portion of the Medicare Part D benefits was paid in the form of a capitation to another party. For

each of those responses, please indicate the percentage of the claim payments that you were assuming were in the form of such a capitation.

For Question No.1: _____percent
For Question No.2: _____ percent
For Question No.3: _____ percent
For Question No.6: _____percent

8. Now that actual experience is available, each carrier is able to compare its bid to actual experience. With regard to the standard (or actuarially equivalent) benefit, reinsurance payment demonstration program (if your plan participated), and supplemental benefits, indicate how the results in your bid compared to actual experience. In answering the question adjust the claims in the bid for any difference in risk between what was filed with CMS and the risk score that actually was experienced. When reporting supplemental benefits, only claims in excess of defined standard or actuarially equivalent benefits should be analyzed, not the full amount of claims related to an enhanced supplemental benefit plan. For 2007, 2008, and 2009 provide a factor indicating actual claims as a percent of expected claims for each of the categories. If your plan did not participate in the Reinsurance Payment Demonstration or offer supplemental benefits, leave those sections of the survey blank. In answering this question, ignore the risk corridor protection. Your responses below should be greater than 100 percent if the actual claims per bid exceed the expected and less than 100 percent if experience was better than expected.

Actual claims vs. expected (per bid) with respect to standard or actuarially equivalent benefits:

	(i) Plan level	(ii) Legal entity level
a. 2007	_____	_____
b. 2008	_____	_____
c. 2009	_____	_____

Actual claims vs. expected with respect to reinsurance payment demonstration experience:

	(i) Plan level	(ii) Legal entity level
a. 2007	_____	_____
b. 2008	_____	_____
c. 2009	_____	_____

Actual claims vs. expected with respect to supplemental benefit experience:

	(i) Plan level	(ii) Legal entity level
a. 2007	_____	_____
b. 2008	_____	_____
c. 2009	_____	_____

9. The Medicare Part D RBC risk factors currently are tiered, with a higher factor applying to the first $25 million of premium revenue, and a lower factor applying to amounts in excess of $25 million (so that for total volumes greater than $25 million, the applicable factor is a weighted average of the two stated factors). This formula structure presumes that smaller volumes of business experience more volatility than higher volumes, and that a premium level of $25 million is approximately where the size-related advantage becomes significant. We expect that this $25 million breakpoint will remain in effect at least through 2010.

a. Please indicate whether you believe that this breakpoint will be appropriate for 2011, or whether the breakpoint should be changed; and in the latter case, what alternative breakpoint you would recommend.

_____ $25 million is an appropriate breakpoint.

_____ A more appropriate breakpoint would be $_____.

b. For the breakpoint that you indicated in response to question No. 9a (whether $25 million or otherwise), please indicate the approximate number of Medicare Part D enrollees to which that dollar amount would correspond.

Corresponding number of Medicare Part D enrollees: _____