AMERICAN ACADEMY of ACTUARIES

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August 24, 2016

Mr. Patrick McNaughton
Chair, Health Risk-Based Capital Working Group
National Association of Insurance Commissioners
2301 McGee Street, Suite 800
Kansas City, MO 64108-2662

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

Dear Mr. McNaughton:

On behalf of the Medicare Part D RBC Subgroup of the American Academy of Actuaries,[1] I would like to present the attached report recommending the RBC risk factors for Medicare Part D coverage remain the same for standard coverage, but be increased for supplemental coverage. These recommendations are based on a recent analysis of detailed carrier experience, and this report serves as a follow-up to our report released in April 2014.

We appreciate the opportunity to provide these recommendations and would welcome the opportunity to discuss them with you in more detail. If you have any questions or would like to discuss further, please contact David Linn, the Academy's health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

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

[1] The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted 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.

Report on RBC Risk Factors for Medicare Part D Coverage From the American Academy of Actuaries Medicare Part D RBC Subgroup

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

August 2016

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I. Background

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

In September 2005, the subgroup provided recommendations to the NAIC task force regarding changes to the RBC formula structure and instructions addressing the risk considerations specific to Medicare Part D. Changes were recommended for both the health RBC formula and the life RBC formula. These changes involved the introduction of several additional factors for Medicare Part D. In December 2005, the subgroup recommended values for those additional factors, which were subsequently adopted by the NAIC.

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

In March 2008, the NAIC working group asked the subgroup to re-evaluate the reasonableness of the Medicare Part D factors, in light of the changes to the risk corridor protection and the industry's additional experience with Medicare Part D.

In a letter dated March 20, 2009, the subgroup proposed changes to the Medicare Part D RBC factors for both standard coverage and supplemental coverage Part D benefits based on the working group request. Standard coverage refers to the Part D benefit design conforming to certain standards prescribed by the government; supplemental coverage refers to benefits in excess of the standard coverage. Because we were unable to gather actual experience data, the factors were developed using data from a survey the NAIC sent to plans that participated in the Part D marketplace. The recommended factors for standard coverage were not a significant change from those initially recommended, but the recommended supplemental coverage factor increased by 292 percent (compared to the initial supplemental coverage factor). These changes were eventually adopted by the NAIC and became effective with the 2009 RBC calculation.

In the March 20, 2009, report, the subgroup recommended certain factors be revisited in the near future. Specifically, the subgroup recommended trying to use actual experience from either NAIC Annual Statement Filings or the Centers for Medicare and Medicaid Services (CMS) to further refine the RBC factors. This included determining whether the supplemental coverage factor was reasonable given that the 35 percent recommended factor was based on a survey of industry actuaries and not an analysis of hard data by the subgroup.

In its April 2014 report, the subgroup recommended the factors be unchanged based on a study of actual experience obtained through an NAIC survey of companies that market the Medicare Part D product. In that report, it was noted the supplemental coverage experience was volatile, but due to changes in the design of the Medicare Part D product and observed trends in medical loss ratios, there was not enough evidence to recommend changing the current factor. In that report, the subgroup recommended that another survey be conducted when additional years of data were available to refine the current factors, if necessary. Further, the report indicated the following items should also be analyzed for reasonableness:

- Determine whether the 4.9 percent assumed profit margin utilized to determine the underwriting factors is a reasonable assumption based on actual emerging experience.

- Consider adjusting the breakpoint between the initial and excess factors.

- Consider whether the supplemental benefits factor should be applied to claims instead of premium to make it more responsive to each entity's experience.

- Collect information on employer-based stand-alone coverage to determine whether it should have its own factor.

On May 26, 2015, a new survey was distributed by the NAIC to gather experience through 2013. The year 2013 was chosen because as of May 26, 2015, the most recent bid submissions to CMS would have been the 2014 submitted bids, which included actual experience through 2013. Therefore, we would be able to compare actual-to-expected experience up to this point in time. The survey requested actual-to-expected experience for a five-year period from 2009 through 2013.

II. Recommendations

In this section, we give a summary description of the RBC factors required for Medicare Part D and the subgroup's recommendation regarding factors to be used for 2017 and later.

A. Required Factors

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

- There are two underwriting risk factors applicable to standard coverage: a factor applicable to annual premium up to a specified dollar breakpoint ($25 million), and another factor applicable to annual premium in excess of that breakpoint. Below we

refer to those factors as the underwriting risk initial factor and the underwriting risk excess factor, respectively. These factors are used on page XR012 of the health RBC formula and page LR020 of the life RBC formula.

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

- There is another underwriting risk factor applicable to premium received for supplemental benefits. No discount factors are applicable. This factor is used on page XR014 of the health RBC formula and page LR019 of the life RBC formula.

Note these factors apply only to business written as stand-alone individual coverage by a Prescription Drug Plan (PDP) sponsor (i.e., a legal entity providing Medicare Part D as a stand-alone coverage, rather than as part of a Medicare Advantage plan). Medicare Part D coverage integrated with a Medicare Advantage plan is included in comprehensive medical coverage, along with the non-Part-D portion of the coverage (including any pharmacy coverage outside of Part D the plan may provide). Government-subsidized employer-based pharmacy coverage (commonly provided through Employer Group Waiver Plans (EGWPs)) either is included with comprehensive medical coverage, if it is part of an insured medical plan, or is treated as "other health" if it is a stand-alone insured coverage. Note the factors for standard coverage also will apply to coverage actuarially equivalent to standard coverage.

B. Recommended Factors for 2017 and Later

We recommend no change to the standard coverage factors currently being used, but we recommend an increase to the underwriting risk factor for supplemental benefits from 0.350 to 0.500. **We also recommend the 0.500 factor be applied to supplemental benefit incurred claims instead of supplemental benefit premiums**. The current and new factors are summarized below with discussion regarding the reason for the subgroup's conclusion to maintain the current standard coverage factors and change the underwriting risk factor for supplemental benefits in Section II.C.

Current Factors

Underwriting Risk Factors for Standard Coverage:

- Initial factor 0.251
- Excess factor 0.151

Discount Factors for Standard Coverage:

- Risk corridor protection only 0.667
- Reinsurance coverage and risk corridor protection 0.767

Underwriting Risk Factor for Supplemental Benefits (**applied to supplemental premium**) 0.350

Proposed Factors for 2017

Underwriting Risk Factors for Standard Coverage:

- Initial factor 0.251
- Excess factor 0.151

Discount Factors for Standard Coverage:

- Risk corridor protection only 0.667
- Reinsurance coverage and risk corridor protection 0.767

Underwriting Risk Factor for Supplemental Benefits (**applied to supplemental incurred claims**) 0.500

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

Please note:

- Factors for business without either reinsurance coverage or risk corridor protection (as described in the Appendix to this report) are not presented here. Currently, there is no Medicare Part D business to which such factors would actually apply.

- The initial factors are those applicable to premium below the $25 million breakpoint.

- The excess factors are those applicable to premium in excess of the $25 million breakpoint. They are not the weighted average factors applying to the total premium of an entity with more than $25 million of premium.

- Factors with risk corridors only would apply to business with risk corridor protection but no reinsurance coverage (namely, the payment demonstration business, as described in the Appendix under "Reinsurance Coverage"). These plans no longer

exist because the demonstration program expired, but we maintained this factor because it was previously included in subgroup reports and in case the structure of the Medicare Part D program changes and such a factor would be needed again.

- Factors with risk corridors and reinsurance would apply to business with both reinsurance coverage and risk corridor protection.

C. Results of the Survey and Reasons for Maintaining the Current Standard Coverage Factors and Reasons for Changing the Supplemental Coverage Factors

The NAIC survey, discussed in Section III, gathered the experience of 19 Part D plans to better assess whether the current RBC factors were reasonable in relation to actual experience, although three of those plans did not have any experience during the survey period. For the standard coverage plans, the subgroup determined the current factors were reasonable in relation to the results of the survey. The following table shows the current factor as well as the estimated factor based on the survey results.

Table 1

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

	Current Factor	Survey Factor
Initial	0.05850	0.03022
Excess	0.03510	0.05152

Based on the above analysis, using the factors developed based on the survey data would result in an approximate 4 percent increase in the net underwriting risk RBC for a Part D plan with $75 million in revenue and an 85 percent loss ratio. The survey factors used to develop those shown in Table 1, for large groups (those with excess of $25 million in premium) and small groups (those under $25 million in premium), were based on the average potential loss over a three-year period in relation to the company's target profit margin (where it is assumed two of the three years would produce an actual-to-expected level equal to the average of the two worst performance years and the third year would produce a profit equal to the expected profit level). We note that for this methodology a three-year period was used because it was more representative of recent experience, and looking at all five years of data available today produced more volatility in relation to the most recent three years. In developing the above factors, we assumed each company targets its pricing profit margin, which in some cases was a loss. We used the actual target profit/loss margin because assuming a profit for all plans would lead to results requiring less capital than would have otherwise been required had the actual target profit/loss not been used in the calculations. We do note that only three of the 16 survey respondents that had experience over the study period targeted a loss at some point over the five-year period, but only two of the 19 targeted a loss in the most recent three-year period. One of those two companies targeted a loss in all three years, while the other company targeted a loss only in 2011. Given that 16 plans that had experience in the study period participated in the survey and the required RBC results were

relatively close to the current required capital for a plan with $75 million in premium, the subgroup concluded that the current standard coverage factors remain reasonable at this time.

Further, the subgroup recommends keeping the standard coverage factors as-is even though the results showed the initial factor should be lower and the excess factor higher. We make this recommendation because larger plans should have more stability in experience, so it makes sense for the excess factor to be lower than the initial factor. Therefore, it is assumed the development of the combination of the initial and excess factors are more credible than the development of the factors by themselves.

For supplemental coverage plans, the subgroup concluded there was enough evidence to increase the risk factor. In the prior version of this analysis, there was enough volatility in the experience from year to year, and given there were changes in the Part D benefit design (the coverage gap began to close in 2011), the subgroup concluded there was not enough evidence to change the factor based on the prior study. This year, with two additional years of data, it does not appear experience improved, and the subgroup determined an increase in the supplemental coverage risk factor from 0.350 to 0.500 was supported by the study. The weighted average actual-to-expected claims from 2011, 2012, and 2013 were 205.6 percent, 186.6 percent, and 138.7 percent respectively. This most recent three-year analysis was used to determine the supplemental coverage underwriting factor. Our analysis did support a factor much higher than 0.500, but the subgroup believes the factor should be capped at 0.500 because it may seem excessive to require a company to hold capital in excess of 50 percent of the incurred claims related to the product being marketed.

We are also recommending that the factor be applied to claims instead of premium. One key reason is that this would penalize plans that had a similar premium rate but greater claims than another plan. Further discussion of this change and why it is reasonable is noted in Section IV.3 of this document. We note the supplemental coverage factor is not used significantly due to fewer carriers offering substantial supplemental coverage benefits, partially because of the closing of the coverage gap and a desire to avoid adverse selection. As the coverage gap continues to close, it is possible supplemental coverage will be offered even less in future years.

III. Methodology

The primary basis for the subgroup's recommendations was information obtained through a NAIC survey of selected companies. The 2015 survey was similar to the prior survey approach, but requested additional historical data than the prior survey to estimate actual-versus-expected experience from respondents on a more recent experience base. Further details about data sources and data analysis are given in the remainder of this section.

A. The 2015 Survey

The 2015 survey was a departure from the surveys issued in 2005 and 2008 as a part of the evaluation of Medicare Part D RBC, but similar to the survey issued in 2013. Prior to 2013, the factors historically were based on a survey issued by the NAIC of expected Medicare Part

D results from actuaries who were involved in the pricing of Medicare Part D benefit plans. However, with the 2013 survey, several years of actual plan experience were available to better evaluate the reasonableness of the current RBC factors for Part D coverage. In 2015, the subgroup requested that the NAIC collect two additional years of data, although we concentrated on only using the most recent three years of data in our analysis. More details regarding the survey are described in the remainder of this section. A copy of the survey document is attached to this report.

1. Purpose of Survey

In 2005, the NAIC adopted changes to its RBC formulas to accommodate the Medicare Part D program that became effective in 2006. The adopted changes applied solely to stand-alone 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. EGWPs are either included with comprehensive medical coverage, if they are part of insured medical plans, or are treated as "other health" if they are stand-alone insured coverages. The RBC formula changes were based on recommendations made by the Academy's Medicare Part D RBC Subgroup. Because there was no historical experience on which to base RBC factors, a survey was undertaken to elicit anticipated Medicare Part D experience 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.

The factors were not developed based on actual experience until a 2013 survey was issued by the NAIC to gather credible historical experience for this coverage, which was used to verify the reasonableness of the current factors as of that time. Because of volatility in the supplemental coverage experience, the subgroup recommended the survey be reissued in the near future. Further, the subgroup noted the NAIC may want to consider developing a separate EGWP Part D RBC factor when the new survey was developed.

In response to the 2013 survey, the subgroup worked in conjunction with the NAIC to analyze recent experience to refine the factors as needed. The subgroup engaged the NAIC to survey current writers of Part D stand-alone coverage to gather the experience necessary to complete the study.

2. Solicitation Criteria and Response Rate

The survey was sent by the NAIC to companies submitting Medicare Part D Supplemental filing to the Annual Statements. It was made clear to the recipients that participation in the survey was optional, not an NAIC requirement.

Responses were received from 19 of the survey recipients in time to be included in our analysis, but three of the survey respondents did not have any experience within the study period. Therefore, only experience from 16 respondents was used in the analysis.

Responses to the survey were received and compiled by NAIC staff (to maintain the confidentiality of the information provided) and no identification of the respondents was provided to the subgroup. The subgroup reviewed the responses for reasonableness and follow-up communications were made to NAIC staff to clarify apparent inconsistencies or other anomalies within each company's submission.

We consider the responses to be sufficient in number for our purpose. We note in particular the responses provided a reasonably wide range of results on the most significant questions.

B. Analysis Methods and Results

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

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

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

Basic Plan

Without Risk Sharing: *Adjusted Basic Claims / Target Basic Claims*

With Risk Sharing: *Adjusted Basic Claims / Medical Revenue After Risk Sharing*

Supplemental Plan

Supplemental Plan Liability / Target Supplemental Claims

Where:

- Target Basic Claims = The plan's revenue multiplied by the plan's expected loss ratio per its submitted bid

- Adjusted Basic Claims = Actual paid non-supplemental claims divided by the plan's estimated induced utilization factor

- Medical Revenue After Risk Sharing = Target basic claims adjusted for the CMS risk corridor adjustment

- Target Supplemental Claims = The plan's supplemental revenue multiplied by the plan's expected loss ratio per its submitted bid

- Supplemental Plan Liability = Total actual paid claims less adjusted basic claims

As part of that analysis, we considered the following three scenarios:

(a) a single year of the worst, or highest, actual-to-expected ratio as defined above;

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

(c) five years of experience in which a single year at expected benefit cost levels is followed by four years of the average of the four worst, or highest, actual-to-expected ratios, as defined above.

For all scenarios, the adverse experience was assumed to first reduce reported profits below the expected level, and only after profits were totally eliminated would the adverse experience have an effect on statutory net worth. In prior analyses, we assumed plans were targeting a profit margin of 4.9 percent, but for this survey we collected target profit margins for each respondent. Therefore, if a company had been targeting a loss, the target profit margin, or loss, would have a negative impact on the statutory net worth. Further, in the scenarios above, if a respondent had been targeting a loss over the worst, two worst, or four worst experience years, the model assumed the expected benefit cost levels would be a loss. However, in determining the actual average experience over the worst experience years, if the company earned a profit, the profit was accounted for in the calculation even if the company had been targeting a loss.

A minimum adverse result of 2 percent of claims was assumed (i.e., if the historical experience would have produced a result of less than 2 percent for a particular scenario, the result was replaced with 2 percent in the analysis). The 2 percent minimum value also was used in the 2005, 2009, and 2013 analyses. The minimum was chosen because it is the factor the RBC formulas apply to the Federal Employees Health Benefits Program (FEHBP). The subgroup believed this factor represented a reasonable floor for a risk charge applicable to Medicare Part D.

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

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

Based on the analysis, we concluded the continued use of the 2013 average RBC factor for a large group plan of approximately 3.9 percent would be appropriate as a large group factor. This factor represents a weighted average of an initial factor (applicable to premium volumes below the $25 million breakpoint) and an excess factor (applicable to the excess of the premium volume above the breakpoint). To determine the initial and excess factors requires the determination of the proper proportions between the initial and the excess factors, as well as a typical premium volume for an entity with premium in excess of the breakpoint.

For the current factors, the ratio of the excess factor to the initial factor is approximately 60 percent. This figure was established by considering the comparable ratios the RBC formulas incorporated into the experience fluctuation risk charges for comprehensive medical, Medicare Supplement, and dental / vision: 60 percent, 64 percent, and 63 percent, respectively. In setting the current factors, the subgroup determined the diversification benefit of large volumes of Medicare Part D business should be greater than was assumed for these other coverages and thus chose 60 percent. Partitioning historical experience into small versus large groups based on the $25 million premium breakpoint, we evaluated the current 60 percent factor based on the implied excess to initial factors and determined the continued use of 60 percent to be reasonable. No change was made to the assumed $25 million premium breakpoint or the $150 million typical premium volume.

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

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

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

2. Discount Factors for Standard Coverage.

Because currently there are not any plans in force for which only reinsurance coverage is applicable, the subgroup did not study whether the reinsurance coverage discount factor needed to be refined. Further, because the underwriting RBC factor is ultimately based on the results of our analysis, we assumed the reinsurance coverage and risk corridor protection discount factor were appropriate based on prior survey results and used them to determine the necessary initial and excess factors.

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

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

Note these underwriting risk factors, without any discount, are not expected to apply to any business in the foreseeable future. These factors only serve as a basis to which the discount factors will be applied.

4. Underwriting Risk Factor for Supplemental Benefits

A similar methodology was used to determine an underwriting risk factor for supplemental coverage, and the formulas used are outlined in Section III.B.1. of this report. It should be noted that not all plans offered supplemental coverage or reported supplemental coverage data in the survey responses. Therefore, we only used 14 of the 16 responses we received for each year.

IV. Other Considerations

1. 4.9 Percent Profit Assumption

As previously noted, in prior surveys, the subgroup had assumed an average profit of 4.9 percent for each plan in determining the underwriting factors. In this survey, we collected information on the target average profit, and we decided to use that information in the analysis of the updated factors, because 1) it reflects each plan's actual target and 2) based on the information collected, the 4.9 percent assumed target profit seemed greater than what entities were actually targeting. Based on the respondents, the average weighted target profit for the basic benefit was 1.4 percent, 2.7 percent, 2.7 percent, 4.4 percent, and 3.7 percent for 2009, 2010, 2011, 2012, and 2013 respectively.

2. Consideration of the breakpoint between the initial and excess factors

Given that only 16 respondents submitted data over the study period, the subgroup did not believe there was enough credible data to refine the breakpoint between the initial and

excess factors. Therefore, we are recommending these factors not change, consistent with those previously recommended.

3. Consider whether the supplemental benefits factor should be applied to claims instead of premium to make it more responsive to each entity's experience

   Given the volatility of the supplemental benefit experience, it makes sense that the supplemental benefit factor should be applied to the prior year's claims and not the premium. So doing would result in those plans that price the supplemental benefit at an unprofitable level to hold more capital than an entity with a similar plan that is priced to be profitable. Further, given the results of our analysis, the subgroup does not believe the 0.500 factor needs to be adjusted because the factor will be applied to claims instead of premium, as our analysis is built in a manner that already considers this fact because the results are based on the capital required under certain loss scenarios that are driven by the amount of claims. Further, the subgroup concluded that a factor greater than 0.500 may be excessive given the capital required to be held in relation to the premium for this product.

4. Employer-Based Stand Alone Considerations

   In the most recent survey conducted, the NAIC collected information related to employer-based, stand-alone coverage to determine whether a separate factor for this type of coverage needed to be developed. Employer-based, stand-alone coverage is currently subject to the "other health" factor. The number of employer-based coverage PDP members has grown more than 350 percent between December 2010 and April 2014, and annual growth rates between 2011 and 2013 have ranged from 40 percent to 115 percent. Since that time, growth has leveled off and the market has decreased by approximately 3 percent between December 2015 and April 2016. Of the survey respondents, 11, 12, and 13 companies provided employer-based, stand-alone experience for 2012, 2013, and 2014 respectively. The subgroup believes the information collected was useful but lacked credibility to draw a conclusion on whether a separate factor should be used for employer-based, stand-alone coverage. The main driver of the fact the group believed the data lacked credibility is that many of the groups had less than $25 million in revenue related to these plans, and the group with the most revenue—accounting for nearly 50 percent of the total revenue within the survey—did not provide its target loss ratio. Therefore, it was unclear how actual experience varied from expected for the majority of the data collected. Further, there are not separate bids submitted to CMS for employer-based PDP benefits, which makes it difficult to compare actual-to-expected experience in any case. Should employer-based data be collected in the future, it may be best to just assume an average profit margin that is equal for all companies and estimate a potential employer-based RBC requirement factor using a common profit margin assumption.

Appendix: Risk Mitigation Features of Medicare Part D

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

A. Health Status Risk Adjustment

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

B. Reinsurance Coverage

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

C. Risk Corridor Protection

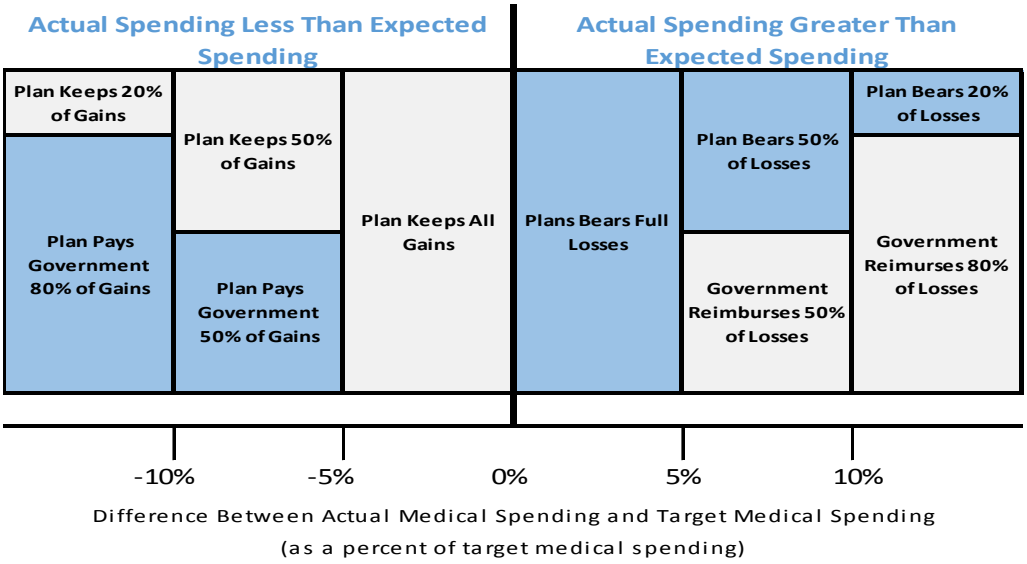
The federal government adjusts its payments to each entity providing Medicare Part D coverage, based on the degree to which actual benefit costs vary from the level anticipated (the target amount) in the entity's bid for its Medicare Part D contract. The government establishes thresholds for symmetric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

The law creating Medicare Part D provided specific risk corridor thresholds and risk sharing percentages for 2006-2007, and a different set of thresholds and percentages for 2008-2011. The law provides that the risk corridor protection will continue after 2011, but the corridors may be redefined at the discretion of federal regulators. Based on current regulations, the risk corridors remain in place through at least 2017.

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

For 2008-present, the risk corridors are widened to ±5.0 percent and ±10.0 percent, the 75 percent factor is reduced to 50 percent, and the 80 percent factor is unchanged. For 2012 and later, the thresholds can be reset, but the threshold percentages must be at least 5 percent and 10 percent, respectively. CMS has chosen not to change the thresholds at least through 2017.[2]

The following chart illustrates the percentage of risk the plan and CMS take on.[3]



[2] Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter – Issued by the Center for Medicare and Medicaid Services on February 19, 2016—Page 51.

[3] Advance Notice of Methodological Changes for Calendar Year (CY) 2017 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2017 Call Letter – Issued by the Center for Medicare and Medicaid Services on February 19, 2016—Page 52.

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

Note the risk corridor protection does not apply to supplemental benefits (that is, benefits in excess of what the federal government has defined as standard coverage or coverage actuarially equivalent to standard coverage). It also does not apply to employer-based Medicare Part D coverage.

D. Coverage Gap Discount Program (CGDP)

Section 3301 of the Affordable Care Act established the CGDP in contract year 2011. Under this program, pharmaceutical manufacturers provide a 50 percent discount to beneficiaries who are not eligible for low-income subsidies who receive applicable (brand) medications in the coverage gap phase of the Part D benefit. The discounts made available under this program are considered incurred costs and therefore are applied toward each beneficiary's true out-of-pocket costs and eligibility for reinsurance.

Attachment: Medicare Part D Industry Survey

May 26, 2015

TO: Statutory Statement Contact

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

Re: Medicare Part D Survey

The NAIC Health Risk-Based Capital (E) Working Group adopted new factors in 2009 for stand-alone Medicare Part D coverage and reviewed those factors again in 2013. In the American Academy of Actuaries original report to the Health Risk-Based Capital (E) Working Group it was recommended the factors for stand-alone Medicare Part D coverage be raised and it was also recommended that the prescription drug plan (PDP) factors be reviewed after companies had several additional years of experience. In the June 2014 report, the Academy suggested that an updated survey be sent, the purpose of the additional survey will provide additional data that will allow the Academy to study three years of data under the CGDP, which could have an impact on the actual-to-expected results of the supplemental coverage program.

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

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

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

We are asking for your help to ensure that we have the most accurate data possible in which to review the RBC factors for the PDP coverage. Please forward this letter and the attached Excel file to be completed by the person responsible for, or actuary in charge of Medicare Part D reporting. If you have any problems opening the attached Word document or Excel file, they will be posted on the NAIC website at http://www.naic.org/committees_e_capad_hrbc.htm under the Related Documents and Resources tab.

We ask that you send the completed survey (Excel file) back to the NAIC by June 26, 2015. Please send all responses to frssurvey@naic.org. If you have any questions regarding the completion of the survey or

completing the Medicare Part D Coverage Supplement, please feel free to contact Crystal Brown at cbrown@naic.org or 816-783-8146.

Thank you for your help with this matter.

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Overview

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

Survey Purpose

In 2005, the NAIC adopted changes to its RBC formulas to accommodate the Medicare Part D program that became effective in 2006. The adopted changes apply solely to stand-alone Medicare Part D Prescription Drug Plan (PDP) business. Medicare Part D benefits offered as part of a Medicare Advantage plan are considered part of a comprehensive medical plan, and do not receive the separate treatment accorded to stand-alone PDPs. The RBC formula changes were based on recommendations made by the Academy's Subgroup. Because there was no historical experience on which to base RBC factors, a survey was undertaken to elicit opinions from actuaries who were involved in the pricing of Medicare Part D benefit plans at that time. An analysis of the survey responses was the primary basis for the Academy's Subgroup's recommendations.

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

In the Academy's Subgroup's report to the NAIC, it indicated that it would revisit the Part D RBC factors again when it was able to obtain experience to verify how reasonable the factors are. The supplemental benefit factor was specifically identified as a concern given the large increase of this factor between the time the factor was initially developed and the time it was adjusted effective in 2009. Any changes identified would be effective for RBC filings.

In 2013, the NAIC issued a survey to collect data from Part D plans to analyze actual data. Utilizing the information collected resulted in verification that the standard RBC factors were

reasonable, but experience around the supplemental factor was volatile and it was determined two additional years of data was needed to better reflect the impact of the closing of the coverage gap on Supplemental benefit experience. We believe it is now possible to obtain, depending on the number of responses received, enough credible historical experience to verify the current factors. In order to gauge the accuracy of the assumptions made in 2009, and analyzed again in 2013, the Academy's Subgroup, working to assist the NAIC, would like to analyze recent experience to refine the factors where needed.

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

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

This survey is intended to gather information that can be used to review and update (if needed) the RBC factors applicable to PDP products. In order for the NAIC to adopt any needed changes to the RBC formulas in a timely fashion, we are asking for survey responses to be submitted no later than May 15, 2015. Upon completion of the survey and collection of the data, the NAIC will provide a blind summarized version of the information to the Academy's Subgroup to perform the required analysis to refine the necessary RBC factors.

Use of the Survey Responses

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

Data Request

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

Note that if the company participated in the reinsurance demonstration program they should exclude data/information from those bids/experiences in the survey. This program was

discontinued after 2010 and the NAIC will not be analyzing the experience of the reinsurance demonstration program in this study.

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

II. Basic Experience Items – List of items that will be pulled from worksheet 1 (Drug Plan Base Financials) relating to the experience period. Note that the study will only utilize experience from 2009, 2010, 2011, 2012, and 2013. This information will be pulled from the 2011, 2012, 2013, 2014, and 2015 PDP bids.

   a. Plan Crosswalk – Includes 1 through 8 plans that may have been aggregated to make up the current PDP plan. This would include the plan ID and the member months from the crosswalked plans.
   b. Total Member Months.
   c. The Centers for Medicare & Medicaid Services (CMS) Part D Payment – This is the direct subsidy amount received from CMS.
   d. Basic Member Premium – This is the amount paid directly by the member to the health plan related to the defined basic benefit.
   e. LI Premium Subsidy – This is the amount that is paid as premium by CMS on behalf of low-income members related to the defined basic benefit.
   f. Supplemental Member Premium – This is the amount of supplemental premium paid to the health plan.
   g. Basic Net Plan Liability – This is the amount of claims incurred relating to the defined standard benefit.
   h. Supplemental Cost Sharing Reduction – This is the amount of claims paid by the insurance company that relate to cost sharing that would normally be part of the defined standard benefit but are paid by the health plan instead.
   i. Net Cost of Supplemental Drugs – This is the amount of supplemental claim costs paid by the insurance company in excess of the supplemental cost-sharing reduction.
   j. Net Plan Rebates – This is the amount of rebates collected by the insurance company that is not paid back to the government per the reinsurance subsidy calculation.
   k. Non-Benefit Expense – This is the amount of direct and indirect overhead expense incurred by the plan. This amount does not include any contingency for profit.
   l. Gain/Loss Including Buy Down – This is the profit or loss on the Part D business after accounting for pharmacy claims and non-benefit expenses.

III. Projection Period Items – The following amounts are extracted from the "Standard Coverage," "Stand Covg with Act Equiv C.S.," "Alternative Coverage," and "Summary" tabs contained within the PDP bid. Note that the amounts will be pulled for 2009, 2010, 2011, 2012, and 2013 experience periods and will be pulled from the respective year's bids.

a. PD Benefit Type (Defined Standard, Actuarial Equivalent, Basic Alternative, or Enhanced Alternative)
b. Defined Standard Gain/Loss – This is the projected gain/loss on the defined standard benefit
c. Defined Standard Total Basic Bid – This is the basic bid amount for the defined standard set of benefits as defined by CMS
d. Actuarial Equivalent Gain/Loss – This is the projected gain/loss should the plan file an actuarial equivalent plan type
e. Actuarial Equivalent Total Basic Bid – This is the basic bid amount should the plan file an actuarial equivalent plan type
f. Supplemental Benefit Cost Share – This is the estimated liability to the plan should they decide to have an enhanced alternative plan type
g. Supplemental Benefit Gain/Loss – This is the estimated gain/loss for the benefit amount in excess of the defined standard benefits.
h. Supplemental Benefit Premium – This is the premium to be charged for the benefit amount in excess of the defined standard benefits.
i. Target Amount – This is the target loss ratio for the PDP bid.
j. Induced Utilization Adjustment – This is the amount of additional utilization that is expected to be incurred due to the fact that a supplemental benefit is offered.
k. Type of Gap Coverage – This summarizes whether or not there is gap coverage and if so, what type of gap coverage.