AMERICAN ACADEMY *of* ACTUARIES

October 6, 2008

Paul Spitalnic
Director, Parts C & D Actuarial Group
Office of the Actuary, Centers for Medicare and Medicaid Services

Subject: Medicare Part D data request

Dear Mr. Spitalnic:

On behalf of the American Academy of Actuaries'[1] Medicare Part D RBC Subgroup, this is a formal request for data pursuant to our conference call of July 16, 2008. As we explained then, the National Association of Insurance Commissioners (NAIC) has indicated its intent to update its risk-based capital formula with regard to Medicare Part D, and the subgroup has accepted a charge to assist in that effort. Toward that end, the subgroup is requesting data from your agency relating to the 2006 and 2007 financial results for Medicare Part D.

Attached is a list of the data that the subgroup is requesting. I am hopeful that you will be able to provide the subgroup with the basic data listed in the first part of our request (Part I). However, you indicated to me that if, in your judgment, confidentiality considerations preclude you from providing data at a detailed level, you might be able to provide us with summary statistics. If that is the case, the subgroup seeks the analytical results indicated in the second part of our request (Part II).

Please contact Dianna Pell, the Academy's State Health Policy Analyst, as to a convenient day and time to discuss this request further. She may be reached by phone at (202) 785-6924 or by e-mail at pell@actuary.org. We look forward to speaking with you further and thank you for your efforts in this matter.

Sincerely,

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

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

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Medicare Part D Data Requested for Purposes of Updating the Part D Factors in the NAIC Risk-Based Capital Formula

I. Basic data needed – for stand-alone PDP only

A. List of items

All of these items should exclude the risk-corridor adjustments; that is, they should be determined before any application of the risk corridors.

1. Revenue

This would include revenue from both CMS and the individual enrollees. The premium portion of the Low-Income Subsidy would be included as revenue. For plans participating in the Payment Demonstration, this would also include the revenue that is payable to the plans in lieu of the Reinsurance Coverage reimbursements.

This would <u>exclude</u> payments made pursuant to federal Reinsurance Coverage and the "cost-sharing" portion of the Low-Income Subsidy.

2. Claims

a. "Target"

b. Adjusted Allowable Risk Corridor Costs (AARCC - the actual claims taken into account in determining the risk-corridor adjustments)

c. Total actual claims paid by the PDP sponsor (i.e., Covered Plan Paid Amounts plus Non-covered Plan Paid Amounts, minus Direct and Indirect Remuneration)

Claims would be net of the federal Reinsurance Coverage and the "cost-sharing" (benefit reimbursement) portion of the Low-Income Subsidy. If more convenient, the claims could be provided on a gross basis, with the Reinsurance Coverage and Low-Income Subsidy amounts provided separately. It is intended that all claim amounts be net of the applicable offsets, such as pharmacy rebates.

3. Expenses (per the bid)

This would include "administrative costs" but exclude "return on investment" and "profit" components.

4. Number of enrollees

B. Splits

The splits are applied successively rather than severally. That is, application of the splits will result in 16 separate cells for each data item.

1. 2006 vs. 2007

2. Defined standard (or actuarially equivalent) vs. supplemental

   "Supplemental" here means the benefits provided by enhanced-benefit plans in excess of the defined standard (or actuarially equivalent) coverage, not the total coverage of enhanced-benefit plans.

3. With federal Reinsurance Coverage vs. without federal Reinsurance Coverage

   "Without federal Reinsurance Coverage" includes business subject to the Payment Demonstration and Group business not eligible for Reinsurance Coverage.

4. Individual vs. Group

C. Roll-ups

Presumably, the basic data unit is the plan benefit package. We would request some sort of indicator (that you deem would preserve confidentiality) to permit the aggregation of data at various levels.

1. Plan benefit package

2. Contract (i.e., S#### number)

3. Carrier

   If possible, we would like to be able to distinguish among the following categories of carriers:

   a. State-licensed carriers (licensed as insurance companies, HMOs, or the equivalent), other than Knox-Keene plans

   b. Carriers licensed by the state of California as Knox-Keene plans

   c. Carriers that received from CMS a temporary waiver of state licensure

II. Analytical results

If we cannot obtain the basic data because of confidentiality considerations, then we request that certain analyses be performed and the results provided to us. The splits and roll-ups indicated above would still apply.

A. Items for analysis

1. Target loss ratio: target claims divided by revenue

2. Actual loss ratio: total actual claims (as in I.A.2.c. above) divided by revenue

   a. With no risk-corridor adjustments

   b. After application of the 2006-07 risk-corridor adjustments

   c. After application of the 2008-11 risk-corridor adjustments

   The risk-corridor adjustments should be made to the denominator of this ratio to be consistent with statutory financial reporting practices as prescribed by state insurance regulators. The risk-corridor adjustments should be based on the AARCC from I.A.2.b.

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3. Target combined ratio: target claims plus bid expenses, divided by revenue

B. Statistics to be reported

1. Mean

2. Median

3. Minimum

4. Maximum

5. 95th percentile (where the maximum is considered the 100th)

6. 75th percentile (where the maximum is considered the 100th)

7. 25th percentile (where the maximum is considered the 100th)

8. Standard deviation

   In the calculation of the standard deviation, data would not be dollar-weighted; each data point would be given equal weight.

C. Categorization by size

1. When data items are rolled up to the carrier level, we would like each statistic to be calculated for each of the following groupings of carriers:

   a. All carriers

   b. Carriers with Medicare Part D revenue (as defined above) less than $25 million

   c. Carriers with Medicare Part D revenue (as defined above) greater than $25 million

2. For each of the three categories in II.C.1 above, we would like the following additional information:

   a. Number of carriers in the category

   b. Total dollars of Medicare Part D revenue

   c. Median of Medicare Part D revenue per carrier

   d. Total number of enrollees

   e. Median of the average (for each carrier in the category) Medicare Part D revenue per enrollee