OMB Approved # 0938-0944

DRAFT
INSTRUCTIONS FOR COMPLETING THE MEDICARE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2009

December 27, 2007

Deleted: . October 1

Deleted:

Formatted: Font: 12 pt

CMS-10142 (03/2009)

Deleted: ¶

Table of Contents

Introduction

Each Prescription Drug Plan (PDP) and Medicare Advantage Prescription Drug (MA-PD) plan must submit a separate bid for each Rx plan it offers to Medicare beneficiaries. The bid must be submitted to the Centers for Medicare & Medicaid Services (CMS) using the CMS bid form in accordance with applicable regulation and guidance

The submitted bids will be subject to review and negotiation by CMS. As part of that negotiation, CMS may request supporting documentation for the information included on the bid form. Organizations must be prepared to provide CMS and its representatives with documentation to support the development of their bid upon request. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

Organizations must provide a series of data entries on the appropriate form worksheet to complete the bid form. The number of inputs depends on the type of plan and how long it has operated. Organizations must submit the information through HPMS in the CMS-approved electronic format by using the CMS bid form in accord with these instructions to develop a pricing structure for each prescription drug plan offered. The following sections contain specific instructions regarding completing the bid form. In addition to the line-by-line instructions, there is also a glossary to assist the user with unfamiliar terms.

Following are the most common steps that an organization must complete:

- For plans with appropriate and credible base period experience
    - Report the Medicare base period experience.
    - Illustrate the assumptions used to project the base period costs to the contract year.
- For plans with either partially credible or no base period experience, provide a summary of the manual rates and the techniques used in their development.
- Project the estimated costs for defined standard prescription drug coverage for the contract year, including the estimated Federal Reinsurance and Low Income Subsidy (LIS) amounts.
- Demonstrate actuarial equivalence for any plans to be offered that do not provide defined standard coverage.

If you have any questions about the content of the bid form, please e-mail them to CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov .

If there are any technical questions regarding HPMS or the upload process, please see the "Bid Submission User's Manual" (available in HPMS) and *Appendix F - Bid Pricing Tool Technical Instructions*, or contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov .

Special Considerations

Base Experience

Worksheet 1 should be completed when plans have appropriate base period experience for modeling the Part D benefit. The determination of the appropriateness of a plan's experience must include an evaluation of whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience must be representative of the benefits that will be offered in the contract period. For example, a plan that will be offering defined standard Part D coverage must have experience for a benefit with a gap in benefits and catastrophic coverage for a population similar to the population they expect to be covering in order to summarize base period experience in Worksheet 1.

CMS expects that most plans that operated in 2007 will have appropriate base period experience to be used in completing Worksheet 1 for contract year 2009. A plan that has appropriate base period data must exercise actuarial judgment in determining the credibility factor for a plan's base period experience. Based on an application of classical credibility theory to Medicare Fee-for-Service experience, CMS has established a guideline for full credibility for Medicare Advantage plans of 24,000 base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. Although credibility guidelines for the Part D benefit have not been established, prescription drug experience is expected to have a higher level of credibility than medical coverage for a similarly sized group. Actuaries should take into account the quality of the data being relied upon in establishing credibility.

Plans with experience providing Part D benefits in contract year 2007 are expected to use Prescription Drug Event (PDE) transactions, including state-to-plan and plan-to-plan PDEs as base period experience for contract year 2009, unless the PDEs do not appropriately capture the plan's expected experience.

In the event that a plan has PDE data that does not appropriately represent the plan's expected experience, plan-specific pharmacy claims experience should be adjusted to reflect the plan's best expectation of the final PDE transactions that will be sent to CMS for payment reconciliation. A mapping of PDE fields to required pricing tool inputs is provided in the instructions for completing Worksheet 1.

When a plan relies on pharmacy claims experience in lieu of PDE data, the plan must provide a detailed written explanation of the variation and sufficient data to support the development of the base period experience. The supporting data and written narrative must be uploaded into HPMS at the time of bid submission.

As explained later in these instructions, a plan that does not have fully credible base period experience in the form of PDE or pharmacy claims data must develop manual rates for the pricing tool, using available data that is adjusted to reflect the expected contract year population and the benefit design being offered.

In summary:

- Plans with fully credible experience must complete all sections of Worksheet 1 and Sections II, III, and V of Worksheet 2.

- Plans with partially credible experience must complete all sections of Worksheet 1 and Worksheet 2.

- Plans that have no applicable, fully or partially credible experience must complete Section I of Worksheet 1, and Section IV of Worksheet 2.

Required Sections

Plans must complete different sections depending on the type of coverage that will be offered. Following are the sections that need to be completed for each type of coverage.

All plans must complete Section 1 of Worksheet 1.

Defined Standard Coverage

Plans submitting a bid for defined standard coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience, Worksheet 3, columns f, g, and h of Section II of Worksheet 6 and Worksheet 7.

Actuarially Equivalent Standard Coverage

Plans submitting a bid for actuarially equivalent standard coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience, Worksheet 3, Worksheet 4, all columns of Section II of Worksheet 6 and Worksheet 7.

Basic and Enhanced Alternative Coverage

Plans submitting a bid for basic or enhanced alternative are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience, Worksheet 3, Worksheet 5, all columns of Section II of Worksheet 6 and Worksheet 7.

Actuarial Equivalence

Plans submitting a bid for standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on Worksheet 4. Plans submitting a bid for alternative coverage must satisfy the various tests on Worksheet 5 to qualify.

The five tests for alternative coverage plans are specified in the statute and in the final regulations and apply to both basic and enhanced alternative coverage.

- The first test ensures that the value of total coverage is at least actuarially equivalent to standard coverage.

- The second test ensures that the alternative unsubsidized value of coverage is no less than the standard unsubsidized value of coverage.

- The third test ensures that the average alternative benefits for beneficiaries with allowed drug costs at the initial coverage limit ($2,510) are no less than the average standard benefits at the initial benefit limit.

- The fourth test ensures that the deductible is no greater than $275.

- The fifth test ensures that the average alternative catastrophic cost sharing percentage is no greater than under standard coverage.

We expect that plans can change the cost sharing provisions, meet the five tests, and provide a basic alternative plan.

Worksheet 6 illustrates the assumptions used in demonstrating actuarial equivalence and develops values to support the tests in Worksheets 4 and 5.

All plans are required to develop projected utilization for the defined standard benefit in columns f, g, and h in Section II of Worksheet 6. In addition, plans submitting a bid for an actuarially equivalent or alternative benefit are required to report projected utilization in columns i, j, and k. If the bid is defined standard, then columns i, j, and k should be left blank.

Data is collected for four levels of allowed costs on lines 1 through 36 of "Projections for Equivalence Tests," Section II of Worksheet 6. Members and member months are no longer captured on Worksheet 6; however, the distribution of population and data reported in Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8 collect data on all allowed costs for the "Population Not Exceeding $2510 with Standard Coverage." All of the utilization for the population with total allowed costs that do not exceed $2510 must be reported in this section.

Lines 10 through 17 collect data on all allowed costs for the "Population Exceeding $2510 with Standard Coverage." All of the utilization for the population with total allowed costs that exceed $2510 must be reported in this section.

Lines 19 through 26 collect data on all allowed costs up to $2510 for the "Population Exceeding $2510 with Standard Coverage." All of the utilization for allowed costs allocated up to $2510, for the population with allowed costs that exceed $2510, is reported in this section.

Lines 28 through 35 collect data on all allowed costs over the catastrophic coverage limit for the "Population Exceeding $2510 with Standard Coverage." All of the utilization for allowed costs allocated over catastrophic coverage, for the population with allowed costs that exceed $2510, is reported in this section.

<u>Values for A, B, C, and D in Worksheet 4</u>

Plans proposing a benefit that has standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on lines 16 and 17, Section III of Worksheet 4:

Line 16 - Plans that meet the following criteria will be considered equal and pass the test for Actuarial Equivalence of "A=B."

- The value for "A" is 25%.

- The ratio of A/B is between .98 and 1.02.

Line 17 - Plans that meet the following criteria will be considered equal and pass the test for Actuarial Equivalence of "C=D."

- The values for both C and D are greater than or equal to 5.0%.
- The ratio of C/D is between .98 and 1.02.

Risk Score

Risk Score Development for CY 2009:
The CY 2009 risk score must be based on the Part D RxHCC risk model, be adjusted for normalization, and reflect appropriate projection factors. The RxHCC model was recalibrated based on the experience of fee-for-service (FFS) beneficiaries in the year 2002 and Medicaid dual eligible beneficiaries in 2000, with both dollar values trended forward to 2006.

At time of payment, the risk scores for each plan enrollee will be adjusted by a factor, known as the Part D normalization factor, which is TBD for 2009. This adjustment accounts for the expectation of higher intensity in the aggregate risk scores for the contract year vs. the model calibration year. Accordingly, the 2009 bid projected risk scores must reflect the TBD normalization factor. Additional information on the 2009 normalization factor is contained in the 2009 rate book announcement:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage

Acceptable approaches for the development of risk scores depend on whether or not the plan pricing is based on manual rates or actual plan experience. Plans that are priced using a manual rating approach must estimate risk scores based on the expected expenses for their projected enrollees. Further, the risk scores for new plans must be developed consistent with the Part D RxHCC risk model. Details of this model may be found at: http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/, under "risk adjustment". Additional information on the risk adjustment process can be found at the web site: http://www.csscoperations.com/new/usergroup/july2006_regtrn/raps-participant-guide_081606.pdf.

Use of the Part D RxHCC risk scores for the 2007 enrollee cohort is the preferred basis for the projecting the 2009 risk scores for experienced-rated plans. CMS has released plan-specific risk score data that may be used as the basis for projecting CY2009 risk scores. This information is available in HPMS under the "Risk Adjustment" link from the HPMS Home page. (Note: You must have HPMS user access to view this information. The HPMS weblink is either: https://32.90.191.19/hpms/secure/home.asp or https://gateway.cms.hhs.gov , depending on your firm's connection method.) The risk score data posted in HPMS is accompanied by technical notes to assist actuaries with interpreting the data presented. There are several advantages to using the 2007 cohort Part D RxHCC risk scores in the projection of the CY 2009 risk score including: (i) consistency with the base-period medical expenses; (ii) they are based on a mid-year cohort and require no adjustment for seasonality; (iii) they reflect non-lagged diagnosis data; and (iv) they are based on the latest risk model.

The projection of scores from 2007 to 2009 must reflect relevant projection factors, which include, but are not limited to, coding intensity trend, changes in plan population and the

effect of partial year enrollments. Since the mid-year risk scores may be the most appropriate basis for projecting the 2009 risk scores without making adjustment for partial year enrollments, actuaries should note that the underlying experience for 2007 may need to be adjusted to reflect the effects of partial year enrollments. Please note that the reported scores are based on a mid-year cohort with nearly-complete run-out of data and require no explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. Finally, the projected "raw" scores must be normalized by dividing by the 2009 Part D normalization factor of TBD.

An alternate approach to forecasting the CY 2009 Part D risk scores for experience-rated plans is to use as the base scores, the scores from a 2008 Medicare Membership Report (MMR) file. This approach may be appropriate in situations where the plan was first offered in 2008, there was limited enrollment in 2007, or there were significant changes in plan or enrollment characteristics between 2007 and 2008.

The starting "raw" risk scores for this alternative approach are the average risk scores from one, or more, of the 2008 MMR files for non-adjustment records. These scores are trended to 2009 with explicit adjustment for the following factors:

- Coding intensity,
- Impact of lagged vs. non-lagged diagnosis data,
- Run-out of diagnosis data,
- Seasonality,
- Population changes, and
- Other appropriate factors.

Finally, the projected "raw" scores must be normalized by dividing by the 2009 Part D normalization factor of TBD.

Lock-In versus Pass-Through Model for PBM Gain/Loss

For plan year 2009, a Part D Plan that uses a PBM may use either the lock-in amount or the pass-through amount as the basis for developing bidding assumptions. The plan must choose only one approach to develop their bids, and cannot switch between them in the contract year for purposes of calculating cost-sharing and allowed drug costs.

More specifically, regardless of which approach Part D Sponsors choose, they must use a consistent basis for: (i) calculating beneficiary cost sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the Prescription Drug Event (PDE) records, and (v) developing bids submitted to CMS. This ensures that the beneficiary cost sharing and reinsurance payments received by the Part D Sponsor are consistent with the Sponsor's bidding assumptions.

Direct and Indirect Remuneration (DIR)

All rebates, subsidies, and other price concessions from any source that serve to decrease the costs incurred by the Part D sponsor must be reported as a rebate when these subsidies are not used to directly reduce the cost at the point of sale. Any charges or fees for the administration of rebates, price concessions, or other services must be included separately in the bid pricing tool as a component of direct administrative costs.

Plans must include all expected amounts that will be reported as Direct and Indirect Remuneration (DIR) under Rebate in the bid pricing tool. It is important for plans to understand that the DIR reported under Rebate into the bid tool represents the plans best expectation of all DIR categories and amounts the plan expects to report under the Part D payment reconciliation process for the respective contract year.

Defining Direct and Indirect Remuneration (DIR)

Per 42 C.F.R. Section 423.308, direct and indirect remuneration (DIR) is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serves to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D Sponsors, such as pharmaceutical benefit managers (PBM), if they are retained in lieu of higher service fees. As stated in the 2007 Call letter, CMS must assume that if a PBM retains a portion of the manufacturer rebates it negotiates on behalf of a Part D sponsor, the direct payment the sponsor pays the PBM for its services will be less, such that the sponsor receives a price concession from the PBM. Thus, as a price concession received by the Part D sponsor, these retained rebates must be reported as DIR for payment purposes.

In accordance with CMS guidance, sponsors may enter into risk sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed fees. Any gains or losses that the Part D Sponsor may receive as a result of these risk sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments and any adjustments to generic dispensing incentive payments made to pharmacies after the point of sale dispensing event are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

Part D Payment Demonstration

The Part D Payment Demonstration allows varied payment rules for plans offering supplemental benefits. The details for this demonstration are provided in our “Instructions for Part D Payment Demonstration.” The May 10, 2005 instructions describe the following three demonstration options:

- Flexible capitation option
- Fixed capitation option
- Flexible MA rebate option

Generally, the capitation options replace the typical reinsurance subsidy of 80% of allowed costs that apply after the beneficiary has reached the out-of-pocket threshold of $4,050 of true out-of-pocket payments (TrOOP) with a capitation amount reflecting the actuarial value of that subsidy under the defined standard benefit structure. The distinction between the flexible and fixed options is that catastrophic coverage is required to begin at $5,726.25 of total drug expenditures (consistent with the point at which the beneficiary would have catastrophic coverage under the defined standard benefit) for a beneficiary in the fixed option. The flexible option permits catastrophic coverage to begin at any point after the beneficiary has $4,050 of TrOOP spending.

The Flexible MA rebate option permits supplemental benefits that fill in the coverage gap to count toward the accumulation of the beneficiary's TrOOP. In this option, as is the case for non-demonstration Part D plans, reinsurance will be paid based on 80% of allowed reinsurance costs after beneficiaries have satisfied their TrOOP requirement. No change to the bidding requirements or bid pricing tool (BPT) is necessary to support plans choosing this option.

It should be noted that a non-demonstration Part D plan that provides supplemental coverage will generally delay the point at which a beneficiary reaches catastrophic coverage. Accordingly, a non-demonstration Part D plan will likely see a shift in allowed costs - from amounts that would be provided under catastrophic coverage for defined standard coverage to amounts in the coverage gap for alternative coverage. Since the fixed capitation option and the flexible MA rebate option do not delay the point at which a beneficiary reaches catastrophic coverage, there should not be a shift from catastrophic costs to gap coverage costs for these options. For the flexible capitation option, a shift in costs between catastrophic and coverage gap is to be expected.

The impact described above is illustrated in the following table of the benefit options available for Part D plans. In this table, the only benefit design change represented in the non-standard options is the variation of the point at which the coverage gap begins. In addition, the values reflect the benefit parameters in effect for 2006.

Benefit Design	Defined Standard	Enhanced Alternative	Flexible Capitation	Fixed Capitation	Flexible MA Rebate
Deductible	$250	$250	$250	$250	$250
Coinsurance	25%	25%	25%	25%	25%
Coverage Gap Begins	$2,250	$3,250	$3,250	$3,250	$3,250
Catastrophic Threshold	$5,100	$5,850	$5,850	$5,100	$5,100

The alternative coverage worksheet in the BPT requires costs to be allocated to below the initial coverage limit, in the coverage gap and above the catastrophic threshold. The initial coverage limit is statutorily defined to be $2,250 for 2006. For the enhanced alternative option outlined above, the actuarial value of costs for the alternative coverage between the initial coverage limit ($2,250) and the catastrophic threshold ($5,850) must be presented in the coverage gap column. The coinsurance percentage for this period must reflect that the portion of the coverage between $2,250 and $3,250 would have 25% coinsurance and that the portion of coverage between $3,250 and $5,850 would have 100% coinsurance. The same would be true for the flexible capitation option summarized in the table; both the fixed

capitation option and the flexible MA rebate option would have the same pattern except that the catastrophic threshold would begin at $5,100 instead of $5,850.

The following is an explanation of each option:

- **Capitation Options.** The reinsurance capitation amounts reflected on the alternative coverage worksheet are based on the development of the estimated reinsurance amounts included in the defined standard worksheet.

- **Flexible MA Rebate Option.** The only supplemental cost-sharing permitted in the flexible MA Rebate option is the filling in of the coverage gap. As such, no reduction in the deductible, in the cost sharing amounts up to the initial coverage limit of $2,250, or in the amounts in the catastrophic period are allowed. For catastrophic coverage plan bids must reflect a $250 deductible and have cost-sharing percentages within 2% of the 25% amount (i.e., between 24.5% and 25.5%) up to the initial coverage limit and within 2% of the cost-sharing percentage estimated for the defined standard benefit structure.

Modeling Considerations

We require that plans consider the effects of the benefit design they choose on the underlying population they expect to enroll, and that they complete the BPT accordingly. Specifically, providing supplemental coverage in exchange for a premium, or at the expense of offering other benefits, is likely to result in a change in the plan's expected risk/cost profile as compared to a plan that is offering basic benefits only. If the net value of these supplemental benefits, defined to be the difference between the actuarial value of the supplemental benefits and the amount of the premium, is positive for a class of beneficiaries, a plan should expect a greater proportion of these beneficiaries in their plan as compared to the class of beneficiaries with a negative value. For purposes of evaluating the effect on the anticipated enrolled population, the plan must consider the impact of the value of supplemental benefits at all points of the drug expense distribution.

The following table illustrates the pattern of supplemental benefit value for the designs summarized in the table above. Note that a supplemental premium is presented for illustrative purposes only; actual premium amounts for such coverage could differ significantly. Again, this example reflects the benefit parameters in effect for 2006.

Benefit Design	Defined Standard	Enhanced Alternative	Flexible Capitation	Fixed Capitation	Flexible MA Rebate
Supplemental Premium	$0	$240	$220	$315	$315
Beneficiary Cost Share at Drug Expense of:					
$1,250	$500	$500	$500	$500	$500
$2,250	$750	$750	$750	$750	$750
$3,250	$1,750	$1,000	$1,000	$1,000	$1,000
$5,100	$3,600	$2,850	$2,850	$2,850	$2,850
$5,600	$3,625	$3,350	$3,350	$2,875	$2,875
$6,100	$3,650	$3,613	$3,613	$2,900	$2,900
$10,000	$3,845	$3,808	$3,808	$3,095	$3,095
Value of Supplemental Benefit:					
$1,250	NA	$0	$0	$0	$0
$2,250	NA	$0	$0	$0	$0
$3,250	NA	$750	$750	$750	$750
$5,100	NA	$750	$750	$750	$750
$5,600	NA	$275	$275	$750	$750
$6,100	NA	$38	$38	$750	$750
$10,000	NA	$38	$38	$750	$750

When modeling supplemental benefits, plans must factor behavioral impacts into the anticipated selection. Beneficiaries spending less than the $2,250 initial coverage limit will not receive any additional benefits from purchasing the supplemental coverage. Plans modeling these types of benefits should consider the possibility that a lower percentage of enrollees with spending under the initial coverage limit may participate than if they were modeling a standard benefit.

Similarly, the value of the supplemental benefits decreases as the spending level exceeds the catastrophic threshold for the standard benefit in the enhanced alternative and flexible capitation options. The illustrative net value, after subtracting out the premium for the supplemental benefits, is negative for beneficiaries in the above table spending in excess of $6,100. Again, during their development, plans must consider the possibility that fewer such beneficiaries will enroll. We recognize that the average risk profiles of members enrolled in existing MA organizations are not likely to change significantly from 2006 to 2007. This tendency towards stability may mitigate some of the behavioral effects outlined above. Plans must consider the implications of the plan designs being offered in estimating their projected population.

Also of interest in the table is the difference between the supplemental premiums for the enhanced alternative and the flexible capitation options. Although a benefit pattern for two designs may be identical, the supplemental premium will be slightly lower for the flexible capitation option. This difference exists because the supplemental premium development for the enhanced alternative plan includes a cost component for the estimated reduction in reinsurance payments between the enhanced alternative plan and the defined standard plan (the typical TrOOP impact). Since the reinsurance capitation in the flexible capitation option is based on the defined standard estimate, there is no reduction in reinsurance value, and thus no additional supplemental premium needs to be incorporated.

Gain/Loss Margin Guidance

Individual-market plans (that is, non-EGWP & non-SNP):

Overall Medicare margin levels for individual-market plans are to be consistent with the plan sponsor's corporate requirement. Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level. The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range (for example, plus or minus 1% or 1.5%) of other lines of business. Additionally, for sponsors that price based on return or investment (ROI) or return on equity (ROE) bases, the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business should take into account the degree of risk or reserve levels of the business.

It is expected that the overall margin level expectations will be consistent on a year-by-year basis. Actual organization returns are expected to vary year-to-year in practice, but are expected to achieve the organization's requirement over a longer term period (for example, three to five years). Individual plan margins may vary from the overall organization level.

The overall margin levels included in the MA and Part D components of MA-PD bids must be within a reasonable range of each other (for example, plus or minus 1% or 1.5%) with any differences reflecting the different levels of risk underlying the two reimbursements. The individual Part D margin of an MA-PD bid may be allocated by applying the overall Part D margin requirement to each Part D bid of the MA-PD organization or alternatively, in similar relationships as the MA margins.

Plans with negative margins must develop and follow a business plan to get to profitability. An exception to the business plan requirement are cases where multiple MA products are offered in a given service area and the pricing reflects implicit "subsidies" to mitigate premium spirals.

Anti-competitive practices will not be accepted. For example, significantly low or negative margins for plans that have substantial enrollment and stable experience or "bait and switch" approaches to specific plan margin buildup, will be rejected, absent sufficient support that such pricing is consistent with these instructions.

Special Needs Plans serving Dual-Eligibles (DE-SNP):

The foundation for the claim and administrative costs for DE-SNPs should be based on appropriate experience. The margin assumptions used for individual plans should be the basis for the margin requirements for DE-SNP plans. There may be small differences (that is, up to 1 percent) in the margin levels between DE-SNP and individual plans.

If corresponding individual-market plans are not offered, then the margin guidance for individual-market plans applies to the DE-SNP margin pricing. That is, overall DE-SNP margin levels are to be consistent with the organization's margin requirement and this requirement is to be within a reasonable range (for example, plus or minus 1% or 1.5%) around a return-on-equity or return-on-investment type measure or comparable to other comparative lines of businesses.

Documentation Requirements
Supporting documentation for the gain/loss margin is required (see Appendix B). This documentation must include the following:

- Support for overall margin levels, including description of methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.
- Support for bids with negative margins, i.e., a business plan that illustrates profitability within few years.
- Justification of the margin for bids with relatively large projected overall gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other supporting documentation. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.
- If applicable, further analysis of the organization's ROI / ROE and distinctions between recouping start-up costs versus ongoing organizational gain/loss.

Note that supporting documentation requirements are the same regardless of the source of the assumption: whether developed by the actuary, the plan sponsoring organization, or a third party.

Support for variation that accounts for the difference in risks between products for DE-SNPs must be available upon request.

In future years, comparisons to the original business plan are to be provided including details and source of deviation from prior years' plans.

The development of the margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

First Dollar Generic Coverage

Plans that are implementing a deductible that is not applied consistently among categories of drugs (for example, $0 deductible for generic drugs, and $275 deductible for brand drugs)

must make several modifications to pricing of this benefit in the BPT. Specifically, Worksheet 5 the BPT requests the proposed deductible. Plans with a non-uniform deductible must enter $0 for the proposed deductible in D6 and F8 in Section IV of Worksheet 5. Plans with a uniform deductible must enter in Worksheet 6 the cost-sharing items for the population with spending under $2,510, and for the population with spending over $2,510 applying the effective cost-sharing by drug class for the interval between the deductible and the initial coverage limit. Plans with a non-uniform deductible must reflect the impact of the brand deductible in the brand cost-sharing categories in addition to the cost-sharing required after the deductible has been satisfied.

Decreased Initial Coverage Limit (ICL)

Plans that are lowering the initial coverage limit (ICL) must still report in lines 3 through 8 of Worksheet 6 all costs and cost-sharing for drug spending up to the defined initial coverage limit in 2009. For plans that are reducing the ICL to $2,000, the amounts in column k must reflect the cost-sharing appropriate up to the $2,000 level plus 100% of costs for drug spending between $2,000 and $2,510. The entries on Worksheet 6 (Script Projection) must fit in the specified intervals. For example, for members with allowed drug costs (under defined standard coverage) above $2,510, their entire allowed amounts and scripts are to be entered in the section for persons with expenses above $2,510, regardless of the alternative plan's benefit limit. Note that the section for persons with expenses above $2,510 also includes amounts for members with expenses exceeding $5,726.25. A member's expenses and scripts are entered in the expense section as projected under defined standard coverage. No matter what expense category a member is assigned under the defined standard benefit, the member must remain in the same expense category under the alternative coverage even if the expense level changes due to the incentive of alternative coverage.

Coverage in Payment Gap

Enhanced alternative coverage can reduce cost-sharing and/or provide coverage for drugs that are specifically excluded from the definition of Part D drugs. While enhanced alternative coverage can fill in some or all of the coverage gaps in the defined standard coverage, it cannot affect the true out-of-pocket threshold of $4,050 in 2009 (see Payment Demonstration discussion for exceptions). Therefore, reductions in cost-sharing would impact the point at which the member reaches the true out-of-pocket threshold for catastrophic coverage.

Worksheet 1 - Rx Base Period Experience

Section 1 of Worksheet 1 collects general information that carries over to all sheets; entries are required for each item. The remaining sections of Worksheet 1 summarize the base period Rx experience and should be left blank if no applicable, fully or partially credible Part D coverage was in effect during the base period. Section II includes base period background information. Section III summarizes the base period Rx claims data, Section IV summarizes the non-benefit expenses, and Section V summarizes the various components of revenue that relate to the Part D coverage. Section VI is an income statement summary.

Discussion on Base Period Data

Plans with experience providing Part D benefits in contract year 2007 are expected to use Prescription Drug Event (PDE) transactions, including state-to-plan and plan-to-plan PDEs as base period experience for contract year 2009, unless the PDEs do not appropriately capture the plan's expected experience.

In the event that a plan has PDEs that do not appropriately represent the plan's expected experience, plan-specific pharmacy claims experience should be adjusted to reflect the plan's best expectation of the final PDE transactions that will be sent to CMS for payment reconciliation.

When a plan relies on pharmacy claims experience in lieu of PDE data, the plan must provide a detailed written explanation of the variation and sufficient data to support the development of the base period experience. The support data and written narrative must be uploaded into HPMS at the time of bid submission.

As explained later in these instructions, a plan that does not have fully credible base period experience in the form of PDE or pharmacy claims data must develop manual rates for the pricing tool, using available data that is adjusted to reflect the expected population and the benefit design being offered. The support data and written narrative that documents the development of the manual rates must be uploaded into HPMS at the time of bid submission.

Note that scripts and allowed amount data are input into Section III of Worksheet 1 in aggregate for each allowed claim interval, while paid amount, cost sharing, supplemental cost sharing reduction, reimbursement for LIS and reimbursement for federal reinsurance are input on a per member basis. The per member per month (PMPM) values are calculated on line 8 of the worksheet. Also note that it is important to enter data on covered Part D drugs in lines 1 through 5 of Section III of Worksheet 1, and non-covered Part D drugs on lines 12 and 13.

A mapping of PDE fields to required pricing tool inputs is provided in the following table. When relying upon PDE data, actuaries must be familiar with how the plan develops the PDE transactions from the claims data, and the timing of the adjustment and deletion process to ensure that the summary of claims appropriately reflects the final transaction. For example, only one script count should be reflected in Worksheet 1 even if there were three adjustment records processed for the claim.

Mapping of Prescription Drug Events to Section III, Part D Claims Experience in Worksheet 1		
Column	**Field Name**	**PDE Reference Information**
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax) > Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax)
(i)	Average Paid Amount per Member	Σ [Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP) + Low Income Cost Sharing (LICS)] / Members
(j)	Average Cost Sharing per Member	Σ [Patient Pay Amount + Other TrOOP Amount + Patient Liability Reduction due to other Payer Amount (PLRO)] / Members
(k)	Supplemental Cost Share Reduction per Member	Σ [Non-Covered Plan Paid Amount (NPP)] / Members
(l)	Reimbursement for LIS per Member	Σ [Low Income Cost Share (LICS)] / Members
(m)	Reimbursement for Federal Reinsurance per Member	Σ {[Gross Drug Cost Above Out-of-Pocket Threshold (GDCA) with Catastrophic Coverage Codes A or C]* 0.8} / Members

Section I – General Information

The following paragraphs provide line-by-line instructions for Section I. This information is required for all plans, and carries forward to all other worksheets.

Line 1 – Contract Number

Enter the contract number for the plan on Line 1. The designation begins with a capital alphabetic letter H, R, or S and includes four Arabic numerals (for example, H9999, R9999, or S9999). Please include all leading zeros. Obtain this number from your contract.

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the plan being priced in the bid form. Plan IDs contain three Arabic numerals. Please enter all leading zeros. For example, enter “001” for plan number one.

Line 3 – Segment ID

If the bid is for a service area segment of a local plan, enter the segment ID.

Line 4 – Contract Year

This cell is automatically completed with the calendar year for which the contract applies.

Line 5 – Organization Name

Enter the organization's legal entity name on Line 5.

Line 6 – SNP

Enter the Special Needs Plan (SNP) Indicator as "Y" or "N".

Line 7 – Plan Name

Enter the name of the MA-PD or PDP plan that you are offering to Medicare enrollees.

Line 8 – Plan Type

Enter the type of plan. The valid options are listed below:

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization	HMO
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS
Provider-Sponsored Organization w/ State License	PSO State License
Provider-Sponsored Organization w/ Federal Waiver of State License	PSO Federal Waiver
Preferred Provider Organization	LPPO
Regional Coordinated Care Plans:	
Regional Preferred Provider Organization	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan	PFFS
Employer/Union Only Direct Contract Private Fee-for-Service Plan	ED PFFS
Continuing Care Retirement Community	
Continuing Care Retirement Community	CCRC
Demonstration Plans:	
ESRD I	ESRD I
ESRD II	ESRD II
Minnesota Disability Health Options	MN DHO
Minnesota Senior Health Options	MN SHO
Wisconsin Partnership Program	WI PP
Massachusetts Health Senior Care Options	MA HSCO
National PACE	PACE
1876 Cost	1876 Cost
Prescription Drug Plans:	
Medicare Prescription Drug Plan	PDP
Employer/Union Only Direct Contract Prescription Drug Plan	ED PDP
Fallback Plans	
Fallback Plan	Fallback

Line 9 – Enrollee Type

Select the enrollee type from the drop-down-menu if applicable; options are “Part B Only” and “A/B.” When plan type is “PDP”, “ED PDP” or “Fallback”, the enrollee type cell is white and locked; no input is required.

Line 10 – PD Region

Enter “Multiple” or National” if applicable, or enter the PD Region from the valid options listed in the following table:

Region	Description
1	Maine and New Hampshire
2	Connecticut, Massachusetts, Rhode Island, and Vermont
3	New York
4	New Jersey
5	District of Columbia, Delaware, and Maryland
6	Pennsylvania and West Virginia
7	Virginia
8	North Carolina
9	South Carolina
10	Georgia
11	Florida
12	Alabama and Tennessee
13	Michigan
14	Ohio
15	Indiana and Kentucky
16	Wisconsin
17	Illinois
18	Missouri
19	Arkansas
20	Mississippi
21	Louisiana
22	Texas
23	Oklahoma
24	Kansas
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming
26	New Mexico
27	Colorado
28	Arizona
29	Nevada
30	Oregon and Washington
31	Idaho and Utah
32	California
33	Hawaii
34	Alaska
35	American Samoa
36	Guam
37	Northern Mariana Islands
38	Puerto Rico
39	Virgin Islands

Line 11 – Plan Benefit Type

Enter the plan benefit type that identifies the type of plan reflected in this bid. The options are "DS" for Defined Standard, "AE" for Actuarially Equivalent, "BA" for Basic Alternative and "EA" for Enhanced Alternative.

Line 12 – Payment Demo Type

Enter the payment demo type to identify whether this bid is a payment demonstration and if so, which type. The options are "NA" (when the plan is not offering supplemental benefits under a payment demonstration), "Fixed Cap" (the fixed capitation option), "Flex Cap" (the flexible capitation option) and "MA Rebate" (the MA Rebate option).

Section II – Base Period Background Information

Line 1 – Time Period Definition

Enter the base period experience incurral information on the first two lines. In addition to the incurral dates, enter the "paid through" date. For example, if the incurral period is calendar year 2007, the "incurred from" date is 1/1/2007 and the "incurred to" date is 12/31/2007. If the data reflect payment information through February 2008, then the "paid through" date is 2/28/2008. Note that we do not require that the base time period incurral data be based on one calendar year.

Line 2 – Member Months

Enter the number of member months represented in the base period experience used.

Line 3 – Risk Score

Enter the plan's prescription drug risk score underlying the base period data. The CMS drug model must be used, and must be estimated to three decimal places.

Line 4 – Completion Factor

Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date.

Line 5 – Network Pricing

Select one of the following two choices from the drop-down box: "pass-thru" or "lock-in."

Line 6 – Mapping

Enter the contract-plan number and corresponding member months for every plan where the plan's experience is mapped to the base period experience.

Line 7 - Base period description

Use the text box provided to briefly describe the base period data. The base period data need not reflect the same benefit plan or service area as the contract year. Do not adjust

Deleted: Credibility¶
¶
If the base period experience is fully credible, enter "F"; if partially credible, enter "P". If the plan has no applicable credible experience, enter "N". ¶
¶
Line 4 –

Formatted: Don't keep with next, Don't keep lines together

Formatted: Font: Not Bold

Deleted: 5

Formatted: Font: Bold

data for credibility, which is addressed on Worksheet 2 with the manual rate. Examples of different base period data include:

- Same benefit plan, but larger or smaller service area.
- Same benefit plan, but an entirely different service area.
- Similar benefit plan in same or different service area.

Section III – Part D Claims Experience

Section III summarizes the base period experience for Part D coverage. Please note that these data:

- Need not exactly match the benefit plan or service area for the bid (see Section II instructions).
- Reflect either calendar year or other annualized experience.
- Reflect the current best estimate of incurred claims including estimates of unpaid claims, but excluding margin for adverse deviation (which must be included as part of the gain/loss margin).
- Include total services (both in-network and out-of-network).

Note that scripts and allowed amount data are input into Section III of Worksheet 1 in aggregate for each allowed claim interval, while paid amount, cost sharing, supplemental cost sharing reduction, reimbursement for LIS and reimbursement for federal reinsurance are input on a per member basis. The per-member per-month values are calculated on line 8 of the worksheet. Also note that it is important to enter data on covered Part D drugs in lines 1 through 5 of Section III of Worksheet 1, and non-covered Part D drugs on lines 12 and 13.

Lines 1 through 11 must include experience relating to Part D covered drugs only. Lines 12 through 14 summarize experience for any drugs that are covered by the plan but are not Part D covered at the time they are dispensed.

Lines 1 through 5 stratify the members, member months, and covered Part D claims expenses into intervals based upon the allowed Rx expense per member. Columns d through g reflect the total values, while columns h through n reflect per member values. Enter claims for which Part D is primary in lines 1 through 5. Enter claims for which Part D is secondary in line 10.

Column d, Lines 1 through 5 – Number of Members

Enter the number of members with total allowed claims in the interval experience period defined for each line. For example, if 7,000 members had allowed expenses between $250 and $2,249, then 7,000 would be entered in line 3 of column d.

Column e, Lines 1 through 5 - Member Months

For each line, enter the number of member months associated with the members included in column d.

Column f, Lines 1 through 5 - Total Number of Scripts

For each line, enter the number of Part D covered Rx prescriptions filled in the experience period for the members included in column d.

Column g, Lines 1 through 5 - Total Allowed Dollars

For each line, enter the total allowed dollars for the prescriptions filled in the experience period for the members included in column d. Allowed expenses are defined as ingredient cost plus dispensing fee, plus state sales tax where applicable, prior to application of any rebates recovered after the point of sale of the prescription.

Column h, Lines 1 through 5 - Average Allowed Amount per Member

For each line, this amount is automatically calculated based on the entries in columns d and g (column g divided by column d).

Column i, Lines 1 through 5 – Average Paid Amount per Member

For each line, enter the total dollars paid by the plan for prescriptions filled in the experience period, divided by the number of members in column d. Dollars paid include both basic and supplemental payments for Covered Part D drugs, and must not be net of rebates, reimbursements received by the plan for low-income subsidy payments, Federal reinsurance, or other reimbursements received with respect to such payments.

Column j, Lines 1 through 5 – Average Cost-Sharing Per Member

For each line, enter the average cost-sharing per member with respect to the members included in column d.

Column k, Lines 1 through 5 – Supplemental Cost-Sharing Reduction per Member

For each line, enter the average value of supplemental cost-sharing with respect to the members included in column d.

Column l, Lines 1 through 5 – Reimbursement for Low-Income Cost-Sharing Subsidy per Member

For each line, enter the average low income cost-sharing subsidy amount received or receivable with respect to the members included in column d.

Column m, Lines 1 through 5 – Reimbursement for Federal Reinsurance per Member

For each line, enter the average federal reinsurance amount received or receivable with respect to the members included in column d.

Column n, Lines 1 through 5 – Net Plan Responsibility per Member

This value is automatically calculated by subtracting the values in columns j through m, from the value in column i.

Line 6, Columns d through n – Subtotal

For columns d through g, this line represents the sum of lines 1 through 5. For columns h through n, this line represents the weighted average of lines 1 through 5 based on the number of members included in column d.

Line 7, Columns g, i and j – % OON

For column g, enter the percent of total allowed dollars from line 6 for prescriptions filled out-of-network. For column i, enter the percent of average paid dollars from line 6 for prescriptions filled out-of-network. For column j, enter the percent of average cost-sharing per member from line 6 for prescriptions fill out-of-network.

Line 8, Column g, i and columns k through n – PMPM Values

This line represents the calculated PMPM values for these columns based on the amounts in line 6.

Line 9, Columns g, I, m and n – Minus PMPM Rebates

All rebates, subsidies, and other price concessions from any source that serve to decrease the costs incurred by the Part D sponsor must be reported as a rebate when these subsidies are not used to directly reduce the cost at the point of sale. Any charges or fees for the administration of rebates, price concessions, or other services must be included separately in the bid pricing tool as a component of direct administrative costs.

Plans must include all expected amounts that will be reported as Direct and Indirect Remuneration (DIR) under Rebate in the bid pricing tool. It is important for plans to understand that the DIR reported under Rebate into the bid tool represents the plans best expectation of all DIR categories and amounts the plan expects to report under the Part D payment reconciliation process for the respective contract year.

Defining Direct and Indirect Remuneration (DIR)

Per 42 C.F.R. Section 423.308, direct and indirect remuneration (DIR) is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serves to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D Sponsors, such as pharmaceutical benefit managers (PBM), if they are retained in lieu of higher service fees. As stated in the 2008 Call letter, CMS must assume that if a PBM retains a portion of the manufacturer rebates it negotiates on behalf of a Part D sponsor, the direct payment the sponsor pays the PBM for its services will be less, such that the sponsor receives a price concession from the PBM. Thus, as a price concession received by the Part D sponsor, these retained rebates must be reported as DIR for payment purposes.

In accordance with CMS guidance, sponsors may enter into risk sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed

fees (please refer to Q&A 4877 issued on June 6, 2005). Any gains or losses that the Part D Sponsor may receive as a result of these risk sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments and any adjustments to generic dispensing incentive payments made to pharmacies after the point of sale dispensing event are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

Enter in column g the total amount of rebates received with respect to the claims included in lines 1 through 5. Total rebates should be allocated to the plan using a method that reasonably represents the way in which the rebates were generated, and rebates should be allocated to column m based upon the amount on line 6. Column i and n are calculated based upon the entries in the other columns.

Line 10, Columns g, i and n – PMPM Value of Part D as Secondary

Enter in column g the total PMPM value of any payments for Part D covered drugs for which Part D is secondary. Column i and n are calculated.

Line 11, Columns i, k through n – PMPM Net Expenses

This line is calculated as line 8 minus 9 plus 10.

Line 12, Columns g and i - PMPM Value of Non-Part D Covered D Drugs

Enter the PMPM value of claims for drugs covered by the plan that are not Part D covered drugs. Enter the allowed PMPM in column g and paid PMPM in column i.

Line 13, Column i - PMPM - Rebates on Non-Part D Covered D Drugs

Enter the PMPM value of any rebates allocable to the drug payments included on line 12.

Line 14, Columns i and n – Net PMPM on Non-Part D Covered D Drugs

Column i and n are calculated automatically.

Section IV – PMPM Non-Benefit Expense

This section summarizes the PMPM value of the Part D non-benefit expenses throughout the base period. The intent is for plans to include all costs associated with operating a prescription drug plan including any administrative expense that may be offset through direct or indirect remuneration. A plan that provided Part D benefits in 2006, 2007 and 2008 is expected to prepare the 2009 bid using data that reflects the actual cost to administer the program by function.

Plans must provide documentation outlining the development of the non-benefit expense at the time of bid submission, and be prepared to provide CMS with additional data upon request. In support of the development of the non-benefit expense, plans must provide the following at the time of bid submission:

- Document non-benefit expenses by line item.
- Show the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.

Plans must be prepared to report on the contractual terms of administrative services, and to identify when the service is performed by the plan sponsor, by a related party, or by an unrelated party. Administrative service agreements with related parties must reflect a competitive cost for the contracted services, and be prepared to support this upon request. For example, a plan or the related party could demonstrate that the terms of related party agreement are comparable to those terms offered by a comparable and competitive unrelated party for performing a comparable service.

The non-benefit expenses must be shown separately on the bid pricing tool for the following categories:

- Sales and Marketing (for example, the cost of marketing materials, commissions, enrollment packages, identification cards).
- Direct Administration (for example, functions that are directly related to the administration of the program, such as customer service, billing and enrollment, claims administration, calculation of LIS reimbursement, and True Out-of-Pocket (TrOOP) administration.

    - Pharmacy benefits management (PBM) administration. All of the costs for performing call center, claims, formulary management, network development, rebate management functions at the plan, or through a subcontractor must be reported in the BPT as direct administration.
    - Crossover Fees. (fees paid to obtain information from other payers in order to calculate TrOOP expenses).
    - Medicare User Fees.
    - Uncollected enrollee premium.
    - Uncollected cost-sharing (for example, plan liability resulting from cost-sharing not recovered in state-to-plan or plan-to-plan transactions).
    - Medication Therapy Management Program expenses.
    - Disease management functions (such as patient education and disease monitoring) are considered to be direct administration.
    - Over the Counter (OTC) drug utilization. To the extent that OTCs are permitted to be covered, they must be reported as a component of direct administration, and not as a Part D covered drug or as supplemental coverage.
- Indirect Administration (for example, functions that may be considered “corporate services,” such as accounting operations, actuarial services, legal services, and human resources).
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).

All non-benefit expenses must be reported using the appropriate generally accepted accounting practice (GAAP) methodology. For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to

the extent this is consistent with the organization's standard accounting practices, if not subject to GAAP). Also, acquisition expenses (marketing and sales) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability are FASB's Statement of Financial Accounting No. 60, Accounting and Reporting by Insurance Enterprises.

Costs not pertaining to administrative activities, including goodwill amortization, income taxes, changes in statutory surplus and investment expenses must be excluded from non-benefit expenses. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid.

Start-up costs that are not considered capital expenditures under GAAP are reported as follows:

- Expenditures for tangible assets must be capitalized and amortized according to relevant GAAP principles, e.g., a new computer system purchased to support Part D.

- Expenditures for non-tangible assets, e.g., salaries and benefits, must be reported consistently with the organization's internal accounting practices and the reporting of similar expenditures in other lines of business.

Costs that are common to offering a Medicare Advantage-Prescription Drug (MA-PD) plan must be allocated proportionately between the Medicare Advantage and Part D bid pricing tools based on total revenue.

Enter amounts on lines 1 through 4 of columns e and f. Line 5 and column g are calculated automatically.

Section V – PMPM Premium Revenue

This section summarizes the PMPM value of the components of premium revenue for Part D during the base period.

Enter amounts on lines 1 through 4 of column e and on line 3 of column f. Line 5 and column g are calculated automatically.

Section VI – PMPM Income Statement Summary

This section provides an income statement summary of the base period for Part D coverage, including the amount of MA rebate allocable to Part D in the base period.

Enter an amount on line 4 for MA rebate used for Part D.

Worksheet 2 - PDP Projection of Allowed/Non-Benefit

The purpose of this worksheet is (i) to identify the components of trend in the allowed Rx cost for covered Part D drugs and for non-benefit expenses between the base period and the contract period, and (ii) to blend in manual rate information for plans that do not have fully credible base period experience data. The base period information must be consistent with that in Worksheet 1 and the projection information must be consistent with that in Worksheet 3.

A plan that has appropriate base period data must exercise actuarial judgment in determining the credibility factor for a plan's base period experience. Based on an application of classical credibility theory to Medicare Fee-for-Service experience, CMS has established a guideline for full credibility for Medicare Advantage plans of 24,000 base period member months. The formula for partial credibility is the square root of the result of base period member months divided by 24,000. Although credibility guidelines for the Part D benefit have not been established, prescription drug experience is expected to have a higher level of credibility than medical coverage for a similarly sized group. Actuaries should take into account the quality of the data being relied upon in establishing credibility.

Worksheets 2 and 6 summarize the utilization, allowed amounts and cost sharing amounts of generic, preferred brand, non-preferred brand and specialty drugs, by place of service for the proposed defined standard plan. In addition, Worksheet 6 summarizes the same information for the proposed alternative plan, when applicable. These summaries assist in determining actuarial equivalence and are cross referenced with information submitted in the plan's formulary and Plan Benefit Package (PBP).

Brand Drugs

Single source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA), and Innovator Multi-source Drugs originally marketed under an original NDA that now have generic equivalents.

Preferred / Non-Preferred Brand Drugs

Brand name drugs placed in the most favorable position on the formulary in comparison to other similar brand drugs should be allocated to the preferred brand drug category. In contrast, brand drugs that are positioned in a less favorable position on the formulary should be allocated to the non-preferred brand category when completing the bid tool.

Generic Drugs

Non-Innovator Multi-source Drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately under type of script only when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier is designated a specialty tier, (ii) cost sharing associated with that tier is limited to 25% in the initial coverage range and (iii) only Part D drugs with plan negotiated prices greater than $600 per month may be placed in the tier.

When a designated specialty tier is used, all drugs in the designated specialty tier must be reported by place of service, on lines 4 and 8, under both Section II and Section III of Worksheet 2. When a designated specialty tier is used, the drugs in the specialty tier are not sorted by brand or generic status, and are not reported as a component of the brand and generic drugs in the non-specialty tiers.

When a plan does not utilize a designated specialty drug tier in the formulary and benefit design, specialty drugs should be sorted by generic, preferred brand, and non-preferred brand status, and reported in these categories by place of service. In this situation, the specialty categories in Section II and Section III of Worksheet 2 should not be completed.

Section I – General Information

This information is carried forward from Worksheet 1.

Section II – Utilization for Covered Part D Drugs

Lines 1 through 8, Column e - Number of Scripts/1000

For each type of prescription, enter the number of prescriptions that were filled in the base period, expressed in terms of annual prescriptions per 1,000 beneficiaries.

Lines 1 through 8, Column f - Allowed per Script

For each type of prescription, enter the average allowed amount per script for scripts filled in the base period. The amount allowed is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable. This cost should be adjusted to include rebates credited at the point-of-sale but should not include medication or utilization management costs.

Lines 1 through 8, Column g - PMPM Allowed

The value is automatically calculated and equals column e times column f, divided by 12,000.

Lines 1 through 8, Column h - Trend in Scripts/1,000

For each type of prescription, enter the factor that would be applied to the base period scripts/1,000, if there were no change in formulary, population, or benefit plan, to project scripts/1,000 in the contract period.

Lines 1 through 8, Column i - Formulary Change

For each type of prescription, enter the factor that would be applied to the base period scripts/1,000 to reflect changes in classification of certain drugs from the base period to the contract period. Reflect changes in classification as well as new to market entities.

Lines 1 through 8, Column j - Risk Change

For each line, enter the factor that represents the impact of the covered population's change in risk between the base period and the contract period. This change may include the effect for adjusting the base period claims experience to account for partial year enrollments.

Lines 1 through 8, Column k - Induced Utilization

For each line, enter the factor that would be needed to adjust the scripts/1,000 for the expected utilization difference that would apply if the base period benefit plan were modified to be the defined standard prescription drug plan.

Lines 1 through 8, Column l – Other Change

For each line, enter the factor that represents the impact of any other changes not captured in the previous columns. Additional documentation may be requested to support entries in this column.

Lines 1 through 8, Column m - Total Utilization Change

The value is automatically calculated as the product of the factors in columns h through l.

Lines 1 through 8, Column n - Projected Scripts/1000

The value is automatically calculated as the product of columns e and m.

Lines 9 through 14, Columns e through n

The values are automatically calculated using the information on lines 1 through 8.

Section III – Cost for Covered Part D Drugs

Lines 1 through 8, Column e - Inflation Trend

For each line, enter the factor representing the expected change in cost between the base period and the contract period due to changes in drug prices.

Lines 1 through 8, Column f - Discount Change

For each line, enter the factor representing the expected change in contracted discounts and dispensing fees between the base period and the contract period. Do not include any changes in expected rebates.

Lines 1 through 8, Column g - Formulary Change

For each line, enter the factor representing the expected change in cost per script due to changes in the formulary structure.

Lines 1 through 8, Column h - Other Change

For each line, enter the factor representing the expected change in cost per script due to changes other than those described in columns e through g. As an example, an anticipated change in the day's supply per script would be entered here.

Lines 1 through 8, Column i - Total Unit Cost Change

The value is automatically calculated as the product of columns e through h.
Lines 1 through 8, Column j – Projected Unit Cost

The value is automatically calculated using Section III, column i and Section II, column f.

Lines 1 through 8, Column k - Projected Allowed PMPM

The value is automatically calculated using Section III, column j, and Section II, column n.

Lines 9 through 14, Columns e through k

The value is automatically calculated using lines 1 through 8.

Section IV – Projected Allowed PMPM

Lines 1 through 8, Columns l and m - Manual Utilization/1000 and Manual Unit Cost

For base experience that is not fully credible, enter in columns l and m the utilization/1,000 and unit cost, respectively, from a credible, non-plan manual rate source.

Lines 1 through 8, Column n - Manual Rate PMPM

The manual rate PMPM is automatically calculated based on inputs in columns l and m (lines 1through 8).

Lines 1 through 8, Column o – Credibility

Enter the credibility percentage that is applied to the actual experience to blend the manual experience to produce contract period projections.

Lines 1 through 8, Column p - Blended Allowed PMPM

The value is automatically calculated using columns k, n, and o.

Lines 9 through 14, Columns l through p.

The value is automatically calculated using lines 1 through 8.

Section V – PMPM Non-Benefit Expense

This section summarizes the PMPM value of the Part D non-benefit expenses by component and is expected to include any administrative expense that may be offset through direct or indirect remuneration.

Lines 1 through 5, Column e – Base Period

Base period non-benefit expenses carry over from Section IV of Worksheet 1.

Lines 1 through 4, Column f – Trend

When base period non-benefit expenses are carried over from Section IV of Worksheet 1 into column e, enter trend values in lines 1 through 8 of column f to project from the base period to the contract period. If base period non-benefit expenses were not entered on Worksheet 1, then column f may be left blank.

Lines 1 through 5, Column g – Contract Period PMPM Non-Benefit Expense

The value is automatically calculated using columns e and f.

Lines 1 through 4, Column h– Manual Rate Non-Benefit Expense

When base period non-benefit expenses are not fully credible, enter in lines 1 through 8 a manual rate non-benefit expense from a credible source.

Lines 1 through 4, Column i – Credibility

Enter the percentage that would be applied to the trended base non-benefit expenses when blending with manual rate non-benefit expenses to produce contract period projections.

Lines 1 through 5, Column j – Blended Contract Period PMPM Non-Benefit Expense

The value is automatically calculated using columns g, h, and i.

Section VI – Development of Manual Rate

Describe the source and year of the information used as the manual rate, as well as any other relevant information, such as benefit design, group size, group characteristics, utilization trends, pricing basis, formulary changes, induction and risk assumptions.

Worksheet 3 - Contract Period Projection for Defined Standard Coverage

This worksheet is used for the development of the Defined Standard Bid Amount and must tie to Worksheet 2 and Worksheet 6, columns f, g, and h. All plans are required to fill out this worksheet.

Plans are required to provide a written description of the plan's average discount and rebate assumptions for the utilization in Worksheet 3 and 6. This documentation must be uploaded into HPMS at the time of bid submission. Rebate assumptions should be provided on a per claim basis. The discount assumptions should reflect information on generic, brand and specialty drugs separately for mail and retail.

Section I - General Information

This section automatically populates from entries on Worksheet 1.

Section II - Projection Data

Line 1 – Projected Member Months

The projected member months is carried over from the subtotal value for the member months in Section III.

Line 2 - Projected Average Risk Score

Enter the projected Rx risk score for the enrollees expected in the contract period. This value must be consistent with the base period risk score (if any) and with the expectation for the change in risk score from Worksheet 2. Reference the section on Risk Scores in the Special Considerations section of the instructions for more information.

Line 3 - Projected Low Income Subsidy (LIS) Member Months

Enter the estimated number of member months for the contract period for those enrollees who qualify for and obtain low-income subsidy (LIS) status.

Line 4 – Network Pricing

Select one of the following two choices from the drop-down box: "pass-thru" or "lock-in."

Section III – Part D Covered Drug claims

Entries in Sections III, IV, and V must reflect the risk score included in Section II, line 2.

Lines 1through 5, Column d - Number of Members

Enter the number of members who are expected to have allowed Part D Rx expenses falling in the range applicable to the line. For example, when modeling 6,500 members with allowed expenses falling in the range between $275 and $2,510, enter 6,500 on line 3, column d. For purposes of lines 1through 5, do not include estimates for any claims for which Part D is secondary coverage.

Lines 1 through 5, Column e - Member Months

For each line, enter the number of member months expected in the contract period for the members identified.

Lines 2 through 5, Columns f and g - Number of Scripts, Projected Allowed Dollars

For each line, enter the number of scripts and projected allowed dollars expected in the contract period for the members identified in column d. Allowed dollars must reflect the price incurred at the point of sale. Any rebates or price concessions reflected at the point of sale must reduce allowed dollars.

Lines 1 through 5, Column h – Avg Amt Allowed PMPM

The average amount allowed PMPM is calculated automatically.

Lines 2 through 5, Column i - Cost Sharing

For each line, enter the total amount of cost sharing that would apply to the individuals identified in the line under the assumption that the benefits are those of Part D defined standard coverage with no low-income subsidy and no supplemental coverage from any source. The member liability in the gap, before TrOOP is satisfied, is considered cost sharing for this purpose. The cost sharing amounts should be consistent with the total allowed dollars in column g.

Lines 4 through 5, Column j - GAP PMPM

For each line, enter the PMPM amount corresponding to amounts between the initial coverage limit and the catastrophic limit for the individuals identified in column d. For 2009 this amount would correspond to allowed amounts between $2,510 and $5,726.25 of total drug spending.

Lines 2 through 5, Columns k and l- PMPM Deductible, Other Cost Sharing PMPM

For each line, for individuals identified in column d, enter the projected PMPM values for the deductible and other cost sharing (based on 25% coinsurance below the initial coverage limit and catastrophic coinsurance above the catastrophic limit). Calculate the PMPM values based on the total dollars for each category, divided by the total projected member months in Section II, line 1.

Line 5, Column m - Federal Reinsurance PMPM

Enter the Federal Reinsurance applicable to the individuals identified in column d. Calculate the PMPM values based on the total dollars divided by the total projected member months in Section II, line 1.

Lines 1 through 5, Column n - Plan Liability

The plan liability PMPM is calculated automatically.

Lines 2 through 5, Column o - Federal LIS Cost Sharing PMPM

For each line, enter the projected dollar amount of low-income cost sharing subsidy applicable to individuals identified in column d who are eligible for low-income subsidy, divided by the total projected member months in Section II, line 1.

Line 6, all Columns - Subtotal

Each column is calculated automatically.

Line 7, Columns g, h, m, and n – Minus Rebates

Although rebates are not directly allocable to individual claims, the method used to allocate rebates to the plan must be reasonable and similar to the way in which the rebates are generated. For the purpose of this worksheet, rebates must include any price concession recognized after the point of sale.

Enter, as a positive dollar amount in column g and as a positive PMPM in column h, the total projected rebates to be generated in the contract period. This amount is allocated to columns m and n based on the relative amount of reinsurance compared to all allowable costs.

Line 8, Columns h, m and n – Minus Other Insurance

As positive amounts in columns h and m, enter the estimated PMPM reduction due to the presence of other Rx insurance. Column n is calculated automatically.

Line 9, Columns h, m and n – Plus Part D as Secondary

Enter in columns h and m the estimated PMPM liability of the plan where Part D coverage is secondary. Column n is calculated automatically.

Lines 10 and 11, Column e - Out-of-Network (OON) Expenses

In line 10, enter the percentage of line 6, column g that represents OON allowed claims. In line 11, enter the percentage of line 6, column n that represents OON plan liability.

Line 12, Columns g through o - Total

The values are automatically calculated based on the previous lines.

Section IV – PMPM Non-Benefit Expense and Gain/ (Loss)

Lines 1 through 5

The values for lines 1 through 5 are automatically calculated by the BPT from entries on Worksheets 2, 3, and 5.

Line 6 – Total Gain/ (Loss)

Enter the value for the plan's expected total Gain/ (Loss). Consistent with statutory intent, the gain/loss margin must reflect the revenue requirements of benefits provided under the plan.

Section V – Defined Standard Coverage Bid Development

The values for Section V are automatically calculated by the BPT from entries on worksheet 3.

Worksheet 4 - Standard Coverage with Actuarially Equivalent Cost Sharing

This worksheet is only completed for standard coverage with actuarially equivalent cost sharing plan benefit types. The two tests that must be met to demonstrate actuarial equivalence are:

- The average coinsurance percentage for amounts between the deductible and the initial coverage limit must be actuarially equivalent to 25%.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for defined standard coverage.

The amount of the bid must be determined since the bid is based on the cost of the proposed plan rather than the defined standard plan.

Considerations for Actuarial Equivalent Coverage

Although defined standard plans have 25% cost sharing for all classes of drugs, it is expected that Actuarial Equivalent (AE) plans will restructure the 25% to provide incentive for beneficiaries to access the benefit in a way that results in more efficient drug use. AE plans will generally have higher use in the generic and possibly preferred brands, and lower use in non-preferred brands; AE plans are expected to generally have higher mail use. When these favorable shifts occur, AE bids will have lower costs under the initial coverage limit (ICL) and the catastrophic phases of the benefit than do the defined standard bids. It is expected that the utilization in Worksheet 6 will adequately reflect these changes.

Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making appropriate adjustments in utilization and possibly average script pricing in Worksheet 6. The distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an actuarially equivalent plan with a zero dollar generic cost share.

Section I – General Information

The information in this section carries forward from Section I of Worksheet 1.

Section II – Projection Data

The information in this section carries forward from Section II of Worksheet 3.

Section III – Development of Bid for Defined Standard Coverage

The information in this section carries forward from Section V of Worksheet 3.

Section IV – Development of Bid Components and Tests for Actuarial Equivalence

Lines 1 through 3 and 5 through 14, Columns e, h, and k.

These items are calculated automatically.

Lines 4, Columns e and h - Allowed PMPM

For amounts below the initial coverage limit, enter in column e the allowed PMPM for standard coverage with actuarially equivalent cost sharing. For amounts above the catastrophic threshold, enter the allowed PMPM in column h.

Lines 15, Column k - Rebates

Enter in column k the total rebate amount for the plan. Rebates will be prorated for reinsurance.

Lines 16 and 17, Column e - Success/Failure of Actuarial Equivalence Tests

If line 8 of column e equals line 9 of column e using the threshold test for equivalence, line 16 of column e will display "Yes".

If line 8 of column h equals line 9 of column h using the threshold test for equivalence, line 17 of column e will display "Yes".

If both equivalence tests display "Yes," the bid for standard coverage with actuarially equivalent cost sharing will be automatically be calculated in Section IV.

Section V – Standard Coverage Bid Development with Actuarially Equivalent Cost Sharing

Lines 1 through 5 are automatically calculated. The amounts in the first column reflect the plan risk score, while those in the second column reflect a 1.000 risk score.

Line 6, LIS

Enter the estimated value of low-income cost sharing consistent with the anticipated risk factor.

Worksheet 5 - Alternative Coverage

This worksheet is only used for alternative coverage plan benefit types. Basic alternative coverage plans result in no supplemental premium. The supplemental premium for enhanced alternative coverage is automatically calculated by this worksheet.

Considerations for Basic and Enhanced Alternative Plans

Although defined standard plans have 25% cost sharing for all classes of drugs, it is expected that alternative plans will restructure the 25% to provide incentive for beneficiaries to access the benefit in a way that results in more efficient drug use. Alternative plans may also change cost sharing up to the ICL and are likely to restructure to provide incentive for beneficiaries to increase the efficiency of their drug use. It is expected that these plans will generally have higher use in the generic and possibly preferred brands and lower use in non-preferred brands, as well as higher mail utilization. When these favorable shifts occur, bids will have lower costs under the initial coverage limit (ICL) and the catastrophic phases of the benefit than do the defined standard bids.

Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making appropriate adjustments in utilization and possibly average script pricing in Worksheet 6. The distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an alternative plan with a zero dollar generic cost share as compared to the expectation from the modeling of the defined standard benefit.

Alternative plans can reduce the value of the deductible, which may in turn reduce the risk profile of the group. Although these changes may be compensated by increased cost sharing up to the initial coverage limit (ICL), it is reasonable to expect some induced utilization.

Finally, alternative plans may provide for coverage in the payment gap. Since the value of coverage up to the ICL must remain the same relative to defined standard, unless the cost of the additional coverage is offset by savings in catastrophic coverage, a supplemental premium will result. Additional coverage in the gap can also delay the point at which a beneficiary (i) achieves $4,050 of true out-of-pocket (TrOOP) cost-sharing, and (ii) gets catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, can cause induced utilization, and can also increase the risk profile of the group, although those with extremely high spending will not benefit as much as those with a moderate amount of spending and may not opt for these plans.

Section I – General Information

The information in this section is automatically populated from Section I of Worksheet 1.

Section II – Projection Data

The information in this section is automatically populated from Section II of Worksheet 3.

Section III – Development of Bid for Defined Standard Coverage

The information in this section is automatically populated from Worksheet 3.

Section IV – Development of Bid Components

Type of Deductible

Select one of the following three choices from the drop-down box: applies to all drugs; applies to brand drugs only; other.

Alternative Coverage ICL

Enter the initial coverage limit (ICL) for the proposed Alternative Coverage benefit.

Type of Gap Coverage

Select one of the following five choices from the drop-down box: no coverage; full coverage; partial - increased ICL; partial - generics only; partial - other.

Columns d through o – Part D Covered Drugs

These amounts represent Part D covered drugs.

Column q – Non-Part D Covered Drugs

These amounts represent Non-Part D covered drugs.

Line 5, Columns k and m – Allowed PMPM in Gap and Above Catastrophic

Enter the amounts that represent the allocation of the total PMPM of the gap and catastrophic coverage for the alternative benefit.

Line 6, Column d - Proposed Deductible

Enter the deductible to be used in the development of alternative coverage.

Line 8, Column f – Value of Proposed Deductible

Plans must adequately demonstrate the impacts of different approaches for pricing various deductibles as well as the impact on the initial coverage limit. Please review the information under “Special Considerations” for more information on first dollar generic coverage.

Enter the value of the proposed deductible for members not meeting the initial coverage limit.

Line 12, Column k - Coinsurance Percentage in Gap

Enter the effective coinsurance percentage for alternative coverage provided in the gap. This amount must take into account the benefit structure for these benefits, including any variations made to the initial coverage limit.

Line 18, Columns o and q - Alternative Plan Rebates

Enter the rebates generated for covered Part D drugs in column o and for non-Part D covered drugs in column q. The rebates for covered drugs will be allocated to reinsurance.

Line 20, Columns m, o and q - Alternative minus Other Insurance

Enter the impact of other insurance on total covered, reinsurance-eligible covered and non-covered drugs.

Line 22, Columns m, o, and q - Alternative Plus Part D as Secondary

Enter the cost of Part D as the secondary payer for total covered, reinsurance eligible covered, and non-covered drugs.

Section V – Development of Actuarial Equivalent Test

Lines 1 through 8 are calculated automatically. No entries are required. No calculations are made in the second column of lines 6 and 7.

Line 9 - LIS

Using the projected risk scores, enter the estimated PMPM value of Low Income Cost Sharing subsidy under the alternative plan.

Section VI – Tests for Alternative Coverage

This section applies the various tests to determine if the proposed benefit plan qualifies as Alternative Coverage. No entries are required.

Section VII – Development of Supplemental Premium

Lines 1 through 5 and line 8 are calculated automatically. No entries are required.

Line 6 - Additional Non-Benefit Expenses

Line 6 is calculated automatically from Worksheet 3. No entries are required.

Line 7 - Additional Gain/ (Loss)

Line 7 is calculated automatically from Worksheet 3. No entries are required.

Section VIII – Development of Induced Utilization Adjustment

This section captures the additional costs for basic coverage associated with offering an

enhanced alternative plan with supplemental benefits, and will be used to adjust allowable costs for risk corridor payments.

Line 2 - Impact of Alternative Utilization on Standard Benefit

Enter the additional basic Part D costs in the first column if the utilization for alternative coverage was used to price defined standard coverage. This adjustment must reflect the additional costs associated with basic coverage. For the 2009 benefit year, this amount represents 75% of costs between the $275 deductible and the $2,510 initial coverage limit, plus 15% of costs in excess of the basic catastrophic limit or $5,726.25. This adjustment should be calculated only for enhanced alternative plans and the adjustment must be a positive number.

Worksheet 6 - Script Projections for Defined Standard, Actuarially Equivalent, or Alternative Coverage

The purpose of this worksheet is to illustrate the underlying assumptions that are being used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. All of the data in Section II are collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit.

There are two significant changes to Worksheet 6 in the BPT for contract year 2009. Specialty drugs are broken out and reported separately under type of script and data is now collected for four levels of allowed spend under "Projections for Equivalence Tests."

Specialty Drugs

Plans that include a designated specialty drug tier in their plan benefit package (PBP) must separately identify the mail and retail utilization for the specialty tier in each level of spend in Section II of Worksheet 6. The additional information is expected to minimize the distortion of cost sharing that occurs when high cost specialty drugs are reported as brand drugs, and permit a more accurate comparison of the cost sharing on Worksheet 6 with the plan benefit package in HPMS.

A separate breakout of specialty drugs on Worksheet 6 is only required when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier is designated a specialty tier, (ii) cost sharing associated with that tier is limited to 25% in the initial coverage range, and (iii) only Part D drugs with plan negotiated prices greater than $600 per month be placed in the tier.

When a designated specialty tier is used, all drugs in the designated specialty tier must be reported by place of service, on the respecting lines in Section II of Worksheet 6. When a designated specialty tier is used, the drugs in the specialty tier should only be reported in the specialty line items and not in any other category. In this situation, the specialty drugs are not sorted by preferred brand, non-preferred brand or generic status, and are not reported as a component of the brand and generic drugs in the non-specialty tiers.

When a plan does not utilize a designated specialty drug tier in the formulary and benefit design, specialty drugs should be identified by preferred brand, non-preferred brand or generic status, and reported in these categories according to status and place of service. In this situation, the specialty categories in Section II of Worksheet 6 should not be completed.

Data Required for Levels of Allowed Spend

Data is collected for four levels of allowed costs on lines 1 through 36 of "Projections for Equivalence Tests," Section II of Worksheet 6. Members and member months are no longer captured on Worksheet 6, however the distribution of population and data reported in Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8 collect data on all allowed costs for the "Population Not Exceeding $2,510 with Standard Coverage." All of the utilization for the population with total allowed costs that do not exceed $2,510 must be reported in this section.

Lines 10 through 17 collect data on all allowed costs for the "Population Exceeding $2,510 with Standard Coverage." All of the utilization for the population with total allowed costs that exceed $2,510 must be reported in this section.

Lines 19 through 26 collect data on all allowed costs up to $2,510 for the "Population Exceeding $2,510 with Standard Coverage." All of the utilization for allowed costs allocated up to $2,510, for the population with allowed costs that exceed $2,510, is reported in this section.

Lines 28 through 35 collect data on all allowed costs over the catastrophic coverage limit for the "Population Exceeding $2,510 with Standard Coverage." All of the utilization for allowed costs allocated over catastrophic coverage, for the population with allowed costs that exceed $2,510, is reported in this section.

Considerations

Although this worksheet is not expected to be a detailed model of the cost sharing of the proposed plan design, the impact of alternative cost sharing and other programs, such as mandatory generic, on utilization should be clearly demonstrated compared to the defined standard benefit. The distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit, and significant changes in the alternative benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an alternative plan with a zero dollar generic cost share.

Plans submitting a bid for standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on Worksheet 4. Plans submitting a bid for alternative coverage must satisfy the various tests on Worksheet 5 to qualify. Worksheet 6 illustrates the assumptions used in demonstrating actuarial equivalence as it develops values to support the tests in Worksheets 4 and 5.

All plans are required to develop projected utilization and costs for their proposed defined standard benefit in columns f, g, and h in Section II of Worksheet 6. In addition, plans submitting a bid for an actuarially equivalent or alternative benefit are required to report projected utilization and costs in columns i, j, and k. If the bid is defined standard only, then column i through k may be left blank.

Data in Section II of Worksheet 6 are collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit and is not expected to model all of the aspects of plan design. Lines 1 through 18 summarize all of the claims expected to be utilized, with lines 1 through 9 capturing the claims for individuals with less than $2,510 in annual drug claims and lines 10 through 18 capturing the claims for individuals with $2,510 or more in annual drug claims. Lines 19 through 27 capture the claims or amounts allocated up to ICL for individuals with $2,510 or more in allowed costs. Lines 28 through 36 capture the claims for individuals expected to reach catastrophic coverage, which is $5,726.25 or more in annual drug claims for a defined standard benefit in contract year 2009. Note that amounts summarized in lines 19 through 27, and 28 through

36 are subsets of the amounts summarized in lines 10 through 18; amounts in the gap are intentionally excluded.

Plans should follow instructions carefully in developing cost sharing values for column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the cost sharing elements for the proposed defined standard benefit. For lines 1 through 8, and lines 19 through 27, column h captures the cost sharing for the claims summarized in columns f and g using the cost sharing applicable between the deductible and the initial coverage limit for all claims allocated up to the ICL. This means that column h develops cost sharing without the impact of the deductible, the gap in coverage and catastrophic coverage. For the purpose of this worksheet, plans should ignore the impact of low-income cost sharing subsidy. Since column h summarizes the defined standard benefit, all of the claims reflect cost sharing of 25%.

The worksheet must be completed for column h for lines 28 through 36 using cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this amount is greater of 5% or $2.25 for generic/preferred multi-source brand or $5.60 for all others.

Plans submitting a bid to provide an actuarially equivalent or alternative benefit are required to report the projected utilization and costs on the proposed benefit in Section II, column i, j, and k. Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making appropriate adjustments in utilization and average script pricing in Worksheet 6. Specifically, the distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. The distributions should be based on the splits as outlined in the defined standard coverage. For example, lines 1 through 9 should reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,510 in annual coverage based on the defined standard coverage. In other words, the amounts summarized in columns i, j and k are based on the same population summarized in columns f, g, and h.

Plans should follow instructions carefully in developing the cost sharing values in lines 1 through 9, and lines 19 through 27, of column k in Section II of Worksheet 6. Values in column k are calculated using the copay and coinsurance structure of the proposed actuarially equivalent or alternative benefit, for all claims allocated up to the ICL. As does column h, column k develops cost sharing without the impact of the deductible, any gap in coverage and catastrophic coverage. Calculate lines 28 through 36 assuming the cost sharing applicable beyond the catastrophic threshold for the actuarial equivalent or alternative coverage.

Plans should be aware of the situations outlined in the “Special Considerations” section of these instructions for Worksheet 6 implications when offering first dollar generic coverage or reducing the initial coverage limit.

Section I – General Information

The information in this section is automatically populated from Section I of Worksheet 3.

Section II – Projections for Equivalence Tests

Data is collected for four levels of allowed costs on lines 1 through 36 of “Projections for Equivalence Tests,” Section II of Worksheet 6. Members and member months are no longer

captured on Worksheet 6; however the distribution of population and data reported in Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8

Columns f through h – Enter the projected scripts, allowed dollars, and cost sharing for defined coverage, with cost sharing calculated as if there were no deductible and no LIS subsidy.

Columns i through k – If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars, and cost sharing for the population identified in Section III of Worksheet 3, cells D-21 plus D-22, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage. These numbers include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 9

The value is automatically calculated as the sum of lines 1 through 8.

Lines 10 through 17

Columns f through g – Enter the projected scripts and allowed dollars for defined standard coverage, with coinsurance calculated at 25% as if there were no deductible, no GAP, and no LIS subsidy.

Columns i through j - If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts and allowed dollars for the population identified in Section III of Worksheet 3, cells D-23 plus D-24. These numbers must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 18

The value is automatically calculated as the sum of lines 10 through 17.

Lines 19 through 26

Columns f through h – For amounts allocated up to the ICL, enter the projected scripts, allowed dollars, and cost sharing for defined standard coverage, with coinsurance calculated at 25% as if there were no deductible, no gap, and no LIS subsidy.

Columns i through k - If offering an actuarially equivalent standard or alternative benefit, for amounts allocated up to the ICL, enter the projected scripts, allowed dollars and cost sharing for the population identified in Section III of Worksheet 3, cells D-23 plus D-24, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage prior to the catastrophic limit. These amounts must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 27

The value is automatically calculated as the sum of lines 19 through 26.

Lines 28 through 35

Columns f through h – Enter the projected scripts, allowed dollars, and cost sharing for defined standard coverage, with cost sharing calculated using the copay/coinsurance structure that applies in defined standard coverage once the catastrophic threshold has been reached.

Columns i through k - If offering an actuarially equivalent standard or alternative benefit enter the projected scripts, allowed dollars and cost sharing for the population identified in Section III of Worksheet 3, cell D-24 using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage once the catastrophic coverage limit has been reached. These amounts must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 36

The value is automatically calculated as the sum of lines 28 through 35.

Line 37

For columns i through k, enter the projected scripts, allowed dollars and copay/coinsurance structure for non-Part D covered drugs.

Example

Below is an illustrative example of how lines 10 through 36 should be completed. The example assumes that Beneficiaries A and B reach catastrophic coverage with total allowed costs of $10,000 and $6,425, respectively. The following cost sharing provisions apply:

Cost Sharing	Up to ICL	Catastrophic
Retail Generic	$5	$2.25
Retail Preferred Brand	$25	$2.25
Retail Non-Preferred Brand	$50	$5.60
Retail Specialty	25%	5%
Mail Order Generic	$10	$2.25
Mail Order Preferred Brand	$50	$2.25
Mail Order Non-Preferred Brand	$100	$5.60
Mail Order Specialty	25%	5%

For illustrative purposes only, the beneficiaries are shown separately and in aggregate.

Beneficiary A's costs are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Beneficiary A Allowed	Cost-sharing
10. Retail Generic	20	$ 500.00	
11. Retail Preferred Brand	15	$ 1,500.00	
12. Retail Non-Preferred Brand	8	$ 1,200.00	
13. Retail Specialty (2)	2	$ 2,000.00	
14. Mail Order Generic	10	$ 550.00	
15. Mail Order Preferred Brand	10	$ 2,250.00	
16. Mail Order Non-Preferred Brand	5	$ 2,000.00	
17. Mail Order Specialty (2)	-		
18. Total	70	$ 10,000.00	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	5.02	$ 125.50	$ 25.10
20. Retail Preferred Brand	3.77	$ 376.50	$ 94.13
21. Retail Non-Preferred Brand	2.01	$ 301.20	$ 100.40
22. Retail Specialty (2)	0.50	$ 502.00	$ 125.50
23. Mail Order Generic	2.51	$ 138.05	$ 25.10
24. Mail Order Preferred Brand	2.51	$ 564.75	$ 125.50
25. Mail Order Non-Preferred Brand	1.26	$ 502.00	$ 125.50
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	17.57	$ 2,510.00	$ 621.23

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	8.55	$ 213.69	$ 19.23
29. Retail Preferred Brand	6.41	$ 641.06	$ 14.42
30. Retail Non-Preferred Brand	3.42	$ 512.85	$ 19.15
31. Retail Specialty (2)	0.85	$ 854.75	$ 42.74
32. Mail Order Generic	4.27	$ 235.06	$ 9.62
33. Mail Order Preferred Brand	4.27	$ 961.59	$ 9.62
34. Mail Order Non-Preferred Brand	2.14	$ 854.75	$ 11.97
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	29.92	$ 4,273.75	$ 126.74

Beneficiary B's costs are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Beneficiary B Allowed	Cost-sharing
10. Retail Generic	18	$ 450.00	
11. Retail Preferred Brand	12	$ 1,200.00	
12. Retail Non-Preferred Brand	10	$ 1,500.00	
13. Retail Specialty (2)	-	$ -	
14. Mail Order Generic	5	$ 275.00	
15. Mail Order Preferred Brand	8	$ 1,800.00	
16. Mail Order Non-Preferred Brand	3	$ 1,200.00	
17. Mail Order Specialty (2)	-		
18. Total	56	$ 6,425.00	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	7.03	$ 175.80	$ 35.16
20. Retail Preferred Brand	4.69	$ 468.79	$ 117.20
21. Retail Non-Preferred Brand	3.91	$ 585.99	$ 195.33
22. Retail Specialty (2)	-	$ -	$ -
23. Mail Order Generic	1.95	$ 107.43	$ 19.53
24. Mail Order Preferred Brand	3.13	$ 703.19	$ 156.26
25. Mail Order Non-Preferred Brand	1.17	$ 468.79	$ 117.20
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	21.88	$ 2,510.00	$ 640.68

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	1.96	$ 48.94	$ 4.40
29. Retail Preferred Brand	1.31	$ 130.51	$ 2.94
30. Retail Non-Preferred Brand	1.09	$ 163.13	$ 6.09
31. Retail Specialty (2)	-	$ -	$ -
32. Mail Order Generic	0.54	$ 29.91	$ 1.22
33. Mail Order Preferred Brand	0.87	$ 195.76	$ 1.96
34. Mail Order Non-Preferred Brand	0.33	$ 130.51	$ 1.83
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	6.09	$ 698.75	$ 18.44

The aggregate costs of Beneficiaries A and B are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Total A & B Allowed	Cost-sharing
10. Retail Generic	38	$ 950.00	
11. Retail Preferred Brand	27	$ 2,700.00	
12. Retail Non-Preferred Brand	18	$ 2,700.00	
13. Retail Specialty (2)	2	$ 2,000.00	
14. Mail Order Generic	15	$ 825.00	
15. Mail Order Preferred Brand	18	$ 4,050.00	
16. Mail Order Non-Preferred Brand	8	$ 3,200.00	
17. Mail Order Specialty (2)	-	$ -	
18. Total	126	16,425	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	12.05	$ 301.30	$ 60.26
20. Retail Preferred Brand	8.45	$ 845.29	$ 211.32
21. Retail Non-Preferred Brand	5.91	$ 887.19	$ 295.73
22. Retail Specialty (2)	0.50	$ 502.00	$ 125.50
23. Mail Order Generic	4.46	$ 245.48	$ 44.63
24. Mail Order Preferred Brand	5.64	$ 1,267.94	$ 281.76
25. Mail Order Non-Preferred Brand	2.43	$ 970.79	$ 242.70
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	39.45	$ 5,020.00	$ 1,261.91

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	10.51	$ 262.63	$ 23.64
29. Retail Preferred Brand	7.72	$ 771.57	$ 17.36
30. Retail Non-Preferred Brand	4.51	$ 675.98	$ 25.24
31. Retail Specialty (2)	0.85	$ 854.75	$ 42.74
32. Mail Order Generic	4.82	$ 264.96	$ 10.84
33. Mail Order Preferred Brand	5.14	$ 1,157.35	$ 11.57
34. Mail Order Non-Preferred Brand	2.46	$ 985.26	$ 13.79
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	36.01	$ 4,972.50	$ 145.18

(2) - The Specialty tier is only used when the Plan places Specialty drugs on a separate tier in accordance with CMS guidelines.

Formatted: Font: (Default) Arial, 10.5 pt

Formatted: Justified

Network Pricing

Enter the percentage discount off AWP, and the Dispensing Fee for all generic, brand and specialty drugs dispensed at mail or retail.

Worksheet 7 – Summary of Key Bid Elements

The purpose of this worksheet is to capture a summary of the key payment-related components of the bid and the plan's estimate of the National Average Monthly Bid Amount and calculated premiums. The inputs on this worksheet must be reasonable and represent the plan's best estimates of these projected values.

SECTION II – 2009 Defined Standard Benefit Parameters

Line 1 – Deductible

This value is the deductible for the defined standard benefit.

Line 2 - Initial Coverage Limit

This value is the initial coverage limit (ICL) for the defined standard benefit.

Line 3 - Out-of-pocket Limit

This value is the out-of-pocket limit (OOP) for the defined standard benefit.

SECTION III – Summary of Key Bid Elements

Line 1 – Standardized Part D Bid

This value is the plan's Standardized Part D bid. The value is automatically calculated from the plan bid.

Line 2 - National Average Monthly Bid Amount

This field requires a manual input at the time of bid submission. Enter the estimated National Average Monthly Bid Amount that the plan is anticipating. The final value for the National Average Bid Amount for contract year 2009 will be released some time after this value is entered and the bid is submitted.

Line 3 – Base Beneficiary Premium

This field requires a manual input at the time of bid submission. Enter the estimated Base Beneficiary Premium amount that the plan is anticipating. Together with the National Average Monthly Bid Amount and the Basic Part D A/B Rebate allocation reported on the MA Bid Pricing Tool for MA plans, these amounts will determine the plan's basic Part D Target Premium that will be used during the rebate reallocation period.

Line 4 and 5 – Basic Part D Premium (prior to A/B rebate reallocation)

The values on lines 4 and Line 5 are the plan's expected base beneficiary premium, calculated from the plan's manual inputs on lines 1, 2, and 3 of this section. Line 4 reflects the value of the Basic Part D premium before application of the rounding rule, and line 5 reflects the value after the rounding rule selected on Line 8 of this section has been applied.

These amounts will be updated to reflect the actual National Average Monthly Bid Amount and Base Beneficiary Premium after these amounts are published in early August.

Lines 6 and 7 - Supplemental Part D Premium (prior to A/B rebate allocation)

This value is the plan's Supplemental Part D Premium before rebate allocation and is only developed when supplemental benefits are offered. The value is reflected both before and after the application of the rounding according to the rule in line 11 of this section. Line 6 reflects the value of the Basic Part D premium before application of the rounding rule and line 7 reflects the value after the rounding rule has been applied.

Line 8 - Prospective Federal Reinsurance (non-standardized)

This value is the prospective federal reinsurance requirement developed in the bid.

Line 9 - Prospective Low-income Cost Sharing Subsidy (non-standardized)

This value is the prospective low-income cost-sharing requirement developed in the bid.

Line 10 - Target Adjustment (allowed costs as a ratio of bid)

This value is the administrative cost percentage of the bid and the value is used in calculating the target amount for risk corridor payments. The target amount is calculated according to the following:

> [(1.00 – administration cost percentage) X (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount)]

Line 11 - Rounding Rule

This field requires a manual input. MA-PD plans are required to round to the nearest $0.10; PD plans are required to round to either the nearest $0.10 or nearest $0.50 and must select the preferred method for rounding the Part D premium from the drop-down menu. **The default will be $0.10 in all cases where a selection is not made.**

Section IV - Part D Bid Pricing Tool Contacts and Date Prepared

Plans are required to identify two persons who are readily available and are authorized to discuss the development of the bid. Provide the requested contact information (name, phone, and e-mail) for the Plan Bid Contact and Part D Certifying Actuary. Credentials are a required input for the certifying actuary.

Section IV also contains a field labeled "Date Prepared." This field must contain the date that the BPT was prepared. If the BPT is revised and resubmitted during the bid review process, then this date field should be updated accordingly.

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany *every* bid submitted to HPMS. A qualified actuary who is a *member of the American Academy of Actuaries* (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater reliance on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

Actuarial Standards of Practice and Other Considerations

In preparing the actuarial certification, the actuary must consider whether the actuarial work supporting the bid conforms to the current Actuarial Standards of Practice (ASOP), as promulgated by the Actuarial Standards Board. While other ASOPs apply, particular emphasis is placed on the following:

- ASOP No. 5, Incurred Health and Disability Claims.
- ASOP No. 8, Regulatory Filings for Health Plan Entities. Particular focus is placed on the sections dealing with the Use of Business Plans to Project Future Results (3.2.3), Use of Past Experience to Project Future Results (3.2.4), Recognition of Plan Provisions (3.2.5), New Plans or Benefits (3.2.6), Regulatory Benchmark (3.2.8), and Reasonableness of Assumptions (3.2.9).
- ASOP No. 23, Data Quality. Particular focus is placed on the following sections: Analysis of Issues and Recommended Practices (Section 3), Communications and Disclosures (Section 4).
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage.
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking. Particular focus is placed on the section dealing with the Extent of Documentation (3.2).
- ASOP No. 41, Actuarial Communications. Particular focus is placed on the section dealing with the Actuarial Report (3.3.3),

The certifying actuary must also consider whether the actuarial work supporting the bid complies with applicable laws, rules, current bid instructions and CMS guidance. In addition, actuaries must consider whether the actuarial work supporting the bid is consistent and reasonable with the plan benefit package and the organization's current business plan.

Background on previous certification process

In previous contract years (CY2006-2007), actuaries were required to prepare an actuarial certification document. These documents were uploaded to HPMS by the plan sponsor with the initial June bid submission.

During the bid review process, resubmissions may occur for a variety of reasons in order to revise the bid package (i.e., the bid pricing and/or benefits). In such circumstances, the initial certification submitted may become outdated. There was confusion among plan sponsors regarding when/if a certification needed to be re-uploaded for certain types of resubmissions.

In CY2007, CMS attempted to address these issues. In addition to the initial certification, plan sponsors were required to upload a "final" certification in late August. While no material changes were permitted to the certification language, actuaries were expected to update the certification document to contain certain HPMS references to the final bid that was pending CMS approval.

While this alleviated some of the certification issues, other concerns with the certification process still remained. Not all certifying actuaries had access to HPMS, which created several problems. First, actuaries could not view the uploaded Bid Pricing Tool, Plan Benefit Package, and certification to ensure that they were on a consistent basis. Secondly, CMS sometimes released bidding guidance through HPMS, which actuaries could not easily access. And lastly, when the final certifications were being prepared, actuaries had a difficult time obtaining the HPMS bid references to include in the final certification.

In addition to the HPMS access issues, the certification process itself was not efficient. Actuaries needed to prepare multiple free-form text documents (for each bid submitted). When the final certifications were submitted in August, CMS had little time to re-review these documents before the bid approval process was scheduled to begin. And there continued to be confusion among plans regarding when/if a revised certification was required for intermittent resubmissions.

Certification process for CY2009

All CY2009 certifying actuaries are required to have user access to HPMS. Actuaries will have access to the bid package uploaded (BPT, PBP, substantiation, etc.) to ensure their consistency. Actuaries will have access to any guidance that may be released by CMS via HPMS. And most importantly, *the only way to certify a bid in CY2009 will be through a new certification module within HPMS*. (The previous process of uploading certification documents will be replaced by the new certification module.)

The new certification module will contain the following features:

- Standardized required language (the required elements are described below in a subsequent section)
- The ability to append free-form text language to the required standardized language
- A summary of key information from the submitted bids
- Links to additional information regarding the bid package (such as the PBP, BPT, substantiation, etc.)
- The ability to certify multiple bids/contracts
- The ability to print and save the submitted certification

The new module will eliminate the need for actuaries to prepare and upload separate certification documents to HPMS. The new certification module/process is similar to the Benefit Attestation module/process that plan sponsors currently complete in HPMS.

An initial actuarial certification must be submitted via the new certification module in June. And then in late August, the actuary must certify the final bid (that is pending CMS approval) via the new certification module. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but may do so if they choose to.

As was instructed in previous contract years, material changes to the certification language (after the initial June certification submission) are not permitted without prior written permission from CMS Office of the Actuary.

Applying for access to the new certification module

All certifying actuaries and plan sponsors must take action to gain access to the new certification module. This includes:

- All actuaries certifying the MA portion of a bid (i.e., MA BPT)
- All actuaries certifying the Part D portion of a bid (i.e., PD BPT)
- Consulting actuaries who will be certifying bids for a plan sponsor
- Health plan staff actuaries (i.e., actuaries employed by the plan sponsor) who will be certifying bids

Even actuaries with current HPMS access must still take action to gain access to the new certification module.

Detailed instructions on how to apply for access to the new certification module were released via HPMS on March 9, 2007. The memo was also e-mailed to the certifying actuaries on file from last year. Below contains instructions on how to apply for the module, based on that memo.

Step 1: **All certifying actuaries who do not have current HPMS access** must submit an application form. The application requirement applies to both consulting actuaries and health plan staff actuaries. If the certifying actuary already has user access to HPMS, then skip step 1 and proceed to step 2.

Complete the following:

Download the *Application for Access to CMS Computer Systems* form at: http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf

Complete the form as follows:

a) Section 1 – Check “New” as the type of request.
b) Section 2 – Check “Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only”.
c) Section 3 – Enter the contract number(s) for which you will be submitting actuarial certifications for CY 2009.
d) Section 4 – Check the first row beneath the "Default Non-CMS Employee” row (i.e., place a check in the Connect box of the third row). On the blank line beside your check mark, write "HPMS_P_CommlUser".
e) Section 5 – State briefly that you require HPMS access to submit the actuarial certification. Also indicate whether you are employed by the contracting organization or whether you are under contract as an actuarial consultant with the contract organization(s).
f) Section 6 – Leave blank.
g) Sign and date the Privacy Act Statement on page 3 of the form. Also enter your name and Social Security Number at the top of page 3. This step is critical to ensuring the successful processing of your request.

Common mistakes to avoid when completing the application form:

- You must include the contract number(s) in Section 3 for which you will be submitting an actuarial certification.

- You must always provide a Social Security Number. CMS will not process a request without this piece of information.
- You must complete the form in ink, not pencil.
- You must submit the original hardcopy form with an original signature and date.
- Photocopies and faxes are not acceptable.

Step 2: **All certifying actuaries** must submit an official letter from each plan sponsor that they intend to certify bids for in CY2009. The letter requirement applies to both consulting actuaries and health plan staff actuaries, and also applies to actuaries who have current HPMS access.

Letter requirements:

- The letter must specify the contract number(s) and type of functionality required by the certifying actuary:
  - Actuarial Certification Profile only
    - Actuarial certification submission functionality, and related PBP and BPT reports
  - Actuarial Certification Profile and Plan Profile
    - Actuarial certification submission functionality and related reports, as well as all other standard plan functionality, including bid upload, formulary upload, marketing submission, etc.
- The letter must be provided on the organization's official letterhead, with an original dated hardcopy signature of a senior official of the plan sponsoring organization.
- If the certifying actuary already has HPMS access (and has skipped step 1), then the official letter must include the HPMS user ID of the actuary and an explanation that the user already has HPMS access.

CMS recommends using the following sample language for the letter (to be prepared on the organization's letterhead):

(*Date of Letter*)

Ms. Sara Walters,
(Name of Organization) hereby requests that *(Name of Actuary)* with the firm of *(Name of Consulting Firm, if applicable)* requires HPMS access to submit actuarial certifications on our behalf. *(Name of Actuary)* requires access to the following contract number(s):
(list specific contract numbers).

(Name of Actuary) requires the following HPMS access (please check one box):

- ☐ Actuarial Certification Profile only (actuarial certification submission functionality and related PBP and BPT reports)
- ☐ Actuarial Certification Profile and Plan Profile (actuarial certification submission functionality as well as all other standard plan functionality, including bid upload, formulary upload, marketing submission, etc.)

[*If the actuary currently has HPMS access, then add a sentence to indicate that the actuary already has HPMS access and to indicate what is their HPMS user ID.]*

If you have any questions, please feel free to contact me at (*phone number*).

Sincerely,
(*Signature of Plan Sponsor senior official*)
(N*ame and title of Plan Sponsor senior official*)

Step 3: Consider the following:

If a certifying actuary is serving multiple plan sponsors (for ex., as a consulting actuary), only one application is required, but a letter must be provided from each plan sponsor for which the actuary will be serving as an agent in HPMS.

At least one letter from a plan sponsor must be included with the application in order for the HPMS access request to be processed. Please note that additional letter(s) from other plan sponsor(s) may be submitted following the initial submission for HPMS access.

If the certifying actuary already has HPMS access, they do not need to resubmit the application form (i.e., may skip step 1), but they still must submit the letter (see step 2).

Plan sponsors can have multiple actuaries assigned to one contract to perform the certification module. For example, a consulting actuary may certify the Part D portion of a bid while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify Hxxxx-002. The instructions contained in this appendix should be followed by all actuaries who will be doing any certification(s) for CY2009 bid(s).

Step 4: Submit the letter(s), and any applications, to CMS as soon as possible:

Please submit the original (not a copy) application and the corresponding organization letter(s) via traceable carrier to:

Ms. Sara Walters
Re: Actuarial HPMS Access
7500 Security Blvd.
Location: C4-17-05 / Mailstop: C4-14-21
Baltimore, MD 21244

If you have any questions regarding the certification access instructions, please contact:
Sara Walters: 410-786-3330 or sara.walters@cms.hhs.gov .

Required Certification Elements

The certification module will contain the following information as part of the standardized language:

- When the certification is submitted, the certification will be "stamped" with the certifying actuary's name/user ID and the date.
- Attestation that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy's qualification standards for doing so.
- The specific contract, plan ID(s), and segment ID(s) of the bids associated with the certification.
- The Contract Year of the bid(s) contained in the certification.

- Indication of whether the certification applies to the Medicare Advantage bid, the Prescription Drug bid, or both.
- Attestation that the certification complies with the applicable laws[1], rules[2], CY2009 bid instructions and current CMS guidance.
- Attestation that, in accordance with Federal law, the bid(s) is based on the "average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile."
- Attestation that the data and assumptions used in the development of the bid(s) are reasonable for the plan's benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid(s) are consistent with the organization's current business plan.
- Attestation that the bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries and that the bid complies with the appropriate ASOPs.
-
- Attestation that, in accordance with ASOP No. 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency.

If you have any questions regarding the CY2009 certification instructions, please contact CMS Office of the Actuary at actuarial-bids@cms.hhs.gov .

[1] Social Security Act Sections 1851 through 1859; and Social Security Act Sections 1860D-1 through 1860D-42.
[2] 42 CFR Parts 400, 403, 411, 417, 422, and 423.

Appendix B – Supporting Documentation

In addition to the bid form and actuarial certification, organizations must provide CMS with supporting material. All data submitted as part of the bid process are subject to review and audit by CMS, or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Before submitting the Rx bid forms, plans must complete a series of calculations and enter the results on the appropriate worksheet. Therefore, it is required that any relevant supporting information be summarized and included with the bid submission to CMS.

Supporting documentation requirements are the same regardless of the source of the assumption: whether developed by the actuary, the plan sponsoring organization, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, they are still subject to the same documentation requirements. The actuary may be asked for a list of materials that were relied on and a reliance letter. The actuary must be prepared to produce the substantiation, even if it was prepared based on a reliance.

Supporting documentation must be clearly labeled and easily understood by CMS reviewers. The substantiation should clearly identify if it is related to MA, Part D or both. The documentation for the bid must include quantitative support and details, rather than just narrative descriptions of assumptions, and identify all reliances applicable to the materials provided.

Acceptable forms of supporting documentation include, but are not limited to, the following items:

- Meeting minutes from any discussions related to bid development.
- Email correspondence related to bid development.
- A complete description of data sources, i.e., report name, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information include, but are not limited to, the following items:

- A reference to the supporting documentation for another plan such as “the same as for plan Hxxxx-xxx” and not the documentation itself, i.e., the supporting documentation for a plan must be self-contained.
- A statement that the source of a pricing assumption is “professional judgment“, with no additional explanation, reasoning, supporting factors, studies, etc.
- “Living worksheets” that are overwritten with current data, (i.e. save the version of the worksheet that is used in bid preparation.)
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on inclusion in a bid approved by CMS in a prior contract year. Data, assumptions, methodologies and projections must be determined to be reasonable and appropriate for the current bid independently of prior bid filings.

The supporting documentation for a plan should be self-contained and not contain references such as "the same as for plan Hxxxx-xxx".

Supporting materials must be in electronic format (i.e., Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, whereby multiple files are compressed into one file (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when selecting plans.

To expedite the bid review process, CMS requires plans to upload complete supporting documentation *with the initial June bid submission to HPMS*.

Cover Sheet. Organizations often upload multiple documents that contain supporting documentation. To expedite the bid review process, organizations must upload a "cover sheet" that lists all of the supporting documentation that is uploaded or provided in the bid form.

The cover sheet must include detailed information for each support item such as filename and location within the file, if applicable. The cover sheet should clearly identify the bid IDs and whether the substantiation is related to MA, Part D or both.

Note that certain documentation requirements will apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements will only apply to bids that contain certain assumptions (for example, manual rate documentation would only apply if a bid's projection is based on manual rates). For documentation categories that apply for a subset of bids that contain a specified assumption, the cover sheet should not refer to a "range" of bid IDs (such as "plans 001 – 030", or "all plans under contract Hxxxx"). For these items, the cover sheet should contain the exact bid IDs (contract/plan/segment) that the documentation applies to.

For subsequent substantiation uploads, the cover sheet should only summarize the *additional* documents uploaded at that time (i.e., the cover sheet should not be a maintained as a cumulative list). The subsequent cover sheets should also contain the exact bid IDs, rather than a "range" of bid IDs.

Sample cover sheets are provided at the end of this section.

Required Documentation

Initial June Bid Submission. The following items *must* be included with the *initial* bid submission:

- Support for the manual rate development.
    - Plans that develop manual rates for the pricing tool using available data adjusted to reflect the expected population and the benefit design being offered must provide data and a written narrative that supports the development of the manual rates.
- All plans must provide a written summary of the rebate assumptions on a per claim basis for the utilization in Worksheet 6.

- All plans must provide the discount assumptions for generic, preferred and non-preferred brand and specialty drugs obtained at mail and retail for the utilization in Worksheet 6. This summary should include discounts and dispensing fee.
- Plans that rely upon pharmacy claims experience in lieu of PDE data must provide a detailed written narrative explaining the variation, accompanied by sufficient data to support the development of the base period experience.
- Supporting documentation for the development of projected risk scores is required, and must include the following:
    - A detailed description of the methodology used to develop projected 2009 risk scores.
    - A description of the source data for the development of the projected 2009 risk scores.
    - A description of all projection factors and the basis for the factors.
    - A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected medical expenses, if the plan pricing is based on manual rates.
- Support for the credibility calculation if applicable.
- Support for gain/loss margin assumptions (see Special Considerations section for description of documentation requirements).
- A written document outlining the development of the non-benefit expenses. In support of the development of the non-benefit expense, plans must provide the following at the time of bid submission:
    - Document non-benefit expenses by line item.
    - Show the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.

Upon Request by CMS Reviewers. The following additional items are not required to be included with the initial bid submission. Plans should prepare these items while developing their bids so they are available upon request as part of the bid desk review and bid audit processes. If these materials are requested by CMS reviewers, the requested substantiation is expected to be provided within 48 hours.

- The contractual terms of administrative services, and whether each is performed by a related party, or by an unrelated party. Administrative service agreements with related parties must reflect a competitive cost for the contracted services.
- A plan that provided Part D benefits in 2006, 2007 and 2008 is expected to have considered data that reflects the actual cost to administer the program by function.
- Reconciliation of base period experience with company financial data.
- Support for projection assumptions.
- If applicable, a list of materials that were relied on and an accompanying reliance letter.
- Communication between CMS reviewers and the organization throughout the bid review process (i.e., e-mail communication).

- Additional information (not specified in this list) may be requested by CMS reviewers, as needed.

Sample Cover Sheet – Submitted with initial bid upload

Supporting Documentation Cover Sheet
CY2009 Bid Submission

Organization Name: Health One
Contract(s): H1234, H9999, and S9999

Date: June 1, 2008

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, PD, or both
Cover Sheet	All bids	Cover 6-1-08.doc	n/a	both
Product Narrative	All bids	Cover 6-1-08.doc	Pages 2+	both
MA and Part D Non-Benefit Expenses	All bids	AdminProfit.xls	Sheet1	both
MA and Part D Gain/Loss Margins	All bids	AdminProfit.xls	Sheet2	both
MA and Part D Risk Scores	All bids	Risk CY09.xls	MA-Sheet 1 PD-Sheet 2	both
MA and/or Part D Manual Rate Development, if projection(s) based on manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
MA Base period member month distribution (if >4 plans used)	H1234-002-0	N/A (contained in the MA BPT)	MA BPT Worksheet 1, Section II line 6 text box	MA
MA Credibility assumption if differs from CMS guidelines	N/A			
MA Significant Non-Covered allowed costs, if any	N/A			
MA Adjustment to cost sharing for OOP max	N/A			
MA Cost sharing test, if outside limits	N/A			
MA ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA
MA ISAR factors, if used	N/A			
MA Actuarial swaps/ equivalences, if used	N/A			
Part D rebate and discount assumptions	All bids	Manual.xls	Section III	PD
Part D credibility assumptions	All bids	PartD.xls	"Credibility" worksheet	PD
Part D base period experience development	H1234-001-0 H1234-002-0 H1234-004-0 H9999-001-0 S9999-001-0	PartD.xls	"Base" worksheet	PD

Sample Cover Sheet – Submitted with subsequent substantiation uploads

Supporting Documentation Cover Sheet #2
CY2009 Bid Submission

Organization Name: Health One
Contract(s): H1234, H9999, and S9999

Date: July 16, 2008

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, PD, or both
Cover Sheet	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0 H9999-001-0 S9999-001-0	Cover 7-16-08.doc	n/a	both
Reliance Letter	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0	Reliance CY09.pdf	n/a	both
E-mail communication with CMS Bid Reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	E-mail1.doc	n/a	MA
E-mail communication with CMS Bid Reviewers	H9999-001-0 S9999-001-0	Email2.doc	n/a	PD
E-mail communication with CMS Bid Reviewers	H9999-001-0 S9999-001-0	Email3.doc	n/a	PD

Appendix C – Employer/Union-only Group Requirements

The Medicare Modernization Act (MMA) gives employers and unions a number of options for providing prescription drug coverage to their retirees. Employers and unions can:

- Provide coverage at least as good as Medicare's Part D Defined Standard benefit and receive a tax-free retiree subsidy of 28% of a retiree's drug costs between $275 and $5,600.
- Purchase customized benefits from a PDP or MA-PD pursuant to CMS waivers, or
- Contract directly with CMS to become a PDP and provide customized benefits pursuant to CMS waivers.

Under Sections 1860D-22(b) and 1857(i) of the Social Security Act (SSA), CMS may waive or modify Part D requirements that hinder the design of, offering of or enrollment in an employer or union Part D retiree plan. The waiver authority applies to PDPs and MA-PDs that offer employer/union-only group plans and employer/union-only groups that contract directly with CMS to become a PDP.

For CY2006, CMS issued guidance waiving or modifying many of the requirements for these entities. CMS waiver guidance is located at http://cms.hhs.gov/EmpGrpWaivers. All of the standard Part D bidding guidelines applies with the exception of those specifically waived.

For CY2009, CMS does not require a Part D bid pricing tool for Employer/Union Only Group Plans.

For additional information on CY2009 EGWP bidding policy, please refer to:

- The CY2009 Call Letter

Appendix D – Calculation of the National Average Monthly Bid Amount

For the 2006 contract year, the national average monthly bid amount was calculated using equal weighting applied to all PDP sponsors, and assigned MA-PD plans a weight based upon prior enrollment. New MA-PD plans were assigned a zero weight. This approach was used because no PDP enrollment data existed for 2005.

For contract year 2007, the national average monthly bid calculation was performed according to the guidelines established by the "Medicare Demonstration to Limit Annual Changes in Part D Premiums due to Beneficiary Choice of Low-Cost Plans." Specifically, 80 percent of the calculation for contract year 2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average, and 20 percent was based on an enrollment-weighted average.

As announced in the April 2, 2007 Notification of Changes in Medicare Part Payment for Calendar Year 2008, the 2008 national average monthly bid amount will be based on 40 percent of the uniform-weighted average and 60 percent of the enrollment-weighted average.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2006 and February 2007. The June 2006 enrollment shows the basis of the actual 2007 benchmark calculation. Recall that the 2007 benchmark was calculated as 80 percent of the uniform weighted approach, and 20 percent of the enrollment weighted approach. The table summarizes the final benchmark as well as the components of each weighting method.

The same values are presented based on the February 2007 enrollment. Since the 2008 benchmarks will be based on 2007 enrollment, these values may be useful for estimating the 2009 benchmarks. The final 2009 benchmarks will be based on the 2007 enrollments applied to the 2009 bids. The left section of the table shows the actual 2007 benchmarks, which were calculated based on June 2006 enrollment. The right section, titled "February 2007 Enrollment," indicates how the 2007 benchmarks would have been calculated based on more current enrollment data.

	June 2006 Enrollment			February 2007 Enrollment		
	2007 Demonstration (80% uniform, 20% enrollment)	Uniform Weighted Approach	Enrollment Weighted Approach	2007 Demonstration (80% uniform, 20% enrollment)	Uniform Weighted Approach	Enrollment Weighted Approach
National average monthly bid amount	80.43	81.39	76.59	80.19	81.33	75.61
Base beneficiary premium	27.35	27.63	26.23	27.3	27.58	26.18
Direct subsidy	53.08	53.76	50.36	52.89	53.75	49.43

Appendix D

This illustrative recalculation of the 2007 benchmarks with the revised weighting approach is provided for the purpose of assisting plans in developing the projected 2008 national average monthly bid amount and base beneficiary premium which will be used in the calculation of the plan's target premium. The final 2008 benchmarks will be based on the 2007 enrollments applied to the 2008 bids.

Appendix E – Calculation of Low Income Benchmark Premium Amounts

For the 2006 contract year, the low income benchmark premium amounts were calculated using equal weighting applied to all PDP sponsors, and assigned MA-PD plans a weight based upon prior enrollment. New MA-PD plans were assigned a zero weight. This approach was used because no PDP enrolment data existed for 2005.

For contract year 2007, the low income benchmark premium amounts were calculated according to the guidelines established by the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries." Specifically, 100 percent of the calculation for contract year 2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average.

As announced in the April 2, 2007 Notification of Changes in Medicare Part Payment for Calendar Year 2008, the 2008 low income premium benchmark amounts will be based on 50 percent of the uniform-weighted average and 50 percent of the enrollment-weighted average.

The following table illustrates the impact of the enrollment-weighted methodology for the enrollment used in the development of the 2007 low income benchmark premium amounts. These amounts were based on enrollments as of June 2006. The final 2008 benchmarks will be based on the 2007 enrollments applied to the 2008 premiums using the weighting methodology described above.

Region	State(s)	June 2006 Enrollment	
		Uniform Weighted	Enrollment Weighted
01	NH, ME	30.72	27.33
02	CT, MA, RI, VT	27.35	22.97
03	NY	24.45	19.30
04	NJ	28.12	19.23
05	DE, DC, MD	29.65	25.74
06	PA, WV	28.45	25.66
07	VA	30.52	25.82
08	NC	32.13	29.65
09	SC	31.41	27.90
10	GA	31.07	27.78
11	FL	22.63	15.18
12	AL, TN	29.60	25.00
13	MI	30.79	28.14
14	OH	28.51	23.10
15	IN, KY	32.42	28.20
16	WI	29.67	26.28
17	IL	29.66	26.57
18	MO	27.88	20.84
19	AR	30.51	26.32
20	MS	31.70	27.41
21	LA	28.45	22.63
22	TX	26.93	21.08
23	OK	30.35	24.26
24	KS	30.56	23.82
25	IA, MN, MT, ND, NE, SD, WY	29.50	20.47
26	NM	22.72	16.35
27	CO	27.37	18.70
28	AZ	21.37	11.52
29	NV	20.56	11.57
30	OR, WA	28.71	22.60
31	ID, UT	31.77	25.22
32	CA	21.03	15.00
33	HI	26.35	19.82
34	AK	33.56	31.47

Appendix F - Bid Pricing Tool Technical Instructions

CMS strongly encourages all BPT users and certifying actuaries to read the Technical Instructions before working with the CY2009 bid tools.

The CY2009 BPT Technical Instructions are located in HPMS under:
HPMS Home > Plan Bids > Bid Submission > CY2009 > Documentation > BPT Technical Instructions

If you have any technical questions regarding the Bid Pricing Tool workbooks, please contact the HPMS Help Desk at 1-800-220-2028, or via email at: hpms@cms.hhs.gov .

Appendix G – Red-Circle Validation Edits

The purpose of the “red-circle” validation rules in the BPT is:

- to highlight *some* of the fields that require data entry by the user, and
- to highlight *some* user-entered data that may be invalid.

Following is a description of all validation rules in the PD BPT.

Worksheet 1

Section I

D5	Contract Number cannot be blank and text length must be 5.
D6	Plan ID Number cannot be blank and text length must be 3.
D7	Segment ID Number cannot be blank and text length must be between 1 and 3.
F6	The Organization Name cannot be blank and may be up to 200 characters.
F7	The SNP Indicator must be "Y" or "N".
I5	The Plan Name cannot be blank and the text length must be between 1 and 200.
I6	The Plan Type cannot be blank must be between 1 and 40.
I7	If the Plan Type is Employer Sponsored PDP, Medicare Prescription Drug Plan or Fallback than the Enrollee Type must be blank, otherwise the Enrollee Type must be 'A/B' or 'Part B Only'
N5	The PD Region cannot be blank or 'N/A' if the Plan Type is RPPO, otherwise it must be a number between 01 and 39 or 'Multiple', 'National', ’N/A’.
N6	The PD Benefit Type must be DS, AE, BA or EA.
N7	The Payment Demo Type must be NA, Fixed Cap, Flex Cap, or MA Rebate.

Section II

D12	Time Period Definition - Incurred from date must be earlier than today's date.
D13	Time Period Definition - Incurred to date must be between Incurred from date and today's date.
D14	Time Period Definition - Paid through date cannot be greater than today's date.
I13	The Credibility must be 'F' for full credibility, 'P' for partial credibility, or 'N' for none.

Section III

G37	The Total Amount of Rebates received by the Plan should be entered. The PMPM value is calculated in Column I.
G38	The Total Value of Part D as Secondary should be entered. The PMPM value is calculated in Column I.
N33	The Net Plan Responsibility per Member Subtotal should be greater than zero.

Section IV

E48-E51	All Components of Non-Benefit expenses for Basic must be greater than or equal to zero.
F48-F51	All Components of Non-Benefit expenses for Supplemental must be greater than or equal to zero.

Section V

E58-E61	Each component of Premium Revenue for Basic must be greater than or equal to zero.
F60	Member Premium for Supplemental must be greater than or equal to zero.

E62 The Total of Member Premium for Basic must be greater than or equal to zero.
F62 The Total of Member Premium for Supplemental must be greater than or equal to zero if PD Benefit Type is equal to “EA”.
G62 The Total of Member Premium must be greater than or equal to zero.

Worksheet 2

Section II
G32 The Total Allowed PMPM should be within +/- $1 of the Subtotal of the Average Allowed Amount PMPM on Drug Plan Financials Worksheet (G36).

Section III
K56 The Total Projected Allowed PMPM must be greater than zero if the Total Credibility is greater than zero %.

Section IV
N56 The Total Manual Rate PMPM must be greater than zero if the Total Credibility is less than 100%.

Worksheet 3

Section II
H11 Projected Average Risk Score for the contract year must be between 0.3 and 10.0.
L11 The projected LIS member months for the contract year must be greater than or equal to zero.

Section III
F25 The Subtotal of the Number of Scripts should be within +/- 2 from the sum of cells F19 and F31 on Script Projections Worksheet.
G25 The Subtotal for Projected Allowed should be within +/- $5 from the sum of cells G19 and G31 on Script Projections Worksheet.
G27 The Projected Allowed for Minus Rebates must be greater than or equal to 0.
E20-E24 Member Months should be less than or equal to the Projected Members times 12.
H25 The Subtotal for the Average Amount of Allowed PMPM should be within +/- $1 of the Total Blended Allowed Cost on Projection of Allowed-Admin Worksheet.
E31 The Allowed Member Months for the Projected % OON Included should be between 0% and 100%

Section IV
D44 Enter the expected Gain/(Loss).

Worksheet 4

Section IV
E34 The Standard with Actuarially Equivalent Cost Share Allowed PMPM for members below the Initial Limit must be greater than zero if PD Benefit Type is "AE".
H34 The Standard with Actuarially Equivalent Cost Share Allowed PMPM for members above the Catastrophic Limit must be greater than zero if PD Benefit Type is "AE".

K54	The Standard with Actuarially Equivalent Cost Share Rebates Including Reinsurance must be greater than zero if PD Benefit Type is "AE".
E59-E60	The Actuarial Equivalence Tests should equal "Yes" if the PD Benefit Type is "AE".

Section V

K19	The Total Basic Bid must equal the sum of cells K16 through K18.
K21	The LIS for Bid with Actuarially Equivalent Cost Sharing must be greater than zero if the Federal LIS PMPM Total is greater than zero and PD Benefit Type is AE.

Worksheet 5

Section II

K11	The risk score must be consistent with the risk score from Standard Coverage Worksheet.

Section IV

D39	Proposed Deductible for the Alternate Coverage should be greater than or equal to zero and less than or equal to the Deductible on the Summary Worksheet.
F41	Value of the Proposed Deductible should be greater than zero if cell D39 is greater than zero.
O36	Standard Total Allowed PMPM should be equal to the Average Amount Allowed PMPM Subtotal on Standard Coverage Worksheet, +/- $0.02.
O37	Alternative Total Allowed PMPM should equal the sum of the Total Allowed Dollars divided by the Projected Member Months, +/- $0.02.
K37	Allowed PMPM Amounts in Gap for Alternative Coverage must be greater than zero.
K47	Coinsurance % for Alternative Coverage Amounts in Gap must be less than or equal to 100%.
M37	The Allowed PMPM Amounts above Catastrophic Threshold for Alternative Coverage must be greater than zero.
M59	Federal Reinsurance - Other Insurance Alternative Amounts above Catastrophic Threshold must equal to Other Insurance Standard Amounts above Catastrophic Threshold if Payment Demo Type is "Flex Cap" or "Fixed Cap".
M62	The Plus Part D as Secondary - Alternative Amounts above Catastrophic Threshold must be equal to Plus Part D as Secondary - Standard Amounts above Catastrophic Threshold if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O56	The Alternative Minus Rebates for all members must be greater than or equal to zero.
O59	The Alternative Minus Other Insurance for All Members must be equal to Standard Minus Other Insurance for All Members if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O62	The Alternate Part D as Secondary Total PMPM for All Members must be equal to Standard Part D as Secondary Total PMPM for All Members if Payment Demo Type is "Flex Cap" or "Fixed Cap".
O64	The Standard Net Cost Benefit for the Total PMPM should equal the Total Plan Liability PMPM on Standard Coverage Worksheet.

Section V

O24 The LIS at plan risk for Alternative Coverage must be greater than zero if the Total of Federal LIS PMPM in Standard Coverage Worksheet (O33) is greater than zero.

Section VI

G68 Total Coverage Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G69 Unsubsidized Value Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G70 Average Cost at Initial Coverage Limit Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G71 Deductible Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

G72 Average Catastrophic cost sharing Actuarial Test should be "Yes" if PD Benefit type is "BA" or "EA".

Section VII

O76 Development of Supplemental Premium Gain/Loss should be zero if PD Benefit Type is "BA" or greater than zero if it is "EA".

Section VIII

F77 Impact of Alternative Utilization on Standard Coverage at plan risk must be blank or greater than or equal to zero.

Worksheet 6

Section II

F19 Number of Scripts on Script Projection Worksheet must be within +/- 2 scripts of the Standard Coverage Worksheet (F21:F22).

G19 Total Allowed Dollars must be within +/- $5 of the Standard Coverage Worksheet (G21:G22).

I19 Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J19 Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

K19 Total Cost Sharing Dollars should be greater than or equal to zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan Type is not DS.

F31 Number of Scripts on Script Projection Worksheet must be within +/- 2 scripts of the Standard Coverage Worksheet (F23:F24).

G31 Total Allowed Dollars must be within +/- $5 of the Standard Coverage Worksheet (G23:G24).

I31 Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J31 Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

I42 Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.

J42 Total Allowed Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.
K42 The Total Cost Sharing Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan type is not DS.
H34-H41 The Cost Sharing Dollars should be equal to 25% of the Allowed Dollars and it should be greater than zero if the associated Population/Member Months cells are greater than zero.
H45-H52 The Cost Sharing Dollars should be equal to 25% of the Allowed Dollars and it should be greater than zero if the associated Population/Member Months cells are greater than zero.
I53 The Total Number of Scripts should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.
J53 The Total Allowed Dollars should be greater than zero if the Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.
K53 The Total Cost Sharing Dollars should be greater than or equal to zero if the Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.
I56 Non-Part D Covered Number of Scripts for Actuarially Equivalent or Alternative Coverage must be greater than or equal to zero if the PD Benefit Plan is not DS.
J56 Non-Part D Covered Allowed Amount for Actuarially Equivalent or Alternative Coverage must greater than or equal to zero if PD Benefit Plan is not DS.
K56 The Total Cost Sharing Dollars should be greater than zero if the associated Population/Member Months cells are greater than zero and PD Benefit Plan is not DS.

Worksheet 7

Section III
F16 Summary of Key Bid Element for National Average Monthly Bid Amount must be greater than zero.
F17 The Summary of Key Bid Elements for Base Beneficiary Premium must be greater than zero and less than the Summary of Key Bid Element for National Average Monthly Bid Amount.
F32 $0.10 or $0.50 must be selected. If neither is selected, the default is $0.10.

Section IV
C36 Plan Bid Contact Name cannot be blank.
C37 Plan Bid Contact Phone cannot be blank.
C38 Plan Bid Contact Email cannot be blank.
C40 Part D Certifying Actuary Name cannot be blank.
C41 Part D Certifying Actuary Phone cannot be blank.
C42 Part D Certifying Actuary Email cannot be blank.
C43 Date Prepared cannot be blank.

Glossary of Terms

The Part D program uses a number of terms that have specialized meanings. The terms included here are primarily those that came about as a direct result of the Medicare Modernization Act (MMA) or the development of the bid form.

Actuarial Equivalence. A state of equivalent value demonstrated through the use of generally accepted actuarial principles and in accordance with the MMA and CMS guidelines; refers to a determination that the overall value of drug coverage for a set of beneficiaries under one plan can be shown to be equal to the overall value for those same beneficiaries under another plan. See the definitions for "Standard Coverage with Actuarially Equivalent Cost Sharing" and "Alternative Prescription Drug Coverage."

Allocated Buy-Down. The use of rebate dollars to buy down Part D basic premium (not true revenue).

Allowed Costs. The medical costs before reduction for member cost sharing, coordination of benefits/subrogation, reinsurance recoveries or other amounts paid by a third party.

Alternative Prescription Drug Coverage. See the definition for "Actuarial Equivalence." Sponsoring organizations may offer this coverage through plans are approved by the Secretary that provide (i) coverage, the actuarial value of which is at least equal to the actuarial value of standard prescription drug coverage, (ii) access to negotiated prices. Such coverage must meet certain other statutorily-defined parameters. Specifically, the proposed benefit must meet the following specific actuarial equivalency requirements when compared to defined standard benefit:

- The total actuarial value of the alternate coverage equals or exceeds the total actuarial value of standard coverage.
- The unsubsidized value of the alternate coverage (defined as the amount by which the total actuarial value exceeds the total actuarial value of federal subsidies) equals or exceeds the unsubsidized value of standard coverage.
- The total payment made for costs below the initial coverage limit under the alternate coverage equals or exceeds the total payments made at that same limit under standard coverage.
- The alternate deductible does not exceed the standard deductible.
- The alternate coverage provides the same out-of-pocket limit and beneficiary cost sharing in the catastrophic coverage range as does standard coverage.

Annual Deductible. Standard drug coverage has an annual deductible of $250 in 2006. For subsequent years, the deductible amount will be indexed to the annual growth in average per capita spending by Medicare beneficiaries for Part D drugs and rounded to the nearest $5. Plans providing basic coverage may apply a lower, but not greater, deductible within the overall actuarial equivalence requirements.

Basic Coverage. Part D coverage that is either statutorily defined standard coverage or alternative prescription drug coverage without supplemental benefits.

Basic Plan Premiums. Premiums that are based on a national percentage of the national average monthly bid amount with adjustments up or down depending on the competitive standing of the plan bid relative to this national average.

Basic Premium Calculation. Basic beneficiary premium amounts up to 25.5% of the national average bid amount adjusted for reinsurance. Plan-specific premiums will equal the basic beneficiary premium adjusted for 100% of the variation between the plan's standardized bid and the national average bid amount.

Catastrophic Threshold. Catastrophic coverage is triggered when the beneficiaries true out-of-pocket (TrOOP) expenses equals the following:

1) For 2006 - $3600. For defined standard this amount will be reached when the beneficiary true out-of-pocket (TrOOP) expenses equal $5100 in allowed costs.
2) For years subsequent to 2006 - The amount specified for the previous year, increased by the annual percentage increase specified in the CFR and rounded to the nearest multiple of $50.

Coinsurance and Co-payments. The standard drug coverage has beneficiary coinsurance of 25% for spending above the deductible and up to the initial coverage limit ($250 to $2,250 in 2006). Plans providing basic coverage may require different coinsurance or copayments that are actuarially consistent with an average cost sharing of 25%. Once the annual out-of-pocket (OOP) threshold is reached ($3600 in 2006), enrollees will pay the greater of (i) $2 for generics/$5 for brand name drugs, or (i) 5% coinsurance.

Completion Factor. Adjusts for incurred but not reported expenses (IBNR).

Credibility. The determination of the appropriateness of a plans experience must include the evaluation of whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience must be representative of the benefits that will be offered in the contract period. For example, a plan that will be offering defined standard Part D coverage must have experience for a benefit with a gap in benefits and catastrophic coverage for a population similar to the population they expect to be covering.

Crossover Fees. Payments made by the Part D carrier to other entities in order to obtain information about other available Rx coverage.

Defined Standard Benefit. All plans develop information for the defined standard benefit which represents (i) the bid for plans offering defined standard, and (ii) comparison points for actuarial equivalency tests for plans offering actuarially equivalent cost sharing or alternative coverage. In 2006, defined standard coverage includes the following:

1) A deductible of $250.
2) Coinsurance of 25 percent up to an initial coverage limit of $2250.
3) Protection against high out-of-pocket prescription drug costs, with co-pays once an enrollee's out-of-pocket spending reaches a limit of $3,600of the greater of $2 for generics and preferred multiple source drugs and $5 for all other drugs or 5 percent of the price.

Defined Standard Coverage Bid. The total monthly plan bid for providing a Medicare - eligible beneficiary with a national average risk profile with Part D coverage through a defined standard benefit.

Direct Subsidy Payment. Monthly payments received by PDPs and MA-PD plans equal to their bid amounts, risk-adjusted for enrollee health status and minus the enrollee premium.

Enhanced Alternative Prescription Drug Coverage. A benefit that offers alternative prescription drug coverage with supplemental benefits.

Induced Utilization. The factor that would adjust the scripts/1,000 for the expected utilization difference that would apply if the enhanced alternative benefits in the base period were modified to be the defined standard prescription drug plan.

Initial Coverage Limit. Allowed costs above any deductible for which coinsurance would apply. The amount is equal to the following:

1) For 2006 - $2250 dollars in allowed costs.
2) For years subsequent to 2006 - The amount specified in this paragraph for the previous year, increased by the annual percentage increase specified in paragraph (e) (5) (IV), and rounded to the nearest multiple of $10.

Interim Prospective Payments. Monthly interim payments that will be made on estimated reinsurance payments and low-income cost sharing. Amounts estimated in the bidding process are used as interim payment, and reconciliation will occur after the plan year.

Low-Income Benefit. For 2006, the premium and cost-sharing subsidy amounts for various subsidy eligible groups are as follows:

FPL & Assets	Percentage of Premium Subsidy Amount (1)	Deductible	Copayment up to out-of-pocket limit	Copayment above out-of-pocket limit
Full-benefit dual eligible – institutionalized individual	100%*	$0	$0	$0
Full-benefit dual eligible– Income at or below 100% FPL (non-institutionalized individual)	100%*	$0	The lesser of: (1) an amount that does not exceed $1-generic/preferred multiple source and $3-other drugs, or (2) the amount charged to other full subsidy eligible individuals who are not full-benefit dual eligible individuals or whose incomes exceed 100% of the FPL	$0
Full-benefit dual eligible – Income above 100% FPL (non-institutionalized individual)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Non-full benefit dual eligible beneficiary with income below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Non-full benefit dual eligible beneficiary with income below 135% FPL and with assets that exceed $6,000 but do not exceed $10,000 (individuals) or with assets that exceed $9,000 but do not exceed $20,000 (couples)	100%*	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs

Non-full benefit dual eligible beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy assistance (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs

(1) Premium subsidy amount as defined in §423.780(b)
*The percentage shown in the table is the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region.

Low-Income Cost-Sharing Subsidy. The final low-income cost-sharing payment will be based on actual reduction of beneficiary cost sharing resulting from the low-income subsidy. Amounts estimated in the bidding process will be used as interim payment, and the reconciliation will occur after the plan year.

Low-Income Premium Subsidy. Plan premiums are used to determine the low-income regional benchmark. The weights are similar to those used in the national average but are allocated to the regions of the projected enrollees. This benchmark is used to determine the low-income premium subsidy.

MA. Medicare Advantage.

MA-Prescription Drug (MA-PD) Plan. A MA plan that provides qualified prescription drug coverage under Part D of the Social Security Act. Effective January 1, 2006, MA plan sponsors (except MA private fee-for service and MSA plans) must offer at least one plan in each of their service areas that includes basic Part D coverage or Part D coverage that includes supplemental benefits, the costs of which are offset by a rebate for Part A and Part B benefits.

Manual Rate. Rate that is used when the experience period data are deemed to be less than fully credible. In such cases, the projected experience rate is weighted with the estimated costs developed under some other (fully credible) basis in the proportion to which the experience data are deemed credible. Most plans will not have appropriate base period experience to be used in completing Worksheet 1 for contract years 2006 or 2007. As explained in the instructions, plans without appropriate base period experience must develop manual rates to be used in the pricing tool using available data adjusted to reflect the expected population and the benefit design that will be offered.

Medical Therapy Management Payments (MTMP). Those costs incurred by the Part D carrier for managing drug therapy for complex cases as required by the MMA.

Medicare User Fees. The MMA expands user fees to apply to PDP sponsors as well as MA plans. The expansion of the application of user fees recognizes the increased Medicare beneficiary education activities that are required as part of the new prescription drug benefit. In 2006 and beyond, user fees will help to offset the costs of educating over 41 million beneficiaries about the drug benefit through written materials, internet sites, and other media. The user fee provisions establish the applicable aggregate contribution portions for PDP sponsors and MA organizations.

National Average Monthly Bid Amount. Bids will be aggregated to generate a single national average monthly bid amount. Weights will be based upon prior enrollment. For plan year 2006, MA plan bids will be based upon prior year enrollment; PDP weights will be based upon the allocation of those not in the MA weights, applied across all PDPs in the Region.

Net Cost of Private Reinsurance. The re-insurance premium less projected reinsurance recoveries.

Part D Drugs. Those drugs covered under the Medicaid program plus insulin, insulin-related supplies, certain vaccines and smoking cessation agents. Drugs currently covered in Parts A and B of Medicare will continue to be covered there, rather than Part D. The definition excludes certain drugs, such as barbiturates and benzodiazepines.

Part D Premiums. The plan's premium for basic coverage will be set at approximately 25.5 percent of the national weighted average plan bid adjusted for reinsurance plus or minus the difference between the average and the plan's bid. Premiums will vary by plan. The plan premium will be uniform for all enrollees except that the premium will be increased by any late enrollment penalty that applies or decreased if the enrollee is eligible for low-income assistance. The plan will charge the full cost for any supplemental coverage it offers.

Plan Benefit Package (PBP). The summary of benefits offered by the MA-PDP or PDP plan. Health plans fill out a separate form and submit the information to CMS.

Plan Standardized Bid. The organization submits a bid based upon the projected cost for the standard benefit based upon the population assumed to enroll. The standard benefit excludes beneficiary cost sharing, reinsurance, and low-income cost sharing subsidies. Projected costs are adjusted by the projected risk score of the population to get a standardized bid.

Prescription Drug Plan (PDP). Refers to a private prescription drug plan that offers drug-only Part D coverage under a policy, contract, or plan that has been approved as meeting the requirements specified in the rule and that is offered by an MA organization that has a contract with CMS that meets the contract requirements under part 423 of this chapter and does not include a fallback plan unless specifically identified as a prescription drug plan.

Rebate. Price concessions that are provided after sale, as opposed to any price concessions that may have contributed to a lower negotiated ingredient cost at point of sale and that we would expect to be included in the price paid at the point of sale.

Reconciliation Process. Processes required to settle prepaid to actual enrollment, risk adjustment, low-income subsidy, and reinsurance payments (in that order) prior to calculation of risk sharing.

Reinsurance. For Part D services, reinsurance refers to the Federal government's coverage of 80% of costs over the catastrophic coverage level. Final reinsurance payment will be based upon 80% of the allowable reinsurance costs after TrOOP threshold. The amount estimated in the bidding process is used as interim payment, and reconciliation will occur after the plan year.

Risk Adjusted Bid. The Basic Bid multiplied by the Risk Adjustment Factor.

Risk Adjustment Factor. Prescription drug risk adjustment methodology based on the relationship of prescription drug utilization within the entire Medicare population to medical

diagnoses, and applied at the individual beneficiary level. The long-term plan is to refine the risk adjustment model to account for predictable risk based on both medical and drug claim data.

Risk Corridors. Used to limit an insuring entity's risk of losing money but also limit its gains (profits). A target is established based on an estimate of the claims of the benefit. Gains or losses inside a risk corridor around that target are the full responsibility of the insuring organization. Additional gains or losses beyond the risk corridor are shared with the federal government. There is no risk-sharing for supplemental benefits.

Risk Corridor Targets. Risk corridor payments are based on the direct subsidy payments plus beneficiary premiums adjusted to exclude administrative expenses. The percent of the standardized bid attributable to administrative costs are identified in the bid, and this percentage will be used to adjust the total direct subsidy plus beneficiary premiums collected in the risk corridor target development. Risk corridor payment adjustments will made on allowed amounts actually incurred by the plan that are above or below the target amount. For 2006, the first threshold will result in 75% payment of receipt for allowable costs between 2.5% and 5% of the target, and 80% for amounts greater than 5%.

Standard Coverage with Actuarially Equivalent Cost Sharing. See the definition for **Actuarial Equivalence**. The proposed benefit must meet the following specific actuarial equivalency requirements when compared to the defined standard benefit:

1) For individuals whose claim costs exceed the initial coverage limit, the average coinsurance percent under the initial coverage limit must be 25%.

2) The average coinsurance percent above the catastrophic limit must be the same as it would be for basic standard coverage.

Standardized Bid. The organization projects the cost for the standard benefit based on the population assumed to enroll. The standard benefit excludes beneficiary cost sharing, reinsurance and low-income cost-sharing subsidies. To get the standardized bid, the projected costs are adjusted by the projected risk score of population.

Supplemental Benefits. Benefits that include reduced cost sharing or coverage of non-Part D covered drugs. The full cost of supplemental benefits is paid for by beneficiary premiums and includes the cost of induced utilization on standard benefits. The BPT includes the development of the cost of enhanced coverage.

True out-of-pocket (TrOOP). The amounts actually paid by the enrollee or another person on the enrollee's behalf (or by certain state programs) for covered Part D drugs that are included (or treated as included) in the Part D plan's formulary count toward the out-of-pocket limit that must be reached before the catastrophic benefit becomes available. These costs count as TrOOP only when they are paid for by the beneficiary, by another person on their behalf (such as a family member), by a qualified State Pharmaceutical Assistance Program (SPAP), or by a bona fide charity. A “person” is defined broadly to include any individual (including non-family members), a corporation such as a pharmaceutical manufacturer, association, etc. The deductible does not have to be satisfied by out-of-pocket payments; it can be paid by insurance or another payer such as Indian Health Service. Amounts reimbursed by a third-party insurer, including an employer-sponsored retiree plan or a supplemental package within a Part D plan, do not count.

User Fees. Fees whose purpose is to defray part of the ongoing costs of the national beneficiary education campaign, which develops and disseminates print materials, and maintains the 1-800-MEDICARE telephone line.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.