
INSTRUCTIONS FOR COMPLETING
THE PRESCRIPTION DRUG PLAN
BID PRICING TOOL
FOR CONTRACT YEAR 2012

December 16, 2010

TABLE OF CONTENTS

I. Introduction.....	4
Background.....	4
Document Overview	4
New for Contract Year 2012 (CY2012).....	4
Bidding Resources	5
II. Pricing Considerations.....	6
Bidding/Pricing Approach	6
Specific Topics.....	6
III. Data Entry and Formulas	21
PD Worksheet 1 – Rx Base Period Experience.....	24
Section I – General Information.....	24
Section II – Base Period Background Information	26
Section III – Part D Claims Experience	27
Section IV – PMPM Non-Benefit Expenses.....	30
Section V – PMPM Premium Revenue.....	30
Section VI – PMPM Income Statement Summary.....	31
PD Worksheet 2 – PDP Projection of Allowed/Non-Benefit.....	32
Section I – General Information.....	32
Section II – Utilization for Covered Part D Drugs.....	32
Section III – Cost for Covered Part D Drugs	33
Section IV – Projected Allowed PMPM.....	34
Section V – PMPM Non-Benefit Expense.....	35
Section VI – Development of Manual Rate	36
PD Worksheet 3 – Contract Period Projection for Defined Standard Coverage	37
Section I – General Information.....	37
Section II – Projection Data	37
Section III – Part D Covered Drug Claims	37
Section IV – PMPM Non-Benefit Expense and Gain/Loss	40
Section V – Defined Standard Coverage Bid Development	40
PD Worksheet 4 – Standard Coverage with Actuarially Equivalent Cost Sharing.....	42
Section I – General Information.....	42
Section II – Projection Data	42
Section III – Development of Bid for Defined Standard Coverage	42
Section IV – Development of Bid Components and Tests for Actuarial Equivalence.....	42
Section V – Standard Coverage Bid Development with Actuarially Equivalent Cost Sharing	43
PD Worksheet 5 – Alternative Coverage	44
Section I – General Information.....	45
Section II – Projection Data	45
Section III – Development of Bid for Defined Standard Coverage	45
Section IV – Development of Bid Components.....	45
Section V – Development of Actuarial Equivalent Test	46
Section VI – Tests for Alternative Coverage	46
Section VII – Development of Supplemental Premium.....	47
Section VIII – Development of Induced Utilization Adjustment.....	47
PD Worksheet 6 – Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage.....	48
Section I – General Information.....	48
Section II – Projections for Equivalence Tests	48
PD Worksheet 7 – Summary of Key Bid Elements	55

Section I – General Information.....	55
Section II – 2012 Defined Standard Benefit Parameters.....	55
Section III – Summary of Key Bid Elements.....	55
Section IV – Part D Bid Pricing Tool Contacts and Date Prepared	56
Section V – Working Model Text Box	57
IV. Appendices.....	58
Appendix A – Actuarial Certification	58
Appendix B – Supporting Documentation	61
General.....	61
Submitting Supporting Documentation.....	62
Part D Checklist for Required Supporting Documentation.....	67
Sample Cover Sheet – Submitted with Initial Bid Upload.....	68
Sample Cover Sheet – Submitted as a Subsequent Substantiation Upload.....	69
Sample Format for Reliance on Information Supplied by Others.....	69
Appendix C – Employer/Union-Only Group (EGWP) Requirements	70
Appendix D – Calculation of National Average Monthly Bid Amount.....	71
Appendix E – Calculation of Low-Income Benchmark Premium Amounts	72
Appendix F – Impact of Health Care Reform on CY2012 Bids	74
Provisions.....	74
Pricing Considerations	74
Changes to the BPT.....	75

I. INTRODUCTION

BACKGROUND

Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each prescription drug plan they intend to offer Medicare beneficiaries.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format—the Prescription Drug Bid Pricing Tool (BPT). An actuarial certification and supporting documentation must be submitted for each bid as described in Appendix A and Appendix B, respectively.

The submitted bids will be subject to review, negotiation, and audit by CMS. As part of the negotiation process, CMS or its representative may request additional documentation supporting the information in the BPT. Organizations must be prepared to provide this information in a timely manner. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

DOCUMENT OVERVIEW

This document contains general pricing considerations and detailed instructions for completing the BPT. Following are the contents of each section:

- Section I, “Introduction”: contains a list of key changes from the CY2011 BPT and Instructions and provides sources of information that can be accessed for assistance during the bid submission process.
- Section II, “Pricing Considerations”: contains guidance for preparing bids and presenting pricing results in the BPT.
- Section III, “Data Entry and Formulas”: contains directions for completing the seven worksheets in the BPT and explains the formulas for calculated cells.
- Section IV, Appendices A through F: contain requirements for Actuarial Certification, Supporting Documentation, Employer/Union-Only Group Waiver Plans, Calculation of the National Average Monthly Bid Amount, Calculation of the Low-Income Benchmark Premium Amounts and Impact of Health Care Reform on CY2012 Bids, respectively.

NEW FOR CONTRACT YEAR 2012 (CY2012)

The key changes between the CY2012 BPT and CY2011 BPT are highlighted below. The changes improve the usability and functionality of the BPT and reflect updated regulatory guidance.

See Appendix F – Impact of Health Care Reform on CY2012 Bids for the changes required to accommodate the provisions of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 that apply to Part D bids.

BIDDING RESOURCES

- The CY2012 Advance Notice may be found at <http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2012.pdf>
- The CY2012 Call Letter and CY2012 Rate Announcement may be found at <http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2012.pdf>
- The CY2012 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at http://www.cms.gov/MedicareAdvtgSpecRateStats/09a_BidTrainingIntro.asp and http://www.cms.gov/MedicareAdvtgSpecRateStats/09b_BidTraining2012.asp
- For questions about the bid form, e-mail the CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov.
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2012 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. The call-in information is as follows:
 - Every Thursday from April 14 through June 2, 2011
 - 11:00am – 12:30pm ET
- For technical questions about the BPT, HPMS, or the upload process, refer to the following resources:
 - The Technical Instructions are located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2012 > Documentation > BPT Technical Instructions
 - The *Bid Submission User's Manual*, also available in HPMS
 - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

By statute, the bid must represent the revenue requirement of the expected population. Therefore, in most circumstances, Part D sponsors must use credible bid-specific experience in the development of projected allowed costs. This approach does not preclude Part D sponsors from reaching specific benefit and premium goals; the gain/loss margin guidance allows sufficient flexibility to achieve pricing targets provided that the overall margin meets the requirements in the guidance and that anti-competitive practices are not used.

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the plan level if the plan existed in CY2010, regardless of the level of enrollment. This experience must also be projected in Worksheet 2 and assigned an appropriate level of credibility by the certifying actuary. Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year.

SPECIFIC TOPICS

Actuarial Equivalence

Actuarial equivalence must be demonstrated for plan benefit types other than Defined Standard (DS).

When the plan benefit type is Actuarially Equivalent (AE), two tests must be satisfied on Worksheet 4, Section IV, lines 16 and 17 to demonstrate actuarial equivalence:

- The average coinsurance percentage for amounts between the deductible and the initial coverage limit (ICL) must be actuarially equivalent to 25 percent.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

When the plan benefit type is Basic Alternative (BA) or Enhanced Alternative (EA), five tests must be satisfied to demonstrate actuarial equivalence on Worksheet 5, Section VI, lines 1 through 5:

- The value of total coverage is at least actuarially equivalent to DS coverage.
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage.
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL.
- The deductible is not greater than the DS deductible.
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.

Base Period Experience

The experience data must be based on a calendar year 2010 incurred period with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

Worksheet 1 must be completed with data for the plan ID. Note that these data–

- Must be submitted in Worksheet 1 for all plans with experience data for 2010, regardless of the level of enrollment.
- Must reconcile in an auditable manner to the plan-level Prescription Drug Event (PDE) data submitted to CMS for payment and reconciliation and the Plan sponsor's audited financial statements. Some values may be estimated to account for unresolved events in the effort to estimate the final PDEs used in the reconciliation.
- Must be reported without adjustment. Adjustments may be made in Worksheet 2, Sections II and III to accommodate population, benefit design or other changes from the base period to the contract period.
- May be reported in aggregate for a number of plans only when there are enrollment changes associated with the dissolution of a plan and the retained members are cross-walked into existing plans in the same contract or across contracts. Each contract-plan ID must be identified in Section II, line 6.
- Must be provided for plans acquired by the Part D sponsor.
- May not be used to aggregate data from a number of plans in order to achieve credibility.
- Must be reported in total at the plan level for every contract-plan ID when plans are aggregated; do not include partial plan experience on Worksheet 1.
- May be reported on more than one bid when plans are aggregated, depending upon the mapping of enrollment.

Plan Terminations and Enrollment Shifts

The requirements for reporting base period data for plan terminations and enrollment shifts are described below.

✓ Rule 1 – Plan Termination

When a plan is terminated and the members are retained and cross-walked into an existing or new plan, the terminated plan's base period experience must be reported in Worksheet 1 of each plan into which the members are cross-walked. CMS allows data for more than one plan to be aggregated in Worksheet 1 only in this circumstance. Note that this rule applies when members are cross-walked within the same contract and when members are cross-walked between contracts.

✓ Rule 2 – Shifts in Enrollment

When enrollment shifts among plans and the base period plan is offered in the contract year, then the base period experience of the base period plan must only be reported in Worksheet 1 of the base period plan.

PRICING CONSIDERATIONS

✓ Rule 3 – Partial Experience

Base period experience must be reported in total at the plan level for every contract-plan ID; do not include partial plan experience on Worksheet 1.

Example 1

A PDP offers plans 001 and 002 in CY2010 and plans 002 and 003 in CY2012. Plan 001 terminates and the membership is cross-walked into plans 002 and 003 for CY2012. Base period experience must be reported on Worksheet 1 of the CY2012 BPT as follows:

- For plan 002, report aggregate base period experience for plans 001 and 002. (Rule 1 and Rule 3)
- For plan 003, report base period experience for plan 001. (Rule 1 and Rule 3)

Example 2

A PDP offers plans 001 and 002 in CY2010 and plans 002 and 003 in CY2012. Plan 001 terminates and the membership is cross-walked into plan 003 for CY2012. The current membership in plan 002 is expected to enroll in plan 003 in CY2012; however, plan 002 is still offered in CY2012. Base period experience must be reported on Worksheet 1 of the CY2012 BPT as follows:

- For plan 002, report base period experience for plan 002. (Rule 2 and Rule 3)
- For plan 003, report base period experience for plan 001. (Rule 1)

PRICING CONSIDERATIONS

PDE Mapping

A mapping of PDE fields to required BPT inputs is provided in the following table.

Mapping of Prescription Drug Events to Part D Claims Experience in Worksheet 1, Section III

Column	Field Name	PDE Reference Information
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administrative Fee) > Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administrative Fee)
(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

When using PDE data, actuaries must be familiar with the process by which the PDE transactions are developed from claims data and with the timing of the adjustment and deletion processes to ensure that the final transaction is accurately summarized. This includes, but is not limited to, consideration of rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments to Plan-to-Plan (P2P) transactions and, if appropriate, transfer of over-the-counter (OTC) drug data from the base period experience to the non-benefit expense component. It is important to note that a PDE maps to one script throughout the BPT regardless of the number of days for which the prescription is dispensed.

Coverage in the Gap

Under EA coverage, a Part D sponsor may reduce member cost sharing and/or provide coverage for drugs that are statutorily excluded from the definition of a Part D covered drug. One way for the Part D sponsor to reduce cost sharing is to provide partial or full coverage in the gap—that portion of DS coverage between the ICL and true out-of-pocket (TrOOP) threshold in which the cost sharing is 93 percent. While enhanced coverage in the gap is not

PRICING CONSIDERATIONS

permitted to change the TrOOP threshold of \$4,550 in CY2012, it will affect the point at which the member reaches the TrOOP threshold for catastrophic coverage. This impact must be modeled in Worksheets 5 and 6.

Credibility

Based on an application of classical credibility theory to Medicare Part D experience, CMS has established a guideline for full credibility of 12,000 base period member months. The formula for partial credibility is the square root of the result of actual base period member months divided by 12,000. This formula is a guideline; actuaries must consider the quality of the base period experience when calculating credibility. Part D sponsors may use a different credibility methodology only if the alternate method is consistently applied among all plans in the contract and is deemed acceptable by CMS.

The certifying actuary must adhere to the following rules of overriding the CMS formula for partial credibility:

- If the CMS formula for partial credibility is applied to base period member months and the resulting credibility is—
 - Less than or equal to 20 percent (that is, 480 or fewer Part D member months), then the actuary may override the computed credibility with 0 percent.
 - Greater than or equal to 90 percent (that is, 9,720 or more Part D member months), then the actuary may override the computed credibility with 100 percent.

The override is applicable only to the CMS credibility formula; it is not applicable to any alternative credibility formula. If the certifying actuary overrides the CMS credibility, then the override option must be applied consistently among all bids and cannot be applied selectively to certain bids. If the certifying actuary proposes a variation to the override, then the alternate credibility method proposal and documentation requirements apply.

When considering the credibility of plan experience, actuaries must consider ASOP No. 8, *Regulatory Filings for Health Plan Entities*.

Decreased Initial Coverage Limit

Part D sponsors that are decreasing the ICL must modify the pricing of the benefit in the BPT. Specifically:

✓ **Worksheet 6, column k, lines 1 through 8 and 19 through 27**

Enter the total cost sharing for allowed costs up to the DS ICL of \$2,840 by point-of-sale and type of drug for each line. Total cost sharing is the sum of (i) the amounts calculated based on the cost sharing structure of the alternative coverage up to the decreased ICL and (ii) 100 percent of the allowed costs between the decreased ICL and standard ICL.

Direct and Indirect Remuneration (DIR)

Part D sponsors must include all expected amounts that will be reported as DIR under “Rebate” in the BPT. The DIR reported under “Rebate” represents the Part D sponsor’s best estimate of

PRICING CONSIDERATIONS

all DIR categories and amounts that they expect to report under the Part D payment reconciliation process for the respective contract year.

Definition of Direct and Indirect Remuneration

Per 42 CFR Section 423.308, direct and indirect remuneration (DIR) comprises any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve 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 pharmacy benefit managers (PBM), even if the price concessions are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the PBM receives from the sponsor for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, Part D 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 experience 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 PDE record and therefore are not included in the DIR Report for Payment Reconciliation.

Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirements beyond allowed prescription drug costs and non-benefit expenses.

When Medicare benefits are funded by an outside source such as a state Medicaid program, the gain/loss margin must be consistent for Medicare and the other funding source.

General Enrollment Plans and Institutional/Chronic Care SNPs:

Overall Medicare margin levels for general enrollment and institutional/chronic care SNP plans are to be consistent with the Part D sponsor's corporate requirement.

Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level.

PRICING CONSIDERATIONS

The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range, not to exceed plus or minus 1.5 percent of other lines of business. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE), the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business must take into account the degree of risk or surplus requirements of the business.

The overall margin level expectations are to be consistent on a year-by-year basis. Actual organization returns are expected to vary year to year in practice, but to achieve the organization's requirement over a longer-term period (for example, 3 to 5 years).

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, not to exceed plus or minus 1.5 percent, with any variation reflecting the different levels of financial risk for the two components. The individual Part D margin of an MA-PD bid can either be the same for all plans or vary by plan in relation to the MA margin.

There is flexibility in setting gain/loss margin at the plan level provided that the overall margin meets CMS requirements, anti-competitive practices are not used, the plan offers benefit value in relation to the margin level and negative margin satisfies the requirements in this subsection.

For plans with negative margins, the Part D sponsor must develop and follow a business plan to achieve profitability. CMS expects that in subsequent years the gain/loss margin for the plan will meet or exceed the year-by-year gain/loss margin contained in the original business plan. Exceptions to the business plan requirement are cases in which multiple Part D products are offered in a given service area and the pricing reflects implicit "subsidies" across benefit or service area offerings—for example, a low benefit plan with a positive margin is paired with a rich benefit plan with a negative margin such that the combined gain/loss margin is positive and satisfies the guidance in this subsection.

Note that exceptions to the business plan requirement do not include a positive margin at the contract level or at a more aggregated level.

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.

Relationship of Margin Requirements and Non-Benefit Expenses:

The gain/loss margin 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.

PRICING CONSIDERATIONS

Impact of Health Care Reform on CY2012 Bids

See Appendix F for information concerning the provisions of the PPACA and Health Care and Education Reconciliation Act of 2010, pricing considerations and changes to the BPT for CY2012.

Non-Benefit Expenses

Non-benefit expenses are all administrative costs of operating the Medicare Prescription Drug Plan.

The non-benefit expenses must be entered separately on the BPT for the following categories:

- Marketing & Sales (for example, the cost of marketing materials, commissions, enrollment packages, identification cards, and salaries of sales and marketing staff).
- Direct Administration (for example, functions that are directly related to the administration of the Medicare Prescription Drug Plan). Examples of Direct Administration functions are as follows:
 - Customer service.
 - Billing and enrollment.
 - Claims administration.
 - True out-of-pocket (TrOOP) administration.
 - Pharmacy benefit management administration, which includes all of the costs for performing call center, claims, formulary management, network development and rebate management functions incurred by the plan or through a subcontractor.
 - Crossover fees, which are paid to obtain information from other payers to calculate TrOOP expenses.
 - Medicare Part D user fees, which are \$1.17 per-member per-year or \$0.10 per-member-per-month (pmpm) on a national basis for CY2012.
 - Uncollected enrollee premium.
 - Uncollected cost sharing, which includes plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions.
 - Medication therapy management programs.
 - Disease management functions (such as patient education and disease monitoring).
 - Over-the-counter drugs.
- Indirect Administration (for example, functions that may be considered “corporate services,” such as CEO, 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 appropriate, generally accepted accounting principles (GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that is consistent with the organization’s standard accounting practices, if not subject to GAAP).

PRICING CONSIDERATIONS

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 is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes, changes in statutory surplus, investment expenses and the cost of lobbying activities. Similarly, non-insurance revenues pertaining to investments and fee-based activities cannot be reflected in the bid. See the announcement concerning lobbying activities released via an HPMS memorandum dated October 16, 2009.

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

- Expenditures for tangible assets (for example, a new computer system must be capitalized and amortized according to relevant GAAP principles).
- Expenditures for non-tangible assets (for example, salaries and benefits must be reported in a manner consistent with the organization's internal accounting practices and the reporting of similar expenditures in other lines of business).

Non-benefit expenses that are common to offering an MA-PD must be allocated proportionately between the Medicare Advantage and Part D BPTs.

When Medicare benefits are funded by an outside source such as by a state Medicaid program, non-benefit expenses must be allocated proportionately between the Medicare revenue and the other revenue source.

Related-Party Agreements

The level of disclosure of related-party agreements must demonstrate that the operating results and financial positions for organizations participating in such agreements are not significantly different from the operating and financial arrangements that would have been achieved in the absence of the relationships.

These requirements for related-party agreements apply to a Part D sponsor that enters into any type of service agreement involving a parent company and subsidiary or between subsidiaries of a common parent. CMS requires Part D sponsors to disclose all related-party agreements at the time of bid submission and to prepare the bid in accord with the guidance below for each related-party agreement identified.

A Part D sponsor in a related-party agreement with an organization that does not have an agreement with an unrelated party must prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. A Part D sponsor in this type of agreement must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, the Part D sponsor must consider the gain/loss and non-benefit expense of the related party

PRICING CONSIDERATIONS

to be those of the sponsor. The Part D sponsor cannot allocate all administrative costs in the related-party agreement to non-benefit expense.

- Develop the gain/loss and non-benefit expense of the related-party subcontractor in accord with these Instructions.
- Support the development of the gain/loss and the actual costs associated with the non-benefit expense as required by these Instructions.

A Part D sponsor in a related-party agreement with an organization that has an agreement with an unrelated party must either (i) demonstrate that fees associated with the sponsor's related-party transaction are comparable to the fees between the related-party organization and other related parties of similar size and market position to the Part D sponsor, or (ii) prepare the BPT in a manner that does not recognize the independence of the subcontracted related party.

To demonstrate that fees associated with a related-party transaction are comparable to the fees between the related-party organization and other unrelated parties of similar size and market position, a Part D sponsor must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- Provide a written document at the time of bid submission fully explaining the manner in which the terms of one or more of the agreements between the related-party organization and other unrelated parties and the associated fees are comparable.
- Prepare the BPT in a manner that recognizes the independence of the subcontracted related party by allocating all administrative costs in the related-party agreement to non-benefit expense.

A Part D sponsor in a related-party agreement with an organization that has an agreement with an unrelated party and chooses to prepare the BPT in a manner that does not recognize the independence of the subcontracted related party must—

- Disclose the related-party agreement to CMS at the time of bid submission.
- Prepare the BPT in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the BPT, the Part D sponsor must consider the gain/loss and non-benefit expense of the related party to be those of the sponsor. The Part D sponsor cannot allocate all administrative costs in the related-party agreement to non-benefit expense.
- Develop the gain/loss and non-benefit expense of the related-party subcontractor in accord with these Instructions.
- Support the development of the gain/loss and the actual costs associated with the non-benefit expense as required by these Instructions.

To satisfy proprietary concerns, CMS can initiate separate contact with the Part D sponsor and subcontracted related party when addressing related-party issues in the bid. Part D sponsors interested in this level of discussion must request it and identify a point of contact at the related party at the time of bid submission.

PRICING CONSIDERATIONS

Regardless of the bidding approach, Part D sponsors must substantiate all information presented in the BPT pertaining to related-party agreements even when that information is held by the related party.

Non-Uniform Deductible

Part D sponsors that are implementing a deductible that is not applied consistently among all formulary tiers (for example, \$0 deductible for Tier 1 – Generics and \$310 deductible for all other tiers) must modify the pricing of the benefit in the BPT. Specifically:

✓ **Worksheet 5**

Enter “\$0” in cell D39 and F41.

✓ **Worksheet 6**

Reflect the impact of the non-uniform deductible in addition to the cost sharing required after the deductible is met in the applicable cost-sharing categories by point-of-sale and type of drug.

PBM Pricing

For CY2012, Part D sponsors must develop their Part D bids using the pass-through price or negotiated amount paid to the dispensing provider at the point-of-sale as the basis for drug costs. For Part D sponsors that are contracted with a PBM, the following provisions apply: (i) when contracted under a lock-in pricing approach, the administrative expense component of the bid must reflect the expected difference between the lock-in price, or amount negotiated with the PBM, and pass-through price (this difference is referred to as the risk premium or PBM spread) and (ii) when the PBM retains a portion of the rebates, the administrative expense component of the bid must include these costs.

Risk Score Development for CY2012

The projected CY2012 risk score must—

- Be based on the Part D RxHCC model used in payment year 2012.
- Reflect plan-specific coding trend.
- Reflect population changes.
- Reflect diagnoses missing from data.
- Be adjusted for normalization.
- Be consistent with the development of the projected pharmacy expenses.

Risk Score Definitions and Information Sources

Part D RxHCC Risk Model

The Part D RxHCC risk model was updated for CY2012. Diagnosis data from CY2008 was used to predict CY2009 expenditures; the denominator year is CY2009. Additional information on the Part D RxHCC model, including the 2012 normalization factor, is contained in the CY2012 Payment Notice.

Missing Diagnosis Adjustment Factor

The updated Part D RxHCC risk model reflects a clinical revision of the diagnoses included in Rx hierarchical condition categories (RxHCCs). The risk scores provided by CMS exclude diagnoses mapped in the new risk model to RxHCCs for which ICD-9 codes have not been collected from Plan sponsors. CMS will provide an adjustment factor for Plan sponsors to account for this missing data in the technical notes that accompany the beneficiary level files

Normalization Factor

At time of payment, the risk scores for each plan enrollee will be adjusted by the Part D normalization factor, which is 1.029 for CY2012. This adjustment accounts for the actual program risk score experience and the expected increase in coding reflected in the risk scores for the contract year versus the model calibration year. Accordingly, the projected risk scores for CY2012 bids must reflect the 1.029 normalization factor.

Risk Adjustment Information Sources

The following materials can be found under the “Medicare Advantage Rates and Statistics” page of the CMS website at

<http://www.cms.gov/MedicareAdvgtgSpecRateStats/>:

- “Advance Notice of Methodological Changes for Calendar Year (CY) 2012 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2012 Call Letter”
- “Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies”

See the links under “Risk Adjustment”, “Announcements & Documents”, and “Ratebooks & Supporting Data”.

Additional information on the risk adjustment process can be found under

<http://www.csscooperations.com/new/usergroup/traininginfo.html>

Risk Score Calculation Approaches

Preferred Methodology

The preferred method for projecting the 2012 risk scores is use of the Part D RxHCC risk scores for the risk model provided by CMS in—

- The plan-level data for the July 2010 enrollee cohort with retroactive enrollment and status adjustments, or
- The beneficiary-level file with twelve months of 2010 membership with retroactive enrollment adjustments and status adjustments.

These data are 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

PRICING CONSIDERATIONS

score data posted in HPMS are accompanied by technical notes to assist actuaries with understanding the material presented.

There are several advantages to using the 2010 Part D RxHCC risk scores in the projection of the CY2012 risk score:

- They are consistent with the base-period prescription drug expenses.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2009 dates of service submitted through January 31, 2011, which is the final reporting deadline for this period.
- They are based on the latest risk model.

Please note that since the HPMS reported scores are based on a mid-year cohort or a full calendar year data with nearly complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2010 to 2012 with explicit adjustment for the following factors, as appropriate:

- Plan-specific coding trend.
- Changes in plan population.
- Missing diagnosis data.
- Other appropriate factors.

Finally, the projected risk scores must be normalized by dividing by the 2012 Part D normalization factor.

Alternate Approaches

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2011, if there was limited enrollment in 2010, or if there were significant changes in plan or enrollment characteristics between 2010 and 2011.

If a Plan sponsor chooses to develop its risk score by using a methodology different from that preferred by CMS, then depending on the starting point, the following adjustments must be considered:

- Conversion to a raw risk score.
 - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized) risk score before making other adjustments.
- Impact of lagged versus non-lagged diagnosis data.
 - If the starting risk score is based on lagged diagnosis data, as it is when the starting point is the March 2011 MMR data (which has risk scores based on the July 2009 to June 2010 diagnosis data), then an adjustment is required to transition the scores from lagged to non-lagged.
- Run-out of diagnosis data.
 - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is MMR data or diagnosis data, then an adjustment

PRICING CONSIDERATIONS

factor is required to transition the scores from incomplete to complete diagnosis data.

- Seasonality.
 - If the starting risk score is based on membership that is other than the July cohort or a full calendar year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
 - If the starting risk scores are calculated using a risk model other than the risk model to be used for CY2012 payments, then an adjustment for the risk model change must be made. The adjustment must include accounting for diagnoses that are missing from older risk models.
- Plan-specific coding trend.
- Population changes.
- Other appropriate factors.

Once projected to CY2012, the scores must be normalized by dividing by the 2012 Part D normalization factor. Note that, if you are normalizing a nominal or actual risk score associated with a different model calibration year, the CY 2012 Part D normalization factor is not the appropriate normalization factor.

Supporting documentation that clearly demonstrates consistency with the preferred approach is required.

Manual Rating Approach

For plans that are priced using a manual rating approach, risk scores must be estimated based on the expected pharmacy expenses for their projected enrollees. Further, the risk scores for new plans must be developed in a manner consistent with the latest Part D RxHCC model.

Supporting Documentation

In addition to the BPT and actuarial certification, organizations must submit supporting documentation for every bid. See Appendix B for a description of the supporting documentation requirements, including content, quality and timing.

Types of Part D-Covered Drugs

Brand Drugs

Brand drugs consist of (i) single-source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA) and (ii) innovator multi-source drugs that were originally marketed under an original NDA and that now have generic equivalents.

Preferred/Non-Preferred Brand Drugs

Brand drugs that are placed in the most favorable position on the formulary in comparison to other similar brand drugs should be allocated to the preferred brand drug

PRICING CONSIDERATIONS

category. Brand drugs that are positioned in a less favorable position on the formulary should be allocated to the non-preferred brand category in the BPT.

Generic Drugs

Non-innovator multi-source drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately only when a plan utilizes a designated Specialty tier in the formulary and PBP in accord with CMS guidelines. The CMS guidelines require that (i) only one tier be designated a Specialty tier, (ii) only Part D-covered drugs with plan-negotiated prices greater than \$600 per month be placed in the tier, and (iii) cost sharing associated with that tier be limited to 25 percent in the initial coverage range when the plan has the standard deductible, which is \$310 for CY2012. When the plan has a decreased or no deductible, then an actuarially equivalent coinsurance is permitted.

When a designated Specialty tier is used, all drugs in that tier must be reported by point-of-sale in Worksheet 2 and Worksheet 6 of the BPT. The drugs in the Specialty tier must not be sorted by type of drug status and must not be reported as a component of the generic, preferred brand and non-preferred brand drugs in the non-Specialty tiers.

When a designated Specialty drug tier is not used in the formulary and PBP, Specialty drugs must be sorted by generic, preferred brand and non-preferred brand status and must be reported in these categories by point-of-sale. In this situation, the Specialty categories in Worksheet 2 and Worksheet 6 are not completed.

III. DATA ENTRY AND FORMULAS

This section includes line-by-line instructions for completing the Part D BPT. It also describes the formulas for calculated cells.

Prescription Drug

To complete the Part D bid form, Part D sponsors must provide a series of data entries on the appropriate BPT worksheets. The number of inputs depends on the type of plan being offered and the length of time it has had a contract with CMS, among other factors.

The Part D bid form is organized as outlined below:

- Worksheet 1 – Rx Base Period Experience
- Worksheet 2 – PDP Projection of Allowed/Non-Benefit
- Worksheet 3 – Rx Contract Period Projection for Defined Standard Coverage
- Worksheet 4 – Rx Standard Coverage with Actuarially Equivalent Cost Sharing
- Worksheet 5 – Rx Alternative Coverage
- Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage
- Worksheet 7 – Summary of Key Bid Elements

All Part D sponsors must complete Section I of Worksheet 1; completion of subsequent sections of the BPT is based on the plan benefit type being offered. The worksheets and sections that must be completed for each plan benefit type are defined below.

Defined Standard Coverage

✓ Worksheet 1

For plans with claims experience in CY2010, complete all sections; for new plans in CY2012, complete Section I.

✓ Worksheet 2

For plans with fully credible claims experience in CY2010, complete Sections II, III and V; for plans with partially credible claims experience in CY2010, complete all sections. For new plans in CY2012, complete Section IV.

✓ Worksheet 3

Complete all sections for all plans.

✓ Worksheet 6

Complete columns f, g, and h of Section II for all plans.

✓ Worksheet 7

Complete all sections for all plans.

Actuarially Equivalent Coverage

✓ **Worksheet 1**

For plans with claims experience in CY2010, complete all sections; for new plans in CY2012, complete Section I.

✓ **Worksheet 2**

For plans with fully credible claims experience in CY2010, complete Sections II, III and V; for plans with partially credible claims experience in CY2010, complete all sections. For new plans in CY2012, complete Section IV.

✓ **Worksheet 3**

Complete all sections for all plans.

✓ **Worksheet 4**

Complete all sections for all plans.

✓ **Worksheet 6**

Complete all columns of Section II for all plans.

✓ **Worksheet 7**

Complete all sections for all plans.

Basic and Enhanced Alternative Coverage

✓ **Worksheet 1**

For plans with claims experience in CY2010, complete all sections; for new plans in CY2012, complete Section I.

✓ **Worksheet 2**

For plans with fully credible claims experience in CY2010, complete Sections II, III and V; for plans with partially credible claims experience in CY2010, complete all sections. For new plans for CY2012, complete Section IV.

✓ **Worksheet 3**

Complete all sections for all plans.

✓ **Worksheet 5**

Complete all sections for all plans.

✓ **Worksheet 6**

Complete all columns of Section II for all plans.

✓ **Worksheet 7**

Complete all sections for all plans.

DATA ENTRY & FORMULAS

Data Entry

Do not leave a field blank to indicate a zero amount. If zero is the intended value, then enter a "0" in the cell.

PD WORKSHEET 1 – RX BASE PERIOD EXPERIENCE

Worksheet 1 contains general information about the plan and summarizes the base period Rx experience. Specifically, Section I collects general information about the plan that is displayed on all Part D BPT worksheets. Section II collects base period background information; Section III summarizes the base period Rx experience. Sections IV and V summarize components of the base period non-benefit expense and premium revenue, respectively. Section VI is an Income Statement Summary.

Section I must be fully completed for all plans. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2010 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the “General” format in Excel to support the link functionality to other spreadsheets. Therefore, certain numeric fields, such as Plan ID, Segment ID and Region Number, must be entered as text—that is, using a preceding apostrophe—and must include any leading zeros.

Line 1 – Contract Number

Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional Preferred Provider Organization plan), or S (Prescription Drug Plan) and includes four Arabic numerals (for example, H9999, R9999, S9999). Include all leading zeros (for example, H0001).

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the PBP being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input and must include any leading zeros.

Line 3 – Segment ID

If the bid is for a “service area segment” of a local plan, enter the segment ID. This field must be entered as a text input and must include any leading zeros.

Line 4 – Contract Year

The cell is pre-populated with the calendar year to which the contract applies.

Line 5 – Organization Name

Enter the organization’s legal entity name. This information also appears in HPMS and in the PBP.

Line 6 – SNP

If the plan is a Special Needs Plan (SNP), enter “Y”. Otherwise, enter “N”.

WORKSHEET 1

Line 7 – Plan Name

Enter the name of the PBP. This information also appears in HPMS.

Line 8 – Plan Type

Enter the type of Part D plan. The valid options are listed in the table below.

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMO POS
HMO with a POS Option	HMO POS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
Regional Coordinated Care Plan:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Employer/Union-Only Direct Contract PFFS	ED PFFS
Prescription Drug Plans:	
Medicare Prescription Drug Plan (PDP)	PDP
Fallback Plan	Fallback
Demonstration Plans:	
Continuing Care Retirement Community (CCRC)	CCRC
National PACE	PACE
End-Stage Renal Disease (ESRD) I	ESRD I
ESRD II	ESRD II
1876 Cost	1876 Cost
1833 Cost	1833 Cost

Line 9 – Enrollee Type

If the plan covers enrollees eligible for both Part A and Part B of Medicare, enter “A/B”. If the plan covers enrollees eligible for Part B only, enter “Part B Only”. When the plan type is “PDP” or “Fallback”, then the enrollee type cell is white and locked; no input is required.

Line 10 – PD Region

Enter the region number of the region the plan will cover. This field must be entered as a text input and must include any leading zeros.

WORKSHEET 1

The valid entries are shown in the following table:

Region	Description
01	Maine and New Hampshire
02	Connecticut, Massachusetts, Rhode Island and Vermont
03	New York
04	New Jersey
05	Delaware, District of Columbia and Maryland
06	Pennsylvania and West Virginia
07	Virginia
08	North Carolina
09	South Carolina
10	Georgia
11	Florida
12	Alabama and Tennessee
13	Michigan
14	Ohio
15	Indiana and Kentucky
16	Wisconsin
17	Illinois
18	Missouri

Region	Description
19	Arkansas
20	Mississippi
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 coverage in the PBP. The valid options are “DS” for Defined Standard, “AE” for Actuarially Equivalent, “BA” for Basic Alternative and “EA” for Enhanced Alternative.

SECTION II – BASE PERIOD BACKGROUND INFORMATION

Line 1 – Time Period Definition

Enter the incurred dates of the base period data on the first two lines and the paid through date on the third line. For example, if the data reflect claims paid through February 2011, then the paid through date is 2/28/2011.

Line 2a – Total Member Months

Enter the total member months represented in the base period experience based on CMS eligibility records.

Line 2b – LIS Member Months

Enter the number of low-income subsidy (LIS) member months represented in the base period experience based on CMS eligibility records.

Line 3 – Risk Score

Enter the normalized risk score, estimated to three decimal places, for the population represented in the base period data using the Part D RxHCC risk model that was in place for the payment year.

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

Enter the option that corresponds to the network pricing that was in effect in the base period. The valid options are “pass-through” or “lock-in”.

Line 6 – Mapping

Enter the contract and plan ID (in the format H9999-999) of the plan reported in Section III in the first column. With the exception of plan ID changes and/or plan mergers, CMS expects that the contract and plan ID for the base period experience will be the same as that shown in Section I. Enter the corresponding number of member months in the second column.

Line 7 – Base Period Experience Description

Use the text box to briefly describe the base period data reported in Section III.

SECTION III – PART D CLAIMS EXPERIENCE

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

Lines 1 through 5:

✓ **Column d – Number of Members**

Enter the number of members with total allowed claims in the allowed claim interval defined for each line. For example, if 7,000 members had total allowed claims between \$296 and \$2,700, then enter “7,000” in line 3, column d.

✓ **Column e – Member Months**

Enter the number of member months associated with the number of members in column d for each line.

✓ **Column f – Total Number of Scripts**

Enter the number of prescriptions filled for Part D-covered drugs for the members in column d for each line.

WORKSHEET 1

✓ **Column g – Total Allowed Dollars**

Enter the total allowed dollars for the prescriptions filled for the members in column d for each line. Total allowed dollars are defined as ingredient cost plus dispensing fee, plus sales tax where applicable, plus the vaccine administration fees, prior to the application of any rebates recovered after the point-of-sale.

✓ **Column h – Average Allowed Amount per Member**

The value is calculated automatically in the BPT as column g divided by column d for each line.

✓ **Column i – Average Paid Amount per Member**

Enter the result of dividing the total dollars paid by the plan for the members in column d by the number of members in column d. Total paid dollars are defined as basic and supplemental payments for Part D-covered drugs and are not net of rebates, low-income subsidy payments or federal reinsurance.

✓ **Column j – Average Cost Sharing per Member**

Enter the average cost sharing per member for Part D-covered drugs for the members in column d for each line.

✓ **Column k – Supplemental Cost-Sharing Reduction per Member**

Enter the average value of supplemental cost sharing per member for Part D-covered drugs for members in column d for each line.

✓ **Column l – Reimbursement for Low-Income Cost-Sharing Subsidy per Member**

Enter the average low-income cost-sharing subsidy amount received and receivable for the members in column d for each line.

✓ **Column m – Reimbursement for Federal Reinsurance per Member**

Enter the average federal reinsurance amount received and receivable for the members in column d for each line.

✓ **Column n – Net Plan Responsibility per Member**

The value is calculated automatically in the BPT as column i minus the sum of columns j through m for each line.

Line 6, columns d through n – Subtotal

The values are calculated automatically in the BPT as the sum of lines 1 through 5 for columns d through g and as the weighted average based on the number of members in column d of lines 1 through 5 for columns h through n.

Line 7 – Percentage OON

✓ **Column g**

Enter the percentage of total allowed dollars in line 6 for prescriptions filled at out-of-network (OON) pharmacies.

✓ **Column i**

Enter the percentage of average paid dollars in line 6 for prescriptions filled at OON pharmacies.

✓ **Column j**

Enter the percentage of average cost sharing per member in line 6 for prescriptions filled at OON pharmacies.

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

They are calculated automatically by the BPT as the result of the subtotal of the column in line 6 divided by the number of member months in column d.

Line 9 – Minus Rebates

✓ **Column g**

Enter the total amount of rebates received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction and must be allocated to the plan using a methodology that represents the manner in which the rebates were generated.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter the amount of rebates attributable to the federal reinsurance amount in line 6.

✓ **Column n**

The value is calculated automatically in the BPT as column i minus the sum of columns k through m.

Line 10 – Plus Part D as Secondary

✓ **Column g**

Enter the total amount of payments for Part D-covered drugs for which the Part D plan is the secondary payer.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column n**

The value is calculated automatically in the BPT as column i minus the sum of columns k through m.

Line 11, columns i and k through n – Net Average Paid Amount PMPM

The values are calculated automatically in the BPT as line 8 minus line 9 plus line 10.

Line 12 – Non-Covered Supplemental Drugs

✓ **Column g**

Enter the total amount of claims for prescription drugs that are covered by the plan but are not Part D-covered drugs.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

Line 13, column i – Rebates on Supplemental Drugs

Enter the total amount of rebates received for the claims in line 12. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction and must be allocated to the plan using a methodology that represents the manner in which the rebates were generated.

Line 14, columns l and n – Net PMPM on Supplemental Drugs

The value in column i is calculated automatically in the BPT as line 40 minus line 41 and is carried to column n.

SECTION IV – PMPM NON-BENEFIT EXPENSES

Section IV summarizes all administrative expenses associated with the operation of the prescription drug plan in the base period, including any expenses that were offset by direct or indirect remuneration.

Lines 1 through 4, column e – Basic

Enter the sales and marketing, direct administration, indirect administration and net cost of private reinsurance average pmpm amounts for basic coverage on lines 1 through 4, respectively. Include uncollected enrollee premium, uncollected cost sharing and OTC drugs in direct administration.

Lines 1 through 4, column f – Supplemental

Enter the sales and marketing, direct administration, indirect administration and net cost of private reinsurance average pmpm amounts for supplemental coverage on lines 1 through 4, respectively.

Lines 1 through 4, column g and line 5 – Total Non-Benefit Expenses

The values are calculated automatically in the BPT as the sums of columns e and f.

SECTION V – PMPM PREMIUM REVENUE

Section V summarizes the components of premium revenue of the prescription drug plan for the base period.

WORKSHEET 1

Lines 1 through 4, column e – Basic

Enter the CMS Part D direct subsidy payment, low-income premium subsidy, member premium and member penalty premium average pmpm amounts for basic coverage on lines 1 through 4, respectively. The direct subsidy amount must account for the final risk-adjusted reconciliation payment for CY2010 which will be received in mid-2011.

Line 3, column f – Supplemental

Enter the member premium average pmpm amount for supplemental coverage on line 3.

Lines 1 through 4, column g and line 5 – Total Premium

The values are calculated automatically in the BPT as the sums of columns e and f.

SECTION VI – PMPM INCOME STATEMENT SUMMARY

Section VI is a summary of the prescription drug plan's income, including the amount of MA rebate allocable to Part D when applicable, for the base period.

Lines 1 through 9, column m

Enter in line 4 the average pmpm amount of the MA rebate dollars used to buy down the Part D premium in line 4. The values in lines 1 through 3 and lines 5 through 9 are carried from other sections in Worksheet 1 or are calculated automatically in the BPT as sums or differences in column m.

PD WORKSHEET 2 – PDP PROJECTION OF ALLOWED/NON-BENEFIT

Worksheet 2 projects the base period experience to the contract year, blending with a manual rate when the base period experience is not fully credible, by point-of-sale and type of drug. Specifically, Section I displays general information about the plan. Sections II and III summarize the base period and contract period utilization per 1,000 members and allowed costs per script and the components of utilization and cost trends. Section IV blends the projected allowed costs with a manual rate based on the plan's credibility. Section V summarizes the components of non-benefit expense in the base and contract periods. Section VI is a text box for entering a description of the development of the manual rate.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – UTILIZATION FOR COVERED PART D DRUGS

Lines 1 through 8 – Base Period

✓ **Column e – Number of Scripts/1000**

Enter the number of prescriptions that were filled in the base period, expressed as annual prescriptions per 1,000 members, by point-of-sale (retail or mail order) and type of drug (generic, preferred brand, non-preferred brand or Specialty) for each line.

✓ **Column f – Allowed per Script**

Enter the average allowed amount per script by type of script filled in the base period for each line. Allowed amount is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable, plus the vaccine administration fee, prior to the application of any rebates recovered after the point-of-sale.

✓ **Column g – PMPM**

The value is calculated automatically in the BPT as column e times column f divided by 12,000 for each line.

Lines 1 through 8 – Components of Utilization Change

✓ **Column h – Trend in Scripts/1,000**

Enter the utilization trend factor by type of script to project scripts/1,000 to the contract period for each line.

✓ **Column i – Formulary Change**

Enter the factor that represents the impact on utilization of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

✓ **Column j – Risk Change**

Enter the factor that represents the impact on utilization of the covered population's change in risk from the base period to the contract period by type of script for each line.

✓ **Column k – Induced Utilization**

Enter the factor that adjusts for the utilization difference between the base period type of benefit plan (DS, AE, BA or EA) and a DS plan by type of script for each line.

✓ **Column l – Other Change**

Enter the factor that represents the impact on utilization of any differences between the base period and contract period not included in the other components of utilization change, columns h through k, by type of script for each line.

✓ **Column m – Total Utilization Change**

The value is calculated automatically in the BPT as the product of columns h through l for each line.

Lines 1 through 8, column n – Projected Scripts/1000

The value is calculated automatically in the BPT as the product of columns e and m for each line.

Lines 1 through 8, column o – Covariance

The value is calculated automatically in the BPT as projected allowed pmpm divided by the product of base period allowed pmpm times total utilization change times total unit cost change for each line.

Lines 9 through 14, columns e through o

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION III – COST FOR COVERED PART D DRUGS

Lines 1 through 8 – Components of Unit Cost Change

✓ **Column e – Inflation Trend**

Enter the factor that represents the impact on cost between the base period and contract period because of changes in drug prices by type of script for each line.

✓ **Column f – Discount Change**

Enter the factor that represents the impact on cost between the base period and contract period because of changes in point-of-sale network pricing, including discounts off of average wholesale price (AWP) and dispensing fees, by type of script for each line.

✓ **Column g – Formulary Change**

Enter the factor that represents the impact on cost because of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

✓ **Column h – Other Change**

Enter the factor that represents the impact on cost of any differences between the base period and contract period not included in the other components of unit cost change, columns e through j, by type of script for each line.

✓ **Column i – Total Unit Cost Change**

The value is calculated automatically in the BPT as the product of columns e through h by type of script for each line.

Lines 1 through 8, column j – Projected Unit Cost

The value is calculated automatically in the BPT as the product of base period allowed per script times total unit cost change for each line.

Lines 1 through 8, column k – Projected Allowed PMPM

The value is calculated automatically in the BPT as scripts/1,000 times projected unit cost divided by 12,000 for each line.

Lines 9 through 14, columns e through k

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION IV – PROJECTED ALLOWED PMPM

Lines 1 through 8

✓ **Column l – Manual Utilization/1,000**

When the base period experience is not fully credible, enter the projected utilization per 1,000 members, based on a fully credible manual rate, by type of script for each line.

✓ **Column m – Manual Unit Cost**

When the base period experience is not fully credible, enter the projected unit cost per script, based on a fully credible manual rate, by type of script for each line.

✓ **Column n – Manual Rate PMPM**

The value is calculated automatically in the BPT as column l times column m divided by 12,000 by type of script for each line.

✓ **Column o – Credibility**

Enter the credibility percentage by point-of-sale and type of drug that is applied to the projected pmpm allowed amount in Section IV and blended with the pmpm manual rate to calculate the blended pmpm allowed amount for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

✓ **Column p – Blended Allowed PMPM**

The value is calculated automatically in the BPT as the sum of (column o times column k) and [(1 minus column o) times column n] for each line.

Lines 9 through 14, columns l through p

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column. Cell O57, CMS Guideline Credibility is calculated automatically in the BPT as the square root of total member months from Worksheet 1 divided by 12,000, not to exceed 100 percent.

SECTION V – PMPM NON-BENEFIT EXPENSE

Section V summarizes the components of non-benefit expenses in the base period, applies trends and blends with manual rate non-benefit expenses to project administrative expenses in the contract period.

Lines 1 through 4

✓ **Column e – Base Period**

The value is carried from Worksheet 1, Section IV for each line.

✓ **Column f – Trend**

When the values in column e are greater than \$0.00, enter the expected trend in non-benefit expenses from the base to the contract period.

✓ **Column g – Contract Period**

The value is calculated automatically in the BPT as column e times column f for each line.

✓ **Column h – Manual Rate Expense**

When the base period non-benefit expenses are not fully credible, enter the projected non-benefit expense by component based on a fully credible source for each line.

✓ **Column i – Credibility**

Enter the credibility percentage by non-benefit expense component that is applied to projected pmpm non-benefit expenses and blended with pmpm manual rate expenses to calculate blended pmpm expenses for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

✓ Column j – Blended Non-Benefit Expense

The value is calculated automatically in the BPT as the sum of (column g times column i) and [(1 minus column g) times column h] for each line.

Line 5, columns e, g and j – Total Non-Benefit Expenses

The values are calculated automatically in the BPT using information entered on lines 1 through 4 for each column.

SECTION VI – DEVELOPMENT OF MANUAL RATE

Provide a description of the source of the experience data used as the basis for the manual rate, as well as other relevant information including, but not limited to, benefit design, group size, group characteristics, utilization trends, pricing methodology, formulary changes, induction and risk assumptions.

PD WORKSHEET 3 – CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

Worksheet 3 develops the defined standard bid amount. Specifically, Section I displays general information about the plan. Section II collects contract period information; Section III summarizes the contract period Rx experience. Sections IV and V summarize components of the contract period non-benefit expenses and gain/loss margin and components of the defined standard bid amount, respectively.

Sections II through V must be completed by all plans.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

Line 1 – Projected Member Months

The value is carried from Section III, line 6, column e. For an MA-PD, Part D projected member months are the sum of projected member months for MA, ESRD and hospice members.

Line 2 – Projected Average Risk Score

Enter the estimated average Rx risk score for the population expected to enroll in the contract period. Refer to the topic “Risk Scores” in the “Pricing Considerations” section of the Instructions for information concerning the development of the CY2012 risk score.

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

Enter the estimated number of member months for enrollees who will qualify for and obtain LIS status in the contract period.

SECTION III – PART D COVERED DRUG CLAIMS

The projection of contract period Rx experience must reflect the risk score entered in Section II, line 2.

Lines 1 through 5:

✓ Column d – Number of Members

Enter the number of members expected to have total allowed claims in the allowed claim interval defined for each line. For example, if 6,500 members are expected to have total allowed claims between \$310 and \$2,839, then enter “6,500” on line 3, column d. Do not include estimates for claims for which the Part D plan is the secondary payer.

✓ **Column e – Member Months**

Enter the number of member months expected in the contract period associated with the number of members in column d for each line.

✓ **Column h – Average Amount Allowed PMPM**

The value is calculated automatically in the BPT as column g divided by column d for each line.

✓ **Column n – Plan Liability PMPM**

The value is calculated automatically in the BPT as column h minus the sum of columns j through m for each line.

Lines 2 through 5

✓ **Column f – Number of Scripts**

Enter the estimated total number of prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line.

✓ **Column g – Projected Allowed Amount**

Enter the estimated total allowed dollars for prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line. Total allowed dollars must reflect the price paid to the dispensing provider at the point-of-sale and must be net of point-of-sale rebates and price concessions.

✓ **Column i – Cost Sharing**

The value is calculated automatically in the BPT as the sum of columns j through l for each line.

✓ **Column k – PMPM Deductible**

Enter the projected pmpm value of the deductible for the members in column d for each line.

✓ **Column l – Other Cost Sharing PMPM**

Enter the projected pmpm value of the 25 percent cost sharing between the deductible and ICL and the catastrophic coinsurance above the catastrophic limit for the members in column d for each line.

✓ **Column o – Federal LIS Cost Sharing PMPM**

Enter the projected amount of low-income cost sharing subsidy that will be received for the members in column d who are LIS-eligible divided by the total projected member months entered in Section II, line 1 for each line. Reflect the impact of generic gap coverage in these amounts.

Lines 4 through 5, column j – GAP PMPM

Enter the projected pmpm value corresponding to amounts between the ICL and catastrophic limit for members in column d for each line.

Line 5, column m – Federal Reinsurance PMPM

Enter the projected amount of federal reinsurance that will be received for the members in column d divided by the total projected member months entered in Section II, line 1 for each line. Reflect the impact of generic gap coverage in this amount.

Line 6 – Subtotal

The value is calculated automatically in the BPT as the sum of lines 1 through 5 for each column.

Generics in Gap PMPM

Enter the projected pmpm amount of the Gap PMPM from line 6, column j attributable to generic coverage in the gap in cell J26.

Line 7 – Minus Rebates

✓ **Column g**

Enter the estimated total amount of rebates expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction and must be allocated to the plan using a methodology that represents the manner in which the rebates were generated. Point-of-sale rebates reported in “Column g – Projected Allowed Amount” are not reported here.

✓ **Column h**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Columns m and n**

The value in column h is allocated automatically to columns m and n in the BPT based on the relative amount of federal reinsurance to the total allowed amount.

Line 8 – Minus Other Insurance

✓ **Column g**

Enter, as a positive value, the projected total reduction to the total allowed amount attributable to other Rx insurance.

✓ **Column h**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter, as a positive value, the projected pmpm reduction to federal reinsurance attributable to other Rx insurance.

✓ **Column n**

The value is calculated automatically in the BPT as column h minus column m.

Line 9 – Plus Part D as Secondary

✓ **Column g**

Enter, as a positive value, the projected total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer.

✓ **Column h**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter, as a positive value, the projected pmpm plan liability for Part D-covered drugs attributable to federal reinsurance for which the Part D plan is the secondary payer.

✓ **Column n**

The value is calculated automatically in the BPT as column h minus column m.

Line 10 – Projected Percentage Out-of-Network (OON) Allowed

Enter the percentage of line 6, column g of projected allowed dollars for prescriptions that will be filled OON.

Line 11 – Projected Percentage Out-of-Network (OON) Plan Liability

Enter the percentage of line 6, column n of projected Part D plan liability for prescriptions that will be filled OON.

Line 12, columns g through o – Total

The values are automatically calculated in the BPT as line 6 minus line 7 minus line 8 plus line 9 for each column.

SECTION IV – PMPM NON-BENEFIT EXPENSE AND GAIN/LOSS

Section IV summarizes components of the contract period non-benefit expenses and gain/loss margin.

Lines 1 through 5

The values are carried from other worksheets or are calculated automatically in the BPT.

Line 6 – Total Gain/loss

Enter the estimated pmpm amount of gain or loss projected during the contract period.

SECTION V – DEFINED STANDARD COVERAGE BID DEVELOPMENT

Section V summarizes the components of the defined standard bid amount.

WORKSHEET 3

Lines 1 through 5, columns i and j

The values are carried from other sections in Worksheet 3 or are calculated automatically in the BPT as sums or quotients.

PD WORKSHEET 4 – STANDARD COVERAGE WITH ACTUARIALLY EQUIVALENT COST SHARING

Worksheet 4 must be completed when the plan benefit type is actuarially equivalent. The two tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The average coinsurance percentage for amounts between the deductible and the ICL must be actuarially equivalent to 25 percent; and
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

Considerations for Actuarially Equivalent Coverage

Although the average cost sharing between the deductible and ICL must be 25 percent for an AE plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, AE plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization. As a result of these favorable shifts, AE bids have lower costs under the ICL and in the catastrophic phase of the benefit than do DS bids.

Part D sponsors must model the differences between the AE benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale in Worksheet 6. The distribution of utilization between generic and brand, and between 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 DS bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an AE plan with a zero-dollar generic cost share.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS AND TESTS FOR ACTUARIAL EQUIVALENCE

Lines 1 through 3 and 5 through 14, columns e, h, and k

The values are carried from other worksheets in the BPT.

Line 4 – Allowed PMPM

✓ **Column e – Amounts below the Initial Coverage Limit**

Enter the projected average allowed amount pmpm below the ICL.

✓ **Column h – Amounts above Catastrophic Threshold**

Enter the projected average allowed amount pmpm above the catastrophic threshold.

Line 15 – Rebates

✓ **Column k**

Enter the estimated total amount of rebates expected to be received by the plan.

✓ **Column h**

The value is calculated automatically in the BPT and is prorated for reinsurance.

Lines 16 and 17 – Tests for Actuarial Equivalence

The two actuarial equivalence tests are applied to certain values in Section IV to determine whether the proposed benefit plan qualifies as standard coverage with actuarially equivalent cost sharing.

SECTION V – STANDARD COVERAGE BID DEVELOPMENT WITH ACTUARIALLY EQUIVALENT COST SHARING

Lines 1 through 5

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 6 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

PD WORKSHEET 5 – ALTERNATIVE COVERAGE

Worksheet 5 must be completed when the plan benefit type is basic alternative or enhanced alternative. The five tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The value of total coverage is at least actuarially equivalent to DS coverage;
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage;
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL;
- The deductible is not greater than the DS deductible; and
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.

Considerations for Basic Alternative and Enhanced Alternative Coverage

Although the average cost sharing between the deductible and ICL must be 25 percent for a BA or EA plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, BA and EA plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization. As a result of these favorable shifts, BA and EA bids have lower costs under the ICL and in the catastrophic phase of the benefit than do DS bids.

Part D sponsors must model the differences between the BA or EA benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale 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 DS bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in a BA or EA plan with a zero-dollar generic cost share.

BA and EA plans may reduce the value of the deductible. This action may in turn reduce the risk profile of the group and cause induced utilization.

BA and EA plans may provide additional coverage in the gap. Since the value of coverage up to the ICL must remain the same relative to the DS, a supplemental premium will result unless the cost of the additional coverage is offset by savings in catastrophic coverage.

Additional coverage in the gap can delay the point at which a beneficiary achieves \$4,550 of true out-of-pocket (TrOOP) costs and reaches catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, cause induced utilization and increase the risk profile of the group. Members with extremely high spending will not benefit as much as those with moderate amounts of spending.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS

Lines 1 through 3

✓ **Columns f, g and m**

The values are carried from Worksheet 3 in the BPT.

✓ **Columns i and o**

The values are calculated automatically in the BPT as column f plus column g.

Type of Deductible

Enter the type of deductible consistent with the description in the PBP for the alternative coverage. The valid options are “no deductible”, “applies to all tiers” or “applies to some tiers”.

Alternative Coverage ICL

Enter the ICL consistent with the description in the PBP for the alternative coverage.

Type of Gap Coverage

Enter the type of gap coverage consistent with the description in the PBP for the alternative coverage. The valid options are “no coverage”, “full coverage”, “partial – generics only”, “partial – increased ICL”, or “partial – other”.

Lines 4 through 24

The values in columns d through o include Part D-covered drugs only; the values in column q include non-Part D-covered drugs only. The values are carried from other worksheets or are calculated automatically in the BPT, with the exception of the following, which must be entered:

✓ **Line 5, column k – Amounts in Gap**

Enter the projected average allowed amount pmpm in the coverage gap.

✓ **Line 5, column m – Amounts above Catastrophic**

Enter the projected average allowed amount pmpm above the catastrophic limit.

✓ **Line 6, column d – Proposed Deductible**

Enter the dollar value of the deductible consistent with the description in the PBP.

✓ **Line 8, column f – Value of Proposed Deductible**

Enter the projected pmpm value of the deductible for members with total allowed amount less than the ICL. Refer to the topic “Non-Uniform Deductible” in the “Pricing Considerations” section of the Instructions for more information.

✓ **Line 12, column k – Coinsurance Percentage in Gap**

Enter the effective coinsurance percentage for any coverage provided in the gap, including coverage because of variations in the ICL.

✓ **Line 18, column o – Minus Rebates**

Enter the estimated total rebates pmpm expected to be received for Part D-covered drugs.

✓ **Line 18, column q – Minus Rebates**

Enter the estimated total rebates pmpm expected to be received for non-Part D-covered drugs.

✓ **Line 20, columns m, o and q – Minus Other Insurance**

Enter, as a positive value, the projected reduction to average allowed amount pmpm attributable to other Rx insurance for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

✓ **Line 22, columns m, o, and q – Plus Part D as Secondary**

Enter, as a positive value, the projected plan liability pmpm for which the Part D plan is the secondary payer for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

SECTION V – DEVELOPMENT OF ACTUARIAL EQUIVALENT TEST

Lines 1 through 8

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan’s risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 9 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

SECTION VI – TESTS FOR ALTERNATIVE COVERAGE

This section applies the five actuarial equivalence tests to certain values in Sections III through V to determine whether the proposed benefit plan qualifies as alternative coverage.

SECTION VII – DEVELOPMENT OF SUPPLEMENTAL PREMIUM

Lines 1 through 5 and 8

The values are calculated automatically by the BPT from values in Worksheet 5.

Line 6 – Additional Non-Benefit Expenses

The value is carried from Worksheet 3.

Line 7 – Additional Gain/loss

The value is carried from Worksheet 3.

SECTION VIII – DEVELOPMENT OF INDUCED UTILIZATION ADJUSTMENT

This section summarizes the additional costs of DS coverage with respect to the enhanced alternative plan with supplemental benefits and is used to adjust allowable costs for risk corridor payments.

Line 2 – Impact of Alternative Utilization on Standard Benefit

Enter the additional costs for Part D-covered drugs under a DS plan in the first column if the utilization of the EA plan was used to price the DS coverage in the bid. The adjustment applies to the EA plan type and must be a positive value. For CY2012, this amount represents 75 percent of costs between the \$310 deductible and the \$2,840 ICL, plus 15 percent of costs in excess catastrophic coverage.

PD WORKSHEET 6 – SCRIPT PROJECTIONS FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6 summarizes drug utilization and costs by type of drug and in different distributions of drug spending. In addition, Worksheet 6 illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

Considerations

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, non-uniform deductible, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS 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.

Part D sponsors must model the impact of the alternative benefit compared to the DS by making adjustments in utilization and average script pricing in Worksheet 6. The distributions must be based on the intervals defined for DS coverage. For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 9 must reflect the utilization for the AE, BA or EA plan for members expected to have less than the DS ICL of \$2,840 in CY2012. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.

Refer to the “Pricing Considerations” section of the Instructions for information on modeling the impact of coverage in the gap, decreased ICL and non-uniform deductible.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTIONS FOR EQUIVALENCE TESTS

Data are collected for four levels of allowed costs on lines 1 through 36. The distribution of the population and Part D covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the deductible, coverage gap and LIS subsidy. To model column h,

use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 8 – Population Not Exceeding Allowed Costs of \$2,840 with Standard Coverage

All utilization for members with projected total allowed costs less than \$2,840 must be reported on these lines.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost-sharing structure of the DS plan by point-of-sale and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost sharing structure of the AE, BA or EA plan by point-of-sale and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 9, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 1 through 8 for each column.

Lines 10 through 17 – Population Exceeding Allowed Costs of \$2,840 with Standard Coverage

All utilization for members with projected total allowed costs greater than or equal to \$2,840 must be reported on these lines.

✓ **Columns f and g – Defined Standard Coverage**

Enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale and type of drug in columns f and g, respectively, for each line.

✓ **Columns i and j – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale and type of drug in columns i and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 18, columns f, g, i and j – Total

The values are calculated automatically in the BPT as the sum of lines 10 through 17 for each column.

Lines 19 through 26 – Population Exceeding \$2,840 with Standard Coverage Amounts Allocated up to ICL

All utilization for total allowed costs up to \$2,840 for members with projected total allowed costs greater than or equal to \$2,840 must be reported on these lines. These amounts are a subset of the amounts reported in lines 10 through 18; amounts in the gap are intentionally excluded.

✓ Columns f through h – Defined Standard Coverage

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts allocated up to the ICL of \$2,840 in CY2012, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost sharing structure of the DS plan by point-of-sale and type of drug, in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

✓ Columns i through k – Actuarially Equivalent or Alternative Benefits

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts allocated up to the ICL, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale and type of drug, in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 27, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 19 through 26 for each column.

Lines 28 through 35, columns f through k – Amounts Allocated over Catastrophic Coverage

The amounts in these lines are a subset of the amounts reported in lines 10 through 18.

✓ Columns f through h – Defined Standard Coverage

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the DS plan by point-of-sale and type of drug, in columns f, g and h, respectively, for each line.

✓ Columns i through k – Actuarially Equivalent or Alternative Benefits

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale and type of drug, in columns i, j

and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 36, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 28 through 35 for each column.

Line 37, columns i through k – Non-Part D-Covered Drugs All Spending

When the plan benefit type is EA and the plan covers non-Part D drugs, enter the projected total number of scripts, total allowed dollars and total cost sharing, for the population identified in Worksheet 3, Section III, using the cost-sharing structure of the EA plan by point-of-sale and type of drug, in columns i, j and k, respectively, for each line.

Example

Below is an example of how lines 10 through 36 are to be completed. It is based on the CY2008 defined standard benefit parameters:

- Deductible: \$275.00
- ICL: \$2,510.00
- OOP Threshold: \$4,050.00
- Total Covered Part D Drug Spend at OOP Threshold: \$5,726.25

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 used only when the Part D sponsor places Specialty drugs on a separate tier in accord with CMS guidelines.

Network Pricing

Enter the projected average percentage discount off of AWP and the projected average dispensing fees for generic, brand and Specialty drugs dispensed at retail and mail.

The values in this section must be based on the network pricing contracts that will be effective in CY2012 and on the projected weighted utilization by pharmacy of the population identified in Worksheet 3.

PD WORKSHEET 7 – SUMMARY OF KEY BID ELEMENTS

Worksheet 7 summarizes key payment-related components of the bid and the Part D sponsor's estimate of the national average monthly bid amount and calculates premiums.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – 2012 DEFINED STANDARD BENEFIT PARAMETERS

Line 1 – Deductible

The cell is pre-populated with the deductible for the DS plan benefit type.

Line 2 – Initial Coverage Limit

The cell is pre-populated with the ICL for the DS plan benefit type.

Line 3 – Out-of-Pocket Limit

The cell is pre-populated with the OOP for the DS plan benefit type.

SECTION III – SUMMARY OF KEY BID ELEMENTS

Line 1 – Standardized Part D Bid

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 2 – National Average Monthly Bid Amount (NAMBA)

Enter the Part D sponsor's estimate of the national average monthly bid amount at the time of bid submission. The final national average monthly bid amount for CY2012 will be calculated and published by CMS in early August 2011.

Line 3 – Base Beneficiary Premium (BBP)

Enter the Part D sponsor's estimate of the base beneficiary premium amount. The national average monthly bid amount, basic Part D A/B rebate allocation reported on the MA BPT for MA plans and base beneficiary premium will determine the plan's basic Part D target premium.

Lines 4 and 5 – Basic Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT. Line 4 is calculated as line 1 minus line 2 plus line 3. Line 5 reflects the value of the basic Part D premium from line 4 after the rounding rule selected on line 8 of this section has been applied. If the basic Part D premium is negative and the plan benefit type is DS, AE or BA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP. If the plan benefit type is EA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP or fully offset the negative basic

premium with a supplemental Part D premium. The basic Part D premium, before and after the rounding rule is applied, will be updated based on the actual national average monthly bid amount and base beneficiary premium that are calculated and published by CMS in early August.

Lines 6 and 7 – Supplemental Part D Premium (prior to A/B Rebate Reallocation)

The values are calculated automatically in the BPT when supplemental benefits are offered. Line 6 is carried from Worksheet 5 of the BPT. Line 7 reflects the value of the supplemental Part D premium from line 6 after the rounding rule selected on line 8 of this section has been applied.

Line 8 – Prospective Federal Reinsurance (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 9 – Prospective Low-income Cost-Sharing Subsidy (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 10 – Target Adjustment (Allowed Costs as a Ratio of Bid)

The target adjustment is the administrative cost percentage of the bid and it is used in calculating the target amount for risk corridor payments. The value is calculated as—
[(1.00 – administration cost percentage) X (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount)]

Line 11 – Rounding Rule

Select the option from the drop-down box that corresponds to the preferred method for rounding the Part D premium. The valid options are \$0.10 and \$0.50; the default is \$0.10. MA-PD plans are required to round to the nearest \$0.10; Part D plans are permitted to round to either the nearest \$0.10 or nearest \$0.50.

SECTION IV – PART D BID PRICING TOOL CONTACTS AND DATE PREPARED

Part D sponsors must identify three persons as plan bid contact, Part D certifying actuary and additional Part D BPT contact. The Part D certifying actuary and additional Part D BPT contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number and e-mail information for all three contacts; credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

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 desk review process, then this date field must be updated accordingly.

SECTION V – WORKING MODEL TEXT BOX

This section contains multiple cells that may be used by bid preparers to enter internal notes—for example, to facilitate communication between BPT and PBP preparers or to track internal version schemes.

Section V will be deleted from the finalized file and therefore will not be uploaded to HPMS. Bid preparers must not enter information in this section meant to be communicated to CMS or to CMS reviewers, as CMS will not have access to it. Section V will not be deleted from the working file or the backup file during finalization.

IV. APPENDICES

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 responsibility 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*.
- ASOP No. 23, *Data Quality*.
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*.
- ASOP No. 41, *Actuarial Communications*.

The certifying actuary must also consider whether the actuarial work supporting the bid complies with applicable laws, rules, "Instructions for Completing the Medicare Prescription Drug Plan Bid Pricing Tool for Contract Year 2012" and current CMS guidance. In addition, he/she must consider whether the actuarial work supporting the bid is consistent and reasonable with respect to the plan benefit package and the organization's current business plan.

Certification Module

The certification module contains the following features:

- Standardized required language. (The required elements are described in a subsequent section of this appendix.)
- 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 and supporting documentation.
- The ability to certify multiple bids/contracts.
- The ability to print and save the submitted certification.

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is pending CMS approval) via the certification module in August following the CMS publication of the Part D national average monthly bid amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts and the MA regional benchmarks. Actuaries are not required to certify every

intermittent resubmission throughout the bid review process, but they may do so if they wish. Note that in the event that the PBP changes after the “final” bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

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

Part D sponsors may have multiple actuaries assigned to one contract to perform the certifications. 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 plan Hxxxx-002. The instructions contained in this appendix must be followed by all actuaries who will be certifying CY2012 bids.

If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

Every Part D BPT requires a certification.

Required Certification Elements

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

- The certifying actuary’s name/user ID and the date, “stamped” when the certification is submitted.
- 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 MA and Part D bid submissions and meets the Academy’s qualification standards for doing so.
- The specific contract-plan-segment ID of the bid associated with the certification.
- The contract year of the bid contained in the certification.
- Indication of whether the certification applies to the MA bid, the Part D bid or both.
- Attestation that the certification complies with the applicable laws,¹ rules,² Instructions and current CMS guidance.
- Attestation that, in accordance with federal law, the bid is based on the “average revenue requirements in the payment area for a Medicare Advantage/Part D enrollee with a national average risk profile.”
- Attestation that the data and assumptions used in the development of the bid are reasonable for the PBP.
- Attestation that the data and assumptions used in the development of the bid are consistent with the organization’s current business plan.

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 A

- 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.
- A statement that, in accordance with ASOP No. 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency and that supporting documentation for the reliance on information provided by others is uploaded with the bid.

Please refer to ASOP No. 23, *Data Quality*, and ASOP No. 41, *Actuarial Communications*, for additional details regarding reliances. Also, see Appendix B for information regarding supporting documentation required for reliances.

If you have any questions regarding the CY2012 certification instructions, please contact the CMS Office of the Actuary at actuarial-bids@cms.hhs.gov.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2012 certification module were released via an HPMS memorandum dated March 3, 2010.

APPENDIX B – SUPPORTING DOCUMENTATION

GENERAL

In addition to the BPT and actuarial certification, Part D sponsors must provide CMS with supporting documentation for every bid, as described in these Instructions.

Unless otherwise noted, Part D sponsors must upload all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation must be made available to CMS reviewers upon request, and within 48 hours of the request, as required by these Instructions.

Supporting documentation requirements apply regardless of the source of the assumption, whether it was developed by the actuary, the Part D sponsor or a third party. If the actuary relied upon others for certain bid data and/or assumptions, those individuals are subject to the same documentation requirements. The actuary must be prepared to produce all substantiation pertaining to the bid, even if it was prepared by others or is based on a reliance.

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.3.3, “Actuarial Report,” the materials provided must be written “with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”

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.

Supporting documentation must–

- Be clearly labeled and easily understood by CMS reviewers.
- Explain the rationale for the assumptions, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Describe plan-specific variations in addition to the overall pricing assumption or methodology.
- Tie to the values entered in the current BPT and the PBP.
- Include Excel spreadsheets with working formulas, rather than pdf files.
- Clearly identify if it is related to MA, Part D or both.
- Clearly identify the bid(s) relating to the support. At a minimum, the contract number must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart or as an attachment.

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

- Meeting minutes from discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources—for example, a report’s official name/title, 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 includes, but is not limited to, the following items:

- Materials that are accessed only through a secure server link that requires a password.
- A reference to the supporting documentation for another plan, such as “the same as for plan Hxxxx-xxx,” and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is “professional judgment” with no additional explanation of the data points underlying the assumptions—for example, supporting factors, studies or public information.
- “Living worksheets” that are overwritten with current data. Supporting documentation must include the version of the worksheet that was used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was 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, independent of prior bid filings.

SUBMITTING SUPPORTING DOCUMENTATION

Supporting materials must be in electronic format (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, which compress multiple files into one (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload to multiple plans materials specific to a Part D plan, MA plan or certain contract ID.

Cover Sheet

To expedite the bid review process, Part D sponsors must upload a “cover sheet” that lists all of the supporting documentation that is uploaded or provided with the bid form. The filename must include the phrase “cover sheet.” A cover sheet is required for each upload of substantiation.

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

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a

bid's projection is based on manual rates). For documentation categories that apply to a subset of bids that contain a specified assumption, the cover sheet must 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 must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

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

Sample check lists and cover sheets for the initial June bid submission, and for subsequent substantiation uploads, are provided at the end of this appendix.

Timing

Part D sponsors and certifying actuaries must prepare all supporting documentation and upload required documentation into HPMS at the time of the initial June bid submission. These items are described in the "Initial June Bid Submission" section below.

Moreover, CMS recommends that other supporting documentation materials be uploaded with the initial June bid submission, though this is not required. These items are described in the "Upon Request by CMS Reviewers" section of this appendix. However, these materials must be prepared at that time in order to be readily available to CMS reviewers upon request. When additional substantiation is requested by CMS reviewers, it must be provided within 48 hours and be uploaded into HPMS prior to bid approval. The CMS bid reviewer will determine whether the Part D sponsor or the CMS bid reviewer will upload additional substantiation provided in e-mail correspondence and will communicate this requirement to the Part D sponsor during bid review.

Initial June Bid Submission

The following documentation requirements apply to all bids (as all bids contain these assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.
- Support for the credibility assumptions (Worksheet 2), including—
 - A statement of the credibility methodology used—for example, the CMS guideline or the CMS override.
 - A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
 - The method for blending differences in the credibility for utilization and unit cost into a composite pmpm credibility factor.
- A mapping of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale categories used in pricing (Worksheets 2 and 6).

- Support for non-benefit expense assumptions (Worksheet 2). The required elements include—
 - A summary of the non-benefit expenses by category of expense or by line item.
 - An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.
 - A description of the relationship between the non-benefit expense line items reported in the BPT and auditable material such as corporate financials and plan-level operational data.
- Justification of the gain/loss margin (Worksheet 2). The required elements include—
 - Support for overall margin levels, including a description of the methodology used to develop margin assumptions, demonstration of year-by-year consistency and supporting data.
 - A demonstration of year-by-year consistency between the expected overall margin level and the Part D sponsor's corporate margin requirement over time (for example, 3 to 5 years) including any change in the Part D sponsor's corporate margin requirement in the prior 2 years.
 - Support for bids with negative margins—that is, a year-by-year numeric business plan that illustrates profitability within a few years.
 - A numerical comparison of the gain/loss margin to the original business plan for plans with negative margins in prior years. This comparison includes details and sources of deviation from the original business plan.
 - 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) and/or (ii) demonstration of corporate return requirement(s). 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 and ongoing organizational gain/loss.
- Detailed support for the development of projected risk scores (Worksheet 3). The required elements include—
 - A detailed description and corresponding numerical demonstration of the methodology used to develop projected CY2012 Part D risk scores.
 - A description of the source data for the development of the projected CY2012 Part D 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 prescription drug expenses, if the plan pricing is based on manual rates.

The following documentation requirements apply to all bids that contain these specified assumptions:

- Detailed support for the base period experience (Worksheet 1).
- Detailed support for the trend projection factors (Worksheet 2).
- Detailed support for the manual rate development (Worksheet 2), including a description/illustration of the underlying data source(s) and data/methodology used in the development of the manual rates, if manual rates are used. The required elements include—
 - A description of the source data, including the data’s relevance to the Part D plan.
 - Credibility standards applied to the data and corresponding adjustments, if applicable.
 - Consideration of any adjustments made for annual volatility of the source data.
 - Any applicable adjustments to the source data, such as—
 - Approach and factors applied to account for incomplete claim run-out, formulary differences and/or expenditures that are not reflected in the source data;
 - Techniques and factors used to reflect differences between the underlying population and that expected of the Part D plan; and
 - Techniques and factors used to adjust for differences in plan design between the source data and the Part D plan.
 - Data and methodology used to project the data from base period to CY2012.
 - A description of the source of data for the development of corresponding CY2012 risk scores and how that source compares to the risk profiles of the population underlying the manual rate source data.
 - All other applicable factors and/or adjustments.
- Disclosure of related-party service agreements (Worksheet 2).
 - A Part D sponsor in a related-party agreement with an organization and prepares the BPT in a manner that does not recognize the independence of the subcontracted related party must provide the following:
 - The identity of the related-party organization.
 - A description of the business arrangement and services provided.
 - The financial terms.
 - A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
 - A Part D sponsor in a related-party agreement with an organization that is providing services to unrelated parties and chooses to demonstrate that the terms and fees associated with their agreement are comparable to those obtained by unrelated parties of the organization must provide the following:
 - The identity of the related-party organization.
 - A description of the business arrangement and services provided.
 - The financial terms.

APPENDIX B

- ▶ A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
- ▶ A written summary outlining the terms of actual contracts between the subcontractor and the comparable, unrelated parties for similar services. The support must demonstrate that the financial arrangements between related parties are not significantly different from those that would have been achieved by the Part D sponsor in the absence of the related-party relationships.
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of how CY2011 bid audit findings and observations were addressed in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that–
 - Identifies the source(s) of the information—for example, name, position, company, date;
 - Identifies the information relied upon;
 - States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and
 - Indicates to which plan(s) the reliance information applies.

See the sample format at the end of this appendix.

Upon Request by CMS Reviewers

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request. If substantiation is requested by CMS reviewers, it must be provided within 48 hours. These materials will be reviewed at audit:

- Reconciliation of base period experience with company financial data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including both claims paid and unloaded claim reserves. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
- Copies of related-party agreements for a Part D sponsor who has entered into a related-party agreement with an organization that is providing services to unrelated parties.
- A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.
- Communication between CMS reviewers and the Part D sponsor throughout the bid review process (that is, e-mail communication).

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

PART D CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Credibility assumption
Mapping of allowed costs, script counts and cost sharing in formulary tiers to type-of-drug and point-of-sale categories
Non-benefit expenses
Gain/loss margin
Projected risk scores

Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and projections
Manual rate development
Trend projection factor development
Disclosure of related-party agreements
Input sheet(s) for pricing model
Bid audit results
Reliance information

Upon Request by CMS Reviewers
Reconciliation of base period experience with company financial data
Related-party agreements
Reliance letter
Bid review communications
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD

Supporting Documentation Cover Sheet

CY2012 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999 and S9999

Date: June 7, 2011

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 Sheet 6-7-10.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-7-10.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-7-10.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-7-10.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet2	both
Risk scores	All bids	Risk CY11.xls	MA-Sheet 1 PD-Sheet 2	both
Manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD

Supporting Documentation Cover Sheet #2

CY2012 Bid Submission

Organization Name: Health One

Contract(s): H1234, H9999, and S9999

Date: July 16, 2011

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 Sheet 7-16-10.doc	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

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid ID	MA or PD or Both	Source (Name, Position, Company)	Type of Information	Comments
H1234-002-00	MA and PD	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
H1234-002-00	MA and PD	Jane Doe, Medicare Analyst, ABC Health Plan	Claim modeling, risk score	I have not performed any independent audit or otherwise verified the accuracy of these data or information.

APPENDIX C – EMPLOYER/UNION-ONLY GROUP (EGWP) REQUIREMENTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (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 DS benefit and receive a tax-free retiree subsidy of 28 percent of a retiree’s drug costs between \$310 and \$6,300;
- 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 to employer/union-only groups that contract directly with CMS to become a PDP.

For CY2006, CMS issued guidance that waives or modifies many of the requirements for these entities. CMS waiver guidance is located at <http://cms.gov/EmpGrpWaivers>. All of the standard Part D bidding guidelines apply, with the exception of those specifically waived.

For CY2012, CMS does not require a Part D BPT for employer/union-only group plans.

For additional information on CY2012 EGWP bidding policy, please refer to the CY2012 Call Letter.

APPENDIX D – CALCULATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT

For CY2006, the national average monthly bid amount was calculated using equal weighting applied to all PDP sponsors, and MA-PD plans were assigned 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 CY2007 and CY2008, 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 CY2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average, and 20 percent was based on an enrollment-weighted average. For CY2008, 40 percent of the calculation was based on the uniform-weighting average and 60 percent was based on an enrollment-weighted average. The demonstration was no longer in effect for CY2009 and the benchmarks were based on the 2008 enrollments applied to the 2009 bids. The CY2012 benchmarks will be based on the 2011 enrollments applied to the 2012 bids.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2010 and February 2011. Recall that the 2011 benchmark was calculated as 100 percent of the enrollment-weighted approach.

The same values are presented based on the February 2011 enrollment. Since the 2012 benchmarks will be based on 2011 enrollment, these values may be useful for estimating the 2012 benchmarks. The left section of the table shows the actual 2011 benchmarks, which were calculated based on June 2010 enrollment. The right section, titled “February 2011 Enrollment,” indicates how the 2011 benchmarks would have been calculated based on more current enrollment data.

	Enrollment Weighted Approach	
	June 2010 Enrollment	February 2011 Enrollment
National average monthly bid amount	\$88.33	\$86.96
Base beneficiary premium	\$31.94	\$31.34
Direct subsidy	\$56.39	\$55.62

This illustrative recalculation of the 2011 benchmarks is provided for the purpose of assisting Part D sponsors in developing the projected 2012 national average monthly bid amount and base beneficiary premium, which will be used in the calculation of the plan’s target premium. The final 2012 benchmarks will be based on the 2011 enrollments applied to the 2012 bids.

APPENDIX E – CALCULATION OF LOW-INCOME BENCHMARK PREMIUM AMOUNTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) directs CMS to use a weighted average to calculate the regional low-income benchmark premium amounts used in the determination of the low-income premium subsidy amounts. In determining the 2006 low-income benchmark premium amounts, PDPs were weighted equally, MA-PDs were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PDs were assigned a zero weight. For CY2007, under the “Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries,” CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006.

For CY2008, CMS implemented a transition to the statutorily required weighting such that the regional low-income benchmark premiums would experience a smaller decrease. CMS calculated the 2008 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average), as described below:

- The first component, the simple average, was the same as the 2006 weighting methodology for the regional low-income benchmark premium amount. The PDP organization premium amounts for basic prescription drug coverage in each region were weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, were weighted based upon prior enrollment.
- The second component was a weighted average of the premium amounts for each PDP and MA-PD with a weighting based on each plan’s prior enrollment as a percentage of all beneficiaries enrolled in those plans.

For CY2008, the regional low-income benchmark amount was based on 50 percent of the first component and 50 percent on the second component, as described above.

For CY2009, the “Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries” and the de minimus policy were not in effect. The regional low-income benchmark amounts were calculated based on 100 percent of the weighted LIS enrollments.

For CY2010, the “Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation” established that the regional low-income benchmark amounts, based on 100 percent of the weighted LIS enrollments, would be calculated using the Part D premiums for MA-PD plans before they were reduced by any applicable MA A/B rebates.

For CY2011 and subsequent years, in accord with the codification of the “Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation”, the weighted average premium amounts will be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable Part A/B rebates.

The following table illustrates the impact of calculating the regional low-income benchmark amounts based on 100 percent of the weighted LIS enrollments for two enrollment periods, June 2010 and February 2011.

PD Region	State(s)	Enrollment Weighted Approach	
		June 2010 Enrollment	February 2011 Enrollment
01	NH, ME	\$26.96	\$26.09
02	CT, MA, RI, VT	\$34.57	\$33.76
03	NY	\$33.32	\$32.38
04	NJ	\$35.01	\$33.12
05	DE, DC, MD	\$33.71	\$33.02
06	PA, WV	\$32.09	\$30.88
07	VA	\$34.15	\$32.87
08	NC	\$34.90	\$33.43
09	SC	\$35.02	\$33.98
10	GA	\$29.62	\$28.78
11	FL	\$27.45	\$25.56
12	AL, TN	\$30.73	\$30.06
13	MI	\$34.92	\$33.55
14	OH	\$30.47	\$28.32
15	IN, KY	\$35.75	\$34.15
16	WI	\$38.20	\$37.15
17	IL	\$31.59	\$29.76
18	MO	\$40.01	\$36.76
19	AR	\$28.48	\$27.48
20	MS	\$33.02	\$30.75
21	LA	\$31.32	\$32.02
22	TX	\$27.53	\$26.96
23	OK	\$32.31	\$31.86
24	KS	\$35.77	\$35.20
25	IA, MN, MT, ND, NE, SD, WY	\$37.55	\$36.41
26	NM	\$21.42	\$21.32
27	CO	\$30.99	\$30.38
28	AZ	\$24.75	\$24.91
29	NV	\$27.31	\$20.20
30	OR, WA	\$35.60	\$34.88
31	ID, UT	\$40.89	\$39.37
32	CA	\$28.99	\$28.86
33	HI	\$25.55	\$24.29
34	AK	\$38.00	\$35.37

APPENDIX F – IMPACT OF HEALTH CARE REFORM ON CY2012 BIDS

PROVISIONS

The following provisions of the Patient Protection and Affordable Care Act (PPACA) and Health Care and Education and Reconciliation Act of 2010 apply to Part D bids for CY2012.

Coverage in the Gap

A phase-in approach will be implemented to reduce beneficiary cost sharing in the coverage gap from 100 percent to 25 percent in CY2020. In CY2012, beneficiary cost sharing is reduced from 100 percent to 93 percent for generic drugs; the Plan sponsor's liability for DS coverage is increased to 7 percent. Beneficiary cost sharing is reduced from 100 percent to 50 percent. Pharmaceutical manufacturers will provide a 50 percent discount off of the plan sponsor's negotiated price of the brand-name drug at the point-of-sale. The total negotiated price of the drug will count toward the beneficiary's TrOOP; the Plan sponsor's liability remains at 0 percent.

Low-Income Premium Subsidy Amounts

The approach to determine the low-income premium subsidy amounts that was established in the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" and approved on August 11, 2009 was codified. Therefore, the weighted average premium amounts will be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable MA A/B rebates.

Income-Related Part D Premium

Similar to Medicare Part B, an income-related premium is established. The income thresholds for CY2012 through CY2019 are \$85,000 per individual and \$170,000 per couple. The direct subsidy will be reduced by the amount of the increased income-related premium.

PRICING CONSIDERATIONS

Part D sponsors must model the impact of the addition of coverage in the gap on the DS benefit. The following guidelines apply to all Part D bids.

- The changes to projected average allowed amounts from the base period to the contract year that are expected to occur as a result of reduced beneficiary cost sharing in the coverage gap must be reflected in the "Other Change" components of utilization and unit cost trend factors on Worksheet 2.
- The CMS guideline concerning Specialty drugs is not changed. When a designated Specialty tier is used, all drugs in that tier must be reported by point-of-sale in Worksheet 2 and Worksheet 6 of the BPT. The drugs in the Specialty tier must not be sorted by type of drug status and must not be reported as a component of the generic, preferred brand and non-preferred brand drugs in the non-Specialty tiers. When a designated Specialty drug tier is not used in the formulary and PBP, Specialty drugs

must be sorted by generic, preferred brand and non-preferred brand status and must be reported in these categories by point-of-sale. In this situation, the Specialty categories in Worksheet 2 and Worksheet 6 are not completed.

- While coverage in the gap will not change the TrOOP threshold of \$4,550, it will affect the point at which the beneficiary reaches the TrOOP threshold for catastrophic coverage.
- The impact on the LIS Cost Sharing PMPM must be reflected in lines 4-5, column o of Worksheet 3.
- The impact on the Federal Reinsurance PMPM must be reflected in line 5, column m of Worksheet 3.

The following guideline applies when the type of coverage is AE, BA or EA.

- When modeling an alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits.

The following guideline applies when the type of coverage is EA.

- When an EA plan offers coverage in the gap that exceeds the DS coverage, the “Amounts in Gap PMPM” and “Coinsurance Percentage in Gap” on Worksheet 5, cells K37 and K47, respectively, must reflect the projected allowed amount pmpm for DS coverage and the additional partial of full coverage.

CHANGES TO THE BPT

The following changes were made to the BPT to accommodate the provisions.

- In Worksheet 3 –
 - The headings, “Generics in Gap PMPM” and “Generic Gap Coverage”, were added to cells I26 and M31, respectively.
 - The headings in cells C23 and C24 were changed to “\$2,840-Catastrophic” and “Above Catastrophic”, respectively.
 - An input field was added to cell J26 for “Generics in Gap PMPM”.
 - A formula was added to cell N31 to calculate the 7% Plan sponsor liability for “Generic Gap Coverage”.
 - The formulas in cells I33, J33 and N33 were updated to reflect the impact of “Generic Gap Coverage”.
- In Worksheet 4 –
 - The heading in cell H28 referencing the dollar amount at which catastrophic coverage begins was removed.
- In Worksheet 5 –
 - A formula was added to cell K46 to calculate the percentage coinsurance amount in the gap for DS coverage.
 - The formula in cell K49 was updated to reflect the PMPM impact on the amount in the gap for DS coverage.

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 12 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
