OMB Approved # 0938-NEW

INSTRUCTIONS FOR COMPLETING THE MEDICARE PRESCRIPTION DRUG PLAN BID FORM FOR CONTRACT YEAR 2006

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Introduction

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

The submitted bids will be subject to negotiation with CMS. As part of that negotiation, CMS may request supporting documentation for the information included on the bid form. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

Organizations must provide a series of data entries on the appropriate form pages to complete the bid form. The number of inputs depends on the type of plan and how long it has operated. The CMS bid form must be used to develop a pricing structure for each prescription drug plan offered. Organizations must submit the information in the CMS-approved electronic format.

The following describes the most common steps in completing the bid form. The organization must:

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

Base Experience

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

It is expected that most plans will not have appropriate base period experience to be used in completing Worksheet 1 for contract years 2006 and 2007. As explained later in these instructions, plans without appropriate base period experience need to develop manual rates to be used in the pricing tool. Development of these manual rates should include the use of

available data adjusted to reflect the expected population and the benefit design that will be offered. A plan that has experience in covering Medicaid dual beneficiaries and is bidding on becoming a special needs plan covering dual beneficiaries will likely have appropriate base period experience for contract year 2006 since the covered population is comparable to that which will be offered Part D.

A plan that has appropriate base period data needs to evaluate the credibility of this data. Although we have not yet established credibility guidelines, we expect that prescription drug experience to have a higher level credibility than medical coverage for a similarly sized group. We expect that an appropriate use of actuarial judgment will be exercised in determining the credibility factor for a plan's base period experience.

In summary:

- Plans with fully credible experience should complete all sections of Worksheet 1 and Sections II, III, and V of Worksheet 2.
- Plans with partially credible experience should complete all sections of Worksheet 1 and Worksheet 2.
- Plans with no applicable, fully or partially credible experience should complete Section I of Worksheet 1, and then proceed to Section IV of Worksheet 2.

Required Sections

The sections that a plan must complete are dependent on the type of coverage that will be offered. The following summarizes the sections that need to be completed for each type of coverage.

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

Actuarially Equivalent Standard Coverage
Plans submitting a bid for Actuarially Equivalent Standard Coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience, Worksheet 3, Worksheet 4, and all columns of Section II of Worksheet 6.

Basic and Enhanced Alternative Coverage
Plans submitting a bid for Basic and Enhanced Alternative are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience, Worksheet 3, Worksheet 5, and all columns of Section II of Worksheet 6.

Actuarial Equivalence

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

All plans are required to develop projected utilization for their proposed Defined Standard Benefit in columns f, g and h in Section II of Worksheet 6. In addition, plans submitting a bid

for an Actuarially Equivalent or Alternative benefit are required to report projected utilization in columns i, j, and k. If the bid is Defined Standard, then columns d, e, and f may be left blank.

Data in Section II of Worksheet 6 is collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit; it is not expected to model all of the aspects of plan design. Lines 1-20 summarize all of the expected claims of the proposed benefits, with lines 1-10 capturing the claims for individuals with less than $2,250 in annual drug claims, and lines 11-20 capturing the claims for individuals with $2,250 or more in annual drug claims. Lines 21-30 capture the claims for individuals expected to reach catastrophic coverage, which is $5,100 or more in annual drug claims for contract year 2006. Note that the amounts summarized in lines 21-30 will be a subset of those summarized in lines 11-20.

Plans should follow the instructions carefully in developing cost sharing values for column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the cost sharing elements for the proposed Defined Standard benefit. For lines 1-20, column h captures the cost sharing for the claims summarized in columns f and g reflecting the cost sharing applicable between the deductible and the initial coverage limit for all claims. This means that column h develops cost sharing ignoring the impact of the deductible, the gap in coverage and catastrophic coverage. For this purpose, plans should ignore the impact of the low-income cost sharing subsidy. Since column c summarizes the defined standard benefit, the claims reflect cost sharing of 25%. Similarly, items in column c for lines 21-30 are developed assuming cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this would be the greater of 5% or $2 for generic/ $5 for brand.

Plans submitting a bid to provide an Actuarially Equivalent or Alternative benefit are required to report the projected utilization on the proposed benefit in Section II, columns i, j, and k. The distributions should be based on the splits as outlined in the defined standard coverage. For example, rows 1-10 should reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,250 in annual coverage based on the defined standard coverage. In other words, the utilization summarized in columns i, j and k is based on the same population summarized in columns f, g and h.

Plans should follow the instructions carefully in developing the cost sharing values in column k, lines 1-20, Section II of Worksheet 6. Values in column k are calculated using the copay and coinsurance structure the proposed Actuarially Equivalent or Alternative benefit applies to allowed utilization between the applicable deductible and the initial coverage limit. In a similar manner as column h, column k develops cost sharing ignoring the impact of the deductible, any gap in coverage and catastrophic coverage. Lines 21-30 are developed assuming the cost sharing applicable beyond the catastrophic threshold for the actuarial equivalent or alternative coverage.

<u>Values for A, B, C, and D in Worksheet 4</u>
Plans proposing a benefit that has standard coverage with actuarially equivalent cost sharing must satisfy the tests to demonstrate actuarial equivalence on lines 16 and 17, Section III of Worksheet 4:

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

- The value for “A” is 25%.
- The ratio of A/B is between .98 and 1.02.

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

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

Worksheet 1 - Rx Base Period Experience

SECTION I – GENERAL INFORMATION

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

Line 1 – Contract Number

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

Line 2 – Plan ID

The plan ID and corresponding Contract Number form a unique identifier for the plan being priced in the bid form. Plan IDs contain three Arabic numerals. Please enter all leading zeros. For example, enter 001 for plan number one. If the bid is for an employer-group only plan, the plan ID must be 800 or higher.

Line 3 – Segment ID

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

Line 4 – Contract Year

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

Line 5 – Organization Name

Enter the organization's legal name on Line 4.

Line 6 – SNP

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

Line 7 – Plan Name

On line 7, enter the name of the MA-PD or PDP plan that you are offering to Medicare enrollees. This need not exactly match what is in the PBP. It is only used as an identifier for the user's benefit.

Line 8 – Plan Type

Enter the type of plan - the valid options are listed below:

Type of Plan	Plan Type Code:
Local Coordinated Care Plans:	
Health Maintenance Organization	HMO
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS
Provider-Sponsored Organization w/ State License	PSO (State License)
Provider-Sponsored Organization w/ Federal Waiver of State License	PSO (Federal Waiver of State License)
Preferred Provider Organization	Local PPO
Regional Coordinated Care Plans:	
Regional Preferred Provider Organization	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan	PFFS
Demonstration Plans:	
Social HMO	SHMO
Minnesota Disability Health Options	MN Disability Health Options
Minnesota Senior Health Options	MN Senior Health Options
Wisconsin Partnership Program	WI Partnership Program
Massachusetts Health Senior Care Options	MA Health Senior Care Options
1876 Cost Plans:	
1876 Cost	1876 Cost
National PACE Plans:	
National PACE	National PACE
Prescription Drug Plans:	
Medicare Prescription Drug Plan	Medicare Prescription Drug Plan
Employer Sponsored PDP	Employer Sponsored PDP
Fallback Plans:	
Fallback	Fallback

The remaining sections of Worksheet 1 summarize the base period Rx experience. They should be left blank if there was no applicable, credible Part D coverage in effect during the base period. Section II includes base period background information. Section III summarizes the base period Rx claims data. Section IV summarizes the non-pharmacy expenses. Section V summarizes the various components of revenue that relate to the Part D coverage. Section VI is an income statement summary.

Line 9 – MA-PD Indicator

Enter “Y” if plan is a MA-PD plan or “N” if plan is PDP only.

Line 10 – Enrollee Type

Enter enrollee type if applicable.

Line 11 – PD Region

Enter the PD Region from 1-36 or “Multiple” or “National” if applicable.

Section II – Base Period Background Information

Line 1 – Time Period Definition

Enter the base period experience incurral information on the first two lines. In addition to the incurral dates, enter the “paid through” date. For example, if the incurral period is calendar year 2004, the “incurred from” date is 1/1/2004 and the “incurred to” date is 12/31/2004. If the data is from payment information through February 2005, then the “paid through” date is 2/28/2005. Note that the base time period incurral data is not required to be a calendar year.

Line 2 – Member Months

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

Line 3 – Credibility

If the base period experience is fully credible, enter “F”; if partially credible, enter “P”; or if the plan has no applicable, credible experience, enter "N”.

Line 4 – Risk Score

Enter the plan’s prescription drug risk score underlying the base period data. The risk score should be estimated to three decimal places. The CMS drug model risk score should be used. Where the plan risk score is not known, CMS will provide information so that plans may estimate the projected risk score for their population.

Line 5 – 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 6 – Base period description

Use the text box provided to briefly describe the base period data. The base period data need not reflect the same benefit plan or service area as the contract year. Do not adjust data for credibility, which is addressed on Worksheet 2 with the manual rate. Examples of different base period data include:

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

- Similar benefit plan in same or different service area.

Section III – Part D Claims Experience

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

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

Lines 1-11 should include only experience relating to Part D covered drugs. Lines 12-14 summarize experience for any drugs that are covered by the plan and that are not on the Part D covered drug list at the time they are dispensed.

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

Column d, Lines 1 through 5 – Number of Members

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

Column e, Lines 1 through 5 - Member Months

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

Column f, Lines 1 though 5 - Total number of Scripts

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

Column g, Lines 1 through 5 - Total Allowed Dollars

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

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

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

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

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

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

For each line, enter the difference between the average paid amount in column i and the amount that would have been entered in column j if the Rx plan had been defined standard coverage.

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

For each line, enter the average Low Income Cost-Sharing Subsidy amount received or receivable with respect to the members included in column d.

Column l, Lines 1 though 5 – Reimbursement for Federal Reinsurance per Member

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

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

This value is calculated by subtracting the values in columns j, k, and l from the value in column i.

Line 6, columns d through m – Subtotal

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

Line 7, columns g and i – % OON

For column g, enter the percent of total allowed dollars from line 6 that are for prescriptions filled out-of-network. For column i, enter the percent of average paid dollars from line 6 that are for prescriptions filled out-of-network.

Line 8, columns g and i through m – PMPM Values

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

Line 9, columns i, l, and m – Minus PMPM Rebates

Enter, in each of columns i and l, the PMPM value of rebates received with respect to the claims included in lines 1 through 5. Total rebates should be allocated to the plan using a method that reasonably represents the way in which the rebates were generated, and rebates should be allocated to columns j and m based upon the amount on line 6 for each column. Column m is calculated based upon the entries in the other columns. All rebates and price concessions not used to directly reduce the cost at the point of sale must be included. Rebates and price concessions must be reported in full. Any charges or fees for the administration of rebates or price concessions must be included separately as a component of direct administrative costs.

Line 10, columns i and m – PMPM Value of Part D as Secondary

Enter in column i the PMPM value of any payments for Part D covered drugs for which Part D is secondary. Column m is calculated based upon column i.

Line 11, columns i through m – PMPM Net Expenses

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

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

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

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

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

Line 14, columns i and m – Net PMPM on Non-Part D Covered D Drugs

Column i is calculated as line 12 minus line 13. Column m is calculated automatically.

Section IV – PMPM Non-Pharmacy Expense

This section summarizes the PMPM value of the components of Part D non-pharmacy expenses in the base period. The allocation of expenses between basic and supplemental benefits should reasonably reflect the degree of additional cost engendered by the provision of supplemental benefits.

Two non-pharmacy expense components are different from those used for MA bidding. Crossover fees refer to payments made by the Part D carrier to other entities in order to obtain information about Rx coverage and payments by those entities for individuals with Part D coverage. Medical Therapy Management Payments (MTMP) represent costs incurred by the Part D carrier to fulfill its responsibilities for managing drug therapy for complex cases, as required by the MMA.

Amounts may be entered on lines 1 - 8 of column e; amounts may be entered on lines 2-6 and line 8 of column f. Line 9 and column g are calculated automatically.

Section V – PMPM Premium Revenue

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

Amounts may be entered on lines 1 - 4 of column e; amounts may be entered on line 3 of column f. Line 5 and column g are calculated automatically.

Section VI – PMPM Income Statement Summary

This section provides an income statement summary of the base period for Part D coverage after considering the amount of MA Rebate allocable to Part D in the base period.

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

Worksheet 2 - PDP Projection of Allowed/Non-Pharmacy

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

Worksheets 2 and 6 develop summaries of the distribution of generic and brand drugs (preferred and non-preferred) for a proposed plan, including allowed amounts and cost sharing amounts. These summaries will assist in determining actuarial equivalence, and will be cross referenced with information submitted in the plan's formulary and Plan Benefit Package (PBP). The bid form does not capture information on each individual tier when the plan makes use of more than three tiers.

The following guidelines are provided for purposes of completing the Bid Pricing Tool:

- Generic drugs: Identified by the plan, most often placed in the most available cost share tier.
- Preferred brand drugs: Brand drugs that are placed in the most favorable position on the formulary for comparison to other similar brand drugs. Plans often represent these brand drugs to beneficiaries as "preferred" based upon their overall ability to meet patient needs at a reasonable cost. Preferred brand drugs are most frequently positioned in the 2nd tier with a higher cost share than the most favorable tier. Brand drugs positioned in the most favorable 1st tier along with generic drugs should be considered to be preferred.
- Non-preferred brand drugs: Brand drugs placed in the 3rd or higher tier with cost sharing that is greater than the lowest available cost share tier predominantly populated with brand drugs.

SECTION I – GENERAL INFORMATION

This information is carried forward from Worksheet 1.

SECTION II – UTILIZATION FOR COVERED PART D DRUGS

Lines 1 through 6, column e - Number of Scripts/1000

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

Lines 1 through 6, column f - Allowed per Script

For each type of prescription, enter the average allowed amount per script for scripts filled in the base period. The amount allowed is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable. Rebates and medication therapy management costs should not be included.

Lines 1 through 6, column g - PMPM Allowed

For each type of prescription, enter the total allowed costs total allowed costs is calculated by the base period divided by the number of member months in the base period. Since the utilization reported in column e is annualized, the amount in column g should equal column e times column f, divided by 12,000.

Lines 1 through 6, column h - Trend in Scripts/1,000

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

Lines 1 through 6, column i - Formulary Change

For each type of prescription, enter the factor that would be applied to the base period scripts per 1,000 to reflect changes in classification of certain drugs from the base period to the contract period. For example, introduction of a generic version of a preferred brand between the base period and the contract period would be expected to produce a factor of less than 1.000 for lines 2 and 5 and a factor of greater than 1.000 for lines 1 and 4.

Lines 1 through 6, column j - Risk Change

For each line, enter the factor that represents the impact of the change in risk of the covered population between the base period and the contract period.

Lines 1 through 6, column k - Induced Utilization

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

Lines 1 through 6, column l – Other Change

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

Lines 1 through 6, column m - Total Utilization Change

Calculated as the product of the factors in columns h through l.

Lines 1 through 6, column n - Projected Scripts/1000

Calculated as the product of columns e and m.

Lines 7 through 13, columns e through n

Calculated using the information input on lines 1 through 6.

SECTION III – COST FOR COVERED PART D DRUGS

Lines 1 through 6, column e - Inflation Trend

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

Lines 1 through 6, column f - Discount Change

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

Lines 1 through 6, column g- Formulary Change

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

Lines 1 through 6, column h - Other Change

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

Lines 1 through 6, column i - Total Unit Cost Change

Calculated as the product of columns e through h.

Lines 1 through 6, column j - Projected Unit Cost

Calculated using Section III, column i and Section II, column f.

Lines 1 through 6, column k - Projected Allowed PMPM

Calculated using Section III, column j, and Section II, column n.

Lines 7 through 13, columns e through k

Calculated using lines 1 through 6.

SECTION IV – PROJECTED ALLOWED PMPM

Lines 1 through 6, columns l and m- Manual Utilization/1000 and Manual Unit Cost

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

Lines 1 through 6, column n- Manual Rate PMPM

The manual rate PMPM is calculated based on inputs in columns l and m (lines 1-6).

Lines 1 through 6, column o - Credibility

Enter the percentage that would be applied to the actual experience when blending with manual experience to produce contract period projections.

Lines 1 through 6, column p - Blended Allowed PMPM

Calculated using columns k, n, and o.

Lines 7 through 13, columns l through p.

Calculated using lines 1 through 6.

SECTION V – PMPM NON-PHARMACY EXPENSE

This section identifies the PMPM value of the components of Part D non-pharmacy expenses. The Non-Pharmacy expenses must be shown separately for the following categories:

- Crossover Fees. (These are the fees paid to obtain information from other payers in order to calculate TROOP (True Out-of-Pocket).
- Medication Therapy Management Program expenses.
- Marketing & Sales.
- Direct Administration (for example, functions that are directly related to the administration of the program, such as customer service, billing and enrollment, claims administration, calculation of LIS reimbursement, and (TrOOP administration).
    - Disease management functions such as patient education and disease monitoring are considered to be direct administration.
    - Over the Counter (OTC) drug utilization is reported as a component of direct administration, and not as a Part D covered drug, or as supplemental coverage. Over the counter drugs can only be covered to the extent that they are part of an approved step therapy program and no cost sharing is required of the beneficiary.
- Indirect Administration (for example, functions that may be considered “corporate services,” such as accounting operations, actuarial services, legal services and human resources).
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).
- Medicare User Fees.
- Uncollected Enrollee Premium.

All non-pharmacy expenses must be reported using the appropriate generally accepted accounting practice (GAAP) methodology. For example, acquisition expenses and capital expenditures must be deferred and amortized consistent with the relevant GAAP standards. Also, acquisition expenses (marketing and sales) must be deferred and amortized consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards are promulgated by the Financial Accounting Standards Board (FASB). Of

particular applicability are FASB's Statement of Financial Accounting No. 60, Accounting and Reporting by Insurance Enterprises.

Additionally, for organizations that have entered into administrative service agreements, the non-pharmacy expense must reflect the actual cost of providing services, which may be different than the contractual charge.

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

Three non-pharmacy expense components are different from those used for MA bidding. Crossover fees refer to payments made by the Part D carrier to other entities in order to obtain information about Rx coverage and payments by those entities for individuals with Part D coverage. Medical Therapy Management Payments (MTMP) represent costs incurred by the Part D carrier to fulfill its responsibilities for managing drug therapy for complex cases, as required by the MMA. As stated above, Over the Counter (OTC) drug utilization is reported as a component of direct administration, and not as a Part D covered drug, or as supplemental coverage.

Lines 1-9, column e – Base Period

Base period Non-Pharmacy expenses are carried over from Section IV of Worksheet 1.

Lines 1-8, column f – Trend

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

Lines 1-9, column g – Contract Period PMPM Non-Pharmacy Expense

Calculated using **columns** e and f.

Lines 1-8, column h– Manual Rate Non-Pharmacy Expense

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

Lines 1-8, column i – Credibility

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

Lines 1-9, column j – Blended Contract Period PMPM Non-Pharmacy Expense

Automatically calculated using columns g, h, and i.

SECTION VI – DEVELOPMENT OF MANUAL RATE

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

Worksheet 3 - Contract Period Projection for Defined Standard Coverage

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

SECTION I – GENERAL INFORMATION

This information is carried forward from Worksheet 1.

SECTION II – PROJECTION DATA

Line 1 – Projected Member Months

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

Line 2 - Projected Average Risk Score

Enter the projected Rx risk score for the enrollees expected in the contract period. This must be consistent with the base period risk score (if any) and with the expectation for the change in risk score from Worksheet 2.

Line 3 - Projected LIS Member Months

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

SECTION III – PART D COVERED DRUG CLAIMS

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

Lines 1-5, column d - Number of Members

Enter the number of members who are expected to have allowed Part D Rx expenses falling in the range applicable to the line. For example, if you expect to have 6,500 members with allowed expenses falling in the range between $250 and $2,250, enter 6,500 on line 3, column d. For purposes of lines 1-5, do not include estimates for any claims for which Part D is secondary coverage.

Lines 1-5, column e - Member Months

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

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

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

Lines 1-5, column h – Avg Amt Allowed PMPM

The average allowed PMPM will be calculated automatically.

Lines 2-5, column i - Cost Sharing

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

Lines 4-5, column j - GAP PMPM

For each line, enter the PMPM amount corresponding to amounts between the initial coverage limit and the catastrophic limit for the individuals identified in column d. For 2006, this amount would correspond to allowed amounts between $2,250 and $5,100.

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

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

Line 5, column m - Federal Reinsurance PMPM

For line 5, enter the Federal Reinsurance applicable to the individuals identified in column d. The PMPM value must be calculated based on the total dollars divided by the total projected member months in Section II, line 1.

Lines 1-5, column n - Plan Liability

The Plan Liability PMPM will be calculated automatically.

Lines 2-5, column o - Federal LIS Cost Sharing PMPM

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

Line 6, all columns - Subtotal

Each column is calculated automatically.

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

While rebates are not directly allocable to individual claims, the method used to allocate rebates to the plan must be reasonably related to the way in which the rebates are

generated. For this purpose, rebates should include any price concession recognized after the point of sale.

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

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

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

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

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

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

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

Line 12, columns g through o - Total

These are calculated based on the previous lines.

SECTION IV – PMPM NON-PHARMACY EXPENSE

Lines 1 through 9

PMPM Non-Pharmacy Expense is carried over from Section V of Worksheet 2.

SECTION V – DEFINED STANDARD COVERAGE BID DEVELOPMENT

Lines 1-5, column i, reflect amounts at the plan's projected risk score (Section II, line 2). Lines 1-5, column j, reflect amounts at a risk score of 1.000, calculated as the amount in column f divided by the plan risk score (Section II, line 2).

Line 3, column i - Gain/ (Loss)

Enter the organization's target PMPM gain/ (loss) at the expected risk score in column i. The value in column j is calculated by dividing column i by the expected risk score. Consistent with statutory intent, the gain/loss margin must reflect the revenue requirements of benefits provided under the plan. CMS' interpretation of this requirement is that the gain/loss margin be developed using an accepted actuarial technique, such as a Return on Investment or Return or Equity approach.

One components of CMS' review will be assessment of the reasonableness of the gain/loss margin relative to other MA bids. Organizations will be required to provide justification of the margin for bids with relatively large projected gains/losses. Examples of support to be provided are: (i) illustration of return on investment / equity requirement(s), (ii) demonstration

of corporate return requirement(s), and/or (iii) other actuarial support. The development of margin requirements may reflect revenue offsets not captured in non-pharmacy expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

Lines 1, 2, and 5 - Claims, Non-Pharmacy Expense and Federal Reinsurance

The information in column i carries over from Sections III and IV for the expected risk score and is calculated for column i at the 1.00 risk score.

Line 4 – Total Basic Bid

The basic bid at the expected risk score is calculated as the sum of lines 1 to 3, column i. The bid standardized to a risk score of 1.00 is calculated as the sum of lines 1 to 3, column j.

Worksheet 4 - Standard Coverage with Actuarially Equivalent Cost Sharing

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

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

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

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

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

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

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

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

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

These items are calculated automatically.

Lines 4, columns e and h - Allowed PMPM

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

Lines 15, columns h and k - Rebates

Input the total rebate amount for the plan in column k. Rebates will be allocated for reinsurance.

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

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

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

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

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

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

Line 6, LIS

Enter the estimated value of Low Income Cost Sharing consistent with the anticipated risk factor.

Worksheet 5 - Alternative Coverage

This worksheet is used if the plan is offering alternative coverage. Basic alternative coverage would result in no supplemental premiums. The worksheet also calculates the supplemental premium for enhanced alternative coverage.

SECTION I – GENERAL INFORMATION

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

SECTION II – PROJECTION DATA

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

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

The information in this section is carried forward from Worksheet 3.

SECTION IV – DEVELOPMENT OF BID COMPONENTS

Columns d through o – Part D Covered Drugs

These amounts represent Part D Covered Drugs.

Column q – Non-Part D Covered Drugs

These amounts represent Non-Part D covered drugs.

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

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

Line 6, column d - Proposed Deductible

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

Line 8, column f – Value of Proposed Deductible

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

Line 12, column k - Coinsurance Percentage in Gap

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

Line 18, columns o and q - Alternative Plan Rebates

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

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

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

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

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

SECTION V – DEVELOPMENT OF ACTUARIAL EQUIVALENT TEST

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

Line 9 - LIS

Enter the estimated PMPM value of Low Income Cost Sharing subsidy under the alternative plan using the projected risk score.

SECTION VI – TESTS FOR ALTERNATIVE COVERAGE

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

SECTION VII – DEVELOPMENT OF SUPPLEMENTAL PREMIUM

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

Line 6 - Additional Non-Pharmacy Expenses

Enter the additional non-pharmacy expenses associated with administering supplemental benefits. We would expect that the non-pharmacy expenses would be distributed proportionately between Medicare Covered and A/B mandatory supplemental.

Line 7 - Additional Gain/ (Loss)

Enter the additional gain or loss associated with offering supplemental benefits. We would expect that the gain/loss margin would be distributed proportionately between basic and supplemental coverage.

SECTION VIII – DEVELOPMENT OF INDUCED UTILIZATION ADJUSTMENT

This section captures the additional costs for basic coverage associated with offering an enhanced alternative plan with supplemental benefits. This will be used to adjust allowable costs for risk corridor payments.

Line 2 - Impact of Alternative Utilization on Standard Benefit

Enter the additional basic Part D costs in the first column if the utilization for alternative coverage was used to price defined standard coverage. This adjustment should reflect the additional costs associated with basic coverage. For the 2006 benefit year, this represents 75% of costs between the $250 deductible and the $2,250 initial coverage limit plus 15% of costs in excess of the basic catastrophic limit or $5,100. This adjustment should be calculated only for enhanced alternative plans and the adjustment must be a positive number.

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

The purpose of this worksheet is to illustrate the underlying assumptions that are being used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. All of the data in section II is collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit; it is not expected to be a detailed model of the cost sharing of the proposed plan design.

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

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

Data in section II of Worksheet 6 is collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit; it is not expected to model all of the aspects of plan design. Lines 1-20 summarize all of the claims expected to be utilized, with lines 1-10 capturing the claims for individuals with less than $2,250 in annual drug claims, and lines 11-20 capturing the claims for individuals with $2,250 or more in annual drug claims. Lines 21-30 captures the claims for individuals expected to reach catastrophic coverage, which is $5,100 or more in annual drug claims for contract year 2006. Note that amounts summarized in lines 21-30 will be a subset of the amounts summarized in lines 11-20.

Plans should follow instructions carefully in developing cost sharing values for column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the cost sharing elements for the proposed Defined Standard benefit. For lines 1-20, column h captures the cost sharing for the claims summarized in columns f and g reflecting the cost sharing applicable between the deductible and the initial coverage limit for all claims. This means that column h develops cost sharing ignoring the impact of the deductible, the gap in coverage and catastrophic coverage. For this purpose, plans should ignore the impact of low-income cost sharing subsidy. Since column h summarizes the defined standard benefit, all of the claims reflect cost sharing of 25%. Similarly, items in column h for lines 21-30 are developed assuming cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this will be the greater of 5% or $2 for generic/ $5 for brand.

Plans submitting a bid to provide an Actuarially Equivalent or Alternative benefit are required to report the projected utilization and costs on the proposed benefit in Section II, column i, j, and k. The distributions should be based on the splits as outlined in the defined standard coverage. For example, rows 1-10 should reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,250 in annual coverage based on the defined standard coverage. In other words, the amounts summarized in columns i, j and k are based on the same population summarized in columns f, g and h.

Plans should follow instructions carefully in developing the cost sharing values in column k, lines 1-20, Section II of Worksheet 6. Values in column k are calculated using the copay

and coinsurance structure the proposed Actuarially Equivalent or Alternative benefit applies to allowed utilization between the applicable deductible and the initial coverage limit. In a similar manner as column h, column k develops cost sharing ignoring the impact of the deductible, any gap in coverage and catastrophic coverage. Lines 21-30 are developed assuming the cost sharing applicable beyond the catastrophic threshold for the actuarial equivalent or alternative coverage.

SECTION I – GENERAL INFORMATION

The information in this section is carried forward from Section I of Worksheet 3.

SECTION II – PROJECTIONS FOR EQUIVALENCE TESTS

Lines 1 and 2

Column f contains amounts from Worksheet 3. These amounts represent the projected members and associated member months that would be expected to generate less than $2,250 in allowable Part D Rx costs if the bid were for a benefit plan being bid with defined standard coverage only.

Lines 3 through 9

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

Columns i through k – If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars, and cost sharing for the population identified in line 1, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage. These numbers include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 10

Sum of lines 3-9.

Lines 11 and 12

Column f contains amounts from Worksheet 3. These amounts represent the projected members and associated member months that would be expected to generate more than $2,250 in allowable Part D Rx costs if the bid were for a benefit plan with defined standard coverage only.

Lines 13 through 19

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

Columns i through k - If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars, and coinsurance for the population identified in line 11, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage prior to the catastrophic limit. These numbers must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 20

Sum of Lines 13-19.

Lines 21 and 22

Column f contains amounts from Worksheet 3. These amounts represent the projected members and associated member months that would be expected to generate more than $5,100 in allowable Part D Rx costs if the bid were for a benefit plan with defined standard coverage only.

Lines 23 through 29

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

Columns i through k - If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars and cost sharing for the population identified in line 21, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage once the catastrophic threshold has been reached. These numbers must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 30

Sum of Lines 23-29.

Line 31

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

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany each bid. A qualified actuary who is a member of the American Academy of Actuaries (MAAA) must complete the certification. The new bid approach is more reliant on actuarial techniques; whereas, many aspects of the preceding ACR approach were more accounting based. The objective of obtaining an actuarial certification is to place greater reliance on the actuary's professional judgment and to hold him or her accountable for the reasonability of the assumptions and projections.

At the actuary's professional discretion, a certification may apply to more than one bid. However, the certification must list all bids to which the document applies.

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

- ASOP No. 5, Incurred Health and Disability Claims
- ASOP No. 8, Regulatory Filings for Rates and Financial Projections for Health Plans: Particular focus is placed on the sections dealing with the Recognition of Benefit Plan Provisions (5.2), Consistency of Business Plan and Assumptions (5.3), Reasonableness of Assumptions (5.4), and Use of Past Experience to Project Future Results (5.5)
- ASOP No. 16, Actuarial Practice Concerning Health Maintenance Organizations and Other Managed-Care Health Plans
- ASOP No. 23, Data Quality: Particular focus is placed on Section 5, Analysis of Issues and Recommended Practices, and Section 6, Communications and Disclosures
- ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverage
- ASOP No. 31, Documentation in Health Benefit Plan Ratemaking

The certification must include the following types of information:

- Name of the actuary, including qualifications. The relationship of the actuary to the organization submitting the bid must also be disclosed.
- Specification that the certification complies with the applicable Federal laws, rules, and instructions and is based on the "average revenue requirements in the payment area for an (Medicare Advantage) enrollee with a national average risk profile."
- Attestation of the reasonableness of the assumptions.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this must be disclosed, and the actuary must obtain a letter of reliance from that person. The reliance letters do not need to be included with the initial bid submission, but must be available upon request and for an audit.
- Limitations and qualifications.

The following is an example of a certification statement. You may revise this language as appropriate for each particular bid.

"I, _____, am a member of the American Academy of Actuaries and am associated with the firm of _____. I am familiar with the requirements for preparing Medicare Advantage bid submissions and meet the Academy's qualification standards for doing so. This bid has been prepared for the Centers for Medicare & Medicaid Services to approve a benefit plan under a Medicare Advantage contract in calendar year ____ as identified by:

Organization Name:

Contract Number:

Plan ID(s):

I hereby certify that to the best of my knowledge and judgment, the entire bid is in compliance with the appropriate laws[1], rules[2], and instructions and complies with the appropriate Actuarial Standards of Practice. In making this statement, I certify that:

- In accordance with Federal law, bid is based on the "average revenue requirements in the payment area for an (Medicare Advantage) enrollee with a national average risk profile."
- The data and assumptions used in the development of the are reasonable and are consistent with the current business plan,
- The bid was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries.

In preparing this bid, I relied upon others for certain data and assumptions as summarized below. A copy of each individual's certification is available upon request.

Name/Title	Affiliation	Data/Information Relied Upon

The impact of unanticipated events subsequent to the date of this bid submission is beyond the scope of my certification.

Further,

_____
[Name and credentials]
[Date]

[Address/Phone]

[1] Social Security Act, Sections 1851 – 1859; and Social Security Act Sections 1860D-1 through 1860D-42.

[2] 42 CFR Parts 400, 403, 411, 417, 422, and 423

Appendix B – Supporting Documentation

In addition to the Rx bid form, plans must provide CMS with additional supporting material. All data submitted as part of the PDP bid process are subject to audit by CMS or any person or organization that CMS designates.

To complete the Rx bid forms, plans will need to complete a series of calculations and enter the results on the appropriate worksheet. Therefore, it is required that any relevant supporting information be summarized and included with the bid submission to CMS. Supporting materials are to be in electronic format (for example, Microsoft Excel, Microsoft Word, or Adobe Acrobat) and will be attached to the bid form as part of the upload process. Organizations will *not* be required to send paper copies of supporting documentation.

CMS requires that the following supporting documentation be included with the bid submission:

- Signed actuarial certification
- Support for the manual rate development

The following additional items are not required to be included with the initial submission, but should be available upon request, and will be reviewed at audit:

- Reconciliation of base period experience with company financial data
- Support for projection assumptions
- Support for non-pharmacy expense assumptions
- Support for risk factors

CMS may also request additional information as part of the bid review process.

Glossary of Terms

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

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

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

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

Alternative Prescription Drug Coverage. See the definition for Actuarial Equivalence. Sponsoring organizations may offer this coverage through plans that provide (1) coverage, the actuarial value of which is at least equal to the actuarial value of standard prescription drug coverage, (2) access to negotiated prices, and (3) are approved by the Secretary. Such coverage must meet certain other statutorily-defined parameters. Specifically, the proposed benefit must meet the following specific actuarial equivalency requirements when compared to defined standard benefit:

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

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

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

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

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

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

1) For 2006. $3600. For defined standard this amount will be reached when the beneficiary true out-of-pocket (TrOOP) equals $5100 in allowed costs.
2) For years subsequent to 2006. The amount specified in this paragraph for the previous year, increased by the annual percentage increase specified in paragraph (e) (5) (iv) of this section, and rounded to the nearest multiple of $50.

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

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

Credibility. The determination of the appropriateness of a plans experience should include the evaluation of the whether the group included in the experience is consistent with the group that the plan expects to cover. In addition, the experience should be representative of the benefits that will be offered in the contract period. For example, a plan that will be offering defined standard Part D coverage must have experience for a benefit with a gap in benefits and catastrophic coverage for a population similar to the population they expect to be covering. It is expected that most plans will not have appropriate base period experience to be used for contract years 2006 or 2007. A plan that has appropriate base period data needs to evaluate the credibility of this data. Although we have not yet established credibility guidelines, we expect that prescription drug experience to have a higher level credibility than medical coverage for a similar sized group. We expect that an appropriate use of actuarial judgment will be exercised in determining the credibility factor for a plan's base period experience.

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

Defined Standard Benefit. All plans develop information for the defined standard benefit. This represents the bid for plans offering defined standard. This represents comparison points for actuarial equivalency tests for plans offering actuarial equivalent cost sharing or alternative coverage. In 2006, defined standard coverage includes:

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

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

Direct Subsidy Payments. PDPs and MA-PD plans receive a monthly "direct subsidy" equal to their bid amount, risk-adjusted for enrollee health status and minus the enrollee premium.

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

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

Initial Coverage Limit. Allowed costs above any deductible where coinsurance would apply. The amount is equal to:

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

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

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

FPL & Assets	Percentage of Premium Subsidy Amount (1)	Deductible	Copayment up to out-of-pocket limit	Copayment above out-of-pocket limit
Full-benefit dual eligible – institutionalized individual	100%*	$0	$0	$0
Full-benefit dual eligible– Income at or below 100% FPL (non-institutionalized individual)	100%*	$0	The lesser of: (1) an amount that does not exceed $1-generic/preferred multiple source and $3-other drugs, or (2) the amount charged to other full subsidy eligible individuals who are not full-benefit dual eligible individuals or whose incomes exceed 100% of the FPL	$0
Full-benefit dual eligible – Income above 100% FPL (non-institutionalized individual)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Non-full benefit dual eligible beneficiary with income below 135% FPL and with assets that do not exceed $6,000 (individuals) or $9,000 (couples)	100%*	$0	An amount that does not exceed $2-generic/preferred multiple source and $5-other drugs	$0
Non-full benefit dual eligible beneficiary with income below 135% FPL and with assets that exceed $6,000 but do not exceed $10,000 (individuals) or with assets that exceed $9,000 but do not exceed $20,000 (couples)	100%*	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs
Non-full benefit dual eligible beneficiary with income at or above 135% FPL but below 150% FPL, and with assets that do not exceed $10,000 (individuals) or $20,000 (couples)	Sliding scale premium subsidy assistance (100%-0%)	$50	15% coinsurance	An amount that does not exceed $2-generic/preferred multiple source drug or $5-other drugs

(1) Premium subsidy amount as defined in §423.780(b)

*The percentage shown in the table is the greater of the low income benchmark premium amount or the lowest PDP premium for basic coverage in the region.

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

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

MA. Medicare Advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Adjustment Factor. Prescription drug risk adjustment methodology based on the relationship of prescription drug utilization within the entire Medicare population to medical diagnoses, and applied at the individual beneficiary level. The long-term plan is to refine the risk adjustment model to account for predictable risk based on both medical and drug claim data.

Risk Corridors limit an insuring entity's risk of losing money but also limit its gains (profits). A target is established based on an estimate of the claims of the benefit. Gains or losses inside a risk corridor around that target would be the full responsibility of the insuring

organization. Additional gains or losses beyond the risk corridor are shared with the federal government. There is no risk-sharing for supplemental benefits.

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

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

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

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

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

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

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

User Fees. These fees are for the purpose of defraying part of the ongoing costs of the national beneficiary education campaign that includes developing and disseminating print materials, the 1-800-MEDICARE telephone line.

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