November 2025 Actuarial User Group Call

Thursday, November 20, 2025
11:00AM - 12:00PM ET

Three ways to join the call—

1) **Join online:**
   - https://teams.microsoft.com/l/meetup-join/19%3ameeting_NzY4OTcwNzQtYjRjZC00YzZlLWJkOTgtNTZhZDlhMDdiYTIw%40thread.v2/0?context=%7b%22Tid%22%3a%22fbdcedc1-70a9-414b-bfa5-c3063fc3395e%22%2c%22Oid%22%3a%224cc0eca3-c89e-4c34-84fe-06bff83243cb%22%7d
   - Meeting ID: 267 152 825 645 0
   - Passcode: YN9Xo9fb
2) **Join by phone:**
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   - https://dialinfo.pexgov.com/?conf=1143285070&ivr=teams&d=video.cms.gov

- Welcome

- CY2026 Bid Review: Lessons Learned
  - We appreciate all the feedback we received during the industry comment period. We have shared pertinent comments with other areas within CMS and are taking the comments into consideration when developing the CY2027 BPTs and Bid Instructions.
  - Supporting Documentation
    - We continue to receive feedback from bid reviewers that submitted Appendix B documentation items do not always clearly tie to amounts in the MA and/or PD BPT and/or do not provide thorough enough explanation.
      - Excel spreadsheets with data that cannot be directly traced back to data entered in the BPT and require manual formulas to tie to the BPT.
      - Definitions of the adjustment factors that provide no additional quantitative support or description of the methodology used to develop the adjustment.
      - Plan sponsors not clearly identifying which adjustments apply to which plans. For population adjustments to risk scores, for example, multiple adjustments are combined.
    - We would like to clarify that Appendix B.7 applies to all non-benefit expenses, which for Part D includes Uncollected Cost Sharing Payments M3P development and assumption support.
    - Additional information not listed by number in Appendix B may be requested by CMS reviewers and auditors at any point during bid desk review or a CMS audit.

        - We want to remind plan sponsors to be mindful of the supporting documentation files being uploaded into HPMS. The files should be complete and relevant to the bid ID for which the files are being uploaded. Please do not upload the same file to bids for which it is not applicable as this causes unnecessary work for CMS and our contractors when sifting through these extraneous files.
    - Related Party
        - We received a comment from industry asking OACT to consider a reporting requirement at the parent organization level within supporting documentation rather than reporting related-party margins in the BPT at the bid level.
        - Related-party arrangements must be reported at the bid level (not at the parent organization level) because CMS' review of these arrangements is conducted for each specific bid.
    - Part B Premium for DE beneficiaries
        - We received a comment from industry asking OACT to clarify whether, in the scenario that a dual-eligible beneficiary's Part B premium is paid by the state's Medicaid plan, does CMS retain the rebate dollars for the Part B premium buydown?

          Yes. The rebate dollars are used to lower the cost of the beneficiary's Part B premium. Additionally, when a Medicare Advantage plan applies a rebate to reduce the Part B premium, that reduction saves money for both CMS and the state. This is because CMS reimburses the state for its share (the Federal Medical Assistance Percentage, or FMAP) of the Part B premium payment. In other words, the rebate helps reduce the overall Part B premium costs that CMS and the state would otherwise pay.
    - Appendix B 8.6.2
        - We remind plan sponsors that Appendix B 8.6.2 requires a comparison in an Excel spreadsheet of (i) data from Worksheet 4, Section IIC, column R, lines a through u in the BPT, and (ii) the best estimate of the same items changing only the A/B mandatory supplemental benefits to be identical to the prior year.
        - Item (ii) in the above must consider both changes in Mandatory Supplemental Benefits that affect Net PMPM for Add'l Svcs (column P) and changes in cost sharing that affect Reduction in A/B Cost Sharing (column Q).
    - To help us respond in a timely manner to feedback that involves other areas of CMS, we remind you to please copy the appropriate resource mailboxes in addition to any emails sent to the actuarial-bids mailbox. These email addresses can always be found in the introductory note within the UGC Q&A file, and a few are noted here:
        - For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
        - For Part D policy-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
        - For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
        - For risk adjustment topics: riskadjustmentoperations@cms.hhs.gov and riskadjustmentpolicy@cms.hhs.gov

- CY2027 Bid Pricing Tools (BPTs)
    - Reminder: List of draft BPT changes is included in the posted agenda.
    - Proposed Changes to MA BPT:
        - We are proposing the removal of VBID-C indicator on Worksheet 1 Section I
        - We are proposing changing the validation on MA Worksheet 6, cell R37 from "If R47 is LIS and R36 is greater than zero, then R37 must be greater than zero" to "If R47 is LIS and R36 is greater than zero, then R37 must be greater than **or equal to** zero." This change addresses cases in which MA rebates are allocated to the Part D basic premium and the LIS is $0.
    - Proposed Changes to Part D BPT:
        - We are proposing the removal of VBID-D indicator on Worksheet 1, Section I.
        - We are proposing the removal of the Total Non-LI Brand Discount Amount on Worksheet 1, cell M60.
        - We are proposing activating the "Uncollected Cost Sharing Payments M3P" line on Worksheet 1, Section IV, cell G52.
        - We are proposing activating and relocating "Manufacturer Discount" on Worksheet 1 from Section III to cell M60. This is because the PDE does not include the manufacturer discount in the CPP field, so it does not need to be subtracted from Average Paid Amount per Member.
        - We are proposing removing Worksheet 7, Section III, line 4 (maximum base beneficiary premium) from the BPT. The 106% limit over the prior contract year BBP still applies.
        - We are proposing adding a critical validation such that the total Part D premium must be greater than or equal to zero. Specifically, WS7 cells F21+F25 must be >= 0.

- CY2027 Bid Pricing Instructions
    - Detailed instructions changes can be seen in Appendix 1 of this agenda.
    - MA and Part D BPT Instruction Changes
        - We intend to add a pricing consideration for catastrophic claims consistent with prior UGC guidance (UGC #937 from 05/16/2013). These represent exceptionally high projected member-level claim amounts that can significantly impact pricing. To address this, plan sponsors may use various approaches—such as obtaining external reinsurance or applying catastrophic claim pooling techniques for claims exceeding a defined attachment point. Catastrophic claim pooling is an optional pricing method allowed in the BPT and is used to adjust for pricing purposes only, not for actual funding arrangements. When applied, it must be net revenue neutral and report adjustments in the Net Cost of Private Reinsurance field on MA Worksheet 4 or PD Worksheet 2 rather than projected medical/claims expenses.
            - In addition, we intend to add Appendix B item 7.2.2, which will be a required supporting documentation item for all plans that participate in catastrophic claim pooling across plans.

- We intend to update the Timing section of Appendix B to clarify that, prior to the final actuarial certification, the following items must be revised and uploaded to be consistent with the final certified bid:
    - All initial supporting documentation items that were required with the initial bid and continue to be required with the final bid must be revised and uploaded. In addition, if issues were discovered with these items during bid desk review, support must be revised to address these issues.
    - All new supporting documentation items that were not applicable to the initial bid, but are applicable to the final bid must be uploaded (for example, if the gain/loss margin as a percentage of revenue at the bid level exceeds 11.5% in the final submission, Appendix B.8.6 must be uploaded even when the gain/loss margin as a percentage of revenue at the bid level did not exceed 11.5% in the initial submission).
    - All upon request items that were requested by the bid desk reviewer must be revised and uploaded.

◦ Risk-Sharing Arrangements

- In OACT's review of the risk sharing payment cells on MA WS1 and MA WS4, we noticed instances of incorrect reporting and would like to clarify these requirements:
    - Capitation payments, including the payout of capitation withholds, must not be reported in these cells.
    - Quality incentive payments based on performance metrics (such as star ratings thresholds, utilization targets, etc.) must be reported in these cells.
- In OACT's review of MA Appendix B Item 23, we identified instances of insufficient documentation and support:
    - Items 23.1 and 23.2 must be provided at the provider arrangement level.
    - Item 23.2 requires a separate submission for each provider arrangement, including a numerical demonstration showing how the payment was allocated across each associated BPT, rather than an example of this for a single provider arrangement.
    - We intend to update the instructions to clarify these requirements.
- In OACT's review of provider payments, we noticed incorrect and inconsistent use of terminology. For example—
    - "Global capitation" is being used to describe provider payments that do not satisfy the definition of capitation. For example, shared savings and losses arrangements are not "global capitation" arrangements.
    - "Payment adjustment," as used in the instructions, appears to cause misunderstandings.
        - We intend to update references to "Payment Adjustment" in the instructions to "Payment" to help clarify. This includes renaming the MA WS1 and MA WS4 risk-sharing cells.

- For CY2028, we are considering an update to the allocation method across service categories in the MA BPT. This update would apply to arrangements with quality incentive payments, payments for shared savings and losses (also referred to as "gain share," "surplus/deficit share," etc.), and similar types of risk-sharing payments:
    - Currently, various allocation methods are used to allocate payments across service categories; establishing a single standard method will ensure consistent reporting.
    - Typically, providers who receive quality incentive payments and payments for shared savings and losses are initially paid to provide a set of medical services directly to their attributed members under capitation or FFS terms. These providers are then further paid to share in claims risk for both services that they provide directly and services that they do not provide directly.
    - Under the proposed update, the risk-sharing payment would be allocated to only the service categories for which the provider directly provides the services rather than to all categories for which the provider's payments are at risk.
    - Part D services are typically not directly provided by the provider accepting risk. Under the proposed update, we would not expect to see amounts reported in the Part D BPT for these arrangements.
    - Please send feedback to this proposal to the actuarial-bids mailbox by 11:59PM PST on December 4, 2025.

◦ MA BPT Instruction Changes

- We intend to remove all references to VBID-H and VBID-C due to discontinuation as of December 31, 2024 and December 31, 2025.
- Base Period Experience
    - We intend to update Rule #4 to clarify that when there is a service area reduction, Worksheet 1 should not include members if all enrollees from a plan crosswalked in CY2026 are fully disenrolled in CY2027. However, if any members remain, Rule #3 applies, and all experience must be reported on Worksheet 1.
- Benefits and Service Categories
    - We intend to relocate the MA Pricing Consideration for "Point-Of-Service (POS)" to be a subcategory within the topic "Benefits and Service Categories".
    - We intend to add clarification for BPT reporting and include an example for "Point-of-Service (POS)" limited benefits in cases where a plan has both coinsurance and an annual limit.
- Supporting Documentation
    - We intend to update Appendix B item 6 in the MA Instructions to clarify that when the PMPM impact of the maximum OOP is zero, the justification must include all applicable Contract-Plan ID-Segment IDs, the source data, and an explicit statement confirming that the value is zero (or essentially zero).

- We intend to update Appendix B item 15 in the MA Instructions to clarify that this item does not apply if the plan audited for CY2026 is not renewed in CY2027. However, any audit findings remain applicable to other plans under the same parent organization in CY2027, and their pricing should be applied consistently with those findings.
- We intend to update Appendix B item 21 in the MA Instructions to clarify that (1) when non-covered services are bundled into a single benefit (e.g., debit/OTC/flex card), each service must be reported separately with its PMPM value consistent with the BPT; and (2) supporting documentation must use terminology consistent with the PBP so benefits can be clearly mapped.

▪ Appendix E – Rebate Reallocation Guidelines

- We intend to update Appendix E guideline 10.1 and 10.2 for scenarios where the Part D basic premium prior to rebates (line 7a of Worksheet 6, Section IIIC) results in a negative value—either at initial submission or after the published direct subsidy is applied to the BPT. In these cases, the amount of unallocated rebates includes the amount required to return the total Part D premium to that originally submitted.
- We intend to update Appendix E guideline 10.3.1 to allow changes in Worksheet 4, cell R108, ensuring the value is between $0.00 and 110% of the unallocated rebate.
- We intend to update Appendix E guideline 11 to clarify that if a plan is out of compliance with the Total Beneficiary Cost (TBC) following the release of published benchmarks, any changes to A/B mandatory supplemental benefits that do not affect the TBC calculation—such as non-covered or Professional Supplemental Benefits not included in the Out-of-Pocket Cost (OOPC) model—must be prioritized before adjusting the MA gain/loss margin PMPM.

◦ Part D BPT Instruction Changes

▪ We intend to update our instructions surrounding estimating the National Average Monthly Bid Amount (NAMBA) and negative Part D premiums.

- We intend to require that the NAMBA must be equal for all plans under a single parent organization.
- Corresponding with the BPT update, we intend to require that the total Part D premium must be greater than or equal to zero.
- We also intend to add Appendix B item 17, which will require support for the NAMBA estimate.
- Due to the updated NAMBA guidance, we intend to remove the instructions that allow for lowering the NAMBA in cases where the Part D basic premium is negative.

- The guidance changes we are making reflect what statute requires, while maintaining a non-negative total Part D premium at initial bid submission, as well as during rebate reallocation. We request feedback regarding the following:
    - The requirement to enhance the Part D benefit at initial submission to maintain a non-negative total Part D premium.
    - The possibility of further enhancement to the Part D benefit during rebate reallocation.
    - Please send responses to the actuarial-bids mailbox by 11:59PM PST on December 4, 2025.

- Since CY2025 is the first base year where the Inflation Reduction Act (IRA) was in place, we intend to make the following adjustments to the instructions for Worksheet 1 reporting:
    - We intend to update the "Mapping of Prescription Drug Events to Part D Claims Experience in Worksheet 1, Section III" table with the updated "Reimbursement for Federal Reinsurance per Member" formula.
    - We intend to update the instructions for the "Column d – Number of Members" cells, to be consistent with the Worksheet 3 instructions, since members progressed through coverage phases in line with the IRA in CY2025.
    - We intend to update the "Plus Part D as Secondary" instructions, which includes an outdated reference to the pre-IRA federal reinsurance amount.
    - We intend to remove instructions for the Total Non-LI Brand Discount Amount and add instructions for the Manufacturer Discount Amount, which replaces this cell in the BPT.
    - We intend to add instructions for the Medicare Prescription Payment Plan (M3P).
- We intend to add instructions indicating that the Estimated Remuneration at Point-of-Sale Amount (ERPOSA) must not be reported in the "Minus Rebates" line of Worksheet 1 and Worksheet 3, since this amount is already netted out of lines 1 through 5 on these worksheets.
- We intend to add an example clarifying that members must be reported in Line 2 on Section III of Worksheet 1 and Worksheet 3 until they satisfy the DS deductible.
- We intend to remove the instructions for the Maximum Base Beneficiary Premium cell on Worksheet 7, since this cell is being removed from the BPT. In conjunction with this, we intend to add instructions explaining that the BBP must be less than or equal to a six percent increase over the prior year's BBP.
- We intend to remove instructions for the VBID-D indicator. All subsequent Worksheet 1, Section I items will be renumbered. In conjunction with this, we removed Appendix B item 17, which was specific to VBID. This item has been replaced with the NAMBA item mentioned above.
- We intend to remove Appendix C, the Employer/Union Only Group (EGWP) Requirements appendix. All subsequent appendices will be re-lettered.

- Please submit comments regarding these proposed **BPT and bid instruction** topics by 11:59 PM Pacific Standard Time on **December 4, 2025** to: actuarial-bids@cms.hhs.gov

- Other Bidding Topics/Announcements
  - Bid Improvement Initiative Program
    - OACT is seeing continuous improvement in the bids being submitted.
    - Outreach is complete.
    - If you have heard from us, we ask that you take the feedback constructively to address our concerns in the next bid submission.
    - If you did not hear from us, please continue to evaluate your supporting documentation and peer review process and make improvements where possible.
  - The Cumulative User Group Call Q&A File has been updated with questions and answers from CY2007 to CY2026 and can be found at: https://www.cms.gov > Medicare > Payment > Medicare Advantage Rates & Statistics > Actuarial Bid Questions

- Live Q&A

- Conclusion

Appendix 1
Proposed Changes to the CY2026 Bid Instructions

Medicare Advantage (MA)

II. PRICING CONSIDERATIONS

Base Period Experience

…

Data Aggregation

- ✓ **Rule 4 – Two-Year Perspective**

  For BPT reporting purposes, the actuary must consider the crosswalks from the base period to the contract period (that is, two years of crosswalks, from CY2025 to CY2026 and then from CY2026 to CY2027) taking into account MARx disenrollment transactions, as explained below. That is, Rule 4 applies only if members are: (i) crosswalked both years or (ii) crosswalked one year and disenrolled the following year.

  - …
  - The calculation of the aforementioned proportion includes the following types of crosswalks and MARx enrollment and disenrollment transactions occurring over the course of the two-year period:
    - …
    - A proposed service area reduction (SAR) for CY2027. The calculation pertains only to prior Bid X members (that is, Bid X members who were moved to Bid Y for CY2026) who will be disenrolled from Plan Y via MARx transactions due to the SAR for CY2027. If all Bid X members are removed for CY2027, then Bid X members should be excluded from the base period. If some of the Bid X members are disenrolled from Bid Y for CY2027 then Rule #3 applies.

…

Benefits and Service Categories

…

Point-of-Service (POS)

There is no separate service category for point-of-service (POS); therefore, POS base period experience data and projected allowed costs must be included in the appropriate service categories.

Section 422.105 of the *Code of Federal Regulations* and Chapter 4 of the *Medicare Managed Care Manual* allow HMOs to offer a POS option as a mandatory or optional supplemental benefit. Therefore, the projected allowed cost of all POS benefits must be allocated to A/B mandatory supplemental benefits or entered in Worksheet 7 consistent with the PBP. The Plan A/B Bid for Medicare-covered services may not include the cost of POS benefits.

For POS limited benefits, any benefit value exceeding the annual limit must be excluded from projected allowed costs. When cost sharing applies, the projected allowed cost should include both the plan-paid amount and the beneficiary cost sharing, but only up to the annual limit. For example, assume an HMO-POS plan covers out-of-network Part B services with 20 percent member coinsurance and a $500 annual limit. If a member incurs a $2,500 out-of-network claim,

the plan pays $500 (its maximum responsibility) and the member pays $125 in coinsurance on the covered portion. The projected allowed cost is therefore $625, and the remaining $1,875 above the annual limit must be excluded from projected allowed costs.

Catastrophic Claims

Catastrophic claims refer to exceptionally high claim amounts at the member level for projected enrollees. The impact of these claims on pricing should be addressed using appropriate pricing techniques. One solution is obtaining reinsurance from an external reinsurer. Another acceptable solution involves applying catastrophic claim pooling techniques for claims that exceed a defined attachment point. Alternative approaches may also be considered when actuarially justified.

Catastrophic claim pooling is permitted as a pricing technique in the MA BPT. This optional technique is for pricing purposes only and does not represent an actual funding or financial arrangement. If an actuary uses catastrophic claim pooling, the pricing must comply with the following conditions:

- The pooling technique is permitted only for the projection period and may not be applied to reporting base period experience. That is, any catastrophic claims in the base period experience must be reflected in WS1, Section III and any pooling present in the base period experience must not be reflected in the Net Cost of Private Reinsurance line 7d of WS1, Section V.
- The pooling calculations must be aggregate net revenue neutral—meaning the total pooling charge across all BPTs must equal the total pooled excess claims.
- The pooling calculations must be entered into the Net Cost of Private Reinsurance entry on MA Worksheet 4. For each BPT, enter the pooling charge minus the bid-specific excess claims. Do not enter the pooling calculations in the BPT by adjusting net projected medical expenses. Therefore, for each BPT, the net projected medical expenses must reflect the full impact of catastrophic claims, while the Net Cost of Private Reinsurance must include the pooling charge and offset any excess catastrophic claims, if applicable.

Non-Benefit Expenses

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

- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries; however, for quota share reinsurance, the net cost of private reinsurance must be entered as $0). Plan sponsors that choose to participate in large claim pooling across plans must reflect the net cost here. The entry must be net revenue neutral across the pool of plans (i.e. pooling charges must equal pooling claims).

APPENDIX B – SUPPORTING DOCUMENTATION

Timing

- Prior to the final actuarial certification—
  - MAOs and certifying actuaries must revise supporting documentation consistent with the final certified bid and must upload any additional information or materials provided during bid desk review to support the bid. Specifically—
    - All initial supporting documentation items that were required with the initial bid and continue to be required with the final bid must be revised and uploaded consistent with the final certified bid. In addition, if issues were discovered with these items during bid desk review, support must be revised to address these issues.

- All new supporting documentation items that were not applicable to the initial bid, but are applicable to the final bid must be uploaded (for example, if the gain/loss margin as a percentage of revenue at the bid level exceeds 11.5% in the final submission, Appendix B.8.6 must be uploaded even when the gain/loss margin as a percentage of revenue at the bid level did not exceed 11.5% in the initial submission).
- All upon request items that were requested by the bid desk reviewer must be revised and uploaded consistent with the final certified bid.

Initial June Bid Submission

6. A detailed description of the process used for adjusting cost sharing due to maximum OOP limits, including how the PMPM impact of the maximum OOP was determined. (Worksheet 3). If the PMPM impact of the maximum OOP is zero, a justification must be included that contains all applicable Contract-Plan ID-Segment IDs, the source data, and an explicit statement that the projected PMPM impact for the contract year equals zero (or "essentially zero").

7.2.2. For the "Net Cost of Private Reinsurance" category, detailed support if the plan sponsor applied catastrophic claim pooling techniques for claims that exceed a defined attachment point. The required elements include the attachment point, the list of plans participating, the pooling charge, the excess claims for each BPT, and any other pertinent information.

15. An explanation of and detailed support for how CY2026 bid audit findings and compliance issues were corrected in the current bid for the same plan. To the extent that an issue applies to other bids in the same contract or parent organization, the documentation for the audited bids must describe how the bids for all plans are treated consistently regarding that issue. This does not apply if the plans audited for CY2026 are not renewed in CY2027. However, any audit findings remain applicable to other plans under the same parent organization in CY2027, and their pricing should be applied consistently with those findings.

21. Support, at the benefit level, for non-covered services (Worksheet 2, lines l through q, column o), if any, including a breakdown of the PMPM value shown in the BPT. For example, a $4.00 PMPM in column o of row p, "Suppl. Ben. Chpt 4 (Non-Covered)," is to be shown in the supporting documentation as $1.50 PMPM for a smoking and tobacco cessation counseling and $2.50 PMPM for medical nutrition therapy. (Detailed support for the pricing of non-covered services is available upon request.)

    21.1 If non-covered services are aggregated into a single benefit (for example, debit card, OTC card, flex card, or any comparable means that can be applied across multiple PBP benefits), the support must report each underlying non-covered service separately. The reporting must include a breakdown of the PMPM value corresponding to each service, consistent with the amounts reflected in the BPT.

    21.2 Ensure that the benefits described in your supporting documentation are consistent with the benefit terminology used in the PBP. Benefits listed in the support must be easily traceable to the corresponding PBP benefits. For example, referencing "Meals on Wheels" in support for the PBP benefit "Food and Produce" is not acceptable unless both benefits are clearly identified and mapped.

23. Support for each provider capitation arrangement and risk-sharing arrangement. The required elements include—

23.1. For each provider capitation arrangement—

a. A description of the arrangement.

b. A numerical demonstration of the methodology used to allocate payments to service categories.

23.2. For each provider risk-sharing arrangement—

a. A description of the arrangement.

b. A numerical demonstration of the methodology used to allocate payments to service categories.

c. A numerical demonstration of the methodology used to allocate payments across each associated BPT.

Appendix E – Rebate Reallocation and Premium Rounding
II. Rebate Reallocation Guidelines

A. Primary Guidelines

10. CMS will not allow MAOs to substantially change A/B mandatory supplemental benefits during the rebate reallocation period. CMS expects only marginal adjustments during this period and will evaluate material differences.

10.1 For a non-RPPO plan, the value of unallocated rebates is defined as the amount of unallocated rebates remaining after achieving the target plan intention for the Part D basic premium.

10.1.1 If the Part D basic premium prior to rebates (line 7a of Worksheet 6, Section IIIC) results in a negative value—either at initial submission or after the published direct subsidy is applied to the BPT—the amount of unallocated rebates includes the amount required to return the total Part D premium to that originally submitted.

10.2 For an RPPO plan, the value of unallocated rebates is defined as the amount of unallocated rebates remaining after—

10.2.1 For an MA-PD plan, (i) applying the MA regional benchmark, and (ii) if applicable, achieving the target plan intention for the Part D basic premium. If the Part D basic premium prior to rebates (line 7a of Worksheet 6, Section IIIC) results in a negative value—either at initial submission or after the published direct subsidy is applied to the BPT—the amount of unallocated rebates includes the amount required to return the total Part D premium to that originally submitted.

10.2.2 For an MA-only plan, applying the MA regional benchmark.

10.3 When changing A/B mandatory supplemental benefits during the rebate reallocation period,—

10.3.1 The change in Worksheet 4, cell R108, must be between $0.00 and 110 percent of unallocated rebate value as described above; and…

11. CMS will allow additional changes to the MA gain/loss margin PMPM when it is required for an MAO to comply with CMS's TBC requirement.

11.1 After CMS's release of the MA regional benchmarks and the Part D benchmarks and prior to an MAO's participation in rebate reallocation for a plan, if the plan's premium increases due to the updates to the benchmarks such that it is no longer compliant with CMS's TBC

requirements, the MAO is required to make any necessary changes to ensure compliance with TBC requirements. Additionally, when making adjustments for TBC compliance, the MAO may be required, permitted, or not permitted to return to the target intention for the Part D basic premium, as specified in applicable guidance.

11.1.1 Changes in A/B mandatory supplemental benefits that do not affect the TBC calculation—such as non-covered or Professional supplemental benefits not included in the OOPC model—must be prioritized before making any adjustment to the MA gain/loss margin PMPM. Any change in the MA gain/loss margin PMPM cannot exceed the amount needed to change the premium such that the plan's TBC value is reduced to equal the TBC threshold amount.

Part D (PD)

PRICING CONSIDERATIONS

PDE Mapping

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

Column	Field Name	PDE Reference Information
(m)	Reimbursement for Federal Reinsurance per Member	Σ {[Gross Covered Drug Cost Above Out-of-Pocket Threshold (GDCA) with Catastrophic Codes A or C] × 0.4 for non-applicable drugs (Drug Status Indicator = 2) or 0.2 for applicable drugs (Drug Status Indicator = 1)] ÷ Members

Catastrophic Claims

Catastrophic claims refer to exceptionally high claim amounts at the member level for projected enrollees. The impact of these claims on pricing should be addressed using appropriate pricing techniques. One solution is obtaining reinsurance from an external reinsurer. Another acceptable solution involves applying catastrophic claim pooling techniques for claims that exceed a defined attachment point. Alternative approaches may also be considered when actuarially justified.

Catastrophic claim pooling is permitted as a pricing technique in the Part D BPT. This optional technique is for pricing purposes only and does not represent an actual funding or financial arrangement. If an actuary uses catastrophic claim pooling, the pricing must comply with the following conditions:

- The pooling technique is permitted only for the projection period and may not be applied to reporting base period experience. That is, any catastrophic claims in the base period experience must be reflected in Worksheet 1, Section III and any pooling present in the base period experience must not be reflected in the Net Cost of Private Reinsurance line 4 of Worksheet 1, Section IV.
- The pooling calculations must be aggregate net revenue neutral—meaning the total pooling charge across all BPTs must equal the total pooled excess claims.

- The pooling calculations must be entered into the Net Cost of Private Reinsurance entry on Worksheet 2. For each BPT, enter the pooling charge minus the bid-specific excess claims. Do not enter the pooling calculations in the BPT by adjusting net projected claims expenses. Therefore, for each BPT, the net projected claims expenses must reflect the full impact of catastrophic claims, while the Net Cost of Private Reinsurance must include the pooling charge and offset any excess catastrophic claims, if applicable.

Direct and Indirect Remuneration (DIR)

Part D sponsors must include all expected amounts CMS will calculate as net covered DIR for the Part D reconciliation process under "Rebates" in the BPT. The DIR reported under "Rebates" represents the Part D sponsors' best estimate of all DIR categories and amounts that CMS will calculate as net covered DIR under the Part D payment reconciliation process for the respective contract year. The development of the DIR amounts must be consistent with the development of projected costs.

Non-Benefit Expenses

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

- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries; however, for quota share reinsurance, the net cost of private reinsurance must be entered as $0). Plan sponsors that choose to participate in large claim pooling across plans must reflect the net cost here. The entry must be net revenue neutral across the pool of plans (i.e. pooling charges must equal pooling claims).

PD BPT WORKSHEET 1

SECTION III – PART D CLAIMS EXPERIENCE

Lines 1 through 4:

- ✓ **Column d – Number of Members**

  Enter the number of members that were in the claim interval defined for each line. Do not include estimates for claims for which the Part D plan is the secondary payer.

  If the member's allowed claims were $0, the member must be reported in Line 1. If the member's allowed claims exceeded $0, but did not exceed the deductible, the member must be reported in Line 2. If the member's allowed claims exceeded the DS deductible, but the member did not satisfy the DS deductible, the member must be reported in Line 2. If the member's allowed claims exceeded the deductible, but the member's TrOOP costs did not exceed the out-of-pocket limit, the member must be reported in Line 3. If the member's TrOOP costs exceeded the out-of-pocket limit, the member must be reported in Line 4.

  TrOOP-eligible costs for drugs not subject to the DS deductible, specifically covered insulin products, as well as TrOOP-eligible costs for drugs not subject to a non-DS plan deductible or drugs subject to a reduced deductible under non-DS plans, all count towards a beneficiary's

satisfaction of the DS deductible. These costs must be considered when determining where members and their costs are reported on Worksheet 1.

Line 7 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates received as of the "Paid through" date in Section II and expected to be received for the claims in lines 1 through 4. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction, net of Estimated Remuneration at Point-of-Sale Amount (ERPOSA). Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

Line 8 – Plus Part D as Secondary

- ✓ **Column g**

  Enter the total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer. The term "total plan liability" is defined as CPP plus NPP minus 40 percent (for non-applicable drugs) or 20 percent (for applicable drugs) of either GDCA or GDCA minus PLRO as appropriate.

Line 11 – Rebates on Supplemental Drugs

- ✓ **Column g**

  Enter the total amount of rebates received as of the "Paid through" date in Section II and expected to be received for the claims in line 10. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction, net of ERPOSA. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

SECTION IV – PMPM NON-BENEFIT EXPENSES

Line 5, column g – Total

Enter the uncollected cost sharing payments associated with the Medicare Prescription Payment Plan (M3P). Exclude all other types of bad debt and all administrative costs incurred from administering the M3P.

SECTION VII – PMPM INCOME STATEMENT SUMMARY

Manufacturer Discount Amount

Enter in cell M60 the total manufacturer discount amount for the base period, which is reported in the "Reported Manufacturer Discount" field on the PDEs.

PD BPT WORKSHEET 3

SECTION III – PART D COVERED DRUG CLAIMS

Lines 1 through 4

- ✓ **Column d – Number of Members**

  Enter the number of members expected to be in the claim interval defined for each line. Do not include estimates for claims for which the Part D plan is the secondary payer.

  If the member's allowed claims are $0, the member must be reported in Line 1. If the member's allowed claims exceed $0, but do not exceed the deductible, the member must be reported in Line 2. If the member's allowed claims exceed the DS deductible, but the member has not satisfied the DS deductible, the member must be reported in Line 2. If the member's allowed claims exceed the deductible, but the member's TrOOP costs have not exceeded the out-of-pocket limit, the member must be reported in Line 3. If the member's TrOOP costs have exceeded the out-of-pocket limit, the member must be reported in Line 4.

  TrOOP-eligible costs for drugs not subject to the DS deductible, specifically covered insulin products, count towards a beneficiary's satisfaction of the DS deductible. These costs must be considered when determining where members and their costs are reported on Worksheet 3.

Lines 2 through 4

- ✓ **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 (i.e. ERPOSA).

Line 6 – Minus Rebates

- ✓ **Column g**

  Enter the total amount of rebates expected to be received for the claims in lines 1 through 4. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Point-of-sale rebates reported in "Column g – Projected Allowed Amount" are not reported here (i.e. ERPOSA). Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates and all other types of DIR must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

PD BPT WORKSHEET 7

SECTION III – SUMMARY OF KEY BID ELEMENTS

Line 2 – National Average Monthly Bid Amount (NAMBA)

Enter the Part D sponsor's estimate of the NAMBA at the time of bid submission. The final NAMBA for CY2027 will be calculated and published by CMS after the initial June bid submission.

The NAMBA estimate must be equal for all plans under a single parent organization.

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

The values are calculated automatically in the BPT. Line 5 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 13 of this section has been applied. The basic Part D premium, before and after the rounding rule is applied, will be updated based on the final NAMBA and BBP that are calculated and published by CMS after the initial June bid submission.

The total Part D premium (Worksheet 7, line 5 plus Worksheet 7, line 7) must be greater than or equal to zero.

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

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 13 of this section has been applied.

The total Part D premium (Worksheet 7, line 5 plus Worksheet 7, line 7) must be greater than or equal to zero.

APPENDIX B – SUPPORTING DOCUMENTATION

Timing

- Prior to the final actuarial certification—
  - Part D sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid and must upload any additional information or materials provided during bid desk review to support the bid. Specifically—
    - All initial supporting documentation items that were required with the initial bid and continue to be required with the final bid must be revised and uploaded consistent with the final certified bid. In addition, if issues were discovered with these items during bid desk review, support must be revised to address these issues.
    - All new supporting documentation items that were not applicable to the initial bid, but are applicable to the final bid must be uploaded (for example, if the gain/loss margin as a percentage of revenue at the bid level exceeds 11.5% in the final submission, Appendix B.8.6 must be uploaded even when the gain/loss margin as a percentage of revenue at the bid level did not exceed 11.5% in the initial submission).
    - All upon request items that were requested by the bid desk reviewer must be revised and uploaded consistent with the final certified bid.

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7.2.2. For the "Net Cost of Private Reinsurance" category, detailed support if the plan sponsor applied catastrophic claim pooling techniques for claims that exceed a defined attachment point. The required elements include the attachment point, the list of plans participating, the pooling charge, the excess claims for each BPT, and any other pertinent information.

17. Detailed support for the development of the Part D sponsor's estimate of the NAMBA in line 2 of Worksheet 7.