DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-22
Baltimore, Maryland 21244

CENTER FOR MEDICARE

Date: August 18, 2010

To: All Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors

From: Jonathan Blum, Director, Center for Medicare

Subject: Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information

CMS is announcing today that the Part D national average monthly bid amount for 2011 is $87.05, the 2011 Part D base beneficiary premium is $32.34, and the de minimis amount is $2. Please see the attached notice for more detailed information concerning the 2011 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the Medicare Advantage regional PPO benchmarks.

Detailed information regarding the de minimis amount and the prospective Medicare coverage gap discount program payments is also attached in a separate memo. The memo also contains instructions and a timeline for volunteering to waive the de minimis amount and completing rebate reallocation. Plans will have until 11:59 PM Eastern Time on Monday, August 23rd to inform CMS of their intent to participate in the de minimis program and complete rebate reallocation.

Further Information
If you have questions, please contact Deondra Moseley at (410) 786-4577 or Meghan Elrington at (410) 786-8675.

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Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

OFFICE OF THE ACTUARY

DATE: August 18, 2010

NOTE TO: Medicare Advantage Organizations, Medicare Prescription Drug Plan Sponsors, and Other Interested Parties

SUBJECT: Annual Release of Part D National Average Bid Amount and other Part C & D Bid Related Information

Today we are releasing the 2011 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the Medicare Advantage regional PPO benchmarks.

Below we describe the determination of these amounts. The regional low-income premium subsidy amounts and the regional MA benchmarks can be downloaded from the CMS web site at:

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

Part D National Average Monthly Bid Amount

In accordance with section 1860D-13(a)(4) of the Social Security Act ("the Act"), codified in 42 CFR §423.279 CMS has calculated the national average monthly bid amount for 2011. For each coverage year, CMS computes the national average monthly bid amount from the applicable Part D plan bid submissions in order to calculate the base beneficiary premium, as provided in 42 CFR §423.286(c).

The national average monthly bid amount is a weighted average of the standardized bid amounts for each prescription drug plan and for each MA-PD plan described in section 1851(a)(2)(A)(i) of the Act. The weights are based on the number of enrollees in that plan. The weight for each plan bid is equal to a percentage with the numerator equal to the number of Part D eligible individuals enrolled in the plan in the reference month (as defined in 42 CFR §422.258(c)(1)) and the denominator equal to the total number of Part D eligible individuals enrolled in the reference month in all applicable Part D plans. The calculation does not include bids submitted by MSA plans, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, any "fallback" prescription drug plans, and plans established through reasonable cost reimbursement contracts under section 1876(h) of the Act. The reference month for the 2011 calculation was June 2010.

The national average monthly bid amount for 2011 is $87.05.

Part D Base Beneficiary Premium

The base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount. The beneficiary premium percentage ("applicable percentage") is a fraction, with a numerator of 25.5 percent and a denominator that is 100 percent minus a

percentage equal to (i) the total reinsurance payments that CMS estimates will be paid for the coverage year, divided by (ii) that amount plus the total payments that CMS estimates will be paid to Part D plans based on the standardized bid amount during the year, taking into account amounts paid by both CMS and plan enrollees.

In accordance with section 1860D-13(a) of the Act, codified in 42 CFR §423.286, Part D beneficiary premiums are calculated as the base beneficiary premium adjusted by the following factors: (i) the difference between the plan's standardized bid amount and the national average monthly bid amount; (ii) an increase for any supplemental premium; (iii) an increase for any late enrollment penalty; (iv) a decrease for Medicare Advantage Prescription Drug Plans (MA-PDs) that apply MA A/B rebates to buy down the Part D premium; and (v) elimination or decrease with the application of the low-income premium subsidy.

The Part D base beneficiary premium for 2011 is $32.34. [1]

Part D Regional Low-Income Premium Subsidy Amounts

In accordance with 42 CFR §423.780, full low-income subsidy (LIS) individuals are entitled to a premium subsidy equal to 100 percent of the premium subsidy amount. The premium subsidy amount is equal to an amount which is the lesser of the plan's premium for basic coverage or the regional low-income premium subsidy amount.

The regional low-income premium subsidy amounts are the greater of the low-income benchmark premium amount for a PDP region or the lowest monthly beneficiary premium for a prescription drug plan that offers basic prescription drug coverage in the PDP region. In accordance with section 1860D-14 of the Social Security Act and the Final Rule "Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount," published in the Federal Register on April 3, 2008, the low-income benchmark premium amount for a PDP region is a weighted average of the monthly beneficiary premiums for basic prescription drug coverage in the region. The weight for each PDP and MA-PD plan is equal to a percentage—the numerator being equal to the number of Part D eligible LIS individuals enrolled in the plan in the reference month and the denominator equal to the total number of Part D eligible LIS individuals enrolled in all PDP and MA-PD plans in a Part D region in the reference month.

The Affordable Care Act amends the statute governing the calculation of the LIS benchmark premium amount (see section 3302, as amended by section 1102 of HCERA). As amended, Section 1860D-14(b)(3)(B)(iii) of the Act requires the calculation of the weighted average premium amounts described above using MA-PD basic Part D premiums before the application of Part C rebates each year.

The calculation does not include bids submitted by MA private fee-for-service plans, PACE programs under section 1894, "800 series" plans, and contracts under reasonable cost reimbursement contracts under section 1876(h) of the Act ("Cost Plans"). The reference month for the 2011 calculation was June 2010.

The regional low-income premium subsidy amounts are provided in a spreadsheet called "PartDLowIncomePremiumSubsidyAmounts2011-final.csv" which can be accessed on the CMS website through the following path:

[1] As noted above, the actual Part D premiums paid by individual beneficiaries equal the base beneficiary premium adjusted by a number of factors. In practice, premiums vary significantly from one Part D plan to another and seldom equal the base beneficiary premium.

www.cms.hhs.gov > Medicare > Medicare Advantage Rates & Statistics (under the Health Plans header) > Ratebooks & Supporting Data > 2011 > Regional rates and benchmarks 2011

A direct link to the Ratebooks & Supporting Data page is:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

MA Regional PPO Benchmarks

Per section 1858(f)(2), the standardized benchmark for each MA region is a blend of two components: (i) a statutory component consisting of the weighted average of the county capitation rates across the region; and (ii) a competitive, or plan-bid, component consisting of the weighted average of all of the standardized A/B bids for regional MA PPO plans in the region. (Such regional MA plan bids relate to the benefits covered under Parts A and B of Medicare.) The two components are then blended for each region, with the statutory component reflecting the national market share of traditional Medicare and the regional MA plan-bid component reflecting the market share of all MA organizations in the Medicare population nationally. In other words, the weights used to combine the statutory and competitive components of the benchmark are the same for all regions and equal the national enrollment percentages for traditional Medicare and all MA plans. For 2011, the national weights applied to the statutory and plan-bid components are 74.6 percent and 25.4 percent, respectively.

The separate weighted-average statutory component and weighted-average competitive component in each region are determined based on the following weights:

- The weighting for the statutory component is based on all MA eligible individuals in the region—i.e., all Medicare beneficiaries who are either in the traditional, fee-for-service Medicare program or enrolled in MA plans and who are entitled to benefits under Part A and enrolled in Part B.
- The weighting for the plan-bid component is based on the enrollment in regional MA plans in the region for the reference month of June 2010. (That is, the weight for each plan's bid is based on the plan's market share in the region.)

The statutory and plan-bid components of the MA regional standardized benchmarks for 20 of the 26 MA regions[2] are in a file labeled "MARegionalRate2011-final.csv" which can be accessed on the CMS website through the following path:

www.cms.hhs.gov > Medicare > Medicare Advantage Rates & Statistics (under the Heath Plans header) > Ratebooks & Supporting Data > 2011 > Regional rates and benchmarks 2011

The direct link to the Ratebooks & Supporting Data page is:
http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp

/s/
Paul Spitalnic, A.S.A., M.A.A.A.
Director Parts C & D Actuarial Group
Office of the Actuary
Centers for Medicare & Medicaid Services

[2] In the remaining 6 MA regions, there are no regional MA plans.

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CENTER FOR MEDICARE

Date: August 18, 2010

To: All Medicare Advantage Organizations and Medicare Prescription Drug Plan Sponsors

From: Cheri Rice, Acting Director, Medicare Plan Payment Group

Subject: Release of the De Minimis Amount, Prospective Medicare Coverage Gap Discount Program Payments and Operational Guidance

In this memo CMS is releasing information regarding the de minimis amount and the prospective Medicare coverage gap discount program payments. This memo also contains instructions and a timeline for volunteering to waive the de minimis amount and completing rebate reallocation. Plans will have until 11:59 PM Eastern Time on Monday, August 23rd to inform CMS of their intent to participate in the de minimis program and complete rebate reallocation.

De Minimis Amount

Under the Affordable Care Act (ACA) §3303(a), a prescription drug plan (PDP) or Medicare Advantage Plan with Prescription Drug coverage (MA-PD) may volunteer to waive the portion of the monthly adjusted basic beneficiary premium that is a de minimis amount above the low-income subsidy (LIS) benchmark for a subsidy eligible individual. This provision was also announced in the Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, which was released on April 5, 2010. The law also prohibits CMS from reassigning LIS members from plans who volunteered to waive the de minimis amount.

The de minimis amount for 2011 will be $2.

Prospective Medicare Coverage Gap Discount Program Payments

Section 3301 of the ACA, as amended by the HCERA, establishes the Medicare Coverage Gap Discount Program (the "Discount Program"), which will make manufacturer discounts available to non-low income subsidy eligible (non-LIS) Medicare Part D beneficiaries. These beneficiaries will receive manufacturer discounts for applicable brand drugs while in the coverage gap starting in 2011. As stated in the Part D Sponsor guidance on the Discount Program released May, 21, 2010, CMS will provide monthly prospective payments to Part D sponsors for the manufacturer discounts made available to their enrollees under this program. Similar to our current policy for prospective low-income cost sharing subsidy and reinsurance subsidy payments, EGWPs will not receive prospective discount program payments. CMS has calculated the monthly prospective discount program payments that Part D sponsors will receive for each non-LIS enrollee in 2011. These monthly prospective discount program payments are now available in HPMS on the Part C & D Bid and

Premium Information page. Part D sponsors may use the following pathway to view their plan specific prospective discount program payment amounts: HPMS Homepage > Plan Bids > Bid Submission > Contract Year 2011 > Manage Plans> Review Plan Data > Part D Payment Amounts. Information regarding the calculation of these prospective discount program payments is provided below.

Calculation Methodology for 2011 Prospective Discount Program Payments

The monthly prospective discount program payments for each Part D sponsor is based on the coverage gap drug cost and low-income subsidy enrollment projected in the 2011 Part D bid. Specifically, the projected amount for coverage gap drug costs (gap PMPM costs) is calculated in the Bid Pricing Tool in Worksheet 3 for "defined standard" and "actuarially equivalent" plan types and Worksheet 5 for "basic alternative" and "enhanced alternative" plan types. In addition, the proportion of non-LIS enrollees is calculated using the projected enrollment included in Worksheet 3 of the Bid Pricing Tool.

The first step is to calculate the "non-LIS gap amount", the estimated amount that non-LIS beneficiaries will spend in the coverage gap. The non-LIS gap amount is calculated by adjusting the plan projected gap amount based on the proportion of non-LIS enrollees and the national relationship of LIS gap costs to non-LIS gap costs. Based on 2009 program experience for beneficiaries not enrolled in employer plans, LIS beneficiaries are assumed to have 3.66 times more spending in the coverage gap than non-LIS beneficiaries.

The next step is to calculate the "non-LIS brand gap amount", the estimated amount that non-LIS beneficiaries will spend in the coverage gap for brand drugs. The non-LIS brand gap amount is calculated by adjusting the non-LIS gap amount by the national proportion of brand drug costs in the coverage gap for non-LIS beneficiaries. Based on 2009 program experience for beneficiaries not enrolled in employer plans, 77.9% of non-LIS coverage gap spending is on brand drugs.

The non-LIS brand gap amount is then compared to amounts in the bid to ensure it is less than the total available brand gap amount. For "defined standard" and "actuarially equivalent" plan types the available brand gap amount is the total coverage gap amount less the non-LIS coverage gap amount for generics. For "basic alternative" or "enhanced alternative" plan types, the available brand gap amount is the alternative coinsurance amount in the coverage gap.

The final step is to apply the 50% factor for the lesser of the estimated non-LIS brand gap amount or the available gap amount. Provided below are two examples of the monthly prospective discount program payment calculation.

Examples

A. Defined Standard or Actuarially Equivalent plan

Step	Value	Calculation
1. Percentage of LIS Beneficiaries	40%	WS3: L11/D11
2. Gap Amount PMPM	$75.00	WS3: J25
3. Generics in Gap PMPM	$10.00	WS3: J26
4. Non-LIS Gap Amount PMPM	$36.34	$75.00/((3.66*40%)+(1-40%))
5. Non-LIS Brand Gap Amount PMPM	$28.31	$36.34*77.9%
6. Total Brand Gap Amount PMPM	$65.00	$75.00-$10.00
7. Lesser of Non-LIS Brand Gap Amount or Total Brand Gap Amount PMPM	$28.31	Lesser of $28.31 or $65.00
8. Discount Amount	$14.15	$28.31*50%

B. Basic Alternative or Enhanced Alternative plan

Step	Value	Calculation
1. Percentage of LIS Beneficiaries	40%	WS3: L11/D11
2. Gap Amount PMPM	$75.00	WS5: K37
3. Gap Alternative Coinsurance Amount	$60.00	WS5: K50
4. Non-LIS Gap Amount PMPM	$36.34	$75.00/((3.66*40%)+(1-40%))
5. Non-LIS Brand Gap Amount PMPM	$28.31	$36.34*77.9%
6. Total Brand Gap Amount	$60.00	WS5: K50
7. Lesser of Non-LIS Brand Gap Amount or Total Brand Gap Amount PMPM	$28.31	Lesser of $28.31 or $60.00
8. Discount Amount	$14.15	$28.31*50%

Operational Considerations – Action by 11:59PM EDT on Monday, August 23, 2010

Rebate Reallocation

Plan-specific information, such as plan standardized bid amounts, plan-specific premiums, and MA rebate dollars used, can be found at the following path in HPMS:

HPMS Home > Plan Bids > Bid Submission > Contract Year 2011 > Manage Plans > Review Plan Data.

After reviewing the plan-specific information in HPMS, some bids may need to be resubmitted to adjust the MA rebate dollars in the Bid Pricing Tool (BPT). Local MA-only plans (which do not offer Part D), PDPs (which do not have MA rebates), and local employer plans (non-regional "800-series" plans) cannot resubmit their bids during the rebate reallocation period.

Guidance on rebate reallocation and premium rounding can be found in Appendix E of the Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2011. Changes to the Bid Pricing Tool must be in accordance with the guidance contained in Appendix E.

You will have until 11:59PM EDT on Monday, August 23, 2010 to complete any resubmissions.

If resubmitting, the Part D bid pricing tools must reflect the final benchmarks released earlier in this announcement. No pricing changes will be accepted to the Part D bid forms. Since the Part D bid is not changing, there is no need to update the Date Prepared field in the PD BPT.

A "final" actuarial certification must be submitted by all plans later this month. A separate announcement will be released regarding the submission of final actuarial certifications.

If you have questions about this information, please contact Jennifer Lazio at 410-786-0747.

If you have technical questions about your resubmissions, please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov.

Volunteering to Waive the De Minimis Amount

Eligible plans must actively inform CMS of their intent to participate in the de minimis program. Plans will have until 11:59 PM Eastern Time on Monday, August 23rd to inform CMS of their intent to participate.

The mechanism to volunteer for de minimis can be found at the following path in HPMS: HPMS Home>Plan Bids>Bid Submission>Contract Year 2011>Manage Plans. The 'Voluntary De Minimis' link will be available at the left navigation bar. The default value will be unchecked (i.e., "No"), so eligible plans must select the checkbox to indicate that they want to volunteer to participate.

For questions, please contact Deondra Moseley at Deondra.Moseley@cms.hhs.gov or 410-786-4577 or Meghan Elrington at Meghan.Elrington@cms.hhs.gov or 410-786-8675.