

Actuarial Bid Training

Presentation: Introduction to Bidding

[SLIDE #1] Welcome to the “Introduction to Bidding” Actuarial Training Session. It’s aimed at new users of CMS’s bid pricing tool, but returning users may find it useful also. The goal is to introduce and explain basic but important concepts and terms used in the bidding process as a means of preparing people to use CMS’s bid pricing tool (or BPT). A separate training session, called BPT101, elaborates on this session by describing the structure and content of the BPTs. This session provides an overview of the competitive bidding process, beginning with elements that apply to both the Medicare Advantage and Part D programs, and then proceeding to program-specific terms and concepts.

[SLIDE #2] In 2003, Congress enacted “The Medicare Prescription Drug, Improvement, and Modernization Act” commonly referred to as MMA. Title I of the Act created Medicare Part D, which established prescription drug coverage within Medicare. Title II of the Act defined the Medicare Advantage (or MA) program, which was previously called the Medicare-Plus-Choice Program. MMA also defined the bidding process that is described in these slides.

[SLIDE #3] The competitive bidding process defined by MMA applies to both the MA and Part D programs. It was first used for Contract Year 2006. It is an annual process that encompasses the release of the MA rate book in April, the bid’s that plans submit to CMS in June, and the release of the Part D and RPPD benchmarks, which typically occurs in August.

[SLIDE #4] To be acceptable to CMS, each bid must—
present the estimated revenue requirements of the plan

Ensure that bid amounts are standardized with respect to risk, and
Adequately document the methods and assumptions used to develop the bid, in
compliance with—

Any applicable Actuarial Standards of Practice;

The CMS bid instructions; and

All applicable rules or laws.

The bid must also be certified by a qualified actuary.

In summary, each bid must include—a completed bid pricing tool, adequate
documentation, and an actuarial certification.

[SLIDE #5] The plan’s revenue requirement is equal to Benefit Expenses plus Non-
benefit Expenses plus a Gain/Loss or profit margin. This amount is reported on a PMPM
basis in the BPT.

[SLIDE #6] Risk scores enable CMS to view bid amounts on a standardized basis.
Projected costs that are based on actual plan experience will necessarily reflect the risk
profile of that plan’s population. When these costs are divided by the plan’s risk score,
the costs become “standardized.” Standardized costs have a risk score equal to one,
which means that they reflect the risk profile of the average Medicare beneficiary. Risk
scores are based on a beneficiary’s demographic characteristics, health status, and disease
information. They are used to standardize bid amounts and to adjust payments to plans.
Separate risk models are used for Medicare Advantage and Part D.

[SLIDE #7] CMS understands that organizations do extensive pricing and analysis in
their own models before they fill out the bid pricing tool. The instructions for filling out
the BPT are comprehensive and—in some areas—rigid. For example, bids must report

plan experience and assign it an appropriate level of credibility. Achieving desired pricing results using manual rates and experience credibility factors that are understated or set equal to zero is not acceptable. Where the BPT does allow some flexibility is in the gain/loss margin. Recall that the Gain/loss margin is added to benefit expenses and non-benefit expenses in calculating the plan's revenue requirement. At the plan level, bidders have flexibility in setting the gain/loss margin to produce the desired revenue requirement. However, at the contract level, the gain/loss margin is more restricted. See the Bid Instructions for more details about gain/loss margin. We now turn to concepts and terms associated with plans offered under the MA program.

[SLIDE #8] Medicare Advantage continues to offer Medicare beneficiaries an alternative to fee-for-service coverage under Medicare Parts A and B, namely beneficiaries may choose plan coverage under Medicare Advantage through a variety of plan types, including—HMOs, PPOs, private-fee-for-service plans, and others. MMA added a new type of plan called a Special Needs Plan, or “SNP;” these plans can target specific Medicare populations for enrollment, such as: 1) institutionalized beneficiaries; 2) people who are dually eligible for Medicare and Medicaid; and/or 3) individuals with severe or disabling chronic conditions. MMA also introduced a new plan type called a regional PPO, and CMS defined 26 regions made up of individual states or groups of states; for these plans, the service area must be one of the 26 regions. All other MA plans (i.e., non-RPPOs) can have service areas that are as small as one county but can include multiple counties.

[SLIDE #9] Since MA plans are an alternative to coverage under Parts A and B, Medicare Advantage plans **MUST**—cover all items and services that Medicare

beneficiaries receive under Parts A and B. It is worth noting that Parts A and B are referred to in many ways, including— “Basic” services, “Medicare-Covered” services, “Medicare FFS,” “Original Medicare,” or “Traditional Medicare.”

Medicare Advantage plans **MAY**—and often do—cover additional benefits, that is, benefits NOT covered under the traditional Medicare program. These fall into two categories.

Mandatory Supplemental Benefits are additional benefits that the plan covers **for every person enrolled in the plan.**

Optional Supplemental Benefits are additional benefits that enrollees **may elect to purchase separately.**

[SLIDE #10] Mandatory Supplemental Benefits can be provided in the form of reduced cost sharing or in the form of additional benefits.

Reduced cost sharing, is also called “FFS cost-sharing buydown.” It applies when cost sharing under the MA plan is less than cost sharing under traditional Medicare. An example is an MA plan that does not have a hospital deductible.

Additional benefits include coverage of Non-covered services, which is anything not offered under traditional Medicare, like routine dental benefits, for example. Additional benefits also include coverage of Medicare-covered services beyond the limits included in traditional Medicare. For example, covering inpatient hospital days beyond the Medicare lifetime limit would be considered an additional benefit.

[SLIDE #11] The bid process for MA plan relies on two benchmarks amounts: one for regional plans and one for all other plans. The non-regional benchmark is a weighted average of county-specific rate book values, where the weights are each county’s share of

the total projected enrollment for the plan. For regional PPOs, the benchmark is a blend of two components: A statutory component, which is based on rate book values; and a plan bid component, which is based on plan bid amounts.

[SLIDE #12] The amount that CMS pays plans to provide coverage to Medicare beneficiaries is always risk adjusted, i.e., it depends on the risk score of each beneficiary, but it also depends on the relationship between the plan's bid amount and the MA benchmark. If the bid amount is greater than the benchmark, CMS pays the benchmark amount, and the beneficiary pays the difference (i.e., the bid minus the benchmark). If the bid is less than the benchmark, CMS pays the bid amount plus the MA rebate amount which is equal to a percentage of the difference (i.e., the benchmark minus the bid amount). The percentage is between 50% and 75% and depends on the plan's quality rating.

[SLIDE #13] It is instructive to consider the component parts of the total plan payment—the bid amount and the rebate—in terms of the benefits that they fund. The bid amount funds the Medicare Covered services included in the plan's total benefits. The rebate funds all other benefits, usually called supplemental benefits, provided by the plan. Supplemental benefits, however, can be provided in different forms: they can be used to reduce premiums (for Part B or Part D benefits), they can be used to reduce cost sharing for Medicare Covered Services, or they can be used to increase benefits. Note that increased benefits can be—either expansion of Medicare Covered benefit limits or offering benefits not offered under traditional Medicare, such as vision benefits. Next we consider plans offered under the Part D program.

[SLIDE #14] Under the Part D program, coverage is provided and administered exclusively by private plans. Plan sponsors can offer prescription drug benefits in conjunction with an MA plan, which is then called an MA-PD, or they can offer a stand-alone Prescription Drug Plan (or PDP), which is region-based. CMS has defined 34 state-based regions and 5 regions that cover U.S. territories.

[SLIDE #15] This slide summarizes the “Part D Defined Standard Benefit” using 2006 benefit values for illustrative purposes. In actuality, these values are indexed and updated by CMS every year. Under the Defined Standard Benefit, the amount that the plan pays varies as the amount spent on drugs reaches certain thresholds. For example, if total drug spending (shown in the first column) is less than the Deductible amount of \$250, the beneficiary pays 100% of the cost. For drug spending in excess of the deductible but less than the Initial Coverage Limit (or ICL), the beneficiary pays 25% and the plan pays 75%. For costs in excess of the ICL, the beneficiary once again pays 100% of the cost—and this continues until catastrophic coverage comes into play, which happens when “Beneficiary Spending” (shown in the second column) reaches the TrOOP spending threshold of \$3,600. TrOOP stands for true out-of-pocket cost to the beneficiary. For catastrophic coverage, the beneficiary pays the lesser of co-payment amounts or 5% of the cost; the plan pays 15% and the government pays 80%. The amount the government pays is called “federal reinsurance.” It should be noted that the Affordable Care Act will modify the chart in this slide in 2 important ways: First, it will reduce what non-LIS beneficiaries pay in the coverage gap—grading from 100% in 2010 to 25% in 2020; second, the reduction of beneficiary spending in the gap results in each beneficiary

having a unique drug spending amount to reach TrOOP instead of the constant \$5,100 shown in this slide.

[SLIDE #16] There are four Benefit Types for Part D plans.

The first is the “Defined Standard,” which **offers** the Standard Benefit package summarized on the previous slide.

The second benefit type is “Actuarially Equivalent.”

These plans are NOT permitted to alter the Deductible or the ICL amounts determined for the Defined Standard benefit. But these plans MAY vary the cost-sharing requirements between the Deductible and the ICL, and above the catastrophic coverage limit; for example by instituting co-pays. Actuarially Equivalent plans must pass three actuarial equivalence tests in the bid pricing tool.

[SLIDE #17] The third and fourth types of plans are called alternative plans: one is the Basic Alternative plan and the other is the Enhanced Alternative plan.

Alternative plans MAY reduce the deductible, and they may increase or decrease the ICL.

Alternative plans MAY vary the cost-sharing requirements between the deductible and the ICL, and also above the catastrophic threshold.

Alternative plans must pass six actuarial equivalence tests in the bid pricing tool.

Enhanced Alternative plans offer supplemental benefits by—reducing cost sharing, or by covering non-covered Part D drugs, or both; this may include providing coverage in the gap. Enhanced Alternative plans charge a supplemental premium that covers the value of the supplemental benefits, non-benefit expenses and any gain/loss margin.

[SLIDE #18] The Part D national average monthly bid amount and the base beneficiary premium are used to determine the premium payment for each plan. The National Average Monthly Bid Amount is a weighted average of bids submitted to CMS excluding any supplemental premiums. The national average is typically released by CMS in August.

The Base Beneficiary Premium is equal to 25.5% of the national average, after an adjustment for reinsurance. The part D basic premium is set equal to the plan bid amount minus the national average monthly bid amount plus the base beneficiary premium.

[SLIDE #19] Next we'll discuss the components of Plan Payment under Part D, which include the Direct Subsidy, the Federal Reinsurance Subsidy, Risk Sharing, and the Low Income Subsidy, or "LIS".

[SLIDE #20] The Direct Subsidy funds the portion of the Defined Standard benefit paid by the plan. It is based on 75% of costs incurred between the deductible and the ICL and 15% of costs incurred beyond the catastrophic coverage limit.

The Direct Subsidy is based on the standardized bid amount, then risk adjusted for health status, and net of beneficiary premiums.

Federal Reinsurance provides periodic payments during the year, which are reconciled after the end of the year. The federal government reimburses the plan for 80% of costs in the catastrophic coverage level.

[SLIDE #21] Risk sharing limits the plan's and the government's exposure to unexpected expenses not included in the reinsurance subsidy or accounted for through risk adjustment.

The federal government and plan share in experience that differs from that projected in the bids.

Risk corridors are symmetrically structured around the Plan's target amount.

[SLIDE #22] Target amount = direct subsidy + beneficiary premiums + A/B rebate applied to premium – administrative cost ratio.

Reconciliation of risk sharing involves determining the difference between the Plan's target amount and actual allowable costs excluding administrative expenses.

[SLIDE #23] Allowable risk corridor costs are equal to actual plan paid costs for covered Part D drugs under the Defined Standard benefit excluding—Direct and Indirect Remuneration (or DIR), enhanced alternative cost-sharing amounts, federal reinsurance payments, Low Income Cost-sharing subsidy payments and beneficiary cost sharing. If a Plan offers supplemental benefits, the insurance effect of supplemental coverage, or induced utilization, is excluded.

[SLIDE #24] Risk corridors determine how the plan and the government share gains and losses that arise when actual plan costs differ from the plan costs projected in the bid. The applicable risk corridors for contract years 2008 through 2011 are as follows. The plan retains 100% of the difference if it is less than 5%. If the Difference is between 5% and 10%, it is shared equally between the plan and the government. And if the difference is greater than 10%, the plan retains 20% and the government retains 80%. Note that when the difference results in a gain (i.e., actual costs are less than projected costs) the plan pays the government; whereas, if the difference results in a loss, (i.e., the actual costs are greater than the projected costs) then the government pays the plan.

[SLIDE #25] The Low Income Premium Subsidy is the amount paid to plans by the government for LIS beneficiaries.

The subsidy is equal to the lesser of:

The Part D basic premium for the plan, and

The Low Income regional benchmark. However, if the lowest PDP premium in the region is greater than the Low Income regional benchmark, it should replace the Low Income regional benchmark in the determination of the subsidy.

When LIS beneficiaries enroll in plans where the plan premium is greater than the subsidy, they are required to pay the difference.

[SLIDE #26] The Low Income Premium Benchmarks that are used in the determination of the subsidy are based on submitted plan premiums.

These benchmarks are typically released by CMS in August.

Low income beneficiaries benefit from:

A reduced or eliminated deductible,

Reduced cost-sharing,

A reduced or eliminated premium, and

No late enrollment penalty.

[SLIDE #27] LIS beneficiaries pay reduced cost-sharing amounts for Part D coverage.

The low income cost sharing subsidy funds the difference between cost sharing amounts actually paid by LIS beneficiaries and the plan's cost sharing amounts for non-LIS beneficiaries. It is paid prospectively to the plan sponsor based on estimated amounts submitted in the bid. During reconciliation there is a true-up for the actual amount.

[SLIDE #28] This concludes the “Introduction to Bidding” training session. For further guidance please view “BPT101” and the other Bidder Training Sessions. You will then be well prepared to read the Bid instructions, which can be found at the links listed in this slide.