Instructions for Submitting Justification of Medicare Advantage Mid-Year Benefit Enhancement For Contract Year 2006

May 1, 2006

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Introduction

CMS will allow one mid-year benefit enhancement (MYBE) per plan to be submitted by a Medicare Advantage (MA) organization for the improvement of only mandatory supplemental non-prescription drug benefits. Consistent with the discussion in the MA final rule permitting only non-Part D benefits as a MYBE, we will not permit an MYBE that would provide only cash in the form of a reduced Part B premium or Part C premium for A and B services.

Consistent with our April 24, 2006, memorandum, MYBE proposals can only be submitted to CMS between June 1 and June 30, 2006. See Appendix B for submission instructions. Enhancements can be effective only on September 1, 2006, and will be in effect for the remainder of the calendar year.

MYBE proposals must be funded by forecasted CY 2006 plan retention (that is, revenues less medical expenses) that is in excess of the retention reflected in the approved bid. To ensure that the excess retention is based on actual experience, MYBEs may only be submitted for plans with a minimum of 6,000 member months during the experience period, which represents a minimum of 50 percent credibility per CMS' guidelines. Further, up to 25 percent of the value of the MYBE will be retained by CMS, consistent with the statutory bid savings requirement.

These instructions provide guidance and standards for the completion of the MYBE justification tool (MJT). Each section of these instructions applies to a corresponding component of the MJT. Also, please note the use of the following terms in these instructions and the MJT:

- Projected revenues and medical expenses are those contained in the approved CY 2006 Bid Pricing Tool (BPT).
- Incurred revenues and medical expenses represent actual experience for the period 1/1/2006 through 3/31/2006.
- Forecast revenues and medical expenses represent the actual experience for the first quarter of 2006 projected for all of CY 2006.

If there are any questions about the content of this document or the accompanying MYBE Justification Tool, please e-mail them to CMS at CMSMYBE@cms.hhs.gov.

Section I – Basic Inputs

Most of the fields in the "Basic Input" section of the MJT are from the approved CY 2006 MA bid pricing tool (BPT). The remaining fields are either values developed by the certifying actuary, or are spreadsheet calculations. The specific source of each field is identified under the "data source" column. Following is an overview of the data sources for each field.

Lines 1 through 5, represent plan identification data and can be obtained from the Worksheet 1, Section I, of the approved CY 2006 MA BPT.

Line 6. Experience period, identifies key dates of the experience period.

- Line 6a, Incurred from, is fixed at 1/1/2006
- Line 6b, Incurred to, is fixed at 3/31/2006.
- Line 6c, Paid through, is fixed at 5/31/2006 and represents the end of the time period for cash claim activity and the date for the valuation of claim reserves.

Lines 7, 8, 9, and 10 are to be input from Worksheet 5, Sections II and III, of the approved CY 2006 MA BPT.

Lines 11 is a spreadsheet calculation, and no input is required.

Lines 12, 13, and 14 are to be input from Worksheet 6, Section III, of the approved CY 2006 MA BPT.

Section II – Actual CMS Payments and Enrollment for Experience Period

Data elements to be input into Section II of the MJT are to be determined by the certifying actuary, or by another person for whom the actuary has relied upon for information. (The certifying actuary must obtain an appropriate data reliance statement in support of data supplied by other individuals.)

Following are guidelines for the completion of each data element.

Line 1, Actual per-capita CMS capitation payment (PMPM) - Instructions for the development of this data:

- Data source: CY 2006 Monthly Membership Report (MMR) data files.
- This data represents the average per-capita CMS capitation payment for the experience period for non-ESRD and non-hospice enrollees.
- The capitation payment is to reflect only the basic demographic and risk adjusted payment and exclude payments for rebates.
- The data includes retroactive adjustments that apply to the experience period, but exclude retroactive adjustments for prior calendar years.
- Payments are to exclude reduction due to user fees, but include other plan- (or contract-) level adjustments that apply to the experience period (for example, working-aged adjustment).

Line 2, Forecast per-capita CMS capitation payment. This value represents the forecasted average per-capita CMS capitation payment for all of CY 2006. The forecast factors are to account for the effect of additional CY 2005 diagnosis data and other full-year influences that are expected to effect the average CMS capitation payment.

Line 3, CMS capitation completion factor. Calculated as Line 2 / Line 1.

Line 4, Average risk factor. To be developed from MMR files for the experience period, including retroactive adjustments.

Line 5, Member months. To be developed from MMR files for the experience period, including retroactive adjustments.

Line 6, Experience credibility. Calculated using member months input in Line 5 and CMS credibility guideline contained in the April 24, 2006 CMS Guidance on Mid-Year Benefit Enhancements (MYBEs) for Contract Year 2006. The formula for this value is the square root of the actual member months divided by 24,000, not to exceed 1.

Section III – Forecast of Net Medical Expenses

This section of the MJT illustrates the original net medical expenses, as reflected in the approved CY 2006 MA BPT and corresponding forecast based on actual plan experience. The categories of medical expenses are the same as those contained in the BPT. Also, the medical expenses represent the total benefits offered to plan enrollees, including both basic and mandatory supplemental benefits.

Following are guidelines for the completion of each data element.

Column d, Projected: BPT Worksheet 4, Section II, column G. Input values from corresponding cells in the approved CY 2006 MA BPT.

Column e, Experience through 3/31/2006, paid through 5/31/2006. Input PMPM value of medical expenses incurred for the period 1/1/2006 through 3/31/2006, and paid through 5/31/2006.

Column f, Claim reserve as of 5/31/2006. Input PMPM value of reserve for unpaid claims as of 5/31/2006, for medical expenses incurred 1/1/2006 through 3/31/2006.

Column g, Incurred claims through 3/31/2006. Calculated as sum of columns e and f.

Column h, Trend and aging factor for CY 2006. Input actuarial projection factor for trending and aging PMPM medical expenses from the period 1/1/2006 – 3/31/2006 to the period 1/1/2006 - 12/31/2006. Elements to be considered in the development of these factors include, but are not limited to, wear-off of initial selection, seasonality, trend in utilization, trend in case-mix, trend in provider reimbursement rates, and impact of out-of-pocket maximums.

Column i, Forecast of incurred claims CY 2006. Calculated as column g * (1 + column h).

Column k, Claim reserve relative to incurred claims. Calculated as column f / column g.

Section IV – Calculation of Excess Retention and Enhanced Benefits

Using the values input into Sections I, II, and III of the MJT, this section determines the excess of the forecast vs. projected retention and the corresponding maximum value of the MYBE. In the only input to this section, line 6a, the certifying actuary is to input the amount of the excess retention to be applied to the MYBE, and CMS savings (if applicable).

Following is a description of each line in this section.

Line 1, Revenues.

- Line a, CMS Capitation: "BPT Projection" column, or column c, is pulled from Section I, Line 10; "Actual Experience" column, or column d, is from Section II, Line 2.
- Line b, Rebate: A/B cost sharing, is pulled from Section I, Line 12.
- Line c, Rebate: A/B Mandatory Supplemental benefit, is pulled from Section I, Line 15.
- Line d, A/B Mandatory supplemental premium, is from Section I, Line 14.
- Line e, total is sum of lines a through e.

Line 2, Net medical expense.

- Value for column c is from Section III, line t, column d.
- Value for column d is from is from Section III, line t, column i.

Line 3, Retention.

- Calculated as line 1 minus line 2 for values in columns c and d.
- Excess retention for column e is equal to (line 3 column c * line 4 column c) + (line 3 column d * line 4 column d).
- Value for column f is calculated as (line 3 column e - line 3 column c).

Line 4, Credibility factor.

- Value for column d is from Section II, Line 6.
- Value for column c is equal to 1 minus value in column d.

Line 5, Maximum Values.

- Line a, Excess retention, is equal to value in Line 3, column f.
- Line b, Enhanced benefit, is calculation of excess retention to be returned to plan enrollees. Calculation takes into account the relationship contained in the approved bid of the Plan A/B bid to the Plan A/B benchmark.
- Line c, "Savings" retained by CMS. Line a minus line b.
- Column g, the percentage of excess retention, is calculated as line b or c divided by line a.

Line 6, Proposed MYBE value.

- Line a, Excess retention, is input by certifying actuary. Value may not exceed Line 5a.
- Line b, Enhanced benefit, is calculation of excess retention to be returned to plan enrollees. Calculation takes into account the relationship contained in the approved bid of the Plan A/B bid to the Plan A/B benchmark
- Line c, “Savings” retained by CMS. Line a minus line b.
- Column g, the percentage of excess retention calculated as line b or c divided by line a.

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany *every MYBE proposal* submitted to CMS. A qualified actuary who is a *member of the American Academy of Actuaries* (MAAA) must complete the certification. The objective of obtaining an actuarial certification is to place greater reliance on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

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

Actuarial Standards of Practice

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

- ASOP No. 5, Incurred Health and Disability Claims.
- ASOP No. 8*, Regulatory Filings for 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.

* Note that a *revised edition of ASOP No. 8* was adopted by the Actuarial Standards Board in December 2005 and will be effective May 1, 2006. The certifying actuary should be aware of the changes to this standard of practice.

** Note that a *revised edition of ASOP No. 23* was recently adopted by the Actuarial Standards Board. The certifying actuary should be aware of the changes to this standard of practice. As indicated in the ASOP: "This standard will be effective for any actuarial work product for which data were provided to or developed by the actuary on or after May 1, 2005. In all cases, this standard will be effective for any actuarial work product commenced on or after July 1, 2006."

Required Elements

The certification *must* include the following information:

- Signature of the certifying actuary. CMS prefers that the certification submitted by email contain an electronic signature. However, if the electronic certification does not contain the signature, mail the paper copy of the signed certification (postmarked by Friday June 30, 2006) to:

  Rhoda Friedman

  Centers for Medicare & Medicaid Services
  Office of the Actuary, Mail Stop N3-26-00
  7500 Security Boulevard
  Baltimore, MD 21244

- Name of the certifying actuary, title, employing firm, contact information, credentials, qualifications, and relationship of the actuary to the organization submitting the MYBE proposal. As indicated at the beginning of this appendix, the certifying actuary must be a member of the American Academy of Actuaries (MAAA).
- The date of the certification.
- The specific CY 2006 contract, plan ID(s), and segment ID(s) associated with the certification.
- The version # of the approved CY 2006 Bid Pricing Tool (BPT) that contains the projected revenues and medical expense data that the MYBE proposal is based on.
- The version #, of the approved PBP that identifies the benefits priced in the approved CY 2006 BPT. If version # is unavailable, the certification must include the PBP upload date (i.e., the date that the latest PBP was uploaded to HPMS).
- Specification that the certification complies with the applicable Federal laws, rules, and *instructions.*
- Attestation of the reasonableness of the data and assumptions for the plan's MYBE proposal. Attestation that the data and assumptions are in accordance with the organization's business plan.
- Attestation that the MYBE proposal was prepared based on the current standards of practice as promulgated by the Actuarial Standards Board of the American Academy of Actuaries and that the MYBE proposal complies with the appropriate ASOPs.
- Reliances. If the actuary has relied upon another person for certain assumptions or data, this reliance must be disclosed in the certification. Any reliance must be in accordance with ASOP No. 23.
- Limitations and qualifications.

Sample Language

The following is an example of a certification statement. This language may be revised, as appropriate, for each MYBE proposal, but must contain all of the required elements described in this appendix.

I, __(Name)_____, am a Member of the American Academy of Actuaries and am a __(Title)_____ with the firm of __(Firm)_____ and have been retained by __(Organization)_____ to prepare the MYBE identified in this certification. I am familiar with the requirements for preparing Medicare Advantage bid submissions and MYBE proposals, and meet the Academy's qualification standards for doing so. This MYBE proposal has been prepared for the Centers for Medicare & Medicaid Services to approve a MYBE for a plan under a contract in calendar year 2006 as identified in the following table:

Organization Name	Bid ID (Contract - Plan - Segment)	CY 2006 MA BPT Version # Approved	CY 2006 MA PBP Version # Approved
Health One	H9999-001-00	05/15/2006	1
Health One	H9999-002-00	05/04/2006	1
Health One	H9999-003-00	05/10/2006	1

I hereby certify that, to the best of my knowledge and judgment, the MYBE proposals identified in this certification are in compliance with the appropriate laws, rules, and instructions and comply with the appropriate Actuarial Standards of Practice. In making this statement, I certify that:

- The data and assumptions used in the development of the MYBE proposal are reasonable for the plan's benefit package (PBP) and MYBE, and are consistent with the organization's current business plan.
- The MYBE proposal 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 MYBE proposal, I relied upon others for certain data and assumptions. I have reviewed this data for reasonableness and consistency, in accordance with ASOP No. 23. I have uploaded supporting documentation that contains further information describing the nature of these data and assumptions.

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

Sincerely,

__(Signature)_____
[Name and Credentials]
[Title, Firm]
[Date of Certification]

[Address]
[Phone]
[E-Mail Address]

Appendix B – Submission and Supporting Documentation

In addition to the MJT bid form and actuarial certification, organizations must provide CMS with:

- An exhibit that illustrates, at the benefit level, the pricing of the enhanced benefits.
- A narrative description of the mid-year benefit enhancement.

Section V of the MJT provides an example of appropriate exhibit that supports the pricing of the MYBE benefits. However, organizations are encouraged to customize the supporting exhibit to meet the requirements of their benefits and related pricing.

No earlier than June 1, 2006, and no later than June 30, 2006, e-mail 2006 MYBE submissions completed in accordance with these instructions to CMSMYBE@cms.hhs.gov. Upon CMS' approval of a MYBE, CMS will request an electronic attestation of the MA organization's commitment to provide the MYBE benefits for the remainder of the year.

Questions on the guidance or submission process may be addressed by e-mail to Mark.Keller@cms.hhs.gov or by phone at (410) 786-0107.

As mentioned earlier in Appendix A, completed hard-copy actuarial certifications (where electronic signature is unavailable) are to be mailed (postmarked) by June 30, 2006, to:

Rhoda Friedman

Centers for Medicare & Medicaid Services

Office of the Actuary, Mail Stop N3-26-00

7500 Security Boulevard

Baltimore, MD 21244