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INSTRUCTIONS FOR COMPLETING THE MEDICARE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2009

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Introduction

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

The submitted bids will be subject to review and negotiation by CMS. As part of that negotiation, CMS may request supporting documentation for the information included on the bid form. Organizations must be prepared upon request, to provide CMS and its representatives with documentation to support the development of their bids. All data submitted as part of the bid process are subject to audit by CMS or by any person or organization that CMS designates.

Organizations must provide a series of data entries on the appropriate form worksheet to complete the bid form. The number of inputs depends on the type of plan and how long it has operated. Organizations must submit the information through HPMS in the CMS-approved electronic format; that is, by using the CMS bid form in accord with these instructions. Organizations must develop a pricing structure for each prescription drug plan offered. The following sections contain specific instructions regarding completing the bid form. In addition to the line-by-line instructions, there is also a glossary to assist the user with unfamiliar terms.

Following are the most common steps that an organization must complete:

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

If you have any questions about the content of the bid form, please e-mail them to CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov .

If there are any technical questions regarding HPMS or the upload process, please see the "Bid Submission User's Manual" (available in HPMS) and "Appendix F - Bid Pricing Tool Technical Instructions," or contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov .

Special Considerations

Base Experience

Worksheet 1 must be completed when plans have appropriate base period experience for modeling the Part D benefit.

- Plans with fully credible experience must complete all sections of Worksheet 1 and Sections II, III, and V of Worksheet 2.
- Plans with partially credible experience must complete all sections of Worksheet 1 and Worksheet 2.
- Plans that have no applicable, fully or partially credible experience must complete Section I of Worksheet 1 and Section IV of Worksheet 2.

CMS expects that most plans that operated in 2007 will have appropriate base period experience to be used in completing Worksheet 1 for contract year 2009. A plan that has appropriate base period data must exercise actuarial judgment in determining the credibility factor for a plan's base period experience. Based on an application of classical credibility theory to Part D experience, CMS has established a guideline for full credibility for Part D plans of 12,000 base period member months. The formula for partial credibility is the square root of the result of actual base period member months divided by 12,000. Actuaries must take into account the quality of the data being relied upon in establishing credibility.

Plans with experience providing Part D benefits in contract year 2007 are expected to use Prescription Drug Event (PDE) transactions, including plan-to-plan PDEs as base period experience for contract year 2009, unless the PDEs do not appropriately capture the plan's expected experience.

Per 42 C.F.R. Section 423.308, direct and indirect remuneration (DIR) is any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmaceutical benefit managers (PBMs), if they are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the sponsor pays the PBM for its services will be less, such that the sponsor will have received a price concession from the PBM. This price concession received by the Part D sponsor is a retained rebate and thus must be reported as DIR for payment purposes.

Generic dispensing incentive payments, and any adjustments to generic dispensing incentive payments made to pharmacies after the point of sale dispensing event, are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

In the event that a plan has PDE data that do not appropriately represent the plan's expected experience, plan-specific pharmacy claims experience must be adjusted to reflect the plan's best expectation of the final PDE transactions that will be sent to CMS for payment reconciliation. A mapping of PDE fields to required pricing tool inputs is provided in the instructions for completing Worksheet 1.

A plan that has experience in contract year 2007 and that does not use PDE data for completing Worksheet 1 must provide written support outlining the circumstances that require the use of pharmacy claims or manual rating in lieu of PDEs. The supporting data and written narrative must specifically address the credibility of the data, and explain why claims were used in lieu of PDEs. This support must be uploaded into HPMS at the time of bid submission.

A plan that does not have fully credible base period experience in the form of PDE or pharmacy claims data must develop manual rates for the pricing tool, using available data that are adjusted to reflect the expected contract year population and the benefit design being offered.

Plans must complete Worksheet 1 in accord with the following:

- Every plan with experience in contract year 2007 must complete Worksheet 1, regardless of the level of enrollment.
- Base period experience must be reported without adjustment. Adjustments may be made in Worksheet 2 to accommodate population, benefit design, or other changes for the base period to the projection period.
- Data from a number of plans can be presented in aggregate only when there are enrollment changes associated with the dissolution of a plan and retained members are mapped into existing plans. Each plan must be identified in Line 6, Section II, of Worksheet 1.
- Data from a number of plans cannot be used to aggregate data to achieve credibility.
- When plans are aggregated, experience must be reported in whole at the plan level for every contract-plan number relied upon; plans cannot include partial plan experience on Worksheet 1.
- When plans are aggregated, it is possible for a single plan to be reported on more than one bid, depending upon the mapping of enrollment.
- All adjustments for use of partial plan experience must be made on Worksheet 2.
- Data presented in Worksheet 1 must reconcile in an auditable manner to the plan-level PDE data submitted to CMS for reconciliation.

Required Sections

Plans must complete different sections of the bid pricing tool depending on the type of coverage that will be offered. Following are the sections that need to be completed for each type of coverage.

All plans must complete Section 1 of Worksheet 1.

Defined Standard Coverage

Plans submitting a bid for defined standard coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience; Worksheet 3; Columns f, g, and h of Section II of Worksheet 6; and Worksheet 7.

Actuarially Equivalent Standard Coverage

Plans submitting a bid for actuarially equivalent standard coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2 as determined by the available experience; Worksheet 3; Worksheet 4; all columns of Section II of Worksheet 6; and Worksheet 7.

Basic and Enhanced Alternative Coverage

Plans submitting a bid for basic or enhanced alternative coverage are required to complete applicable sections of Worksheet 1 and Worksheet 2, as determined by the available experience; Worksheet 3; Worksheet 5; all columns of Section II of Worksheet 6; and Worksheet 7.

Actuarial Equivalence

Plans submitting a bid for standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on Worksheet 4. Plans submitting a bid for alternative coverage must satisfy the various tests on Worksheet 5 to qualify.

The five tests for alternative coverage plans are specified in the statute and in the final regulations and apply to both basic and enhanced alternative coverage.

- The first test ensures that the value of total coverage is at least actuarially equivalent to standard coverage.
- The second test ensures that the alternative unsubsidized value of coverage is no less than the standard unsubsidized value of coverage.
- The third test ensures that the average alternative benefits for beneficiaries with allowed drug costs at the initial coverage limit ($2,700) are no less than the average standard benefits at the initial coverage limit.
- The fourth test ensures that the deductible is no greater than $295.
- The fifth test ensures that the average alternative catastrophic cost-sharing percentage is no greater than under standard coverage.

Plans can change the cost-sharing provisions, meet the five tests, and provide a basic alternative plan.

Worksheet 6 illustrates the assumptions used in demonstrating actuarial equivalence and develops values to support the tests in Worksheets 4 and 5.

All plans are required to develop projected utilization for the defined standard benefit in Columns f, g, and h in Section II of Worksheet 6. In addition, plans submitting a bid for an actuarially equivalent or alternative benefit are required to report projected utilization in Columns i, j, and k. If the bid is defined standard, then Columns i, j, and k must be left blank.

Data are collected for four levels of allowed costs on Lines 1 through 36 of "Projections for Equivalence Tests," Section II of Worksheet 6. Members and member months are no longer captured on Worksheet 6; however, the distribution of population and data reported in Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8 collect data on all allowed costs for the "Population Not Exceeding $2,700 with Standard Coverage." All of the utilization for the population with total allowed costs that do not exceed $2,700 must be reported in this section.

Lines 10 through 17 collect data on all allowed costs for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for the population with total allowed costs that exceed $2,700 must be reported in this section.

Lines 19 through 26 collect data on all allowed costs up to $2,700 for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for allowed costs allocated up to $2,700, for the population with allowed costs that exceed $2,700, must be reported in this section.

Lines 28 through 35 collect data on all allowed costs over the catastrophic coverage limit for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for allowed costs allocated over catastrophic coverage, for the population with allowed costs that exceed $2,700, must be reported in this section.

<u>Values for A, B, C, and D in Worksheet 4</u>

Plans proposing a benefit that has standard coverage with actuarially equivalent cost sharing must satisfy the two tests to demonstrate actuarial equivalence on Lines 16 and 17,

Section III of Worksheet 4:

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

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

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

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

Risk Score

Risk Score Development for CY 2009:

The CY 2009 risk score must be based on the Part D RxHCC risk model, be adjusted for normalization, and reflect appropriate projection factors. The RxHCC model was calibrated based on the experience of fee-for-service (FFS) beneficiaries in the year 2002 and Medicaid dual-eligible beneficiaries in 2000, with both dollar values trended forward to 2006.

At time of payment, the risk scores for each plan enrollee will be adjusted by the Part D normalization factor, which is 1.085 for 2009. This adjustment accounts for the expectation of higher intensity in the aggregate risk scores for the contract year versus the model calibration year. Accordingly, the 2009 bid-projected risk scores must reflect the 1.085 normalization factor. Additional information on the 2009 normalization factor is contained in the 2009 Rate Announcement:

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage
Acceptable approaches for the development of risk scores depend on whether or not the plan pricing is based on manual rates or actual plan experience. Plans that are priced using a manual rating approach must estimate risk scores based on the expected expenses for their projected enrollees. Further, the risk scores for new plans must be developed consistent with the Part D RxHCC risk model. Details of this model may be found at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/, under "risk adjustment." Additional information on the risk adjustment process can be found at the web site: http://www.csscoperations.com/new/usergroup/2007raps/ra-particpantguide_120607.pdf

Use of the Part D RxHCC risk scores for the 2007 enrollee cohort is the preferred basis for projecting the 2009 risk scores for experienced-rated plans. CMS has released plan-specific risk score data that may be used as the basis for projecting CY 2009 risk scores. This information is available in HPMS under the "Risk Adjustment" link from the HPMS Home page. (Note: You must have HPMS user access to view this information. The HPMS weblink is either https://32.90.191.19/hpms/secure/home.asp or https://gateway.cms.hhs.gov depending on your firm's connection method.) The risk score data posted in HPMS are accompanied by technical notes to assist actuaries with interpreting the data presented. There are several advantages to using the 2007 cohort Part D RxHCC risk scores in the projection of the CY 2009 risk score: (i) they are consistent with the base-period prescription drug expenditures; (ii) they are based on a mid-year cohort and require no adjustment for seasonality; (iii) they reflect the most complete MA diagnosis data for 2006 dates of service submitted through January 31, 2008, which is the final reporting deadline for this period; and (iv) they are based on the latest risk model.

The projection of scores from 2007 to 2009 must reflect relevant projection factors, which include, but are not limited to, coding intensity trend, changes in plan population, and the effect of partial-year enrollments. While the mid-year cohort may be the most appropriate basis for projecting the 2009 risk scores, the underlying experience for 2007 may need to be adjusted to reflect the effects of partial year enrollments. The reported scores are based on a mid-year cohort with nearly complete run-out of data and require no explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. Finally, the projected "raw" scores must be normalized by dividing by the 2009 Part D normalization factor which is 1.085.

An alternate approach to forecasting the CY 2009 Part D risk scores for experience-rated plans is to use the scores from a 2008 Monthly Membership Report (MMR) file as the base

scores. This approach may be appropriate if the plan was first offered in 2008, there was limited enrollment in 2007, or if there were significant changes in plan or enrollment characteristics between 2007 and 2008.

The starting "raw" risk scores for this alternative approach are the average risk scores from one or more, of the 2008 MMR files for non-adjustment records. These scores are trended to 2009 with explicit adjustment for the following factors:

- FFS normalization (multiply MMR scores by 1.065 to reverse 2008 normalization)
- Coding intensity
- Impact of lagged versus non-lagged diagnosis data
- Run-out of diagnosis data
- Seasonality
- Population changes
- Other appropriate factors

Finally, the projected "raw" scores must be normalized by dividing by the 2009 Part D normalization factor of 1.085.

Pass-Through Model for PBM Gain/Loss

For contract year 2009, as in 2006, 2007, and 2008, Part D sponsors that use a PBM may apply either the pass through or lock-in pricing approach when calculating cost-sharing and reporting drug costs. Part D sponsors must choose only one approach and cannot switch between them for purposes of calculating cost-sharing and reporting drug costs. Thus, the chosen pricing approach must be used consistently as a basis for: (i) calculating beneficiary cost-sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the Prescription Drug Event (PDE) records; and (v) developing bids submitted to CMS.

Direct and Indirect Remuneration (DIR)

All rebates, subsidies, and other price concessions from any source that serve to decrease the costs incurred by the Part D sponsor must be reported as a rebate in the BPT when these subsidies are not used to directly reduce the cost at the point of sale. Any charges or fees for the administration of rebates, price concessions, or other services must be included separately in the bid pricing tool as a component of direct administrative costs.

Plans must include all expected amounts that will be reported as Direct and Indirect Remuneration (DIR) under "Rebate" in the bid pricing tool. It is important for plans to understand that the DIR reported under "Rebate" represents their best estimate of all DIR categories and amounts that they expect to report under the Part D payment reconciliation process for the respective contract year.

<u>Defining Direct and Indirect Remuneration (DIR)</u>

Per 42 CFR Section 423.308, direct and indirect remuneration (DIR) comprises any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks, average percentage rebates, cash discounts, free goods

contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmaceutical benefit managers (PBMs), if they are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the sponsor pays the PBM for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession received by the Part D sponsor, is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed fees. Any gains or losses that the Part D sponsor may receive as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments, and any adjustments to generic dispensing incentive payments made to pharmacies after the point of sale dispensing event, are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

Part D Payment Demonstration

The Part D Payment Demonstration allows varied payment rules for plans offering supplemental benefits. The details for this demonstration are provided in our "Instructions for Part D Payment Demonstration." The May 10, 2005 instructions describe the following three demonstration options:

- Flexible capitation option
- Fixed capitation option
- Flexible MA rebate option

Generally, the capitation options replace the typical reinsurance subsidy of 80% of allowed costs that apply after the beneficiary has reached the out-of-pocket threshold of $4,350 of true out-of-pocket payments (TrOOP) with a capitation amount reflecting the actuarial value of that subsidy under the defined standard benefit structure. The distinction between the flexible and fixed options is that, for a beneficiary in the fixed option, catastrophic coverage is required to begin at $6,153.75 of total drug expenditures (consistent with the point at which the beneficiary would have catastrophic coverage under the defined standard benefit). The flexible option permits catastrophic coverage to begin at any point after the beneficiary has $4,350 of TrOOP spending.

The flexible MA rebate option permits supplemental benefits that fill in the coverage gap to count toward the accumulation of the beneficiary's TrOOP. In this option, as is the case for non-demonstration Part D plans, reinsurance will be paid based on 80% of allowed reinsurance costs after the beneficiary has satisfied the TrOOP requirement. No change to

the bidding requirements or bid pricing tool (BPT) is necessary to support plans choosing this option.

It should be noted that a non-demonstration Part D plan that provides supplemental coverage will generally delay the point at which a beneficiary reaches catastrophic coverage. Accordingly, a non-demonstration Part D plan will likely see a shift in allowed costs from amounts that would be provided under catastrophic coverage for defined standard coverage to amounts in the coverage gap for alternative coverage. Since the fixed capitation option and the flexible MA rebate option do not delay the point at which a beneficiary reaches catastrophic coverage, neither should entail a shift from catastrophic costs to gap coverage costs for these options. For the flexible capitation option, a shift in costs between catastrophic and coverage gap is to be expected.

The impact described above is illustrated in the following table of the benefit options available for Part D plans. In this table, the only benefit design change represented in the non-standard options is the variation of the point at which the coverage gap begins. In addition, the values reflect the benefit parameters in effect for 2006.

Benefit Design	Defined Standard	Enhanced Alternative	Flexible Capitation	Fixed Capitation	Flexible MA Rebate
Deductible	$250	$250	$250	$250	$250
Coinsurance	25%	25%	25%	25%	25%
Coverage Gap Begins	$2,250	$3,250	$3,250	$3,250	$3,250
Catastrophic Threshold	$5,100	$5,850	$5,850	$5,100	$5,100

The alternative coverage worksheet in the BPT requires costs to be allocated to below the initial coverage limit, in the coverage gap, and above the catastrophic threshold. The initial coverage limit is statutorily defined to be $2,250 for 2006. For the enhanced alternative option outlined above, the actuarial value of costs for the alternative coverage between the initial coverage limit ($2,250) and the catastrophic threshold ($5,850) must be presented in the coverage gap column. The coinsurance percentage for this period must reflect that the portion of the coverage between $2,250 and $3,250 would have 25% coinsurance and that the portion of coverage between $3,250 and $5,850 would have 100% coinsurance. The same would be true for the flexible capitation option summarized in the table; both the fixed capitation option and the flexible MA rebate option would have the same pattern, except that the catastrophic threshold would begin at $5,100 instead of $5,850.
Following is an explanation of each option:

- **Capitation Options.** The reinsurance capitation amounts reflected on the alternative coverage worksheet are based on the development of the estimated reinsurance amounts included in the defined standard worksheet.

- **Flexible MA Rebate Option.** The only supplemental cost-sharing permitted in the flexible MA rebate option is the filling in of the coverage gap. As such, no reductions in the deductible, in the cost sharing amounts up to the initial coverage limit of $2,250, or in the amounts in the catastrophic period are allowed. For catastrophic coverage, plan bids must reflect a $250 deductible and have cost-sharing percentages within 2% of the 25% amount (i.e., between 24.5% and 25.5%) up to the

initial coverage limit and within 2% of the cost-sharing percentage estimated for the defined standard benefit structure.

Modeling Considerations

Plans must consider the effects of the chosen benefit design on the underlying population they expect to enroll and that they complete the BPT accordingly. Specifically, providing supplemental coverage in exchange for a premium, or at the expense of offering other benefits, is likely to result in a change in the plan's expected risk/cost profile as compared to a plan that is offering basic benefits only. If the net value of these supplemental benefits, defined as the difference between the actuarial value of the supplemental benefits and the amount of the premium, is positive for a class of beneficiaries, a plan should expect to enroll greater proportion of these beneficiaries as compared to the class of beneficiaries with a negative value. For purposes of evaluating the effect on the anticipated enrolled population, the plan must consider the impact of the value of supplemental benefits at all points of the drug expense distribution.

The following table illustrates the pattern of supplemental benefit value for the designs summarized in the table above. Note that a supplemental premium is presented for illustrative purposes only; actual premium amounts for such coverage could differ significantly. Again, this example reflects the benefit parameters in effect for 2006.

Benefit Design	Defined Standard	Enhanced Alternative	Flexible Capitation	Fixed Capitation	Flexible MA Rebate
Supplemental Premium	$0	$240	$220	$315	$315
Beneficiary Cost Share at Drug Expense of:					
$1,250	$500	$500	$500	$500	$500
$2,250	$750	$750	$750	$750	$750
$3,250	$1,750	$1,000	$1,000	$1,000	$1,000
$5,100	$3,600	$2,850	$2,850	$2,850	$2,850
$5,600	$3,625	$3,350	$3,350	$2,875	$2,875
$6,100	$3,650	$3,613	$3,613	$2,900	$2,900
$10,000	$3,845	$3,808	$3,808	$3,095	$3,095
Value of Supplemental Benefit:					
$1,250	NA	$0	$0	$0	$0
$2,250	NA	$0	$0	$0	$0
$3,250	NA	$750	$750	$750	$750
$5,100	NA	$750	$750	$750	$750
$5,600	NA	$275	$275	$750	$750
$6,100	NA	$38	$38	$750	$750
$10,000	NA	$38	$38	$750	$750

When modeling supplemental benefits, plans must factor behavioral impacts into the anticipated selection. Beneficiaries spending less than the $2,250 initial coverage limit will not receive any additional benefits from purchasing the supplemental coverage. Plans modeling these types of benefits should consider the possibility that a lower percentage of enrollees with spending under the initial coverage limit may participate than if a standard plan were offered.

Similarly, the value of the supplemental benefits decreases as the spending level exceeds the catastrophic threshold for the standard benefit in the enhanced alternative and flexible capitation options. The illustrative net value, after subtracting out the premium for the supplemental benefits, is negative for beneficiaries in the above table spending in excess of $6,100. Again, during their development, plans must consider the possibility that fewer such beneficiaries will enroll. We recognize that the average risk profiles of members enrolled in existing MA organizations are not likely to change significantly from 2006 to 2007. This tendency towards stability may mitigate some of the behavioral effects outlined above. Plans must consider the implications of the plan designs being offered in estimating their projected population.

Also of interest in the table is the difference between the supplemental premiums for the enhanced alternative and the flexible capitation options. Although a benefit pattern for two designs may be identical, the supplemental premium will be slightly lower for the flexible capitation option. This difference exists because the supplemental premium development for the enhanced alternative plan includes a cost component for the estimated reduction in reinsurance payments between the enhanced alternative plan and the defined standard plan (the typical TrOOP impact). Since the reinsurance capitation in the flexible capitation option is based on the defined standard estimate, there is no reduction in reinsurance value, and thus no additional supplemental premium needs to be incorporated.

Gain/Loss Margin Guidance

General enrollment (that is, non-EGWP and non-SNP plans and institutional / chronic care SNPs:

Overall Medicare margin levels for general enrollment plans and institutional / chronic care SNPs are to be consistent with the Plan sponsor's corporate requirement. (Please note that the 2008 bid instructions included the term "individual market," not "general enrollment," to describe non-EGWP, non-SNPs.) Overall Medicare margin levels may be determined either at the contract level or at a more aggregated level. The sponsor's Medicare margin requirement, as measured by percentage of revenue, is to be within a reasonable range (for example, plus or minus 1% or 1.5%) of other lines of business. Additionally, for sponsors that price based on return on investment (ROI) or return on equity (ROE), the projected Medicare returns must be consistent with the company's return requirements. Comparisons to other lines of business must take into account the degree of risk or reserve levels of the business.

The overall margin level expectations are likely to be consistent on a year-by-year basis. Actual organization returns are expected to vary year to year in practice, but to achieve the organization's requirement over a longer term period (for example, three to five years). Individual plan margins may vary from the overall organization level.

The overall margin levels included in the MA and Part D components of MA-PD bids must be within a reasonable range of each other (for example, plus or minus 1% or 1.5%), with any variation reflecting the different levels of financial risk underlying the two components. The individual Part D margin of an MA-PD bid may be allocated by applying the overall Part D margin requirement to each Part D bid of the MA-PD organization or, alternatively, in similar relationships as the MA margins.

Plans with negative margins must develop and follow a business plan to achieve profitability. Exceptions to the business plan requirement are cases in which multiple MA products are offered in a given service area and the pricing reflects implicit "subsidies" to mitigate premium spirals.

Anti-competitive practices will not be accepted. For example, significantly low or negative margins for plans that have substantial enrollment and stable experience, or "bait and switch" approaches to specific plan margin buildup, will be rejected, absent sufficient support that such pricing is consistent with these instructions.

Employer-Only Group and Union-Only Waiver Plans (EGWPs):

The foundation for the claim and administrative costs for EGWP plans should be appropriate EGWP experience. The margin assumptions used for general enrollment plans must be the basis for the margin requirements for EGWP plans. Organizations may choose to use the overall margin levels for general enrollment plans as the basis for the group plan margin assumptions or may rely on the margins used in comparable general enrollment plans.

There may be small differences (that is, up to 1%) in the margin levels between EGWP and general enrollment plans. If corresponding general enrollment plans are not offered, then the margin guidance for general enrollment plans applies to the EGWP margin pricing. That is, overall EGWP margin levels are to be consistent with the organization's margin requirement and this requirement, is to be within a reasonable range (for example, plus or minus 1% or 1.5%) around a return-on-equity or return-on-investment type measure or comparable to other similar lines of businesses.

Special Needs Plans Serving Dual-Eligible (DE-SNP):

The foundation for the claim and administrative costs for DE-SNPs should be appropriate experience. The margin assumptions used for general enrollment plans should be the basis for the margin requirements for DE-SNP plans. There may be small differences (that is, up to 1%) in the margin levels between DE-SNP and general enrollment plans.

If corresponding general enrollment plans are not offered, then the margin guidance for general enrollment plans applies to the DE-SNP margin pricing. That is, overall DE-SNP margin levels are to be consistent with the organization's margin requirement, and this requirement is to be within a reasonable range (for example, plus or minus 1% or 1.5%) around a return-on-equity or return-on-investment type measure or comparable to other similar lines of businesses.

Relationship of Margin Requirements and Non-Benefit Expenses:

The development of the margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

Documentation Requirements

Supporting documentation for the gain/loss margin is required (see Appendix B). This documentation must include the following:

- Support for overall margin levels, including a description of the methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.

- Support for bids with negative margins, for example, a business plan that illustrates profitability within a few years.

- Justification of the margin for bids with relatively large projected overall gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) other methodological illustrations. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses,

income taxes, and changes in statutory surplus) and may also include investment income.

- If applicable, further analysis of the organization's ROI / ROE and distinctions between recouping start-up costs versus ongoing organizational gain/loss.

Supporting documentation requirements are the same regardless of the source of the assumption, for example, whether developed by the actuary, the Plan-sponsor, or a third party.

Support for variation that accounts for the difference in risks between products for DE-SNPs must be available upon request.

In future years, comparisons to the original business plan are to be provided, including details and source of deviation from prior years' plans.

The development of the margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.

First Dollar Generic Coverage

Plans that are implementing a deductible that is not applied consistently among categories of drugs (for example, $0 deductible for generic drugs and $295 deductible for brand drugs) must make several modifications to the pricing of this benefit in the BPT. Specifically, Worksheet 5 of the BPT requests the proposed deductible. Plans with a non-uniform deductible must enter $0 for the proposed deductible in D6 and F8 in Section IV of Worksheet 5. Plans with a uniform deductible must enter in Worksheet 6 the cost-sharing items for the population with spending under $2,700 and for the population with spending over $2,700, applying the effective cost-sharing by drug class for the interval between the deductible and the initial coverage limit. Plans with a non-uniform deductible must reflect the impact of the brand deductible in the brand cost-sharing categories in addition to the cost-sharing required after the deductible has been satisfied.

Decreased Initial Coverage Limit (ICL)

Plans that are lowering the initial coverage limit (ICL) must still report in Lines 3 through 8 of Worksheet 6 all costs and cost-sharing for drug spending up to the defined initial coverage limit in 2009. For plans that are reducing the ICL to $2,000, the amounts in Column k must reflect the cost-sharing appropriate up to the $2,000 level, plus 100% of costs for drug spending between $2,000 and $2,700. The entries on Worksheet 6 (Script Projection) must fit in the specified intervals. For example, for members with allowed drug costs (under defined standard coverage) above $2,700, their entire allowed amounts and scripts are to be entered in the section for persons with expenses above $2,700, regardless of the alternative plan's benefit limit. Note that the section for persons with expenses above $2,700 also includes amounts for members with expenses exceeding $6,153.75. A member's expenses and scripts are entered in the expense section as projected under defined standard coverage. No matter what expense category a member is assigned under the defined standard benefit, the member must remain in the same expense category under the alternative coverage, even if the expense level changes due to the incentive of alternative coverage.

Coverage in Payment Gap

Enhanced alternative coverage can reduce cost-sharing and/or provide coverage for drugs that are specifically excluded from the definition of Part D drugs. While enhanced alternative coverage can fill in some or all of the coverage gaps in the defined standard coverage, it cannot affect the true out-of-pocket threshold of $4,350 in 2009 (see Payment Demonstration discussion for exceptions). Therefore, reductions in cost-sharing would impact the point at which the member reaches the true out-of-pocket threshold for catastrophic coverage.

Worksheet 1 - Rx Base Period Experience

Section 1 of Worksheet 1 collects general information that carries over to all sheets; entries are required for each item. The remaining sections of Worksheet 1 summarize the base period Rx experience and must be left blank if no applicable, fully, or partially credible Part D coverage was in effect during the base period. Section II includes base period background information. Section III summarizes the base period Rx claims data, Section IV the non-benefit expenses and Section V the various components of revenue that relate to the Part D coverage. Section VI is an income statement summary.

Discussion on Base Period Data

Plans with experience providing Part D benefits in contract year 2007 must report their Prescription Drug Event (PDE) transactions, including plan-to-plan PDEs as base period experience for contract year 2009, unless the PDEs do not appropriately capture the plans' expected experience.

Plans must complete Worksheet 1 in accord with the following:

- Every plan with experience in contract year 2007 must complete Worksheet 1, regardless of the level of enrollment.
- Base period experience must be reported without adjustment. Adjustments may be made in Worksheet 2 to accommodate population, benefit design, or other changes for the base period to the projection period.
- Data from a number of plans can be presented in aggregate only when there are enrollment changes associated with the dissolution of a plan and retained members are mapped into existing plans. Each plan must be identified in Line 6, Section II, of Worksheet 1.
- Data from a number of plans cannot be used to aggregate data to achieve credibility.
- When plans are aggregated, experience must be reported in whole at the plan-level for every contract-plan number relied upon; plans cannot include partial plan experience on Worksheet 1.
- When aggregating plans, it is possible for a single plan to be reported on more than one bid, depending upon the mapping of enrollment.
- All adjustments for use of partial plan experience must be made on Worksheet 2.
- Data presented in Worksheet 1 must reconcile in an auditable manner to the plan level PDE data submitted to CMS for reconciliation.

The base period experience reported on Worksheet 1 must be used in the projection of allowed costs in the contract year according to the level of credibility reported in Worksheet 2.

A plan that has fully credible base period experience is expected to use the data without blending with a manual rate.

A plan that does not have fully credible base period experience must develop manual rates for the pricing tool, using available data that are adjusted to reflect the expected population and the benefit design being offered. These manual rates must be blended with the trended base period experience according to the level of credibility reported in Worksheet 2. The supporting data and written narrative that documents the development of the manual rates must be uploaded into HPMS at the time of bid submission.

Note that scripts and allowed amount data are input into Section III of Worksheet 1 in aggregate for each allowed claim interval, while paid amount, cost sharing, supplemental cost-sharing reduction, reimbursement for LIS and reimbursement for federal reinsurance are input on a per-member basis. The per-member per-month (PMPM) values are calculated on Line 8 of Section III of Worksheet 1. Also note that it is important to enter data on covered Part D drugs in Lines 1 through 5 of Section III of Worksheet 1, and on non-covered Part D drugs on Lines 12 and 13.

A mapping of PDE fields to required pricing tool inputs is provided in the following table. When relying upon PDE data, actuaries must be familiar with how the plan develops the PDE transactions from the claims data, and the timing of the adjustment and deletion process to ensure that the summary of claims appropriately reflects the final transaction. For example, only one script count must be reflected in Worksheet 1 even if there were three adjustment records processed for the claim.

Mapping of Prescription Drug Events to Section III, Part D Claims Experience in Worksheet 1		
Column	**Field Name**	**PDE Reference Information**
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax) > Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax)
(i)	Average Paid Amount per Member	Σ [Covered Plan Paid Amount (CPP) + Non-Covered Plan Paid Amount (NPP) + Low Income Cost Sharing (LICS)] / Members
(j)	Average Cost Sharing per Member	Σ [Patient Pay Amount + Other TrOOP Amount + Patient Liability Reduction due to other Payer Amount (PLRO)] / Members
(k)	Supplemental Cost Share Reduction per Member	Σ [Non-Covered Plan Paid Amount (NPP)] / Members
(l)	Reimbursement for LIS per Member	Σ [Low Income Cost Share (LICS)] / Members
(m)	Reimbursement for Federal Reinsurance per Member	Σ {[Gross Drug Cost Above Out-of-Pocket Threshold (GDCA) with Catastrophic Coverage Codes A or C]* 0.8} / Members

Section I – General Information

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

Line 1 – Contract Number

Enter the contract number for the plan on Line 1. The designation begins with a capital alphabetic letter H, R, or S and includes four Arabic numerals (for example, H9999, R9999, or S9999). Please include all leading zeros. Obtain this number from your contract.

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the plan being priced in the bid form. Plan IDs contain three Arabic numerals. Please enter all leading zeros. For example, enter “001” for plan number one.

Line 3 – Segment ID

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

Line 4 – Contract Year

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

Line 5 – Organization Name

Enter the organization's legal entity name on Line 5.

Line 6 – SNP

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

Line 7 – Plan Name

Enter the name of the MA-PD or PDP plan that you are offering to Medicare enrollees.

Line 8 – Plan Type

Enter the type of plan. The valid options are listed below:

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization	HMO
Health Maintenance Organization with a Point-of-Service (POS) Option	HMOPOS
Provider-Sponsored Organization w/ State License	PSO State License
Preferred Provider Organization	LPPO
Regional Coordinated Care Plans:	
Regional Preferred Provider Organization	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan	PFFS
Employer/Union Only Direct Contract Private Fee-for-Service Plan	ED PFFS
Continuing Care Retirement Community	
Continuing Care Retirement Community	CCRC
Demonstration Plans:	
ESRD I	ESRD I
ESRD II	ESRD II
National PACE	PACE
1876 Cost	1876 Cost
1833 Cost	1833 Cost
Prescription Drug Plans:	
Medicare Prescription Drug Plan	PDP
Employer/Union Only Direct Contract Prescription Drug Plan	ED PDP
Fallback Plans	
Fallback Plan	Fallback
RFBs	
Religious Fraternal Benefit PFFS	RFB PFFS
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMOPOS	RFB HMOPOS
Religious Fraternal Benefit Local PPO	RFB Local PPO
Religious Fraternal Benefit PSO	RFB PSO

Line 9 – Enrollee Type

Select the enrollee type from the drop-down-menu if applicable; options are “Part B Only” and “A/B.” When plan type is “PDP,” “ED PDP” or “Fallback,” the enrollee type cell is white and locked; no input is required.

Line 10 – PD Region

Enter “Multiple” or National” if applicable, or enter the PD region from the valid options listed in the following table:

Region	Description
1	Maine and New Hampshire
2	Connecticut, Massachusetts, Rhode Island, and Vermont
3	New York
4	New Jersey
5	District of Columbia, Delaware, and Maryland
6	Pennsylvania and West Virginia
7	Virginia
8	North Carolina
9	South Carolina
10	Georgia
11	Florida
12	Alabama and Tennessee
13	Michigan
14	Ohio
15	Indiana and Kentucky
16	Wisconsin
17	Illinois
18	Missouri
19	Arkansas
20	Mississippi
21	Louisiana
22	Texas
23	Oklahoma
24	Kansas
25	Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming
26	New Mexico
27	Colorado
28	Arizona
29	Nevada
30	Oregon and Washington
31	Idaho and Utah
32	California
33	Hawaii
34	Alaska
35	American Samoa
36	Guam
37	Northern Mariana Islands
38	Puerto Rico
39	Virgin Islands

Line 11 – Plan Benefit Type

Enter the plan benefit type that identifies the type of plan reflected in this bid. The options are "DS" for Defined Standard, "AE" for Actuarially Equivalent, "BA" for Basic Alternative, and "EA" for Enhanced Alternative.

Line 12 – Payment Demo Type

Enter the payment demo type to identify whether this bid is a payment demonstration and, if so, which type. The options are "NA" (when the plan is not offering supplemental benefits under a payment demonstration), "Fixed Cap" (the fixed capitation option), "Flex Cap" (the flexible capitation option), and "MA Rebate" (the MA rebate option).

Section II – Base Period Background Information

Line 1 – Time Period Definition

Enter the base period experience incurral information on the first two lines. In addition to the incurral dates, enter the "paid through" date. For example, if the incurral period is calendar year 2007, the "incurred from" date is 1/1/2007 and the "incurred to" date is 12/31/2007. If the data reflect payment information through February 2008, then the "paid through" date is 2/28/2008.

Line 2 – Member Months

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

Line 3 – Risk Score

Enter the plan's prescription drug risk score underlying the base period data. The CMS drug model must be used, and must be estimated to three decimal places.

Line 4 – Completion Factor

Enter the factor used to adjust the paid data to an incurred basis. The base period data must represent the best estimate of incurred claims for the time period, including any unpaid claims as of the "paid through" date.

Line 5 – Network Pricing

Select one of the following two choices from the drop-down box: "pass-thru" or "lock-in."

Line 6 – Mapping

Enter the contract-plan number and corresponding member months for every plan used as a source of experience to develop Worksheet 1. Report by the contract-plan ID in effect in the base period, and the corresponding member months for every plan used as a source for base period experience.

CMS expects that the contract-plan ID for the base period data will be the same as that shown in Section I except for plan number changes.

Line 7 - Base Period Description

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

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

Section III – Part D Claims Experience

Section III summarizes the base period experience for Part D coverage. Plans must complete this section of Worksheet 1 in accord with the following:

- Plans with experience in contract year 2007 must complete Worksheet 1, regardless of the level of enrollment.
- Base period experience must be reported without adjustment. Adjustments may be made in Worksheet 2 to accommodate population, benefit design, or other changes for the base period to the projection period.
- Data from a number of plans can be presented in aggregate only when there are enrollment changes associated with the dissolution of a plan and retained members are mapped into existing plans. Each plan must be identified in Line 6, Section II, of Worksheet 1.
- Data from a number of plans cannot be used to aggregate data to achieve credibility.
- When plans are aggregated, experience must be reported in whole at the plan-level for every contract-plan number relied upon; plans cannot include partial plan experience on Worksheet 1.
- When aggregating plans, it is possible for a single plan to be reported on more than one bid, depending upon the mapping of enrollment.
- All adjustments for use of partial plan experience must be made on Worksheet 2.
- Experience presented in Worksheet 1 must reconcile in an auditable manner to the plan level PDE data submitted to CMS for reconciliation.
- Experience need not exactly match the benefit plan or service area for the bid (see Section II instructions).
- Experience must be on either calendar year or other annualized basis.

- Experience must reflect the current best estimate of incurred claims including estimates of unpaid claims but excluding margin for adverse deviation (which must be included as part of the gain/loss margin).

- Experience must include total services (both in-network and out-of-network).

Note that scripts and allowed amount data are input into Section III of Worksheet 1 in aggregate for each allowed claim interval, while paid amount, cost sharing, supplemental cost-sharing reduction, reimbursement for LIS and reimbursement for federal reinsurance are input on a per-member basis. The per-member per-month values are calculated on Line 8 of the worksheet. Also note that it is important to enter data on covered Part D drugs in Lines 1 through 5 of Section III of Worksheet 1, and on non-covered Part D drugs in Lines 12 and 13.

Lines 1 through 11 must include experience relating to Part D covered drugs only. Lines 12 through 14 summarize experience for any drugs that are covered by the plan but are not Part D covered at the time they are dispensed.

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

Lines 1 through 5, Column d – Number of Members

Enter the number of members with total allowed claims in the interval experience period defined for each line. For example, if 7,000 members had allowed expenses between $266 and $2,400, then 7,000 would be entered in Line 3 of Column d.

Lines 1 through 5, Column e - Member Months

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

Lines 1 through 5, Column f - Total Number of Scripts

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

Lines 1 through 5, Column g - Total Allowed Dollars

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

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

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

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

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

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

For each line, enter the average cost-sharing per member with respect to the members included in Column d.

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

For each line, enter the average value of supplemental cost-sharing with respect to the members included in Column d.

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

For each line, enter the average low-income cost-sharing subsidy amount received or receivable with respect to the members included in Column d.

Lines 1 through 5, Column m – Reimbursement for Federal Reinsurance per Member

For each line, enter the average federal reinsurance amount received or receivable with respect to the members included in Column d.

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

This value is automatically calculated by subtracting the values in columns j through m from the value in Column i.

Line 6, Columns d through n – Subtotal

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

Line 7, Columns g, i and j – % OON

For Column g, enter the percent of total allowed dollars from Line 6 for prescriptions filled out-of-network (OON). For Column i, enter the percent of average paid dollars from Line 6 for prescriptions filled out-of-network. For Column j, enter the percent of average cost sharing per member from Line 6 for prescriptions filled out-of-network.

Line 8, Column i and Columns k through n – PMPM Values

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

Line 9, Columns g, i, m, and n – Minus Rebates

All rebates, subsidies, and other price concessions from any source that serve to decrease the costs incurred by the Part D sponsor must be reported as a rebate when these subsidies are not used to directly reduce the cost at the point of sale. Any charges or fees for the administration of rebates, price concessions, or other services must be included separately in the bid pricing tool as a component of direct administrative costs.

Plans must include all expected amounts that will be reported as Direct and Indirect Remuneration (DIR) under "Rebate" in the bid pricing tool. It is important for plans to understand that the DIR reported under "Rebate" represents their best estimate of all DIR categories and amounts that they intend to report on the DIR Report for Payment Reconciliation under the Part D payment reconciliation process for the respective contract year.

Defining Direct and Indirect Remuneration (DIR)

Per 42 CFR Section 423.308, direct and indirect remuneration (DIR) comprises any and all rebates, subsidies, or other price concessions from any source (including manufacturers, pharmacies, enrollees, or any other person or entity) that serve to decrease the costs incurred by the Part D sponsor (whether directly or indirectly) for the Part D drug. DIR includes discounts, chargebacks, average percentage rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits.

DIR also includes price concessions from pharmaceutical manufacturers for purchases under the Medicare prescription drug benefit that are received by subcontractors of Part D sponsors, such as pharmaceutical benefit managers (PBMs), if they are retained in lieu of higher service fees. CMS must assume that if a PBM retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the sponsor pays the PBM for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession received by the Part D sponsor, is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, sponsors may enter into risk-sharing arrangements with entities other than CMS by sharing risk only around the cost of the drug as reflected on claims data, not around administrative services, professional services or other disallowed fees. Any gains or losses that the Part D sponsor may receive as a result of these risk-sharing arrangements also constitute DIR that must be reported to CMS. As with other types of DIR, the value can be negative.

Generic dispensing incentive payments, and any adjustments to generic dispensing incentive payments made to pharmacies after the point of sale dispensing event, are also considered DIR. Please note that generic dispensing incentive payments made to the pharmacy at the point of sale are part of the dispensing fee reported on the prescription drug event (PDE) record and therefore are not included in the DIR Report for Payment Reconciliation.

Enter in Column g the total amount of rebates received with respect to the claims included in Lines 1 through 5. Total rebates must be allocated to the plan using a method that reasonably represents the way in which the rebates were generated, and rebates must be allocated to Column m based upon the amount in Line 6. Columns i and n are calculated based upon the entries in the other columns.

Line 10, Columns g, I, and n – Plus Part D as Secondary

Enter in Column g the total amount of payments for Part D covered drugs for which Part D is secondary. Column i and n are calculated automatically.

Line 11, Columns i, k through n – Net Average Paid Amount PMPM

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

Line 12, Columns g and i - Non-Covered Supplemental Drugs

Enter the total amount of claims for drugs covered by the plan that are not part D-covered drugs. Column i is calculated automatically.

Line 13, Column i - Rebates on Supplemental Drugs

Enter the total amount of any rebates allocable to the drug payments included on Line 12.

Line 14, Columns i and n – Net PMPM on Supplemental Drugs

Columns i and n are calculated automatically.

Section IV – PMPM Non-Benefit Expense

This section summarizes the PMPM value of the Part D non-benefit expenses throughout the base period. Plans must report all costs associated with operating a prescription drug plan, including any administrative expense that may be offset through direct or indirect remuneration. A plan that provided Part D benefits in 2007 must prepare the Non-Benefit Expense in the 2009 bid using data that reflect the actual cost to administer the program by function, and must develop the supporting documentation in a manner that explains the relationship between the reported expenses, and auditable material such as corporate financials and plan-level operational data.

Plans must upload a document outlining the following at the time of bid submission:

- A list of all items that contribute to non-benefit expense.
- A description of the development of each line item, using reference to relevant operational data, assumptions, contracts, financial information, business plans, and other experience.
- A description of the relationship between the non-benefit expense line items reported and auditable material such as corporate financials and plan-level operational data.

<u>Non-benefit Expense</u>

The non-benefit expenses must be shown separately on the bid pricing tool for the following categories:

- Sales and Marketing (for example, the cost of marketing materials, commissions, enrollment packages, and identification cards).

- Direct Administration (for example, functions that are directly related to the administration of the program, such as customer service, billing and enrollment, claims administration, calculation of LIS reimbursement, and True Out-of-Pocket (TrOOP) administration).
    - Pharmacy Benefits Management (PBM) administration. All of the costs for performing call center, claims, formulary management, network development, and rebate management functions at the plan, or through a subcontractor must be reported in the BPT as direct administration.
    - Crossover Fees (fees paid to obtain information from other payers in order to calculate TrOOP expenses).
    - Medicare User Fees.
    - Uncollected Enrollee Premium.
    - Uncollected Cost Sharing (for example, plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions).
    - Medication Therapy Management Program expenses.
    - Disease Management Functions (such as patient education and disease monitoring, which are considered to be direct administration).
    - Over-the-Counter (OTC) Drug Utilization. To the extent that OTCs are permitted to be covered, they must be reported as a component of direct administration, and not as a Part D-covered drug or as supplemental coverage.
- Indirect Administration (for example, functions that may be considered "corporate services," such as accounting operations, actuarial services, legal services, and human resources).
- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries).

All non-benefit expenses must be reported using the appropriate generally accepted accounting principles (GAAP) methodology. For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that this is consistent with the organization's standard accounting practices, if not subject to GAAP). Also, acquisition expenses (marketing and sales) must be deferred and amortized in a manner consistent with the revenue stream anticipated on behalf of the newly enrolled members. Guidance on GAAP standards is promulgated by the Financial Accounting Standards Board (FASB). Of particular applicability are FASB's Statement of Financial Accounting No. 60, and Accounting and Reporting by Insurance Enterprises.

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

Start-up costs that are not considered capital expenditures under GAAP are reported as follows:

- Expenditures for tangible assets must be capitalized and amortized according to relevant GAAP principles, for example, a new computer system purchased to support Part D.

- Expenditures for non-tangible assets, for example, salaries and benefits, must be reported consistently with the organization's internal accounting practices and consistently with the manner in which other lines of business report similar expenditures.

Costs that are common to offering a Medicare Advantage-Prescription Drug (MA-PD) plan must be allocated proportionately between the Medicare Advantage and Part D bid pricing tools based on total revenue.

Enter amounts on Lines 1 through 4 of Columns e and f. Line 5 and Column g are calculated automatically.

Related Party Agreements

The objective of these instructions is to obtain a level of disclosure of related-party agreements that demonstrates that the operating results and financial positions for organizations participating in such agreements are not significantly different from the operating and financial arrangements that would have been achieved in the absence of the relationships. This level of disclosure is consistent with our 2008 guidance, and comparable to the level required by GAAP.

Plans are required to demonstrate that the above is true, and that fees associated with these transactions are based on appropriately allocated, actual costs that are comparable with those experienced by unrelated organizations of similar size and market position.

To satisfy proprietary concerns, CMS can initiate separate contact with the sponsor and the subcontracted related party when addressing related-party issues in the bid. Plan sponsors interested in this level of discussion must request it and identify a point of contact at the related party at the time of bid submission.

These requirements for related-party agreements apply to a Plan sponsor that enters into an administrative service agreement involving a parent company and subsidiary, or between subsidiaries of a common parent. A plan that meets these criteria must provide the following supporting documentation at the time of bid submission for each related-party agreement:

- The identity of the related-party organization.
- A description of the business arrangement and services provided.
- The financial terms.
- A point of contact at the related party (when the sponsor is requesting that CMS enter into a separate discussion with a subcontracted related party).
- A demonstration that the operating and financial results of the participating organizations are not significantly different from those that would have been achieved by the plan in the absence of the related party relationships, outlined as follows:

A Plan sponsor in a related party agreement with an organization that is providing services to unrelated parties must directly or indirectly, or through agreement with the subcontracted party, provide the following:

- A written summary outlining the terms of actual contracts between the subcontractor and the comparable, unrelated parties for similar services. The support must demonstrate that the financial arrangements between related parties are not significantly different from those that would have been achieved by the Plan sponsor in the absence of the related-party relationships.
- An explanation of the disparities in the financial arrangements between related parties and unrelated parties. The explanation must fully address the advantaged or disadvantaged positions and, overall, must demonstrate that the financial arrangements are not significantly different from those that would have been achieved by the Plan sponsor in the absence of the related party relationships.
- The actual copies of agreements to CMS upon request.

A Plan sponsor in a related-party agreement with an organization that supports only the Part D sponsor must directly or indirectly, or through agreement with the subcontracted party do the following:

- Prepare the bid pricing tool in a manner that does not recognize the independence of the subcontracted related party. For purposes of completing the bid pricing tool, the Plan sponsor must consider the gain/ (loss) and non-benefit expense of the related-party to be those of the sponsor. The sponsor cannot allocate all administrative costs in the related party agreement to non-benefit expense.
- Develop the gain/(loss) and non-benefit expense of the related-party subcontractor in accord with the instructions for completing the bid pricing tool.
- Support the development of the gain/ (loss) and the actual costs associated with the non-benefit expense as required by these instructions.
- Subcontracted related party related party agreements for all parties represented in the bid must be disclosed in accord with the instructions for completing the bid pricing tool.

Section V – PMPM Premium Revenue

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

Enter amounts on Lines 1 through 4 of Column e and on Line 3 of Column f. Line 5 and Column g are calculated automatically.

Section VI – PMPM Income Statement Summary

This section provides an income statement summary of the base period for Part D coverage, including the amount of MA rebate allocable to Part D in the base period.

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

Worksheet 2 - PDP Projection of Allowed/Non-Benefit

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

Worksheet 3.

A plan that has appropriate base period data must exercise actuarial judgment in determining the credibility factor for a plan's base period experience. Based on an application of classical credibility theory to Part D experience, CMS has established a guideline for full credibility for Part D plans of 12,000 base period member months. The formula for partial credibility is the square root of the result of actual base period member months divided by 12,000. Actuaries must take into account the quality of the data being relied upon in establishing credibility.

Worksheets 2 and 6 summarize the utilization, allowed amounts, and cost-sharing amounts of generic, preferred brand, non-preferred brand, and specialty drugs, by place of service for the proposed defined standard plan. In addition, Worksheet 6 summarizes the same information for the proposed alternative plan, when applicable. These summaries assist in determining actuarial equivalence and are cross referenced with information submitted in the plan's formulary and Plan Benefit Package (PBP).

Brand Drugs

Brand drugs consist of single source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA), and Innovator Multi-source Drugs originally marketed under an original NDA that now have generic equivalents.

Preferred / Non-Preferred Brand Drugs

Brand name drugs that are placed in the most favorable position on the formulary in comparison to other similar brand drugs should be allocated to the preferred brand drug category. In contrast, brand drugs that are positioned in a less favorable position on the formulary must be allocated to the non-preferred brand category for purposes of completing the bid tool.

Generic Drugs

Non-Innovator Multi-source Drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately under type of script only when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier be designated a specialty tier, (ii) cost sharing associated with that tier be limited to 25% in the initial coverage range, and

(iii) Only Part D drugs with plan-negotiated prices greater than $600 per month be placed in the tier.

When a designated specialty tier is used, all drugs in that tier must be reported by place of service, on Lines 4 and 8, under both Section II and Section III of Worksheet 2. The drugs in the specialty tier are not to be sorted by brand or generic status, and must not reported as a component of the brand and generic drugs in the non-specialty tiers.

When a plan does not utilize a designated specialty drug tier in the formulary and benefit design, specialty drugs must be sorted by generic, preferred brand, and non-preferred brand status, and reported in these categories by place of service. In this situation, the specialty categories in Section II and Section III of Worksheet 2 are not completed.

Section I – General Information

This information is carried forward from Worksheet 1.

Section II – Utilization for Covered Part D Drugs

Lines 1 through 8, Column e - Number of Scripts/1000

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

Lines 1 through 8, Column f - Allowed per Script

For each type of prescription, enter the average allowed amount per script for scripts filled in the base period. The amount allowed is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable. This cost must be adjusted to include rebates credited at the point-of-sale but must not include medication or utilization management costs.

Lines 1 through 8, Column g - PMPM Allowed

The value is automatically calculated and equals Column e times Column f, divided by 12,000.

Lines 1 through 8, Column h - Trend in Scripts/1,000

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

Lines 1 through 8, Column i - Formulary Change

For each type of prescription, enter the factor that would be applied to the base period scripts/1,000 to reflect changes in classification of certain drugs from the base period to the contract period. Reflect changes in classification as well as new-to-market entities.

Lines 1 through 8, Column j - Risk Change

For each line, enter the factor that represents the impact on utilization of the covered population's change in risk between the base period and the contract period. This change may include the effect of adjusting the base period claims experience to account for partial year enrollments.

Lines 1 through 8, Column k - Induced Utilization

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

Lines 1 through 8, Column l – Other Change

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

Lines 1 through 8, Column m - Total Utilization Change

The value is automatically calculated as the product of the factors in Columns h through l.

Lines 1 through 8, Column n - Projected Scripts/1000

The value is automatically calculated as the product of Columns e and m.

Lines 9 through 14, Columns e through n

The values are automatically calculated using the information on Lines 1 through 8.

Section III – Cost for Covered Part D Drugs

Lines 1 through 8, Column e - Inflation Trend

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

Lines 1 through 8, Column f - Discount Change

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

Lines 1 through 8, Column g - Formulary Change

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

Lines 1 through 8, Column h - Other Change

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

Lines 1 through 8, Column i - Total Unit Cost Change

The value is automatically calculated as the product of Columns e through h.

Lines 1 through 8, Column j – Projected Unit Cost

The value is automatically calculated using Section III, Column i and Section II, Column f.

Lines 1 through 8, Column k - Projected Allowed PMPM

The value is automatically calculated using Section III, Column j, and Section II, Column n.

Lines 9 through 14, Columns e through k

The value is automatically calculated using Lines 1 through 8.

Section IV – Projected Allowed PMPM

Lines 1 through 8, Columns l and m - Manual Utilization/1000 and Manual Unit Cost

For base experience that is not fully credible, enter in Columns l and m the utilization/1,000 and unit cost, respectively, from a credible manual rate source.

Lines 1 through 8, Column n - Manual Rate PMPM

The manual rate PMPM is automatically calculated based on inputs in Columns l and m (Lines 1 through 8).

Lines 1 through 8, Column o – Credibility

Enter the credibility percentage that is applied to the actual experience used to blend with manual experience to produce contract period projections. The credibility must be greater than or equal to 0%, and less than or equal to 100%.

Lines 1 through 8, Column p - Blended Allowed PMPM

The value is automatically calculated using Columns k, n, and o.

Lines 9 through 14, Columns l through p

The value is automatically calculated using Lines 1 through 8.

Section V – PMPM Non-Benefit Expense

This section summarizes the PMPM value of the Part D non-benefit expenses by component. Any administrative expense that may be offset through direct or indirect remuneration is expected to be reported here.

Lines 1 through 5, Column e – Base Period

Base period non-benefit expenses carry over from Section IV of Worksheet 1.

Lines 1 through 4, Column f – Trend

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

Lines 1 through 5, Column g – Contract Period PMPM Non-Benefit Expense

The value is automatically calculated using Columns e and f.

Lines 1 through 4, Column h– Manual Rate Non-Benefit Expense

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

Lines 1 through 4, Column i – Credibility

Enter the percentage that would be applied to the trended base non-benefit expenses when manual rate non-benefit expenses are blended to produce contract period projections.

Lines 1 through 5, Column j – Blended Contract Period PMPM Non-Benefit Expense

The value is automatically calculated using Columns g, h, and i.

Section VI – Development of Manual Rate

Describe the source and year of the information used as the manual rate, as well as any other relevant information, such as benefit design, group size, group characteristics, utilization trends, pricing basis, formulary changes, induction, and risk assumptions. The supporting data and written narrative must be uploaded into HPMS at the time of bid submission.

Worksheet 3 - Contract Period Projection for Defined Standard Coverage

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

Plans are required to provide a written description of their average discount and rebate assumptions for the utilization in Worksheet 3 and 6. This documentation must be uploaded into HPMS at the time of bid submission. Rebate assumptions must be provided on a per-claim basis. The discount assumptions must reflect information on generic, brand, and specialty drugs separately for mail and retail.

Section I - General Information

This section automatically populates from entries on Worksheet 1.

Section II - Projection Data

Line 1 – Projected Member Months

The projected member months are carried over from the subtotal value for the member months in Section III.

Line 2 - Projected Average Risk Score

Enter the projected Rx risk score for the enrollees expected in the contract period. This value must be consistent with the base period risk score (if any) and with the expectation for the change in risk score from Worksheet 2. Reference the section on Risk Scores in the Special Considerations section of the instructions for more information.

Line 3 - Projected Low-Income Subsidy (LIS) Member Months

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

Line 4 – Network Pricing

Select one of the following two choices from the drop-down box: “pass-thru” or “lock-in.”

Section III – Part D-Covered Drug Claims

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

Lines 1 through 5, Column d - Number of Members

Enter the number of members who are expected to have allowed Part D Rx expenses falling in the range applicable to the line. For example, when modeling 6,500 members with allowed expenses falling in the range between $295 and $2,700, enter 6,500 on Line 3,

Column d. For purposes of Lines 1 through 5, do not include estimates for any claims for which Part D is secondary coverage.

Lines 1 through 5, Column e - Member Months

For each line, enter the number of member months expected in the contract period for the members identified.

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

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

Lines 1 through 5, Column h – Avg Amt Allowed PMPM

The average amount allowed PMPM is calculated automatically.

Lines 2 through 5, Column i - Cost Sharing

The cost-sharing amounts are calculated automatically.

Lines 4 through 5, Column j - GAP PMPM

For each line, enter the PMPM amount corresponding to amounts between the initial coverage limit and the catastrophic limit for the individuals identified in Column d. For 2009 this amount would correspond to allowed amounts between $2,700 and $6,153.75 of total drug spending.

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

For each line, for individuals identified in Column d, enter the projected PMPM values for the deductible and other cost-sharing (based on 25% coinsurance below the initial coverage limit and catastrophic coinsurance above the catastrophic limit). Calculate the PMPM values based on the total dollars for each category, divided by the total projected member months in Section II, Line 1.

Line 5, Column m - Federal Reinsurance PMPM

Enter the Federal Reinsurance applicable to the individuals identified in Column d. Calculate the PMPM values based on the total dollars divided by the total projected member months in Section II, Line 1.

Lines 1 through 5, Column n - Plan Liability

The plan liability PMPM is calculated automatically.

Lines 2 through 5, Column o - Federal LIS Cost Sharing PMPM

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

Line 6, all Columns - Subtotal

Each column is calculated automatically.

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

Although rebates are not directly allocable to individual claims, the method used to allocate rebates to the plan must be reasonable and similar to the way in which the rebates are generated. For the purpose of this worksheet, rebates must include any price concession recognized after the point of sale.

Enter, as a positive dollar amount in Column g, the total projected rebates to be generated in the contract period. The PMPM value in Column h is calculated automatically, and is allocated to Columns m and n based on the relative amount of reinsurance compared to all allowable costs.

Line 8, Columns g, h, m, and n – Minus Other Insurance

As positive amounts in Columns g and m, enter the total reduction due to the presence of other Rx insurance. Columns h and n are calculated automatically.

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

Enter in Columns g and m the total liability of the plan for which Part D coverage is secondary. Columns h and n are calculated automatically.

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

In Line 10, enter the percentage of Line 6, Column g that represents OON allowed claims. In Line 11, enter the percentage of Line 6, Column n that represents OON plan liability.

Line 12, Columns g through o - Total

The values are automatically calculated based on the previous lines.

Section IV – PMPM Non-Benefit Expense and Gain/ (Loss)

Lines 1 through 5

The values for Lines 1 through 5 are automatically calculated by the BPT from entries on Worksheets 2, 3, and 5.

Line 6 – Total Gain/ (Loss)

Enter the value for the plan's expected total gain/ (loss). Consistent with statutory intent, the gain/(loss) margin must reflect the revenue requirements of benefits provided under the plan.

Section V – Defined Standard Coverage Bid Development

he values for Section V are automatically calculated by the BPT from entries on Worksheet 3.

Worksheet 4 - Standard Coverage with Actuarially Equivalent Cost Sharing

This worksheet is to be completed only for standard coverage with actuarially equivalent cost sharing plan benefit types. The two tests that must be met to demonstrate actuarial equivalence are as follows:

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

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

Considerations for Actuarially Equivalent Coverage

Although defined standard plans have 25% cost sharing for all classes of drugs, it is expected that actuarially equivalent (AE) plans will restructure the 25% to provide incentive for beneficiaries to access the benefit in a way that results in more efficient drug use. AE plans generally have higher use in the generic and possibly preferred brands, and lower use in non-preferred brands; AE plans generally have higher mail use. Due to favorable shifts, AE bids have lower costs under the initial coverage limit (ICL) and the catastrophic phases of the benefit than do the defined standard bids. It is expected that the utilization in Worksheet 6 will adequately reflect these changes.

Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making adjustments in utilization and possibly average script pricing in Worksheet 6. The distribution of utilization between generic and brand, and retail and mail, must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an actuarially equivalent plan with a zero dollar generic cost share.

Section I – General Information

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

Section II – Projection Data

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

Section III – Development of Bid for Defined Standard Coverage

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

Section IV – Development of Bid Components and Tests for Actuarial Equivalence

Lines 1 through 3 and 5 through 14, Columns e, h, and k

These items are calculated automatically.

Line 4, Columns e and h - Allowed PMPM

For amounts below the initial coverage limit, enter in Column e the allowed PMPM for standard coverage with actuarially equivalent cost sharing. For amounts above the catastrophic threshold, enter the allowed PMPM in Column h.

Line 15, Column k - Rebates

Enter in Column k the total rebate amount for the plan. Rebates will be prorated for reinsurance.

Section V – Standard Coverage Bid Development with Actuarially Equivalent Cost Sharing

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

Line 6 - LIS

Enter the estimated value of low-income cost sharing consistent with the anticipated risk factor.

Worksheet 5 - Alternative Coverage

This worksheet is used only for alternative coverage plan benefit types. Basic alternative coverage plans result in no supplemental premium. The supplemental premium for enhanced alternative coverage is automatically calculated by this worksheet.

Considerations for Basic and Enhanced Alternative Plans

Although defined standard plans have 25% cost sharing for all classes of drugs, it is expected that alternative plans will restructure the 25% to provide incentive for beneficiaries to access the benefit in a way that results in more efficient drug use. Alternative plans may also change cost sharing up to the initial coverage limit (ICL) and are likely to restructure to provide incentive for beneficiaries to increase the efficiency of their drug use. These plans generally have higher use in the generic and possibly preferred brands and lower use in non-preferred brands, as well as higher mail utilization. Due to these favorable shifts, these bids have lower costs under the ICL and the catastrophic phases of the benefit than do the defined standard bids.

Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making adjustments in utilization and possibly average script pricing in Worksheet 6. The distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. Significant changes to the benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an alternative plan with a zero dollar generic cost share as compared to the expected generic use under the defined standard benefit.

Alternative plans can reduce the value of the deductible, which may in turn reduce the risk profile of the group. Although these changes may be compensated by increased cost sharing up to the ICL it is reasonable to expect some induced utilization.

Finally, alternative plans may provide for coverage in the payment gap. Since the value of coverage up to the ICL must remain the same, relative to defined standard, unless the cost of the additional coverage is offset by savings in catastrophic coverage, a supplemental premium will result. Additional coverage in the gap can also delay the point at which a beneficiary (i) achieves $4,350 of true out-of-pocket (TrOOP) cost sharing, and (ii) gets catastrophic coverage. This delay can reduce the amount of reinsurance that will be provided, cause induced utilization, and increase the risk profile of the group, although those with extremely high spending will not benefit as much as those with a moderate amount of spending and therefore may not opt for these plans.

Section I – General Information

The information in this section is automatically populated from Section I of Worksheet 1.

Section II – Projection Data

The information in this section is automatically populated from Section II of Worksheet 3.

Section III – Development of Bid for Defined Standard Coverage

The information in this section is automatically populated from Worksheet 3.

Section IV – Development of Bid Components

Type of Deductible
Select one of the following three choices from the drop-down box: applies to all drugs; applies to brand drugs only; other. This entry must be consistent with the deductible that is described in the Plan Benefit Package for this plan.

Alternative Coverage ICL
Enter the initial coverage limit (ICL) for the proposed alternative coverage benefit.

Type of Gap Coverage
Select one of the following five choices from the drop-down box: no coverage; full coverage; partial - increased ICL; partial - generics only; partial – other: and partial – limited monetary amount.

Columns d through o – Part D-Covered Drugs

These amounts represent Part D covered drugs.

Column q – Non-Part D-Covered Drugs

These amounts represent Non-Part D-covered drugs.

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

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

Line 6, Column d - Proposed Deductible

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

Line 8, Column f – Value of Proposed Deductible

Plans must adequately demonstrate the impacts of different approaches for pricing various deductibles as well as the impact on the initial coverage limit. Please review the information under “Special Considerations” for more information on first dollar generic coverage.

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

Line 12, Column k - Coinsurance Percentage in Gap

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

Line 18, Columns o and q - Alternative Plan Rebates

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

Line 20, Columns m, o and q - Alternative Minus Other Insurance

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

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

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

Section V – Development of Actuarial Equivalent Test

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

Line 9 - LIS

Using the projected risk scores, enter the estimated PMPM value of Low-Income Cost Sharing subsidy under the alternative plan.

Section VI – Tests for Alternative Coverage

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

Section VII – Development of Supplemental Premium

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

Line 6 - Additional Non-Benefit Expenses

Line 6 is calculated automatically from Worksheet 3. No entries are required.

Line 7 - Additional Gain/ (Loss)

Line 7 is calculated automatically from Worksheet 3. No entries are required.

Section VIII – Development of Induced Utilization Adjustment

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

Line 2 - Impact of Alternative Utilization on Standard Benefit

Enter the additional basic Part D costs in the first column if the utilization for alternative coverage was used to price defined standard coverage. This adjustment must reflect the additional costs associated with basic coverage. For the 2009 benefit year, this amount represents 75% of costs between the $295 deductible and the $2,700 initial coverage limit, plus 15% of costs in excess of the basic catastrophic limit or $6,153.75. Calculate this adjustment only for enhanced alternative plans. The adjustment must be a positive number.

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

The purpose of this worksheet is to illustrate the underlying assumptions that are being used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. All of the data in Section II are collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit.

Specialty Drugs

Plans that include a designated specialty drug tier in their plan benefit package (PBP) must separately identify the mail and retail utilization for the specialty tier in each level of spending in Section II of Worksheet 6. The additional information is expected to minimize the distortion of cost sharing that occurs when high-cost specialty drugs are reported as brand drugs, and permit a more accurate comparison of the cost sharing on Worksheet 6 with the plan benefit package in HPMS.

A separate breakout of specialty drugs on Worksheet 6 is required only when a plan utilizes a designated specialty tier within the formulary and benefit design in accord with CMS guidelines. The CMS guidelines require that (i) only one tier be designated a specialty tier, (ii) cost sharing associated with that tier be limited to 25% in the initial coverage range, and (iii) only Part D drugs with plan-negotiated prices greater than $600 per month be placed in the tier.

When a designated specialty tier is used, all drugs in that tier must be reported by place of service, on the appropriate lines in Section II of Worksheet 6. Further, the drugs in the specialty tier must be reported only in the specialty line items and not in any other category. In this situation, the specialty drugs are not to be sorted by preferred brand, non-preferred brand or generic status, and must not be reported as a component of the brand and generic drugs in the non-specialty tiers.

When a plan does not utilize a designated specialty drug tier in the formulary and benefit design, specialty drugs must be identified by preferred brand, non-preferred brand or generic status, and must be reported in these categories according to status and place of service. In this situation, the specialty categories in Section II of Worksheet 6 are not be completed.

Data Required for Levels of Allowed Spend

Data are collected for four levels of allowed costs on Lines 1 through 36 of “Projections for Equivalence Tests,” Section II of Worksheet 6. Members and member months are no longer captured on Worksheet 6; however the distribution of population and data reported in

Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8 collect data on all allowed costs for the “Population Not Exceeding $2,700 with Standard Coverage.” All of the utilization for the population with total allowed costs that do not exceed $2,700 must be reported in this section.

Lines 10 through 17 collect data on all allowed costs for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for the population with total allowed costs that exceed $2,700 must be reported in this section.

Lines 19 through 26 collect data on all allowed costs up to $2,700 for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for allowed costs allocated up to $2,700, for the population with allowed costs that exceed $2,700, is reported in this section.

Lines 28 through 35 collect data on all allowed costs over the catastrophic coverage limit for the "Population Exceeding $2,700 with Standard Coverage." All of the utilization for allowed costs allocated over catastrophic coverage, for the population with allowed costs that exceed $2,700, is reported in this section.

Considerations

Although this worksheet is not expected to be a detailed model of the cost sharing of the proposed plan design, the impact of alternative cost sharing and other programs, such as mandatory generic, on utilization must be clearly demonstrated compared to the defined standard benefit. The distribution of utilization between generic and brand, and retail and mail, must be reasonable given the proposed benefit, and significant changes in the alternative benefit are expected to result in meaningful differences in utilization when compared to the defined standard bid. For example, it is reasonable to expect a noticeable increase in the utilization of generic drugs in an alternative plan with a zero dollar generic cost share.

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

All plans are required to develop projected utilization and costs for their proposed defined standard benefit in Columns f, g, and h in Section II of Worksheet 6. In addition, plans submitting a bid for an actuarially equivalent or alternative benefit are required to report projected utilization and costs in Columns i, j, and k. If the bid is for defined standard coverage, then Columns i through k are left blank.

Data in Section II of Worksheet 6 are collected in a manner that supports an actuarial comparison of the proposed benefit to the defined standard benefit and are not expected to model all of the aspects of plan design. Lines 1 through 18 summarize all of the claims expected to be utilized, with Lines 1 through 9 capturing the claims for individuals with less than $2,700 in annual drug claims and Lines 10 through 18 capturing the claims for individuals with $2,700 or more in annual drug claims. Lines 19 through 27 capture the claims or amounts allocated up to ICL for individuals with $2,700 or more in allowed costs. Lines 28 through 36 capture the claims for individuals expected to reach catastrophic coverage, which is $6,153.75 or more in annual drug claims for a defined standard benefit in contract year 2009. Note that amounts summarized in Lines 19 through 27, and in lines 28 through 36 are subsets of the amounts summarized in Lines 10 through 18; amounts in the gap are intentionally excluded.

Plans must follow instructions carefully in developing cost sharing values for Column h in Section II of Worksheet 6 because this column is not expected to specifically model all of the

cost-sharing elements for the proposed defined standard benefit. In Lines 1 through 8, and Lines 19 through 27, Column h captures the cost sharing for the claims summarized in Columns f and g using the cost sharing applicable between the deductible and the initial coverage limit for all claims allocated up to the ICL; Column h develops cost sharing without the impact of the deductible, the gap in coverage, and catastrophic coverage. For the purpose of this worksheet, plans are to ignore the impact of low-income cost sharing subsidy. Since Column h summarizes the defined standard benefit, all of the claims reflect cost sharing of 25%.

The worksheet must be completed for Lines 28 through 36 of Column h using cost sharing applicable beyond the catastrophic threshold. For defined standard coverage, this amount is the greater of 5% or $2.25 for generic/preferred multi-source brand, or $5.60 for all others.

Plans submitting a bid to provide an actuarially equivalent or alternative benefit are required to report the projected utilization and costs on the proposed benefit in Section II, Columns i, j, and k. Plans must appropriately model the impact of the alternative benefit compared to the defined standard by making adjustments in utilization and average script pricing in Worksheet 6. Specifically, the distribution of utilization between generic and brand, and retail and mail must be reasonable given the proposed benefit. The distributions must be based on the splits as outlined in the defined standard coverage. For example, Lines 1 through 9 must reflect the utilization for the actuarial equivalent or alternative plan for individuals expected to have less than $2,700 in annual coverage based on the defined standard coverage. In other words, the amounts summarized in Columns i, j and k are to be based on the same population summarized in Columns f, g, and h.

Plans must follow instructions carefully in developing the cost-sharing values in Lines 1 through 9, and Lines 19 through 27, of Column k in Section II of Worksheet 6. Values in Column k are calculated using the copay and coinsurance structure of the proposed actuarially equivalent or alternative benefit, for all claims allocated up to the ICL. As does Column h, Column k develops cost sharing without the impact of the deductible, any gap in coverage and catastrophic coverage. Plans are to calculate Lines 28 through 36 assuming the cost sharing applicable beyond the catastrophic threshold for the actuarially equivalent or alternative coverage.

Plans must be aware of the situations outlined in the “Special Considerations” section of these instructions when offering first dollar generic coverage or reducing the initial coverage limit.

Section I – General Information

The information in this section is automatically populated from Section I of Worksheet 3.

Section II – Projections for Equivalence Tests

Data are collected for four levels of allowed costs on Lines 1 through 36 of “Projections for Equivalence Tests,” Section II of Worksheet 6. Members and member months are no longer captured on Worksheet 6; however, the distribution of population and data reported in Section II of Worksheet 6 must be consistent with the distribution and data reported on Worksheet 3.

Lines 1 through 8

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

Columns i through k – If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts, allowed dollars, and cost sharing for the population identified in Section III of Worksheet 3, cells D-21 plus D-22, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage. These numbers include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 9

The value is automatically calculated as the sum of Lines 1 through 8.

Lines 10 through 17

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

Columns i through j – If offering an actuarially equivalent standard or alternative benefit, enter the projected scripts and allowed dollars for the population identified in Section III of Worksheet 3, cells D-23 plus D-24. These numbers must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 18

The value is automatically calculated as the sum of Lines 10 through 17.

Lines 19 through 26

Columns f through h – For amounts allocated up to the ICL, enter the projected scripts, allowed dollars, and cost sharing for defined standard coverage, with coinsurance calculated at 25% as if there were no deductible, no gap, and no LIS subsidy.

Columns i through k – If offering an actuarially equivalent standard or alternative benefit, for amounts allocated up to the ICL, enter the projected scripts, allowed dollars, and cost sharing for the population identified in Section III of Worksheet 3, cells D-23 plus D-24, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage between the deductible and the ICL. These amounts must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 27

The value is automatically calculated as the sum of Lines 19 through 26.

Lines 28 through 35

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

Columns i through k – If offering an actuarially equivalent standard or alternative benefit enter the projected scripts, allowed dollars, and cost sharing for the population identified in Section III of Worksheet 3, cell D-24, using the copay/coinsurance structure being proposed for actuarially equivalent or alternative coverage once the catastrophic coverage limit has been reached. These amounts must include changes to utilization patterns that could be expected based upon the difference between defined standard coverage and the coverage being proposed.

Line 36

The value is automatically calculated as the sum of Lines 28 through 35.

Line 37

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

Example

Below is an illustrative example of how Lines 10 through 36 are to be completed. The example assumes that beneficiaries A and B reach catastrophic coverage with total allowed costs of $10,000 and $6,425, respectively. The following cost sharing provisions apply:

Cost Sharing	Up to ICL	Catastrophic
Retail Generic	$5	$2.25
Retail Preferred Brand	$25	$2.25
Retail Non-Preferred Brand	$50	$5.60
Retail Specialty	25%	5%
Mail Order Generic	$10	$2.25
Mail Order Preferred Brand	$50	$2.25
Mail Order Non-Preferred Brand	$100	$5.60
Mail Order Specialty	25%	5%

For illustrative purposes only, the beneficiaries are shown separately and in aggregate.

Beneficiary A's costs are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Beneficiary A Allowed	Cost-sharing
10. Retail Generic	20	$ 500.00	
11. Retail Preferred Brand	15	$ 1,500.00	
12. Retail Non-Preferred Brand	8	$ 1,200.00	
13. Retail Specialty (2)	2	$ 2,000.00	
14. Mail Order Generic	10	$ 550.00	
15. Mail Order Preferred Brand	10	$ 2,250.00	
16. Mail Order Non-Preferred Brand	5	$ 2,000.00	
17. Mail Order Specialty (2)	-		
18. Total	70	$10,000.00	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	5.02	$ 125.50	$ 25.10
20. Retail Preferred Brand	3.77	$ 376.50	$ 94.13
21. Retail Non-Preferred Brand	2.01	$ 301.20	$ 100.40
22. Retail Specialty (2)	0.50	$ 502.00	$ 125.50
23. Mail Order Generic	2.51	$ 138.05	$ 25.10
24. Mail Order Preferred Brand	2.51	$ 564.75	$ 125.50
25. Mail Order Non-Preferred Brand	1.26	$ 502.00	$ 125.50
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	17.57	$ 2,510.00	$ 621.23

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	8.55	$ 213.69	$ 19.23
29. Retail Preferred Brand	6.41	$ 641.06	$ 14.42
30. Retail Non-Preferred Brand	3.42	$ 512.85	$ 19.15
31. Retail Specialty (2)	0.85	$ 854.75	$ 42.74
32. Mail Order Generic	4.27	$ 235.06	$ 9.62
33. Mail Order Preferred Brand	4.27	$ 961.59	$ 9.62
34. Mail Order Non-Preferred Brand	2.14	$ 854.75	$ 11.97
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	29.92	$ 4,273.75	$ 126.74

Beneficiary B's costs are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Beneficiary B Allowed	Cost-sharing
10. Retail Generic	18	$ 450.00	
11. Retail Preferred Brand	12	$1,200.00	
12. Retail Non-Preferred Brand	10	$1,500.00	
13. Retail Specialty (2)	-	$ -	
14. Mail Order Generic	5	$ 275.00	
15. Mail Order Preferred Brand	8	$1,800.00	
16. Mail Order Non-Preferred Brand	3	$1,200.00	
17. Mail Order Specialty (2)	-		
18. Total	56	$6,425.00	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	7.03	$ 175.80	$ 35.16
20. Retail Preferred Brand	4.69	$ 468.79	$ 117.20
21. Retail Non-Preferred Brand	3.91	$ 585.99	$ 195.33
22. Retail Specialty (2)	-	$ -	$ -
23. Mail Order Generic	1.95	$ 107.43	$ 19.53
24. Mail Order Preferred Brand	3.13	$ 703.19	$ 156.26
25. Mail Order Non-Preferred Brand	1.17	$ 468.79	$ 117.20
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	21.88	$2,510.00	$ 640.68

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	1.96	$ 48.94	$ 4.40
29. Retail Preferred Brand	1.31	$ 130.51	$ 2.94
30. Retail Non-Preferred Brand	1.09	$ 163.13	$ 6.09
31. Retail Specialty (2)	-	$ -	$ -
32. Mail Order Generic	0.54	$ 29.91	$ 1.22
33. Mail Order Preferred Brand	0.87	$ 195.76	$ 1.96
34. Mail Order Non-Preferred Brand	0.33	$ 130.51	$ 1.83
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	6.09	$ 698.75	$ 18.44

The aggregate costs of Beneficiaries A and B are distributed as follows:

Population Exceeding $2,510 with Standard Coverage

	Utilization	Total A & B Allowed	Cost-sharing
10. Retail Generic	38	$ 950.00	
11. Retail Preferred Brand	27	$2,700.00	
12. Retail Non-Preferred Brand	18	$2,700.00	
13. Retail Specialty (2)	2	$2,000.00	
14. Mail Order Generic	15	$ 825.00	
15. Mail Order Preferred Brand	18	$4,050.00	
16. Mail Order Non-Preferred Brand	8	$3,200.00	
17. Mail Order Specialty (2)	-	$ -	
18. Total	126	16,425	

Amounts Allocated Up to ICL $2,510

19. Retail Generic	12.05	$ 301.30	$ 60.26
20. Retail Preferred Brand	8.45	$ 845.29	$ 211.32
21. Retail Non-Preferred Brand	5.91	$ 887.19	$ 295.73
22. Retail Specialty (2)	0.50	$ 502.00	$ 125.50
23. Mail Order Generic	4.46	$ 245.48	$ 44.63
24. Mail Order Preferred Brand	5.64	$1,267.94	$ 281.76
25. Mail Order Non-Preferred Brand	2.43	$ 970.79	$ 242.70
26. Mail Order Specialty (2)	-	$ -	$ -
27. Total	39.45	$5,020.00	$ 1,261.91

Amounts Allocated over Catastrophic Coverage

28. Retail Generic	10.51	$ 262.63	$ 23.64
29. Retail Preferred Brand	7.72	$ 771.57	$ 17.36
30. Retail Non-Preferred Brand	4.51	$ 675.98	$ 25.24
31. Retail Specialty (2)	0.85	$ 854.75	$ 42.74
32. Mail Order Generic	4.82	$ 264.96	$ 10.84
33. Mail Order Preferred Brand	5.14	$1,157.35	$ 11.57
34. Mail Order Non-Preferred Brand	2.46	$ 985.26	$ 13.79
35. Mail Order Specialty (2)	-	$ -	$ -
36. Total	36.01	$4,972.50	$ 145.18

(2) - The Specialty tier is only used when the Plan places Specialty drugs on a separate tier in accordance with CMS guidelines.

Network Pricing

Enter the average expected percentage discount off of AWP, and the average dispensing fees for generic, brand and specialty drugs dispensed at mail or retail.

The numbers in this section must be based upon the network pricing contracts and the weighted utilization by pharmacy of the population.

Worksheet 7 – Summary of Key Bid Elements

The purpose of this worksheet is to capture a summary of the key payment-related components of the bid and the plan's estimate of the National Average Monthly Bid Amount and calculated premiums. The inputs on this worksheet must be reasonable and represent the plan's best estimates of these projected values.

SECTION II – 2009 Defined Standard Benefit Parameters

Line 1 – Deductible

This pre-loaded value is the deductible for the defined standard benefit.

Line 2 - Initial Coverage Limit

This pre-loaded value is the initial coverage limit (ICL) for the defined standard benefit.

Line 3 - Out-of-Pocket Limit

This pre-loaded value is the out-of-pocket limit (OOP) for the defined standard benefit.

SECTION III – Summary of Key Bid Elements

Line 1 – Standardized Part D Bid

This value is the plan's standardized Part D bid. The value is automatically calculated from the plan bid.

Line 2 - National Average Monthly Bid Amount

This field requires a manual input at the time of bid submission. Enter the estimated national average monthly bid amount that the plan is anticipating. The final value for the national average bid amount for contract year 2009 will be released some time after this value is entered and the bid is submitted.

Line 3 – Base Beneficiary Premium

This field requires a manual input at the time of bid submission. Enter the estimated base beneficiary premium amount that the plan is anticipating. Together with the national average monthly bid amount and the basic Part D A/B rebate allocation reported on the MA bid pricing tool for MA plans, these amounts will determine the plan's basic Part D target premium that will be used during the rebate reallocation period.

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

The values on Lines 4 and 5 are the plan's expected base beneficiary premium, calculated from the plan's manual inputs on Lines 1, 2, and 3 of this section. Line 4 reflects the value of the basic Part D premium before application of the rounding rule, and Line 5 reflects the value after the rounding rule selected on Line 8 of this section has been applied. These

amounts will be updated to reflect the actual national average monthly bid amount and base beneficiary premium after these amounts are published in early August.

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

This value is the plan's supplemental Part D premium before rebate allocation and is developed only when supplemental benefits are offered. The value is reflected both before and after the application of the rounding according to the rule in Line 11 of this section. Line 6 reflects the value of the basic Part D premium before application of the rounding rule and Line 7 reflects the value after the rounding rule has been applied.

Line 8 - Prospective Federal Reinsurance (non-standardized)

This value is the prospective federal reinsurance requirement developed in the bid.

Line 9 - Prospective Low-income Cost-Sharing Subsidy (non-standardized)

This value is the prospective low-income cost-sharing requirement developed in the bid.

Line 10 - Target Adjustment (allowed costs as a ratio of bid)

This value is the administrative cost percentage of the bid, and the value is used in calculating the target amount for risk corridor payments. The target amount is calculated according to the following:

> [(1.00 – administration cost percentage) X (total direct subsidy payments + total beneficiary premiums related to the standardized bid amount)]

Line 11 - Rounding Rule

This field requires a manual input. MA-PD plans are required to round to the nearest $0.10; PD plans are required to round to either the nearest $0.10 or nearest $0.50 and must select the preferred method for rounding the Part D premium from the drop-down menu.

The default will be $0.10 in all cases in which a selection is not made.

Section IV - Part D Bid Pricing Tool Contacts and Date Prepared

Plans must to identify three persons who are readily available and are authorized to discuss the development of the bid: Credentials are a required input for the certifying actuary.

Section IV also contains a field labeled "Date Prepared." This field must contain the date that the BPT was prepared. If the BPT is revised and resubmitted during the bid review process, then this date field must be updated accordingly.

Appendix A – Actuarial Certification

CMS requires an actuarial certification to accompany *every* bid submitted to HPMS. 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 responsibility on the actuary's professional judgment and to hold him/her accountable for the reasonableness of the assumptions and projections.

Actuarial Standards of Practice and Other Considerations

In preparing the actuarial certification, the actuary must consider whether the actuarial work supporting the bid conforms to the current 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 Health Plan Entities*. Particular focus is placed on the following sections: "Use of Business Plans to Project Future Results" (3.2.3), "Use of Past Experience to Project Future Results" (3.2.4), "Recognition of Plan Provisions" (3.2.5), "New Plans or Benefits" (3.2.6), "Regulatory Benchmark" (3.2.8), and "Reasonableness of Assumptions" (3.2.9).
- ASOP No. 23, *Data Quality*. Particular focus is placed on the following sections: "Selection of Data" (3.2), "Reliance on Data Supplied by Others" (3.3), "Reliance on Other Information Relevant to the Use of Data" (3.4), "Review of Data" (3.5), "Use of Data"(3.7), and "Communications and Disclosures" (Section 4).
- ASOP No. 25, *Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages*.
- ASOP No. 31, *Documentation in Health Benefit Plan Ratemaking*. Particular focus is placed on the following section: "Extent of Documentation" (3.2).
- ASOP No. 41, *Actuarial Communications*. Particular focus is placed on the following sections: "Reliance on Other Sources" (3.1.6) and "Actuarial Report" (3.3.3).

The certifying actuary must also consider whether the actuarial work supporting the bid complies with applicable laws, rules, CY2009 bid instructions, and current CMS guidance. In addition, he/she must consider whether the actuarial work supporting the bid is consistent and reasonable with the plan benefit package and the organization's current business plan.

Certification Module

The certification module contains the following features:

- Standardized required language (the required elements are described in a subsequent section of this appendix)
- The ability to append free-form text language to the required standardized language.
- A summary of key information from the submitted bids
- Links to additional information regarding the bid package (such as the PBP, BPT, substantiation, etc.)
- The ability to certify multiple bids/contracts
- The ability to print and save the submitted certification

An initial actuarial certification must be submitted via the HPMS certification module in June. The actuary must also certify the final bid (that is pending CMS approval) via the certification module in August following the CMS publication of the Part D National Average Monthly Bid Amount, the Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the MA regional benchmarks. Actuaries are not required to certify every intermittent resubmission throughout the bid review process, but may do so if they wish.

As was instructed in previous contract years, material changes to the certification language (after the initial June certification submission) are not permitted without prior written permission from the CMS Office of the Actuary.

Plan sponsors may have multiple actuaries assigned to one contract to perform the certifications. For example, a consulting actuary may certify the Part D portion of a bid, while an internal plan staff actuary may certify the MA portion of the bid. Also, one actuary may certify plan Hxxxx-001, while a different actuary may certify plan Hxxxx-002. The instructions contained in this appendix should be followed by all actuaries who will be doing any certifications for CY2009 bids.

If a certification is not submitted via the HPMS certification module, the bid will not be considered for CMS review and approval.

Every MA BPT requires a certification. Every PD BPT requires a certification. Since Part D BPTs are not submitted for “800-series” EGWP employer bids, a Part D actuarial certification is not required. However, a certification is still required for the MA portion of “800-series” employer bids.

Required Certification Elements

The certification module contains the following information, as part of the standardized language:

- The certifying actuary's name/user ID and the date, "stamped" when the certification is submitted,
- Attestation that the actuary submitting the certification is a member of the American Academy of Actuaries (MAAA). As such, the actuary is familiar with the requirements for preparing Medicare Advantage and Prescription Drug bid submissions and meets the Academy's qualification standards for doing so.
- The specific contract, plan ID, and segment ID of the bid associated with the certification.
- The contract year of the bid contained in the certification.
- Indication of whether the certification applies to the Medicare Advantage bid, the Prescription Drug bid, or both.
- Attestation that the certification complies with the applicable laws,[1] rules,[2] CY2009 bid instructions, and current CMS guidance.
- Attestation that, in accordance with Federal law, the bid is based on the "average revenue requirements in the payment area for a Medicare Advantage/Prescription Drug enrollee with a national average risk profile."
- Attestation that the data and assumptions used in the development of the bid are reasonable for the plan's benefit package (PBP).
- Attestation that the data and assumptions used in the development of the bid are consistent with the organization's current business plan.
- Attestation that the bid 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 bid complies with the appropriate ASOPs.
- A statement that, in accordance with ASOP 23, any data and assumptions provided by reliances were reviewed for reasonableness and consistency, and that supporting documentation for the reliance on information provided by others is uploaded with the bid.

Please refer to ASOP No. 23, Data Quality, and ASOP No. 41, "Actuarial Communications", for additional details regarding reliances. Also see Appendix B for information regarding supporting documentation required for reliances.

If you have any questions regarding the CY2009 certification instructions, please contact the CMS Office of the Actuary at actuarial-bids@cms.hhs.gov.

[1] Social Security Act sections 1851 through 1859; and Social Security Act sections 1860D-1 through 1860D-42.
[2] 42 CFR Parts 400, 403, 411, 417, 422, and 423.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2009 certification module were released via HPMS on February 14, 2008. Below is the guidance included in that memo.

SUBJECT: Contract Year 2009 Actuarial Certification Process

For Contract Year (CY) 2008, certifying actuaries (both consulting actuaries and actuaries employed by contracting organizations) were required to complete the actuarial certification portion of the bid submission process via the Health Plan Management System (HPMS). This same actuarial certification process will apply in CY2009.

In order to meet this requirement, each contract submitting a bid must have at least one certifying actuary with active HPMS access. This memo provides the instructions for requesting and obtaining HPMS access for the actuarial certification process or renewing user access as a certifying actuary.

Submitting a Request for a New HPMS User - Actuaries Employed by the Organization

If the certifying actuary does **not** have active access to HPMS and is employed by the organization, the user should follow these steps:

- Download the *Application for Access to CMS Computer Systems* form from http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf.
- Complete the form as follows:
  - Section 1 – Check "New" as the type of request.
  - Section 2 – Check "Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only" and complete the data entry fields, where applicable.
  - Section 3 – Enter the contract number(s) for which you will be submitting actuarial certifications for CY 2009.
  - Section 4 – Check the first row beneath the "Default Non-CMS Employee" row (i.e., place a check in the Connect box of the third row). On the blank line beside your check mark, write "HPMS_P_CommlUser".
  - Section 5 – State briefly that you require HPMS access to submit the actuarial certification. **You must indicate that you are employed by the contracting organization**.
  - Section 6 – Leave blank.
  - Sign and date the Privacy Act Statement on page 3 of the form. Also enter your name and Social Security Number at the top of page 3. This step is critical to ensuring the successful processing of your request.

Submitting a Request for a New HPMS User - Consulting Actuaries

If the certifying actuary does **not** have active access to HPMS and is a consulting actuary, the user should follow these steps:

- Download the *Application for Access to CMS Computer Systems* form from http://www.cms.hhs.gov/InformationSecurity/Downloads/EUAaccessform.pdf.

- Complete the form as follows:

  - Section 1 – Check "New" as the type of request.
  - Section 2 – Check "Medicare Advantage / Medicare Advantage with Prescription Drug / Prescription Drug Plan / Cost Contracts – Using HPMS Only" and complete the data entry fields, where applicable.
  - Section 3 – Enter the contract number(s) for which you will be submitting actuarial certifications for CY 2009.
  - Section 4 – Check the first row beneath the "Default Non-CMS Employee" row (i.e., place a check in the Connect box of the third row). On the blank line beside your check mark, write "HPMS_P_CommlUser".
  - Section 5 – State briefly that you require HPMS access to submit the actuarial certification. **You must indicate that you are under contract as an actuarial consultant with the contracting organization(s).**
  - Section 6 – Leave blank.
  - Sign and date the Privacy Act Statement on page 3 of the form. Also enter your name and Social Security Number at the top of page 3. This step is critical to ensuring the successful processing of your request.

In addition to the *Application for Access to CMS Computer Systems* form, **you must include an official letter from each organization for which you are under contract to submit an actuarial certification via HPMS**. This letter must specify the contract number(s) and type of functionality required by the consulting actuary. In addition, the letter must be provided on the organization's official letterhead and signed by a senior official of the sponsoring organization. This letter must also have an original hardcopy signature.

NOTE: If a consulting actuary is serving multiple organizations, only one CMS user access form is required, but **a letter must be provided from each organization for which you will be serving as an agent in HPMS.** At least one letter from a sponsoring organization must be included in your submission in order for your request for HPMS access to be processed. Please note that you are permitted to submit additional letters from other sponsoring organizations following your initial submission for HPMS access.

CMS recommends the use of the following sample language in the letter from the sponsoring organization:

(Name of Organization) hereby requests that *(Name of Actuary)* with the firm of *(Name of Consulting Firm)* requires HPMS access to upload actuarial certifications on our behalf. *(Name of Actuary)* requires access to the following contract number(s): *(list specific contract numbers)*.

(Name of Actuary) requires the following HPMS access (please check one box):

- ☐ Actuarial Certification Profile only (actuarial certification submission functionality and related PBP and BPT reports)

- ☐ Actuarial Certification Profile and Plan Profile (actuarial certification submission functionality as well as **all other standard plan functionality**, including bid upload, formulary upload, marketing submission, etc.)

PLEASE NOTE: The Actuary's level of HPMS access **MUST** be the same across all contracts. The user's level of access cannot vary between contracts.

Submitting a Request for an Existing HPMS User that Previously Was Not a Certifying Actuary - Both Consulting Actuaries and Actuaries Employed by the Organization

If the certifying actuary **does** have active access to HPMS, the user should follow these steps:

- Please do NOT resubmit the user request form.

- Submit an official letter from each organization for which you are under contract to submit an actuarial certification via HPMS. All instructions noted above for this requirement must be followed (see "Submitting a Request for a New HPMS User - Consulting Actuaries").

- In addition, the official letter(s) for an existing HPMS user **must** include the user ID and an explanation that this user already has HPMS access.

Returning Certifying Actuaries – Actuaries Employed by the Organization

If the certifying actuary submitted one or more certifications for CY2008, will submit actuarial certifications for CY2009, and is an employee of the organization, the user should follow these steps:

- Please do NOT resubmit the user request form.

- Recertify your CMS User ID, when notified by CMS. Users will receive an email notification from ess@cms.hhs.gov with the subject "*CMS Certification Due Date*." Please follow these instructions closely to ensure you recertify and retain

your current user ID. If you do not complete the certification in a timely manner, your CMS User ID will be **revoked** and you will have to re-apply as a new HPMS User.

Returning Certifying Actuaries – Consulting Actuaries

If the certifying actuary submitted one or more certifications for CY2008, will submit actuarial certifications for CY2009, and is a consultant for the organization, the user should follow these steps:

- Please do NOT resubmit the user request form.
- Recertify your CMS User ID, when notified by CMS. Users will receive an email notification from ess@cms.hhs.gov with the subject "*CMS Certification Due Date*." Please follow these instructions closely to ensure you recertify and retain your current user ID. If you do not complete the certification in a timely manner, your CMS User ID will be **revoked** and you will have to re-apply as a New HPMS User.
- Submit an official letter from each organization for which you are under contract to submit an actuarial certification via HPMS. All instructions noted above for this requirement must be followed (see "Submitting a Request for a New HPMS User - Consulting Actuaries"). Consulting Actuary users **MUST** submit letters on an annual basis to ensure they have access to the appropriate contracts.
- The official letter(s) for an existing HPMS user **must** include the user ID and an explanation that this user already has HPMS access.

Common Mistakes on the *Application for Access to CMS Computer Systems* Form

Please be aware of the following common mistakes when preparing your request for HPMS access:

- You must include the contract number(s) in Section 3 for which you will be submitting an actuarial certification.
- You must always provide a Social Security Number. CMS will **not** process a request without this piece of information.
- You must complete the form in ink, not pencil.
- You must submit the original hardcopy form with an original signature and date. **Photocopies and faxes are unacceptable**.

Managing Certifying Actuary Access

Ultimately, it is the responsibility of the contracting organization to manage and maintain the set of users for whom they have requested access to the HPMS. This general principle applies to both plan staff and any consultants that are serving as agents of the contracting organization.

Contracting organizations may request the deletion of any user from accessing their data in HPMS at any time. These requests should be sent to hpms_access@cms.hhs.gov. Requests must contain the user ID and name of the individual to be removed from HPMS.

How to Submit Your Access Request

Please submit the original (not a copy) user access form and the corresponding organization letter(s), when required, via traceable carrier to:

Ms. Sara Walters
Re: Actuarial HPMS Access
7500 Security Blvd.
Location: C4-15-11 / Mailstop: C4-14-21
Baltimore, MD 21244-1850

To ensure sufficient time to process your request, we strongly recommend that you submit your requests no later than **March 31, 2008** since the bid upload process becomes available to plans on May 16, 2008 and CY 2009 bids are due no later than June 2, 2008.

For questions regarding these instructions as they pertain to HPMS access, please contact Sara Walters at either 410-786-3330 or Sara.Walters@cms.hhs.gov.

For questions regarding the actuarial certification process, please contact Liz Hale at either Elizabeth.Hale@cms.hhs.gov or 410-786-7604.

Thank you for your cooperation in this matter. We look forward to a successful CY 2009 bidding process.

Appendix B – Supporting Documentation

In addition to the bid form and actuarial certification, organizations must provide CMS with supporting material, as required in these instructions for completing the bid pricing tool. Plan sponsors must provide supporting documentation to support every bid, and additional supporting documentation may be required when the bid is based upon a specific assumption.

Unless otherwise noted, Plan sponsors must upload all required supporting documentation at the time of initial bid submission. When required by the instructions, Plan sponsors must prepare additional supporting documentation and make it readily available to CMS reviewers upon request. Plan sponsors must follow all of the guidance on providing substantiation contained in the INSTRUCTIONS FOR COMPLETING THE MEDICARE PRESCRIPTION DRUG PLAN BID PRICING TOOL FOR CONTRACT YEAR 2009.

Supporting documentation requirements are the same regardless of the source of the assumption, whether it was developed by the actuary, the Plan sponsor, or a third party. If the actuary relied upon others for certain bid data and/or assumptions, they are still subject to the same documentation requirements. The actuary must be prepared to produce the substantiation, even if it was prepared based on a reliance.

In preparing supporting documentation, the actuary must consider ASOP No. 31, Documentation in Health Benefit Plan Ratemaking. In accord with Section 3.2 Extent of Documentation, the materials provided must be written "with sufficient clarity that another actuary practicing in the same field could make an objective evaluation of the reasonableness of the work product."

All data submitted as part of the bid process are subject to review and audit by CMS or by any person or organization that CMS designates. Certifying actuaries must be available to respond to inquiries from CMS reviewers regarding the submitted bids.

Supporting documentation must:

- Be clearly labeled and easily understood by CMS reviewers.
- Include quantitative support and details, rather than just narrative descriptions of assumptions.
- Clearly identify if it is related to MA, Part D or both.
- Include the Contract ID on the first page; however, plan and segment numbers may be included in an attachment or a separate worksheet.

Acceptable forms of supporting documentation include, but are not limited to, the following items:

- Meeting minutes from any discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources, for example, a report name, file name, date obtained, source file, etc.
- Intermediate calculations showing each step taken to calculate an assumption.
- A summary of contractual terms of administrative services agreements.
- A business plan.

Supporting documentation that is not acceptable or that may result in a request for additional information includes, but is not limited to, the following items:

- A reference to the supporting documentation for another plan such as "the same as for Plan Hxxxx-xxx" and not the documentation itself. The supporting documentation for a plan must be self-contained.
- General descriptions of pricing that do not include plan-specific information.
- A statement that the source of a pricing assumption is "professional judgment," with no additional explanation, reasoning, supporting factors, studies, etc.
- "Living worksheets" that are overwritten with current data. Upload the version of the worksheet that is used in bid preparation.
- Information obtained after the bids are submitted.
- A statement that a pricing assumption or methodology is assumed acceptable based on its inclusion in a bid that was approved by CMS in a prior contract year. Data, assumptions, methodologies, and projections must be determined to be reasonable and appropriate for the current bid independent of prior bid filings.

Submitting Supporting Documentation

Supporting materials must be in electronic format (Microsoft Excel, Microsoft Word, or Adobe Acrobat) and must be uploaded to HPMS. CMS will not accept paper copies of supporting documentation. Note that multiple substantiation files can be submitted to HPMS at one time by using "zip" files, which compress multiple files into one file (.zip file extension). Also, one file can be uploaded to multiple plans in HPMS by using the CTRL key when plans are selected. However, documentation must not be uploaded to plans to which it does not pertain. It is not acceptable to upload materials specific to PD plans, MA plans, or certain Contract IDs to all plans.

Timing

Plan sponsors must upload all required supporting documentation into HPMS at the time of the initial June bid submission.

Plan sponsors must also prepare additional supporting documentation so that it is readily available to CMS reviewers upon request. The items specified are not required to be uploaded with the initial June bid submission, but must be prepared around that time in order to be readily available to provide. If substantiation is requested by CMS reviewers, it is expected to be provided within 48 hours. These materials will be reviewed at audit. CMS recommends that these materials be uploaded with the initial June bid submission.

Cover Sheet

Organizations often upload multiple documents that contain supporting documentation. To expedite the bid review process, organizations must upload a "cover sheet" that lists all of the supporting documentation that is uploaded or provided with the bid form. The filename must include the phrase "cover sheet."

The cover sheet must include detailed information for each support item such as filename and location within the file, if applicable. The cover sheet must clearly identify the Contract-Plan IDs and whether the substantiation is related to MA, Part D or both.

Note that certain documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements will apply only to bids that contain certain assumptions (for example, manual rate documentation applies only if a bid's projection is based on manual rates). For documentation categories that apply to a

subset of bids that contain a specified assumption, the cover sheet must not refer to a "range" of Contract-Plan IDs (such as "Plans 001 – 030", or "all plans under contract Hxxxx"). For these items, the cover sheet should contain the exact Contract-Plan-Segment IDs to which the documentation applies.

For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (i.e., the cover sheet should not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact Contract-Plan IDs, rather than a "range" of Contract-Plan IDs.

Requirements

Documentation requirements that apply to all bids (as all bids contain the following assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that gives relevant information about plan design, the product positioning in the market (i.e., high/low), changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.
- Support for non-benefit expense assumptions. The required elements include :
    - A summary of the non-benefit expenses by category of expense, or line item.
    - An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.
- Justification of the gain/loss margin. The required elements include:
    - Support for overall margin levels, including description of methodology used to develop margin assumptions, demonstration of year-by-year consistency, and supporting data.
    - Support for bids with negative margins, i.e., a business plan that illustrates profitability within few years.
    - Justification of the margin for bids with relatively large projected overall gains/losses. Examples of support to be provided are (i) illustration of return on investment/equity requirement(s), (ii) demonstration of corporate return requirement(s), and/or (iii) as applicable, other methodological illustrations. The development of margin requirements may reflect revenue offsets not captured in non-benefit expenses (such as investment expenses, income taxes, and changes in statutory surplus) and may also include investment income.
    - If applicable, further analysis of the organization's ROI / ROE and distinctions between recouping start-up costs versus ongoing organizational gain/loss.
    - In future years, comparisons to the original business plan including details and source of deviation from prior years' plans.
- Detailed support for the development of projected risk scores.
- Detailed support for the development of credibility.

The following is a checklist for required supporting documentation that Plan sponsors must upload to HPMS with the initial June bid submission.

Part D Checklist for Required Supporting Documentation
Initial June Bid Submission - Required for all bids
Cover Sheet
Product Narrative
Part D Non-Benefit Expenses
Part D Gain/Loss Margins
Part D Risk Scores
Part D Credibility assumption
Initial June Bid Submission - Required for all bids that contain the specified assumptions
Manual Rate Development
Part D - Disclosure of Related Party Agreements
Support for not using available PDE data in Worksheet 1
Input sheet for pricing models
Reliance Information
Part D Bid Audit Results (If applicable)
Upon Request by CMS Reviewers
Part D reconciliation of base period experience with company financial data
Part D support for projection assumptions

The following is a sample cover sheet checklist for supporting documentation that Plan sponsors must upload to HPMS with the initial June bid submission.

Supporting Documentation Cover Sheet
CY2009 Bid Submission

Organization Name: Health One
Contract(s): H1234, H9999, and S9999

Date: June 1, 2008

Appendix B

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, PD, or both
Cover Sheet	All bids	Cover 6-1-08.doc	n/a	both
Product Narrative	All bids	Cover 6-1-08.doc	Pages 2+	both
MA and Part D Non-Benefit Expenses	All bids	AdminProfit.xls	Sheet1	both
MA and Part D Gain/Loss Margins	All bids	AdminProfit.xls	Sheet2	both
MA and Part D Risk Scores	All bids	Risk CY09.xls	MA-Sheet 1 PD-Sheet 2	both
MA and/or Part D Manual Rate Development, if projection(s) based on manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
MA Base period member month distribution (if >4 plans used)	H1234-002-0	N/A (contained in the MA BPT)	MA BPT Worksheet 1, Section II line 6 text box	MA
MA Credibility assumption if differs from CMS guidelines	N/A			
MA Significant Non-Covered allowed costs, if any	N/A			
MA Adjustment to cost sharing for OOP max	N/A			
MA Cost sharing test, if outside limits	N/A			
MA ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA
MA ISAR factors, if used	N/A			
MA Actuarial swaps/ equivalences, if used	N/A			
Part D rebate and discount assumptions	All bids	Manual.xls	Section III	PD
Part D credibility assumptions	All bids	PartD.xls	“Credibility” worksheet	PD
Part D base period experience development	H1234-001-0 H1234-002-0 H1234-004-0 H9999-001-0 S9999-001-0	PartD.xls	“Base” worksheet	PD

The following is a sample cover sheet checklist for supporting documentation that Plan sponsors must upload to HPMS with subsequent substantiation uploads:

Supporting Documentation Cover Sheet #2
CY2009 Bid Submission

Organization Name: Health One
Contract(s): H1234, H9999, and S9999

Date: July 16, 2008

Documentation Requirement	Specific Bid ID(s) or N/A	File Name	Location within File (if applicable)	Applies to: MA, PD, or both
Cover Sheet	H1234-001-0 H1234-003-0 H1234-004-0 H1234-801-0 H9999-001-0 S9999-001-0	Cover2 7-16-08.doc	n/a	both
E-mail communication with CMS Bid Reviewers	H1234-001-0 H1234-003-0 H1234-004-0 H9999-001-0	E-mail1.doc	n/a	MA
E-mail communication with CMS Bid Reviewers	H9999-001-0 S9999-001-0	Email2.doc	n/a	PD
E-mail communication with CMS Bid Reviewers	H9999-001-0 S9999-001-0	Email3.doc	n/a	PD

Appendix C – Employer/Union-Only Group Requirements

The Medicare Modernization Act (MMA) gives employers and unions a number of options for providing prescription drug coverage to their retirees. Employers and unions can:

- Provide coverage at least as good as Medicare's Part D defined standard benefit and receive a tax-free retiree subsidy of 28% of a retiree's drug costs between $295 and $6,000;
- Purchase customized benefits from a PDP or MA-PD pursuant to CMS waivers; or
- Contract directly with CMS to become a PDP and provide customized benefits pursuant to CMS waivers.

Under sections 1860D-22(b) and 1857(i) of the Social Security Act (SSA), CMS may waive or modify Part D requirements that hinder the design of, offering of, or enrollment in an employer or union Part D retiree plan. The waiver authority applies to PDPs and MA-PDs that offer employer/union-only group plans and employer/union-only groups that contract directly with CMS to become a PDP.

For CY 2006, CMS issued guidance that waives or modifies many of the requirements for these entities. CMS waiver guidance is located at http://cms.hhs.gov/EmpGrpWaivers. All of the standard Part D bidding guidelines apply, with the exception of those specifically waived.

For CY2009, CMS does not require a Part D bid pricing tool for employer/union only group Plans.

For additional information on CY 2009 EGWP bidding policy, please refer to the CY 2009 Call Letter.

Appendix D – Calculation of the National Average Monthly Bid Amount

For the 2006 contract year, the national average monthly bid amount was calculated using equal weighting applied to all PDP sponsors, and assigned MA-PD plans a weight based upon prior enrollment. New MA-PD plans were assigned a zero weight. This approach was used because no PDP enrollment data existed for 2005.

For contract years 2007 and 2008, the national average monthly bid calculation was performed according to the guidelines established by the "Medicare Demonstration to Limit Annual Changes in Part D Premiums due to Beneficiary Choice of Low-Cost Plans." Specifically, 80 percent of the calculation for contract year 2007 was based on the 2006 averaging methodology, also known as the uniform-weighting average, and 20 percent was based on an enrollment-weighted average. For contract year 2008, 40 percent of the calculation was based on the uniform-weighting average and 60 percent was based on an enrollment-weighted average. For contract year 2009 the demonstration is no longer in effect, and the benchmarks will be based on the 2008 enrollments applied to the 2009 bids.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2007 and February 2008. The June 2007 enrollment shows the basis of the actual 2008 benchmark calculation. Recall that the 2008 benchmark was calculated as 40 percent of the uniform weighted approach, and 60 percent of the enrollment weighted approach. The table summarizes the final benchmark as well as the components of each weighting method.

The same values are presented based on the February 2008 enrollment. Since the 2009 benchmarks will be based on 2008 enrollment, these values may be useful for estimating the 2009 benchmarks. The final 2009 benchmarks will be based on the 2008 enrollments applied to the 2009 bids. The left section of the table shows the actual 2008 benchmarks, which were calculated based on June 2007 enrollment. The right section, titled "February 2008 Enrollment," indicates how the 2008 benchmarks would have been calculated based on more current enrollment data.

	June 2007 Enrollment			February 2008 Enrollment		
	2008 Demonstration (40% uniform, 60% enrollment)	Uniform Weighted Approach	Enrollment Weighted Approach	2008 Demonstration (40% uniform, 60% enrollment)	Uniform Weighted Approach	Enrollment Weighted Approach
National average monthly bid amount	80.52	82.34	79.30	79.54	82.19	77.77
Base beneficiary premium	27.93	28.91	27.28	27.60	28.82	26.79
Direct subsidy	52.59	53.43	52.02	51.94	53.37	50.98

This illustrative recalculation of the 2008 benchmarks with the revised weighting approach is provided for the purpose of assisting plans in developing the projected 2009 national

average monthly bid amount and base beneficiary premium which will be used in the calculation of the plan's target premium. The final 2009 benchmarks will be based on the 2008 enrollments applied to the 2009 bids.

Appendix E – Calculation of Low Income Benchmark Premium Amounts

The Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) directs CMS to use a weighted average to calculate the regional low-income benchmark premium amounts used in the determination of the low-income premium subsidy amounts. In determining the 2006 low-income benchmark premium amounts, PDPs were weighted equally, MA-PD plans were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PD plans were assigned a zero weight. In 2007, under the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006, i.e., all PDP bids were weighted equally, and MA-PD bids received weights based on plan enrollments in the reference month (June 2006).

For contract year 2008, CMS implemented a transition to the statutorily required weighting such that the regional low-income benchmark premiums would experience a smaller decrease. CMS calculated the 2008 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average).

- The first component, the simple average, was the same as the 2006 weighting methodology for the regional low-income benchmark premium amount. The PDP organization premium amounts for basic prescription drug coverage in each region would be weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, would be weighted based upon prior enrollment.

- The second component was a weighted average of the premium amounts for each PDP and MA-PD with a weighting based on each plan's prior enrollment as a percentage of all beneficiaries enrolled in those plans.

In 2008, 50% of the regional low-income benchmark amount was based on the first component, the simple average, and 50% was based on the second component, the enrollment weighted average.

In 2009, the "Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries," and the de minimus policy will not be in effect. The regional low-income benchmark amounts will be calculated based on the approach outlined in the recently released final LIS rule, using a calculation that will be based on 100% of the weighted LIS enrollments.

The following table illustrates the impact of calculating the regional low-income benchmark amounts based on 100% of the weighted LIS enrollments for two enrollment periods, June 2007 and February, 2008.

Region	State(s)	June 2007 Enrollment			February 2008 Enrollment		
		Uniform Weighted	Enrollment Weighted	LIS Enrollment Weighted	Uniform Weighted	Enrollment Weighted	LIS Enrollment Weighted
1	NH, ME	$31.20	$30.08	$28.50	$31.77	$29.84	$28.12
2	CT, MA, RI, VT	$30.34	$28.00	$28.77	$30.56	$26.37	$26.57
3	NY	$27.02	$21.33	$23.78	$27.48	$20.65	$23.58
4	NJ	$30.92	$31.53	$31.64	$31.35	$27.59	$27.05
5	DE, DC, MD	$31.12	$30.44	$28.25	$31.61	$30.03	$27.88
6	PA, WV	$28.19	$24.98	$27.15	$28.55	$24.50	$26.88
7	VA	$31.71	$30.34	$28.82	$32.29	$29.95	$28.11
8	NC	$33.63	$33.22	$30.93	$34.08	$32.62	$30.17
9	SC	$31.79	$30.44	$29.26	$32.23	$29.65	$27.96
10	GA	$31.31	$28.76	$27.13	$31.43	$28.01	$27.13
11	FL	$22.29	$16.03	$17.99	$22.29	$14.83	$19.57
12	AL, TN	$30.23	$26.35	$26.81	$30.66	$25.96	$26.20
13	MI	$31.15	$29.82	$29.66	$31.67	$28.71	$27.49
14	OH	$28.53	$25.11	$27.20	$28.87	$23.90	$25.57
15	IN, KY	$34.41	$32.58	$31.32	$34.80	$31.89	$30.46
16	WI	$32.35	$29.70	$31.02	$32.75	$26.78	$29.18
17	IL	$31.77	$28.74	$27.82	$32.17	$28.36	$27.08
18	MO	$29.58	$23.84	$25.82	$29.77	$22.73	$25.34
19	AR	$29.65	$25.73	$25.78	$30.17	$25.12	$24.74
20	MS	$32.68	$30.02	$29.40	$33.23	$29.22	$27.59
21	LA	$27.66	$21.58	$23.84	$27.76	$20.54	$25.12
22	TX	$26.85	$23.17	$23.77	$27.05	$22.14	$23.15
23	OK	$30.64	$25.44	$27.04	$31.03	$24.33	$25.49
24	KS	$32.57	$28.66	$29.45	$33.08	$27.16	$28.34
25	IA, MN, MT, ND, NE, SD, WY	$32.00	$29.21	$28.08	$32.36	$25.61	$28.65
26	NM	$22.82	$15.73	$17.85	$23.43	$15.87	$17.39
27	CO	$27.51	$21.66	$26.78	$27.78	$20.31	$25.02
28	AZ	$20.43	$11.40	$17.10	$20.74	$11.51	$19.44
29	NV	$20.96	$12.31	$17.27	$21.37	$11.56	$18.76
30	OR, WA	$31.99	$28.38	$29.10	$32.51	$27.15	$28.74
31	ID, UT	$34.87	$32.18	$32.01	$35.06	$29.67	$30.50
32	CA	$23.18	$16.42	$21.21	$23.47	$15.47	$19.64
33	HI	$27.91	$20.72	$25.42	$28.31	$18.23	$22.02
34	AK	$34.86	$37.97	$37.87	$35.49	$35.17	$33.65

Footnote: All columns reflect the 2008 monthly National Average Bid Amount and Base Beneficiary Premium

Appendix F - Bid Pricing Tool Technical Instructions

CMS strongly encourages all BPT users and certifying actuaries to read the Technical Instructions before working with the CY2009 bid tools.

The CY2009 BPT Technical Instructions are located in HPMS under:

HPMS Home > Plan Bids > Bid Submission > CY2009 > Documentation > BPT Technical Instructions

If you have any technical questions regarding the Bid Pricing Tool workbooks, please contact the HPMS Help Desk at 1-800-220-2028, or via email at: hpms@cms.hhs.gov .

Glossary of Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Defined Standard Benefit. All plans develop information for the defined standard benefit which represents (i) the bid for plans offering defined standard, and (ii) comparison points for actuarial equivalency tests for plans offering actuarially equivalent cost sharing or alternative coverage. In 2006, defined standard coverage includes the following:

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

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

Direct Subsidy Payment. Monthly payments received by PDPs and MA-PD plans equal to their bid amounts, risk-adjusted for enrollee health status and minus the enrollee premium.

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

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

Initial Coverage Limit. Allowed costs above any deductible for which coinsurance would apply. The amount is equal to the following:

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

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

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

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

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

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

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

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

MA. Medicare Advantage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Risk Adjustment Factor. Prescription drug risk adjustment methodology based on the relationship of prescription drug utilization within the entire Medicare population to medical

diagnoses, and applied at the individual beneficiary level. The long-term plan is to refine the risk adjustment model to account for predictable risk based on both medical and drug claim data.

Risk Corridors. Used to limit an insuring entity's risk of losing money but also limit its gains (profits). A target is established based on an estimate of the claims of the benefit. Gains or losses inside a risk corridor around that target are the full responsibility of the insuring organization. Additional gains or losses beyond the risk corridor are shared with the federal government. There is no risk-sharing for supplemental benefits.

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

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

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

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

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

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

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

User Fees. Fees whose purpose is to defray part of the ongoing costs of the national beneficiary education campaign, which develops and disseminates print materials, and maintains the 1-800-MEDICARE telephone line.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0944. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.