
INSTRUCTIONS FOR COMPLETING
THE PRESCRIPTION DRUG PLAN
BID PRICING TOOL
FOR CONTRACT YEAR 2015

April 11, 2014

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I. INTRODUCTION

BACKGROUND

Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) must submit a separate bid to the Centers for Medicare & Medicaid Services (CMS) for each prescription drug plan they intend to offer Medicare beneficiaries.

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format – the Prescription Drug Bid Pricing Tool (BPT). An actuarial certification and supporting documentation must be submitted for each bid as described in Appendix A and Appendix B, respectively.

The submitted bids will be subject to review and audit by CMS or by any person or organization that CMS designates. As part of the review and audit process, CMS or its representative may request additional documentation supporting the information in the BPT. Organizations must be prepared to provide this information in a timely manner.

DOCUMENT OVERVIEW

This document contains general pricing considerations and detailed instructions for completing the BPT. Following are the contents of each section:

- Section I, “Introduction”: contains a list of key changes from the CY2014 BPT and Instructions and provides sources of information that can be accessed for assistance during the bid submission process.
- Section II, “Pricing Considerations”: contains guidance for preparing bids and presenting pricing results in the BPT.
- Section III, “Data Entry and Formulas”: contains directions for completing the eight worksheets in the BPT and explains the formulas for calculated cells.
- Section IV, Appendices A through G: contains requirements for Actuarial Certification (Appendix A), Supporting Documentation (Appendix B), Employer/Union-Only Group Waiver Plans (Appendix C), Calculation of the National Average Monthly Bid Amount (Appendix D), Calculation of the Low-Income Benchmark Premium Amounts (Appendix E), Health Care Reform (Appendix F) and Trending Risk Scores (Appendix G).

NEW FOR CONTRACT YEAR 2015 (CY2015)

The key changes between the CY2015 BPT and CY2014 BPT are highlighted below. The changes improve the usability and functionality of the BPT and reflect updated regulatory guidance.

- Worksheet 1
 - “SNP Type” was added in cell M7 and a drop-down box with three options – “Institutional”, “Dual-Eligible” and “Chronic or Disabling Condition” – was added in cell N7.
 - “Basic” and “Supplemental” non-benefit expenses inputs were removed; “Total” non-benefit expenses were changed to input elements in cells G48-G52.
 - “Insurer Fees” was added as an input element in cell G52.
 - “NBE Quality Initiatives”, “Taxes and Fees”, and “Insurer Fees” were removed from cells M62-M64.
- Worksheet 2
 - References to “NBE Quality Initiatives”, “Taxes and Fees” and “Insurer Fees” were removed from cells G69-J71.
 - References to “MLR” were removed from cells G77-H79.
 - “Insurer Fees” was added to Section V. Non-Benefit Expenses.

BIDDING RESOURCES

- The CY2015 Advance Notice and draft CY2015 Call Letter may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2015.pdf>.
- The CY2015 Call Letter and CY2015 Rate Announcement may be found at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf>.
- The CY2015 Actuarial Bid Training is offered as a web-based conference. The conference materials, including slides and streaming video downloads, are available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTraining2015.html> and <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/BidTrainingIntro.html>.
- For questions about the bid form, e-mail the CMS Office of the Actuary (OACT) at actuarial-bids@cms.hhs.gov.
- OACT will host weekly technical user group calls regarding actuarial aspects of the CY2015 bidding process. The conference calls will include live Question and Answer sessions with CMS actuaries. The call-in information is as follows:
 - Every Thursday from April 17, 2014 to May 29, 2014
 - 11:00am – 12:00pm ET
 - See HPMS announcement for call details
- For technical questions about the BPT, BPT Batch Tools, HPMS, or the upload process, refer to the following resources:
 - The Technical Instructions located in HPMS, under HPMS Home > Plan Bids > Bid Submission > CY2015 > Documentation > BPT Technical Instructions
 - The *Bid Submission User’s Manual*, also available in HPMS
 - HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

II. PRICING CONSIDERATIONS

BIDDING/PRICING APPROACH

By statute, the bid must represent the revenue requirement of the expected population. Therefore, in most circumstances, Part D sponsors must use credible bid-specific experience in the development of projected allowed costs. This approach does not preclude Part D sponsors from reaching specific benefit and premium goals; the gain/loss margin guidance allows sufficient flexibility to achieve pricing targets provided that the overall margin meets the requirements in the guidance and that anti-competitive practices are not used.

It is important to note the distinction between reporting base period experience data in Worksheet 1 and projecting credible data for pricing. Base period experience must be reported at the plan level if the plan existed in CY2013, regardless of the level of enrollment. This experience must also be projected in Worksheet 2 and assigned an appropriate level of credibility by the certifying actuary. Data may be aggregated for determining manual rates to blend with partially credible projected experience rates or to account for significant changes in enrollment from the base period to the contract year.

SPECIFIC TOPICS

Actuarial Equivalence

Actuarial equivalence must be demonstrated for plan benefit types other than Defined Standard (DS).

When the plan benefit type is Actuarially Equivalent (AE), three tests must be satisfied on Worksheet 4, Section IV, lines 16 through 18 to demonstrate actuarial equivalence:

- The average coinsurance percentage for amounts between the deductible and the initial coverage limit (ICL) must be actuarially equivalent to 25 percent.
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

When the plan benefit type is Basic Alternative (BA) or Enhanced Alternative (EA), six tests must be satisfied to demonstrate actuarial equivalence on Worksheet 5, Section VI, lines 1 through 6:

- The value of total coverage is at least actuarially equivalent to DS coverage.
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage.
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL.
- The deductible is not greater than the DS deductible.

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- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

Base Period Experience

The experience data must be based on a calendar year 2013 incurred period with at least 30 days of paid claim run-out; 2-3 months of paid claim run-out is preferable.

Worksheet 1 must be completed with data for the plan ID. Note that these data—

- Must be submitted in Worksheet 1 for all plans with experience data for 2013, regardless of the level of enrollment.
- Must reconcile in an auditable manner to the plan-level Prescription Drug Event (PDE) data submitted to CMS for payment and reconciliation and the Part D sponsor's audited financial statements.
- Must include accepted PDEs, rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan (P2P) transactions and, if appropriate, transfer of over-the-counter (OTC) drug data from the base period experience to the non-benefit expense component. The impacts of each of these considerations must be quantifiable and must not be included in the completion factor.
- Must be reported without adjustment. Adjustments may be made in Worksheet 2, Sections II and III to accommodate population, benefit design or other changes from the base period to the contract period.
- May be reported in aggregate for a number of plans only when there are enrollment changes associated with the dissolution of a plan and the retained members are cross-walked into existing plans in the same contract or across contracts. Each contract-plan ID must be identified in Section II, line 6.
- Must be provided for plans acquired by the Part D sponsor.
- May not be used to aggregate data from a number of plans in order to achieve credibility.
- Must be reported in total at the plan level for every contract-plan ID when plans are aggregated; do not include partial plan experience on Worksheet 1.
- May be reported on more than one bid when plans are aggregated, depending upon how enrollment changes are processed.

Data Aggregation

The requirements for reporting base period data for plan consolidations and enrollment shifts depend on—

- How enrollment changes are processed.
 - In these Instructions, the term “formal cross-walk” refers to the cross-walk process submitted in HPMS for plan consolidations (that is, consolidated renewals), whereby members are automatically moved from one plan to another (that is, one plan only). Without an HPMS cross-walk in place,

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members are dis-enrolled from the terminating plan and must actively select to enroll in a new plan of their choosing.

- o MARx enrollment transactions are used to automatically move members from one plan to more than one plan, for example, when the service area of one or more plans is redefined.
- o For more information, see section 140 in Chapter 4 of the *Medicare Managed Care Manual* at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c04.pdf>.
- Whether or not enrollment changes that are processed via MARx enrollment transactions apply to a significant percentage of members in the plan from which the members are moving, as determined by the certifying actuary.

The requirements for reporting base period data for plan consolidations and enrollment shifts are described below.

✓ Rule 1 – Plan Consolidations (Consolidated Renewals)

Base period data for more than one plan must be aggregated and reported on Worksheet 1 of the plan into which the members are cross-walked only in the following circumstances:

- When two or more plans are consolidated and the members are cross-walked into an existing or new plan under a formal cross-walk.
- When a significant proportion of members (as determined by the certifying actuary) in a plan are cross-walked into existing or new plans through MARx enrollment transactions.

Note the following:

- Members may be cross-walked each contract year. For BPT reporting purposes, the actuary must consider the cross-walks from the base period to the contract year (that is, from CY2013 to CY2014 and from CY2014 to CY2015).
- This rule applies when members are cross-walked within the same contract and when members are cross-walked between contracts in accord with limited exceptions described in CMS annual renewal and non-renewal guidance.

✓ Rule 2 – Enrollment Shifts

Base period data for more than one plan cannot be aggregated and reported on Worksheet 1 in the following circumstances:

- When an existing member chooses to enroll in different plans.
- When an insignificant proportion of members (as determined by the certifying actuary) in a plan are cross-walked into existing or new plans through MARx enrollment transactions.
- When enrollment changes do not involve a cross-walk whether or not a plan is terminated.

✓ Rule 3 – Partial Experience

Base period experience must be reported in total at the plan level for every contract-plan ID; do not include partial plan experience on Worksheet 1.

Example 1

A PDP offers plans 001 and 002 in CY2013 and plans 002 and 003 (a new plan) in CY2015. Plan 001 is consolidated and the membership is formally cross-walked into plan 003 for CY2015 in accord with limited exceptions described in CMS annual renewal and non-renewal guidance. Base period experience must be reported on Worksheet 1 of the CY2015 BPT as follows:

- For plan 002, report aggregate base period experience for plan 002 (Rule 1 and Rule 3).
- For plan 003, report base period experience for plan 001 (Rule 1 and Rule 3).

Example 2

A PDP offers plans 001, 002 and 003 in CY2013 and plans 003 and 004 in CY2015. Plan 001 is consolidated and the membership is formally cross-walked into plan 004 for CY2015 as submitted in HPMS. Plan 002 is terminated for CY2015 and the certifying actuary expects the membership in plan 002 to enroll evenly between plans 003 and 004; however, there is no formal cross-walk or approved cross-walk exception in place. Base period experience must be reported on Worksheet 1 of the CY2015 BPT as follows:

- For plan 003, report base period experience for plan 003 (Rule 2 and Rule 3). Do not report base period experience for plan 002 (Rule 2).
- For plan 004, report base period experience for plan 001 (Rule 1). Do not report base period experience for plan 002 (Rule 2).

Example 3

A PDP offers plans 001, 002, 003 and 004 in CY2013 and plans 003 and 004 in CY2015. Plan 001 is consolidated and the membership is formally cross-walked into plan 002 for CY2014. Plan 002 is consolidated and the membership is formally cross-walked to plan 003 for CY2015. Base period experience must be reported on Worksheet 1 of the CY2015 BPT as follows:

- For plan 003, report base period experience for plans 001, 002 and 003 (Rule 1 and Rule 3).
- For plan 004, report base period experience for plan 004.

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PDE Mapping

A mapping of PDE fields to required BPT inputs is provided in the following table.

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

Column	Field Name	PDE Reference Information
(f)	Total Number of Scripts	Count # of PDEs where (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee) > Zero
(g)	Total Allowed Dollars	Σ (Ingredient Cost + Dispensing Fee + Sales Tax + Vaccine Administration Fee)
(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 + Reported Gap Discount + 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

When using PDE data, actuaries must be familiar with the process by which the PDE transactions are developed from claims data and with the timing of the adjustment and deletion processes to ensure that the final transaction is accurately summarized. This process includes, but is not limited to, consideration of rejected PDEs that are expected to be accepted by CMS upon resubmission, adjustments for Plan-to-Plan transactions and, if appropriate, transfer of over-the-counter drug data from the base period experience to the non-benefit expense component. It is important to note that a PDE maps to one script throughout the BPT regardless of the number of days for which the prescription is dispensed.

Coverage in the Gap

Medicare Coverage Gap Discount Program (CGDP)

The following guidelines apply to all Part D bids:

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- Applicable drugs under the Medicare CGDP are defined as those that are on the plan's formulary or are treated as if on formulary through the exceptions process and are approved under a new drug application (NDA) under Section 505(b) of the Federal Food, Drug and Cosmetic Act or, in the case of a biologic, licensed under Section 351 of the Public Health Service Act. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.
- Only those applicable Part D drugs covered by a manufacturer discount agreement are eligible for coverage under the program.
- In CY2015, beneficiary cost sharing for applicable drugs is 45 percent of the negotiated price plus 45 percent of the dispensing and vaccine administration fees, if any; the Part D sponsor's liability is 5 percent of the negotiated price plus 55 percent of the dispensing fee and vaccine administration, if any. Ninety-five (95) percent of the negotiated price of the applicable drug and 45 percent of the dispensing fee and vaccine administration fee, if any, must be reported as beneficiary cost sharing in the bid.
- Coverage gap discounts begin when the beneficiary exceeds the plan-specific ICL.
- The administrative costs associated with administering the program must be included in the non-benefit expense component of the bid.
- The manufacturer discount amounts received under this program are not direct and indirect remuneration because they do not decrease the drug costs incurred by the Part D sponsor. Therefore, the manufacturer discounts must not be reported as rebate amounts in the bid.
- Applicable drugs must be reported as brand drugs in the bid.

Generic Drugs

The following guidelines apply to all Part D bids:

- In the coverage gap, a drug is considered a generic drug, or non-applicable drug, if it is not defined as an applicable drug under the Medicare CGDP. In general, this definition applies regardless of the drug's placement on the plan-specific formulary.
- In CY2015, beneficiary cost sharing is reduced to 65 percent and the Part D sponsor's liability is increased to 35 percent.
- Generic (non-applicable) drug coverage in the gap begins when the beneficiary exceeds the plan-specific ICL.
- Non-applicable drugs must be reported as generic drugs in the bid.

Pricing Considerations

Part D sponsors must model the impact of coverage in the gap on the DS benefit and alternative benefit (AE, BA or EA), if applicable.

- While coverage in the gap does not change the TrOOP threshold, it will affect the point at which the beneficiary reaches the TrOOP threshold for catastrophic coverage.

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- The changes to projected average allowed amounts from the base period to the contract year that are expected to occur as a result of reduced beneficiary cost sharing must be reflected in the “Other Change” components of utilization and unit cost trend factors on Worksheet 2.
- The impact on the Federal Reinsurance PMPM must be reflected in line 5, column m of Worksheet 3.

The following guideline applies when the type of coverage is AE, BA or EA:

- When an alternative coverage is modeled, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spending may be different because of the impact of the alternative benefits.

The following guideline applies when the type of coverage is EA:

- When an EA plan offers coverage in the gap that exceeds the DS coverage:
 - Reflect the projected value of the DS coverage and the additional partial or full coverage in Worksheet 5, Section IV cells K37 and K47, “Amounts in the Gap PMPM” and “Coinsurance Percentage in Gap”, respectively.
 - Report the drugs on the “enhanced” tiers based on the plan-specific formulary.
 - Report all other drugs based on the definition of applicable and non-applicable drugs.

Credibility

Claims Credibility

This section pertains to the experience credibility percentages on Worksheet 2.

Based on an application of classical credibility theory to Medicare Part D experience, CMS has established a guideline for full credibility of 18,000 base period member months. The formula for partial credibility is the square root of the result of actual base period member months divided by 18,000. This formula is a guideline. Part D sponsors may use a different credibility methodology but any method must be consistently applied among all bids in the contract.

The certifying actuary must adhere to the following rules of overriding the CMS formula for partial credibility:

- If the CMS formula for partial credibility is applied to base period member months and the resulting credibility is—
 - Less than or equal to 20 percent (that is, 720 or fewer Part D member months), then the actuary may override the computed credibility with 0 percent.
 - Greater than or equal to 90 percent (that is, 14,580 or more Part D member months), then the actuary may override the computed credibility with 100 percent.

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- The override is applicable only to the CMS credibility formula; it is not applicable to any alternative credibility formula. If the certifying actuary overrides the CMS credibility, then the override option must be applied consistently among all bids and cannot be applied selectively to certain bids.

Risk Score Credibility

This section pertains to the application of credibility in developing projected risk scores. The use of CMS claims credibility guideline above is not permitted for risk scores. The certifying actuary must use actuarial judgment in developing a credibility guideline for risk scores. CMS has not developed a separate credibility guideline for risk scores.

Decreased Initial Coverage Limit

Part D sponsors that are decreasing the ICL must modify the pricing of the benefit in the BPT. Specifically:

✓ Worksheet 6, column k, lines 1 through 8 and 19 through 26

Enter the total cost sharing for allowed costs up to the DS ICL of \$320 by point-of-sale (retail or mail order as defined by the PBP) and type of drug for each line. Total cost sharing is the sum of (i) the amounts calculated based on the cost-sharing structure of the alternative coverage up to the decreased ICL and (ii) 65 percent of the allowed costs of non-applicable (generic) drugs and 95 percent of the negotiated price of applicable (brand) drugs plus 45 percent of dispensing fees and vaccine administration, if any, for applicable (brand) drugs between the decreased ICL and standard ICL.

Direct and Indirect Remuneration (DIR)

Part D sponsors must include all expected amounts that will be reported as DIR under “Rebate” in the BPT. The DIR reported under “Rebate” represents the Part D sponsors’ 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.

Definition of Direct and Indirect Remuneration

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, charge-backs, 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 does not include the manufacturer discount amounts received under the Medicare CGDP.

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 pharmacy benefit managers (PBM), even if the price concessions are retained in lieu of higher service fees. CMS must assume that if a PBM

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retains a portion of the manufacturer rebates that it negotiates on behalf of a Part D sponsor, the direct payment that the PBM receives from the sponsor for its services will be less, since the sponsor will have received a price concession from the PBM. This price concession is a retained rebate and thus must be reported as DIR for payment purposes.

In accordance with CMS guidance, Part D 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 experience 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 PDE record and therefore are not included in the DIR Report for Payment Reconciliation.

Enrollment

The projected enrollment for the Part D bid in an MA-PD plan must be consistent with that for the corresponding MA bid and must reflect the same underlying population.

Gain/Loss Margin

Gain/loss margin refers to the additional revenue requirement beyond allowed prescription drug costs and non-benefit expenses. The gain/loss requirements ensure that gain/loss margins are reasonable and that a Part D organization's Part D business is not used to subsidize its other insurance lines of business.

The gain/loss margin entered in the bid must be determined in consideration of other CMS requirements such as Total Beneficiary Costs (TBC) and Medical Loss Ratio (MLR). CMS expects that the gain/loss margin will be set with appropriate consideration for the need to remit funds to CMS if the Part D sponsor's actual claims experience fails to meet the minimum MLR requirements. Further, if there is a conflict between satisfying gain/loss margin requirements and other CMS requirements, flexibility will be given to the gain/loss margin requirements only to the extent necessary to meet the other CMS requirements. Such modifications to the gain/loss margin requirements must be fully explained and supported.

Requirements apply at two levels—the bid (PBP) level and an aggregate level; both sets of requirements must be met in the initial bid submission and following bid resubmission or withdrawal.

Bid (PBP)-Level Requirements

There is flexibility in setting the gain/loss margin at the bid level provided that—

- The bid offers benefit value in relation to the margin level;
- Anti-competitive practices are not used;

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- The bid margin is non-negative or the special rules for bids with negative margins outlined below are followed; and
- All aggregate-level margin requirements described below are met.

✓ **Benefit Value**

The bid must provide benefit value in relation to the margin level.

✓ **Anti-competitive Practices**

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.

✓ **Bids with Negative Margin**

If the projected gain/loss margin in the BPT is negative, the Part D sponsor must develop, submit and follow a bid-specific business plan that is to achieve profitability within 5 years. Exceptions to the 5-year period for unique situations must be fully explained and supported. CMS expects that in subsequent years, Part D projected gain/loss margins for the plan will meet or exceed the year-by-year Part D gain/loss margins contained in the original business plan or in subsequent business plans, if any.

Exceptions to the business plan requirement are cases in which multiple Part D products are offered in a given service area and the pricing reflects implicit “subsidies” across benefit or service area offerings. The plans in the product offering must—

- Have identical service areas; and
- Have a positive combined gain/loss margin for CY2015.

An example is a low-benefit plan with a positive margin paired with a rich-benefit plan with a negative margin.

Aggregate-Level Requirements (Overall Margin)

In these Instructions, the term “non-Medicare” business refers to all health insurance business that is not Medicare Advantage or Part D. Non-Medicare business includes, but is not limited to, the following lines of business: Medicare-Medicaid, Medicare-supplemental, Medicaid and commercial.

The aggregate gain/loss margin levels in the BPT for Part D plans—

- Must be determined at one of the following three levels: the contract level, organization level (that is, the legal entity that contracts with CMS to provide Part D benefits) or parent organization level. The Part D sponsor must enter the chosen level of aggregation in Worksheet 3, cell D46 of the BPT.

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- Must be consistent from year to year.
- Must be within 1.5 percent of the Part D sponsor's margin for all non-Medicare business, as measured by percentage of revenue. If the volume of the Part D sponsor's commercial non-Medicare business for which it has discretion in rate setting is less than 10% of the Part D sponsor's total non-Medicare business or the Part D sponsor has no non-Medicare business, then the aggregate margin must be consistent with the Part D sponsor's corporate return requirement set by taking into account the degree of risk and capital and surplus requirements of the business.

Although actual aggregate margins may vary from year to year, CMS expects certifying actuaries to price bids such that actual aggregate returns over the long term are consistent with the margin assumptions used for pricing.

The individual Part D margin of an MA-PD bid may either be the same for all plans or vary by plan in relation to the MA margin. The certifying actuary may not satisfy the gain/loss margin requirements by combining margins for the MA and Part D components of the MA-PDs. See the "Instructions for Completing the Medicare Advantage Bid Pricing Tool for Contract Year 2015" for options in setting the margin for the MA and Part D components of MA-PD bids.

For bids participating in the Minnesota Senior Health Options program, additional aggregate-level margin requirements may be found at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf>.

Exclusions

Non-insurance revenues pertaining to investments and fee-based activities designed to influence state or federal legislation such as the cost of lobbying activities cannot be reflected in the bid. See the announcement about lobbying activities released via an HPMS memorandum dated October 16, 2009.

Health Care Reform

See Appendix F for information concerning the provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, known collectively as the Affordable Care Act.

Non-Benefit Expenses

Non-benefit expenses are all of the bid-specific administrative costs incurred in the operation of the Medicare Prescription Drug Plan.

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

- Sales & Marketing
 - Examples include, but are not limited to the cost of—
 - Marketing materials;

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- ▶ Commissions;
- ▶ Enrollment packages;
- ▶ Identification cards; and
- ▶ Salaries of sales and marketing staff.
- Direct Administration
 - Examples include, but are not limited to—
 - ▶ Customer service;
 - ▶ Billing and enrollment;
 - ▶ Claims administration;
 - ▶ True out-of-pocket (TrOOP) administration;
 - ▶ Pharmacy benefit management administration, which includes all of the costs for performing call center, claims, formulary management, network development and rebate management functions incurred by the plan or through a subcontractor;
 - ▶ Medicare CGDP administration;
 - ▶ Medicare Part D user fees, which are \$1.22 per-member per-year (pmpy) or \$0.102 per-member-per-month (pmpm) on a national basis for CY2015. The COB user fee will be collected at a monthly rate of \$0.136 pmpm for the first nine months of the coverage year;
 - ▶ Part D National Medicare Education Campaign (NMEC) user fees. CMS collects NMEC user fees based on a percentage of revenue; however, the BPT entry is a pmpm equivalent value consistent with the calculation of other BPT values. Part D sponsor may use the CMS estimate, which is \$0.60 pmpy or \$0.05 pmpm on a national basis for CY2015, or develop an alternative estimate that is consistently applied to all plans in the contract—for example, the Part D sponsor's historical amount relative to the CMS annual national estimate;
 - ▶ Uncollected enrollee premium;
 - ▶ Uncollected cost sharing, which includes plan liability resulting from cost sharing not recovered in state-to-plan or plan-to-plan transactions;
 - ▶ Medication therapy management programs;
 - ▶ Disease management functions such as patient education and disease monitoring; and
 - ▶ Over-the-counter drugs.
- Indirect Administration
 - Examples include, but are not limited to, functions that may be considered “corporate services,” such as—
 - ▶ The position of CEO;
 - ▶ Accounting operations;
 - ▶ Actuarial services;
 - ▶ Legal services; and
 - ▶ Human resources.

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- Net Cost of Private Reinsurance (that is, reinsurance premium less projected reinsurance recoveries)
- Insurer Fees

All non-benefit expenses must be reported using appropriate, generally accepted accounting principles (GAAP). For example, acquisition expenses and capital expenditures must be deferred and amortized according to the relevant GAAP standards (to the extent that is consistent with the organization's standard accounting practices, if not subject to GAAP). Also, acquisition expenses (sales and marketing) 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 is FASB's Statement of Financial Accounting No. 60, *Accounting and Reporting by Insurance Enterprises*.

Costs not pertaining to administrative activities must be excluded from non-benefit expenses. Such costs include goodwill amortization, income taxes, changes in statutory surplus, investment expenses and the cost of lobbying activities. See the Gain/Loss Margin section of Pricing Considerations for more information.

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

- Expenditures for tangible assets (for example, a new computer system) must be capitalized and amortized according to relevant GAAP principles.
- Expenditures for non-tangible assets (for example, salaries and benefits) must be reported in a manner consistent with the organization's internal accounting practices and the reporting of similar expenditures in other lines of business.

Non-benefit expenses that are common to the MA and Part D components of MA-PD plans must be allocated proportionately between the Medicare Advantage and Part D BPTs.

When Medicare benefits are funded by an outside source such as a state Medicaid program, non-benefit expenses must be allocated proportionately between the Medicare revenue and the other revenue source.

Non-Uniform Deductible

Part D sponsors that are implementing a deductible that is not applied consistently among all formulary tiers (for example, \$0 deductible for Tier 1 – Generics and \$320 deductible for all other tiers) must modify the pricing of the benefit in the BPT. Specifically:

✓ **Worksheet 5**

Enter "\$0" in cells D39 and F41.

✓ **Worksheet 6**

Reflect the impact of the non-uniform deductible in addition to the cost sharing required after the deductible is met in the applicable cost-sharing categories by point-of-sale (retail or mail order as defined by the PBP) and type of drug.

PBM Pricing

For CY2015, Part D sponsors must develop their Part D bids using the pass-through price or negotiated amount paid to the dispensing provider at the point-of-sale as the basis for drug costs. For Part D sponsors that are contracted with a PBM, the following provisions apply: (i) when contracted under a lock-in pricing approach, the administrative expense component of the bid must reflect the expected difference between the lock-in price, or amount negotiated with the PBM, and the pass-through price (this difference is referred to as the risk premium or PBM spread); and (ii) when the PBM retains a portion of the rebates, the administrative expense component of the bid must include these costs.

Related-Party Arrangements

The related-party requirements apply to all Part D sponsors that enter into any type of arrangement with or receive services from an entity that is associated with the Part D sponsor by any form of common, privately-held ownership, control or investment. This includes any arrangement where the Part D sponsor does business with a related party through one or more unrelated parties, such as a pharmacy or a pharmacy benefit manager. The requirements apply to all related-party arrangements supporting the bid which are in effect during the base period and/or contract year.

The objective of the requirements for related-party arrangements is to ensure that financial arrangements between the Part D sponsor and related parties (i) are not significantly different from the financial arrangements that would have been achieved in the absence of the relationship and (ii) do not provide the opportunity to over- or under- subsidize the bid.

CMS requires all Part D sponsors to disclose whether or not they are in a business arrangement with a related party. Part D sponsors in a business arrangement with a related party must disclose and support each and every related-party arrangement at the time of the initial bid submission and prepare the bid and documentation in accord with the requirements in this section and Appendix B of these Instructions for each identified related party.

A Part D sponsor in a related-party arrangement must—

- Declare the related-party arrangement(s) to CMS at the time of the initial bid submission.
- Disclose all services that are covered in the arrangement(s). These include, but are not limited to:
 - Claims processing
 - Network (retail and mail order pharmacy) access
 - Clinical services, such as Utilization Management
 - Formulary management
 - Rebate contracting
 - Drugs at related-party retail and/or mail order pharmacies
 - Marketing materials and ID cards
 - Call center operations
- Select one of the following methods for entering costs associated with the related-party arrangement into the BPT.

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- Actual Cost Method for Administrative Services,
- Actual Cost Method for Benefit Costs,
- Market Comparison through Part D Sponsor, or
- Market Comparison through Related Party

Part D sponsors always have the option to use the Actual Cost Method in bid preparation. Part D sponsors only have the option to use the Market Comparison through Part D Sponsor Method when the Part D sponsor has a comparable arrangement with an unrelated party. Part D sponsors only have the option to use the Market Comparison through Related Party Method when the related party has a comparable arrangement with an unrelated party. For comparison purposes, the unrelated party must be a Part D organization for benefit costs arrangements and may be a Part D or non-Medicare organization for administrative services arrangements.

Comparable rate demonstrations must be based on actual contracts which must be available for review upon request by CMS. When supporting comparable rates through the related party, the analysis must be accompanied by a signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.

Actual Cost Method for Administrative Services

A Part D sponsor using the actual cost method for administrative services must prepare the BPT in a manner that does not recognize the independence of the related party.

Under this method, the BPT is prepared as follows:

- The related party's costs are entered as if they are the Part D sponsor's costs.
- The non-benefit expense and gain/loss margin of the related party are entered as the non-benefit expense and gain/loss margin, respectively, of the Part D sponsor.

Supporting documentation of the development of the actual cost method for administrative services must be provided with the initial bid submission as required in Appendix B of these Instructions.

Actual Cost Method for Benefit Costs

Under the actual cost method for benefit costs, the BPT is prepared as follows:

- All fees paid to the related party for benefit costs are entered as the benefit expense of the Part D sponsor.
- The related-party benefit costs are consistent with the actual and projected PDE experience of the plan.
- The gain or loss of the related party with respect to the Part D benefit costs is provided in the supporting documentation.

Supporting documentation of the development of the actual cost method for benefit costs must be provided with the initial bid submission as required in Appendix B of these Instructions.

Market Comparison through Part D Sponsor Method

A Part D sponsor using the market comparison through Part D sponsor method must prepare the BPT in a manner that recognizes the independence of the related party by reporting all costs in the related-party agreement to non-benefit expense for administrative services arrangements and to benefit expenses for benefit costs arrangements. To demonstrate that the arrangement with the related party is comparable, the Part D sponsor must—

- Provide an analysis that clearly explains how the financial results are not significantly different from what is achieved in the absence of the related-party relationship for the same services.
- Show that results from the same utilization priced through the related and unrelated party contracts are within plus or minus five percent.
- Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

Supporting documentation for the market comparison through Part D sponsor method must be provided with the initial bid submission as required in Appendix B of these Instructions.

Market Comparison through Related Party Method

A Part D sponsor using the market comparison through related party method must prepare the BPT in a manner that recognizes the independence of the related party by reporting all costs in the related-party agreement to non-benefit expense for administrative services arrangements and to benefit expenses for benefit costs arrangements. To demonstrate that the arrangement with the Part D sponsor is comparable to arrangements with unrelated parties, the related party must—

- Provide an analysis that clearly explains how the financial results are not significantly different from what is achieved in the absence of the related-party relationship for the same services.
- Show that results from the same utilization priced through the related and unrelated party contracts are within plus or minus five percent.
- Show that both contracts in the comparison are associated with sufficient costs to be considered valid contracts.

Supporting documentation for the market comparison through related party method must be provided with the initial bid submission as required in Appendix B of these Instructions.

Risk Score Development for CY2015

The projected CY2015 risk score must—

- Be based on the Part D RxHCC model used in payment year 2015;
- Reflect plan-specific coding trend;

- Be appropriate for the expected population; and
- Be adjusted for normalization.

Risk Score Definitions and Information Sources

Part D RxHCC Risk Model

CMS will continue to use the same RxHCC risk model for CY2015 that it is using for CY2014 payment. Diagnosis data from CY2010 were used to predict CY2011 expenditures; the denominator year is CY2011. Additional information, including the CY2015 normalization factor, is contained in the CY2015 Rate Announcement, published April 7, 2014.

Normalization Factor

At time of payment, the risk scores for each plan enrollee will be adjusted by the Part D normalization factor, which is 0.961 for CY2015. This adjustment accounts for the actual program risk score experience and the expected increase in risk scores between the contract year (2015) and the denominator year (2011). Accordingly, the projected risk scores for CY2015 bids must reflect the normalization factor.

Risk Adjustment Information Sources

The following materials can be found through the “Announcements & Documents” link on the “Medicare Advantage Rates and Statistics” page of the CMS website at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html>:

- “Announcement of Calendar Year (CY) 2015 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies”
- “Advance Notice of Methodological Changes for Calendar Year (CY) 2015 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2015 Call Letter”

See also the links under “Risk Adjustment” and “Ratebooks & Supporting Data”.

Additional information on the risk adjustment process can be found at <http://www.csscooperations.com/>.

Risk Score Calculation Approaches

Preferred Methodology

The preferred method for projecting the CY2015 risk scores is to start with the Part D RxHCC risk scores that are provided by CMS in—

- The plan-level data for the July 2013 enrollee cohort with retroactive enrollment and status adjustments; or
- The beneficiary-level file containing 12 months of 2013 membership with retroactive enrollment adjustments and status adjustments.

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The plan-level data will be available after the publication of the 2015 Rate Announcement under the “Risk Adjustment” link on the HPMS Home page. The risk score data posted in HPMS are calculated using the model that will be used for 2015 and are accompanied by technical notes to assist actuaries with understanding the material presented. The beneficiary-level data provide the 2013 risk scores calculated using both the risk model used for 2013 payment and the model to be used for 2015. These data are sent electronically to Part D sponsors at about the same time.

There are several advantages to using these 2013 Part D RxHCC risk scores in the projection of the CY2015 risk score:

- They are consistent with the base-period prescription drug expenses.
- They require no adjustment for seasonality.
- They reflect the most complete MA diagnosis data for 2012 dates of service submitted through January 31, 2014, which is the final reporting deadline for this period.
- They require no adjustment for a risk model change.
- In the beneficiary-level file, they are based on both the model used in 2013 and the RxHCC model to be used in 2015. In the plan-level data, they are based on the latest model.

Please note that since the HPMS plan-level risk scores are based on a mid-year cohort with full calendar year data and nearly complete run-out, they do not require explicit adjustment for (i) transition from lagged to non-lagged diagnosis data, (ii) incomplete reporting of diagnosis data, and (iii) seasonality. However, the starting risk score is to be projected from 2013 to 2015 with explicit adjustment for the following factors, as appropriate:

- Plan-specific coding trend.
- Changes in plan population.
- Other appropriate factors.

Finally, the projected risk scores must be normalized by dividing by the 2015 Part D normalization factor.

Alternate Approaches

An alternate method for the development of risk scores may be appropriate if the plan was first offered in 2014, if there was limited enrollment in 2013, or if there were significant changes in plan or enrollment characteristics between 2013 and 2014.

If a Part D sponsor chooses to develop its risk score by using a methodology different from that preferred by CMS, then, depending on the starting point, the following adjustments must be considered:

- Conversion to a raw risk score.
 - If the starting risk score is normalized, as it is when beginning with MMR data, then the certifying actuary may consider converting the starting risk score to a raw (un-normalized) risk score before making other adjustments.

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- Impact of lagged versus non-lagged diagnosis data.
 - If the starting risk score is based on lagged diagnosis data, as it is when the initial risk scores are used, then an adjustment is required to transition the scores from lagged to non-lagged. An example is a starting point of March 2014 MMR data, which contain risk scores based on the July 2012 to June 2013 diagnosis data.
- Run-out of diagnosis data.
 - If the starting risk score is based on incomplete diagnosis data, as it may be when the starting point is diagnosis data and will be when the starting point is MMR data, then an adjustment factor is required to transition the scores from incomplete to complete diagnosis data. Starting risk scores from MMR data do not reflect the final reconciliation.
- Seasonality.
 - If the starting risk score is based on membership that is other than the July cohort or a full calendar-year cohort, then an adjustment for enrollment seasonality must be made.
- Risk model change.
 - If the starting risk scores are calculated using a risk model other than that to be used for CY2015 payments, then an adjustment for the risk model change must be made. The adjustment must include accounting for diagnoses that are not included in the older risk models, but are included in the updated model.
- Plan-specific coding trend.
- Population changes.
 - If the starting risk score is based on a population with different risk characteristics than the expected population, then an adjustment for population changes must be made.
- Other appropriate factors.

Once projected to CY2015, the scores must be normalized by dividing by the 2015 Part D normalization factor. Note that, if a nominal or actual risk score associated with a different model calibration year is being normalized, the CY2015 Part D normalization factor is not appropriate.

Supporting documentation that clearly demonstrates consistency with the preferred approach is required.

See the credibility pricing consideration for more information about the projection of risk scores.

Sequestration

Pricing assumptions must consistently reflect the certifying actuary's best estimate of the likelihood that sequestration will occur in CY2015.

CMS recognizes that under sequestration the gain/loss margin entered in the BPT is not the gain/loss margin that the Plan sponsor will actually achieve; however, margin requirements must be met with the gain/loss margin entered in the BPT.

Supporting Documentation

In addition to the BPT and actuarial certification, organizations must submit supporting documentation for every bid. See Appendix B for a description of the supporting documentation requirements, including content, quality and timing.

Types of Part D-Covered Drugs

Brand Drugs

Brand drugs consist of (i) single-source drugs with no generic equivalent that were FDA-approved under an original new drug application (NDA) and (ii) innovator multi-source drugs that were originally marketed under an original NDA and that now have generic equivalents.

Preferred/Non-Preferred Brand Drugs

Brand 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. Brand drugs that are positioned in a less favorable position on the formulary should be allocated to the non-preferred brand category in the BPT.

Generic Drugs

Non-innovator multi-source drugs are generic drugs.

Specialty Drugs

Specialty drugs are reported separately only when a plan utilizes a designated Specialty tier in the formulary and PBP in accord with CMS guidelines. The CMS guidelines require that (i) only one tier be designated a Specialty tier, (ii) only Part D-covered drugs with plan-negotiated prices greater than \$600 per month supply be placed in the tier, and (iii) cost sharing associated with that tier be limited to 25 percent in the initial coverage range when the plan has the standard deductible, which is \$320 for CY2015. When the plan has a decreased or no deductible, then an actuarially equivalent coinsurance is permitted.

When a designated Specialty tier is used, all drugs in that tier must be reported by point-of-sale (retail or mail order as defined by the PBP) in Worksheets 2, 6 and 6A of the BPT. The drugs in the Specialty tier must not be sorted by type of drug status and must not be reported as a component of the generic, preferred brand and non-preferred brand drugs in the non-Specialty tiers.

When a designated Specialty drug tier is not used in the formulary and PBP, Specialty drugs must be sorted by generic, preferred brand and non-preferred brand status and must be reported in these categories by point-of-sale (retail or mail order as defined by

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the PBP). In this situation, the Specialty categories in Worksheet 2, 6 and 6A are not completed.

III. DATA ENTRY AND FORMULAS

This section includes line-by-line instructions for completing the Part D BPT. It also describes the formulas for calculated cells.

PRESCRIPTION DRUG

To complete the Part D bid form, Part D sponsors must provide a series of data entries on the appropriate BPT worksheets. The number of inputs depends on the type of plan being offered and the length of time it has had a contract with CMS, among other factors.

The Part D bid form is organized as outlined below:

- Worksheet 1 – Rx Base Period Experience
- Worksheet 2 – PDP Projection of Allowed/Non-Benefit
- Worksheet 3 – Rx Contract Period Projection for Defined Standard Coverage
- Worksheet 4 – Rx Standard Coverage with Actuarially Equivalent Cost Sharing
- Worksheet 5 – Rx Alternative Coverage
- Worksheet 6 – Rx Script Projections for Defined Standard, Actuarially Equivalent or Alternative Coverage
- Worksheet 6A – Coverage in the Gap
- Worksheet 7 – Summary of Key Bid Elements

All Part D sponsors must complete Section I of Worksheet 1; completion of subsequent sections of the BPT is based on the plan benefit type being offered. The worksheets and sections that must be completed for each plan benefit type are defined below.

Defined Standard Coverage

✓ **Worksheet 1**

For all plans, complete Section I; for plans with claims experience in CY2013, complete all sections.

✓ **Worksheet 2**

For plans with fully credible claims experience in CY2013, complete Sections II, III, IV Column O, V and VII; for plans with partially credible claims experience in CY2013, complete all sections. For new plans in CY2014 and CY2015, complete Sections IV, V, VI and VII.

✓ **Worksheet 3**

Complete all sections for all plans.

✓ **Worksheet 6**

Complete columns f, g, and h of Section II for all plans.

✓ **Worksheet 6A**

Complete columns f, g, and h of Section II for all plans.

✓ **Worksheet 7**

Complete all sections for all plans.

Actuarially Equivalent Coverage

✓ **Worksheet 1**

For all plans, complete Section I; for plans with claims experience in CY2013, complete all sections.

✓ **Worksheet 2**

For plans with fully credible claims experience in CY2013, complete Sections II, III, IV Column O, V and VII; for plans with partially credible claims experience in CY2013, complete all sections. For new plans in CY2014 and CY2015, complete Sections IV, V, VI and VII.

✓ **Worksheet 3**

Complete all sections for all plans.

✓ **Worksheet 4**

Complete all sections for all plans.

✓ **Worksheet 6**

Complete all columns of Section II for all plans.

✓ **Worksheet 6A**

Complete all columns of Section II for all plans.

✓ **Worksheet 7**

Complete all sections for all plans.

Basic and Enhanced Alternative Coverage

✓ **Worksheet 1**

For all plans, complete Section I; for plans with claims experience in CY2013, complete all sections.

✓ **Worksheet 2**

For plans with fully credible claims experience in CY2013, complete Sections II, III, IV Column O, V and VI; for plans with partially credible claims experience in CY2013, complete all sections. For new plans for CY2014 and CY2015, complete Sections IV, V, VI and VII.

✓ **Worksheet 3**

Complete all sections for all plans.

✓ **Worksheet 5**

Complete all sections for all plans.

DATA ENTRY & FORMULAS

✓ **Worksheet 6**

Complete all columns of Section II for all plans.

✓ **Worksheet 6A**

Complete all columns of Section II for all plans

✓ **Worksheet 7**

Complete all sections for all plans.

Data Entry

Do not leave a field blank to indicate a zero amount. If zero is the intended value, then enter a “0” in the cell.

PD WORKSHEET 1 – RX BASE PERIOD EXPERIENCE

Worksheet 1 contains general information about the plan and summarizes the base period Rx experience. Specifically, Section I collects general information about the plan that is displayed on all Part D BPT worksheets. Section II collects base period background information; Section III summarizes the base period Rx experience. Sections IV and V summarize components of the base period non-benefit expense and premium revenue, respectively. Section VI is an Income Statement Summary.

Section I must be fully completed for all plans. (Note that some fields may be pre-populated by the Plan Benefit Package (PBP) software.) Sections II through VI must be completed for all plans with experience data for 2013 regardless of the level of enrollment.

SECTION I – GENERAL INFORMATION

The fields of Section I have been formatted as the “General” format in Excel to support the link functionality to other spreadsheets. Therefore, certain numeric fields, such as Plan ID, Segment ID and Region Number, must be entered as text—that is, using a preceding apostrophe—and must include any leading zeros.

Line 1 – Contract Number

Enter the contract number for the plan. The designation begins with a capital letter H (local plan), R (regional Preferred Provider Organization plan), or S (Prescription Drug Plan) and includes four Arabic numerals (for example, H9999, R9999, S9999). Include all leading zeros (for example, H0001).

Line 2 – Plan ID

The plan ID and corresponding contract number form a unique identifier for the PBP being priced in the bid form. Plan IDs contain three Arabic numerals. This field must be entered as a text input and must include any leading zeros.

Line 3 – Segment ID

If the bid is for a “service area segment” of a local plan, enter the segment ID. This field must be entered as a text input and must include any leading zeros.

Line 4 – Contract Year

The cell is pre-populated with the calendar year to which the contract applies.

Line 5 – Organization Name

Enter the organization’s legal entity name. This information also appears in HPMS and in the PBP.

Line 6 – SNP

If the plan is a Special Needs Plan (SNP), enter “Y”. Otherwise, enter “N”.

Line 7 – Plan Name

Enter the name of the PBP. This information also appears in HPMS.

Line 8 – Plan Type

Enter the type of Part D plan. The valid options are listed in the table below.

Type of Plan	Plan Type Code
Local Coordinated Care Plans:	
Health Maintenance Organization (HMO)	HMO
Religious Fraternal Benefit HMO	RFB HMO
Religious Fraternal Benefit HMO with a Point-of-Service (POS) Option	RFB HMO POS
HMO with a POS Option	HMO POS
Provider-Sponsored Organization (PSO) with a State License	PSO State License
Religious Fraternal Benefit with a State License	RFB PSO State License
Preferred Provider Organization (PPO)	LPPO
Religious Fraternal Benefit PPO	RFB LPPO
Regional Coordinated Care Plan:	
Regional Preferred Provider Organization (RPPO)	RPPO
Private Fee-for-Service Plans:	
Private Fee-for-Service Plan (PFFS)	PFFS
Religious Fraternal Benefit PFFS	RFB PFFS
Prescription Drug Plans:	
Medicare Prescription Drug Plan (PDP)	PDP
Fallback Plan	Fallback
Demonstration Plans:	
National PACE	PACE
Cost Plans:	
1876 Cost	1876 Cost
1833 Cost	1833 Cost

Line 9 – Enrollee Type

If the plan covers enrollees eligible for both Part A and Part B of Medicare, enter “A/B”. If the plan covers enrollees eligible for Part B only, enter “Part B Only”. When the plan type is “PDP” or “Fallback”, then the enrollee type cell is white and locked; no input is required.

Line 10 – PD Region

When the plan type is “PDP”, enter the region number of the region the plan will cover. This field must be entered as a text input and must include any leading zeros.

WORKSHEET 1

The valid entries are shown in the following table:

Region	Description
01	Maine and New Hampshire
02	Connecticut, Massachusetts, Rhode Island and Vermont
03	New York
04	New Jersey
05	Delaware, District of Columbia and Maryland
06	Pennsylvania and West Virginia
07	Virginia
08	North Carolina
09	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

Region	Description
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 coverage in the PBP. The valid options are “DS” for Defined Standard, “AE” for Actuarially Equivalent, “BA” for Basic Alternative and “EA” for Enhanced Alternative.

Line 12 – SNP Type

If the plan is a SNP as indicated by “Y” on line 6, then enter the type of SNP. The valid options are “Institutional”, “Dual-Eligible” and “Chronic or Disabling Condition”. The selection must agree with the option identified in the MA BPT.

SECTION II – BASE PERIOD BACKGROUND INFORMATION**Line 1 – Time Period Definition**

Enter the incurred dates of the base period data on the first two lines and the paid through date on the third line. For example, if the data reflect claims paid through February 2014, then the paid through date is 2/28/2014.

Line 2a – Total Member Months

The value is calculated automatically in the BPT from line 6 column e.

Line 2b – LIS Member Months

Enter the number of low-income subsidy (LIS) member months represented in the base period experience based on CMS eligibility records.

Line 3 – Risk Score

Enter the normalized risk score, estimated to three decimal places, for the population represented in the base period data using the Part D RxHCC risk model that was in place for the payment year.

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 – Mapping

Enter the contract and plan ID (in the format H9999-999) of the plan reported in Section III in the first column. With the exception of plan ID changes and/or plan mergers, CMS expects that the contract and plan ID for the base period experience will be the same as that shown in Section I. Enter the corresponding number of member months in the second column.

Line 6 – Base Period Experience Description

Use the text box to briefly describe the base period data reported in Section III.

SECTION III – PART D CLAIMS EXPERIENCE

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

Lines 1 through 5:

✓ **Column d – Number of Members**

Enter the number of members with total allowed claims in the defined standard allowed claim interval defined for each line. For example, if 7,000 members had total allowed claims between \$325 and \$2,969, then enter “7,000” in line 3, column d.

✓ **Column e – Member Months**

Enter the number of member months associated with the number of members in column d for each line.

✓ **Column f – Total Number of Scripts**

Enter the number of prescriptions filled for Part D-covered drugs for the members in column d for each line.

✓ **Column g – Total Allowed Dollars**

Enter the total allowed dollars for the prescriptions filled for the members in column d for each line. Total allowed dollars are defined as ingredient cost plus dispensing fee, plus sales tax where applicable, plus the vaccine administration fees, prior to the application of any rebates recovered after the point-of-sale.

✓ **Column h – Average Allowed Amount per Member**

The value is calculated automatically in the BPT as column g divided by column d for each line.

✓ **Column i – Average Paid Amount per Member**

Enter the result of dividing the total dollars paid by the plan for the members in column d by the number of members in column d. Total paid dollars are defined as basic and supplemental payments for Part D-covered drugs and are not net of rebates, low-income subsidy payments or federal reinsurance.

✓ **Column j – Average Cost Sharing per Member**

Enter the average cost sharing per member for Part D-covered drugs for the members in column d for each line.

✓ **Column k – Supplemental Cost-Sharing Reduction per Member**

Enter the average value of supplemental cost sharing per member for Part D-covered drugs for members in column d for each line.

✓ **Column l – Reimbursement for Low-Income Cost-Sharing Subsidy per Member**

Enter the average low-income cost-sharing subsidy amount received and receivable for the members in column d for each line.

✓ **Column m – Reimbursement for Federal Reinsurance per Member**

Enter the average federal reinsurance amount received and receivable for the members in column d for each line.

✓ **Column n – Net Plan Responsibility per Member**

The value is calculated automatically in the BPT as column i minus the sum of columns k through m for each line.

Line 6, columns d through n – Subtotal

The values are calculated automatically in the BPT as the sum of lines 1 through 5 for columns d through g and as the weighted average based on the number of members in column d of lines 1 through 5 for columns h through n.

Line 7 – Percentage OON

✓ **Column g**

Enter the percentage of total allowed dollars in line 6 for prescriptions filled at out-of-network (OON) pharmacies.

✓ **Column i**

Enter the percentage of average paid dollars in line 6 for prescriptions filled at OON pharmacies.

✓ **Column j**

Enter the percentage of average cost sharing per member in line 6 for prescriptions filled at OON pharmacies.

Line 8, column i and columns k through n – PMPM Values

They are calculated automatically by the BPT as the result of the subtotal of the column in line 6 divided by the number of member months in column d.

Line 9 – Minus Rebates

✓ **Column g**

Enter the total amount of rebates received as of the “Paid thru Date” in Section I and expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the

supporting documentation that is uploaded into HPMS with the initial bid submission.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter the amount of rebates attributable to the federal reinsurance amount in line 6.

✓ **Column n**

The value is calculated automatically in the BPT as column i minus column m.

Line 10 – Plus Part D as Secondary

✓ **Column g**

Enter the total amount of payments for Part D-covered drugs for which the Part D plan is the secondary payer.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column n**

The value is calculated automatically in the BPT as column i minus the sum of columns k through m.

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

The values are calculated automatically in the BPT as line 8 minus line 9 plus line 10.

Line 12 – Non-Covered Supplemental Drugs

✓ **Column g**

Enter the total plan paid amount for prescription drugs that are covered by the plan but are not Part D-covered drugs.

✓ **Column i**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

Line 13, column i – Rebates on Supplemental Drugs

Enter the total amount of rebates received as of the “Paid thru Date” in Section I and expected to be received for the claims in line 12. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

Line 14, columns l and n – Net PMPM on Supplemental Drugs

The value in column l is calculated automatically in the BPT as line 40 minus line 41 and is carried to column n.

SECTION IV – PMPM NON-BENEFIT EXPENSES

Section IV summarizes all administrative expenses associated with the operation of the prescription drug plan in the base period, including any expenses that were offset by direct or indirect remuneration.

Lines 1 through 5, column g – Total

Enter the sales and marketing, direct administration, indirect administration, net cost of private reinsurance and insurer fees average pmpm amounts for total coverage on lines 1 through 5, respectively. Include uncollected enrollee premium, uncollected cost sharing and OTC drugs in direct administration.

Line 6, column g – Total Non-Benefit Expenses

The value is calculated automatically in the BPT as the sum of lines 1 through 5.

SECTION V – PMPM PREMIUM REVENUE

Section V summarizes the components of premium revenue of the prescription drug plan for the base period.

Lines 1 through 4, column e – Basic

Enter the CMS Part D direct subsidy payment, low-income premium subsidy, member premium and member penalty premium average pmpm amounts for basic coverage on lines 1 through 4, respectively. The direct subsidy amount must account for the final risk-adjusted reconciliation payment for CY2013 which will be received in mid-2014 and include the impact of sequestration and PACE add-on, if applicable.

Line 3, column f – Supplemental

Enter the member premium average pmpm amount for supplemental coverage on line 3.

Lines 1 through 4, column g and line 5 – Total Premium

The values are calculated automatically in the BPT as the sums of columns e and f.

SECTION VI – PMPM INCOME STATEMENT SUMMARY

Section VI is a summary of the prescription drug plan's income, including the amount of MA rebate allocable to Part D when applicable, for the base period.

WORKSHEET 2

Lines 1 through 9, column m

Enter in line 4 the average pmpm amount of the MA rebate dollars used to buy down the Part D premium in line 4. The values in lines 1 through 3 and lines 5 through 9 are carried from other sections in Worksheet 1 or are calculated automatically in the BPT as sums or differences in column m.

Total Non-LI Brand Discount Amount

Enter in cell M60 the total non-LI brand discount amount received during or expected to be received for the base period and reported in the “Reported Gap Discount” field on the PDEs.

PD WORKSHEET 2 – RX PDP PROJECTION OF ALLOWED/NON-BENEFIT

Worksheet 2 projects the base period experience to the contract year, blending with a manual rate when the base period experience is not fully credible, by point-of-sale (retail or mail order as defined by the PBP) and type of drug. Specifically, Section I displays general information about the plan. Sections II and III summarize the base period and contract period utilization per 1,000 members and allowed costs per script and the components of utilization and cost trends. Section IV blends the projected allowed costs with a manual rate based on the plan's credibility. Section V summarizes the components of non-benefit expenses in the base and contract periods. Section VI is a text box for entering a description of the development of the manual rate. Section VII calculates the ratios of claims, non-benefit expenses and gain/(loss) to the total basic bid.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – UTILIZATION FOR COVERED PART D DRUGS

Lines 1 through 8 – Base Period

✓ Column e – Number of Scripts/1000

Enter the number of prescriptions that were filled in the base period, expressed as annual prescriptions per 1,000 members, by point-of-sale (retail or mail order as defined by the PBP) and type of drug (generic, preferred brand, non-preferred brand or Specialty) for each line.

✓ Column f – Allowed per Script

Enter the average allowed amount per script by type of script filled in the base period for each line. Allowed amount is defined as the ingredient cost plus the dispensing fee, plus state sales tax where applicable, plus the vaccine administration fee, prior to the application of any rebates recovered after the point-of-sale.

✓ Column g – PMPM

The value is calculated automatically in the BPT as column e times column f divided by 12,000 for each line.

Lines 1 through 8 – Components of Utilization Change

✓ Column h – Trend in Scripts/1,000

Enter the utilization trend factor by type of script to project scripts/1,000 to the contract period for each line.

✓ **Column i – Formulary Change**

Enter the factor that represents the impact on utilization of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

✓ **Column j – Risk Change**

Enter the factor that represents the impact on utilization of the covered population's change in risk from the base period to the contract period by type of script for each line.

✓ **Column k – Induced Utilization**

Enter the factor that adjusts for the utilization difference between the base period type of benefit plan (DS, AE, BA or EA) and a DS plan by type of script for each line.

✓ **Column l – Other Change**

Enter the factor that represents the impact on utilization of any differences between the base period and contract period not included in the other components of utilization change, columns h through k, by type of script for each line.

✓ **Column m – Total Utilization Change**

The value is calculated automatically in the BPT as the product of columns h through l for each line.

Lines 1 through 8, column n – Projected Scripts/1000

The value is calculated automatically in the BPT as the product of columns e and m for each line.

Lines 1 through 8, column o – Covariance

The value is calculated automatically in the BPT as projected allowed pmpm divided by the product of base period allowed pmpm times total utilization change times total unit cost change for each line.

Lines 9 through 14, columns e through o

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION III – COST FOR COVERED PART D DRUGS

Lines 1 through 8 – Components of Unit Cost Change

✓ **Column e – Inflation Trend**

Enter the factor that represents the impact on cost between the base period and contract period because of changes in drug prices by type of script for each line.

✓ Column f – Discount Change

Enter the factor that represents the impact on cost between the base period and contract period because of changes in point-of-sale network pricing, including discounts off of average wholesale price (AWP) and dispensing fees, by type of script for each line.

✓ Column g – Formulary Change

Enter the factor that represents the impact on cost because of changes in the formulary, including the addition, deletion or reclassification of drugs by type of script for each line.

✓ Column h – Other Change

Enter the factor that represents the impact on cost of any differences between the base period and contract period not included in the other components of unit cost change, columns e through j, by type of script for each line.

✓ Column i – Total Unit Cost Change

The value is calculated automatically in the BPT as the product of columns e through h by type of script for each line.

Lines 1 through 8, column j – Projected Unit Cost

The value is calculated automatically in the BPT as the product of base period allowed per script times total unit cost change for each line.

Lines 1 through 8, column k – Projected Allowed PMPM

The value is calculated automatically in the BPT as scripts/1,000 times projected unit cost divided by 12,000 for each line.

Lines 9 through 14, columns e through k

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column.

SECTION IV – PROJECTED ALLOWED PMPM**Lines 1 through 8****✓ Column l – Manual Utilization/1,000**

When the base period experience is not fully credible, enter the projected utilization per 1,000 members, based on a fully credible manual rate, by type of script for each line.

✓ Column m – Manual Unit Cost

When the base period experience is not fully credible, enter the projected unit cost per script, based on a fully credible manual rate, by type of script for each line.

✓ **Column n – Manual Rate PMPM**

The value is calculated automatically in the BPT as column l times column m divided by 12,000 by type of script for each line.

✓ **Column o – Credibility**

Enter the credibility percentage by point-of-sale and type of drug that is applied to the projected pmpm allowed amount in Section IV and blended with the pmpm manual rate to calculate the blended pmpm allowed amount for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

✓ **Column p – Blended Allowed PMPM**

The value is calculated automatically in the BPT as the sum of (column o times column k) and [(1 minus column o) times column n] for each line.

Lines 9 through 14, columns l through p

The values are calculated automatically in the BPT using information entered on lines 1 through 8 for each column. Cell O57, CMS Guideline Credibility is calculated automatically in the BPT as the square root of total member months from Worksheet 1 divided by 18,000, not to exceed 100 percent.

SECTION V – PMPM NON-BENEFIT EXPENSE

Section V summarizes the components of non-benefit expenses in the base period, applies trends and blends with manual rate non-benefit expenses to project administrative expenses in the contract period.

Lines 1 through 5

✓ **Column e – Base Period**

The value is carried from Worksheet 1, Section IV for each line.

✓ **Column f – Trend**

When the values in column e are greater than \$0.00, enter the expected trend in non-benefit expenses from the base to the contract period.

✓ **Column g – Contract Period**

The value is calculated automatically in the BPT as column e times column f for each line.

✓ **Column h – Manual Rate Expense**

When the base period non-benefit expenses are not fully credible, enter the projected non-benefit expense by component based on a fully credible source for each line.

✓ **Column i – Credibility**

WORKSHEET 2

Enter the credibility percentage by non-benefit expense component that is applied to projected pmpm non-benefit expenses and blended with pmpm manual rate expenses to calculate blended pmpm expenses for each line. The credibility must be greater than or equal to 0 percent and less than or equal to 100 percent.

✓ **Column j – Blended Non-Benefit Expense**

The value is calculated automatically in the BPT as the sum of (column g times column i) and [(1 minus column g) times column h] for each line.

Line 7, columns e, g and j – Total Non-Benefit Expenses

The values are calculated automatically in the BPT using information entered on lines 1 through 4 for each column.

SECTION VI – DEVELOPMENT OF MANUAL RATE

Provide a description of the source of the experience data used as the basis for the manual rate, as well as other relevant information including, but not limited to, benefit design, group size, group characteristics, utilization trends, pricing methodology, formulary changes, induction and risk assumptions.

SECTION VII – PERCENTAGE OF REVENUE

Section VII summarizes the components of the total basic bid amount and calculates the ratios of claims, non-benefit expenses and gain/(loss) to the total basic bid.

Lines 1 through 3, column e

The values are carried from Worksheets 3 through 5.

Line 4, column e

The value is calculated automatically in the BPT as the sum of lines 1 through 3.

Lines 5a through 5c, column e

The values are calculated automatically in the BPT as percentages of the total basic bid.

PD WORKSHEET 3 – RX CONTRACT PERIOD PROJECTION FOR DEFINED STANDARD COVERAGE

Worksheet 3 develops the defined standard bid amount. Specifically, Section I displays general information about the plan. Section II collects contract period information; Section III summarizes the contract period Rx experience. Sections IV and V summarize components of the contract period non-benefit expenses and gain/loss margin and components of the defined standard bid amount, respectively.

Sections II through V must be completed by all plans.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

Line 1 – Projected Member Months

The value is carried from Section III, line 6, column e. For an MA-PD, Part D projected member months are the sum of projected member months for MA, ESRD and hospice members.

Line 2 – Projected Average Risk Score

Enter the estimated average Rx risk score for the population expected to enroll in the contract period. Refer to the topic “Risk Scores” in the “Pricing Considerations” section of the Instructions for information concerning the development of the CY2015 risk score.

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

Enter the estimated number of member months for enrollees who will qualify for and obtain LIS status in the contract period.

Line 4 – Projected non-LIS Member Months

The value is calculated automatically in the BPT as projected member months minus projected low-income subsidy member months.

SECTION III – PART D COVERED DRUG CLAIMS

The projection of contract period Rx experience must reflect the risk score entered in Section II, line 2.

Lines 1 through 5:

✓ Column d – Number of Members

Enter the number of members expected to have total allowed claims in the allowed claim interval defined for each line. The “Total Covered Part D

Spending at OOP Threshold for Non-Applicable Beneficiaries” and “Estimated Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries” for CY2015 may be used to approximate the point at which beneficiaries reach catastrophic coverage. Do not include estimates for claims for which the Part D plan is the secondary payer.

✓ **Column e – Member Months**

Enter the number of member months expected in the contract period associated with the number of members in column d for each line.

✓ **Column h – Average Amount Allowed PMPM**

The value is calculated automatically in the BPT as column g divided by projected member months for each line.

✓ **Column n – Plan Liability PMPM**

The value is calculated automatically in the BPT as column h minus the sum of columns j through m for each line.

Lines 2 through 5

✓ **Column f – Number of Scripts**

Enter the estimated total number of prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line.

✓ **Column g – Projected Allowed Amount**

Enter the estimated total allowed dollars for prescriptions expected to be filled for Part D-covered drugs for the members in column d for each line. Total allowed dollars must reflect the price paid to the dispensing provider at the point-of-sale and must be net of point-of-sale rebates and price concessions.

✓ **Column i – Cost Sharing**

The value is calculated automatically in the BPT as the sum of columns j through l for each line.

✓ **Column k – PMPM Deductible**

Enter the projected pmpm value of the deductible for the members in column d for each line.

✓ **Column l – Other Cost Sharing PMPM**

Enter the projected pmpm value of the 25 percent cost sharing between the deductible and ICL and the catastrophic coinsurance above the catastrophic limit for the members in column d for each line.

✓ Column o – Federal LIS Cost Sharing PMPM

Enter the projected amount of low-income cost sharing subsidy that will be received for the members in column d who are LIS-eligible divided by the total projected member months entered in Section II, line 1 for each line.

Lines 4 through 5, column j – GAP PMPM

Enter the projected pmpm value corresponding to amounts between the ICL and catastrophic limit for members in column d for each line. Reflect the impact of gap coverage in this amount.

Line 5, column m – Federal Reinsurance PMPM

Enter the projected amount of federal reinsurance that will be received for the members in column d divided by the total projected member months entered in Section II, line 1 for each line. Reflect the impact of gap coverage in this amount.

Line 6 – Subtotal

The value is calculated automatically in the BPT as the sum of lines 1 through 5 for each column.

Line 7 – Minus Rebates

✓ Column g

Enter the total amount of rebates expected to be received for the claims in lines 1 through 5. Total rebates include all direct and indirect remuneration received after the point-of-sale transaction. Point-of-sale rebates reported in “Column g – Projected Allowed Amount” are not reported here. Report the rebates at the PBP level. If the Part D sponsor does not receive rebates at the PBP level, then an allocation methodology may be used. The methodology used for reporting rebates and all other types of DIR must be substantiated in the supporting documentation that is uploaded into HPMS with the initial bid submission.

✓ Column h

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ Columns m and n

The value in column h is allocated automatically to columns m and n in the BPT based on the relative amount of federal reinsurance to the total allowed amount.

Line 8 – Minus Other Insurance

✓ Column g

Enter, as a positive value, the projected total reduction to the total allowed amount attributable to other Rx insurance.

✓ Column h

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter, as a positive value, the projected pmpm reduction to federal reinsurance attributable to other Rx insurance.

✓ **Column n**

The value is calculated automatically in the BPT as column h minus column m.

Line 9 – Plus Part D as Secondary

✓ **Column g**

Enter, as a positive value, the projected total plan liability for Part D-covered drugs for which the Part D plan is the secondary payer.

✓ **Column h**

The value is calculated automatically in the BPT as column g divided by line 6, column e.

✓ **Column m**

Enter, as a positive value, the projected pmpm plan liability for Part D-covered drugs attributable to federal reinsurance for which the Part D plan is the secondary payer.

✓ **Column n**

The value is calculated automatically in the BPT as column h minus column m.

Line 10 – Projected Percentage Out-of-Network (OON) Allowed

Enter the percentage of line 6, column g of projected allowed dollars for prescriptions that will be filled OON.

Line 11 – Projected Percentage Out-of-Network (OON) Plan Liability

Enter the percentage of line 6, column n of projected Part D plan liability for prescriptions that will be filled OON.

Line 12, columns g through o – Total

The values are automatically calculated in the BPT as line 6 minus line 7 minus line 8 plus line 9 for each column.

SECTION IV – PMPM NON-BENEFIT EXPENSE AND GAIN/LOSS

Section IV summarizes components of the contract period non-benefit expenses and gain/loss margin.

WORKSHEET 3

Lines 1 through 5

The values are carried from other worksheets or are calculated automatically in the BPT.

Line 6 – Total Gain/loss

Enter the estimated pmpm amount of gain or loss projected during the contract period.

Overall Gain/(Loss) Margin Level

Enter in cell D46 the level at which the overall gain/(loss) margin requirements are met. The options are “contract”, “organization” and “parent-organization”.

SECTION V – DEFINED STANDARD COVERAGE BID DEVELOPMENT

Section V summarizes the components of the defined standard bid amount.

Lines 1 through 5, columns i and j

The values are carried from other sections in Worksheet 3 or are calculated automatically in the BPT as sums or quotients.

PD WORKSHEET 4 – RX STANDARD COVERAGE WITH ACTUARIALLY EQUIVALENT COST SHARING

Worksheet 4 must be completed when the plan benefit type is actuarially equivalent. The three tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The average coinsurance percentage for amounts between the deductible and the ICL must be actuarially equivalent to 25 percent; and
- The average coinsurance percentage above the catastrophic limit must be actuarially equivalent to the percentage for DS coverage.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit must be actuarially equivalent to the percentage for DS coverage.

CONSIDERATIONS FOR ACTUARIALLY EQUIVALENT COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for an AE plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, AE plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the AE benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. The distribution of utilization between generic and brand, and between 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 DS bid.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS AND TESTS FOR ACTUARIAL EQUIVALENCE

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

The values are carried from other worksheets in the BPT.

Line 4 – Allowed PMPM

✓ **Column e – Amounts below the Initial Coverage Limit**

Enter the projected average allowed amount pmpm below the ICL.

✓ **Column h – Amounts above Catastrophic Threshold**

Enter the projected average allowed amount pmpm above the catastrophic threshold.

Line 15 – Rebates

✓ **Column k**

Enter the estimated total amount of rebates expected to be received by the plan.

✓ **Column h**

The value is calculated automatically in the BPT and is prorated for reinsurance.

Lines 16 through 18 – Tests for Actuarial Equivalence

The three actuarial equivalence tests are applied to certain values in Section IV to determine whether the proposed benefit plan qualifies as standard coverage with actuarially equivalent cost sharing.

SECTION V – STANDARD COVERAGE BID DEVELOPMENT WITH ACTUARIALLY EQUIVALENT COST SHARING

Lines 1 through 5

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 6 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

PD WORKSHEET 5 – RX ALTERNATIVE COVERAGE

Worksheet 5 must be completed when the plan benefit type is basic alternative or enhanced alternative. The six tests that must be satisfied to demonstrate actuarial equivalence are as follows:

- The value of total coverage is at least actuarially equivalent to DS coverage;
- The alternative unsubsidized value of coverage is no less than the DS unsubsidized value of coverage;
- The average alternative benefits for beneficiaries with allowed drug costs at the ICL are not less than the average DS benefits at the ICL;
- The deductible is not greater than the DS deductible; and
- The average alternative catastrophic cost sharing is not greater than the average DS catastrophic cost sharing.
- The average coinsurance percentage for amounts between the ICL and catastrophic limit is at least actuarially equivalent to DS coverage.

CONSIDERATIONS FOR BASIC ALTERNATIVE AND ENHANCED ALTERNATIVE COVERAGE

Although the average cost sharing between the deductible and ICL must be 25 percent for a BA and less than or equal to 25 percent for an EA plan, it is expected that the cost sharing will be restructured to encourage more efficient drug use through tiered copays and/or coinsurance. As compared to DS plans, BA and EA plans generally have higher generic, preferred brand and mail service utilization and lower non-preferred brand utilization.

Part D sponsors must model the differences between the BA or EA benefit and the DS by making adjustments in utilization and average allowed amounts by type of drug and point-of-sale (retail or mail order as defined by the PBP) in Worksheets 6 and 6A. 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 DS bid.

BA and EA plans may reduce the value of the deductible. BA and EA plans may provide additional coverage in the gap. Since the value of coverage up to the ICL must remain the same relative to the DS, a supplemental premium will result unless the cost of the additional coverage is offset by savings in catastrophic coverage.

Additional coverage in the gap can delay the point at which a beneficiary achieves \$6,680 of true out-of-pocket (TrOOP) costs and reaches 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. Members with extremely high spending will not benefit as much as those with moderate amounts of spending.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTION DATA

This section displays the information entered on Worksheet 3, Section II.

SECTION III – DEVELOPMENT OF BID FOR DEFINED STANDARD COVERAGE

This section displays the information entered on Worksheet 3, Section V.

SECTION IV – DEVELOPMENT OF BID COMPONENTS**Lines 1 through 3****✓ Columns f, g and m**

The values are carried from Worksheet 3 in the BPT.

✓ Columns i and o

The values are calculated automatically in the BPT as column f plus column g.

Type of Deductible

Enter the type of deductible consistent with the description in the PBP for the alternative coverage. The valid options are: “no deductible”, “applies to all tiers” or “applies to some tiers”.

Alternative Coverage ICL

Enter the ICL consistent with the description in the PBP for the alternative coverage.

Type of Gap Coverage

Enter the type of gap coverage consistent with the description in the PBP for the alternative coverage. The options are: “defined standard coverage”, “enhanced – all drugs”, “enhanced – generics”, “enhanced – generics and some brands”, “enhanced – other”, or “increased ICL”. Use the following mapping:

- ✓ When the PBP indicates the defined standard ICL and cost sharing, select “defined standard coverage”.
- ✓ When the PBP indicates an increased ICL and defined standard cost sharing, select “increased ICL”.
- ✓ When the PBP indicates all drugs in all tiers are covered in full, select “enhanced-other”.
- ✓ When the PBP indicates reduced cost sharing on some or all drugs on some or all formulary tiers, select from the remaining options, “enhanced – all drugs”, “enhanced – generics” or “enhanced – generics and some brands”.

Lines 4 through 24

The values in columns d through o include Part D-covered drugs only; the values in column q include non-Part D-covered drugs only. The values are carried from other worksheets or are calculated automatically in the BPT, with the exception of the following, which must be entered:

✓ **Line 5, column k – Amounts in Gap**

Enter the projected average allowed amount pmpm in the coverage gap.

✓ **Line 5, column m – Amounts above Catastrophic**

Enter the projected average allowed amount pmpm above the catastrophic limit.

✓ **Line 6, column d – Proposed Deductible**

Enter the dollar value of the deductible consistent with the description in the PBP.

✓ **Line 8, column f – Value of Proposed Deductible**

Enter the projected pmpm value of the deductible for members with total allowed amount less than the ICL. Refer to the topic “Non-Uniform Deductible” in the “Pricing Considerations” section of the Instructions for more information.

✓ **Line 12, column k – Coinsurance Percentage in Gap**

Enter the effective coinsurance percentage for any coverage provided in the gap, including coverage because of variations in the ICL.

✓ **Line 18, column o – Minus Rebates**

Enter the estimated total rebates pmpm expected to be received for Part D-covered drugs.

✓ **Line 18, column q – Minus Rebates**

Enter the estimated total rebates pmpm expected to be received for non-Part D-covered drugs.

✓ **Line 20, columns m, o and q – Minus Other Insurance**

Enter, as a positive value, the projected reduction to average allowed amount pmpm attributable to other Rx insurance for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

✓ **Line 22, columns m, o, and q – Plus Part D as Secondary**

Enter, as a positive value, the projected plan liability pmpm for which the Part D plan is the secondary payer for Part D-covered drugs, reinsurance-eligible Part D-covered drugs and non-Part D-covered drugs in columns m, o and q, respectively.

SECTION V – DEVELOPMENT OF ACTUARIAL EQUIVALENCE TEST

Lines 1 through 8

The values are calculated automatically in the BPT from values in Section IV. The amounts in the first column are calculated based on the plan's risk score, while the amounts in the second column are based on a 1.000 risk score.

Line 9 – LIS

Enter the projected average low-income cost-sharing pmpm subsidy for the risk score of the expected population.

SECTION VI – TESTS FOR ALTERNATIVE COVERAGE

This section applies the six actuarial equivalence tests to certain values in Sections III through V to determine whether the proposed benefit plan qualifies as alternative coverage.

SECTION VII – DEVELOPMENT OF SUPPLEMENTAL PREMIUM**Lines 1 through 5 and 8**

The values are calculated automatically by the BPT from values in Worksheet 5.

Line 6 – Additional Non-Benefit Expenses

The value is carried from Worksheet 3.

Line 7 – Additional Gain/loss

The value is carried from Worksheet 3.

SECTION VIII – DEVELOPMENT OF INDUCED UTILIZATION ADJUSTMENT

This section summarizes the additional costs of DS coverage with respect to the enhanced alternative plan with supplemental benefits and is used to adjust allowable costs for risk corridor payments.

Line 2 – Impact of Alternative Utilization on Standard Benefit

Enter the additional costs for Part D-covered drugs under a DS plan in the first column if the utilization of the EA plan was used to price the DS coverage in the bid. The adjustment applies to the EA plan type only and must be a positive value.

PD WORKSHEET 6 – SCRIPT PROJECTIONS FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6 summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in different distributions of drug spending. In addition, Worksheet 6 illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, non-uniform deductible, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid. Part D sponsors must model the impact of the alternative benefit compared to the DS by making adjustments in utilization and average script pricing in Worksheet 6. The distributions must be based on the intervals defined for DS coverage. For purposes of modeling the alternative coverage, members must be reported in the claims interval in which they were reported under DS coverage even though their total drug spend may be different because of the impact of the alternative benefits. For example, lines 1 through 9 must reflect the utilization for the AE, BA or EA plan for members expected to have less than the DS ICL of \$2,960 in CY2015. In other words, the amounts summarized in columns i, j and k must be based on the same members represented in columns f, g, and h of each line.

Refer to the “Pricing Considerations” section of the Instructions for information on modeling the impact of coverage in the gap, decreased ICL and non-uniform deductible.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – PROJECTIONS FOR EQUIVALENCE TESTS

Data are collected for four levels of allowed costs on lines 1 through 36. The distribution of the population and Part D covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the deductible, coverage gap and LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 8 – Population Not Exceeding Allowed Costs of \$2,960 with Standard Coverage

All utilization for members with projected total allowed costs less than \$2,960 must be reported on these lines.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost-sharing structure of the DS plan by point-of-sale and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the population identified in Worksheet 3, Section III, cells D21 plus D22, using the cost sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 9, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 1 through 8 for each column.

Lines 10 through 17 – Population Exceeding Allowed Costs of \$2,960 with Standard Coverage

All utilization for members with projected total allowed costs greater than or equal to \$2,960 must be reported on these lines.

✓ **Columns f and g – Defined Standard Coverage**

Enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f and g, respectively, for each line.

✓ **Columns i and j – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts and total allowed dollars for the population identified in Worksheet 3, Section III, cells D23 plus D24 by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 18, columns f, g, i and j – Total

The values are calculated automatically in the BPT as the sum of lines 10 through 17 for each column.

Lines 19 through 26 – Population Exceeding \$2,960 with Standard Coverage Amounts Allocated up to ICL

All utilization for total allowed costs up to \$2,960 for members with projected total allowed costs greater than or equal to \$2,960 must be reported on these lines. These amounts are a subset of the amounts reported in lines 10 through 18; amounts in the gap are intentionally excluded.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts allocated up to the ICL of \$2,960 in CY2015, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts allocated up to the ICL, for the population identified in Worksheet 3, Section III, cells D23 plus D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible, coverage gap and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 27, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 19 through 26 for each column.

Lines 28 through 35, columns f through k – Amounts Allocated over Catastrophic Coverage

The amounts in these lines are a subset of the amounts reported in lines 10 through 18.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns f, g and h, respectively, for each line.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing, for amounts over the catastrophic limit, for the population identified in Worksheet 3, Section III, cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 36, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 28 through 35 for each column.

Line 37, columns i through k – Non-Part D-Covered Drugs All Spending

When the plan benefit type is EA and the plan covers non-Part D drugs, enter the projected total number of scripts, total allowed dollars and total cost sharing, for the population identified in Worksheet 3, Section III, using the cost-sharing structure of the EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug, in columns i, j and k, respectively, for each line.

Example

Below is an example of how lines 10 through 36 are to be completed. It is based on the CY2008 defined standard benefit parameters:

- Deductible: \$275.00
- ICL: \$2,510.00
- OOP Threshold: \$4,050.00
- Total Covered Part D Drug Spend at OOP Threshold: \$5,726.25

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		Cost Sharing
		Allowed		
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 used only when the Part D sponsor places Specialty drugs on a separate tier in accord with CMS guidelines.

Network Pricing

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

The values in this section must be based on the network pricing contracts that will be effective in CY2015 and on the projected weighted utilization by pharmacy of the population identified in Worksheet 3.

PD WORKSHEET 6A – COVERAGE IN THE GAP FOR DEFINED STANDARD, ACTUARIALLY EQUIVALENT OR ALTERNATIVE COVERAGE

Worksheet 6A summarizes drug utilization and costs by type of drug and point-of-sale (retail or mail order as defined by the PBP) in the coverage gap. As a continuation of Worksheet 6, Worksheet 6A illustrates the underlying assumptions used in the demonstration of the actuarial equivalence tests in Worksheets 4 and 5 and calculates the plan-specific prospective brand discount amount payment. Section II collects data in a manner that supports an actuarial comparison of the proposed AE, BA or EA plan benefit type to DS coverage.

CONSIDERATIONS

Although this worksheet is not a detailed model of the cost-sharing structure of the AE, BA or EA plan design, the impact of tiered cost sharing, non-uniform deductible, decreased ICL and benefit management programs on utilization must be clearly demonstrated. The distribution of utilization between generic and brand, and between retail and mail, must be reasonable given the proposed benefit. Significant changes to the alternative benefit are expected to result in meaningful differences in utilization when compared to the DS bid.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – SPENDING IN THE COVERAGE GAP

Data are collected for allowed costs in the coverage gap on lines 1 through 33. The distribution of the population and Part D-covered drug claims reported on Worksheet 3 must be used in completing this section. Columns f through h must be completed for all plans based on DS coverage; columns i through k must be completed when the plan benefit type is AE, BA or EA based on the alternative coverage. In developing the cost-sharing values in columns h and k, do not model the impact of the LIS subsidy. To model column h, use the cost-sharing structure of the DS plan; to model column k, use the cost-sharing structure of the alternative (AE, BA or EA) plan.

Lines 1 through 11, columns f through k – Amounts Allocated between \$2,960 and Catastrophic

The values are calculated automatically in the BPT.

Lines 12 through 21 – Low-Income Population Amounts Allocated between \$2,960 and Catastrophic

All utilization for LIS members with projected total allowed costs greater than \$2,960 and less than the catastrophic limit must be reported on these lines.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 22, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 11 through 21 for each column.

Lines 23 through 32 – Non-Low-Income Population Amounts Allocated between \$2,960 and Catastrophic

All utilization for non-LIS members with projected total allowed costs greater than \$2,960 and less than the catastrophic limit must be reported on these lines.

✓ **Columns f through h – Defined Standard Coverage**

Enter the projected total number of scripts, total allowed dollars, and total standard cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the DS plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns f, g and h, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy.

✓ **Columns i through k – Actuarially Equivalent or Alternative Benefits**

When the plan benefit type is AE, BA or EA, enter the projected total number of scripts, total allowed dollars and total cost sharing for the non-LIS population identified in Worksheet 3, Section III, cell D23 plus cell D24, using the cost-sharing structure of the AE, BA or EA plan by point-of-sale (retail or mail order as defined by the PBP) and type of drug in columns i, j and k, respectively, for each line. Calculate the cost sharing as if there were no deductible and LIS subsidy. These values include changes to utilization patterns based on the difference between DS coverage and the proposed alternative coverage.

Line 33, columns f through k – Total

The values are calculated automatically in the BPT as the sum of lines 23 through 32 for each column.

Non-LI Generics in Gap PMPM

The value is calculated automatically in the BPT.

Non-LI Brand Discount Amount PMPM

The value is calculated automatically in the BPT.

PD WORKSHEET 7 – SUMMARY OF KEY BID ELEMENTS

Worksheet 7 summarizes key payment-related components of the bid and the Part D sponsor's estimate of the national average monthly bid amount and calculates premiums.

SECTION I – GENERAL INFORMATION

This section displays the information entered on Worksheet 1, Section I.

SECTION II – 2015 DEFINED STANDARD BENEFIT PARAMETERS

Line 1 – Deductible

The cell is pre-populated with the deductible for the DS plan benefit type.

Line 2 – Initial Coverage Limit

The cell is pre-populated with the ICL for the DS plan benefit type.

Line 3 – Out-of-Pocket Limit

The cell is pre-populated with the OOP for the DS plan benefit type.

SECTION III – SUMMARY OF KEY BID ELEMENTS

Line 1 – Standardized Part D Bid

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 2 – National Average Monthly Bid Amount (NAMBA)

Enter the Part D sponsor's estimate of the national average monthly bid amount at the time of bid submission. The final national average monthly bid amount for CY2015 will be calculated and published by CMS in early August 2014.

Line 3 – Base Beneficiary Premium (BBP)

Enter the Part D sponsor's estimate of the base beneficiary premium amount. The national average monthly bid amount, basic Part D A/B rebate allocation reported on the MA BPT for MA plans and base beneficiary premium will determine the plan's basic Part D target premium.

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

The values are calculated automatically in the BPT. Line 4 is calculated as line 1 minus line 2 plus line 3. Line 5 reflects the value of the basic Part D premium from line 4 after the rounding rule selected on line 8 of this section has been applied. If the basic Part D premium is negative and the plan benefit type is DS, AE or BA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP. If the plan benefit type is EA, then the Part D sponsor is permitted to lower its estimate of the NAMBA and BBP or fully offset the negative basic premium with a supplemental Part D premium. The basic Part D premium, before and after the rounding rule is applied, will be updated based on the actual national average monthly bid amount and base beneficiary premium that are calculated and published by CMS in early August.

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

The values are calculated automatically in the BPT when supplemental benefits are offered. Line 6 is carried from Worksheet 5 of the BPT. Line 7 reflects the value of the supplemental Part D premium from line 6 after the rounding rule selected on line 8 of this section has been applied.

Line 8 – Prospective Federal Reinsurance (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 9 – Prospective Low-income Cost-Sharing Subsidy (Non-Standardized)

The value is carried from other worksheets in the BPT based on the plan benefit type (DS, AE, BA or EA).

Line 10 – Target Adjustment (Allowed Costs as a Ratio of Bid)

The target adjustment is the allowed cost percentage of the bid and it is used in calculating the target amount for risk corridor payments. The value is calculated as–

$[(1.00 - \text{administration cost percentage}) \times (\text{total direct subsidy payments} + \text{total beneficiary premiums related to the standardized bid amount})]$

Line 11 – Prospective Brand Discount Amount

The value is carried from Worksheet 6A of the BPT.

Line 12 – Rounding Rule

Select the option from the drop-down box that corresponds to the preferred method for rounding the Part D premium. The valid options are \$0.10 and \$0.50. MA-PD plans are required to round to the nearest \$0.10; Part D plans are permitted to round to either the nearest \$0.10 or nearest \$0.50.

SECTION IV – PART D BID PRICING TOOL CONTACTS AND DATE PREPARED

Part D sponsors must identify three persons as plan bid contact, Part D certifying actuary and additional Part D BPT contact. The Part D certifying actuary and additional Part D BPT contact must be readily available and authorized to discuss the development of the pricing of the bid.

In this section, enter the name, phone number and e-mail information for all three contacts; credentials are a required input for the certifying actuary. For the phone number, enter all ten digits consecutively without parentheses or dashes. Do not leave any part of this section blank.

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 desk review process, then this date field must be updated accordingly.

SECTION V – WORKING MODEL TEXT BOX

This section contains multiple cells that may be used by bid preparers to enter internal notes—for example, to facilitate communication between BPT and PBP preparers or to track internal version schemes.

Section V will be deleted from the finalized file and therefore will not be uploaded to HPMS. Bid preparers must not enter information in this section meant to be communicated to CMS or to CMS reviewers, as CMS will not have access to it. Section V will not be deleted from the working file or the backup file during finalization.

IV. APPENDICES

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 certify that 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 ...*
- ASOP No. 23, *Data Quality*.
- ASOP No. 25, *Credibility Procedures*.
- ASOP No. 41, *Actuarial Communications*.
- ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*.

The certifying actuary must also certify that the actuarial work supporting the bid complies with applicable laws, rules, “Instructions for Completing the Medicare Prescription Drug Plan Bid Pricing Tool for Contract Year 2015” and current CMS guidance. The actuarial work supporting the bid must be consistent and reasonable with respect to the plan benefit package.

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 and supporting documentation.
- 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 they may do so if they wish. Note that in the event that the PBP changes after the “final” bid is certified, the bid that is uploaded into HPMS with the revised PBP must be recertified whether or not the BPT changes.

Material changes to the certification language after the initial June certification submission are not allowed without prior written permission from the CMS Office of the Actuary.

Part D 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 must be followed by all actuaries who will be certifying CY2015 bids.

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

Every Part D BPT requires a certification.

Additional information regarding the actuarial certification process including technical instructions for completing the HPMS certification module will be provided in a forthcoming initial actuarial certification deadline memorandum released via HPMS.

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 MA and Part D bid submissions and meets the Academy’s qualification standards for doing so.
- The specific contract-plan-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 MA bid, the Part D bid or both.
- Attestation that the certification complies with the applicable laws,¹ rules,² 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/Part D enrollee with a national average risk profile.”
- Attestation that the data and assumptions used in the development of the bid are reasonable for the PBP.

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

- Attestation that the bid was prepared in compliance with 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.

Certification Module Access

Detailed instructions regarding how to apply for access to the CY2015 certification module are released via an HPMS memorandum regarding consultant access or electronic signature access to HPMS.

APPENDIX B – SUPPORTING DOCUMENTATION

GENERAL

In addition to the BPT and actuarial certification, Part D sponsors must provide CMS with supporting documentation for every bid, as described in these Instructions.

Unless otherwise noted, Part D sponsors must upload all required supporting documentation at the time of the initial June bid submission. Additional supporting documentation must be made available to CMS reviewers upon request, and within 48 hours of the request, as required by these Instructions. Part D sponsors must upload supporting documentation consistent with the final certified bid.

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

In preparing supporting documentation, the actuary must consider ASOP No. 41, *Actuarial Communications*. In accordance with Section 3.2, “Actuarial Report,” the materials provided must be written “with sufficient clarity that another actuary qualified in the same practice area could make an objective appraisal of the reasonableness of the actuary’s work.”

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 and additional Part D BPT actuarial contacts 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.
- Explain the rationale for the assumptions, including quantitative support and details, rather than just narrative descriptions of assumptions.
- Describe plan-specific variations in addition to the overall pricing assumption or methodology.
- Match the values entered in the current BPT and tie to the PBP.
- Include Excel spreadsheets, rather than pdf files, with working formulas and an explanation of the calculations and their components.
- Clearly identify if it is related to MA, Part D or both.
- Clearly identify the bid(s) relating to the support. At a minimum, the contract number and organization name must appear on the first page. Specific plan numbers must be included where appropriate, such as on the first page, in a separate chart or as an attachment.
- Include a hard-coded date.
- Include the contract-plan ID and topic in the beginning of the file name.

- Be labeled “revised” if any information in the file is revised or appended during bid desk review.

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

- Meeting minutes that include comprehensive documentation of discussions related to bid development.
- E-mail correspondence related to bid development.
- A complete description of data sources—for example, a report’s official name/title, 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:

- Materials that are accessed only through a secure server link that requires a password.
- 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 of the data points underlying the assumptions—for example, supporting factors, studies or public information.
- “Living worksheets” that are overwritten with current data. Supporting documentation must include the version of the worksheet that was 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 (.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 to multiple plans materials specific to a Part D plan, MA plan or certain contract ID.

Cover Sheet

To expedite the bid review process, Part D sponsors 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.” A cover sheet is required for each upload of substantiation.

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

Note that some documentation requirements apply to every bid (for example, every bid contains a risk score assumption), while other documentation requirements 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 bid IDs (such as “plans 001 – 030” or “all plans under contract Hxxxx”). For these items, the cover sheet must contain the exact bid IDs (contract/plan/segment) to which the documentation applies.

For subsequent substantiation uploads, the cover sheet must summarize the additional documents uploaded at that time (that is, the cover sheet must not be maintained as a cumulative list). The subsequent cover sheets must also contain the exact bid IDs rather than a “range” of bid IDs.

Sample check lists and cover sheets for the initial June bid submission, and for subsequent substantiation uploads, are provided at the end of this appendix.

Timing

Part D sponsors and certifying actuaries must prepare all supporting documentation at the time of the initial June bid submission so that it is immediately available to CMS and reviewers at initial bid submission or readily available upon request as explained below.

- The “Initial June Bid Submission” section of Appendix B describes supporting documentation materials that Part D sponsors must upload to HPMS with the initial June bid submission.
- The “Upon Request by CMS Reviewers” section of Appendix B describes materials that Part D sponsors and certifying actuaries must provide within 48 hours of request by CMS reviewers and upload to HPMS prior to bid approval.
- When a BPT is resubmitted, the Part D sponsor must upload a summary of changes, including the cause and effect of each revision, authorized by CMS or CMS reviewers. If multiple BPTs are resubmitted at the same time, the supporting documentation must include a mapping of specific bid changes and bid IDs.
- Prior to bid approval
 - Part D sponsors and certifying actuaries must revise supporting documentation consistent with the final certified bid. The upload of e-mail correspondence to HPMS alone does not satisfy this requirement.

- Part D sponsors must upload revised supporting documentation and e-mail correspondence supporting bid resubmissions to HPMS.

Initial June Bid Submission

The following documentation requirements apply to all bids (as all bids contain these assumptions):

- A cover sheet outlining the documentation files, as described above.
- A product narrative that offers relevant information about plan design, the product positioning in the market (such as high/low), enrollment shifts, changes in service area, type of coverage, contractual arrangements, marketing approach and any other pertinent information that would help expedite the bid review.
- A document titled “Related-Party Declaration” that states whether or not the Part D sponsor is in a related-party arrangement (Worksheets 1, 2 and 3).
- Support for sequestration’s effect on the bid, including a detailed qualitative and quantitative description of how it is reflected in pricing assumptions.
- Support for the claims credibility assumptions (Worksheet 2), including—
 - A statement of the credibility methodology used—for example, the CMS guideline or the CMS override.
 - A description of the credibility methodology used if it varies from the CMS guideline or the CMS override.
 - The method for blending differences in the credibility for utilization and unit cost into a composite pmpm credibility factor.
- A quantitative mapping in a spreadsheet format of allowed costs, effective cost sharing and script counts from the formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories used in pricing (Worksheets 2, 6 and 6A). The required elements include—
 - The PBP description of the deductible and copay/coinsurance structure by days supply, point-of-sale and claims interval.
 - Allowed costs, effective cost sharing and script counts by formulary tier within each claims interval based on the cost-sharing structure, including days supply and point-of-sale, specified in the PBP.
 - A quantitative description of the distribution of the allowed costs, effective cost sharing and script counts by formulary tier to each of the categories on Worksheets 6 and 6A.
- Support for non-benefit expense assumptions (Worksheet 2). The required elements include—
 - A reconciliation of the base period non-benefit expenses reported in Worksheet 1 of the BPT to audited material such as corporate financial statements and plan-level operational data.
 - A description of the administrative costs included in each non-benefit expense category in the BPT.
 - Detailed support for the development of projected non-benefit expenses. The required elements include—

- ▶ A description of the methodology used to develop non-benefit expenses.
- ▶ An analysis that demonstrates the development of each line item using relevant data, assumptions, contracts, financial information, business plans and other experience.
- ▶ A description of the relationship between the non-benefit expense line items reported in the BPT and audited material such as corporate financials and plan-level operational data.
- ▶ An explanation for significant differences between actual and expected non-benefit expenses for CY2011, CY2012 and CY2013, including a description of how that knowledge was incorporated into the contract year projection.
- Justification of the gain/loss margin (Worksheet 2). The required elements include—
 - The Part D sponsor's margin requirement for all non-Medicare lines of business, including any change in such requirement in the prior two years and identification of these lines of business.
 - Support for overall margin levels, including a description of the methodology used to develop gain/loss margin assumptions, the level at which overall margins are determined and demonstration of year to year consistency of projected margins.
 - A list of the Part D contract numbers offered by the organization, if aggregate gain/loss requirements are met at the organization level.
 - A demonstration of consistency between the projected aggregate margins for Part D and the actual aggregate returns over the long term. If the returns have been inconsistent historically, provide an explanation of how this is addressed in the current bid submission. For example, what pricing assumptions have been made to bring the projected margin closer to the actual returns?
 - For MA-PD plans, a description of the approach for setting the Part D margin in relation to the MA margin
 - A detailed explanation of the need for flexibility in the gain/loss margin requirements in order to satisfy other CMS requirements.
 - Support for bids with negative margins, including one of the following items:
 - ▶ For a new plan or a plan with a zero or positive projected gain/loss margin for the prior contract year, a bid-specific, year-by-year numeric business plan that demonstrates profitability within 5 years.
 - ▶ For a plan with a negative projected gain/loss margin for the prior contract year, a numerical comparison of the gain/loss margin to the margin in the original business plan The required elements include—
 - Details and sources of deviation from the original business plan.
 - An explanation and demonstration of how the targeted margin in the original business plan will be met, if the plan is progressing toward a positive margin more slowly than projected in the original business plan, including—
 - A revised business plan demonstrating that the plan will reach profitability within 5 years of the original business plan.

- A description of benefits reductions or premium increases for CY2015.
- A copy of the original business plan uploaded to HPMS in a separate file.
- The year that profitability will be achieved or the plan becomes part of a valid product pairing.
- A description of the product pairing that includes the gain/loss margin for each plan and shows that the plans have—
 - Identical service areas,
 - The same plan type, if an MA-PD plan, and
 - A positive combined gain/loss margin.
- A detailed justification for unique situations in which a business plan does not achieve profitability within 5 years, including—
 - A description of extenuating circumstances supporting an exception.
 - Evidence of the evidence of anti-competitive practices and solvency issues.
 - Actions taken to bring the margin differential into compliance with these Instructions.
- Justification of the margin for bids with relatively large projected overall gains including an explanation of how the PBP offers benefit value in relation to the margin.
- Support for bids with high margins including—
 - An explanation of a need for a contingency margin that correlates to the “risk” to the Part D sponsor, low credibility and/or significant claims variability from year to year.
- Detailed support for the development of projected risk scores (Worksheet 3). The required elements include—
 - A detailed description and corresponding numerical demonstration of the methodology used to develop projected CY2015 Part D risk scores.
 - A description of the source data for the development of the projected CY2015 Part D risk scores.
 - A description of all projection factors and the basis for the factors.
 - A statement about the consistency between the development of the projected risk scores for the plan population and the development of projected prescription drug expenses.
 - A demonstration that the method used is consistent with the preferred development approach in these Instructions, including an explanation for using an alternate approach.
 - Justification for and a description of the credibility assumption for actual plan risk scores.

The following documentation requirements apply to all bids that contain these specified assumptions:

- Detailed qualitative and quantitative support for the development of the base period experience (Worksheet 1). The required elements include—
 - A description of the source data, such as a list of the CMS return files that were used in the compilation of the PDEs.
 - Any applicable adjustments, stated as absolute values or percentages, to the source data, including considerations for—
 - Accepted PDEs.
 - Rejected PDEs expected to be accepted by CMS upon resubmission.
 - P2P transactions.
 - Transfer of OTC drug data from the base period experience to the non-benefit expense component.
- Reconciliation of base period experience to the Part D sponsor's audited financial statements and bid-level operational data (Worksheet 1). The data are to be reported on an incurred, rather than an accounting or GAAP, basis, including both claims paid, unloaded claim reserves, non-benefit expenses and revenues. Because the results reflect an experience period versus accounting period, the data need not be based on an audited GAAP financial basis.
- Detailed qualitative and quantitative support for the development of the rebates and all other types of direct and indirect remuneration (DIR) (Worksheets 1 and 3).
- Detailed qualitative and quantitative support of the development of each trend projection factor (Worksheet 2). The required elements include—
 - A description of the source data, including the data's relevance to the Part D plan.
 - A summary of the Part D sponsor's historical trends including—
 - The percentage trends.
 - A description of the methodology used to analyze the data.
 - The numeric calculations.
 - Any applicable adjustments to the source data, such as considerations for—
 - Part D sponsor's experience.
 - PBM reports and contracts.
 - Industry and/or internal studies.
 - Formulary analysis.
 - Benefit design analysis.
 - An explanation for how the knowledge of significant differences between actual and projected claims for recent contract years has been incorporated into the projection factors.
- Detailed support for the manual rate development (Worksheet 2), including a description/illustration of the underlying data source(s) and data/methodology used in the development of the manual rates, if manual rates are used. The required elements include—

- A description of the source data, including the data's relevance to the Part D plan.
- Credibility standards applied to the data and corresponding adjustments, if applicable.
- Consideration of any adjustments made for annual volatility of the source data.
- Any applicable adjustments to the source data, such as—
 - Approach and factors applied to account for incomplete claim run-out, formulary differences and/or expenditures that are not reflected in the source data;
 - Techniques and factors used to reflect differences between the underlying population and that expected of the Part D plan; and
 - Techniques and factors used to adjust for differences in plan design between the source data and the Part D plan.
- Data and methodology used to project the data from base period to CY2014.
- A description of the source of data for the development of corresponding CY2015 risk scores and how that source compares to the risk profiles of the population underlying the manual rate source data.
- All other applicable factors and/or adjustments.
- Detailed support for related-party arrangements (Worksheets 1, 2 and 3).
 - A Part D sponsor in a related-party arrangement must provide the following:
 - Declaration of every related-party arrangement.
 - Disclosure of all services provided in every related-party arrangement.
 - A summary that explains the relationship of the parties involved and common ownership, control and investment.
 - A summary of the contractual terms of each relationship that includes a description of the services provided and money exchanged.
 - Disclosure of the method used in preparing the bid for each arrangement. The options are Actual Cost Method for Administrative Services, Actual Cost for Benefit Costs, Market Comparison through Part D Sponsor Method and Market Comparison through Related Party Method.
 - Supporting documentation for each arrangement, as outlined below.
 - A Part D sponsor that chooses the Actual Cost Method for Administrative Services must—
 - Provide a qualitative and quantitative summary of the development of the related party's non-benefit expense and gain/loss margin.
 - A Part D sponsor that chooses the Actual Cost Method for Benefit Costs must—
 - Provide a qualitative and quantitative analysis of the development of the related party's gain/loss margin reflected in the benefit costs, where the related party's gain/loss margin is defined as the allowed amount entered in the BPT less the cost of purchasing pharmaceuticals and dispensing prescriptions. The gain/loss margin must be reconcilable to the related party's audited financial statements.

- A Part D sponsor that chooses the Market Comparison through Part Sponsor Method must—
 - Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from what is achieved in the absence of the related-party relationship.
 - Show that results of pricing at least two quarters of the Part D plan's experience through the related and unrelated party contracts are within plus or minus five percent. All terms of each of the contracts must be included when pricing the plan's experience.
 - Demonstrate that the contracts with the unrelated parties are associated with sufficient costs to be considered valid contracts.
- A Part D sponsor that chooses the Market Comparison through Related Party Method must—
 - Provide an analysis that clearly explains the terms of each contract in the comparison and how the financial results are not significantly different from what is achieved in the absence of the related-party relationship.
 - Show that results of pricing at least two quarters of the Part D plan's experience through the related and unrelated party contracts are within plus or minus five percent. All terms of each of the contracts must be included when pricing the plan's experience.
 - Demonstrate that the contracts with the unrelated parties are associated with sufficient costs to be considered valid contracts.
 - Provide a signed attestation from the related party stating that the actual contracts will be available for review upon request by CMS.
- Detailed quantitative support of the development of the induced utilization factor (Worksheet 5).
- The input sheet(s) for the pricing model used in the development of the bid.
- An explanation of and detailed support for how CY2014 bid audit findings and observations and compliance issues were corrected in the current bid for the same plan. To the extent that an issue applies to other plans in the same contract or parent organization, the documentation for the audited plan must describe how the bids for all plans are treated consistently regarding that issue.
- Support for reliance on information supplied by others that—
 - Identifies the source(s) of the information—for example, name, position, company, date;
 - Identifies the information relied upon;
 - States the extent of the reliance—for example, whether or not checks as to reasonableness have been applied; and
 - Indicates to which plan(s) the reliance information applies.

See the sample format at the end of this appendix.

Upon Request by CMS Reviewers

It is not required that the items below be uploaded with the initial June bid submission, but they must be prepared at that time in order to be readily available for CMS reviewers upon request. If substantiation is requested by CMS reviewers, it must be provided by the certifying actuary or additional Part D BPT contact within 48 hours. These materials will be reviewed at audit:

- Copies of related-party contracts.
- A letter supporting any information upon which the certifying actuary relied, if applicable. This letter must be signed by the person (source) who provided the information.
- An explanation of how certain findings from the Office of Financial Management (OFM) audit were addressed in the current bid.
- Communication between CMS reviewers and the Part D sponsor throughout the bid review process (that is, e-mail communication) that was not uploaded to HPMS during bid review.

Additional information not specified in this list may be requested by CMS reviewers, as needed, at any point during the bid desk review process.

PART D CHECKLIST FOR REQUIRED SUPPORTING DOCUMENTATION

Initial June Bid Submission – Required for All Bids
Cover sheet
Product narrative
Related-party declaration
Claims credibility assumption
Sequestration assumptions
Mapping of allowed costs, script counts and cost sharing in formulary tiers to type-of-drug and point-of-sale (retail or mail order as defined by the PBP) categories
Non-benefit expenses
Gain/loss margin
Projected risk scores
Initial June Bid Submission – Required for All Bids with Specified Assumptions
Base period experience and projections
Reconciliation of base period experience to company financial data
Rebates – base period and contract year
Manual rate development
Trend projection factor development
Disclosure of related-party arrangements
Induced utilization factor development
Input sheet(s) for pricing model

APPENDIX B

Related-party arrangements
Bid audit results and compliance issues
Reliance information
Upon Request by CMS Reviewers
Related-party contracts
Reliance letter
OFM audit results
Bid review communications
Other

SAMPLE COVER SHEET – SUBMITTED WITH INITIAL BID UPLOAD**Supporting Documentation Cover Sheet****CY2015 Bid Submission****Organization Name:** Health One**Contract(s):** H1234, H9999 and S9999**Date:** June 2, 2014

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 Sheet 6-2-14.pdf	Page 1	both
Product narrative	All bids	Cover Sheet 6-2-14.pdf	Pages 2-4	both
Credibility assumption	All bids	Cover Sheet 6-2-14.pdf	Page 5	both
Cost sharing mapping	All bids	Cover Sheet 6-2-14.pdf	Page 6	both
Non-benefit expenses	All bids	AdminProfit.xls	Sheet1	both
Gain/loss margins	All bids	AdminProfit.xls	Sheet2	both
Risk scores	All bids	Risk CY15.xls	MA-Sheet 1 PD-Sheet 2	both
Related-party declaration	All bids	Cover Sheet 6-2-14.pdf	Page 7	both
Sequestration	All bids	Cover Sheet 6-2-14.pdf	Page 7	both
Manual rates	H1234-003-0 S9999-001-0	Manual.xls	Section II	PD
ESRD subsidy	H1234-001-0 H1234-004-0	Manual.xls	Section I	MA

SAMPLE COVER SHEET – SUBMITTED AS A SUBSEQUENT SUBSTANTIATION UPLOAD**Supporting Documentation Cover Sheet #2****CY2015 Bid Submission****Organization Name:** Health One**Contract(s):** H1234, H9999, and S9999**Date:** July 16, 2014

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	Cover Sheet 7-16-14.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	E-mail2.doc	n/a	PD
E-mail communication with CMS bid reviewers	H9999-001-0 S9999-001-0	E-mail3.doc	n/a	PD

SAMPLE FORMAT FOR RELIANCE ON INFORMATION SUPPLIED BY OTHERS

Bid ID	MA or PD or Both	Source (Name, Position, Company)	Type of Information	Comments
H1234-002-00	MA and PD	Joe Smith, Director of Finance, ABC Health Plan	Administrative expenses, gain/loss margin	
H1234-002-00	MA and PD	Jane Doe, Medicare Analyst, ABC Health Plan	Claim modeling, risk score	I have not performed any independent audit or otherwise verified the accuracy of these data or information.

APPENDIX C – EMPLOYER/UNION-ONLY GROUP (EGWP) REQUIREMENTS

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (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 DS benefit and receive a retiree subsidy of 28 percent of a retiree’s drug costs between \$320 and \$6,600;
- 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 to employer/union-only groups that contract directly with CMS to become a PDP.

For CY2006, CMS issued guidance that waives or modifies many of the requirements for these entities. All of the standard Part D bidding guidelines apply, with the exception of those specifically waived.

For CY2015, CMS does not require a Part D BPT for employer/union-only group plans.

For additional information on CY2015 EGWP bidding policy, please refer to the CY2015 Call Letter.

APPENDIX D – CALCULATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT

For CY2006, the national average monthly bid amount was calculated using equal weighting applied to all PDP sponsors, and MA-PD plans were assigned 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 CY2007 and CY2008, 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 CY2007 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 CY2008, 40 percent of the calculation was based on the uniform-weighting average and 60 percent was based on an enrollment-weighted average. The demonstration was no longer in effect for CY2009 and the benchmarks were based on the 2008 enrollments applied to the 2009 bids. The CY2015 benchmarks will be based on the 2014 enrollments applied to the 2015 bids.

The following table illustrates the impact of the weighted enrollment methodology for two enrollment periods, June 2013 and February 2014. Recall that the 2014 benchmark was calculated as 100 percent of the enrollment-weighted approach.

The same values are presented based on the February 2014 enrollment. Since the 2015 benchmarks will be based on 2014 enrollment, these values may be useful for estimating the 2015 benchmarks. The left section of the table shows the actual 2014 benchmarks, which were calculated based on June 2013 enrollment. The right section, titled “February 2014 Enrollment,” indicates how the 2014 benchmarks would have been calculated based on more current enrollment data.

	Enrollment Weighted Approach	
	June 2013 Enrollment	February 2014 Enrollment
National average monthly bid amount	\$75.88	\$74.36
Base beneficiary premium	\$32.42	\$31.59
Direct subsidy	\$43.46	\$42.77

This illustrative recalculation of the 2014 benchmarks is provided for the purpose of assisting Part D sponsors in developing the projected 2015 national average monthly bid amount and base beneficiary premium, which will be used in the calculation of the plan’s target premium. The final 2015 benchmarks will be based on the 2014 enrollments applied to the 2015 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-PDs were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PDs were assigned a zero weight. For CY2007, 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.

For CY2008, 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), as described below:

- 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 were weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, were 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.

For CY2008, the regional low-income benchmark amount was based on 50 percent of the first component and 50 percent on the second component, as described above.

For CY2009, the “Medicare Demonstration to Transition Enrollment of Low-Income Subsidy Beneficiaries” and the de minimis policy were not in effect. The regional low-income benchmark amounts were calculated based on 100 percent of the weighted LIS enrollments.

For CY2010, the “Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation” established that the regional low-income benchmark amounts, based on 100 percent of the weighted LIS enrollments, would be calculated using the Part D premiums for MA-PD plans before they were reduced by any applicable MA A/B rebates.

For CY2011 and subsequent years, in accord with the codification of the “Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation”, the weighted average premium amounts will be calculated using the Part D premiums for MA-PD plans before they have been reduced by any applicable Part A/B rebates.

The following table illustrates the impact of calculating the regional low-income benchmark amounts based on 100 percent of the weighted LIS enrollments for two enrollment periods, June 2013 and February 2014.

PD Region	State(s)	Enrollment Weighted Approach	
		June 2013 Enrollment	February 2014 Enrollment
01	NH, ME	\$27.78	\$26.84
02	CT, MA, RI, VT	\$27.99	\$27.54
03	NY	\$37.23	\$36.03
04	NJ	\$37.10	\$36.73
05	DE, DC, MD	\$32.34	\$30.46
06	PA, WV	\$35.50	\$35.20
07	VA	\$29.34	\$28.05
08	NC	\$28.28	\$27.53
09	SC	\$33.87	\$30.40
10	GA	\$29.32	\$26.46
11	FL	\$22.13	\$22.01
12	AL, TN	\$29.67	\$28.54
13	MI	\$32.46	\$30.22
14	OH	\$28.93	\$28.46
15	IN, KY	\$34.95	\$32.92
16	WI	\$37.03	\$35.30
17	IL	\$28.59	\$28.12
18	MO	\$31.21	\$30.30
19	AR	\$30.03	\$28.03
20	MS	\$30.56	\$30.10
21	LA	\$31.75	\$31.41
22	TX	\$27.73	\$26.93
23	OK	\$30.18	\$29.40
24	KS	\$34.21	\$31.75
25	IA, MN, MT, ND, NE, SD, WY	\$32.23	\$31.18
26	NM	\$19.92	\$19.97
27	CO	\$26.90	\$26.09
28	AZ	\$27.49	\$27.40
29	NV	\$22.78	\$22.24
30	OR, WA	\$34.82	\$34.36
31	ID, UT	\$39.02	\$38.37
32	CA	\$28.10	\$27.01
33	HI	\$25.69	\$24.45
34	AK	\$37.07	\$31.41

APPENDIX F – HEALTH CARE REFORM

PROVISIONS

The following provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 apply to Part D bids for CY2015.

Coverage in the Gap

A phase-in approach will be implemented to reduce beneficiary cost sharing in the coverage gap from 100 percent to 25 percent in CY2020. In CY2015, beneficiary cost sharing is reduced from 72 percent to 65 percent for non-applicable (generic) drugs; the Part D sponsor's liability for DS coverage is increased to 35 percent. Beneficiary cost sharing is reduced from 47.5 percent to 45 percent of the negotiated price for applicable (brand) drugs and 45 percent of the dispensing fee and vaccine administration fee, if any. Pharmaceutical manufacturers will provide a 50 percent discount off of the Part D sponsor's negotiated price of the brand-name drug at the point-of-sale. Ninety five percent of the negotiated price of the drug and 45 percent of the dispensing fee and vaccine administration fee, if any, will count toward the beneficiary's TrOOP; the Part D sponsor's liability is 5 percent plus 55 percent of the dispensing fee and vaccine administration, if any. Applicable drugs are defined in Section 1860D-14A(g)(2) of the statute and are covered Part D drugs that are either approved under a new drug application (NDA) under Section 505(b) of the Federal Food, Drug, and Cosmetic Act or, in the case of a biologic product, licensed under Section 351 of the Public Health Service Act (BLA). Non-applicable drugs are covered Part D drugs that do not meet the definition of an applicable drug.

These coverages apply to beneficiaries who, on the date of dispensing a covered Part D drug, are enrolled in an MA-PD or PDP plan, are not enrolled in a qualified retiree prescription drug plan, are not entitled to the low-income subsidy, have reached or exceeded the ICL and have not exceeded the TrOOP threshold.

Low-Income Premium Subsidy Amounts

The approach to determine the low-income premium subsidy amounts that was established in the "Medicare Demonstration to Revise Part D Low-Income Benchmark Calculation" and approved on August 11, 2009 was codified. Therefore, the weighted average premium amounts will be calculated for MA-PD plans using the Part D premiums before they have been reduced by any applicable MA A/B rebates.

Income-Related Part D Premium

Similar to Medicare Part B, an income-related premium is established for Part D beneficiaries with modified gross income greater than specified income thresholds. The income thresholds for CY2012 through CY2019 are \$85,000 per individual and \$170,000 per couple. The Part D income-related monthly adjustment amounts will be collected by the federal government and will have no impact on the direct subsidy payments received by Part D sponsors.

APPENDIX G – TRENDING RISK SCORES

This appendix includes the following considerations for trending Part C and Part D risk scores.

- Include the most recent annual consecutive calendar risk scores that are available.
- Use raw risk scores, that is, not normalized and not adjusted for MA coding patterns.
- Reflect the same amount of paid claims run-out for each year's risk scores.
- Use final risk scores from each year or apply a completion factor to the last set of scores to approximate a final score.
- Use the same cohort for each year (e.g., the July cohort).
- Use the same model to estimate all payment year scores. If possible, use the risk adjustment model for the upcoming payment year or apply a conversion factor to each payment year's risk scores to convert to a single risk model.
 - The model conversion factor should be plan-specific. It can be generated from the risk scores that CMS sends to Plan sponsors to support bidding; however, Plan sponsors should also consider whether other years in their trends have a different conversion factor (e.g., when the population mix differs).
 - The conversion factor can be derived by calculating risk scores from a year under two different models. The factor can be a ratio of the scores under each model.
 - The risk scores should have the same run-out and be calculated using the same cohort.
 - Plan sponsors should note that when converting risk scores from one model to another, a conversion between denominator years is, more than likely, occurring also. The risk scores in the conversion factor should be raw if the factor will be applied to an old model raw risk score, which is then projected to the payment year.
- Divide cohorts into meaningful subgroups using the same considerations used to determine allowed costs and project enrollment in each subgroup to the payment year.
- Weight subgroup risk scores by enrollment in each subgroup per year to determine annual risk scores for trending.
- Compare year over year risk scores to obtain a trend factor. Unless the Plan sponsor is anticipating changes in coding efforts or population characteristics, more than two years of risk scores will help minimize the effect of random changes in coding patterns and enrolled population. If deviations from previous trend are expected in the payment year, provide justification for such changes in the supporting documentation.
 - If starting with base year risk scores that are blended, Plan sponsors are to assess whether there are plan-specific risk score trends unique to each model and adjust their overall trend accordingly.

- Use this trend factor to project from base period risk scores to payment (contract) year raw risk scores.

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 12 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
